

## Communication and relationships in medicine: state of the art by Flavia Caretta

There have been few changes in the life of man as profound as those which have happened in the biomedical sciences and in medical practice in the last few decades.

Enormous developments in the field of technology have brought about unimaginable progress in diagnostic and therapeutic ability and, consequently, the emergence of new branches of specialized disciplines, created to keep up with the rapid increase of knowledge and the ever more sophisticated methods of biotechnology. This has brought about a fragmentation of knowledge. For this reason, on the clinical level, a patient no longer finds him or herself under the care of just one physician, but of several specialists in different disciplines who frequently collaborate.

Along with this *maximum* capacity for analysis, in general, there is only a *minimum* capacity for synthesis, and professional commitment is concentrated primarily on analysis.

Yet, medicine's key points of reference - health, sickness, life, death - pertain to a total and unifying element which is the whole person.

Historically and traditionally, medicine has been identified with the applied practice of a doctor during his/her encounter with a patient; therefore, a meeting of persons. The patient-physician relationship represents the historical nucleus of medical practice.

In actuality, the neutrality and objectivity that characterize diagnostic testing runs the risk of turning this relationship into the so-called "silent medicine," - silent on the part of the "owner" of the sickness, that is, the patient. The clinical data remains the only topic of communication one can expect from a patient-physician interaction.

Moreover, a knowledge of the most minute details of the human anatomy does not necessarily coincide with greater capacity to cure. For example, the awesome image technologies can, at times, bring to light data which technicians are unable to interpret with regard to their implications on a person's health. This,

in turn, could generate uncertainties on the part of the physician and, as a consequence, on the patient as well.

The reflections of Karl Jaspers (physician, psychiatrist and philosopher) seem to be more than ever up-to-date. In his book "The Physician in the Technical Age," he writes: "It's strange that in contrast with the extraordinary operative capacities of modern medicine, a sense of failure often emerges. Discoveries in the natural and medical sciences have brought about an unprecedented degree of competence. But, it seems that for the masses of sick persons, each individual sick person has had more and more difficulty finding the right physician. One is tempted to think that while technology is gaining in capacity, good doctors are becoming a rarity."

We would say that in our society of techno-centric thinking and of instant communication, the physician's profession is caught up in the vortex of radical transformations and increasing uncertainties.<sup>1</sup>

Physicians, patients and all the other figures who make up the "health care scene" are involved in all these changes. Their baggage of knowledge, sensitivity and expectations have largely been molded by the previous modern age era. They believed that human beings would eventually be able to control natural phenomena, communicative and social, and make every human action towards people or things the criteria for transparency, foresight and linear programming. Thus they developed more and more specializations of learning and ever more ingenious technological inventions.

The effects, however, are very different from the expectations.

Paradoxically, instead of introducing us to the desired era of certainties, they have led us to the era of permanent uncertainty<sup>2</sup>, which Ulrich Beck calls "the risk society."

Although this scenario may correspond to actual reality, it is not thoroughly exhaustive. Undeniably, the last 20 years in particular have witnessed a growing interest in the topics of communication and relationship in medicine. Such interest reveals a felt need to regain an anthropological perspective that would complement the more specifically biomedical one; a kind of communication and

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<sup>1</sup> Manghi S., *Il medico, il paziente e l'altro. Un'indagine sull'interazione comunicativa nelle pratiche mediche*, Franco Angeli, Milano 2005, pp.11-12

<sup>2</sup> Barman Z., *The individualized Society*, Polity Press, Cambridge, 2000 (trad it. La società individualizzata, Il Mulino, Bologna, 2001)

interaction which has undergone epochal changes at least in the western world. We can think of times not long ago when the physician-patient relationship was described as “a story of silence” ruled by the conviction that “a good patient follows doctor’s orders with no objections, no questions.”<sup>3</sup>

Up to the 1980’s, capacity for relationship in medicine was considered a quality which a physician may or may not possess. Communication skills were conceived as a character trait, more than a professional asset that requires formation in the course of medical studies and has to be developed during clinical practice.<sup>4</sup>

Along with these elements proper to the world of medicine, other external factors have intervened. Communication has reached the point of becoming the foundation of the so-called industrialized civilizations. Therefore, a person might be forced to make choices that could deeply influence his or her way of being and acting.

The things that pertain to health are not exempted from this rule. In fact, medical information is used to influence not only personal but also collective behavior, in the hope of raising the population’s health standards by the prevention of illness and the promotion of health.

Consequently, the exclusive relationship between physician and patient which had been a determining factor some decades ago, is now substituted by a series of explicit or subliminal messages. Messages which have succeeded in creating a “universal medicine” by-pass the physician and go directly to sick individuals or to the healthy who are afraid of getting sick.<sup>5</sup> Thus, a physician finds himself before an “interlocutor” who knows, or at least thinks he or she knows something, and presumes to offer therapeutic options.

Added to this is the increasing pressure exercised by the economy on medicine, that threatens to alter the essential nature of the physician-patient relationship. Some say that in this framework, physicians are in danger of becoming

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<sup>3</sup> Katz J. *Physician and patients: A history of silence*. In Beauchamp LT, Le Roy W. *Contemporary issues in bioethics*, Belmont (CA), Wadsworth Publishing Co 1994

<sup>4</sup> Lailaw TS, Kaufman D, MacLeod H, van Zanten S, Simpson D, Wrixon W. *Relationship of resident characteristics, attitudes, prior training and clinical knowledge to communication skills performance*. *Med Educ*. 2006;40:18-27

<sup>5</sup> cfr. Fernandez C. *Etica della comunicazione in medicina*. *Ital Heart J Supp* 2002; 3(12): 1225-1228

de-professionalized.<sup>6</sup> Others maintain that the covenant of trust between patient and physician is compromised by for-profit forces.<sup>7</sup>

In short, we are faced with a contradictory situation. While our times offer extraordinary possibilities of cure, we are equally witnessing the commercialization of health care, prescription drug consumerism and an increase in bureaucracy. We run the risk of finding ourselves with a decadent, technological medicine that de-personalizes the patient, turning him or her into an object rather than a person. The figure of the physician is also at risk of being distorted into that of a mere technocrat.

Moreover, the practice of evidence based medicine has changed the physician's role from that of information dispenser to information collector and analyzer.

At this point, the fundamental question is this: is patient-physician communication really necessary? If it is - is it a mere form of professional courtesy, or does it actually constitute a patient's right?

Let us look back to the beginnings of medical history (around the 5<sup>th</sup> century B.C.). The Hippocratic doctor represents the archetype of the doctor who is as technically competent and as he is humanly involved. One of the most ancient medical precepts says: "Where there is *philantrofia* (love for human beings) there is also *philotecnia* (love for the art)."

This meant that to be a friend (*filantropo*) was the best way to really help someone through the exercise of one's art (*tecnofilo*). But, it also meant that the commitment to improve technically was the way to attain good friendly relationships, which could facilitate the patient's well-being as much as the therapy. Another ancient aphorism: "Every good physician is a philosopher." This **refers** to the times when a physician was expected to possess the *philosophia naturalis*, which means a profound knowledge of nature, including human nature.

Successively, Rufus of Ephesus, a Greek physician who lived during the Roman Empire (1<sup>st</sup> century A.D.), renowned for the richness of his clinical descriptions, affirmed that it is necessary to interview the patient, because this

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<sup>6</sup> Blumentale D., *Effects of market reform on doctor and their patients. Health Aff (Millwood)*. 1996; 15:170-184; Zoloth-Dorfman L, Rubin S. *The patient as commodity: managed care and the question of ethics. J Clin Ethics*. 1995; 6:339-357

<sup>7</sup> Cassel CK. *The patient-physician covenant: an affirmation of Asklepios. Conn Med*. 1996; 60:291-293

creates an interaction which then helps the doctor to find the best treatment, to know the patient's view of life which might condition the treatment itself.

Let us make a leap to the 19<sup>th</sup> century. Dr. Francis Peabody affirmed: "The importance of a close interpersonal relationship between physician and patient can never be emphasized enough. An infinite number of diagnoses and treatments depend on this. Among the essential traits a physician should have is interest in people, because the secret of curing is caring."

And what is happening today? The apex of medical practice is represented by randomized clinical tests for which clinico-epidemiological methods exist to evaluate their efficacy. At the same time, however, more rigorous research methods are emerging which evaluate the so-called "subjective factor" as a topic for research. These studies put into relief the improvement of communication skills between physician and patient, and between healthcare workers and patients.<sup>8</sup>

There is still one more aspect, which is almost surprising when compared to the limited perspective of medicine today: the re-discovery of spirituality. Already 10 years ago,<sup>9</sup> the statement was made: "Spirituality is the forgotten medical factor," and many have argued that spirituality should be included in the curriculum of medical studies.

Research oriented to the study of the relationship between spirituality and religious faith and a person's state of health<sup>10,11</sup> have multiplied in number, especially during the last 10 years. In the year 2000, at least 1,200 studies published in scientific journals have dealt with the relationship between religiosity and health. A large number of them came up with a positive correlation between these variables. But, if spirituality is so important for the patient's health, it must be the same for the doctor who should consider it as an essential element in the therapeutic environment.

It is evident, therefore, that communication and interaction have always been a constant element since the beginnings of medical history.

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<sup>8</sup> Larson EB. *A new editor for Annals of Internal Medicine- 2001*, Annals of Internal Medicine 2001;134(11):1072-1073

<sup>9</sup> Firshein J. Spirituality in medicine gains support in the USA. The Lancet 1997; 349 May 3: 1300

<sup>10</sup> *Faith & Healing. Can prayer, faith and spirituality really improve your physical health? A growing and surprising body of scientific evidence says they can* in "Time", 24 giugno 1996, p. 35

<sup>11</sup> Caretta F., Petrini M., *Ai confini del dolore. Salute e malattia nelle culture religiose*, Città Nuova, Roma 1999

If we consult medical literature in the last 10 years we will find numberless articles on this theme, a proof of the growing interest in this topic.

Some studies emphasize that difficulties in physician-patient communication have negative consequences, especially regarding adherence to the treatment protocols and respecting medical prescriptions. The quality of communication is a determining factor in patient satisfaction,<sup>12</sup> clinical outcomes,<sup>13, 14</sup> healthcare costs and malpractice lawsuits.<sup>15</sup>

In this regard, it was highlighted way back in 1994 that 2/3 of the lawsuits in the medical field can be blamed to deficiencies in the time given to and in the quality of interpersonal communication, rather than to insufficiencies or diagnostic or technical errors.<sup>16</sup>

In clinical practice, communication problems most frequently arise between healthcare worker and patient when the former shows signs of not listening to the latter. Another obstacle is the use of technical language which, by itself, contradicts the very concept of communication. Communication exists only if the message is interpreted and understood in the same way by the one who emits and the one who receives it. It has been affirmed that patient dissatisfaction caused by poor communication carries much more weight than all other causes of dissatisfaction regarding technical competency.<sup>17</sup>

Another point to consider is the content and mode of communication.

A substantial change has occurred in the last 10 years. Previously, the right to furnish or not to furnish information to the patient was left to the physician's discretion, according to what he deemed favorable to the patient's health. In just these past few years, however, the patient's exclusive right to be informed has been recognized and reinforced by successive legal dispositions to safeguard privacy.

Nevertheless, one gets the impression that the behavior of healthcare workers is influenced not so much by deontological norms as by fear of legal

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<sup>12</sup> Wiggers J.H., Donovan K.O., Redman S., et al. *Cancer patient satisfaction with care*. *Cancer* 1990;66:610-16

<sup>13</sup> Greenfield S., Kaplan S., Ware J-E Jr. *Expanding patient involvement in care: effects on patient outcomes*. *Ann Intern Med* 1985;102:520-28

<sup>14</sup> Stewart M.A. *Effective physician-patient communication and health outcomes: a review*. *Can Med Assoc J* 1995;152:1423-33

<sup>15</sup> Stewart M.A. *Effective physician-patient communication and health outcomes: a review*. *Can Med Assoc J* 1995;152:1423-33

<sup>16</sup> Journal American Medical Association, 1994

<sup>17</sup> Buckmann R., *La comunicazione della diagnosi*, Raffaello Cortina Editore, Milano 2003, pp. 37-39

proceedings. When communication does exist, the physician-patient encounter is reduced to a stark information process, without emphatic involvement, devoid of an authentic interrelationship and ethical foundation, except the respect for each one's rights. An example is the request for informed consent which is generally limited to a mere withdrawal of responsibility on the part of the physician rather than giving correct information to the patient.

There is a gap, therefore, between theory and practice: scientific research has widely emphasized that communication is essential in medicine. It attempts to define how such communication should be conceived, taught and practiced.<sup>18</sup> But, how much influence does this scientific and cultural baggage have on medical 'etiquette'?

Even academicians are asking themselves what contents such a course in the Faculty of Medicine should have. They consider it fundamental to make medical students understand that an effective cure is based on the comprehension of a patient's biological, psycho-social and cultural history.<sup>19</sup> To reach this objective, a physician must make use of communication skills, biological knowledge and clinical reasoning to formulate a diagnostic hypothesis. Academicians insist that a close relationship does exist between using communication skills in medical practice and significant diagnostic and clinical outcomes, decreased medical errors, reduced emotional distress and increased patient and physician satisfaction.

And yet, despite these efforts, it is rare to see medical students being taught how to integrate communication skills with clinical reasoning. Up to now, young physicians learn about the modalities of relating to the patients from their experience in the field and from the example of their older colleagues. This shows the need for effective formation courses.

In conclusion, we could depict the physician-patient relationship as a track to follow, according to several steps: from information to communication, from communication to encounter, where active listening plays a fundamental role. It could, however, be a track in the opposite direction, since in human relationships

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<sup>18</sup> Kurtz S, Laidlaw T, Makoul G, Schnabl G. *Medical education initiatives in communication skills*. *Cancer Prevention Control* 1999; 3:37-45; Kurtz S, Silverman J, Draper J. *Teaching and learning Communication Skills in Medicine*, 2<sup>nd</sup> edn. Abington, Oxon: Radcliffe Publishing Ltd. 2005

<sup>19</sup> Windish D.M., Pric G.E., Clever S.L., Magaziner J.L., Thomas P.A., *Teaching Medical Students the Important Connection between Communication and Clinical Reasoning*. *Journal of General Internal Medicine* 2005;20(12):1108

it is impossible to remain neutral: every encounter produces presence, and presence is always communication.

We can then envision this relationship both as a point of departure and as a goal to strive for. This intense encounter is not a mere exchange between one who is in need and another who has the right solutions nor is it just an exchange between roles. The physician-patient relationship is an interpersonal exchange in a situation of supreme anthropological intensity.

It is a relationship that becomes therapeutic for the physician as well.

It has been affirmed: "Whereas the molecular and chemistry-oriented sciences were adopted as the paradigm of 20<sup>th</sup> century Medicine, the paradigm of 21<sup>st</sup> century Medicine should be one which is centered on interrelationships".<sup>20</sup>

This is the challenge we can accept so that all that we have said here may be an objective that is widely-shared and acted upon.

But I would dare to say more. Why not make this challenge a working project?

Then the challenge would be to substantiate medical practice with the dimensions of reciprocity and communion by putting these at the basis of every relationship.

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<sup>20</sup> cfr. Johns Hopkins University, *Defining the Patient-Physician Relationship for the 21st Century* 3rd Annual Disease Management Outcomes Summit October 30 – November 2, 2003 Phoenix, Arizona V.1 ©2004 American Healthways, In JGIM