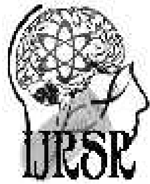

ISSN: 0976-3031

Available Online at http://www.recentscientific.com

International Journal of Recent Scientific Research
Vol. 7, Issue, 12, pp. 14527-14537, December, 2016

International Journal of Recent Scientific Research

Research Article

ESSENTIALITY 'IN THE DOCTOR-PATIENT RELATIONSHIP

Graziano Giorgio Maria Paolo[1]., Giovanni Castelli[2]., Antonino Graziano[3] and Antonio Di Cataldo[4]

[1]University of Catania Italy Dpt Sciences Medical of surgery and technologies advanted
[2]Policlinico University of Catania Italy
[3]Aggregate Professor
[4]Full Professor University of Catania, Medical School Italy Dpt Sciences Medical of surgery and technologies advanted via S Sofia 86 cap 95125 Catania

ARTICLE INFO

Article History:

Received 06th September, 2015
Received in revised form 14th October, 2016
Accepted 23rd November, 2016
Published online 28th December, 2016

ABSTRACT

The treatment of disease, the relief of suffering and the extension of basic care, according to the principle of fairness and justice, are the basic medical art character the presence of the human being stands as question of being and therefore being the person asks as an act of justice Recognition, warmth, hospitality and the defense of its integrity. The transcendent, spiritual dimension of the person has its ultimate roots in the truth of man's creation, intelligent finite being, who lives in a relationship with God in whose image and likeness. Reflect on the themes of health and disease, suffering and hope of the human person, it means researching the sense that these experiences have in the personal project of a person's life There are psychological reasons why we attach great importance to the truth of an assertion: it is not at all indifferent to whether it is true or not; It changes everything if you find that is not true, that those who reported he lied Because a relationship is really shared it is necessary that the doctor is willing to put in common with the patient not only the choices, but also the conditions of doubt and ignorance always keeping in mind that some people put the face of uncertainty are encouraged to making decisions, while others become anxious and unable to choose.

Copyright © Graziano Giorgio Maria Paolo *et al.*, 2016, this is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution and reproduction in any medium, provided the original work is properly cited.

INTRODUCTION

Verity

For the truth is generally defined as an absolute quality, which does not provide nuances, intentions, comparisons (we speak of partial truth, but it does mean that a fact consists of various elements, some are true and the individual elements can not be almost true). There are psychological reasons why we attach great importance to the truth of an assertion: it is not at all indifferent to whether it is true or not; changes everything if you find that is not true, that those who reported he lied. As part of the true / false speech, it is determining the intention of the speaker; the dichotomy lies / sincerity builds a key part of the trust. To have faith we must believe that the other person is telling the truth, then the concept of truth must be compared to that of sincerity, that is a definition of state turns into a definition of intent, of action. You can define the truth in two meanings: a truth is related to the scientific information available to the physician, and one is the truth of the report, which in addition to the technical data, there must also be a personal truth between doctor and patient, a clarity that regard knowing and not knowing, ignorance and known. The truth is subjective pain, the subjective discomfort of the individual patient; the only on, indispensable certainty from which you can start.(32.33) Gone is the old notion of truth as adequatio, correspondence between reality and propositions that define it, hath been growing support for a concept of truth first as consistency and then as compliance with rules, a truth so no metaphysical pretensions but with validity limited to contexts application. For Nietzsche there is neither truth nor falsehood, but only different perspectives on reality. When you know it is estimated, that organizes the reality according to the perspectivism of the values by which each person expresses the singularity of his existence. William James instead believed that the truth tends to coincide with the usefulness and, in particular, with the individual's utility. Every truth is always linked to the existential and environmental context of the knowing subject. The latest developments on the philosophical side is that drawn by the Oxford school, the so-called analytical, and in particular Strawson argues that a

*Corresponding author: *Graziano Giorgio Maria Paolo*
University of Catania Italy Dpt Sciences Medical of surgery and technologies advanted

performative interpretation of saying something that is true not finding anything, be true is not a property of something, but states or approves a sense: it is agreed. Horwich instead gives a minimal conception of truth: every proposition specifies their condition to be true. The condition would be sharing a belief.(34,35) It would be precisely the belief that connects truth, meaning and the world to a given community of speakers. The truth is the momentary representation of certain opinions and ideas, which are the result of individual level and social dominance of precise criteria, interests, power relations.

Today the prevailing view that there is no single truth about things; there are as many truths as there are conceptual systems with which we organizes, describes and not know the reality. Place a certain conceptual system, truth and falsehood do not depend on conventions or arbitrary choices, but by the concept of truth and verification criteria that apply in the context of the system and that a binding regulate transactions performed within it.(36)

Evolution of science, evolution of the truth

Gone down the myth of the nineteenth-century positivism can define true a theory when it is in accord with the facts, you can continue to talk about scientific truth? Doctors who express doubts during the visit, they tend to build through the words a greater relationship of trust who does not express uncertainty and gives the patient more information; usually the doctor more openly expressed his uncertainties or science with patients who want to have more information and that pose more questions. Among the people there are two opposite attitudes towards science: a) science is treacherous, false, fraudulent, defile the world and nature. b) science must be able to solve any problem; that science is rejected by some irrational to entrust to science while others overlook such a faith at the risk of disappointment guaranteed. The concept of science has to evolution and change; whoever believes static, he relies on a dogma destined to collapse. Kuhn for its evolution takes place by a mechanism similar to Darwinian evolution, not an approach to truth, but a more refined and detailed understanding of nature. Progress exists, but it can be understood as cognitive development towards an absolute truth; the proceeds not to know something (the truth), but from a new higher stage of ignorance toward greater understanding.(37,38) Science is not the truth. Scientific means only "procedurally correct" then, in a narrow view, perhaps "real" in the sense of ex-act, consequential, resulting. the scientist's job is not to turn ideas into proven truth, but consider them as hypotheses, as always falsifiable conjectures, that is considered valid until they are not denied. Descartes up all'induttivismo positivist science should have found a conclusive knowledge, yet in the course of its evolution, it became clear that it must not compete with other religions because it is the world of the assumptions that by definition eliminates any potential to reach the truth. For Popper there is no criterion for recognition of the truth; his concept of background knowledge that is the whole of what is not put into question every time for practical reasons, justify the idea that there is a starting point for the cognitive progress. It is a set of theories and conjectures that provisionally are therefore not to be considered-problems and provide a basis for "truth". A similar process takes place in general practice where knowledge of patients' background providing a stable platform on which the individual physician may base its basis in fact built on a social and cultural well known. The concept of likelihood of Popper argues that when you have to compare two truths together (for example, the opinion of the doctor and patient, the opinion of two doctors or two schools) must establish a criterion according to which one is more likely dell ' other; the idea of absolute truth has only regulative value, but you may prefer the theories which will hopefully be more of other true: the evidence-based medicine is not the truth, but what is more likely there is in circulation . Scientific truth is so fluid, transient, always on the verge of experimental refutation, lasts long enough to falsify The public is often exposed to the pendulum of anxiety: waiting for verification or refutation, are affirmed as absolute truth so contradictory, so people do not know what to believe. People need to trust, can choose faith in someone who claims to possess the truth, or trust in those who support the existence of doubt, uncertainty and varying degrees of certainty evolving. Users are aware of the medical power limit, be reckoned with uncertainty and skepticism, with the fact that the truths contained in the evidence is never neutral, that seek a second opinion does not give the truth but fed a healthy skepticism about the power of science. A more conscious access to care may be through greater clarity, greater degree of truth, the greater the uncertainty awareness, less paternalism.(39)

Trust

The difference between faith and trust is that those who have faith believes the other is all-powerful, those who trust him after questioning relies on him, on expectations that nourishes, after clarifying the doubts. The concept of trust is connected with the contract someone something to cherish; the physician is entrusted with the health, but whereas in the past the delivery was complete and uncritical, these days the patient now want control over what he has left in his keeping; it is a limited confidence that led to the fall of a myth medicine: Doctor icon that takes total delivery health and will of the patient has passed away. We give to our health and we do not trust the expert provided you know its strategies and its reasons. Trust is a feeling that gives a particular quality to a relationship and constitutes one of the foundations of the social structure; it is also defined as a firm belief in experiential quality consideration as honesty, truthfulness and justice, is a direct emotional attitude towards the outside, which implies a sense of support, confidence and peace of mind about the fact that certain acts and behavior will occur or not occur. It is a firm belief that has been questioned in the past, but which has been confirmed by positive experiences and are likely to be no longer in doubt. Through the trust you can then abandon unrealistic expectations and make predictions based on an examination of reality. On the contrary distrust is defined as the absence of security and reliability and distrust as suspicious caution, skeptical and doubtful about the possibility of surrender in care to someone. Mediation between trust and choice is made by information and communication.(40,41) The age, sex of the patient, the appearance of the doctor, the fact that the care provider has been recommended by someone else and the way in which the doctor is paid, are factors that affect the level of safety, while the opposite, kindness during the visit, the discussion of the options, the eye contact, a treatment at par, seem secondary elements in the induction of confidence. In a clinical report, the elements that promote trust

are the same that facilitate patient satisfaction. The sense of expectation is the degree of mutual dependency between patient and physician; one would expect that the other will face his agent and that when making decisions that involve specialists or hospital doctors, you let him to his interests. Many other factors contribute to creating and maintaining trust: the search for the real reasons for the visit, the respect for the opinions and feelings, the ability to make efforts and to take charge of the person, the demonstration of competence in the diagnosis and treatment, ability to comfort, the ability to encourage to ask questions, the desire to give explanations and information, respect for the knowledge that the subject has of itself, the ability to accept the love and the patient's hatred without intent vindictive and without that is expected of him emotional satisfaction. It is assumed that the trust is stimulated on the reliability and clarity: when there is no answer to any question you must disclose without fear; caregiver that recognizes the limitations of science makes the patient more realistic and less magically delivered to an illusion of omnipotence of medicine. The reliability is to protect patients from the unpredictability; behind the unreliability hides the chaos of the unthinkable and then somatization. In raising confidence is never a waste of time to use your imagination with caution to enter the thoughts, emotions, in the hopes and fears of the other; it is imperative to maintain her sense of personal identity, assure confidentiality and remember the ethical constraints of the profession. The trust does not have a practical purpose when born, but if you stick to the facts, and there arises a pragmatic, we realize that greater confidence, greater patient satisfaction, its compliance and continuity care. In the presence of a confident patient it is possible that the physician is able to set a relationship in which the waiting and the development of clinical facts find a space without the need to resort to laboratory tests from exclusively defensive significance. This will produce a reduction in costs and favors an observation of the natural history of the disease; if you reduce the claim to heal quickly or not sick at all or never die the atmosphere becomes less strenuous. When a suspicious patient does not agree to wait and see that her malaise takes an understandable form, will seek other medical and other examinations in a doctor shopping that will raise the cost and discomfort of both protagonists of the relationship. Patients who do not receive a diagnosis and remain suspicious, fearing worse their anxiety to be suffering from serious illnesses; in these circumstances, as well as the increase in public spending, there is a risk of an iatrogenic damage produced by unnecessary examinations. Confidence helps the patient to accept the way in which the doctor explains the news about his health and is to accept to be with-win with a decision rather than another. A conscious patient decides to be convinced, to trust, to rely; according to this meaning the trust loses its traditional instinctive character to acquire a conscious. Consciously you may choose to depend in part from another person without abandoning the guidance of himself in an alternate delegate motorcycle and derogation, in a shared process and inter-subjective.(42)

Psychodynamic communication

In medicine the floor of the doctor-patient relationship plays an unavoidable role and the ability of the physician to communicate with the patient is a key aspect of its clinical competence, involving more or less consciously the doctor, who sees in the therapeutic treatment with their own subjectivity.

Trust can be provided by a person supportive, respectful, empathic, participatory, that we do not take advantage, which encourages the use of words to express thoughts and feelings and trying to find the meaning of the suffering of the patient, provides the opportunity to reorganize the experiences and seek more adaptive solutions. Because confidence develops you should also create a complex social elements of regularity, certainty, consistency, seriousness within which are considered desires and needs.

To rely, people project their internal good object into new emerging objects (eg your doctor), thus creating the basis of learning and knowledge; the trust is connected gratitude, which is based on the security to enjoy a good source of physical or mental nourishment. Over a lifetime, many states such as immaturity, illness, old age, make weak physically or psychologically and then employees, but outpatient sick still master of his insight, unlike the ill hospitalized It maintains possession of his person that allows him to grant the trust retaining the awareness of self and of your country. The trust you grant consciously under continuous control and ecumenism can be maintained a high level of information and communication between the parties: the doctor who makes us participants in the patient, increases competence, self-awareness, and it prevents the subjection it promotes the ability to take responsibility for the care of your health. Safety is developed through identification with people who are worthy through positive experiences, it contains the perception and judgment on the other through a serious and repeated evaluation of the professional and interpersonal skills to share decisions and to take responsibility. If a patient does not trust, does not communicate; because they deliver care, it is requested that you carry some element of reality that allows him to compare the level of confidence in the confidence that can realistically expect. The difference between the trust and dependence is the realistic assessment of expectations. Those who try trust is less anxious to control hazards because he knows that to him there is sympathy and compassion and knows relax if experiments security, although it is aware that in some situations you need to be wary. In summary, the unsuspecting patient is convinced that the physician understands something of his problems, hopefully in the therapeutic process and think that if they take part in the clinical trial will heal; recognizes the limits of his interlocutor, he does not consider all-powerful, develops his feelings through a gradual examination of the doubt, not through an unlimited hope. The doctor-patient relationship is the particular relationship that develops between a doctor and a patient from a state of illness of the latter and which is characterized by specific obligations and moral and legal rights. It is an asymmetrical relationship in which the most vulnerable part is the patient, who is dependent on the competence and power of the physician. Generally, this relationship is expressed within a health care setting, public or private, and only in special cases in a home context (for example in the end of life situations that require the presence of palliative care at home). The report is created on symmetric aspects data from the mutual recognition of human nature and asymmetrical aspects resulting from the

different skills and the role they give to one of the two parties: the patient has a pain which does not include the causes, while the doctor is the technical, possessor of privileged spaces of observation and repository of scientific knowledge on which bases its work. Communication and clinical interview in its broadest sense, constitute the elements on which to base a relationship in which the record of the disease may take into account the subjective experience, emotions and psychic defenses. In the absence of narratives, the patient remains completely unknowable in the world and with it the chance to understand the willingness to change and then to cure. The patient's beliefs, however extravagant or wrong they may appear, have deep roots and largely even aware that they are dealing with his family and personal history, with his observations, the correlations between cause and effect that seems He has identified, with its beliefs and its culture. In an increasingly multi-ethnic world, also the medicine will often find itself confronted with cultures that may be very far from the western scientific heritage. It is the duty of the physician determine the patient references, clarify with him what are his views and his ideas about the disease, what he wants to know, what they can understand, that will affect his decisions and that from which will eventually , To take advantage. When you communicate you have universal validity claims concerning the clarity, truthfulness, honesty and in the speech situation should be present and fully respected. Such status does not exist but should exist as a regulative ideal of the reality of the relationship.

According Roter more frequent communication patterns used by the clinic pair are as follows:

Biomedical -Rigidamente: communications are limited to only clinical facts.(44,45)

Biomedico Widened: is there some openness with respect to certain aspects of the context

Biopsicosociale: The physician considers the patient immersed in its social context and is available to receive and send communications that refer to the entire life of the person.

Consumistico: Characterized by a use of the doctor who has to answer the questions of the patient in terms strictly limited to its needs. When they actually a doctor and a patient communicate with each other, are not transmitted aseptic data, exchange also other messages in the form of emotions, assessments on the ongoing relationship through implicit communications, impulses and thoughts are conscious. Every action, even every physical movement takes on a communication function; the physician should be aware of in order to use this resource to become [...] a negotiator, a consultant, with an agent of change and security manager. Communications confused instead produce half-truths that have their roots in the soil of information missing. The patient therefore needs demystification, clear communications, truth; you need to make it better able to express themselves either by lending listening, both suggesting greater awareness of its ways to narrate, it is discussing with him the meaning of the words used to explain the malaise. It is a commonplace notion, and yet you do not mind the fact that there are concerns too little of the elements that promote or inhibit people to seek clarification and information; the patient often feels not to have a favorable environmental situation asking questions: time is limited, the crowded study, the doctor stops immediately. Might as well keep quiet or take the information with more time can obtain the papers, on TV, the pharmacist, the neighbor.(46.47)

Models

The doctor-patient relationship has been characterized since the Hippocratic Oath by paternalistic medical ethics, that is, from an ethical conception that prescribes to act or omit to act, for the sake of a person without the need to ask his assent, as it is believed that the one holding the paternalistic conduct (in this case the doctor) has the technical expertise required to decide in favor and on behalf of the beneficiary (the patient). From this perspective, the doctor has pledged to restore an objective health status (independent of the patient's preferences) and the relationship is strongly asymmetrical because the patient is considered to be not only lacking the technical knowledge but also unable to decide morally. The ethical principles that are the basis of paternalism is the principle of charity, which contain an obligation to act for the patient's well and the principle of non-maleficence, which expresses the obligation not to cause harm to the patient. The contractual ethical model. In light of a framework so deeply changed, the medical paternalism has seemed to represent an ethical role model no longer appropriate, which was to affect the individual's right to self-determination. It has been replaced by a model report that focuses on the ethical principle of patient autonomy compared: the contractual ethical model. In this way the doctor-patient relationship is described as a symmetric relation whose contractors, autonomous, equal and having the same power of negotiation, freely sign a pact. It follows the introduction in medical practice of the practice of informed consent, ie the consent that is required for individual patients by medical staff before submission to diagnostic tests or therapeutic acts or engage them in a trial, having provided a 'adequate information on their health status and treatment options. From this perspective, become relevant the doctor's duty to inform the patient and obtain his consent, and the patient's right to decide what medical treatment to undergo or not undergo at all. However, this model also shows the limits in the context of the doctor-patient relationship. It, for example, fails to capture important elements that are present in this report, such as the fact that this report is not equal and symmetrical, or that there are items that are beyond the contract, such as investment trust, or all those virtues its a moral agent that accompany the fulfillment of an obligation, and that can hardly be enclosed by a signed contract. These difficulties have been faced trying to expand the reference ethical models, paying attention to the approach of the principles, the ethics of care, relational ethics, but without losing sight of the big change with which now any indication of what should be morally approvable behavior in a doctor-patient relationship has to face, namely the recognition of self-determination of the patient in medicine.(48)

The Paternalistic model. The medical paternalism, in its classical concept is a vision of clinical practice that poses a doctor-patient relationship more symbolic than real, excluding the patient, although for noble reasons from the knowledge of the truth of his health. The doctor decides the patient and performs with passive acquiescence to the provisions of professional authority; in this kind of relationship the patient behaves like a child dependent on his master. The outcome will result from the persuasiveness of the clinician; he possesses the

knowledge while the patient is unaware of it, one can inflict pain relief or, receive confidences without giving, can also limit the other's physical freedom through a hospitalization or various rules of taxation. This pressure on the patient so "natural" is what is called by Balint the apostolic function of the doctor. In this role, you find a complementary part of the patient who feels compelled to cooperate, to be good, obey. The doctor is then gratified by this patient's submissive position ending up feeling invincible and omnipotent.

The Shared model. The concept of partnership implies equality in power but also the responsibility. According to this scheme, the patient must receive information that tells him what is the best treatment for him in a way that can be compared with the treatment they would prefer to get. It is necessary that the clinical uses kindness, thoroughness, good communication, you are looking for cooperation seeking to understand what is good for the patient wants, what his personal considerations is based, so that the goal of treatment is in harmony with the hierarchy of values. After all, the essential feature of the partnership model is its interactive nature in which doctor and patient determine each stage of the decision process in a parallel manner; both reveal their predilections and both express their views. For this to happen, we must provide the patient with a comfortable atmosphere that allows him to express his preferences about treatment, including the option to stay on hold without rushing to do something.

The Informed model. The patient chooses by himself after the doctor explained the options. Communication is a one way, from the doctor to the patient; the sufferer gets detailed information about the risks and benefits and then decide. The transfer of information is seen as the only legitimate contribution of the physician: he merely provide guidance and alternatives without expressing personal opinions and trying not affect at all the owner's conclusions. This is an extreme model in which the patient's freedom is maximum and the physician assumes the exclusive role of technical performer. The model informed, in which the patient seems to be able to do without the doctor, appears to be an inexorable direction, as if it were a Darwinian evolution as if the partnership only constitute the intermediate stage of an unstoppable transformation, the consequences of which in 'medical field would be equal if not superior to those introduced from the Internet or from the new genetics.

Form and properties of PPPP model

The Physician Patient Paper Partnership is a model conceived by Rosser, Canadian physician, to foster understanding with the patient, provide the most reliable information about his condition, put in writing a real contract by which planning and diagnostic procedures therapeutic that will be followed during the course of the disease. The Rosser model contains all the elements that could turn a simple clinical report in a shared report; is placed at the patient's disposal a handout dedicated to the problem at clarifying the causes and pathophysiological mechanisms involved, offers several diagnostic tools, describes the natural history of the disease, provides for the possibility that you do not do at all on the issue, finally describes the various options therapeutic and the possible need for follow-up with deadlines considered most suitable to the monitoring of avian flu.(49) Each of the information provided stems from a thorough analysis of the most reliable evidence available and is frequently subjected to a review based on the changes that have occurred in the meantime in the guidelines. The patient brings with him the script, analyzes, evaluates it with those who want to, then come from the physician where the document is signed and kept by both. It is undeniable that a model contract such as the one presented by Rosser possesses the advantages, however, its usefulness can be best used when used primarily as a canvas for a debate and as a basis for the creation of more flexible instruments that do not as a prototype to play. If we examine some positive aspects: 1) the important decisions are taken outside by strong emotional situations. 2) the patient has the opportunity to bring home the artwork, we think calmly, sharing with family members or friends the pros and cons of each choice

A new report in the care

Current clinical medicine has attempted to recreate itself as an operational science by implementing the methodology of the evidence, that is, the conscious use, explicit and judicious use of current best evidence available when making decisions about the care of individual patients. Sackett *et al.* in 1997, he described the evidence-based medicine (EBM) as the use conscientious, explicit and realized of the current evidence in making decisions of individual patients assistance. According Djulbegovic EBM aims to:

Making The need for information in the clinical questions to which we try to give an answer;

Identify, with a proper methodology, the best evidence that allows to respond appropriately to this question; - Critically evaluate the validity and usefulness of such evidence; - Transfer in clinical practice the recommendation provided by the evidence; - Evaluate the performance and impact of the process in clinical practice (application verification); - Transforming the need for information in clinical questions to which we must look for an answer. Faced with such conditions, the question arises, the Evidence Based Medicine (EBM), whose clinical decisions are based on the "best available evidence" and not the "best available evidence", even with its most advanced systems (POEMS - patient Oriented Evidence that Matter) and the CPG (Clinical Practice Guideliness), is exhaustive in the doctor-patient relationship or, conversely, the current biomedical model, made of excessive technicality, the most updated scientific knowledge and, experimentally, more precise, it is not enough to solve the relationship? According Davids (JAMA, 1995) EBM invalidated if the healthcare provider does not feel the need for information is not available or to integrate the results of the literature in their own decisions. Giorgio Bert writes: it is obvious that the interaction between doctor and patient will be guided by the doctor, who will assume the task of accompanying the sick in choices and decisions; but accompany does not mean "push or force." The doctor "modern" caring and empathetic has some provisions in its approach methods that make effective and productive relationship with his patient and which also give new meaning to evidence-based medicine, such as counseling and Narrative Medicine.(50,51) E ', however, equally obvious that these new "relational" techniques he has to approach and learn them with humility and without arrogance. The "modern patient", in turn,

must have therapeutic education, which allows a transfer of powers from the physician to the patient, such as Bert observes, "to determine the relationship between the two, the dependence gives way gradually empowerment and cooperation. The counseling allows the doctor to activate an increasingly fruitful communicative relationship, useful for the two interlocutors, able to avoid the barrier methods and to improve both listening to an atmosphere of trust and cooperation between them. Rita Charon, the Faculty of Medicine at Columbia University, created the so-called Medicine Based on Storytelling (NBM). Today, a humanized medicine, careful and not autoreferenziata, all-powerful and arrogant, that holistically to be valid, must recover the doctor-patient relationship, where the story of her own life disease from patient to doctor starts is considered like signs and symptoms clinical disease itself. The novelty of the NBM is that it refers not only to the experience of the patient, but also to that of the doctor and their mutual relations. The doctor-patient relationship is often hampered and rendered useless for the same diagnosis on various factors, such as quickly, which reduces the time dedicated to the relational value, the distraction by the health care, the overly technical language used, the interruption It prevents the patient to freely continue his speech, the patient's exclusion from consultation between two specialists who discuss his case. In a nutshell, we can say that between the physician based on the patient-centered medicine and there are two theoretical models oriented on the one to cure (cure) and the other to care (caring, caring for each other). With foresight, in 1950 Luigi Condorelli, one of the greatest of the twentieth century Italian clinical., Citing the danger of an exaggerated pragmatism that can lead to the replacement of instrumental technique and the method of observation of the patient, leading to annihilate the personality of physician whose role was likely to be converted into a pedestrian as lackluster reconstruction of mosaic fragments, represented by the search results, often instrumental, performed on various systems and organs, usually by multiple observers, ie by so-called 'experts' of countless fragments of the human body. Medical specialization has frequently led to the misuse of scientific knowledge, mechanistically fragmented, the operator removes the global view of the case, the body and the person of the patient in his unit. There are situations in which the patient is to consult clinical specialists of the most diverse sectors, without which reaches to a diagnosis and a solution, with a consequent lack of responsibility of all. With today's medicine, high technology footprint (think of robotics applied to the surgical techniques), the individual, in his own experience as a patient, feel the discomfort of alienation, lack of empathy, when it interacts with a doctor split between science and bureaucracy, technology and economics. Just think of the sense of loss and abandonment that captures the patient when the control for a given disease, located nell'ambulatorio different from the expected doctor, with whom he had established a relationship and started treatment, which can also be the bearer different therapeutic ideas and choices. The lack of a referring physician to ensure continuity of care makes the patient more anxious and insecure, often leaving him alone to decide the direction to take with respect to their disease.

The patient-based medicine, developed in the 50s by Carl Rogers believed that a patient could only be understood starting from its perceptions and feelings, that is, his phenomenological world and that the doctor was not to manipulate events to the patient's behalf and it should avoid imposing objectives to the patient during therapy. Palma Sbreccia, Professor of Philosophy at the health Camillianum writes: respond to possible abuses of medical paternalism using only the principle of autonomy does not serve to balance the doctor-patient relationship, but rather seems to condemn it to the conflict, in which we compare two autonomies and two perspectives on the disease. Hollander, noting the onset and severity of the disease, distinguishes three levels of physician-patient relationship: - A first level, typical cases of urgency, coma, acute myocardial infarction or surgery: the ratio is one-way, which is active only the physician while the patient is passive and inert; - A second level, typical of acute diseases, where there is a doctor-patient relationship, as the patient is able to participate in therapy at the time, and can express personal views and have a good compliance; - A third level which occurs in chronic diseases and is characterized by a mutual and reciprocal participation. Finally it should be noted that whatever the doctor-patient relationship is always necessary to point out where, when and how it manifests itself and takes place and observe that you can not not communicate. Even a madman can express "rags" nonverbal communication through gestures, facial expressions, emotional reactions, laughed, cried, which can provide numerous well-interpreted, valid information. In these cases, the doctor is required time to devote to the relationship with the patient, active listening, observation of non-verbal communication, empathy and communication skills.

The narrative-based medicine is a kind of clinical practice reinforced by the words (of doctors and nurses, but most of the patients) in order to recognize, absorb, interpret, honor, metabolize and finally be guided by the history with which we are confronted to a certain type of medical action.(52,53) It is not simply to add a little 'of empathy on technical competence, but rather making concrete idea of health and disease is no longer seen only as a specific physical situations, but how deep condition of being from which the suffering depend, pain, health, and death itself. From a practical standpoint, there are many possible variations of this concept focused on the patient, the doctor, on group work or individual, dialogue, writing, or different forms of expression and so on, but always training is necessary because the disease is not simply a technical failure, and who has the responsibility to help others get out of it is to be formed to deal with the complex interactions that develop between real and lived experience of the individual, which therefore include but are not limited to a mere description of symptoms. Modern medicine operates under the constant pressure of speed on the one hand, and of the technical aspects on the other, focusing on the pathology of the disease at the expense, of the affection in the broadest sense of the term. The ability to listen and to respect the sick at the time of their suffering is very difficult to teach and to learn, and requires more time and money than teaching and learning of a medical procedure or instrumental: why not many administrators or politicians I am excited to promote it. In other words, the medical profession today is conditioned, warped by greed, and in this context there is not much interest in promoting a cultural approach that makes little and that requires investment.(54,55) The name Narrative-Based Medicine, is the mirror of

Evidence-Based Medicine, indicating the medicine based on evidence of effectiveness. But critics note that narrative medicine is not supported by statistical data of its clinical effects, and seems quite far from evidence-based medicine. It is true that we do not have impressive figures, but that is because the mathematical methods used today are not designed to evaluate parameters such as psychological well-being, quality of life and the relationship between them and the biological conditions; it is therefore impossible, in many cases, provide an accurate assessment of the effectiveness of the medicine or coherent narrative. Yet, Narrative and Evidence Based Medicine have a profound and positive relationship for both. Normally the content of what the patient says and clinical data that emerge during the narration will be lost, because the doctor does not have time or cultural and professional tools suited to treasure, educated and accustomed as it is to focus only on results. But if you learn to use all the information, and those "digital" is the most hidden in the experience of those who have faced, he automatically has the most comprehensive assessment tools, and find more effective therapeutic weapons. Much has been said and written on the role of the body of the subject in clinical practice, even starting from the timeless reflections of phenomenological imprint, launched in Italy by Umberto Galimberti now twenty years ago: The patient's body is not a simple "object "on which to implement care practices, treatment and rehabilitation, but a" person incarnate ", full of experiences, ideas, experiences and expectations. Although even in health care settings is a long time both began to consider the individual as a multidimensional bio and psycho-social, is still struggling to see health workers who actually put in place as systematized in theory. We must analyze the problematic, in the operation, a nursing practice and rehabilitative understood as meeting between "subjectivity incarnate", in which they enter the emotions in play, intimacy, sexuality, the deeper dimensions of one's being and latent Women and men. The health worker comes into contact not only with the other's body, which is a lived body, full of meaning, but also with his body, which is just as "live", full of emotions and pre-conceptions. The contribution that this study aims to bring in health practices, is precisely to reflect on the processes of care seen as meetings of "me bodily." The clinical training remains in the background of the various essays as a theoretical framework of constant and, at the same time reference, as a powerful educational strategy to develop awareness in health care workers on how to enter with all of oneself and one's body, with the experiences and the preconceptions that inhabit it, in the relationship of care. It must first become a good player, fully appreciate the words and stories, make a note of what refers the patient, re-read it and learn how to evaluate it and take it into account. And certainly learn to sit and listen.(56,57)

Evidence Based Medicine and Narrative Based Medicine. A comparison of two methods.

With EBM and NBM we are therefore intend to two practices, two disciplines, a more quantitative and the other more qualitative. But none of the two, in itself, responds to a single methodology. EBM uses some methods while the NBM will use most other developed within a scientific method and not within EBM. The Narrative Medicine needs a critical mass of people that is able to use its methods and for this, the practice should go into the development plans of health policies. The integration of the tools and methods of the Narrative Medicine (NBM) with the Evidence Based Medicine (EBM) may be a fundamentally important step to realize the care pathways that are more and more quality, and how the epidemiology, to develop 'interior of the great cauldron of the biomedical sciences. Similarly, qualitative research components of the NBM are developed within the context of the social sciences, psychology and so quality of medicine in branch. The methods are the tools to be able to answer certain questions. The question of the origin, then, may be the same and can be addressed through different methodologies. An example: if I have to figure out whether a drug works better than placebo will adopt an experimental methodology that plans to randomize patients to the drug and placebo, thus using an experimental design of randomized type and inserting a number of elements such as a more extensive follow-up , then taking advantage of statistical inference techniques to find an answer; the same way I can make a qualitative research, interviewing patients to see if they take the drug and what type of problems they had in assuming it, and then figures out what are the elements that could explain the result of the trial. So if I do not see a difference between the drug and placebo, this phenomenon could be explained by a low compliance that you can explore by making semi-structured interviews or using a more qualitative methodology such as ethnography, which helps me to understand what are the issues related to the success or failure of the experiment.(58,59,60,61)) Large clinical research traveling within two strands. If you have available a very high budget you can answer a series of questions, but if you do a search that is much more "fragmented" you prefer to answer a question that more quantitative to a more qualitative question. There are two important parts in narrative medicine, with two professional components also different. One is of those who use narrative medicine in a very abstract, so we talk about narrative medicine understood as "the importance of listening to patients" and "humanization of medicine", ideal abstract concepts and not contextual, who can not provide a calculation of the sample or of the numbers (this is often a mode of approaching narrative medicine). Another way is instead a scientific approach, equally as scientific as is the medicine enough evidence. For example, if you have a hypothesis to be tested, they collect the data in a qualitative manner, but the protocol and the methods are developed as much as those of the EBM. Often there are very few researchers and people who deal with narrative medicine and who also have a research background. The research methods of NBM are: shadowing, ethnography, the reflective practices. Unfortunately they are not yet widespread, and there is much talk of narrative medicine in an abstract sense, in the ideal sense, and not enough talk about those who are precisely the methods. The main method is the use of reflective practices in the clinic: having to do with the stories, the stories of patients, in a protected time and in an appropriate context in which physicians have the opportunity to read these stories with a purpose. For example, to understand why the hospital environment is experienced in a negative way by the patients and what are the obstacles that prevent pleasantly perceive it (considering the problems of medical malpractice). Therefore involve not only the history of the patient, but what are the health effects on the organization and the complexity of

the work. At a time when the narrative medicine intervenes with this mode shows the clinical, on the fly, as the process of care and the hospital itself can be improved. Be improved, therefore, to respond also to the needs of patients(.62.63,64,65) It is not just the "patient history", but the fact of observing the patient, observe the patient's habits and what he says, and his own experience, and then attach it to health, and cultural context. If the stories are collected without a finalization is harder then go to extrapolate from the stories themselves what are the implications for the health care context. If the narrative medicine is a way of listening to patients and identify critical system and then go to resolve them, it is a good practice. Therefore it can not be interpreted as defensive medicine(.68,69,70,71) It could be identified as an intervention to improve the quality and appropriateness, while defensive medicine has a strong negative connotation related to the fact that health and medical organizations think to protect themselves and to avoid any legal consequences. There are definitely for the acts and issues that lead the patient to accumulate distrust of organizations because for example there is no willingness to listen or is there a frank rudeness on the part of the system. Better attention to the user, therefore, does not mean doing "narrative medicine" but pay particular attention to when the patient is in the hospital, what are the related needs not only to his care but to the service to make possible improvements to the system, which is in itself a virtuous mechanism. One weakness of narrative medicine is that most often develops in an ideal scenario, no context, it becomes a declaration of intent typical: "We should be more human", "we must listen to the patient." This has little impact from the practical point of view. A relational approach, then, is surely something very important but must have repercussions at the organizational level: we can make very good doctors to listen to the patient but, if you do not provide methods, and you can not also involve the 'organization around the doctors to be sufficiently suitable for putting the patient in a position where it can interact with the system, there will always be an element of weakness.(72,73,74,75) Instead, the more narrative medicine comes into contact with the organizational aspects of becoming a "robust approach", all the more reinforces the sharpness. The last weakness is that at the political level does not have a strong base. At the political level, some instances of narrative medicine must be submitted with the operational plans, compared to health organizations, more precise and cogent. If, for example, the hospital has a problem of infections, in that hospital it is activated a task force to prevent hospital infections. This task force follows the protocols to reduce the risk of nosocomial infection, and if there are any problems acts to contain the damage. In narrative medicine, however, a common protocol has yet to be developed. Thus, if a department needs a nurse who is able to collect the patient histories they need to be activated a series of lessons to form it to apply a specific protocol: a protocol that enables it then to lead to measurable improvements.It is important to talk about "political level" because the key step is to switch contexts as books or meeting, where a lot of narrative medicine speaks, to have a relapse for organizational who has plans of health policy development. So if you decide to involve a narrator doctor or a nurse narrator, you should know what the benefits are going to experience and that these possible benefits must necessarily be quantified.It is difficult to integrate the narrative medicine as a practice within health policy because it still does not exist a critical mass of people who are able to use these methods. Several people involved in narrative medicine but very few of them have a background in research, data collection, and development of a given than a hypothesis, so it can tell the improvement was due to a certain type of intervention. It must be something that goes beyond the individual person that makes narrative medicine also involving doctors of the department, the managers of the company, the general manager. (76,77,78,79)These must tell the improvement and pick it up through the methods of ethnographic research, shadowing and monitoring reflective practices of doctors together with patients. Abroad it is much more common the fact to support quantitative research qualitative research. There are trials that I personally brought in Italy and that they always have a relevant part of qualitative research in which they are listened to both patients and physicians. These are extraordinarily useful data to read then what happens to the complex and have organizational impact interventions. For example, right now we are studying the use of computerized decision support systems, real sailors for medicine. One can imagine the doctor who is directed by a navigator and is controlled diagnosis for diagnosis, therapy to therapy, and if a mistake is immediately input to correct it. This, in terms of both the medical as well as the patient's point of view, it means completely changing medicine and also the impact it has for those who make it and those who receive it. Here the narrative is important because it tells you what are the actual barriers and is no longer just the doctor who follows his "art", but there is also a computer that provides instant feedback on its work. In this context we see immediately the presence of a hypothesis of departure and what are the barriers to adoption of decision support systems. Narrative medicine is joined to EBM and is part of a complex system that makes good research. And the good research is only one, both qualitatively both quantity.(80,8182,83)

What are the methods and tools used in the field of narrative medicine?

The narrative paradigm assumes a particular value in the approach to patients with chronic diseases, where the patient and his family enter fully as partners and co-authors of the course of treatment. Narrative Based Medicine (NBM) was born with this primary objective and would be most essential to know the methods and application techniques. Each in its environment applies storytelling brushstrokes sometimes under the illusion that this approach is only a humanized and deepening awareness to the disease. (84,85,86,87,88,89,90) Narrative medicine requires proven useful methodological approaches, comparability and reproducibility according to the principles of effectiveness and efficiency The purpose that it is intended is to understand through the study of literature as we realize the current stance of narrative medicine by analyzing the methodologies and tools that you use in clinical practice, including with regard to research and development of competence narrative.(91,92,93,94) The development of narrative medicine is based on a dual recognition, namely that human disease is primarily a semantic and full of meaning, and that all clinical practice is inherently interpretive and "hermeneutics.(95,96,97,98)," This implies that, as Charon, the doctor investigates with creative mind, open and with courage,

multiple causal relationships between symptoms and the complex situations that the patient presents, putting in connection events and different elements and far between, to construct a plot that makes the disease something that makes sense for him. (99,100,102,103)Intersubjectivity is born from the encounter between a narrator and a listener through a text, a plot intended as a structure that connects the events between their second significant causal links. The Charon says further that therapeutic relationships are based on complex text, including words, silences, physical aspects and images. The narrative can bring one who says to exhibit aspects and parts of themselves confidential and intimate. (104,105,106,107)The professionalism of the physician implies an ethical attitude of respectful listening and careful in accepting the stories of the patient, avoiding to ask intrusive questions and to search for information not strictly useful, forcing the story that the person is doing. The narrative has to do with individuals. Also it regards what these individuals feel and what others feel compared to them, or simply what they do or is done for them.(108,109,11o,111) All elements that combine to provide an overall picture of the person and the context of social, psychological, and not only that, but also the biological and physical aspects. From these considerations comes the NBM approach. Narrative medicine is not only aimed to better understand the patient and his disease, but become a cornerstone diagnostic act and care; encounter narratives based clinical constructing a history of the disease, exploring all sizes: the doctor and more generally the health care worker enters thus with all his heart, in order to build a knowledge of the patient, understood as a single entity and unrepeatable ..(112,113,114,115)In narrative medicine they appear fit for purpose and some tools are particularly relevant: -the conversation, clearly different from interrogation, including medical / health care worker and person being cared about his experiences of illness; -The story written and reported by the patient on his experience of illness; -the communication and discussion between the doctor / healthcare professional and the person being cared for doubts and difficulties that the current disease involves. The reconstruction of the events and the entire context in which it is inserted, forces you to recompose, to integrate critically, in an overview of the elements that analysis tends to separate. The only way to square the disease of textbooks (which is an abstract concept and probabilistic) with what we have defined the disease as an individual problem is to explore the universe of meanings that constitutes the other's world (116,117,118,119)The other world is revealed to us through the narrative. Exploration is an anthropological intervention by which you venture very gently into unknown territory, but where terms and concepts that might seem rather have shared very different meanings.120 121,122,123) The doctor says, "diabetes" and has in mind a definite condition: the patient says "diabetes" and has in mind a complex and nuanced issue, involving him, his family, his job, his present, his future. In the perspective of narrative medicine questions to find elements of the patient's illness semantic network, according to the anthropological concept of Byron Good can be: -When Started the problem? -What Other things have happened in her life? -How Do you think you might be related to his problem? -What Has had previous experience with this disease? -What Problems led to the disease in his life? -A What he had to give up because of illness? -Conosce Other people who have experienced the same condition? -What Problems caused them? How much thought to worsen the disease in the future? -What Are the most difficult and important experiences that can associate with this problem? -such Experiences are especially significant for her and her family (social, ethnic groups)? -What Other people think than to his problem? -How Have reacted to it? -How Did you feel with respect to these reactions?(124,125,126,127)

References

F.W.Nietzche, *Al di là del bene e del male*; *Genealogia della morale*, versioni di Ferruccio Masini, Adelphi, Milano 1968.

E.Riverso, *Riferimento e struttura. Il problema logico-analitico e l'opera di Strawson*, Armando, Roma 1977.

P.Horwich, *Verità*, trad.it. M. Dell'Utri, Laterza, Milano 1994. La tesi è che una adeguata teoria della verità non è niente altro che la collezione infinita di tutte le istanze dello schema: la proposizione che P è vera se e solo se è P. La sfida del minimalismo consiste nel sostenere che sapere il significato del predicato di verità non significa fornire una analisi del contenuto ma piuttosto spiegare il nostro comportamento linguistico più rilevante, ossia tutti i modi in cui usiamo la parola "vero".

Vedi S.Cataldi, *La ricerca sociale come partecipazione. Il rapporto tra ricercatore e attore sociale nell'indagine sociologica*, Editore Franco Angeli, Milano 2013.

Ibidem

Vedi K.R.Popper, *Verso una teoria evoluzionistica della conoscenza*, Armando, Roma, 1994.

G.Domenighetti, *Il mercato della salute: ignoranza od adeguatezza? Analisi degli effetti dell'informazione sul mercato sanitario*, CIC Edizioni internazionali, Roma 1995.

D.W. Winnicott, *Dal luogo delle origini*, Cortina, Milano 1990.

O.F.Kernberg, *Borderline Conditions and Pathological Narcissism.* New York: Aronson, trad. it. *Sindromi marginali e narcisismo patologico*, Boringhieri, Torino 1978. Quando ci si affida a qualcuno, deve esistere la convinzione che non si subiranno tradimenti o aggressioni. Tra fiducia e dipendenza esiste un rapporto che va compreso a fondo; il senso comune attribuisce alla dipendenza una accezione negativa ed in effetti chi è assoggettato viene sottilmente disprezzato, mentre chi viene descritto come "fiducioso negli altri" riceve una connotazione favorevole.

F.Cioffi, F. Gallo *et al.*, *Corso di filosofia*, Mondadori, Milano 2000.

D.L. Roter, M.Stewart, S.M.Putnam, M.Lipkin, W.Stiles, T.S.Inui, *Communication patterns of primary care physicians,* JAMA 1997 Jan 22-29; 277(4):350-6.

S.Perini, *Psicologia dell'educazione*, Il Mulino, Bologna 1997.

S. Mitchell, *Influenza e autonomia in psicoanalisi*, Bollati Boringhieri, Torino 1993.

M.Balint, *Medico, paziente e malattia*, cit.

S.Perini, *Psicologia dell' educazione*, cit.

W.Rosser, S.Shafir, *Evidence Based Family Medicine,* Decker Inc, Hamilton, London 1998. Vedi anche: W. Rosser And J. Kasperski, *The Benefits of a Trusting Physician-Patient,* Relationship The Journal of Family Practice, April 2001, Vol. 50, No. 4.

Ibidem

P.Fonagy, M.Target, *Attaccamento e funzione riflessiva*, trad.it.,Cortina, Milano, 2001.

D.LSackett, W.M.C.Rosenberg, J.A.M.Gray *et al.*, *Evidence-Based Medicine: What it is and what it isn't*, BMJ 1996; 312:71-2.

B.Djulbegovic, Am J Med 1999; 106: 198-205.

Ricordiamo che per Slawson (J Farm Pract, 1994)

la POEMS è determinata dal rapporto Relevance x Validity / Work , che esprime la potenziale utilità per la pratica clinica e riguarda gli interventi sanitari su end point clinicamente significativi: eventi maggiori, mortalità, qualità di vita, misura il tempo, impegno mentale, costi.

G.Bert, *Per un miglior rapporto,* cit.

L.Condorelli, *Sull'educazione etica del medico*

P. Sbreccia*, Rapporto medico-paziente, consenso informato, dichiarazione anticipata di Trattamento- Corso di Perfezionamento in Bioetica* –UCSC Milano 9 aprile 2008.

Hollander MH. The psychology of medical practice: Saunders Philadephia, 1958. 72 galiberti 91

R. Charon*, Narrative Medicine: Form, Function, and Ethics,* Ann Intern Med 2001; 134: 83-87. Vedi anche R.Charon*, Narrative Medicine: Honoring the Stories of Illness,* Oxford University Press, New York: 2006

Ibidem. Rita Charon identifica cinque aspetti che costituiscono gli elementi narrativi nella relazione con la persona assistita: la temporalità, l'unicità, la causalità, l'intersoggettività e l'etica. La temporalità riguarda lo sviluppo nel tempo della storia del paziente e il riconoscimento della soggettività nel valore attribuito al tempo. L'unicità della persona e della sua esperienza implicano il riconoscere nelle parole del paziente il senso da lui attribuito alla malattia. Questo consente di impostare una relazione terapeutica basata sul dialogo, sulla comprensione e sulla condivisione.

L.Zannini*, Medical Humanities e medicina narativa*, Raffaello Cortina Editore, Milano 2008.

G.Bert, *Medicina narrativa*, Il Pensiero Scientifico Editore, Roma 2007.

[77] B.J.Good, M. Del Vecchio, M.J. Good, *Il significato dei sintomi: un modello ermeneutica culturale per la pratica clinica*, in *Storie di cura* (a cura di), Giarelli G. *et al*. Franco Angeli, Milano 2005.

R.Charon, Narrative Medicine, cit.

J. Launer, *Narrative-based Primary Care. A practical guide*, Radclife Medical Press, Abington 2002

J.A. Sakzlys, *Restoring the patient's voice. The therapeutic of illness narratives*, J Holist Nurs. 2003; 21(3): 228 41.

M.Lavie-Ajayi, N.Almog,M. Krumer-Nevo, *Chronic pain as a narratological distress: a phenomenological study*, Chronic Illness 2012; 8(3) :192–200.

J.Cummings, *Sharing a traumatic event*, Nursing Res 2011; 60, (6) 386-392.

D. Heliker, *Enhancing relationship in long term care through story sharing*, J. Gerontological Nursing 35,6,2009: 43-49. Lo *Story Sharing* ha come presupposti teorici la *Theory of Caring* di Watson (1988/1999) e l'approccio ermeneutico fenomenologico di Heidegger (1927/1962).

L.C. Hyden, E. Antelius, *Communicative disability and stories: Towards an embodied conception of narratives,* Health 2011: 15(6) 588–603.

A.Marini, V.Galetto, E.Zampieri, L.Vorano, M.Zettin, S.Carlomagno, *Narrative language in traumatic brain injury*, Neuropsychologia 2011; 49:2904-2910.

R.Zucchi, A.Moletto, L.Garrino, *La Metodologia "Pedagogia dei Genitori" per il patto educativo terapeutico famiglia e sanità*, Quaderni ACP 2013; 20(6): 260-264. Lo strumento della Metodologia Pedagogia dei Genitori, che si avvale della presentazione dei figli da parte dei genitori, è diventato strumento funzionale al Patto educativo famiglia professionisti.

J.Launer, *Narrative-based medicine: a passing fad or a giant leap for general practice?*, Brit J Gen Pract 2003, 91-93.

S.Ash, P.Moore, S.Antani, G.McCawley, M.Work, M.Grossman, *Trying to tell a tale. Discourse impairments in progressive aphasia and frontotemporal dementia*, Neurology 2006; 66:1405-16.

Ad ogni soggetto è chiesto di sfogliare il libro per familiarizzare con la storia. Quando pronto è chiesto di iniziare a raccontare la storia come se la stesse raccontando a un bambino, seguendo la successione delle immagini. Le narrazioni sono registrate digitalmente. Le registrazioni sono trascritte dettagliatamente da trascrittori addestrati usando Praat. Tutte le trascrizioni sono analizzate da due soggetti indipendenti. Si codificano le seguenti variabili: la durata del racconto; il numero di enunciati; il numero di parole; la difficoltà lessicale; la completezza dei contenuti; la descrizione delle azioni; le interconnessioni globali e le interconnessioni locali.

L.Hassling, S.Nordfelt, H.Eriksson, T.Timpka, *Use of cultural probes for representation of chronic disease experience: Exploration of an innovative method for design of supportive technologies*, Technol. Health Care 2005; 13:87-95.

I. Finiguerra, L.Garrino, E.Picco, P.Simone, *Narrare la malattia rara. Esperienze e vissuti delle persone assistite e degli operatori,* Edizioni Medico-Scientifiche, Torino: 2012.

P.M.Wilcock, G.C.Brown, J.Bateson, J.Carver, S.Machin, *Using patient stories to inspire quality improvement within the NHS Modernization Agency collaborative programmes*, J Clin Nurs. 2003; 12:422-430.

J.F.Steiner, C.T.Nowels, D.S. Main, *Returning to Work after Cancer: Quantitative Studies and Prototypical Narratives,* Psychooncology 2010; 19(2):115–124. I casi tipici, più rappresentativi, usati per trarre conclusioni circa normali membri della categoria, i casi *Nightmare* che esemplificano i risultati che si potrebbe sperare di evitare, i casi *Ideal* o casi "inspirational" usati come standard o benchmark che mostrano quello che potrebbe essere possibile in circostanze eccezionali.

L.J.Phillips,S.A. Reid-Arndt, Y.Pak, *Effects of a creative expression intervention on emotions, communication, and quality of life in persons with dementia,* Nurs. Res. 2010;59(6):417-25.

K. Chan Garrett, *Trajectories of Approaching Death in the Emergency Department: Clinician Narratives of Patient Transitions to the End of Life*, J. Pain Symptom Manage. 2011; 6: 864-81.

D.Docherty, M.A. McColl*, Illness: themes emerging through narrative,* Soc Work Healt Care 2003; 37(1):19-39.

D.Groleau, A.Young, L.J Kirmayer, *the McGill Illness Narrative Interview (MINI): an interview schedule to elicit meanings and modes of reasoning related to illness experience,* Transcult Psychiatry 2006; 43(4): 671-91.

J.A.Overcash, *Narrative research: a review of methodology and relevance to clinical practice*, Crit. Rev. Onc. Hemat. 2003; 48:179–184.

R.Charon, *Commentary: Our Heads Touch: Telling and Listening to Stories of Self*, Acad. Med. 2012; 87:1154

R.Charon, *Commentary: Our Heads Touch: Telling and Listening to Stories of Self*, Acad. Med. 2012; 87:1154–1156.

Rita Charon effettua un commentario che ha la finalità di commemorare il 10° *Academic Medicine's Teaching and Learning Moments feature* (TLM) della *Academic Medicine*, e nello specifico ad un seminario interprofessionale chiamato "*Cultures of Health, Illness, and Health Care*", che si tiene ogni settimana del semestre primaverile. Partecipano al seminario studenti e docenti di quattro scuole diverse: *dental, medical, nursing, and public health della Columbia University.* Insieme, studenti e docenti, si confrontano e imparano sulle differenti culture, sulla malattia e sulle cure, a partire da una riflessione sui loro vissuti e sulle loro esperienze.

B.Ogur, D.Hirsh, *Learning through longitudinal patient care-narratives from the Harvard*, Accademic Education 2009; 84, 844-850.

M.Trento, E.Borgo, L.Semperboni, L.Cirio, V.Dimonte, M.Porta, *La narrazione e la rilettura delle esperienze personali come strumento di formazione in ambito sanitario*, G. It. Diabetol. Metab. 2009; 29:151-155.

T.Greenhalgh, T.Wengral, *Collecting stories: is it research? Is it good research? Preliminary guidance based on a Delphi study,* Med Ed 2008; 42:242-247.

www.stanzenarrative.it, Retrieved from http://www.stanzenarrative.it/default.htm, accessed 13 Aprile 2014.

www.viverlatutta.it, Retrieved from http://www.viverlatutta.it/ accessed 13 Aprile 2014.

S.DasGupta, R.Charon, *Personal illness narratives: using reflective writing to teach empathy*, in Acad. Med. 2004; 79(4):351-356.

D.Hatem, E.Ferrara, *Becoming a doctor: fostering humane caregivers through creative writing*, Patient Educ. Couns. 2001; 45:13-22.

P.Brustenghi, M.Zampolini, *Medicina Narrativa. SIMFER. Ricerca e Riabilitazione*, Edizioni Minerva Medica, Torino 2013.

W.A.Steiner, L.Ryser, E.Huber, D.Uebelhart, A.Aeschlimann, G.Stucki, *Use of the ICF model as a clinical problem-solving tool in physical therapy and rehabilitation medicine*, Phys Ther, 2002; 82:1098-107.

E. Borgna, *Come in uno specchio oscuramente*, Feltrinelli, Milano 2007.

P.Brustenghi, L.Garrino, *Linee di indirizzo per l'utilizzo della Medicina Narrativa in ambito clinico-assistenziale*, Quaderni di Medicina, N.7, 24 Feb- 2 Mar 2015.

J.Launer, *Narrative-based medicine: a passing fad or a giant leap for general practice?,* Brit. J. Gen. Pract. 2003, 91 - 93.

B.Ahlsen, A.M.Mengshoel, K.N.Solbraekke, *Shelter from the storm; men with chronic pain and narratives from the rehabilitation clinic*, Patient Educ. Couns. 2012; 89: 316-20.

R.Charon, *Narrative medicine: honoring the stories of illness*, New York: Oxford University Press, 2006.

F.Griffiths,J. Borkan, D.Byrne, *et al*., *Developing evidence for how to tailor medical interventions for the individual patient*, Qual Health Res 2010; 20(12): 1629-41.

N.Piana, A.Maldonato, D.Bloise, *et al*., *The narrative-autobiographical approach in the group education of adolescents with diabetes: a qualitative research on its effects.* Patient educ. couns. 2010; 80(1): 56-63.

S.Tropea, *"Therapeutic emplotment": a new paradigm to explore the interaction between nurses and patients with a long-term illness,* J Adv Nurs 2012; 68 (4) 939-47.

C.Mattingly, *The concept of therapeutic "emplotment". Special issue: narrative representations of illness and healing,* Soc. Sci. & Med, 1994; 38(6):811-822.

W.E. Stempey, *Clinical reasoning: new challenges*. Theor med bioeth 2009; 30(3):173-9.

S.Angel, L.D.Jensen, B.K.Gonge,T.Maribo, B.Schiottz-Christensen, N.Buus, *Patients' interpretations of a counselling intervention for low back pain: A narrative analysis*, Int J Nurs Stud 2012: 49(7): 784-92.

P.Ricoeur, *Interpretation theory. Discourse and the surplus of meaning*, Fort Worth, TX: Texas Christian University Press, 1976. La teoria di Bury (17) sulla malattia cronica come agente distruttore della biografia personale, è stata usata come cornice teorica interpretativa dei dati.(Vedi M.Bury *Chronic illness as biographical disruption*, Sociol Health Illness 1982; 4(2):167-82

S.Jakobi, R.MacLeod, *Making sense of chronic illness, a therapeutic approach*, J Prim Health Care 2011; 3(2): 136-41.

A.M.Roth, R.T.Ackermann, S.M.Downs, *et al*., *The structure and content of telephonic scripts found useful in a medicaid chronic disease management program*, Chronic illness 2010; 6(2):83-8.

N.Piana, A.Maldonato, D.Bloise, *et al*., *The narrative-autobiographical approach in the group education of adolescents with diabetes: a qualitative research on its effects*, Patient educ couns 2010; 80(1): 56-63.

E.Steeman, *Living with dementia from the perspective of older people: is it a positive story?*, Aging Ment Health 2007; 11(2): 119-30.

M.Heidegger, *Kant e il problema della metafisica*, tr.it. Silva, Milano 1962, Spe salvi, n.26

****

How to cite this article:

Graziano Giorgio Maria Paolo *et al.*2016, Essentiality 'In The Doctor-Patient Relationship. *Int J Recent Sci Res.* 7(12), pp. 14527-14537.