From Rudeness to Care. Clinical Relationship and Healthcare Worker Well-Being from a PNEI Perspective

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Abstract. *Clinical competence is not limited to diagnosis and prescription; it encompasses how the practitioner meets the person, recognizing their needs, vulnerabilities, and resources. This narrative review discusses the harms of a medicine that fragments the patient into organs and test results, the biological evidence regarding the effects of human relationship, the contribution of attachment theory, and the role of emotional training for healthcare providers. Experimental and observational studies indicate that relationship quality can influence pain, adherence, and certain care outcomes; rudeness and devaluation can heighten alarm and hinder the encounter by creating disconnection. The suffering of medical students and healthcare workers calls into question the responsibility of educational and healthcare institutions. A scientifically advanced medicine needs professionals capable of seeing the patient in their entirety, tailoring the relationship with humanity and precision to the individual before them.*

Keywords: *Clinical relationship, Psychoneuroendocrineimmunology (PNEI), Healthcare worker well-being, Attachment theory, Empathy.*

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The Person Beyond the Fragments

At the end of a medical consultation, a patient can walk out with an accurate diagnosis and yet feel entirely alone. The physician did their job: reviewed test results, asked necessary questions, and prescribed a treatment. And yet, stepping through the door, the patient leaves with an unaddressed fear, a half-understood sentence, and doubts about their ability to follow the instructions. On the other side of the desk is often an exhausted professional, tasked by an overburdened healthcare system with addressing more needs than can fit within the available time or their own heart. Human relationships are complex. Malicious intent is not required for a connection to break: a glance remaining glued to a computer screen or an interrupted story just as it was becoming crucial is enough. In 1999, Marvel and colleagues observed in 264 interviews that physicians redirected the patient's narrative after an average of 23.1 seconds. This is not the fate of every visit, but it raises a question for the profession: what do we lose of a patient when we prevent them from telling their story? Are we interested in fixing a broken part or caring for a person?

In this historical era, medicine has achieved an extraordinary ability to study organs and treat diseases, but the price of this accomplishment must not be the disappearance of the patient. Luigi Condorelli, in a reflection cited by Tarquini and revisited by Gregory in 2010, warned against a reconstruction of the patient composed solely of "mosaic fragments" gathered by different specialists. Although each fragment may be analyzed with rigor, the overall outcome leads to a "bland" medicine. The present author does not argue that specialization is unimportant, but rather that very often no one takes responsibility for reconnecting what specializations have torn apart. A person is not a collection of hospital departments: the heart being examined belongs to someone, the reported pain is part of a life, and the proposed treatment, most of the time, will have to fit within real-life relationships, fears, hopes, and concrete resources. Being human does not compete with scientific precision; it should be the ultimate destination of every caregiving profession.

Healthcare professionals need more than solid knowledge; they require the fundamental ability to tailor that knowledge to the person before them. A practitioner can formally explain a procedure flawlessly yet leave the patient terrified; they can provide necessary instructions without realizing that the other person lacks the courage to admit they do not understand. Relational competence is not about offering indiscriminate closeness, but about recognizing what is taking place first within oneself and then with the other person, maintaining emotional attunement. Humanity in clinical practice is not a matter of polite manners, but a pro-

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found, disciplined, and conscious attentiveness to the uniqueness of the individual.

A diagnostic report reveals insights that a conversation cannot replace. However, viewing the person as a whole serves to make actionable what technical expertise has identified. A prescription may be clinically correct yet encounter a daily reality in which it cannot be implemented: shift work, financial hardship, or isolation. A genuinely integrated and human approach requires someone to help the patient navigate instructions that, when taken individually, might even appear contradictory.

Engel's biopsychosocial model (1977) had already highlighted the limitations of interpreting illness in isolation from the person. The PNEI perspective studies the relationships between experience, context, and organismic function, considering the interactions among neural, endocrine, and immune processes. However, this integration loses its meaning when used to claim that every illness has an emotional root cause or that simply learning to be at peace is enough to achieve healing.

This article is a narrative reflection based on a reasoned selection of research and clinical contributions. It does not attribute all relational effects to a single mechanism: perceived safety, trust, empathy, and expectations are closely linked yet distinct dimensions. The point, therefore, is not that a good relationship cures illness, but that without it, technically appropriate care may become virtually impracticable depending on how the person is met.

Feeling Safe in the Care Relationship

Safety is also learned through caregiving. Bowlby (1989) described the attachment figure as a safe base from which to explore and to which to return in times of fear. Illness can reactivate, even in adulthood, the need to find someone reliable. Hospitalization often means losing one's own bed, familiar routines, and the autonomy to decide who enters; even an independent individual can find themselves asking permission for actions they previously performed without a second thought.

Experimental data exists regarding the value of a more attentive encounter. Kaptchuk and colleagues (2008) assigned 262 adults with irritable bowel syndrome to a waitlist, sham acupuncture with limited interaction, or the same treatment accompanied by a more engaged relationship. At three weeks, adequate relief was reported by 28%, 44%, and 62% of participants, respectively. The relational context thus contributed to the benefit, though it encompassed increased time, listening, and favorable expectations rather than isolating perceived safety alone. Certain ways of meeting the patient can make an observable difference, even if the precise mechanism remains to be clarified.

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The review by Howick and colleagues (2018) offers a broader picture. Across seven studies on empathic communication, aggregate benefits on pain, anxiety, and satisfaction were small, with a standardized mean difference of approximately 0.18 in a favorable direction. Other studies addressed positive expectations, yielding varying results depending on the outcomes. Although small in magnitude, this evidence is consistent with a facilitating role for perceived safety.

A sense of relational safety can therefore facilitate the encounter without being a universal prerequisite for efficacy. A frightened person can receive effective therapy, comprehend a clinical choice while trembling, and entrust themselves to care without feeling serene. Care does not have to wait for fear to vanish; it must welcome it without introducing avoidable threats. This distinction protects the patient from the impossible burden of feeling "safe enough" to benefit from treatment. The goal is to facilitate questions, dissent, and reports of pain, observing whether tangible benefits ensue.

The Stories That Enter the Consultation Room

No patient arrives with an empty relational history, and attachment theory reminds us that the experience of seeking help is not identical for everyone: some fear being a burden and limit their questions to the doctor, while others repeat the same questions because a single answer fails to quell their anxiety. A superficial reading can lead to labeling the patient as oppositional or dependent, whereas attention should focus on recognizing that an effective response differs for each person. It is precisely here that humanity and clinical competence intersect. A person fearful of losing autonomy may require greater choice; someone experiencing separation with distress may benefit from predictable access to the practitioner; a patient with a trauma history may need every physical touch preceded by an explanation and consent. These considerations must not become rigid labels, but rather an invitation to observe how each individual experiences trust, proximity, autonomy, and vulnerability. Possessing sensitivity is not enough; it must be molded to the specific form of suffering the patient brings.

Ciechanowski (2001, 2004), in studies involving individuals with diabetes, examined the relationships among attachment styles, perceived quality of the patient–provider relationship, and self-care behaviors. Among individuals with an avoidant attachment style, communication perceived as poor was associated with poorer indicators of glycemic control. These findings illustrate how even appropriately delivered medical recommendations may elicit different responses. At times, greater insistence or attentiveness may not be the most effective approach; instead, it may be more helpful to allow patients some space, communicate more clearly,

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explore their fears, or agree on a less intrusive form of interaction.

To achieve this, beyond their knowledge of the brain, emotions, and behavior, healthcare professionals should develop a deep understanding of themselves. Indeed, unless a patient is unconscious, healthcare interventions take place within a relational context that precedes even the application of clinical techniques or the administration of medications. Every healthcare professional can be regarded as a kind of *relational operating room* that must be understood, consciously maintained, and kept "clean" before each encounter with a patient. It is important to remember, once again, that healthcare professionals are also human beings, shaped by personal histories that may have involved significant difficulties. They must therefore become aware of their own relational patterns before fully engaging in clinical practice.

The experience of vulnerability, which is universal, can be shaped by an individual's personal history. Danese and McEwen (2012) demonstrated how adverse childhood experiences (abuse, abandonment, or emotional neglect) interact with stress adaptation systems throughout life. This highlights a fundamental professional responsibility: healthcare providers should recognize and manage their own emotional triggers while remaining sensitive to the psychological scars their patients may carry. Explaining procedures before touching a patient, allowing time for a pause, asking permission, and accepting refusal without irritation are all expressions of a respectful, flexible, and humane approach to care—one that distinguishes a truly excellent healthcare professional from one who is merely technically competent.

Touch and Words

Medicine gains knowledge through hands: examining, palpating, auscultating, supporting changes in posture. Enzo Bozza in 2022 emphasized the human value of this physical approach, reminding us that the risk in healthcare is not only making diagnostic or procedural errors, but learning to keep oneself too distant from pain. Touching is not in itself proof of empathy. An unexpected hand can frighten, whereas a precise, announced gesture can convey care. Clinical contact does not encounter a biological body alone, but a lived body as well; a good relationship allows for boundary respect and authentic proximity.

Suvilehto's research team in 2015 investigated how the acceptability of touch varies with emotional bonds and relationship types, inviting clinicians to reflect on the meaning of physical contact for the receiver. Gaze and touch require calibration: for instance, a practitioner who gets too close may invade personal space, while one who remains distant may appear indifferent. Competence lies in recog-

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nizing this dynamic and finding a distance the other person can comfortably sustain.

Words represent information chemically processed by the nervous system to regulate stress. In therapeutic experience, an explanation can convey warning without distorting reality, whereas a carelessly spoken phrase can foster negative expectations. Fabrizio Benedetti's team (1995) demonstrated that placebo analgesia can be influenced by neurochemical mechanisms, including proglumide's action on the cholecystokinin system. Research on placebo and nocebo responses shows that treatment response can be influenced by learning, meanings, and expectations through the psychological and neurobiological mechanisms discussed by Benedetti (2008). These are biological phenomena rather than superficial suggestions to be dismissed lightly. Amanzio and colleagues (2001) studied how analgesic response changes when the patient knows the drug is being administered compared to unannounced administration.

Care, therefore, also encompasses what the patient understands and expects. This does not authorize withholding information to protect them, but rather communicating with truthfulness and sensitivity. If a patient fears a side effect, explaining the probability and clinical context of that risk is fundamentally different from implying it will inevitably occur. Telling the truth and knowing how to tell it are two facets of the same responsibility.

The Encounter Changes the Experience of Illness

A person does not experience their illness solely through measurable physiological parameters. They experience it through pain, fear of deterioration, decisions to be made, and relationships that either support or isolate them. For this reason, the relationship is a clinical matter. Haskard Zolnierek and DiMatteo (2009) documented the link between medical communication quality and treatment adherence. Though it may seem obvious, the implications are profound: a correct prescription that finds no viable place in the patient's daily life risks becoming poor care in practice. Understanding a person also means knowing their daily obstacles, work environment, available resources, and the meaning they attribute to what is happening to them.

Rakel and colleagues in 2011, in a study on the common cold, observed that patients who perceived higher levels of practitioner empathy reported less severe symptoms and a shorter average duration of illness. The study also included observations on interleukin-8 responses in nasal wash samples. This result shows that, beyond self-reported satisfaction, the clinical encounter intersects with psychological and biological dimensions of illness. It need not be framed as proof that

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every empathetic physician boosts immunity, but it must be recognized that how one is received is not unrelated to symptom progression.

A lower frequency of acute metabolic complications associated with higher levels of practitioner empathy was observed in patients with diabetes by Del Canale and his research group (2012). While these data do not establish a causal relationship or specific mechanisms, they suggest that relational quality deserves attention in studying chronic disease outcomes. Clinical empathy is not measured by polite words, but by the ability to build shared decisions and navigate uncertainty together.

PNEI provides the framework to contextualize this topic within organismic functioning. In 1998, McEwen showed how stress mediators are essential for adaptation, yet can contribute to adverse outcomes when their activation becomes repeated and persistent. Segerstrom and Miller (2004) documented relationships between psychological stress and various immune indicators. A clinical visit during which one feels humiliated does not in itself constitute a disease, nor does a welcoming visit guarantee recovery. Nevertheless, a healthcare system that continuously induces helplessness, alarm, and isolation creates conditions that warrant attention from a biological perspective. We should not, therefore, exclude the relationship from therapy.

Experiments by Masalha and colleagues in 2026 highlight an intriguing aspect: the regulation of certain physiological functions is more efficient when participants are near an emotionally significant person compared to a state of solitude. This finding concerns glucose metabolism following a carbohydrate load and extends, in other experiments, to thermoregulation and sympathetic activation in both adults and children. Although not specific to the physician-patient relationship, this finding corroborates what clinical practice encounters daily: human beings regulate part of their life and biology in the presence of others. Relationship, therefore, is not alien to the body, and its effects vary according to individual and context. This knowledge fundamentally alters how we conceive of care, dispelling the notion that relational incompetence is negligible as long as the prescription is correct.

Training Professionals Capable of Meeting Suffering

If the relationship is an integral part of care, it must be developed during the years of study and training. Young doctors study anatomy, physiology, and pharmacology, but they must also learn what occurs within themselves and within the patient when navigating fear together. Given current knowledge, relying entirely on innate sensitivity is unacceptable. Recognizing a patient who defends themselves by clinging to the provider, listening to someone repeating a question,

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breaking bad news, and pausing before reacting with irritation are skills that can be learned, practiced, and supervised. What space, then, do educational curricula dedicate to the emotional life of trainees learning to care?

Rotenstein and colleagues (2016), in a systematic review and meta-analysis, estimated among medical students a prevalence of 27.2% for depression or depressive symptoms and 11.1% for suicidal ideation. These estimates stem from heterogeneous data rather than clinical diagnoses established for every student, yet they are significant enough to demand attention toward mental health during medical training. What message is conveyed if those learning to care for others learn that their own suffering has no right of expression? How can trainees seek help if the prevailing model is one of self-sacrifice, the "warrior" mindset, and enduring inherently inadequate relational conditions? The issue involves not only academic workload or grueling shift hours, but also relational shortcomings sanctioned by the educational infrastructure.

At the University of Palermo, Hoffmann, Formica, and Di Maria (2007) compared difficulties in recognizing and communicating emotions among young students enrolled in Medicine, Psychology, and Economics faculties using the Toronto Alexithymia Scale. Results showed higher levels of alexithymia among Medical students. The author interprets this finding by posing a question: does training that exclusively encourages focus on organic pathology risk impoverishing the care relationship and diminishing attention to emotional life in a course of study intended to foster caring for people rather than "fixing" body parts? Alexithymia is not a lack of morality, but points to a necessary capacity for a good physician: naming what happens within oneself. A doctor may understand stress mediators yet fail to recognize their own irritation when facing an insistent patient; unacknowledged emotional experience can ultimately alter clinical practice outcomes. Relational training means teaching providers to observe their own reactions, reflect on the patient's perspective, tolerate uncertainty, and differentiate between the patient's emotions and their own internal activations. It is not about remaining perpetually serene and available, but creating training models that provide permanent supervision, clinical debriefing, distress support, and boundary setting. Healthcare providers may feel helpless, angry, discouraged, or sad; what matters is learning to recognize these experiences so they do not translate into punitive detachment, rigidity, or automatic reactions toward patients. In an environment that humiliates those who seek assistance, it is unsurprising that seeking help becomes difficult once on the wards, extending to colleague interactions. Riskin in 2015, in a randomized simulation with neonatal teams, showed that exposure to rude comments degraded diagnostic and procedural performance, reducing information sharing and help-seeking behaviors. Rudeness in healthcare is not merely a breach of po-

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liteness; it actively impedes team performance. An organization that tolerates humiliation or intimidation while demanding empathy from its staff creates a deeply unsustainable contradiction.

Self-Care as a Shared Responsibility

Those who care also need to be cared for, as caregiving professions involve continuous exposure to stressors relative to the general population. This does not imply that all professionals must undergo psychotherapy, but organizations must ensure support, confidentiality, and sustainable working conditions. Saddawi-Konefka, Moutier, and Ehrenfeld (2025) in JAMA describe the barriers preventing physicians from seeking and receiving mental healthcare. Stigma, fear of professional repercussions, logistical difficulties, and privacy concerns present significant hurdles. Demanding greater empathy without addressing these conditions assigns individuals the burden of offsetting structural limitations. Emotional capacity is not an infinite resource, and quality of care cannot rely solely on personal self-sacrifice.

Burnout is not simple fatigue. Hodkinson (2022), in a major systematic review of observational studies, identified associations between practitioner burnout and compromises in both care quality and patient safety. Certainly, not every error can be attributed to burnout, but patient health and practitioner health share the same environment. Violence prevention, mutual respect among colleagues, supervisory support, and manageable workloads are not corporate perks; they are essential prerequisites for working effectively with human beings.

Victoria Johnson (2025), in a brief reflection in JAMA Neurology, describes an exhausted physician meeting a critically ill patient known initially only through a lengthy list of medical complications. Upon learning something intimate and profound about the patient's life and receiving a gesture of mutual recognition, the doctor reconnects with the deeply human meaning of their work. Indeed, patients sometimes heal their caregivers. This personal account invites reflection because it illuminates what statistics cannot capture: by rediscovering the person behind the diagnosis, the provider reclaims the purpose that led them to practice medicine. Human relationship safeguards the essence of care, provided the organizational context does not erode it.

Conclusions

Chochinov (2002), in the dignity-conserving care model, reminded us that the physical dependence triggered by illness does not erase a person's identity. Introducing oneself, explaining a procedure, and genuinely caring about the patient's

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most difficult concerns are not alternatives to evidence-based medicine; they are how medicine ought to be practiced. Boundaries must also be recognized: a good relationship does not erase a grave diagnosis, does not validate every decision, and should not force providers into limitless emotional exposure. The patient is not responsible for reassuring the caregiver, and the caregiver must not promise what cannot be delivered. Sometimes quality care lies in clearly stating that a cure is not possible, while remaining present and returning as promised. When treatment no longer alters disease progression, caring for the person remains an essential duty without adding isolation or humiliation. A medicine capable of viewing the person whole surrenders none of its tools: diagnostic reports remain necessary, instrumental exams valuable, and clinical expertise indispensable. What changes is the overarching vision: if we reduce the patient to a collection of diagnostic findings, medicine becomes a cold and bland practice; if we understand that a prompt reply, a touch, a thoughtful word, and a kept promise belong to the experience of care, specialization reclaims its human direction. Healthcare providers must know much beyond diseases and treatments: they must know how to engage with the worlds of those they meet, recognize their vulnerabilities, and understand themselves. Technical efficacy and humanity are not competing agendas, for a medicine interweaving both is truer to the complexity of the human being it seeks to heal.

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