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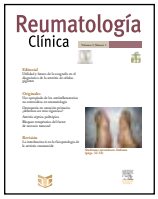

Editorial

Communicating with the patient. The perspective of the psychologist

Habilidades de comunicación con el paciente. La perspectiva del psicólogo

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There are two fundamental aspects in which psychology has knowledge, developed within its field of influence, which can be useful in order to improve patient-physician communication. On the one hand, training in social skills, necessary in order to reach an assertive model of relationship, and on the other hand, counseling. Both the practice of an assertive communication model and the use of counseling improve the health of patients and are also a benefit to the professional's themselves.[1] Good communication increases treatment compliance and reduces patient anxiety, pain, and comorbidities. In addition it constitutes a protective factor against burnout syndrome,[2] which is ever more prevalent in the medical profession and allows us to face in a more effective manner both violent incidents or lawsuits,[3] an issue which is currently larger than commonly supposed.[4]

Ever since the Toronto consensus in 1991, this topic has been considered relevant, and the need to include training in communication skills in medical school curricula and continuous medical education has been acknowledged.[5] Numerous studies and authors have published work in this regard since then so we will not insist on it and will limit ourselves to the arguments employed by Albert Jovell, in his excellent editorial "Affect based Medicine."[6] But in spite of the many published studies, there are still today behaviors and forms of understanding that are based on paternalistic and linear systems which should have been overcome, where a biologic model of understanding health versus the biopsychosocial model, which is making headway with difficulty. Not long ago, during the summer course on Health Professional Motivation at El Escorial, I heard a respected expert say that the motor of the medical act is to think of the moment in which you can tell the patient that he or she is cured. This expert illustrated his statement with the painting *The Doctor* of Sir Luke Fildes (1844–1927), in which a physician is maintaining a vigil over a sick child with the parents in the background, anxious over the outcome of the situation. According to this professional, this painting reflects the motivation of Health professionals: to quench the thirst for hope of those who trust their health will be restored or their lives, or their loved-ones lives, will be saved. This triumphant idea is still transmitted to professionals during their training period, in which they are led to believe that, with the scientific knowledge they have acquired, the technology that has been developed, personal work and their efforts towards achieving this objective, to cure is the only and unquestionable natural outcome. For example, in a recent poll done in Mexico, 40% of medical residents though that a good practice consisted ofcommitting oneself to curing the patient.[7] The truth, however, differs wildly from this ideal situation. Frequently, physicians must evaluate undefined symptoms, which match several possible illnesses, diagnostic tests with diverse percentages of error, multiple treatment options with their balance of benefits and inconveniences which must be weighed, and in general, a degree of uncertainty which stands far apart from the message of cure as an end, especially in rheumatic disease in which patients frequently have chronic or "incurable" processes. To this we must add that the patients coming to the clinic also carry their own uncertainties. In spite of the fact that the new model of patient is assumed to be better informed through the internet, media, etc, in truth they are exposed, as are the physicians, to the opinions and recommendations of experts (or pseudo-experts) which differ among them and are, on occasion, contradicting.[8] It is logical for this uncertainty to generate anxiety on both parts, which is sometimes manifested in sometimes inhibited forms of communication and behavior, or in an aggressive stance, which instead of contributing to a better understanding of the central topic occupying them (how to manage the disease) leads to friction and conflict. In this context, the lack of good communication skills implies lacking the resources necessary to confront a series of situations that will come up often in doctor-patient relationships, and that range from the need to deliver bad news, a situation one is hardly prepared for, to defending oneself against abusive behavior on the part of the patient who might consider him or herself to have been inadequately treated if the physician has not said or done something that the patient expected, passing through a large gamut of different possibilities, including the need to admit that medicine is hardly free from errors and that, in all certainty, a percentage of them will occur during professional practice, something that does make the physician a bad one.

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What can the psychologist provide? The experience of years dedicated to the study of human interaction. Communication is basically that, an interaction between two or more individuals in many different aspects; to paraphrase Watzlawick (Paloalto School) in one of his axioms: "it is impossible not to communicate" and all interactions, verbal or non-verbal, communicate something. An adequate management of that interaction will allow us to achieve our objectives in a more satisfying manner. We have to learn how to practice "assertive medicine," as some authors have called it,[9] in the understanding that assertiveness is the expression and defense of rights and opinions in a hones, direct and appropriate manner, without infringing on the rights of others and based on the respect of opinions, values and decisions of others. We should not forget that health is a right and not an obligation, and as Milton Ericsson said, doctor-patient relationships are collaborations between 2 experts; the physician, who is an expert on the knowledge of his science, and the patient, who is an expert of his or herself.[10]

From this perspective, training in social skills provides the physician with a series of tools which improve the attainment of these objectives through learning of emotional control (cognitive, physiological, and motor), and techniques such as active listening, empathy, providing useful information in a clear way, obtaining the most information through open or closed questions employed adequately, summarizing information and sending "me" messages, and many other possibilities, all of them pointed at achieving optimal communication.

Finally, *counseling*[11] supposes going an extra step in the same direction. Parting from social skills and emotional control, which are necessary for good communication, counseling implies, in addition, the capability to transmit these resources, already integrated by the professional, to patients and their environment, giving these capacities to them also and in this way allowing to simplify their conduct and permitting them to make simpler, more rational and better informed decisions. The goal is to induce possible changes in the patients' conduct, attitude or beliefs, in cases in which doing this would improve their health, but without imposing or forcing them. Health must not be imposed but agreed upon, providing above all adequate information, making the patient an involved part in treatment and progression. And quality information not only supposes explaining disease relevant aspects to the patient, but also mentioning emotional reactions of the disease, or those unleashed by treatment or disease progression, as well as family, work-related or social consequences. The objective is to help (leading to the term "help relationship") the patient to face and manage emotions and environment in a healthy way, providing information on coping alternatives that have helped other patients in similar situations, and also on all of the resources that society can provide them to help them in this stage of their lives.

The following example illustrates, in a simple way, how all of the information exposed above can be used in a concrete case. A physician knows that smoking is associated to multiple health problems. But it might be possible that he or she is a smoker. And he or she must also understand that patients are free to assume their own risks, make their own decisions and continue smoking. However, he also knows that in some patients, this vice is riskier than in others. Therefore he can offer a patient the reasons for, in spite of respecting the patients decision, in their concrete case it is more important, serious and transcendent to follow the therapeutic advice. We know that as physicians. But as assertive physicians we must understand the patients and their resistance to change, putting ourselves in their shoes and recognize their emotions, which are respectable, and understand that we stand beside our patients to help them modify their conduct; the physician can involve their environment, can explain smoking cessation programs or prescribe nicotine patches. We can go beyond simple advice and help the patient follow it, understanding their resistance and offering them all of the resources necessary to overcome the problem.

From the perspective of the psychologist, therefore, communication in medicine is something more than information; it is an opportunity to help. It may not cure, in the sense exposed above, but it allows both parties (doctors and patients) to be at peace with themselves on all senses.

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