International Journal of Psychoanalysis and Education: Subject, Action & Society
V. 6, N. 1, 2026, pp. 20-34
DOI: https://doi.org/10.32111/SAS.2026.6.1.2

The Adventures of a Black Bag: An Exploratory Investigation into Relational Dynamics Between General Practitioners and Patients

Jerilyn Tan Balonan*, Giuseppe Forte, Luca Montoro**, Antonela Shkambi**, Viviana Langher****

Abstract:

The general practitioner (GP) is a key player in the Italian healthcare system—not only as a provider of first-line care, but as a long-term, reliable figure in patients' lives. This study explores the emotional and symbolic dimensions of the GP-patient relationship through qualitative interviews of 65 patients. We examined affective representations that are shared coming up in the narratives of patients a computer assisted text analysis. Our findings substantiate the preeminent position of this association as a pillar of clinical effectiveness and psychological security. The evidence points to two underlying dynamics: one, the tension between the patient's imperative requirement for care and their sense of the doctor's occupational autonomy; two, a symbolic construction of the GP as rational expert and caring parent—a secure haven in times of vulnerability. What is perhaps noteworthy here is that patients' expectations are motivated less by fear of clinical incompetence and more by an impassioned desire for reassurance, presence, and empathic listening. This affective need, if unacknowledged, can become a source of misunderstanding that GPs might confuse with disagreement with their professional worth. These findings indicate that relational and communication competencies in GP training is critical to maintaining therapeutic relationships. This research provides a culture-based lens that can guide policy and practice—favoring more humane, emotionally competent primary care provision.

Keyword: GP–patient relationship, primary care, qualitative research, affective symbolization, computer-assisted text analysis, relational skills, patient-centered care, Italian healthcare system

* School of Specialization in General Practice, ASL Roma 3, Italy
** Department of Dynamic and Clinical Psychology and Health Studies, Sapienza University of Rome, Italy
Corresponding author: Giuseppe Forte, g.forte@uniroma1.it

1. *Introduction*

The general practitioner (GP) serves as a cornerstone of modern healthcare systems, and not merely the point of first contact but also an essential coordinator of the wider care continuum. In Italy, the position is particularly central in the Servizio Sanitario Nazionale (SSN), and GPs are commissioned to deliver holistic, uninterrupted, and coordinated care across life. The GP-patient relationship is central to this mission and has a strong effect on patient satisfaction, treatment adherence, health-related quality of life, and overall effectiveness of primary care. The path of history of the GP's mission in Italy starts with the establishment of the SSN in 1978 (Ministero della Salute, 1978), which was a paradigm shift from the fragmented and inequitable organization to one founded upon equity and universality principles. With the SSN, GPs became community-based care agents, responsible for a wide range of services, from preventive treatment and health education to handling chronic and complicated conditions. However, today's healthcare environment gives rise to significant challenges that detract from the integrity of GP-patient partnership. Italy, as with most high-income countries, is undergoing a demographic transition characterized by population aging and increasing multimorbidity prevalence. These trends require more personalized, time-consuming treatment. Meanwhile, GPs are facing increasing administrative work burdens, reducing consultation lengths, and pressure to deal with a widening medical literature foundation (Starfield et al., 2005; Kringos et al., 2020; Schäfer et al., 2021). Such systemic constraints risk undermining effective communication, loss of confidence, and decreasing the therapeutic value of the doctor-patient encounter.

1.1. *The Therapeutic Power of the GP-Patient Relationship*

A robust evidence base positions the GP-patient relationship as central to outcomes. Research consistently demonstrates that effective, empathetic communication increases patient satisfaction, compliance with treatment, and even physiological indicators of health (Epstein & Street, 2011; Roter & Hall, 2006; Ha & Longnecker, 2010; Mercer & Reynolds, 2020; Bikker et al., 2021). The quality of such a relationship is not a soft skill—it is a therapy in its own right. Core elements such as active listening, collaborative

decision-making, and empathy have been linked to better chronic disease control, better mental health outcomes, and fewer hospitalizations (Beach et al., 2006; Hojat et al., 2011; Kelly et al., 2020; Ferreira-Valente et al., 2022). Conversely, communication obstacles such as cultural differences, poor health literacy, and language differences can interfere with this alliance, leading to misunderstanding, disengagement, and less-than-optimal care (Betancourt et al., 2016; Schillinger et al., 2003; Wang et al., 2021). In the Italian setting, with the GP commonly visiting families generationally, the longitudinal nature of this interaction carries unique potential. Stability of care over time not only creates medical comfort but psychosocial knowledge as well, permitting more sensitive and customized care. System-level inefficiencies combined with an underfunded primary care system increasingly threaten this model, though (Fantini et al., 2020).

1.2. *Beyond (Bio)medicine: The Emotional and Humanistic Dimensions*

Where technical skill remains paramount, current evidence identifies the importance of the affective dimension of care. A seminal work by Ancona et al. (1999) argued that clinical efficacy is inextricably tied to the doctor's emotional intelligence and his/her ability to build empathic, meaningful relationships with patients. More recent literature reinforces this position, placing empathy as a clinical skill with measurable impacts on health outcomes (Derksen et al., 2013; Mercer & Reynolds, 2002; Wilhelmsen et al., 2020; Riess, 2021). This is in keeping with a broader resurgence of interest in narrative medicine and person-focused care, particularly in primary care. The patient is not the passive recipient of care but rather an active partner whose experience, beliefs, and values must direct the clinical encounter (Bensing, 2000; Stewart et al., 2014; Kerasidou & Horn, 2021). Integrative models that pair biomedical knowledge with psychosocial understanding can generate trust, reduce anxiety, and improve adherence—particularly in patients with chronic or stigmatized conditions (Wong et al., 2022).

1.3. *Research Gaps and Study Rationale*

While the importance of the GP-patient relationship has been well established for a long time, relatively few studies have explored its dynamics within the specific socio-cultural and institutional context of Italian primary care. The majority of available literature is

Anglo-American based, with limited validity for the Italian health system. To fill this gap, the present research adopts a qualitative research method to explore Italian patients' perceptions of their interactions with GPs. In-depth interviews were employed to identify facilitators and obstacles of a positive and effective therapeutic relationship according to the patients. The study attempts to yield an in-depth, patient-centered description of the relational processes engaged, making practical recommendations to policy-makers, educators, and practitioners. The findings will help to inform the creation of evidence-based strategies that support the GP-patient relationship—strategies that are even more vital in an age in which primary care is under increasing pressure. Strengthening this relationship may not only improve individual outcomes but also contribute to a stronger and fairer healthcare system overall (Rotar et al., 2021; Flodgren et al., 2020).

2. *Methodology and Data Analysis*

A convenience sample was selected, recruited through the personal networks of the interviewers, consisting of 65 individuals interviewed as patients of general practitioners. A short ad hoc questionnaire was used to record gender, age, and nationality. Specifically, we interviewed 50 subjects residing in Rome and 15 residing in Velletri to understand whether belonging to a small town or metropolitan area community could influence different ways of establishing a relationship with the GP. Additionally, among the 50 subjects residing in Rome, we included 16 individuals from the Albanian community to explore the possibility that the nationality of origin could organize specific ways of establishing a relationship with the GP. For this research, an ad hoc structured interview was constructed, composed of three questions, to elicit detailed and narrative responses that would highlight the most recurrent and shared themes in the patients' representations of GPs. The choice to administer open-ended questions was based on the idea of establishing an exploratory dialogue that would allow patients to freely express their thoughts. The questions were identified after a discussion in a focus group with psychology students working on this topic, and they were articulated to bring out patients' expectations in the relationship. The questions chosen are as follows:

1. In your opinion, how is the general practitioner perceived today?
2. What should your ideal general practitioner be like?

3. Do you have any suggestions on how an optimal general practice service should be?

The interviews were audio-recorded, transcribed, and compiled into a single corpus. For the extraction, comparison, and mapping of textual data, we used the T-LAB software (version Plus 4.1.1), employing it to perform thematic analysis of elementary contexts through lemmatization and clustering techniques (Lancia 2004). For interpretation, we relied on Matte Blanco's bi-logic theory of mind (1975), Fornari's psychoanalytical theory of language (1976) and the construct of affective symbolization (see Carli, 2015a; Carli, 2015b). That allowed us to explore the symbolic level of texts, aiming to capture participants' subjective experiences rather than their objective knowledge, rational thinking and logical reasoning on the matter inquired. Therefore, for the research purposes, discursive sequences were not analyzed, but rather the encounters—in text segments—of dense words, that is, words with high polysemy and low emotional ambiguity. This approach allows us to identify thematic representations and their affective connotations concerning the doctor-patient relationship within the text. These meanings are shared by speakers and cannot be attributed to individual people. They should be considered indicators of a cultural configuration that organizes the doctor-patient relationship. Here, we understand the term culture as the set of shared codes with which a social group, in this case, patients, emotionally reads and adapts to reality.

The thematic analysis of elementary contexts identifies the vocabulary in the text on which the T-Lab software applies automatic lemmatization. Automatic lemmatization transforms inflected forms into their lemmas. For example, a conjugated verb is returned to its infinitive form, nouns and adjectives to the masculine singular form. Researchers can further refine the automatic lemmatization process, for instance, by lemmatizing an adverb as a masculine singular adjective. At the end of the lemmatization, both automatic and manual, T-Lab provides the list of keywords (dense words). This means the list of lemmas excluding forms that represent the connective tissue of discourse, such as temporal adverbs, auxiliary verbs, and modal verbs. Based on the list of keywords, which can be further selected by the researcher according to the study's objective (e.g., eliminating pronouns or lemmas with high emotional ambiguity), T-Lab identifies clusters of keywords that are highly recurrently associated within text segments. T-Lab projects the clusters onto a factorial space.

3. *Results and Discussion*

The corpus analyzed consists of 22,770 occurrences, 2,946 forms, with 15,177 hapax legomena. The hapax index is 0.515, which is considered slightly high for the analysis but is almost inevitable when analyzing a relatively small text, which is more subject to linguistic dispersion. The analysis of our textual corpus produced 4 clusters.

Tabel 1. Lemmas of each cluster

Cluster 1		**Cluster 2**		**Cluster 3**		**Cluster 4**	
Lemma	Chi-Quadro	Lemma	Chi-Quadro	Lemma	Chi-Quadro	Lemma	Chi-Quadro
symptom	69,97	understand	89,82	patient	69,12	experience	50,54
person	66,20	take	34,81	listen	40,37	talk	40,77
health	42,94	err	29,65	available	31,08	figure	23,48
elderly	40,15	medicine	28,73	human	28,20	life	22,39
pleasure	28,64	secretary	21,06	visit	23,08	think	19,29
need	15,71	problem	19,85	appointment	20,48	know	17,51
doctor	15,41	day	16,94	contact	20,25	right	15,86
ask	15,35	put	15,02	first	20,10	family	14,16
young	14,92	queue	13,16	situation	19,32	perception	14,08
prepare	14,77	urgent	13,16	request	18,56	perceive	13,99
psychologist	14,77	wait	11,97			good	13,54
		determine	11,97				

Cluster 1

The first ten lemmas of this cluster are: symptom, person, health, elderly, pleasure, need, doctor, ask, young, prepare, psychologist. The lemma "symptom," the most associated primary lemma, indicates the element that enables the doctor-patient relationship and obliges the doctor to take charge. The symptom is a clue that necessitates exploration until the overall picture is achieved. The symptom is the starting point of a highly intense and engaging request for a relationship: in the face of the symptom, the doctor cannot

withdraw. The next lemma, "person," links the alarm signal to the human dimension, but also to a role-playing aspect. "Persona" etymologically refers to the theatrical mask. Therefore, it evokes not only the personal dimension but also a well-defined role in the relationship, as suggested by the primary lemma, "symptom," which makes one person the doctor and the other the patient. "Health" is the lemma that defines the scope of the doctor-patient relationship, the goal to be achieved, turning bad to good, but also the lost object that both parties in the relationship must attend to. "Elderly" recalls the necessary respect for what has existed for a long time: the ancient, the tradition, the consolidated, the taken-for-granted; but also the looming anxiety of death. The elderly are those who slowly walk towards death, and the doctor is called upon to ensure this journey lasts as long as possible. The elderly are wise and also a reminder of the wisdom of the "elderly" doctor, who has experience, who has lived, who preserves tradition, who has an authoritative voice. But the elderly are also the patient, vulnerable like the elderly but respectable, not to be lost or forgotten. It is the lemma that perhaps most embodies the anxious dimension underlying the doctor-patient relationship, which the doctor is compelled by the patient's need to take care of.

"Pleasure," from the Latin "placere" and French "plaisir," evokes the idea of being united, smooth, and placid, from which derives the sense of being caressed, soothed. It is a verb that recalls pleasant contact, the desire for a pleasing relationship with the doctor but also for soothing the anxiety it is filled with.

"Doctor" is the lemma that evokes the physician, vested in their wisdom, a scholar who can teach from the height of their knowledge. Especially when thinking of the "doctor" who admonishes a child, who if hurt must go to the "doctor." The child who, if he refuses to eat, will be taken to the "doctor" to be scolded, convinced authoritatively, or guided from their elevated position. "Ask" is the action of someone seeking an answer, desiring, but also imploring. It is another verb that strongly binds the two actors in the relationship; when one asks for something, the other cannot simply withdraw.

"Young," etymologically one who defends, who fights, is still the doctor guarding the patient's fragility. The doctor is young, meaning strong; the patient is elderly, meaning vulnerable. "Prepare" involves getting necessary things ready to initiate and accomplish

an objective. It is a forward-projecting verb, creating the conditions for something to end well.

The lemma "psychologist" here refers to the patient's expectation that the doctor will take care of them in their entirety, including the thoughts they have, which are both thoughts and many emotions to be entrusted, cleansed, and freed from, thanks to the reassuring action of the doctor.

The doctor-patient relationship evoked in this cluster is highly asymmetrical; the doctor is bound to the relationship with the patient by the symptom and the patient's need to be taken care of. This is the Hippocratic doctor, who vows adherence to the ethics of care, reaching out to save the patient, relieving their anxiety, and taking care of the patient in their entirety, including all the emotions the patient feels in their relationship with the doctor.

Cluster 2

The first 10 lemmas of Cluster 2 are: understand, take, err, medicine, secretary, problem, day, put, wait, determined. Additional suggested lemmas by T-Lab in this partition include queue and urgent.

This cluster appears highly dynamic due to the significant presence of verbs, indicating actions. "Understand" is a verb that carries the intention of comprehending, of taking onto oneself, of bringing into one's mind, similar to the subsequent lemma "take." The doctor-patient relationship immediately evokes the need for intense interaction; one cannot understand without applying oneself to understand, one cannot take without assertive, intentional action. This process is not without pitfalls: one can make mistakes. Medicine is the response, the remedy, it is trusted, it is a salvific object, but not immediately accessible: there is a secretary, the keeper of secrets, perhaps the secrets of the doctor, who stands in the way of the desired contact; the doctor has an ally who keeps their secrets, excluding the patient from this alliance. The secretary can be a possible point of conjunction, facilitating contact with the doctor, but can also represent a barrier that cannot be overcome. The relationship with the doctor involves a problem, both because one seeks a doctor for a problem and because the relationship itself, with its uncertainties and peculiarities, represents a problem for the patient. "Day" represents, etymologically,

the brightness of light, the beginning of the light that makes day. It is a term that evokes hope, to be preserved while waiting for things to fall into their determined place (it is interesting that the etymological analysis of the lemma "put" highlights the need for something to reach its determined place). The two lemmas that T-Lab suggests as associations in the cluster, queue and urgent, add a dramatic touch to this troubled relationship: one stands in line, waiting, dwelling in an urgency that finds no immediate solution. In this cluster, the relationship with the doctor is yearned for, woven with effort, things to understand, problems to solve, and obstacles to overcome.

Cluster 3

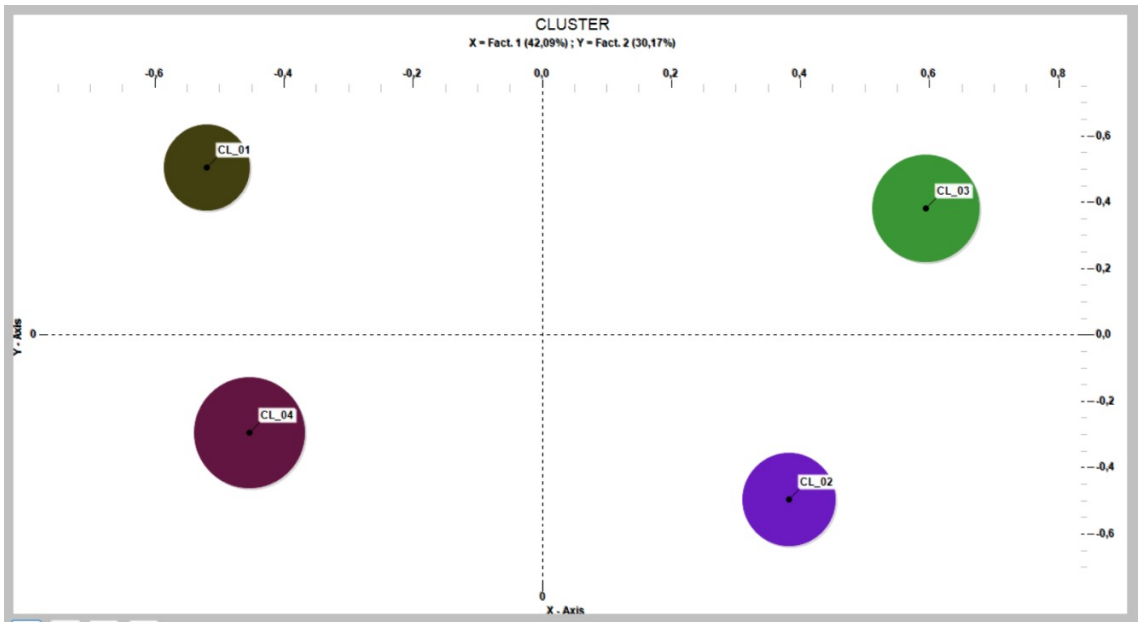
The first 10 lemmas of Cluster 3 are: patient, listen, available, human, visit, appointment, contact, first, situation, request. This cluster seems to indicate how the patient desires a close relationship with the doctor: the word "patient," which begins the list of lemmas in this cluster, evokes the patient but also a patient doctor – the pathos is the shared emotional experience. The patient wants the doctor to listen to them, to be available, to be human (showing compassion for the unhappiness of fellow beings). "Visit" and "appointment" are the lemmas that characterize the relationship: the visit is the time when the doctor's attention is focused on the patient; the appointment is the certainty of the meeting, the prefiguration of a moment dedicated and reserved for the encounter. The patient needs contact, almost like a fragile child, aware of their vulnerability, who is reassured by the contact with the caring figure. The patient is the first, precisely because of their vulnerability, preceding everyone else: when the doctor is with them, they are with no one else, taking into account the situation, that is, the patient's condition, and responding to their request. This is the cluster of the doctor-mother, who alleviates anxieties and fears, accessible and available as soon as the patient needs them, providing care with promptness and full attention, like that expected from a mother towards her young child.

Cluster 4

The first 10 lemmas of Cluster 4 are: experience, speak, figure, life, think, know, right, family, perception, perceive, good. "Experience" is "the course or series of acts through

which one acquires knowledge of particular things." The doctor gains experience of the patient through speaking, the act that places the patient's thoughts and sensations into the doctor's mind. This relational act allows the doctor to know the patient, identifying their specific figure, their outward appearance, because from the outside, the doctor recognizes and understands the nature of the patient in front of them. The doctor knows the patient's life, penetrating that outer shell filled with initial meanings to reach deeper meanings that permeate the patient's life in its complexity. "Think" and "know" are actions that require mental effort and application, just as "perception" and "perceive" call on the doctor's senses to be alert. This is the cluster of the doctor-father, the one who knows, who is good and just with his family, the ancient "famuli" upon whom his authority acts. The father is good, naturally kind and compassionate, but also just, conforming to human and divine laws, knowing what to give and what to take away, acting based on principles and knowledge.

Factorial Plane Analysis



The factorial plane contrasts Cluster 1 and Cluster 2 on the first factor, respectively at the positive and negative poles; and Cluster 3 and Cluster 4 on the second factor, respectively at the positive and negative poles. These two factors explain 73% of the variance.

First Factor Analysis

The first factor shows the urgent need for the doctor-patient relationship, dictated primarily by the appearance of symptoms and thus obligatory (meaning no doctor can refuse), with the painful awareness that any kind of relationship must be faced. The patient struggles between the demand for immediate medical attention and the understanding that the doctor is guided by their own autonomous decision-making processes. This factor represents the patient's effort. When overwhelmed by their need for care, the patient demands an expert, knowledgeable doctor of high moral standing, compelled by the patient's need which becomes an ethical obligation for the doctor. However, the same patient, confronted with reality, accepts with difficult awareness that the relationship with the doctor must be built with hope while also accepting all of its facets and imperfections.

Second Factor Analysis

The second factor represents a powerfully symbolic medical figure: the doctor who welcomes, protects, and heals, and the doctor who supports with reason and discernment, embodying both mother and father roles simultaneously. This powerful symbolization is certainly linked to one of the basic psychological needs of every human being from the beginning of their development: the need to have access to a relationship that serves as a secure base, offering protection and comfort in moments when we are gripped by the anxiety of our vulnerability, our dependence, and the infinite needs of our bodies.

4. *Conclusions*

Our study corroborates existing literature, affirming the profound emotional significance patients attribute to the GP-patient relationship. From the patient's perspective, this relationship is deeply laden with emotional meanings, governed by an intense need for reassurance and care. This aspect transcends perceived differences in background and

context (as evidenced by the lack of significant divergence in thematic content between Italian and Albanian nationals, or between residents of urban and rural settings). Patients seek not only accessibility but also perceived wisdom and reasonableness in their GPs, driven by a fundamental need for trust (Hall et al., 2001). Patient vulnerability is heightened during consultations, particularly with GPs, as they often present with somatic anxieties and perceived functional disruptions. This vulnerability can manifest as emotionally demanding inquiries, potentially placing a substantial burden on GPs, who may feel compelled to address these emotional needs while simultaneously relying on their technical and professional expertise. However, patient perspectives, as reflected in our analysis, suggest a primary focus on establishing a secure and accessible relational dynamic, with less emphasis on explicit expressions of GP competence. This divergence may contribute to a perceived disconnect, wherein GPs interpret patient concerns as challenges to their professional competence, while patients perceive a lack of responsiveness to their emotional needs. It is hypothesized that enhanced GP training in recognizing and addressing patient needs for care and reassurance, without adopting a judgmental or defensive posture, could improve relational management and conflict resolution (Roter & Hall, 2006). While patients exhibit a desire for attention and control, they also demonstrate an awareness of the inherent limitations and time constraints within general practice. They express tolerance for waiting times and limited accessibility, acknowledging the shared need for care among patients. This suggests that patients are not uniformly unreasonable but are capable of establishing and adhering to relational ground rules. These findings advocate for the integration of relational skills training into GP education. The perception of patient disrespect towards GP competence may stem from patient frustration when their emotional needs are not adequately met, leading to reactive behaviors that GPs interpret as professional devaluation. Acknowledging the limitations of this pilot study, including its small, non-representative convenience sample and the absence of controls for cultural variables, the results offer valuable preliminary insights. Future research with larger, more representative samples and controlled variables is warranted to further explore these dynamics. Nevertheless, the study suggests that targeted training in interpersonal and communication skills within continuing medical education could facilitate the development of mutually trusting and respectful

GP-patient relationships, thereby mitigating conflict and reducing GP defensiveness in response to perceived patient demands (Epstein & Street, 2011).

5. *Ethical Issues*

The study was conducted in accordance with the ethical principles set forth in the Declaration of Helsinki (World Medical Association, latest revision), the Oviedo Convention on Human Rights and Biomedicine (Council of Europe, 1997), and the International Ethical Guidelines for Health-related Research Involving Humans (CIOMS, 2016). All participants provided written informed consent in accordance with applicable regulations. The processing of personal data complied with the European Union General Data Protection Regulation (GDPR, Regulation (EU) 2016/679), the EU Charter of Fundamental Rights (Art. 7–8), and relevant national legislation, including the Italian Legislative Decree 196/2003 ('Codice in materia di protezione dei dati personali') as amended by Legislative Decree 101/2018, as well as the guidelines issued by the Italian Data Protection Authority (Garante per la Protezione dei Dati Personali). All collected data were fully anonymized prior to analysis, stored on secure servers with restricted access, and used exclusively for research purposes. Data management and retention procedures were implemented in compliance with current ethical and legal requirements, ensuring confidentiality, integrity, and protection of participants' rights.

References

Ancona, M., Casini, M. P., & De Fiore, L. (1999). *Empatia e relazione medico-paziente*. Il Pensiero Scientifico Editore.

Beach, M. C., Sugarman, J., Johnson, R. L., Arbelaez, J. J., Duggan, P. S., & Cooper, L. A. (2006). Do patients treated with dignity report higher satisfaction, adherence, and receipt of preventive care? *Annals of Family Medicine, 4*(4), 331–338. https://doi.org/10.1370/afm.448

Bensing, J. (2000). Bridging the gap: The separate worlds of evidence-based medicine and patient-centered medicine. *Patient Education and Counseling, 39*(1), 17–25. https://doi.org/10.1016/S0738-3991(99)00087-7

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Owusu Ananeh-Firempong, I. I. (2016). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*(4), 293–302. https://doi.org/10.1093/phr/118.4.293

Bikker, A. P., Mercer, S. W., & Reilly, D. (2021). A pilot prospective study on the effectiveness of empathy training in primary care consultations. *Patient Education and Counseling, 104*(1), 123–130. https://doi.org/10.1016/j.pec.2020.07.007

Carli, R. (2015a). *La simbolizzazione affettiva: Percorsi di psicologia clinica e sociale*. Franco Angeli.

Carli, R. (2015b). Narrativismo e psicoanalisi. *Quaderni della Rivista di Psicologia Clinica*, 1, 70-84.

Derksen, F., Bensing, J., & Lagro-Janssen, A. (2013). Effectiveness of empathy in general practice: A systematic review. *British Journal of General Practice, 63*(606), e76–e84. https://doi.org/10.3399/bjgp13X660814

Epstein, R. M., & Street, R. L. (2011). *Patient-centered communication in cancer care: Promoting healing and reducing suffering*. National Cancer Institute.

Fantini, M. P., Dallolio, L., Golinelli, D., & Mazzocato, C. (2020). Primary healthcare in Italy: Organizational challenges in a changing context. *International Journal of Health Planning and Management, 35*(1), e21–e29. https://doi.org/10.1002/hpm.2854

Ferreira-Valente, M. A., Pais-Ribeiro, J. L., Jensen, M. P., & Almeida, R. (2022). The role of empathy in health and healthcare outcomes: An updated review. *Current Psychology, 41*(1), 17–30. https://doi.org/10.1007/s12144-021-01748-9

Flodgren, G., Rojas-Reyes, M. X., Cole, N., & Foxcroft, D. R. (2020). Effectiveness of strategies to improve primary healthcare delivery in low- and middle-income countries: A systematic review. *Cochrane Database of Systematic Reviews, 2020*(6). https://doi.org/10.1002/14651858.CD011425.pub2

Fornari, F. (1976). *Teoria psicoanalitica del linguaggio*. Armando Editore.

Ha, J. F., & Longnecker, N. (2010). Doctor-patient communication: A review. *Ochsner Journal, 10*(1), 38–43.

Hall, J. A., Roter, D. L., & Rand, C. S. (2001). Communication of affect between patient and physician. *Journal of Health and Social Behavior, 42*(1), 19–31. https://doi.org/10.2307/3090190

Hojat, M., Louis, D. Z., Markham, F. W., Wender, R., Rabinowitz, C., & Gonnella, J. S. (2011). Physicians' empathy and clinical outcomes for diabetic patients. *Academic Medicine, 86*(3), 359–364. https://doi.org/10.1097/ACM.0b013e3182086fe1

Kelly, M. A., Freeman, L. K., & Dornan, T. (2020). Family medicine, empathy and the learning environment: A qualitative study. *BMC Medical Education, 20*(1), 1–10. https://doi.org/10.1186/s12909-020-02300-3

Kerasidou, A., & Horn, R. (2021). Making space for empathy: Supporting doctors in the emotional labour of clinical care. *BMC Medical Ethics, 22*(1), 1–6. https://doi.org/10.1186/s12910-021-00583-9

Kringos, D. S., Boerma, W. G., Hutchinson, A., & Saltman, R. B. (2020). *Building primary care in a changing Europe*. World Health Organization Regional Office for Europe.

Lancia, F. (2004). *T-LAB: Un software per l'analisi dei dati testuali*. Franco Angeli.

Matte Blanco, I. (1975). *The unconscious as infinite sets: An essay in bi-logic*. International Universities Press.

Mercer, S. W., & Reynolds, W. J. (2002). Empathy and quality of care. *British Journal of General Practice, 52*(Suppl), S9–S12.

Mercer, S. W., & Reynolds, W. J. (2020). Empathy in general practice: A systematic review and meta-analysis. *British Journal of General Practice, 70*(691), e408–e415. https://doi.org/10.3399/bjgp20X710957

Ministero della Salute. (1978). *Istituzione del Servizio Sanitario Nazionale (Legge 833/78)*. Gazzetta Ufficiale.

Riess, H. (2021). The science of empathy. *Journal of Patient Experience, 8*, 23743735211032801. https://doi.org/10.1177/23743735211032801

Rotar, A. M., van Loenen, T., Ginneken, E., & Kringos, D. S. (2021). Primary care in 34 high-income countries: An overview. *British Journal of General Practice, 71*(705), e926–e933. https://doi.org/10.3399/BJGP.2021.0315

Roter, D. L., & Hall, J. A. (2006). *Doctors talking with patients/patients talking with doctors: Improving communication in medical visits* (2nd ed.). Praeger.

Schäfer, W. L. A., Van den Berg, M. J., Groenewegen, P. P., & Delnoij, D. M. J. (2021). The challenge of multimorbidity in primary care: The role of care coordination. *BMC Family Practice, 22*(1), 1–11. https://doi.org/10.1186/s12875-021-01427-2

Schillinger, D., Grumbach, K., Piette, J., Wang, F., Osmond, D., Daher, C., Palacios, J., Sullivan, G. D., & Bindman, A. B. (2003). Association of health literacy with diabetes outcomes. *JAMA, 288*(4), 475–482. https://doi.org/10.1001/jama.288.4.475

Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. *Milbank Quarterly, 83*(3), 457–502. https://doi.org/10.1111/j.1468-0009.2005.00409.x

Stewart, M., Brown, J. B., Weston, W. W., McWhinney, I. R., McWilliam, C. L., & Freeman, T. R. (2014). *Patient-centered medicine: Transforming the clinical method* (3rd ed.). CRC Press.

Wang, C., Huang, Y., Li, H., & Liu, Y. (2021). Language barriers and patient safety: A systematic review. *BMJ Open, 11*(9), e048531. https://doi.org/10.1136/bmjopen-2020-048531

Wilhelmsen, M., Bjørgvinsson, T., & Høglend, P. (2020). The impact of emotional intelligence in psychotherapy. *Frontiers in Psychology, 11*, 1911. https://doi.org/10.3389/fpsyg.2020.01911

Wong, S. Y. S., Zhang, D., Sit, R. W. S., Yip, B. H. K., Wong, M. C. S., Mercer, S. W., & Chung, V. C. H. (2022). Person-centered primary healthcare and chronic illness: Empirical evidence and future directions. *International Journal for Quality in Health Care, 34*(Supplement_1), ii23–ii30. https://doi.org/10.1093/intqhc/mzac026