

# PHYSICIAN'S CHALLENGES IN THE RELATIONSHIP WITH THE PATIENT AND HIS WORK: HUMANIZING THOSE WHO ARE DEHUMANIZED

Francisco Lúcio Sátiro Maia Pinheiro<sup>1</sup>

**Abstract:** Doctors and other health professionals have gained wide prominence in society since the dawn of civilization. However, with the COVID-19 pandemic, the whole society has noticed the wide importance of the work of doctors, nurses and other health professionals. In this aspect, it is valuable to discuss the relationship between physician and patient and the aspects that impact on this issue. Thus, the general objective of this work is to analyze the variables and considerable aspects existing in the relationship between physician and patient and the existing challenges. The research methodology used was qualitative research. Thus, data collection was performed with bibliographic research in national databases. This work concludes with the premise that there are several challenges in the relationship between doctor and patient, among these as the patients and difficult families, the long working hours and precarious working conditions, the disregard of the humanity of the doctor and his consideration as a kind of machine and not as a professional who is, above all, a human being.

**Keywords:** Challenges. Humanization. Doctor. Patient.

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<sup>1</sup> Graduado em Direito pelo Centro Universitário Católica de Quixadá e pós graduado em Direito Médico pela Faculdade Verbo Educacional



## INTRODUCTION

The objective of this work is to launch a new look at the already much-debated relationship between the physician – as well as other health professionals – and his patient, addressing several aspects somewhat neglected in much of the work that proposes to analyze this relationship. The doctor-patient relationship has long been debated and the paradigm that for a long time guided this relationship has been reviewed, with the physician in the paternalistic condition of master of the situation in the face of a passive and hyposufficient patient.

Many works have already been done, several works have been written, countless articles have already set out to address this relationship. However, such works generally sinned either by excess or by omission in relation to some aspects that govern these meetings, sometimes focusing on a stereotyped image of the doctor, sometimes omitting certain traits and even the responsibility of the patients who should focus.

The present work was born for this, as a result of the scarcity of a more holistic and detailed analysis of the coexistence between health professionals and their patients. It does not, of course, aim to exhaust this topic, but wishes to focus on aspects that have not yet been sufficiently addressed.

The analysis of the doctor-patient relationship cannot be done well by addressing only superficial and unilateral aspects that lack the most insistent focus on only one of the subjects of this relationship – usually the physician – disregarding other aspects in the other subject of this encounter. The dynamics of this relationship requires that both the physician in his most varied characteristics be taken into account and the patient in his, since in the encounter between the two, these characteristics and states will interfere.



The nineteenth and twentieth centuries saw a substantial change in the vision of the interaction between the doctor and the patient, a change that was quite late in view of the fact that the figure of the doctor spent millennia involved in a kind of mystical golden age and at the same time was the heart of an ironic contradiction, in which the doctor, depositary of all the hopes of those who already felt deprived of it, It was seen with the last ratio, beyond which nothing more could be done.

For this same reason, it could not or would not be desirable for it to fail in its mission to heal, to heal suffering, to relieve the pains and hardships of those who had recourse to it. If it failed, especially in the Spring of Medicine that occurred in ancient societies, it would risk not only tarnishing its reputation, but losing its own life. In fact, the old legal codes abandoned the doctor at the mercy of the patient's family, in the case of a loss caused to him by the doctor, in a kind of private revenge that so characterized the old civil codes.

The Enlightenment shed new light and perspectives on all aspects of human knowledge, rejecting the idea of a transcendent influence on life, to be based on a supposed reason, a cold and rational analysis of things and beings, and, while the Industrial Revolution endowed humanity with new means by which to investigate nature, medicine was evolving technically faster than the paternalistic figure of the doctor was being changed.

The speed with which knowledge multiplied and was disseminated, providing with the Technique to evolve to the point that the human body was seen as something to be investigated in greater detail was not able to give the doctor a more humanized role and equally endowed with humanity, but reinforced the figure of the subject holder of absolute knowledge, against which the lay patient had not even the right to doubt.

All this has only changed recently, from the middle of the twentieth century to now, in the



first wave of reconfiguration of the figure and function of the doctor, as well as that of the freedom and greater autonomy of the hitherto almost invisible figure of the patient. This change followed the trail of questions about the role of Medicine and the influence of diseases in everyday life, the emergence of the discussion on Bioethics that marked the second half of the twentieth century.

The change in the way of seeing the function of the doctor and the growing autonomy of the patient increased with the emergence of the internet at the end of the twentieth century and especially at the beginning of the twenty-first century, and continues to happen today, in which the rapid transition between one discovery and another and the massification of information continues to raise the patient to a decisive level in the relationship with the doctor who, in turn, it is obliged to adapt to this new type of patient, increasingly informed.

The relationship has become more complex and dynamic, to the extent that the patient often does not want only a first diagnosis, but goes after a second and even a third opinion, which ends up sometimes shaking the doctor in his self-confidence or presumed self-sufficiency entering into scenes somewhat neglected aspects, such as emotions. With this it becomes necessary to approach the relationship between the two with new eyes, trying to understand how to improve it for the benefit of both actors, leaving aside certain Manichean and even simplistic tendencies once addressed.

It is not enough to trace the limits or objectives of the performance of the health professional in his dealings with the patient, without first considering the professional himself and in his work environment. It is necessary to go beyond and focus on the multiple factors that influence doctors, nurses, dentists, nursing technicians in their daily lives, considering the difficulties, emotions, stress, physical limits of professionals in the face of an increasingly saturated health system, especially if we consider the heroism with which these professionals behaved in times of Pandemic, in the face of so



much suffering that threatened not only the dignity but the lives of millions of patients.

Due to the task of dealing with the legal good life, in addition to comfort and well-being of people, health professionals, especially doctors, have been increasingly demanded, not to mention the competition factor that is natural in all professional fields. This requirement, both in the public and private networks, added to common aspects in the latter, which is the overpopulation of patients to be cared for, often in poor working conditions, has generated in the medical population around the world a high burden of stress, various diseases and discouragement and this needs to be better addressed in scientific studies.

The researches published by several journals show that the impact on the lives of physicians of the various factors of modern clinical practice is increasing, such as new diagnostic and therapeutic technologies, the pressure of the pharmaceutical industry, the commodification of medical services, as well as the loss of autonomy, the decrease in remuneration, the precariousness of the conditions of work, damage to the health of the doctor, apart from the cases of hyper exploitation by the modern media of cases of medical error. All of this contributes to an ever-increasing burnout of professionals, especially charged during the SARS-Covid Pandemic.

These aspects are often neglected when one wants to talk about the doctor-patient relationship, by placing the physician in the position of hypersufficient and the patient in the inverse condition of hyposufficient, demanding a more humanized care from the patient, which is legitimate, however failing to consider with the necessary attention the physician's own humanity, an essential condition for seeking to improve this relationship by giving both the satisfaction sought.

The numerous studies reviewed on the psychological and emotional situation of medical professionals in the face of current working conditions are sufficiently robust to list a whole series of



situations with which they face and affect the performance of their work, from Burnout Syndrome to violence against professionals, which causes demotivation, psychological and emotional exhaustion and in many cases, suicidal thoughts. The feeling of frustration for the breach of expectations in the face of real working conditions, the high demand for services in a situation of little infrastructure, the excessive working hours can also strongly impact doctors and prevent a better relationship with the patient.

With regard to each of these factors, several important numbers were obtained in the researches that show the main pathologies related to the exercise of Medicine and whose study will contribute to the understanding of what should be done so that the relationship between the doctor and his patient can be the best possible, avoiding wear and tear for both in addition to seeking to avoid the occurrence of judicialization.

## **WORKING CONDITIONS**

### **DEVALUATION AND LOSS OF WAGES**

The general opinion prevailing in society has consecrated the practice of medicine as one of the highest paid liberal professions that exist. If in the not too distant past this was true, nowadays, depending on the area of activity and the region where the doctor works, the reality can be totally different. Not only is there a devaluation of doctors' salaries, including late payment in municipalities where the public management of health resources is deficient, but there is also an unequal distribution of professionals by region.

According to information published in Doctormed for 2015, in Brazil there were 399,692



doctors for a population of 204,411,281 inhabitants, which corresponded to 1.95 doctors per 1,000 inhabitants. At the same time there were 432,870 doctors in the Regional Medical Councils, in the ratio of 2.11 doctors per 1,000 inhabitants. This difference between the number of doctors and the number of registrations in the Councils was due to secondary registrations of professionals registered in more than one state of the Federation.

Already in 2020 the number of doctors in Brazil, according to the study Brazilian Medical Demography, was 500 thousand doctors and information released on the Revisamed website shows that from 2010 to 2019 about 179,838 new medical professionals entered the labor market. This growth was attributed to the greater number of vacancies in existing medical schools and the opening of new medical courses. In 100 years the number of doctors grew 5 times more than the population. But with all the growth, the distribution of these professionals is quite uneven. And this inequality is often expressed in the factor of the remuneration of the medical professional.

The capitals generally concentrate the largest number of doctors. This concentration suggests that these cities, because they have greater resources and infrastructure, as well as a larger population and potentially more customers, are preferred compared to cities in the interior, whose municipalities focus on the network of Primary Care and because they are the smallest entities of the Federation, most of the time they have fewer resources to pay their health professionals well. On average in the capitals, there are 5.65 doctors for every 1,000 inhabitants, while the set of cities in the interior have only 1.49 doctors for the same proportion. The situation is much more dramatic when talking about the states of the Northeast Region, where in general, the municipalities of the interior have only one or less than one doctor for every 1,000 inhabitants. The predictable consequence of this inequality is often a single doctor who in a health center sees dozens of patients every day, with work overload, not



always adequate remuneration, little or almost no structure of work, which favors the development of disorders of various types.

This poor distribution, however, has not prevented that, during the Covid-19 Pandemic, more than 82% of Brazilian doctors have been negatively affected in their income, according to the survey entitled Impact of the Pandemic on the Life of the Doctor, carried out by the group Doctors Without a Jaleco. Especially at the beginning of the Covid pandemic, and with the National Health Agency recommending that patients, doctors, laboratories, offices and hospital institutions postpone examinations, appointments and surgeries that were not urgent, the private health system especially, suffered losses in its revenues.

These restrictions stemming from the pandemic had an immediate negative effect on both an institutional and personal level. According to a survey by the Union of Hospitals of the State of São Paulo, in a period of only 3 months before the suspension by the ANS, of the recommendation given at the beginning of the Pandemic, health plans failed to pass on the amount of R \$ 18 billion to the sector. Operations, appointments and exams have been postponed, with about 60 percent of surgeries having been suspended, according to the Brazilian College of Surgeons.

The adverse economic effects generated by the Health Crisis did not only affect physicians, but also other professionals in the health services chain. Of the approximately 38 million users of health plans, no less than 31 million are linked to business plans. Taking into account that in Brazil, most companies of all sizes were severely affected by the crisis, It is concluded that the increase in unemployment is directly associated with the decrease in the number of clients of health services.

This impact was even observed in large and medium-sized clinics, which considered laying off about 350,000 nurses, nursing assistants and technicians, as well as other professionals, in order





to achieve a reduction in expenses to compensate for the effects of the crisis, predicting a revival of demand after the end of the pandemic. If the income situation of health workers was not the best before the Covid Crisis, this in turn has aggravated the problem beyond the usual structural problems, especially in the public health system.

Among doctors, the study by the group Doctors Without Coat found that the average loss of revenue was around 44% compared to the pre-Crisis situation, while almost half of the doctors had a reduction in earnings greater than 50% compared to the previous situation. Another survey, this one conducted by the Federal University of São Paulo, contacted that mainly professionals in the areas of Orthopedics and Traumatology, 98% had financial losses, having been carried out with about 900 doctors. Not to mention other factors, such as tax issues, in which doctors, according to an article published in the newspaper Estadão, about 89% of doctors would be paying taxes more than they should.

It is worth noting that doctors in Brazil do not have a unified and defined salary floor throughout the country, in addition to being subject to a very derisory remuneration during their residency period. With all the pressure they receive in the face of the real situations demanded by the population, deprived of more social time for leisure, resident physicians are also subjected to income restriction, receiving well below what they should receive. In 2020 the National Federation of Doctors, for example, in its fight for the salary floor of these professionals, recommended a floor of R \$ 15. 274.00 for 5 hours of daily work, and a minimum value for consultations of R\$ 187.49.

On a superficial analysis, it may seem like a good salary, especially if compared to salary floors of other categories, but a closer look at the situation in the various regions of the country shows that the average earnings are far from the amount of this recommendation. Especially considering regions historically less developed, such as the North and Northeast, with municipalities more needy for



the doctor who works in the SUS and with relatively much lower purchasing power compared to the more economically developed regions, for the doctor who works in the private network, who usually also works in the public network to supplement income.

Physicians working in the SUS, for example, are submitted to a payment table established by the System itself, with fixed values. A General Practitioner, for example, earned about R\$ 12.00 per consultation in 2020 working for SUS, while the estimate for the private network was R\$ 60.00. Most doctors after graduation seek the SUS because opening an office may not be as advantageous as building a career with the experience that the SUS offers, even if it pays less. While their offices are not consolidated, it is necessary for recent graduates to start attending through the SUS, even with such a difference in remuneration.

Looking at regional differences, the pay gap among medical professionals is evident. According to the website General Register of Employed and Unemployed with data from 2020, in the Southeast Region, a pediatrician had monthly income of around R \$ 8,055 working 20 hours a week. In Rio de Janeiro this amount was only R\$ 4,951.00. In the Northeast, a cardiologist from Bahia received R\$ 5,215.00 and one from Pernambuco received R\$ 3,032.00 to work both on a 20-hour weekly basis. As can be seen, the difference can occur within the same region.

A psychiatrist from the South Region, according to data from Caged, perceived in 2020 R\$ 5,280.00 for a work regime of 25 hours per week in Rio Grande do Sul. The same specialist received in Paraná something around R \$ 7,935.00 working 6 hours less. In the Northern Region, a general practitioner working in the Amazon received for 30 hours a week of work the amount of R \$ 5,797.50 and the same professional working in Pará had his income decreased to R \$ 4. 356.00. In the Federal District, in the Midwest Region, generally associated with a higher quality of life and better structural



conditions, a gynecologist could perceive R\$ 6,629.34 to work 23 hours per week while in the State of Goiás, the same professional received R\$ 6,280.00.

As can be deduced, all this disparity is the product of the lack of a unified salary floor for doctors in Brazil. This claim, relatively old, product of a search for the improvement and salary stability of doctors throughout the country, is defended in Brazil by the National Federation of Doctors, which every year, recommends the minimum decent pay for professionals, and regrets the negligence of the Legislative Power in the face of the proposals raised, but that in fact, are not carried out by parliamentarians in a vote to decide this matter.

An example of this reality are the two bills that were drafted around the salary floor for doctors, but that the lack of parliamentary interest embodied in the slowness in the assessment of the matter prevented the realization of this claim. What was once defined in law, now seeks a unified parameter. In fact, historically the salary floor was defined by Law No. 3,999/61, which was linked to the value of the current minimum wage. With the promulgation of the Constitution of 1988 this situation changed, and the value began to be calculated based on the variation of inflation. In 1961 the doctor's income set by Law 3,999/61 was three salaries.

Two changes in the referred Law were proposed in the legislatures of 2015 and 2019, being the 2015 the bill 765/2015 authored by Deputy Benjamin Maranhão that establishes the salary floor at R \$ 10,513.00, but the lack of parliamentary interest caused the proposal to be shelved. In 2019 the PL was revived with changes by the parliamentary Dr. Jaziel, this time establishing as a parameter the Floor defined in 2018 by the National Federation of Doctors, and which stipulates a value of R \$ 14,134.58 for the same workload established in the previous PL, of four hours a day or twenty hours a week, for the public and private networks. The reference value of the current Fenam is R \$ 16,106.38.



The difficulty of establishing a salary floor creates distortions that generate negative impacts on the care of the most vulnerable populations, with municipalities that set a value even below the derisory three minimum wages set in the old Law 3,999/61. According to the portal of the Union of Doctors of the Federal District - Sindmed, which dealt with the subject, in 2019 the Regional Council of Medicine of Rio Grande do Sul - Cremers judicially annulled a public tender held by the city of Bagé, whose notice established the derisory value of R \$ 1,3 thousand for a workload of 20 hours per week and in 2020 , managed to annul another contest, this time that of the municipality of Santa Maria, which established a value of R \$ 1,453.06 for the same 20 hours per week.

The distortions created by the lack of the aforementioned Floor create situations of lack or shortage of doctors in many places, because they face a great and tiring demand of patients in municipalities that, in addition to not having an adequate care structure that gives doctors decent working conditions and patients decent conditions of care, also pay a salary that is totally incompatible with the function performed by the doctor. The action of these professionals in coping with the Covid-19 Pandemic showed that unlike the practice of many municipalities and states, which allow themselves to pay an undignified salary of the function of dealing with human lives but also below the inflation rates that cause loss of purchasing power on the part of the professional, it is necessary to have a unified Floor. And not only them, but also the other professionals who help him on the front line for health.

## **DIFFICULT PATIENTS AND THEIR FAMILIES**

The medical encounter usually constitutes a source of mutual satisfaction. There are, however, patients who evoke in us, doctors, negative emotions, such as anger, guilt, hatred and even de-



pression. These patients visit the doctor more often than average, with a variety of acute and chronic problems, receive more prescriptions, get more tests, and are referred more often to get a “second opinion” or advice from various specialists. Some call them patients with “cardiac distress.” Many of these patients have a ‘thick paste’ in the doctor’s office (KOVÁCS, 2010).

Over the years, several attempts have been made, some of them in studies of different types, to describe the difficult patient. There are four types of difficult patients: the demanding, the manipulative, the denier, and the self-destructive. Other researchers have reported patients with somatization symptoms as being difficult, that is, those patients for whom doctors do not find an organic basis for the problem (SALDANHA; BADCH; CRUZ, 2013).

Various social and medical conditions were considered difficult for doctors. Mental illness, alcoholism, drug use, obesity, and musculoskeletal diseases were the most difficult medical conditions for physicians, while dirty and smelly people, aggressive behavior, anger and hostility, lack of cooperation in treatment, and exploitation of the health care system were the most difficult social conditions (STEINMETZ; Tabenkin, 2001).

More and more doctors recognize that the problem is the medical encounter, the interaction between the doctor and his patient, and not just the patient himself. The difficulty may derive from the physician’s personality, his or her work and belief style system, cultural differences between him and his patient, the patient’s character and behavior, and external circumstances that affect the encounter (HINCHEY; JACKSON, 2011).

## **THE WORKING CONDITIONS OF THE DOCTOR**



Although medicine is a high-status, high-skilled occupation that traditionally offers access to good quality jobs and relatively high wages, continuing to provide these benefits in the context of an economic recession and period of austerity is a challenge. Health systems and health employers must adapt to today's expectations of what constitutes good quality medical work, and do so within funding constraints, related to austerity and/or those resulting from long-term historical underfunding (HUMPHRIES et al., 2018).

Work quality is the extent to which a job has work-related and employment-related factors that promote beneficial outcomes for the employee, particularly psychological well-being, physical well-being, and positive attitudes. Good quality jobs also benefit the employers, increasing average stability and productivity (FELSTEAD et al., 2019).

Work organization (including demands and resources), wages and payment systems, security and flexibility (e.g., contracts, working hours, and flexibility), skills and development (e.g., use of skills, training), and engagement (e.g., consultation and voice) were identified as five key dimensions affecting job quality. Jobs are typically classified as good, moderate or poor quality, although employment characteristics may vary between employers and the same job may be good in some respects but not in others (HOLMAN, 2013).

A variant of the health of an extreme job, developed through research with hospital managers, is characterized by long hours and physical presence; tight deadlines and a fast pace of work; unpredictable workflow; disordered scope of responsibility; 24/7 availability; and responsibility for the mentoring team (GRANTER et al., 2015).

Other health care-specific dimensions of extreme work identified include making life-or-death decisions, managing conflicting and shifting priorities, being forced to do more with fewer resour-



ces, responding to regulatory bodies, and combating a climate of negativity. Those who have extreme jobs can be motivated and challenged by this form of work, enjoying the high wages, recognition, status, power and joy that come with extreme work (GRANTER et al., 2019).

However, extreme jobs can also have a negative impact on employee well-being and family relationships, with half of those in extreme roles indicating they don't want to continue working under such pressure. This has led to a recognition of the risks associated with extreme work and suggestions that extreme work – or extreme work – is unsustainable in the long term (GRANTER et al., 2015).

## **PHYSICAL IMPACTS OF THE DOCTOR'S WORKING CONDITIONS**

### **THE HEALTH AND WELL-BEING OF THE DOCTOR**

If there is a finding that, so obvious, ceases to be perceived or is insufficiently considered in the social environment, it is this: the doctor is a human being and, therefore, is also a patient. It is equally vulnerable, although the popular imagination that conceives the doctor for millennia as the one who will solve the most serious health problems of others, is almost incapable of seeing in this professional, the vulnerabilities that in real life, often affect him. It is as if there is still some remnant of that age-old stereotypical image of the agent with powers to heal pain and suffering.

In little more than 100 years, the expansion of medical schools and the greater proximity of these professionals to the popular environment has been in charge of gradually humanizing, so to speak, the figure of the doctor and removing the mythical aura that covered it to reveal the inevitable: the doctor is not only liable to make mistakes, but also to get sick. Not only does he get sick, he dies while treating the illness of others, as we saw recently in the Pandemic, in which countless valiant pro-



professionals, in the fulfillment of their role in the tyrannical fight against the Sars-Covid virus, became infected and died like any patients who were treated by them.

With the advancement of Medicine associated with the development of new technologies, a new panorama was presented to the physician, increasingly complex and challenging of his old autonomy, a reality capable of provoking in the professional not only questions, but also creating insecurity, feeling of powerlessness, dissociation with himself and with others. Varied disorders of a psychic order and physical diseases are increasingly observed in these professionals, factors capable of concretely influencing the doctor's work capacity as well as in the doctor-patient relationship and with professional colleagues.

From excessive working hours, especially in the public health system, with intense demand especially in Primary Care, through precarious working conditions until super-informed patients capable of acting actively challenging the knowledge and autonomy of the physician and the relationship with difficult patients and families, leading to increasingly common cases of violence against doctors, all influence to consider equally the conditions of well-being and health of these professionals in the elaboration of work policies and adequate assistance to aim to guarantee that right to health inscribed in the Constitution and that It is a right not only of the patient, but also of the doctor.

If it is true that the exhaustion of work contributes to the appearance of mental pathologies that will be addressed below, it is also true that numerous physical diseases are developed and have an impact even of an economic order both in the public and in the private network when, for example, the high turnover arising from the lack and decent structure of work and precarious wages cause doctors to migrate to other regions causing shortages in certain places, or when they, for health reasons, are absent for treatment of pathologies acquired in the office or even definitively withdraw from the





profession.

In addition to these factors inherent to the practice of Medicine, there are also others that will be addressed, taking as a necessary example the mismanagement of Public Health resources, which have always caused centuries-old problems in the provision of services and sometimes scrap the local structure of the system, resulting in patients disrespected in their rights and doctors dissatisfied with what they have to offer within this structure.

A poorly designed public management has the ability to negatively affect the quality of the public services provided, even more comprehensively than the mismanagement of the resources of a private clinic or hospital and a greater deficiency by the greater number of patients served, because of the universality of the System. With this, a bridge is created for varied problems in meeting the demand that immediately affects professionals and those assisted, in the physical and psychological spheres.

## **PHYSICAL PATHOLOGIES THAT VICTIMIZE DOCTORS**

In the course of his routine in the care of the population of the public network and the users of the private network, the physician is not only subject to the development of diseases or disorders of a psychological nature. There is also the possibility of the development of various physical injuries arising from medical practice, beyond the mere hypothesis of an accident at work. We have seen, especially at the height of the SARS-Covid Pandemic, an exponential increase in the already large exposure to biological agents that many professionals are subjected to on a daily basis.

If, according to the survey conducted by the Union of Doctors of Minas Gerais and published



on the website of the National Federation of Doctors, before the pandemic there was already such a large percentage of doctors who said they were exhausted, after the beginning of the problem the situation only worsened, according to a study by Fiocruz. Factors such as the high transmissibility of the virus, the lack of a proven treatment, the lack of tests, the need for social isolation and three times more likely to contract the disease than the population

Add to this the fact that in Brazil there is no efficient public policy aimed at the attention and protection of the physical, psychological and emotional health of doctors, which at the other end, dis-favors better care for patients who seek help. The physical structure of work, particularly in the public sphere, is historically poor to say the least, and with the emergence of the Pandemic, even with the contribution of resources to the federative entities, the practical situation has not improved and political issues have also aggravated the situation. In the Fiocruz survey brought to light in 2020, data were presented that express this reality. According to her, 95% of the doctors said they were exhausted.

## **SUICIDE AMONG DOCTORS**

In fact, this is a very urgent issue that has been alarming by the data that are being raised in initial studies on the delicate subject. The Medscape portal, for example, even in 2018 published news reporting that among all professional categories in the United States, doctors were the ones who had the highest suicide rate, with about one occurrence per day, more than double the rate among the general population. The portal Hospitals Brazil in 2021 reported that suicide among doctors and medical students is on the rise.

A candidate for the profession of doctor faces difficult situations since he begins his prepara-



tion for the entrance exam, one of the most, if not the most difficult selection process among students. Once approved and entering college, a new routine of intense studies begins that take the whole day of the student and from then on, the future doctor has little rest. It will be many years of arduous preparation, justified in view of the function for which it is intended. In this exhausting process, factors such as discipline, persistence, willpower and a lot of motivation are the indispensable supports to obtain the diploma and then to specialize in medical residency.

The exhausting work, the eventual bad remuneration, the high demand of patients, the bad sleeping hours, the insomnia crises, the stress and all the factors that contribute to disorders already addressed, not infrequently accumulated with each other, are also triggers capable of propitiating not only depression and anguish, but suicidal ideas, due to the lack of an emotional and psychological balance of the professional.

According to an estimate by the American Foundation for Suicide Prevention reports that, on average, 300 to 400 physicians commit suicide worldwide every year, with Axis I disorders such as mood, drug and alcohol use, psychosocial factors, cognitive style, and particular personality characteristics being influencing factors. Axis I disorders are observed quite frequently in women. In a survey conducted in 2006, more than two-thirds of physicians reported burnout and nearly one-third reported depression.

Alcohol and drug abuse affected between 20% and 40% of doctors who committed suicide. Women were more likely, including in a survey of 114 doctors that discussed the rationality of such an act, and for no less than 61% of this total believed that under certain circumstances, suicide would be a rational option. On the other hand, the psychosocial factors related to suicide can be found in the tension of the profession, in the lack of personal support.



## EMOTIONAL IMPACTS DERIVED FROM THE DOCTOR'S PERFORMANCE

### THE EMOTIONS OF THE DOCTOR

Contemporary bioethics and medical literature highlight the positive effects of empathy for patient care. Very little attention, however, has been paid to the impact of the requirement for empathy on physicians themselves. Physicians are expected to empathize with their patients, but the effect of this requirement on their emotional well-being is rarely recognized (GREENFIELD et al., 2012).

Medical professionalism puts the well-being of patients at the forefront; However, the needs of physicians should also be considered. Empathy requires a certain level of emotional involvement on the part of the physician, but the emotional resources and skills needed for empathy are not always available to physicians. The medical profession is an emotionally challenging environment, which favors the image of the emotionally detached physician.

Often, in practice, the open expression of feelings is perceived as weakness, an attitude that leaves little room for the active pursuit of emotional well-being. Doctors are constantly faced with distressing situations, which can lead to depression, burnout and, consequently, the loss of the capacity for empathy. For empathy to flourish in the medical profession, physicians must feel able to deal with their emotions without fear of being criticized or stigmatized as weak (LORENZETTI et al., 2013).

Medical professionalism defines the types of skills and knowledge required by physicians and articulates their professional values, duties, and obligations. It helps doctors navigate difficult decisions required by their profession and offers them a guide to good practice. In other words, professionalism can be described as the “practical and moral compass” of doctors.



Two basic values for physicians are clinical competence and empathy. Both values are important elements of good medical practice; However, in many Western countries, there is a tendency to favor the technically skilled, rational, and emotionally impartial physician over the compassionate or empathetic physician. The Active expression of compassion in medical care is often seen as a super-erroneous requirement or even perceived as weakness. Physicians from the beginning of their training are taught that “technical skills are [considered] fundamental, while interactive skills (if encouraged) are secondary” (STREET; HAIDET, 2011).

There are several arguments in favor of emotional distancing from doctors. Sanchez-Reilly et al. (2013) demonstrated how physicians learn during their studies to develop emotional detachment in order to maintain scientific and medical objectivity when dealing with distressing situations. On the other hand, emotional attachment to patients is often seen as adverse to good clinical practice.

An example of this is the General Medical Council’s guidelines, advising doctors not to treat members of their families or other people with whom they have a close personal relationship. Strong emotional involvement and overidentification with patients have been associated with a tendency to overtreat without considering side effects (SANCHEZ-REILLY et al., 2013).

In addition, emotional distancing allows the physician to maintain composure in the face of emotionally difficult situations and to guide and support the patient during them. A doctor who breaks down and cries in front of a patient cannot fulfill this role. This puts the patient in an awkward position, in which he may feel obligated to support and comfort the doctor, rather than the other way around. Doctors also need to maintain emotional distancing to protect themselves from stressful situations they face in their daily work. The inability to control emotions in medical practice is often perceived as a lack of professionalism (CASTELHANO; WHABA, 2020).



However, protecting yourself from emotional distress by openly disconnecting from other people, which can be described as apathy, can put medical care at risk. Riess et al. (2012, p. 1281) state that “with the growing distancing comes an attitude of cold indifference to the needs of others and an insensitive contempt for their feelings”, which can result in the depersonalization of the patient.

The NHS in recent years has placed too much emphasis on compassionate care in various guidelines and recommendations. These recommendations highlight the importance of empathy and compassion as fundamental requirements of healthcare professionalism, stating: “Most importantly of all, the NHS could employ hundreds of thousands of staff with the right technological skills, but without the compassion to care, then we will have failed to meet the needs of patients” (CASTILIAN; WHABA, 2020).

However, in practice, it is difficult for physicians to find the right balance between being the technically qualified professional and the objective professional, while being emotionally engaged but not overly identifying with the patient’s suffering.

Even when physicians consciously try to refrain from engaging emotionally with their patients, few will remain unaffected by regular exposure to patients’ suffering, illness, and death. Neglecting such emotions can seriously impact the health and psychological well-being of these professionals. Doctors may suffer from emotional exhaustion, burnout, depression, or even attempted suicide.

A recent study that included 14,000 doctors in Australia found that medical professionals are more likely to suffer from mental disorders and depression than the general population; one of the main reasons is that “doctors and medical students are under immense pressure and regularly deal with pain and death” (CASTELHANO; WHABA, 2020).



Another study examining how grief and well-being relate to empathy showed that increased personal and professional distress and emotional exhaustion are correlated with lower emotional empathy scores. It is suggested that efforts to promote empathy should consider these correlations (EICHBAUM, 2014).

Non-involvement with emotions – the emotions themselves, but also emotional involvement with the other – has two adverse effects; Firstly, it negatively affects doctors as people by increasing their stress and anxiety, making them more subject to mental distress and emotional exhaustion.

Secondly, it affects doctors as professionals as it does not allow them to care for their patients properly and effectively. These two aspects of the physician are integrally connected. If we are concerned with promoting best practices in medical care, then paying much more attention to the doctor as a person and taking care of their emotional and psychological well-being should also become a priority.

## **MAIN DISORDERS THAT AFFECT PHYSICIANS**

According to a review study by Mariana Evangelista et al. (2016) the impact that the work routine has on the psychological conditions of the doctor has been studied and increasingly the harmful results of this intense pressure have been observed in various parts of the world, and in some specialties of Medicine this impact is naturally greater than in others. Low remuneration perceived in many cases, which drives the professional to seek more than one employment bond to supplement income, excessive working hours that cause stress, social isolation and the lack of more hours for leisure and social life are factors immediately linked to the development of disorders.

When it comes to acting in the public sphere, medical professionals are faced beyond few



working conditions, with accentuated bureaucracy, intense demand from patients with overcrowded queues, scarcity of resources and supplies for urgent and emergency care, irritable and sometimes violent patients, which transfer to the doctor the frustrations of not having been attended with the promptness they consider appropriate to the severity of their cases in addition to, with increasing frequency, judicial issues and ethical processes in the Regional Councils.

All this is a system of connected elements that assemble gradually, the framework conducive to the emergence of psychological problems in professionals, having a nature of double loss, because a motivated and rested professional has a performance and a quality in care much higher than a doctor submitted to the stressful routine mainly in a basic health unit or Even in a large hospital with even greater demand and committed resources.

The development of these pathologies directly impacts in all possible senses: the life of the doctor, the solution of his patient's problem, the effectiveness of the use of resources, personal relationships with co-workers, legal issues, labor relations, etc. We will see below the psychological and physical problems that most victimize these doctors. First the most recurrent disorders will be addressed and then the physical pathologies that compromise their work.

### **Burnout syndrome**

Burnout Syndrome is also known as Professional Burnout Syndrome. It affects doctors from all areas, but some of them have a higher incidence. It also frequently affects female, single and young doctors. Doctors subjected to high levels of stress and pressure in the workplace are prone to suffer from this syndrome, according to news about a study done in 2012, published on the Pebmed portal.





In Brazil, at the end of the 1990s, the Ministry of Health, through Ordinance number 1,339, included Burnout Syndrome in the list of work-related diseases. In the following decade, she was placed on Social Security's List B under the classification of work-related mental disorders and behavior. It is a public health problem that especially affects professionals exposed to intense stress, and that can cause numerous problems.

The most recurrent symptoms of Burnout Syndrome are loss of enthusiasm, emotional detachment, exhaustion, loss of feeling of personal accomplishment and even feelings of cynicism. It is evident that a doctor affected by this syndrome will have very little stimulus for empathy with his patient, which can damage the relationship and make the patient understand as if the doctor became very distant from his problem, even disinterested, acting almost mechanically when diagnosing the problem presented to him.

Elements such as fatigue, irritation, inflexibility, lack of empathy with co-workers were symptoms identified in the Burnout Syndrome can be encompassed in a general lack of emotional energy that is sufficient for a greater capacity for enthusiasm and empathy for the profession and for co-workers, but not only with them. There are other associated elements, such as depersonalization.

In an intense work environment, especially if added to a long working day, the possibility of developing Burnout Syndrome is very great, even with a tendency to cause depressive conditions. Wada et al. (2010) and Tomioka et al. (2011) identified the direct relationship between depression and lack of work leave in physicians submitted to long hours of duty and on notice. Such long hours cause social isolation and deprivation of adequate hours of leisure, causing mental fatigue.

Considering that in the Brazilian health system, especially in the SUS, the reality is of hospitals and health posts of Primary Care with massive attendance, often with a reduced number of doc-



tors -sometimes only one- the stress resulting from prolonged shifts can be a trigger for the Burnout Syndrome, as at the same time an enhancer if it is already installed in the professional, impairing their performance and attention levels.

Faced with this situation in which care is impaired, the demand for care is high and the work infrastructure is not always satisfactory, situations may occur not only of emotional or psychological exhaustion, but also medical errors or negligence that may lead to the judicialization of the relationship between the doctor and his patient, by provoking the latter, Outrage because of the perception that the doctor has not been considerate enough to your problem, especially that type of patient who is more demanding and likes to seek information about the symptoms they are experiencing before going to the doctor.

This situation can further aggravate the situation of the professional if he is already subjected to unbalanced working conditions, even causing suicidal thoughts in addition to all other factors related to Burnout Syndrome, such as depression. In studies conducted by Wang et al. (2010) it was found an incidence of 63.5% of the Chinese doctors followed had depressive symptoms, a rate twice as high as the average of the Asian population.

The negative impacts of these factors can be seen in the fact that there is a deterioration not only in the relationship with the patient, but also with professional colleagues and other health professionals, as well as an increase in the number of job turnover, increase in the number of complementary exams, early retirement, use of disability insurance. There is an increase in dissatisfaction and with it a lack of the capacity for interaction, enthusiasm and a sincere interest in the sufferings of the other.

In Brazil, according to a study by Torres et al. (2011) that interviewed 1,224 physicians who graduated from a medical school, although about 66.1% considered satisfaction with their professional



life, 56.3% considered being subject to medium, high or very high levels of stress due to the fact of dealing with deaths, 54.7% for dealing with severe patients, 27.7% for dealing with communication with the patient and family members, as well as alarming 31.1% for dealing with civil proceedings. Communication with family members and especially with difficult patients is also highly stressful and little is addressed in the studies that are done.

### **Depersonalization/unrealization**

In the various symptoms associated with Burnout Syndrome, the action of elements such as physical exhaustion, emotional exhaustion as well as depersonalization stand out, which has a great influence on how doctors feel about their work and on how they see themselves. Especially the depersonalization and the consequent disinterest or coldness in the face of the more or less serious situations with which the resident physician has to deal, is able to make the doctor more inattentive to the patient, which can cause situations of risk, of medical error in which the health and integrity of the patient may be affected.

Depersonalization is understood as a dissociative disorder that consists of a process of recurrent feelings of distancing from one's own body or mental processes, as if the affected person were an external observer of one's own life or of being dissociated from a certain environment, with derealization occurring. In this case, when feeling dissociated from the work environment, the professional may be disinterested in the problems of his patient, compromising the care, with the potential for errors and even the occurrence of an ethical process or even a judicial process that could be even worse for the medical professional.



In their article on the subject, Vencato da Silva et al. (2016) points out that the carrier of Depersonalization usually feels disconnected from their own senses and more than that, from their own body, as if it did not belong to it, configuring somatosensory distortions. It is a phenomenon that affects no less than 80% of psychiatric patients and in 12% of these patients, depersonalization affects more severely and persistently. In the United States, the phenomenon occurs in 2.4% of the general population; in the United Kingdom, this percentage is between 1-2% and in Germany the rate is 1.9% of people affected by Depersonalization.

The disorder is associated with situations of intense stress, use of psychotropic drugs, fatigue and manifests itself as a response to pressure situations in everyday life. In medical students, the phenomenon occurs already during the course and is linked to factors common to the daily life of this area such as the lack of free time, the high pressure that the exams cause, financial difficulties and contact with patients and families.

In Brazil, the study by Vencato et al. (2016) also examined students from a medical school, the Federal University of Roraima, centered on a more active learning methodology, in which students are stimulated from the first year to weekly practice in the scope of Primary Care. Of the 230 students of the course, 96 medical students from different were analyzed periods of the course, with the majority -more specifically 52%- female students, with an average age of 24.4 years.

## **IMPACT OF THE PANDEMIC ON THE HEALTH OF DOCTORS AND NURSES**

The usual work routine of doctors, especially in the public network, with its huge queues, few professionals for care in Primary Care, lack of sufficient resources for satisfactory care to all, was



abruptly changed in 2020 by the appearance of SARS-Covid-2 and its rapid spread throughout the world, with a very high fatality rate. Not so much for the novelty, since this type of virus had appeared before, but for the pandemic character, for the speed in the spread and in modern times, for the level of lethality that has claimed millions of lives on five continents. In July 2021, Johns Hopkins University estimated that about 3.5 million people had died, but The Economist said that number could be four times higher and reach 13 million.

The number of doctors killed in Brazil, according to the CFM website, is 893 people and if we add to this the number of nurses, it easily exceeds a thousand people. The state with the fewest dead doctors was Amapá, with 6 deceased professionals, and the state with the highest number of deceased doctors was Rio de Janeiro, with 107 doctors. The Pebmed portal indicates that a third of the nurses killed in the world as a result of the fight against the pandemic are from Brazil.

According to a study by Irena Durpat and Géssyca Melo (2020) shortly after the first Covid outbreak, about 3,300 health workers had been infected in China alone. In Italy, Covid's major focus in Europe and one of the countries that have suffered the most from the disease, the astronomical number of 16,991 doctors infected with Covid as of mid-April 2020 has been confirmed. If we consider the population of China with the population of Italy, the percentage at that time was much higher in the European country compared to the Asian country, epicenter of the pandemic. In the United States, 62,000 doctors, nurses and other professionals have been infected by May and in Brazil, by August 15, no fewer than 257,156 had been confirmed infected.

Although both professional categories were greatly affected by their direct contact with the problem, nurses were even more impacted than physicians. According to the aforementioned study, the most affected professional categories were the following: nursing technicians or auxiliaries in



88,358 people, representing 34.4%; there were 37,366 nurses, representing 14.5% and 27,423 doctors, or 10.7% of the staff infected by the Coronavirus. Nurses, therefore, are the most affected category and together with physicians, faced other problems such as lack of personal protective equipment, excessive working hours, psychological stress, negligence in adequately protecting the health of these professionals.

All the data collected, whether in relation to physicians or in relation to nurses, nursing technicians and auxiliaries, suggest the need for a change in posture and the elaboration of health care policies of these professionals who, due to the nature of their work, end up compromising their own health in coping with their patients' diseases, which is greatly enhanced in situations like the pandemic. Because it is, especially Public Health, structured in a system, the many elements that make up this gear need to work well and in close tune with each other, which means that if one of the elements works badly, the whole system has its performance compromised.

That is why, if on the side of health professionals there is not greater care for their health, decent working conditions, consistent wages and effective rest, there is no way to expect at the other end, that the patient, especially the most vulnerable patient, has access to the excellence that the health system has the potential to offer, if it is administered correctly and intelligently.

Otherwise, if even with the cooling of the Pandemic, no concrete measures are taken, we will see the cases of disorders evolve more and more into more severe cases, not limited to Burnout Syndrome and Depersonalization, but cases of depression and suicide tendencies. This is a fact that is still little studied in Brazil and on which little attention is paid to the Debates. But as can be seen below, cases of depression and suicide among health professionals are a concrete, growing and worrying reality.



The study by Katarina dos Santos et al. (2020) with 490 nurses regarding the incidence of depression in these professionals found that 86.7% are female, and had income between three and four salaries, which indicates a low remuneration and little professional visibility of the class. Of the total number of nurses analyzed, 30.4% of them reported having a diagnosis of some mental disorder in the last 12 months and 39.6% suffered from moderate or severe anxiety and 38% reported having had moderate or severe symptoms of depression.

The important elements associated with anxiety are the most varied, including brown color, work in a private employment relationship, or even having both public and private bonds-increasing the working day-, symptoms of Burnout syndrome, developing their work without dignified conditions to face the Pandemic, although these factors have been attenuated with body-mind practices and conversations with family and friends. Interestingly, working not only in the public sphere, but also in the private service and where there was no adequate structure to cope with Covid played a notable role in the development of depression.

As direct assistants to physicians, nursing professionals are directly and equally exposed to biological agents and contamination, as well as to the development of burnout syndrome and depression, facing even more than physicians, the mental suffering resulting not only from the activity they practice, but also the lack of professional recognition. While doctors do not have a unified floor in the country, which generates inequalities in the distribution of professionals by region of the country, nurses also fight for recognition and for the class floor. All these factors are linked to the development of symptomatic pictures of depression.



## RETHINKING THE DOCTOR AS A HUMAN BEING

It is necessary to point out the number of victims who lack quality care, because there are several causes that lead an individual to seek emergency care, ranging from a sudden illness, serious diseases, trauma, among others, and may even cause death before arrival at the hospital. This aspect is crucial, because patients with clinical conditions such as these need immediate attention, and optimized nursing care is essential.

According to the understanding of Galvão (2013) it is necessary that the decisions made by the professional are based on the skills necessary for the preservation of the patient's life. It is important to emphasize that respect for the patient is crucial so that the care can be performed with quality and competence.

Health care workers are the real frontline soldiers around the world against COVID-19 and/or any other similar situation. However, taking care of patients is the professional duty of health professionals, but their leisure and rest are also very important.

The sudden coronavirus pandemic has stretched medical resources around the world to the limit. Many countries that are being hit hard by the disease face an immense shortage of health workers, ventilators and basic necessities such as masks, gloves and personal protective equipment. To face a disease of such proportion and nature requires a great deal of goods and resources.

Health professionals have always been in evidence. However, its valuation has been amplified due to the COVID-19 pandemic in the world since December 2019. Doctors, nurses and other professionals faced the pandemic when there was still not much news about the workings of the virus, nor a means of treatment, only prevention.





In this aspect, the importance of seeing the physician as a human being is highlighted. Just as your patient lacks care, so too should the same care be given to the doctor. He is a human being with wants, desires, needs and urgencies, which must be considered by the State, society as a whole and also by its patients.

## **FINAL CONSIDERATIONS**

Globally, a patient's complaints about doctors' communication skills are recorded at the top of the lists of complaints analyzed. It is essential to treat the patient, not only the disease. Modern technology makes the doctor's skills geared towards the treatment of the disease with less emphasis on the patient himself. Consequently, the symptoms of the disease are temporarily alleviated, while the root of the problem is still present.

A doctor who analyzes his patient's history in a similar way to a lawyer who does the interrogation and pays little attention to his patient's answers is doomed to be a lousy clinician. Many doctors are reluctant to improve communication, which is one of the crucial elements of treatment.

Despite the efforts of some medical universities to reform their medical curricula and implement communication skills, it seems that many doctors do not seem to build effective relationships with their patients. As clinics have become more crowded, with an increase in referrals to specialists, doctor-patient exposure decreases as appointments become shorter, and patients are often exposed to different doctors.

Unfortunately, patients are increasingly distant from their doctors. They have more access than ever to medical information. They have much more knowledge about pathology and modes of



therapy and often express their desire to participate in treatment decisions.

To serve those who suffer, the physician must possess not only scientific knowledge and technical skills, but also an understanding of human nature. The patient is not just a group of symptoms, damaged organs and altered emotions. The patient is a human being, at once concerned and hopeful, who seeks relief, help and confidence. The importance of an intimate relationship between patient and doctor can never be overstated, because most of the time an accurate diagnosis, as well as an effective treatment, depends directly on the quality of this relationship.

When considering a relationship that is based on the mutual participation of two individuals, the term “relationship” does not refer to structure or function, but rather to an abstraction that encompasses the activities of two interacting systems or people. The apparent and intrinsic quality of this unique doctor-patient relationship allows two people, previously unknown to each other, to feel at ease with varying degrees of intimacy. This relationship, over time, can develop to allow the patient to convey highly personal and private matters in a safe and constructive environment.

The society advocated a shift in the doctor-patient relationship from the cooperation-orientation model to mutual participation, in which power and responsibility are shared with the patient. Patient-centered consultations reflect recognition of patients’ needs and preferences, characterized by behaviors such as encouraging the patient to express ideas, listen, reflect, and offer collaboration. Thus, patient-centered medicine encourages much greater patient involvement in care than is generally associated with the biomedical model.

The importance of aspects of the doctor-patient relationship is emphasized, including (a) the patient’s perception of the relevance and potency of the interventions offered, (b) agreement on the objectives of the treatment, and (c) cognitive and affective components, such as the personal bond



between physician and patient and the perception of the physician as caring, sensitive and supportive.

Thus, a friendly and sympathetic manner can increase the likelihood of patient adherence to treatment. On the other hand, negative emotional responses from either party (e.g., anger, resentment) can serve to complicate medical judgment (causing misdiagnosis) or cause patients to stop treatment. A common understanding of the goals and requirements of treatment is crucial for any therapy, whether physical or psychological.

Patient-centered medicine is “medicine for two people,” in which the doctor is an integral aspect of any description. The doctor and the patient are influencing each other all the time and cannot be considered separately.

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