Doctor self-disclosure in the consultation

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ABSTRACT

Doctors' self-disclosures to patients are an important dynamic in consultations. These can be categorised as unavoidable, inadvertent or deliberate. It is important in facilitating therapeutic outcomes to reflect on the types of messages unavoidably communicated by the doctor's appearance, speech and practice and consulting room environments, and to recognise self-disclosures caused by disruptive doctor transferences, so these transferences can be processed and minimised. Deliberate choices by doctors to disclose personal information and experiences are common. Without awareness and understanding, this can be unhelpful. Guidelines are provided to facilitate self-disclosures that build the doctor–patient relationship and improve therapeutic outcomes.

It is widely accepted in general practice that the doctor–patient relationship is central to the work of general practice. An important dynamic of relationships is self-disclosure, and this includes the doctor–patient relationship. A variety of classifications has been used to describe types of health professional self-disclosure; for example, unavoidable, accidental, inescapable, inadvertent or deliberate.[1]

The overall concept of self-disclosure is straight forward, but it is not immediately obvious how different aspects of self-disclosure should be classified. In this article, 'unavoidable self-disclosure' is information automatically communicated by the doctor merely being present to the patient, including information communicated by the doctor's practice environment and consulting room. 'Inadvertent self-disclosure' is the subconscious influence of thoughts and emotions transferred from a previous relationship affecting the doctor's behaviour in a relationship with a current patient. 'Deliberate self-disclosure' is the doctor's specific choice to reveal personal information that would normally be unavailable to the patient. This includes information about family, hobbies and other activities, physical health, psychological and relationship issues.[2]

Unavoidable, inadvertent and deliberate self-disclosures will be discussed in more detail, with a specific focus on deliberate self-disclosure. Potential pitfalls will be discussed and guidelines provided for using deliberate self-disclosure to build the doctor–patient relationship and improve therapeutic outcomes.

Unavoidable self-disclosure

It is unavoidable that information is disclosed to the patient by merely being present with the patient and by the doctor's practice and consulting room environment. Examples include the doctor's physical appearance, gender, ethnicity, dress, manner of speech; the size and quality of the doctor's chair compared to the patient's; the consulting room décor, including the display of pictures, photographs and qualifications and the doctor's interactions with staff in front of the patient. Such things may communicate much about the doctor's personality and values, and emphasise dynamics of privilege and power.

Sometimes, what is not displayed may communicate as much as what is displayed. For example, the absence of information and messages relevant to Māori, Pasifika or Asian New Zealanders may raise doubts about the practice's interest and commitment to the health of these groups.

Reflecting on potential effects of unavoidable disclosures can lead to changes for both the doctor and practice environment that facilitate greater trust and rapport with some patients.

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Inadvertent self-disclosure

Inadvertent self-disclosure through the transference of thoughts and emotions from previous relationships affects every doctor's behaviour at times. These transferences can negatively impact the doctor–patient relationship if unrecognised by the doctor. For example: (i) a young doctor's verbal and non-verbal behaviours disclose anxiety and lack of confidence, triggered by interacting with an older patient who reminds him of his aloof, authoritarian high school principal; (ii) a doctor discloses anxiety and withdrawal, triggered by interacting with a patient who reminds the doctor of a previous abuser; and (iii) subconscious race, gender and socioeconomic prejudices can also be considered as another type of transference.

Managing negative transferences requires a high level of doctor awareness to negative or disruptive thoughts and emotions arising in the consultation. Further reflection by asking, 'Who or what situation from the past is this person reminding me?' may generate insight regarding the origin of these thoughts and feelings. Sometimes, insight alone is sufficient to resolve the transference by enabling the doctor to disconnect the current doctor–patient interaction from the thoughts and emotions from the past. More often, supervision or personal psychotherapy is required to identify the negative transference and then resolve or minimise it. This enables the doctor to interact more freely with the patient in future consultations.

Deliberate self-disclosure

As doctors listen to patients' stories, it is to be expected that doctors' own stories may be remembered. Deliberate disclosure of such stories by doctors is common.[3] Without specific training, deliberate self-disclosures can be unhelpful and may hinder the process of the consultation.[4] The benefits and problems of deliberate self-disclosure are addressed in the medical literature, although more commonly in the psychotherapy literature, much of which is applicable to medical consultations.

In the medical literature, there is conflicting research about whether deliberate doctor self-disclosure is beneficial. Doctors have assessed their own deliberate self-disclosures as beneficial,[3] but other research, arguably by more objective observers, casts doubt on those assessments.[4] It is probable that other conflicting results regarding the benefit of doctors' deliberate self-disclosures are due to variations in the content and context of the disclosures and the nature of the doctor–patient relationships.[3] Despite this, there is an increasing consensus in both the psychotherapy and medical literatures of the additional therapeutic benefit of judicious, deliberate self-disclosure.[1,3,5] An important caveat is that this is of secondary importance to the primary task of careful active listening with respect and empathy.

So, what are the benefits of deliberate self-disclosures? Disclosures that implicitly or explicitly acknowledge a shared humanity reduce the power differential between doctor and patient[6] and increase rapport, openness and trust in the doctor.[7] For example, 'I also felt disappointed when I needed a Caesarean.' Disclosures can also normalise the patient's experience.[7] For example, 'At times I also get a headache with stress', when discussing a patient's tension headache, and 'I found parenting difficult too', when parents are struggling with their teenager.

Through deliberate self-disclosure, the doctor can present an alternative perspective. For example, 'I find I need a holiday every three or four months to function at my best', said to a patient who has not had a holiday for a year. Disclosures of the doctor's own healthy behaviour can also enhance patient motivation for behaviour change.[8] For example, 'I halved my alcohol intake after discovering alcohol significantly increases the risk of cancer' or 'I also found it difficult to fit in regular exercise but I'm now managing half an hour four times most weeks'.

Sometimes the doctor's own experience can be used to encourage the patient. For example, a patient with 6 months of cervical spine radicular symptoms was told surgery was not an option. He despaired that his sporting days were over. The doctor responded, 'I recovered from a similar

injury without surgery and I'm now back playing golf'. The patient reported that this disclosure was more reassuring than anything else the doctor said about chances of recovery.

While deliberate self-disclosure can enhance therapeutic outcomes, a lack of awareness or lack of understanding can result in disclosures being unhelpful, disruptive or even harmful to the consultation. In a study of 73 deliberate self-disclosures by primary care doctors meeting new patients,[4] only 15% of self-disclosures were considered by the researchers to be useful to the patient. Of the others, 40% were considered unrelated to the patient's experience, 79% failed to return to the topic preceding the self-disclosure and 11% were considered disruptive. For example, the doctor might say, 'I went through a similar thing', but then talks excessively about her own experience including aspects of low relevance to the patient and about which the patient might disagree. These unhelpful deliberate disclosures interrupt the doctor's focus on the patient, threaten rapport and risk being disruptive or harmful to varying degrees, depending on the nature of the consultation.

At times, the motivation to self-disclose may be more to satisfy the doctor's own, often subconscious, need to be heard. For example, 'I also lost my mother recently.' The grieving patient may recognise that the doctor has not yet dealt with her own grief. Even if not explicitly stated, the doctor's facial expression, tone of voice and other hints and cues usually indicate an unresolved issue. One useful indicator of an unresolved issue is the doctor's unsettled or anxious feeling attached to the urge to self-disclose. These disclosures have a much higher risk of interfering with the focus on the patient, reducing patient respect for the doctor or reversing roles with the patient who may feel pressure to 'look after' the doctor.

Deliberate self-disclosure without careful thought, or when there is over-familiarity with the patient, and especially if there is a degree of sexual attraction, can lead to boundary violations with harm to both patient and doctor. Keeping boundaries as clear as possible between professional and rest-of-life roles reduces the risk of descent into more serious boundary violations, such as sexual involvement. Up to 4% of New Zealand general practitioners have violated this boundary.[9] If a doctor, particularly a rural practitioner, is sexually attracted to a patient and is therefore considering starting a relationship outside the normal doctor–patient relationship, great care should be exercised. Medicolegal advice should be sought to clarify ethical implications and potential consequences.

It should also be remembered that the doctor's self-disclosure is not confidential. One patient passed on to her friend that her doctor had disclosed a previous 'breakdown'. The friend attended the same doctor. The friend thought the disclosure 'unusual' and commented, 'It makes you lose confidence in the doctor'. It is possible the doctor's self-disclosure was helpful during the original consultation, but it created a problem for another patient when the information was passed on.

Guidelines for deliberate self-disclosure

Consultations with long-standing patients sometimes start with questions from the patient to the doctor such as 'How is your sore leg?' or 'How is the new baby?' or 'How was your holiday?'. It is appropriate to answer authentically but carefully. For example, too much detail about the overseas holiday may generate patient feelings of inferiority and disconnection with the doctor. Extended narratives should also be avoided with the increasing risk of irrelevance to the patient and taking too much consultation time.

While gathering information and negotiating a plan, opportunities for doctor self-disclosure often arise with potential to enhance the consultation by building the relationship and strengthening patient commitment to the diagnosis and plan. These self-disclosures should be for the patient's benefit and related to the patient's immediate concern. They should be brief and should not side-track the consultation. They should be followed by prompt return to the topic before the doctor's self-disclosure.

Where self-disclosures relate to the doctor's own emotional issues, only resolved issues should be disclosed and they should not threaten the patient's respect for the doctor.

As with all processes in the consultation, the doctor's self-disclosure should be accompanied by careful attention to how the disclosure affects the patient. It is useful to look for the patient's hints and cues, most of which will be non-verbal. The most important are signs of withdrawal or disengagement such as reduced eye contact, low energy responses, folding arms, crossing legs or shifting backwards in the chair. When detected, the doctor should stop, consider acknowledging the disjunction, and return to the patient's agenda.

In conclusion, doctors' self-disclosures are an important dynamic in consultations. It is useful to reflect on the types of messages unavoidably communicated by the doctor's appearance and speech, as well as by the practice and consulting room environment. It is important to recognise inadvertent self-disclosures caused by disruptive doctor transferences so these can be processed and minimised or resolved.

Deliberate self-disclosures by doctors to patients of personal information is common. It is important to recognise that these disclosures can be unhelpful and may disrupt or even harm the consultation, but with awareness and understanding, brief, deliberate self-disclosures may build the doctor–patient relationship and improve therapeutic outcomes.

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