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THE DOCTOR–PATIENT RELATIONSHIP IN OUTPATIENT NEUROLOGY: SOCIOCULTURAL AND LEGAL DIMENSIONS

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***Abstract**: In outpatient neurology, the relationships between the physician and the neurological patient are complex, as they involve not only medical dimensions but also sociocultural and legal aspects that can influence the perceptions and behavior of all parties involved in the dialogue. In line with these considerations, this paper explores the socioeconomic, cultural, and legal dimensions that regulate the doctor–patient relationship in outpatient neurology, with particular emphasis on informed consent, patient data confidentiality, and patterns of medical communication.*

***Keywords**: mental health; doctor–neurological patient relationship; legislation; sociocultural factors; medical communication.*

Introduction

Outpatient neurology involves assessing the patient's health status, establishing a diagnosis, providing medical treatment, and monitoring the patient's condition without continuous hospitalization. All these objectives can only be achieved by the physician through high-quality professional communication, grounded in constructive and empathetic dialogue.

In line with this reasoning, the objective of our research is to explore the socioeconomic, cultural, and legal dimensions that influence

doctor–patient relationships and medical communication. Particular attention is given to legal aspects such as obtaining informed consent, protecting the confidentiality of patient data, and adapting communication strategies to the specific features of outpatient neurology.

1. Socio-Economic and Cultural Dimensions in the Doctor–Neurological Patient Relationship

The interpersonal relationship between doctor and patient is of major importance in outpatient neurological practice and is closely correlated with a series of socio-economic and cultural factors, such as: (1) the patient's socio-economic status, (2) the level of general education and health literacy, (3) gender equity, (4) cultural affiliation, (5) religious beliefs about illness and health, and so forth.

(1) *Socio-economic status*. „The social determinants of mental health refer to the living conditions in which individuals exist, and which have a major impact on the distribution of mental health problems within the population. Although these determinants are present across all studied cultures, their prevalence varies from one country to another, meaning that populations in certain regions or nations may experience a higher level of exposure to social risks associated with multiple mental health issues" (Bartuczi). The neurological patient's socio-economic position is highly significant because it affects not only access to health-care services but also their quality. In wealthy countries that devote the highest expenditures to health-care, such as the United States (US $12,742 per person), Switzerland (US $9,044), Germany (US $8,541), the Netherlands (US $7,277), etc., patients benefit from numerous free or subsidised services, and their attitude toward the medical sector is generally favourable and optimistic. Consequently, public trust in health professionals is high, and people feel protected should health problems arise (5). Conversely, in countries with limited resources, patients face a range of socio-economic difficulties, including late diagnosis, incomplete treatment, and social marginalisation. Referring to the Republic of Moldova, „we observe a negative trend in the native population's access

to medical care. The proportion of men who report not having visited a doctor in over five years has increased significantly, from 6% in 2015 to 18% in 2024, while among women the situation remains practically stable (5% in 2015 and 6% in 2024)" (Bărbații și egalitatea de gen în Republica Moldova/ Men and gender equality in the Republic of Moldova, p. 110).

(2) *Level of education*. Educational attainment likewise influences both patient longevity and the quality of the doctor–patient relationship during treatment. Highly educated patients understand diagnoses more readily, communicate constructively with physicians, and participate actively in decision-making. By contrast, patients with modest schooling are often passive and marked by the "doormat" syndrome: they rely heavily on the doctor's authority, avoid responsibility, have low confidence in the system, and may easily abandon prescribed therapy. A study by Viju and Wullianallur Raghupathi confirms these observations: adults with higher education enjoy better health and longer life expectancy than peers with lower education. Tertiary education in particular strongly influences infant mortality, life expectancy, childhood vaccination, and school-enrolment rates (Raghupathi).

(3) *Gender roles*. „The population of the Republic of Moldova generally shows a negligent attitude toward health, as indicated by the low frequency of medical visits, especially among men. This situation is directly linked to men's perceptions of gender equality. Research shows that men who do not support gender equality are less likely to use healthcare services. This is explained by the belief that a strong man does not need to seek medical help" (Bărbații și egalitatea de gen în Republica Moldova/ Men and gender equality in the Republic of Moldova, p. 104). În general, în Moldova, men make exceptional decisions and head the family, while women are obedient and caring; medical contexts rarely escape this inequity. When a family faces a health dilemma, final decisions are usually taken by the husband. Likewise, a female patient might refuse to discuss sensitive issues with a male doctor because of

prevailing stereotypes and stigma. A study by R. Satkunasivam, “Comparison of postoperative outcomes among patients treated by male and female surgeons”, shows only minor differences in how male and female physicians treat patients and achieve clinical goals (Satkunasivam). Hence, the notion that male doctors are inherently better than female doctors is a stereotype unsupported by scientific evidence and should not influence patient choice.

(4) *Cultural affiliation*. Cultural background can also shape the doctor–patient relationship. Health-care professionals therefore benefit from familiarity with Edward T. Hall’s theory of high-context (HC) and low-context (LC) cultures. Low-context cultures (e.g., the USA, UK, Canada, German-speaking and Scandinavian countries) favour direct, denotative communication: intentions are stated explicitly, questions are asked whenever clarification is needed, and the message is assumed to be understood unless further queries arise. High-context cultures (e.g., Latin, South-American, Asian, Arab, and post-Soviet societies) favour indirect, connotative communication: answers are often ambiguous to preserve harmony or politeness; non-verbal cues are crucial; confrontation is avoided in public; problems are preferably solved in private. Accordingly, when treating LC neurological patients, physicians should adopt an informal style, treat the patient as an equal, use first names, express opinions openly and confidently, tolerate direct confrontation when it serves the common good, avoid sarcasm and irony, and uphold the patient’s autonomy. In HC settings, doctors should employ indirect, subtle language, respect the patient’s social status and roles, and accept the presence of relatives or spiritual leaders in difficult moments. Knowledge of broader cultural features - national character, worldview, time management, spatial perception, cognitive style, language, and value systems - helps clinicians communicate effectively with international patients (Spînu, 2025, p.125).

(5) *Religious beliefs*. Religion in the Republic of Moldova is a factor that promotes gender stereotypes. It is claimed that „the man is superior to the woman, who is God's servant. Accordingly, only the man is allowed to

enter the altar, while the woman is not. And during communion, the man must be the first to go. The woman, even if she is with a child, must wait her turn" (Bărbații și egalitatea de gen în Republica Moldova/ Men and gender equality in the Republic of Moldova, p. 49). Therefore, male doctors will be favored by patients. Cultural factors frequently mould religious beliefs about illness and health. In certain Christian and Asian traditions, neurological disorders are associated with fatalism, social shame, or divine punishment; sufferers may be stigmatised, isolated, or neglected. Awareness of the patient's cultural and religious status therefore enables the physician to apply communication strategies that meet existing professional and ethical standards.

In conclusion, mental-health professionals must remain aware of the socio-economic and cultural dimensions in dialog with patients. Only by understanding the essence of these factors can they achieve their goals and earn the trust of society.

2. Legal Aspects of the Doctor–Patient Relationship in Outpatient Neurology

The aim of „Law No. 114 of 16 May 2024 on Mental Health and Well-Being is to establish and organise a system of safeguards for the protection of mental health that will ensure a better quality of life". The law defines "the responsibilities of public authorities in the field of mental health and well-being, the general rules for providing medical care, and the protection of the rights of persons with mental and behavioural disorders during the provision of mental-health services."

„In the Republic of Moldova, the State guarantees the protection of mental health and well-being through: a) promoting health protection and maintaining mental well-being among the population, regardless of a person's whereabouts; b) preventing psychological harassment, bullying, discrimination, burnout, and the risk of mental and behavioural disorders, and reducing stress; c) screening, diagnosis, prescription of treatment, referral for treatment, and clinical monitoring; d) assessing temporary incapacity for work and determining disability; e) medical and

psychosocial recovery and rehabilitation, etc." (Law No. 114/2024).

The legal framework governing outpatient neurology is set out in Law No. 411 of 28 March 1995 on Health Protection (Arts. 6, 17-21), Law No. 263 of 27 October 2005 on Patients' Rights and Responsibilities, and various orders of the National Health-Insurance Company. Normally, a patient consults a neurologist on the basis of a referral from the family doctor or seeks a straightforward consultation directly. An Outpatient Medical Record is opened, and the physician is responsible for early diagnosis, proper referral, ongoing monitoring, and respect for the patient's fundamental rights. Where necessary, a medical certificate is issued and informed consent is signed for each procedure to be performed.

Informed consent is the patient's agreement to medical interventions or treatment phases, given in full awareness of potential benefits, critical situations that may arise, and alternative options that might be advantageous. The concept is relatively recent, first used in the United States „in court decisions from the first half of the 20th century (Mohr v. Williams and Pratt v. Davis, beginning in 1905), which laid the foundations of patient autonomy. Two further cases (Rolater v. Strain and Schloendorff v. Society of New York Hospital) consolidated the principle of patient autonomy and the requirement to obtain informed consent" (Bazzano).

In the Republic of Moldova, the drafting of informed-consent forms is based on Law No. 263/2005 on Patients' Rights and Responsibilities („The patient has the right freely to express consent or refusal to medical intervention and to participate in biomedical research"), the „European Convention of 4 April 1997 for the Protection of Human Rights and Dignity with Regard to the Application of Biology and Medicine" (Chapter II, Art. 5: „An intervention in the health field may only be carried out after the person concerned has given free and informed consent … The person concerned may freely withdraw consent at any time"), and the Code of Ethics for Medical Workers and Pharmacists (Chapter VI, Section 3, pt. 48: „Patient consent may be verbal or written and is documented in the medical record, signed by the patient or legal representative and the attending physician or medical

staff, explicitly indicating the name and conditions of the intended medical act and possible risks").

Outpatient neurology places special emphasis on empathetic communication, which supports patients in uncertain situations and facilitates the informed-consent process. In dialogue, the physician must be clear and logical, take account of the patient's socio-economic and cultural background, and comply with current legal regulations.

Neurological disorders that impair consciousness, memory, or decision-making capacity raise questions about protecting patients' personal and medical information. Patient confidentiality is therefore both an ethical and a legal duty of health-care professionals and forms the basis of an honest relationship between patients and medical staff. Patients share sensitive personal information and need assurance that it will not be used against them. Only when convinced of the physician's discretion will patients speak frankly and avoid omitting relevant details.

In Moldova, public policy secures the protection of personal data and the maintenance of confidentiality in health care through Law No. 411-XIII of 28 March 1995 on Health Protection (Art. 14 (1): „Physicians, other medical personnel, and pharmacists must keep secret information about a patient's illness and private life that they learn in the exercise of their profession, except in cases of danger of spreading communicable diseases, at the reasoned request of criminal-investigation bodies or the courts"), the „Criminal Code of the Republic of Moldova" (Art. 261), „Law No. 133 of 8 July 2011 on Personal-Data Protection", and „The Code of Ethics for Medical Workers and Pharmacists" (24 March 2017) (Spinu, 2024, p. 72).

In conclusion, the legal framework applied in outpatient neurology is modern and aligned with international standards, preventing existing psychosocial risks, making a significant contribution to protecting the mental health of the population of the Republic of Moldova.

Conclusions

Therefore, the relationships between doctor and neurological patient in the outpatient setting are complex, as they involve not only medical dimensions but also sociocultural and legal aspects, which can influence the perceptions and behavior of all those involved in the interaction. The views of E. Hall, relevant in the field of intercultural communication, provide valuable guidance for medical professionals in building an authentic and effective dialogue with international patients, provided that the sociocultural context is properly understood. The legal framework protects patients and helps to increase their trust in the medical system. Compliance with current legislation facilitates the development of an honest and empathetic relationship between doctor and patient, thus contributing to the conscious and voluntary obtaining of informed consent, while fully respecting patient data confidentiality.

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