MÉDICAS UIS
REVISTA DE LOS ESTUDIANTES DE MEDICINA DE LA UNIVERSIDAD INDUSTRIAL DE SANTANDER

Editorial

Communication between doctor and patient: Beyond a query, an educational process

*Viviana Paola Forguione-Pérez**

*Medical student, XI level. Faculty of Health. Industrial University of Santander. Intern. University Hospital of Santander. Bucaramanga. Santander. Colombia.

Correspondence: Ms. Viviana Paola Forguione-Pérez. Address: Carrera 28 # 51-47, apartment 404. Bucaramanga. Santander. Colombia. E-mail: vivi_9116@hotmail.com

¿Cómo citar este artículo?: Forguione-Pérez VP. Communication between doctor and patient: Beyond a query, an educational process. MÉD.UIS. 2015;28(1):15-21.

"Whoever doesn't understand a look will hardly understand a long explanation"
Arabian Proverb

Maintaining a proper doctor-patient relationship through training and information of the patient encourages health prevention and treatment adherence. In this regard, there are two big players: the doctor, who has the technical and scientific knowledge, and the patient, who comes looking for help. For this relationship to work properly, mutual trust is needed[1]. Thus, medical performance has been highlighted for having the knowledge about the disease and how to treat it; however, this trust disappears when doctors provide little information to their patients and when they use a language which is not understood by patients, leading to doubts that will be solved, in many cases, by people with little training in the subject, such as pharmacics sellers, who lack of medical knowledge, but have the willingness and time to listen to their customers. Other criticisms of the medical act are listed in Table 1[1-2]. Nonetheless, this erroneous behavior is justified by patients under the pretext that physicians are people who have very little time, thus creating a vicious cycle of ignorance[3].

Table 1. Criticisms of medical performance

- Disregard for the welfare of the patient	- Short time available for the medical appointment
- Hurrying to provide care	- Lack of motivation for his work
- Dehumanized treatment	- Not fulfilling his obligations
- Lack of trust	- Giving little information about diseases and treatments
- Malpractice	- Secondary gains by pharmaceuticals
- Lack of dedication to service	

Source: Autor. Adapted from: Ramos-Rodríguez, C. Percepción de las relaciones médico-paciente, por parte de los usuarios externos de un departamento de medicina. An Fac med. 2008;69(1):12-6.

Moreover, on physician's perspective, many patients mistreat doctors because of their social constructs and unrealistic expectations for recovery and physician's obligations, not knowing that sometimes the healthcare system does not provide the tools and supplies needed to offer a good service. Doctor-patient relationship in Colombia is based on models of confrontation and negotiation, in which patients seek to have greater participation without being deceived, and doctors impose their knowledge to the restoration of patient welfare without being manipulated[4]. Additionally, physicians feel they have lost respect and autonomy in their work, as they are forced to have sporadic encounters with patients, often being unable to provide adequate follow-up, or not having enough time to solve their doubts[4]. This situation also predisposes patients to having aggressive and rude attitudes, going to the doctor merely to demand treatments or procedures that have worked in people they know who suffer from the same disease; this is often due to lack of education of patients about medical subjects.

Divergent beliefs between patient and physician negatively affect healthcare by influencing patient outcomes despite adequate treatment[5]. A clear example of this difference in perception is the fact that doctors tend to overestimate their communication skills, as shown in a study conducted by the American Academy of Orthopaedic Surgeons, on which 75% of the 700 polled orthopedists rated their communication as satisfactory, while only 21% of 807 patients rated them equally. That is why nowadays the model of shared decision-making and patient-centered communication is employed[5]. Knowing personal and sociocultural factors such as age, education level, marital status, employment status and technological knowledge allows improving patient's learning, as it focuses on their particular characteristics[6]. The main tool is empowerment, which aims for critical thinking and independent action of patients; therefore, behavioral and psychosocial situations must be integrated with clinical situations, in order to get patients to reflect their experience and to propose goals to change their behavior. Communication should be given actively in order to get the patient involved with his illness, otherwise if he plays a passive role he will not take control over it[7].

As result of a bad relationship between doctor and patient, higher rates of non-adherence to medical treatment, self-medication and late attendance at healthcare centers are observed. All this leads to an increase in morbidity, drug resistance, inadequate monitoring of diseases and high costs of treatments. Nevertheless, these activities are not only promoted by a bad doctor-patient relationship, but by other factors such as: pharmacists willing to sell drugs without restriction, misinformation on the internet, beliefs and traditions of patients, administrative procedures that generate costs in time and money to patients, and lack of credibility of doctors, health insurers and the healthcare system, caused by the limitations resulting from having great coverage but low quality of service[4].

Benefits

"The great aim of education is not knowledge, but action"
Herbert Spencer

Good communication brings two major benefits: sharing clinical information appropriately and a good doctor-patient relationship. Patients who are informed and educated about their health and how to improve their status, recover faster than those who are not. In addition, patients benefit from physicians with good interpersonal communication skills, because they achieve better understanding of medical information, adapt better psychologically, get more satisfied with their care, adhere better to treatment and trust their doctors. The doctor benefits as well, because he wins as a professional and as a person, as he becomes less stressed, copes better with bad news and anger, establishes better relationships with colleagues, lives more satisfied with his job, identifies the problems of their patients more accurately, improves patient perception regarding his competence, and is less likely to receive formal complaints of malpractice. Moreover, the healthcare system also benefits because a good doctor-patient relationship decreases hospital stay, generates fewer referrals and consultations, and reduces costs when a preventive approach to health is promoted[1,5,8].

Problems

"The man of science appears to be the only man who has something to say, just now — and the only man who does not know how to say it"
Sir James M. Barrie

There are many barriers to good communication in the doctor-patient relationship that hinder education. The main complaints by doctors are: short times for medical appointments, workload, patient anxiety and fear, fear of physical or verbal abuse, unrealistic patient expectations, fear of lawsuits, patient resistance to change, and lack of training in this area[5]. Therefore, empathy is crucial to doctor-patient relationship, because a physician's avoidance behavior will make the patient refuse to tell him their problems, thus delaying the recovery process. Furthermore, most lawsuits against doctors cite as main grievance the lack of communication with the patient[5,8].

According to World Health Organization (WHO), medication adherence is "the degree to which the person's behavior corresponds with the agreed recommendations from a health care provider". This adherence in developed countries is 50% and it is even lower in developing countries, because of the scarcity of resources and inequities in access to health care[9]. Access barriers cause people to seek health services only when their health is deteriorated;

thus returning to a healing vision and hindering the development of preventive programs. Some of the problems that patients have when attending health services are: difficulty in getting appointments, delays in approvals by health insurers, failing to provide services in geographically remote sites, and denial of services mostly because of high treatment costs[4].

The WHO highlights as determinants of adherence socioeconomic factors related to the treatment, the patient, the disease and the system or healthcare team; these are detailed in Figure 1[9].

People who are at increased risk for poor adherence are those with deficiencies in these factors. It has also been observed that women adhere more to treatment than men. Moreover, the level of education is positively associated with improved adherence, because 67% of cases achievers have higher education and 41% have basic education[10]. Cognitive and functional impairments adversely affect adhesion of the elderly. What is sought in order to achieve adhesion is that these patients actively participate in their treatment, attend their control appointments, and make changes in their lifestyle[11].

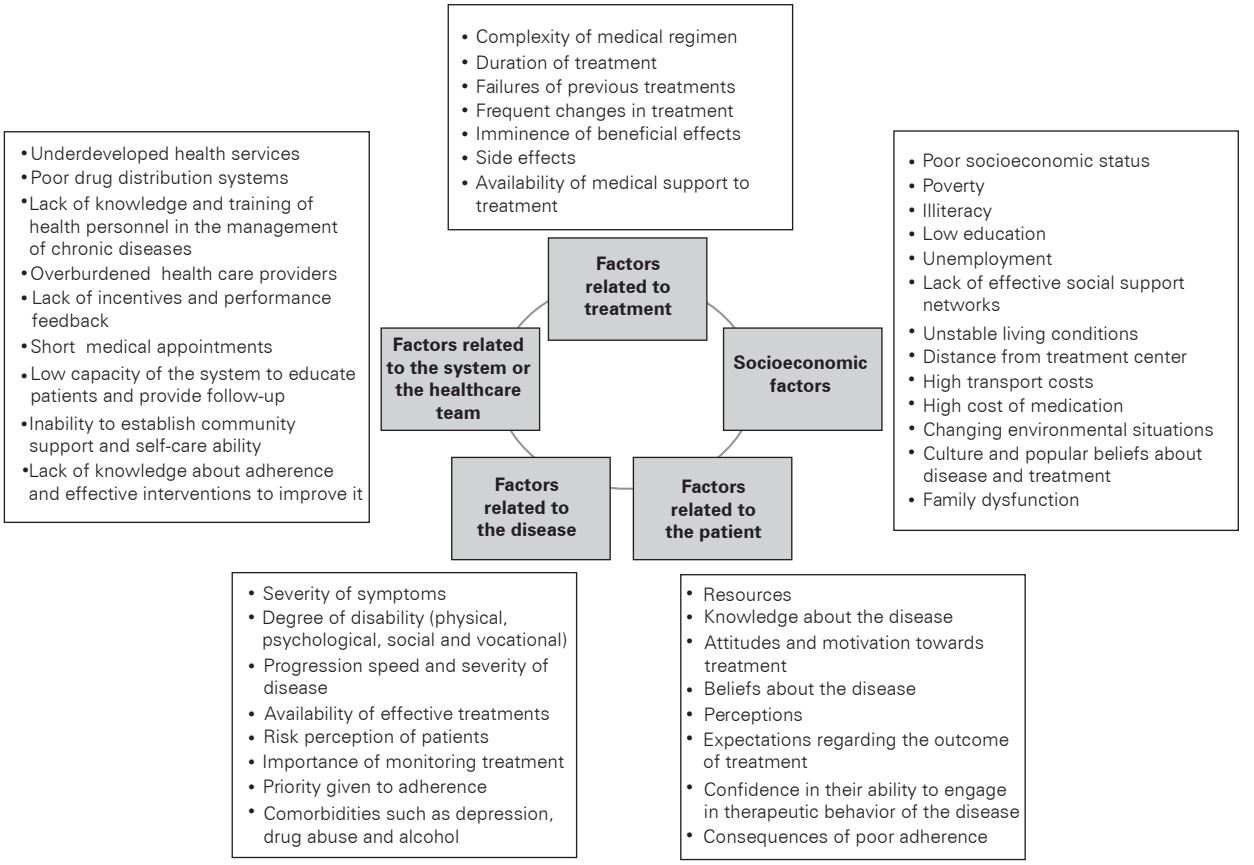

Figura 1. Determinants of medical adherence

Source: Autor. Adapted from: Organización Mundial de la Salud. Adherencia a los tratamientos a largo plazo. Pruebas para la acción. Washington, D.C.: Organización Panamericana de la Salud; 2004.

According to a study conducted in Cartagena, Colombia, moderate risk of nonadherence is given by lack of guidance on how to adjust medication schedules, lack of written recommendations about treatment, no understanding of the reasons for treatment, failures on the part of health personnel, concern for mistakes in taking multiple medications, confusion by constant changing physicians, and perception of the disease. Lack of adherence to medical treatments, especially in chronic diseases, causes both medical and psychosocial complications, reduces productivity and quality of life; besides wasting resources and increasing health care costs[9,11].

Patient education should not be limited to providing information, it must have comprehensive interventions in which cognitive, behavioral and affective components are combined, which have proved to be more effective. Also, the likelihood of adherence will be low if trust in health personnel is low, so there must be adequate interaction between health personnel and patients; understanding that every patient has the right to know about their health problems and to decide what best suits him. However, it is the responsibility of the physician to share relevant information to advise that decision-making and to achieve that the established goals are congruent for both physician and patient[11]. Informed consent is a good example of the communication process that must be established between doctor and patient, given that it should thoroughly explain the patient's condition and possible treatments for him to make a responsible decision. Besides, clinical information is not the only thing the patient expects to receive, they feel the need to be known and recognized by health professionals and believe that their vulnerability should be respected[12].

Tools

"Education is what most people receive, many pass on, and few have"
Karl Kraus

The strategies used by Colombian physicians for their patients to follow their recommendations are: exaggeration of negative consequences if these are not know, scold as a manifestation of concern, and providing explanations to their patients. However, the first two mechanisms do not contribute to improving health, because they predispose the patient to lie to the doctor about the implementation of their recommendations, claiming to have been using their medicines correctly and leading to polypharmacy, drug resistance and higher expenses. This is also observed in patients who believe with certainty that the drugs in the Colombian Mandatory Health Plan have poor quality, so they lie to get another sort of medication[4].

Questions asked to patients should be open, so they can express their concerns and opinions, enhancing their perception toward the physician. These questions should not only be about the medical area, but also about emotional, behavioral and social areas. Nonverbal language shows interest towards the patient and satisfies him. Some of the attitudes that must be promoted are described in table 2[2]. However, patients must also know how to have better communication with their doctor. In this regard, clinical psychologists play an important role because they can teach how to deal with stress, pain, false expectations, and psychosocial weaknesses[13].

Table 2. Attitudes towards doctor-patient relationship

- Proper attire	- Allaying patient anxiety
- Good hygiene	- Availability to listen
- Neat and private practice	-Letting patients expose their discomfort without interruption
- Greeting the patient by name	- Exchanging points of view with the patient
- Reaching out to the patient	- Answering questions
- Presenting and disclosing their title	- Getting patients to participate in treatment decisions
- Sitting facing the patient, looking into his eyes	- Being truthful, educator and encouraging
- Simple and respectful vocabulary	- Respect
- Being empathetic	- Commitment to service
- Expressing humanity	- Having knowledge and being updated
- Giving sense of security	- Individualized care
- Providing confidence as a person and professional	

Source: autor. Adapted from: Ramos-Rodríguez, C. Percepción de las relaciones médico-paciente, por parte de los usuarios externos de un departamento de medicina. An Fac med. 2008;69(1):12-6.

Currently, the use of Internet provides easier access to information, whereby navigation should be directed. A poll conducted by Harris, revealed that the number of people searching about health issues on the Internet has tripled, going from 50 to 175 million, between 1998 and 2010[6]. A good method to integrate this form of education is through brochures with lists of authorized websites and instructions on how to assess the validity of the page, avoiding quackery that only leads to bad practices and creates fear among patients. Using brochures by age group provides a more targeted

and comprehensive education. Namely, the importance of leaflets summarizing key information is that the patient is facing new information, in large quantities and short time, which is overwhelming; speaking in simple terms, being consistent and using metaphors improves retention[6]. The content should be limited to one or two key objectives, and should be written in language for people with basic primary level, accompanied by pictures and graphics. Other options include audio or video tapes, compact discs, interactive programs, applications for mobile devices, and interactive websites[14]. Table 3 summarizes some effective strategies for improving patient adherence.

Table 3. Strategies to improve adherence

TOOLS	EXAMPLES	FEATURES
Techniques	- Simplification of the pharmaceutical regimen - Less frequent dosing - Release-controlled medications - Drug combination	- Useful in patients with polypharmacy - It is not possible in all pathologies or medications - Few combinations - Reiteration in time
Educative	- Information in consultation - Informed dispensation - Health information	- Easy to run - No additional costs - Overtime of healthcare providers - Should be individualized - Must be combined with other strategies
Behavioral	- Custom dosing systems - Schedule reminder systems (for taking, pattern and basic instructions) - Apps for phones or tablets	- Useful in patients with polypharmacy - Overtime of healthcare - May require technological knowledge - May require electronic devices
Directly observed treatment	- Mal prior compliance - Psychoactive substances user - People with mental or psychological disorders	- Useful in tuberculosis and AIDS - Monitoring protocol - Multidisciplinary management
Techniques social support	- Domiciliary help - Family therapy - Support groups	- Reiteration in time
Techniques for professionals	- Information - Courses - Reminders - Own control and monitoring by professionals	- Reiteration in time
Remembering strategies	- Noncompliant patients	- Reiteration in time

Source: Autor. Adapted from: Rodríguez M, Pérez E, García E, Rodríguez A, Martínez F, Faus M. Revisión de estrategias utilizadas para la mejora de la adherencia al tratamiento farmacológico. Pharm Care Esp. 2014;16(3): 110-20.

Support groups are a good tool for people who have no knowledge about technology or who prefer more person-person interaction. The advantages of these groups are that they are attended by people with similar situations, allowing carrying a more widely accepted message; not only to the patients but also to their families[12]. Social and family support plays an important role in improving health conditions of patients. For example, this type of support not only improves adherence, but also the behavior, attitudes and time spent by physicians in the care of these patients[11].

It should be verified as well if the information given to patients has been assimilated in the right way. A good technique based on evidence is teach-back, which

consists on the patient repeating in his own words what he has understood about medical indications, which allows to correct errors or to answer questions from patients. With this method, the patient must be able to define their disease, treatment, the potential problems and ways to solve them[14].

Through patient education, it is expected to achieve health literacy, which is the ability to receive and understand information to make appropriate health decisions. The lack of this ability costs the health system in the United States between 50 and 73 million per year. However, multiple factors affect literacy, such as: shame, stress, vulnerability, medical jargon, excessive information, and poor reading skills. Literacy should be given not only to the patient, but also to his family, assessing which method is most appropriate in each case. Finally, it is important to identify an optimal follow-up with each patient to fortify the knowledge and to ensure the achievement of the objectives previously set[14]. Nevertheless, it is difficult to educate a population who only cares about health when they see it altered, namely, a culture of curation rather than prevention.

Patient Communication and Curriculum of Medical Schools

"The intelligent have a right over the ignorant; namely, the right of instructing them"
Ralph Waldo Emerson

Doctors may be more relevant and effective in their communication with the patient if they receive early training in their curriculum at the undergraduate level[13]. It has been found that students do not feel confident about their communication skills, which decreases patient satisfaction. Furthermore, poor training during medical school is reflected in poor results in practice. It has also been observed that these skills diminish as they progress through the career and eventually doctors in training lose focus of comprehensive care[5].

There are special situations where having good communication skills is essential, such as: end of life, giving bad news, sexual and reproductive health, care of minorities, chronic pain and geriatric patients. Some of the interactive strategies in this area are demonstrations by video, role play and feedback from videos. However, experiential methods are certainly the most effective and preferred by students[13].

As for the training in communication, it is more effective when performed in the clinical years than in preclinical years, and have better results when there is teacher training and participation. This training is profitable because it increases the performance of medical professionals, improving the overall health of patients[8]. Teachers play a significant role in teacher-care practice because they must instill respect for patients and educate by example; also they are responsible for inspiring love to the profession, which is the main determinant of change[16].

In conclusion, understanding that good communication improves the doctor-patient relationship, it is necessary to train medical students in this competence. It is essential to study the perceptions of both doctors and patients in Colombia about this two-way relationship, by conducting new studies. In addition, it should be investigated about what educational strategies are most effective in the Colombian population.

Acknowledgements

MÉDICAS UIS Family shows that teamwork achieves great successes and satisfactions. I am grateful for being part of this wonderful working group. Department of Editorial Possibilities, I would like to say thank you for the good memories and friendships that you gave me. Remember, my lovely future physicians: "you can achieve anything you want".

References

1. Restrepo PA. La relación médico-paciente. Un ideal para el siglo XXI. MÉD.UIS. 2012;25(1):64-9.
2. Ramos-Rodríguez C. Percepción de las relaciones médico-paciente, por parte de los usuarios externos de un departamento de medicina. An. Fac. med. 2008;69(1):12-6.
3. Jaramillo LG, Pinilla CA, Duque MI, González L. Percepción del paciente y su relación comunicativa con el personal de la salud en el servicio de agudos del Hospital de Caldas. Manizales (Colombia). Index Enferm. 2004;13(46):29-33.
4. Herrera N, Gutierrez-Malaver M, Ballesteros-Cabrera M, Izzedin-Bouquet R, Gómez-Sotelo A, Sánchez-Martínez L. Representaciones sociales de la relación médico paciente en médicos y pacientes en Bogotá, Colombia. Rev Salud Pública. 2010;12(3):343-55.
5. Ha JF, Longnecker N. Doctor-patient communication: A Review. The Ochsner Journal. 2010;10(1):38-43.
6. Garfinkel Weiss, G. Cómo adaptar la formación de los pacientes al estilo de aprendizaje, la propensión a la tecnología y demás características para obtener resultados óptimos. MedicalEconomics.es. 2011;(126):27-32.
7. Anderson RM, Funnell MM. Patient empowerment: myths and misconceptions. Patient Educ Couns. 2010;79(3):277-82.
8. Ali AA. Communication skills training of undergraduates. J Coll Physicians Surg Pak. 2013;23(1):10-5.

9. Organización Mundial de la Salud. Adherencia a los tratamientos a largo plazo. Pruebas para la acción. Washington, D.C: OPS/ OMS 2004.
10. Rodríguez M, García-Jiménez E, Rodríguez A, Pérez EM, Amariles P, Martínez-Martínez F, et al. Influencia de las características sociodemográficas y clínicas en la adherencia al tratamiento farmacológico de pacientes con riesgo cardiovascular. Pharm Care Esp. 2012;14(4):138-45.
11. Flórez Torres IE. Adherencia a tratamientos en pacientes con factores de riesgo cardiovascular. Av. Enferm. 2009;27(2):25-32.
12. Wiesner C, Contreras A, Castro J. El Centro de Educación de pacientes con cáncer y sus familias: la experiencia del Instituto Nacional de Cancerología. Rev Colomb Cancerol. 2011;15(2):59-66.
13. Neo F. Working toward the best doctor-patient communication. Singapore Med J. 2011;52(10):720.
14. Tamura-Lis, W. Teach-Back for Quality Education And Patient Safety. Urol Nurs. 2013;33(6):267-71.
15. Rodríguez M, Pérez E, García E, Rodríguez A, Martínez F, Faus M. Revisión de estrategias utilizadas para la mejora de la adherencia al tratamiento farmacológico. Pharm Care Esp. 2014;16(3):110-20.
16. Alonso M, Ruiz I, Ricardo O. Prioridades en la formación ético-profesional para alcanzar una adecuada comunicación médico paciente (segunda parte). Rev. Med. Electrón. 2011;33(1):89-95.