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Mini Review

The Oncologist-Cancer Patient Relationship and Emotions

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Abstract

Although there may be different theoretical frameworks for cancer care, this research should focus both on theory and on the ways or methods by which knowledge is generated, and thus, methodologies that allow for understanding emotions and relationships should be used. In summary, in a specialized clinical context like oncology, the patient needs to understand what "cancer" is, along with what it means to "have cancer." This involves changing their lifestyle and quality of life, attending regular checkups, and receiving treatments that are either long and invasive or short and less invasive, depending on the stage of the disease.

Keywords: doctor-patient relationship; emotions; communicative interaction; cancer patient

Introduction

The doctor-patient relationship has been described as “a consensual relationship in which the patient consciously seeks the doctor's assistance and in which the doctor consciously accepts the person as a patient” [1]. The doctor-patient relationship is a complex phenomenon encompassing several aspects, such as communication, patient participation in decision-making, and patient satisfaction. Furthermore, this relationship varies according to the type of health problem [2-6]. Thus, depending on the psychosocial aspects of illnesses, the doctor-patient relationship can differ. The doctor-patient relationship in oncology has special, highly intense connotations, characterized by a profound emotional charge, the need for honest and continuous communication, and an empathetic approach to the fear of death. It is based on a bond of trust necessary to cope with uncertainties, which requires greater involvement, emotional support, and often the inclusion of the family environment [7]. Communication between the doctor and the patient involves both technical and relational content. It may seem that technical content is neutral or unrelated to the doctor-patient relationship and to emotional or psychological factors; however, this is false. Medical work can be understood as a psychophysiological process of the doctor-patient relationship through which both can influence each other's health [8].

The doctor-patient relationship in oncology has very specific nuances, marked primarily by the emotional burden and the uncertainty of the diagnosis. Some of these are:

1. Communicating “Bad News” and Countertransference: Unlike other pathologies, the word “cancer” is often culturally associated with an incurable disease, generating a profound initial state of fear in the patient. This requires the physician to also be an emotional manager capable of conveying security and confidence from the first contact. Doctor-patient relationship models [9] in oncology are more dynamic than in other situations, and can shift from an Active-Passive model to an Orientation-Cooperation model, and then to a Mutual Participation or “patient-centered” model, depending on the stage of the disease. Oncologists often have to deliver bad news to their patients [10]. Giving a cancer diagnosis is a complex moment for the oncologist, who may experience a mixture of professional and human emotions, including sadness, helplessness, anxiety, disbelief, and even, at times, anger or fear in the face of the severity of the disease. This means that oncologists often feel overwhelmed and exhausted by these tasks, experience little confidence in their communication skills, and approach such tasks with a degree of apprehension. This situation becomes even more stressful when the physician is inexperienced, the patient is young, or the prospects for successful treatment are unfavorable. These reactions are normal and often arise from empathizing with the patient's suffering. To manage these situations, professionals often rely on protocols that structure communication to reduce stress for both the physician and the patient [11]. Countertransference in oncology refers to the unconscious emotional reactions that the physician experiences toward the patient. When delivering bad

news, these responses can drastically influence the quality of care and the professional's well-being [12-14]. Some common ways in which this countertransference manifests are: Desires for "Salvation" or Heroism; Projective Identification (If the patient is of a similar age or life situation to the doctor, for example, a young father, the oncologist may identify too strongly with him. This can lead to: Over-involvementm losing the clinical distance necessary to make objective decisions; Avoidance: Becoming excessively cold or technical to protect himself from the pain caused by this emotional closeness; Inappropriate Guilt and Responsibility (this manifests as difficulty looking the patient in the eye, giving information ambiguously or in an overly optimistic way to "soften" the blow); Rejection or Irritation (if this countertransference is not identified, the doctor may become defensive or shorten the consultation time to avoid conflict).

2. Emotional Management and Empathy: The doctor-patient relationship is often emotionally overwhelming, requiring a focus on empathy, respect, and sometimes mental health support. Empathy, a central characteristic of the doctor-patient relationship [15], must be conceptualized within a broader biopsychosocial approach [16] that includes (in addition to assertiveness) other interconnected psychological phenomena that occur in the consultation, such as transference and countertransference, and the placebo effect [17-19]. Two major types of empathy are considered: cognitive empathy, which involves anticipating what others are thinking, and emotional empathy, which involves sharing emotions [20]. The physician's empathy and assertiveness depend on multiple factors, some related to the physician, others to the patient, others to the illness, and still others to the situation. Acute illness typically has a relatively rapid onset and a short course, lasting days, weeks, or months. Typically, acute illness presents with a clinical picture characterized by clear and obvious manifestations that distress the patient and readily capture the physician's attention. These manifestations appear as bodily symptoms, perceived by the patient as sensory or sensitive sensations (pain, dyspnea, asthenia, tremor, pruritus, paralysis, etc.) that are expressed both in their own body and in their vivid and insightful narrative, reflecting their deep emotional involvement in the situation. In chronic illness, there is a long evolution with the appearance of less obvious, more subtle symptoms, less clinically pronounced. Furthermore, the person with a chronic illness has a different experience of the illness and a different pathobiographical content than the acute patient. Therefore, a prudent conclusion is that, in acute illness, the empathy shown by the physician is emotional, while in chronic illness it is primarily cognitive [21]. In cancer care, both phases can overlap, or have a dynamic evolution.

3. Therapeutic Alliance and Decision-Making: The patient's active participation in their treatment is prioritized, based on their right to know about their illness. However, as mentioned before, there may be nuances in the relationship model - from Active-Passive model to an Orientation-Cooperation model, and then to a Mutual Participation - depending on the phase of the disease, the specific circumstances of the cancer treatment, and the patient's personality, emotional state, and context.

In any case, it should be noted that the bond between oncologist and patient is not dyadic, thought it may appear to be so. It is, at least, in part, defined by many relationships outside the consulting room. Thus, the triad Doctor-Patient-Family must be taken into account. In oncology, the relationship is rarely just between two people. The family environment takes on a leading role, acting as essential support and confidants. Communication must be open with all those involved to avoid burnout and facilitate joint decisions [22, 23]. Finally, it is important to highlight that research on the oncologist-cancer patient relationship is crucial, since empathetic, safe, and honest communication improves treatment adherence, reduces anxiety, and increases patients' quality of life and survival. This relationship, based on mutual trust, fosters teamwork among doctor, patient, and family, which is fundamental for coping with the disease. Although there may be different theoretical frameworks for cancer care, this research should focus both on theory and on the ways or methods by which knowledge is generated, and thus, methodologies that allow for understanding emotions and relationships should be used. In summary, in a specialized clinical context like oncology, the patient needs to understand what "cancer" is, along with what it means to "have cancer." This involves changing their lifestyle and quality of life, attending regular checkups, and receiving treatments that are either long and invasive or short and less invasive, depending on the stage of the disease. In this way, they solidify a new communicative experience in their memory to mentally represent an oncological clinical context. Consequently, the importance of communicative interaction between doctor and patient during cancer treatment must be emphasized. Furthermore, the doctor may feel powerless and frustrated when treating incurable diseases if this is associated with displaced anxieties from other professional or personal situations, and this can hinder the verbal and nonverbal communication necessary to meet the patient's needs. The oncologist-patient relationship is a long-term one. The oncologist often becomes the primary provider of care, accompanying the patient through relapses, chronic treatments, and sometimes palliative care focused on pain relief and listening to fears.

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