ECRONICON OPEN ACCESS

EC CARDIOLOGY
Commentary

Communication in Medicine: Part III: Psychological Aspects of the Doctor-Patient Relationship

Giuseppe Gullace[1]* and Luciano Peirone[2]

[1]Consultant Cardiologist, Multimedica di Limbiate (MB), Former Director of the Dipartimento Cardiovascolare, of the Dipartimento Coordinamento delle Attività Specialistiche Territoriali and of Cardiologia Riabilitativa of Azienda Ospedaliera della Provincia di Lecco, Former Adjunct Professor of Cardiologia, University of Florence, Florence, Italy

[2]Psychotherapistm, Former Adjunct Professor of Psicologia Clinica e della Salute-Benessere, University "G. d'Annunzio" of Chieti-Pescara and University of Brescia, Brescia, Italy

***Corresponding Author:** Giuseppe Gullace, Via San Leonardo 11, 23864 Malgrate (Lecco), Italy. **E- mail:** ggullace47@gmail.com

Received: June 01, 2021; **Published:** June 30, 2021

... It would not be possible to know the medicine for who does not know what man is; but that is what, who should correctly take care of men, must understand... ... if understanding is lacking of the common man and the interlocutors will not be placed in such an arrangement, it is the reality that will be missed ... Hippocrates

Summary

This third part of the paper we cope the different psychological aspects of communication with the patient that influences his relationship with the doctor. The words used in talking with the patient and the story that he tells, the capability of listening by the doctor, the attitudes and the ability to create empathy shall be considered with attention in the doctor-patient relationship due to the influence that they have on it. Above all, to cure (medically) and to care (psychologically) patient, taking the responsibility of his pathway are emphasized seen the implications that this behavior has in the management of the patient with his disease. One must be a doctor to do the doctor well without forgetting that patient with his disease is the final goal of the medical profession.

Word and balance

The first who talked about the Doctor - Patient relationship and communication in Medicine was Imhotep, doctor and architect of Djoser, pharaoh of the III dynasty, who, in his approach to the "health system", the first of antiquity, attributed to the knowledge of the patient and of his illness, the collection of information necessary for the diagnosis and doctors' education, with the story and direct experience taken on the patient, a fundamental role in practicing the medical profession.

Who, however, defines the relational and communicative process in an articulated way is Hippocrates much later. His indications stand out for their sharpness, especially when one thinks of their ever-present validity.

... the doctor must study the customs, the regimen, the lifestyle, the age of each one; the speeches, the silences, the thoughts, the sleep, the insomnia, the dreams - how and when - the involuntary deeds - tearing one's hair, scratching, crying ... because, the biggest mistake we make today is to separate the psyche from the soma... [1].

The Medicine of Hippocrates (ancient but not outdated in the basic principles) binds together body and soul, soma and psyche, through a holistic approach (somatopsychic and psychosomatic) that allows the "movement" between the two poles of the continuum. Consequently, the ability to communicate is an essential element for him: the doctor must "know how to read" (*diagnostic intelligence*), "know how to cure" (*the art of removing the disease*) and "know how to communicate" (*ability to communicate*) that is the ability to transmit the relevant information to all recipients. In the Hippocratic indications we find the interest in man and the importance of his knowledge (... *if there is love for man there will also be love for science*...), attention to the correct asymmetry and symmetry in communication between doctor and patient, between teacher and learner, experts and laymen [2-4].

More recently Sigmund Freud revolutionizes communication structuring it within his Psychology and Psychoanalysis [5]. His entire theoretical-empirical-clinical structure is based on the "Word", on this communicative tool applied to the Therapeutic Relationship, in particular in the search for that mysterious and elusive object called the Unconscious.

"*In the analytic treatment, nothing is done other than an exchange of words between the patient and the doctor. The* **patient talks***, he tells about past experiences and present impressions, he complains and admits his own desires and emotional impulses. The* **doctor listens to***, tries to address the patient's thought processes, exhorts him, pushes his attention towards certain directions, provides him with some clarifications and observes the reactions of understanding or rejection that in this way he arouses in the patient.... Words were originally magic and, even today, the word has retained much of its ancient magical power. With words a man can make the other happy or push him to despair, with words the teacher transmits his knowledge to the students, with words the speaker drags the audience with him and determines their judgments and decisions. Words arouse affection and are the common means by which men influence each other"* [6].

The words and the story of the patient to the doctor are found in Hippocrates and Freud as common and similar elements and are of fundamental importance for understanding the patient himself through his history and the analysis of his disorders.

"Balance" (psychological quality) would seem to be the heart of Medicine (the balance among the elements of ancient memory), despite all the concrete problems that arise every day: not only in "doing" but also in "saying". For example, when faced with a serious problem (serious, but treatable and curable), how to manage the following information: "You, madam, have a lump in your breast". From the range of possible communicative expressions, is it better to choose cold objectivity or to choose a lukewarm diminution of the problem by softening the diagnosis and reassuring the patient? And for example, when faced with a serious problem (insoluble, incurable, difficult to be healed), in which way should we resort to the following message: "You will see that you will succeed". How and when to get the patient to react, through a clearly subjective encouragement, with a falsehood expressed for a good purpose? Should we privilege the problem or the relationship? that is, the clinical reality (objective) or the doctor-patient interaction (subjective) and the emotional point of view, therefore the personality of the patient (and his doctor)? or should we try - within the limits of what is possible to be determined carefully from time to time - to harmonize the two perspectives?

Obviously, the latter would be the best thing to do, but the doctor moves amid certainties and doubts... and he does so within a lot of relativities. And what he knows and what he knows to do are subject to decisions, which in one way or another must be taken, but still with firmness and determination.

Listening

Probably the highlight of the help work in the medical field (but also in other professional and life sectors) is the collection of information: if mistakes are made (especially in the form of deficiencies) in this input phase, the risk to carry them invalidating everything that comes after is very high. This initial phase therefore requires a lot of attention, also in order not to compromise the output action. In particular, for a correct history in the medical-organic field, an effective "listening practice" is required, which consists in assuming, from

the perspective of psychology and therefore of relationality, a "passive" attitude (which in reality is not passive, being a particular form of "intervention").

The formulations of the *truthful diagnosis* and *effective therapy* strictly depend on the "how much", and "how", it was possible to obtain in the communication with the patient (or with the candidate patient), from the first interview, which is sometimes the only one. On the side of the doctor, humility and respect for those "in front of him" are the ethical-emotional pillars which, together with competence and experience, well direct this "passivity", indispensable and whose importance will become increasingly clear precisely with the passage of time, the accumulated years of work and the sensitivity gradually refined, but which must already be present from the beginning of the "career". *To hear: with the ear and with the heart, to feel and the "feeling"*. To auscultate and to listen to. How much richness in the relationship between Medicine and Psychology, between psyche and body, which is expressed through the harmonious function of being and doing of the subject/patient. A close and dynamic correlation between the neuro-hormonal and psycho-behavioral systems that influence each other and remain harmonious in physiological conditions but become disharmonious in conditions of disequilibrium due to disturbing factors [7-9] both on an individual level and in the Doctor - Patient relationship, where attention to the latter, which is also expressed through listening, is an extremely important and facilitating factor in the relationship itself.

It is the basis of the diagnostic process (not unlike its original enunciation) [10], which begins with the patient's story (anamnesis) (listening and the attention shown by the doctor are decisive) and continues with the physician's detection of objective signs (physical examination), including clinical observation and instrumental data. In this process, both the reference of subjective disorders by the patient, who already has a diagnostic orientation in mind even if he does not realize it, and the orientation of the doctor influenced by the patient's story and from the objective data that he detects, must be kept in mind and are of fundamental importance. It is a process that is based on words and the way of pronouncing them but also on the doctor's ability to listen to and on his way of communicating [11]. Finally, we can say that the diagnosis is the result of a compromise between what the patient proposes with the listing of his symptoms and what the doctor detects clinically and with instrumental examinations (a condition that is often the basis of patient satisfaction).

Motivations and Aptitudes

For the purposes of correct communication with the patient, a high performance is played by the type of motivation of the doctor, motivation which, in turn, is intertwined with the deepest and most authentic "Who I am" of the doctor himself. It is important to understand both the identification with one's role and the much stronger identification with one's function (and even "mission"): the "cold" motivation guarantees the operational-communicative work carried out in technical-professional terms; the "hot" motivation guarantees a net surplus determined by deep emotional implications, even affective ones, correlated to the structure of the personality and above all of the character (understood as the original "nucleus" - first years of life and construction of the Self - of the various concentric circles of the personality, acquired over time).

It is evident that motivation is closely intertwined with aptitudes, which are profoundly part of how "we are made", of what "matter" our "being" is made up of. It is no coincidence that certain words already converge linguistically and etymologically: *"aptitude", "attitude*".

The precocity/spontaneity of aptitudes (*ability to do*) and the precocity/spontaneity of numerous attitudes (*ways of putting oneself*) are based precisely on the pleasure/satisfaction of "being like this and not like that".

The more one is intimately involved (almost always, as a "vocation"), and the more one is communicative, the more effective one is in the diagnostic-therapeutic result. Obviously, as long as he is not overwhelmed, the doctor, by the "furor curandi" typical of certain young people, enthusiastic but inexperienced and therefore "out of measure": hence the need for at least minimal psychological preparation made on himself, condensable in "*The more you know yourself, the more you understand your authentic motivations and aptitudes; the better you can communicate with the patient and the better you can help him*".

Empathy

The so-called "empathic and identification capacity with the Other" is of fundamental importance. The *I meets the You*: something far from easy in everyday life and even less so in the banality of "work as a duty". What is even fragile and uncertain in the delicacy that characterizes the "helping relationship": a human and interpersonal relationship ("one with one"), an action highly imbued with subjectivity despite the indispensable "clinical coldness", which, moreover, cannot exclude the "Noble work" of ars curandi (if well done, an authentic "help profession", which is, inevitably, "engaging"). Leaving one's own identity (without losing it) to "enter" the identity of others.

By activating empathy - an operation that is not always easy if one understands this emotion in an authentic and sincere way - a "projection" of oneself takes place in the other. He imagines himself to be in the other, he imagines himself "wearing his clothes". But this sort of projective identification exists not to possess/master him, but to understand him, to establish extra-ordinary levels of communication, mostly subliminal, that is, placed on levels of awareness lower than the state of usual vigilance (daily or specialist-professional). It is well understood, then, how useful the knowledge of the plurality of psycho-relational states and layers can be. The significance of the psychoanalytic "background frame" in which every "shared pathos" is inserted is also well understood.

There is an increasingly decisive need for a minimal knowledge of the patient's personality and his or her communication style: level of education, knowledge of words (daily and technical), ability to "absorb" and process clinical information, and above all, the awareness of the benefits/risks associated with transference experiences (those of the patient) and countertransference experiences (those of the doctor). Both types of Erlebnis (defined as *lived experience, personal, unitary aspect for which the contents of consciousness are not received passively but grasped in a lively way, retrospectively and projectively, in the flow of consciousness itself, all that is life of the single individual*) [12] see projective involvements (mostly unconscious and therefore difficult to manage) activate, for example of the type "*... in this doctor I place my desperate need for support, which I have never had in my life, much less from my father*"as well as, on the other side"*... in this patient I see my mother and all her defects; this influences my action on this person who asks for my help, both technical and human*".

Above all, there is another undeniable fact to complicate things (but also to enrich them). There is no patient equal to another; there is no individual equal to another. Relativity and subjectivity, therefore. Hence the complexity of communication and the need - for doctors (themselves all different from each other) - to be flexible (beyond the obvious scientific laws, essentially the same for everyone). Relational, communicative and identity flexibility: "*I am me, but the Other is different from me, as well as this Other is Other and many others", so "I must be other than myself and I must also be in the plural*". Many individuals, many people, many personalities.

"**Medice, cura te ipsum**" [13]: the famous saying of Jesus told by Luke [14], used to stimulate the doctor not to forget his own health, is also valid in the interpretation according to which one must "look inside", that is not only physiologically but also psychologically, by tracking down the fragments (or even the mountains) of one's relational and communicative capacity: relating to oneself, communicating with oneself. To then go further, towards the Other-from-Self.

Empathy, passion, pathos are strong words dripping with existential meanings, where the technique is not diminished but enhanced by the ethical impulse. Understanding the passion of others (whether positive or negative). "Understanding" (taking together) the sick passion of others, making it "one's own" (cum grano salis) and bringing the suffering "within" oneself (however, without being overwhelmed). The double quotation mark ("own", "inside") means a metaphorical-symbolic operation, not "real" but "similar to the real", not material but psychic, carried out technically by simulating the external pathos in one's "Internal World", going to "touch" (without "getting burned") the Evil of the Other [15].

Therefore, without the doctor necessarily becoming a psychologist or even a psychoanalyst, a certain amount of empathy is methodologically necessary, even where bodies and cells prevail. To a certain extent the doctor and the patient must speak the same "language", and in this the doctor is certainly more prepared (or led to) than the patient. In the context of a medical-type clinical relationship, empathy

plays an important role: it is useful, recalling a (more or less intense) emotional harmony (and even effective in the sense of "affection/feeling/to feel").

In coping with the patient's problems, the doctor must/should have recourse to two working guidelines:

a) The *strictly objective and technical* action of treatment for the benefit of the living organism affected by disease, without forgetting that the doctor should not treat the disease but he should treat the patient with his disease, where the disease within the person assumes specific connotations (in terms of information, management and evolution) and the fight against it must be undertaken and carried out while safeguarding its "bearer";

b) The *strictly subjective and relational* one of inter-human action, characterized by "knowing how to welcome" and "knowing how to manage" the patient, with a style that sees communication emerging in the foreground.

I care

Simplifying, in a crude but significant way, one could say: **to cure** with physics, chemistry, biology and related tools; **to care** with psychology, sociology and related tools, but also taking responsibility for the patient's pathway. It comes to mind I care (taking care, taking responsibility... of the other, written on the school of Barbiana) by Don Milani's memory [16], a condition that requires relational capacity and the activation of attention and interest in the other, for his problems, his behavior, his emotions and his feelings; necessary prerequisites for developing a helping relationship, in which one tries to facilitate the other in solving problems by enhancing personal resources and favoring the development of a greater possibility of expression [15].

In providing "material help" on the one hand (operating on the soma) and on the other hand "immaterial help" (operating on the psyche), one could metaphorically say that "the scalpel must be handled with the soul". Sometimes the latter is even decisive in achieving the result, therefore, the combination of "efficiency + effectiveness" is guaranteed by an output imbued with subjectivity.

Staying in the relational and communicative topic, the doctor who knows how to be aware of his own "inner strength" is determined and convincing. His "positive and proactive" attitude/behavior is able to strengthen the patient's ego, leading/accompanying the patient to face the problems of the disease (and the trials of life...) with a greater capacity for resilience. The situation in which the patient finds himself entangled should be declined in the continuum "illness-malaise-discomfort", then with a wider range of reading than the traditional one, thus managing to make the patient work with additional help, which would favor the consciousness-raising of conscience that if there is a problem then there is (possibly and probably) its solution as well.

To make the patient the protagonist of his own pathological condition (and relative way out). Within the limits allowed by the contingent and specific situations, this is a viable path, which at the same time "informs and trains" the patient: a portion of "self-help" is combined with "technical and professional help" and of this enrichment of the user the doctor should be responsible, precisely by communicating actively and correctly regarding helping.

Final Remarks

It is therefore evident that communicating with the patient effectively means putting them in the best possible conditions of attention and receptive availability, possible only if the doctor has adequate knowledge of the person and his psycho-behavioral profile [7-9,11,17]; but it also means using adequate ways and means of communication, transmitting safety and responsibility, showing the willingness to take charge of the patient's diagnostic and therapeutic path, using an understandable and suitable language for an effective explanation, transmitting what one is able to respond to expectations and satisfying needs, avoiding disturbing factors as much as possible and encour-

aging the patient's participation in choosing the pathways to follow and the decisions to be taken [17].

It is undeniable that the contribution of Psychology to communication in Medicine and to the doctor-patient relationship is of fundamental importance.

Empathy (or "putting yourself in the shoes of") is an important skill in the doctor's scientific, professional and ethical background. On the level of awareness, the doctor should know that communication can or must be, from time to time and moment by moment, explicit or implicit, conscious or unconscious, made up of observation or insight: which requires a lot of sensitivity, a lot of "humanity". In terms of meaning, the doctor should always be sure of the correct interpretation (Deutung) given by the patient to the health information provided by the doctor himself. Unfortunately, there are increasingly short times for an adequate "personological" investigation, useful for accompanying the medical relationship-communication in the clinical field.

However, despite the hurry and various difficulties, there is a difference between "**doing a doctor**" (*superficial and routine behavior*) and "**being a doctor**" (*feeling and living this in a profound way, combining the best experience/Erlebnisse with the technical action*). So, what identity for the doctor? Surely that which requires an adequate involvement (etymologically: turning around together), a fruitful immersion [18,19] in the concrete (unrepeatable?) experience of the concrete (unrepeatable?) patient.

…. it is therefore necessary that whoever wants to acquire a profound mastery of medicine must have these: natural propensity; culture; favorable place; education from childhood; industriousness; time… [20].

The Doctor must be able in clinical practice to combine organized knowledge (**science**), application of knowledge to treatment (**art**), taking charge of the patient's path (**management**) and appropriate use of **technology** by communicating its contents in an adequate, correct and useful way with the purposes of individual and collective improvement [11]. In the first edition of his Principles of Internal Medicine text, Harrison wrote in the introduction…*No greater opportunity, responsibility, or obligation can fall to the lot of a human being than to become a physician. In the care of the suffering he needs technical skill, scientific knowledge, and human understanding. He who uses these with courage, with humility, and with wisdom will provide a unique service for his fellow man and will build an enduring edifice of character within himself. The physician should ask of his destiny no more than this; he should be content with no less… [21]*. But above all he must have empathic and communicative skills in order to be in tune with the world of the patient and his illness. The Doctor becomes then a source of knowledge in the medical field and represents the point of reference not only for patients and relatives but also for the community (the general public, companies, institutions, colleagues and other health professionals). Harmony, source of knowledge, point of reference: all these items converge in highlighting the effectiveness and effects of a real information capacity.

It is clear that the identity of being a doctor differs from being a doctor as a practice of the profession, but if combined in the correct way then the identity becomes unique, that is, **to do the doctor well** (*practice the profession with responsibility, dignity, competence, availability, respect*) **one must be a doctor** (*to feel and to live the profession with passion, interest, curiosity, research, knowledge and a great desire to learn to give back to the patient who is and remains the final goal*).

Paraphrasing William James Mayo, founder of the Mayo Clinic with his father William Worrall and his brother Charles Horace, famous throughout the world, the ultimate goal of medicine is to prevent disease and prolong life, but also to assist and cure the sick and alleviate their suffering. Communication in Medicine travels in an indispensable way along this path without forgetting that, as William James Mayo himself said, "*the best interest of the patient is the only interest to be considered*" [22].

Bibliography

1. Ippocrate: Epidemie 1 11 e 23.
2. Hippocrates of Cos. The Oath. Loeb Classic Library 147 (1923): 298-299.
3. Hippocrates D. In: Jones WHS, translator. Hippocrates. Volume II. Cambridge, MA: Harvard Press (1923): 297.
4. Ippocrate - Sull'arte, in Opere 46.
5. Rycroft Ch. "Dizionario critico di psicoanalisi". Astrolabio-Ubaldini, Roma (1970).
6. Freud S. "Introduzione alla psicoanalisi 1915-1917". Opere vol 8. Bollati Boringhieri.
7. Gullace G. "Behavioral cardiovascular risk factors: changing perspective to approach the problem". *Journal of Cardiology and Cardiovascular Therapy* 2.1 (2016): 1-5.
8. Gullace G and De Prospero M. "Stress e fattori di rischio cardiovascolare comportamentali". SISMED. Cuore (2021).
9. Gullace G., *et al*. "Stress Dresses Woman: Sex and Gender Differences". *EC Neurology* 12.11 (2020): 01-14.
10. Ippocrate - Epidemie VI, 3, 12.
11. Gullace G., *et al*. "Hippocrates' Dream. What has Hippocratic Revolution Left in Modern Medicine". *Journal of Cardiology and Cardiovascular Therapy* 13.2 (2019): 1-14.
12. Enciclopedia on line Treccani.
13. Vocabolario on line Treccani.
14. Vangelo secondo Luca (4,23).
15. Rogers CR. "La terapia centrata sul cliente". Firenze, Psycho (2000).
16. Don Milani Lorenzo e Don Bruno Borghi: I Care. Lettera ai Giudici. Introduzione (1965).
17. Gullace G and Khalaf H. "Preclinical diagnosis and risk assessment of atherosclerosis – At birth? At event? When is best?" *European Cardiology* 7.3 (2011): 162-164.
18. Turabian JL. "Psychology of doctor-patient relationship in general medicine". *Archives of Community Medicine and Public Health* 5.2 (2019): 062-068.
19. Matusitz J and Spear J. "Effective doctor-patient communication: an updated examination". *Social Work in Public Health* 29 (2014): 252-266.
20. Ippocrate: Legge (trad. M. Vegetti).
21. Harrison TR. "Introduction, In Principles of Internal Medicine". First edition, The Bleckiston Company, Philadelphia (1950): 1.
22. William James. Mayo: Commencement address speech at Rush Medical College in Chicago (1910).

Volume 8 Issue 7 July 2021