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Editorial

# The difficult doctor–patient relationship

## A difícil relação médico-paciente

Our relationship with patients is close, technical and professional. Close, because we deal with personal problems in their lives; technical, in order to give the correct dimensions to their complaints and the consequences; and professional, so that we can guide patients regarding the best therapeutic choice. We are always in a situation of superiority, since we have been sought to solve problems that only we can solve. No other service provision relationship is anything like this. This is perhaps the reason why this relationship is so complex.

Fortunately, this relationship usually has a positive balance and we experience it through a mixture of friendship and admiration, which is life-long. The best source of patients is referrals from other patients.

A small but highly dangerous proportion of the patients that we attend may create situations of fantasy and generate serious problems for our professional activity. These situations may be created due to psychiatric problems that we, because of our objective training, prefer to ignore.

The line between psychiatric disorders and character failures is tenuous and sometimes these states overlap.

A study published in *RBO* 48(4), on factitious hand injuries, reported the worst manifestation of this pathological relationship between a doctor and his patient, in a very interesting manner. In this, the patient causes injuries to his or her own body and maintains them, which adds great difficulty to the diagnosis and treatment.

There are many descriptions of patients who cause symptoms such as ulcerative lesions, edema due to a tourniquet, bleeding due to wounds made by sharp instruments, introduction of needles into subcutaneous tissues, and so on. There is an intermediate situation that is less serious, in which an enormous range of patients simulate symptoms, refuse therapeutic actions and hold the doctor responsible for the worsening of their symptoms. These situations are described in psychiatry as the SHAFT syndrome (*sad*, *hostile*, *anxious*, *frustrating* and *tenacious*), in which patients describe symptoms that do not exist or place absurdly high value on symptoms that they present. In some cases, based on other people's symptoms, they may describe a set of symptoms that are totally nonexistent. Such patients generally seek out many doctors and undergo a variety of procedures.

Another syndrome is Münchausen, which has been known for many years. This description is given to patients who lie about their symptoms and deceive their doctors. It was first described in 1950 by Asher, who gave it this name in "homage" to Baron Münchausen, a nobleman who was well known for his tall stories. There are also descriptions of "Münchausen by proxy", in which a relative or caregiver of the patient simulates symptoms, for example by heating up the thermometer to simulate a feverish state.

It is always of interest to recall these disorders, which either due to psychiatric disorders or due to character failures may occur in patients who seek our assistance. These patients signify much more than diagnostic variation: they may give rise to a severe risk to our professional activity, since they may hold us responsible for complaints that lay people have difficulty in recognizing as nonexistent.

A lay person, even if he is a judge of law, will never contest a complaint by a patient who says that she is suffering from lumbar pain that has been stopping her from going to the bathroom for weeks (which was described recently in one of those television magazines), like so many other symptoms that we grow tired of hearing about but are unable to observe:

- My knee swelled up like a pumpkin and now it is not swollen;
- My hand went numb and I cannot move my arm;
- I spent the night howling with pain in my back;
- I took this medicine and it was like water;
- I suffered a lot with an infection that has now gotten better all on its own.

In the eyes of lay people, patients with complaints are always right and are always victims of doctors with little dedication.

We are the only ones who are able to and know how to clearly distinguish the intensity of a symptom and

therapeutic effect of a medication, and other absurd manifestations that are described. Only our acceptance makes these situations real and capable of harming the colleague who preceded us. When a colleague speaks badly of another to a patient, everyone loses: the patient, because he or she does not know who to believe; the doctor who is spoken of badly, for obvious reasons; and the one who speaks badly of others, because this generates insecurity in patients.

Patients who are not made aware that their symptoms are absurd will persist in endless peregrinations, which may end up in disastrous procedures. In *RBO* 22(10), in 1987, I published a case series of young female patients with uncharacteristic and sometimes absurd pain in their knees who underwent countless surgical procedures. One of them had more than ten operations!

We know that, unfortunately, the formula of patient with fantasies plus unscrupulous doctor leads to serious harm for the patient, for correct colleagues and, by extension, for medicine.

We do not know whether there is a solution for perverse or psychologically ill patients, but we know what is real and what is a lie in the doctor–patient relationship. The only way for us to protect ourselves and protect our patients is to keep our relationship *close*, *technical* and *professional*, to debunk complaints based on fantasy and not to accept untrue comments from colleagues who precede us in attending patients.

Acceptance of defamation from a colleague is to enroll on the list as the next person to be spoken of badly.

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