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"Enough about Me, Let's Get Back to You": Physician Self-disclosure during Primary Care Encounters

Diane S. Morse, MD,
University of Rochester School of Medicine and Dentistry, and Hebrew University of Jerusalem (Fulbright Program), Rochester, NY 14642

Susan H. McDaniel, PhD,
University of Rochester, Rochester, NY 14620

Lucy M. Candib, MD, and
Family Health Center of Worcester and University of Massachusetts Medicine Center, Worcester, MA 01610

Mary Catherine Beach, MD
Johns Hopkins University, Baltimore, MD 21210

Patients want a relationship with a physician with whom they can talk freely, and physicians vary in how they engage with patients. One form of engagement is self-disclosure, in which the physician reveals something personal about himself or herself. Historically, self-disclosure has been considered unacceptable in both psychiatry and medicine. Freud advocated that psychotherapists act as blank slates, and Osler advised physicians to maintain *aequanimitas* or impartiality (1). Recent psychodynamic literature stresses boundaries, calling clinician self-disclosure risky, potentially motivated by projection, and distracting to patients (2–5).

Nevertheless, recent studies reveal that primary care physicians are talking about themselves to 25% to 30% of patients, and that these disclosures may not be effective in increasing rapport, conveying understanding, or helping patients engage in improved self-care (6–8). Using simulated dialogue as illustration for primary care physicians and drawing on theory and evidence in the literature, we discuss the effectiveness of physician self-disclosure and offer practical suggestions. We focus mainly on spontaneous verbal self-disclosures (for example, information that the physician offers about his or her own physical or mental health, personal life, or beliefs, but *not* in response to a patient question) and make recommendations for improving or replacing these disclosures on the basis of research we and others have conducted. We then briefly discuss inadvertent disclosure and patient requests for self-disclosure.

Requests for Single Reprints: Diane S. Morse, MD, University of Rochester Medical Center, Box Psych, 300 Crittenden Boulevard, Rochester, NY 14642; e-mail, diane_morse@urmc.rochester.edu.
Current author addresses are available atwww.annals.org.
Current Author Addresses: Dr. Morse: Departments of Internal Medicine and Psychiatry, University of Rochester Medical Center, Box Psych, 300 Crittenden Boulevard, Rochester, NY 14642.
Dr. McDaniel: Departments of Family Medicine and Psychiatry, University of Rochester, 777 South Clinton Avenue, Rochester, NY 14620.
Dr. Candib: Department of Family Medicine, Family Health Center of Worcester, 26 Queen Street, Worcester, MA 01610.
Dr. Beach: Department of Internal Medicine, Johns Hopkins University, 2024 East Monument Street, Baltimore, MD 21210.

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SPONTANEOUS SELF-DISCLOSURE

One trigger for spontaneous self-disclosure occurs when physicians meet patients facing symptoms, challenges, or life situations that they themselves have encountered. We recommend that physicians who feel the impulse to self-disclose in these instances become more aware of the impulse and its triggers and consider the usefulness of each disclosure. Often, physicians can replace the disclosure with a more effective, empathic statement or make the self-disclosure more effective by keeping it brief and transitioning quickly back to the patient.

Consider Self-disclosures Carefully

A recent study of self-disclosures by community doctors revealed that 40% of physician self-disclosures were unrelated to patients' preceding remarks (6). Most self-disclosures (85%) did not seem to address patients' medical concerns or promote relationship-building, and 11% seemed disruptive, in that they interrupted patient histories, were competitive, or raised potentially troubling emotional issues. In many examples, researchers found clinicians telling patients in seemingly reflexive ways that they share an experience and also that many physicians lost sight of patients in their disclosures (5,6,8).This loss of focus may explain the finding that physician self-disclosure can reduce patient satisfaction (7). We recommend that physicians examine situations that trigger their impulses to disclose personal information and consider the relevance of the potential disclosure to patients. Enhanced awareness is likely to avert a substantial number of irrelevant disclosures.

Ultimately, the only appropriate purpose of physician self-disclosure is to serve patient needs, requiring physicians to reflect on their motivations for and the potential utility of each self-disclosure. Some potentially good reasons for physician self-disclosure include role-modeling and building and maintaining relationships with patients. In the following example, the physician uses her own experience to both reassure the patient and model a health behavior.

> *Patient*: I feel nervous about my colonoscopy.
>
> *Physician*: Any particular reason?
>
> *Patient*: It's embarrassing. And what if it hurts?
>
> *Physician*: Well, I've had one myself, and they keep you pretty sedated. It wasn't that bad. You could ask Dr. J [the gastroenterologist], because she is the one who would manage your pain during the procedure.

Physicians might use similar self-disclosures to encourage patients to undergo other screening tests or to adhere to recommended medications. One study examined primary care patients' reactions to such role-modeling by asking them to rate 2 psychoeducational videotapes (9). In one video, a physician spoke about her own health behaviors and, in the other video, the same physician counseled without self-disclosure. Patients rated the self-disclosing video as more believable and motivating. In a study of 357 Israeli patients, 20% reported that physicians used self-disclosure to convince them to accept a procedure or treatment, and 76% of those patients felt it was effective (10).

Experienced family physicians report that use of self-disclosure can promote intimacy and mutuality (11), and some believe that physician self-disclosure can decrease hierarchy (12, 13). In the following example, the physician expresses personal understanding, acceptance, and solidarity with the patient's situation, and then follows with a transition back to the physician role and to the patient's situation.

> *Patient*: I just can't seem to stop crying and no one seems to understand …

Physician: I cried a lot with my divorce, too. You know, when our bodies say we need to cry, maybe there's something helpful happening. How are your kids handling it?

In one study, 22% of patients reported that knowledge of their physician's private life would improve the relationship (10). Primary care patients who were generally dissatisfied with physician self-disclosures did not perceive disclosures categorized as rapport-building negatively (8).

Consider Alternatives to Self-disclosure

We suggest that physicians consider potentially more effective alternatives to self-disclosures. To show support, physicians might offer empathy and partnership, such as "*I know how frightening getting a biopsy is. I want you to know you can call me anytime*," in place of self-disclosure, such as "*I know how frightening getting a biopsy is because I had one last year*" (14–18). Before assuming that the patient shares the same response to a shared life experience, she might explore further the patient's situation ("*So you have a new baby! How is that going for you?*" instead of, "*So you have a new baby! I was so bored staying home with my newborn*"). Finally, in giving advice based on personal experience, the physician might find it just as helpful to generalize the experience ("*Having a spouse with Parkinson's can be very difficult*," instead of, "*My mother just had a horrible time when my father was diagnosed*"). This conveys understanding without shifting focus to the physician.

Engage in Self-care

We suggest that physicians find ways to care for themselves because of the risk for excessive self-disclosure when their own needs are not being met. All practicing physicians constantly face emotionally provocative situations. Sharing with a colleague, friend, or family member can diffuse stress, as can briefly stepping out of the room. Also, Balint groups (in which physicians can discuss and explore patient care issues in a confidential and supportive setting), mindfulness training, relaxation, psychotherapy, or practice consultations can address countertransference and help in maintaining focus (19–22).

If the physician decides that self-disclosure may be helpful to the patient or finds himself or herself in the midst of a spontaneous disclosure, the following steps may make disclosure more effective.

Keep Disclosures Brief and Patient-Focused

In studies in which most self-disclosures in primary care seemed unhelpful, the potentially beneficial disclosures were brief and directly related to patient concerns (6–8). Physicians should be attentive to patients' level of interest and follow patient cues about the length of disclosure. Although patients may feign interest out of concern about the physician's reaction, a lukewarm response to disclosure can indicate that additional information might not be helpful.

Transition the Focus Back to the Patient

In the following example, as well most of the others we use for illustration, the physician self-discloses in response to a cue from the patient, quickly resumes focus on the patient, and minimizes the risk for distraction from the patient's concerns.

Patient: I have been struggling with this infertility issue. My husband and I lost a spontaneous sex life a while ago. It seems like no one understands how I feel.

Physician: It sounds very difficult. I understand some of what you are going through, having had infertility problems too. It puts a lot of stress on the marriage. Tell me where you are in the process. …

Despite our recommendation to quickly resume focus on the patient after self-disclosure, a recent study that used qualitative analysis of self-disclosures made by community physicians revealed that only 21% of physicians returned to the patient's topic preceding the disclosure (6), which decreased the likelihood that the disclosure would benefit the patient.

PATIENT REQUEST FOR SELF-DISCLOSURE

Patient-initiated physician self-disclosure may differ from physician-initiated self-disclosure because the patient is requesting information. Patient queries run the gamut from social chitchat to more personal and discomfiting inquiries. In one study, female physicians considered personal questions to be boundary violations more often than male physicians did (23). However, responses to personal inquiries often help to create ease in a long-term patient–physician relationship, and they can be brief and easily redirected to resume focus on the patient, as seen in the following example:

Patient: What are your kids doing this summer?

Physician: They're looking for jobs at the moment. What about yours?

INADVERTENT SELF-DISCLOSURE

Sometimes, as the example below illustrates, physician self-disclosure is unavoidable, such as when a physical characteristic indicates pregnancy or hair loss from chemotherapy, or when living in a small community (24).

Patient: Your nurse said it's OK to ask about your cancer. I heard about it the other day. I've been praying for you.

Physician: I appreciate your concern. Did you have any specific questions?

Patient: Of course, I'm wondering if you will be all right.

Physician: At this point, things are stable and I am hopeful. It is very kind of you to include me in your prayers. Let's talk about what brought you in today …

Also, physicians cannot always conceal their nonverbal reactions to events in their patients' lives, and sometimes their genuine human response is appreciated (25,26). Although these types of disclosures are not completely under the physician's control, their impact should be managed to the patient's benefit, by warmly acknowledging the patient's concerns and then transitioning back to the patient's own health, as demonstrated above.

In conclusion, little empirical evidence about physician self-disclosure is available, but we offer some tentative conclusions based on available evidence and our experience. Limited data suggest that when content directly relates to patient concerns and length is brief, some physician disclosures may be appreciated. To curtail unhelpful disclosures, physicians must become aware of their impulses to self-disclose and consider using alternative strategies, such as empathy. Doing so will usually lead to fewer, shorter disclosures quickly followed by renewed focus on the patient. Most important, self-disclosure, when it does occur, should benefit the patient, thereby advancing the therapeutic relationship between physician and patient.

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