

CHALLENGES OF PATIENT-DOCTOR COMMUNICATION AND EDUCATIONAL PROSPECTIVES IN HEALTH STUDIES

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Title: “Challenges of patient-doctor communication and educational prospectives in health studies”

Abstract: While exploring the doctor-patient communication from a narrative perspective among patients suffering from cardiovascular conditions within the social context, as well as how this interpersonal conversation relates to the modern concepts of patient-centered care (PCC) or Shared Decision Making (SDM), we expose the fact that there is a noticeable shift to the paternal paradigm in the Romanian medical system, by considering the researched sample group. For this study, based on an extensive research, we considered relevant to approach the topic from the patient's viewpoint, given that in the case of cardiovascular diseases, how the patient understands to manage his/her condition and how he/she is aware of and corrects the aggravating factors of their lifestyle results from good communication with the doctor and the medical personnel. Considering the data on cardiovascular diseases (CVDs) in Romania's and Europe's mortality statistics (cardiovascular conditions rank first as death causes) and the fact that one of the most critical components in the CVD management is the patient's compliance with the treatment and with the implementation of the recommended lifestyle changes, the research of the doctor-patient roles and their communication in the therapeutic process is of significant educational importance.

Keywords: *health; communication; patient; doctor; cardiovascular;*

Communication in the healthcare setting

One of the main challenges while researching the conversations occurring in the healthcare setting before the COVID-19 crisis was mapping those mechanisms in the doctor-patient conversation, which substantially reduce the functional asymmetry (Martin and Dimatteo, 2014) between the two actors, the communication's leading role is continuing to belong to the doctor, in an adjusted relational context (Nussbaum, 2016). The aim was to evaluate both participants' general satisfaction level at the conversation in a cardiovascular healthcare context. We suggest three main research questions: 1) what are the features of interpersonal communication satisfactory for the cardiovascular patient; 2) how does this communication work in the medical environment and how are dysfunctionalities described from the communication viewpoint; and 3) what are the roles identified for the doctor, patient and family that translates into narratives of public health policies in the cardiovascular field. The research hypotheses to be explored are a) the doctor-patient communication is insufficient for a successful therapeutic

act (the slow transition to patient-centered care and shared decision making are negative consequences in the population's health); b) patients' narratives have a strong personal side (the narratives on the illness and curing depend on extremely customized social- and value-related factors); c) the doctor-patient narrative is divergent (different understanding of the health state and illness).

This article explores a problematic field while identifying ways to correct doctor-patient interpersonal communication and produce relevant information for the cardiovascular field's public policies' narrative. Notwithstanding the numerous challenges, the field was directly and unlimitedly accessible: the entire patients' therapeutic process, from consultations inside the doctor's practice, analysis of social documents to communication, and behavioral observation within the surgical context.

The patients participating were approached with semi-structured interviews while on physicians' care. The resulted narratives were open-coded, and the codes corroborated with the obtained data from the research field's ethnographical study and the participatory observation notes. Doctor-patient communication could be used in two directions: 1) in valorizing the narrative medicine concept in the education of students in medical sciences and young residents, for whom the study of medical sociology brings a better understanding of the social fundaments of health and illness, of the interdependency between the social factors, group behavior and getting ill. The study of medical sociology is recommended in the specialized literature for the discipline's double capacity, i.e., to explore the social phenomenon embodied in the medical profession and the rules that regulate the profession's relationship with society as a whole (McIntire, 1991). The improvement of public communication in the cardiovascular field is the second direction in which this study can turn valuable based on the model of the international government institutions' best practice guides (Ceitlin et al., 2017).

Research field approach and methodology

As the methodology is concerned, the study explores the doctor-patient communication in the field of cardiovascular diseases through a double approach: meta-analytical, for a specialized literature corpus published in Romanian, and narrative analysis of the field data by applying a semi-structured interviewing guide and the open encoding of the thus obtained data. The short assessment of a sample comprised of 63 scientific articles published in Romania about doctor-patient communication or narrative medicine shows the necessity to continue researching this field. We chose to make the segmentation exclusively in Romanian to assess the theme's availability for the medical sciences students or the medical employees interested in the patient communication theme and narrative medicine. The study results prove that there are a small number of scientific publications or inaccessible, which validates the intention to contribute to future research to enrich Romanian specialized literature.

The health-related communication theories' constellation, medical communication theories, and theories impacting the medical narrative highlight their im-

pact on the social life aspects. The new concept of medical narrative covers from definitions and genre hereof (narratives are connected to the sociological study of the medical profession and of the doctor-patient dynamics) to the explanation of the concepts of narrative medicine and patient-centered care (PCC) and shared decision making (SDM). These concepts are relevant in the sociological study as they shape behavior and communication in the medical environment; therefore, they describe, explain, and find solutions for changing the health field's social communication paradigms.

The methodological approach to the medical narrative is considering the contextual information in the appropriate environment, the asymmetries registered in the doctor-patient conversation, the importance of doctors' holding soft-skills, and the existing limitations of narrative medicine practice. We also explore how the narratives of the actors in the health field generate and amend the construction of public health policies, with the purpose of underlining the importance of 'listening' various types of the discourse of the various roles involved in the medical act (doctor, patient, next of kin, other medical personnel categories, and patient associations). Considering the cardiovascular field in which this research emerged, we find it necessary to articulate the results of the research in Romania's public health policy, where cardiovascular diseases rank first as causes of death, both for women and men (Serb, 2019).

During consultations, the patients were observed within the medical practice, pre-operative, or post-operative, and free discussions had also taken place outside the medical environment. The obtained data were transcribed and encoded, classified under themes and categories, and afterward, the research hypotheses were supported by a common theoretical element. The research observed the Grounded Theory (GT) construction principles, which are relatively less studied and applied within Romania's qualitative research.

Narrative medicine as an interventional tool

From a theoretical viewpoint, we have primarily used two narrative concepts - **medical narrative**, i.e., that narrative universe within the medical environment, and **narrative medicine**, with particular reference to its practical aspects, with material purpose in the medical education personnel. Narrative medicine, according to the authors in the field, remains a health practice, nevertheless, without aiming at replacing traditional medicine, but improving it with communication abilities on the doctor's behalf, who listens, gathers, and understands the story of a patient's disease (Charon, 2006). Even though narrative medicine, i.e., practicing medicine with increased communication abilities, is not the universal solution for all the dissatisfaction and deficiencies complained about in the Romanian medical system, the research results show that the net patient's preference for open, empathetic communication, showing him/her respect and understanding of how he/she is affected by the disease. From the doctor's perspective, the ability to decode much more attentively, quickly, and efficiently a patient's disease's history results in a much more satisfactory professional collaboration, with better results

for both involved actors. The study considers the literature indications which valorize the hypothesis of changing the paradigm (Rudnick, 2011) in the doctor-patient relationship. We consider that this role balancing is also impacting the social phenomenon of a population's individual and group health and indicates what changes are desirable at the level of society to satisfy the needs of the actors in the health field who are already in the new paradigm. Validating the research hypotheses and its results led to the conclusion that the study of medical narrative contributes to redefining the doctor-patient relationship, within the meaning of endowing the former with abilities to communicate and take over information relevant from the patients' stories. This disclosure of narrative valances in doctor-patient communication is sociologically contouring the construction of the phenomenon and its thorough understanding. Eduardo Nunes writes in "Sociology of health textbooks and narratives: Historical significance" (Nunes, 2016) that narrative embraces various health sociology shapes. In his work, he carries out a historical analysis, concluding that in our days, sociologically, the narrative information in the medical field can and must accompany the medical education process.

Challenges within healthcare education

In the final part of the study, we suggest two possible paths for continuing the research: one goes in the educational area aiming at offering to medical students to young practitioners a set of sociological instruments developed based on communication skills, and the second one goes towards enforcing the narrative methods in building public policies in the cardiovascular field. Suppose the researcher's role seems to be volatile in the narrativity field conjoined to the sociological and medical fields. In that case, Nunes's suggestion is worth taking into consideration: "in this case, the researcher is an intermediary between the participant and the reader rather than an analyst" (Nunes, 2016), where the roles of the participant and the reader might be the equivalent of the doctor-patient roles, irrespective of the research perspective.

The fact that health sociology accounts for a complementary instrument in the medical professionals' education is also argued in the literature (Cox, 1999). Doctors and auxiliary health personnel will only find advantages concerning their patients if they also succeed in mastering a sociological way of thinking by extrapolating the data obtained from individual patients to the disease phenomenon, as mentioned in "Normal science? Texts for teaching the sociology of health and illness" (Cox, 1999). As a consequence, acquiring narrative skills (equally in his/her communication with the patients, as well as for gathering information from the patients' narratives) is also very useful (Greenhalgh and Hurwitz, 1999) for reconnecting the physician with his patient, after several decades of medicine increasingly more focused on biomedical aspects. Considering as global objective of medical science, the reconnection with the patient, we believe that the study offers information on how patients' narratives indicate "how", "when", and especially "why" they need a change in medical communication which forms the basis of clinical interaction. By connecting to the patients' narratives, doctors may draw

information regarding the path they can take to reduce the doctor's dominant role (Greenfield et al., 2014).

The volume "Spitalul în mișcare" (Gheorghiu and Moatty, 2017) exposes the social, economic, cultural, and interpersonal relationships paradigm changes in the medical environment. It points out the need for change in what the patients are concerned about, whose interests play the leading role in the doctor-patient relationship's dynamics, not only curing the disease.

"The interviews attest to the fundamental transformations of hospital units" social space and evolutions of professional groups, as well as the adjustment of identity relations between them. One of the most important development is symbolic: the patient's interest is the center of justifying the professional positions, both for the supporters of reforms and their resisters. Thus, the discourse is centered on the ill's interest, not only on the illness (Gheorghiu and Moatty, 2017, p. 262)."

Narrative medicine is a relatively new discipline. Its particular scope is to rebuild the connection between doctor and patient when the relationship between the two can be improved by dialogue as a bridge for passing this relationship in the new paradigm (Armstrong, 2002). Waiving the asymmetric and paternalistic approach (Bayer and Fairchild, 2004; Salmon and Young, 2009; Kon, 2010) is studied and validated by the researches' results, which indicate a greater interaction satisfaction both for the doctor and for the patient (Roter and Hall, 2006; Klitzman, 2008; Schleifer and Vannatta, 2013; Ofri, 2017).

The purpose of the medical narrative defines a successful medical act for the patient. In an era in which technology, numbers, tests, all that builds a clinical medicine based on evidence have replaced the doctor-patient discourse and the direct interaction in medicine, the need to build a bridge between the two ways of practicing medicine is increasingly more desired. This connection is narrative medicine, a discipline which is still medicine, but practiced with understanding and empathy (Charon 2000), having the capacity to "recognize, absorb, metabolize, interpret and be touched by the illnesses' stories" (Charon, 2006).

Medical narrative that can be taught, acquired, and applied to clinical practice is neither infallible nor an easy endeavor. The analysis of medical discourses requires time and effort because effective patient interaction techniques and attitudes do not come easily (Marini, 2015, 7). Then, the involvement in a narrative endeavor may cause a mutation in the way we see medical practice, and it may also determine a relaxation of scientific borders. On the other hand, the narrative medicine's complementary role is explained by theoreticians, which underline that the discipline cannot replace medical practice and that "the greatest challenge (...) is to know when to stop. The disease, disability, depression, or death are not narratives. They are facts. If narrative ideas draw professionals up to a point where they forget all that, than it is not safe (Marini, 2015, 6)".

The narrative is not meant to decrease medicine's value founded on evidence and clinical practice. Likewise, there may be completely uninterested patients in such narrative research in sharing their stories and feelings. Medical narrative,

similar to all medicine-related human sciences, emerged as a need to restore the patient's voice, which became vulnerable due to the illness (Marini, 2015, 13); nevertheless, the patient can be unwilling restitution.

The medical narrative is subjected to a risk similar to “humming a wonderful song, but in one's mind, so that nobody can enjoy it, except for the one who is humming it” (Hojat et al. 2009). The explanation comprised in the volume “The devil is in the third year: a longitudinal study of erosion of empathy in medical school” is that only real empathy continuously practiced, with clear objectives, will produce real results. Tangible changes in medical education, having results, come after implementing target programs, not only by supporting some good ideas (Hojat et al., 2009).

Thus, the paths for continuing the research in the doctor-patient communication field can be the following:

1) Insight on the educational path

One of the paths in which the research in this field can be continued in Romania is the one similar to the studies carried out in France by Goupy et al., 2013 or Maguire, P., Fairbairn, S., & Fletcher, 1986 in order to identify the availability of the medical students and young residents to improve their capacities as communicators and to acquire additional abilities in gathering medical information from patients. Maguire, Fairbairn, and Fletcher noted even since 1986 in their study “Consultation Skills Of Young Doctors: Benefits Of Feedback Training In Interviewing As Students Persist” that those skills acquired during the faculty time by the students are useful even after five years of practice. The study was carried out on 36 young doctors who, during their studies, participated either in feedback gathering training or in conventional lectures on medical history (*anamnesis*) and have been reassessed five years later. Each of them took over the medical history of a patient with a mental illness and two patients suffering from physical illnesses. Each interview was independently noted, and the study proves the superiority of the group of former medical students who learned feedback techniques. Even though both groups demonstrated inefficiency in gathering psycho-social information from their patients, they mainly used closed questions and showed a certain degree of disinterest in clarifying their patients' statements. Nevertheless, the study's authors conclude that supplementing the lectures during the medical school years with communication skills and to create a bidirectional communication flow with the patient is quite necessary (Maguire, P., Fairbairn, S., & Fletcher, 1986).

Returning to the research's results, patients valorize the doctor's human qualities they interact with, being instead drawn by the closeness shown to patients and secondly, by the doctor's professional skills. Patient M.O. talks about how one of the doctors she satisfactorily interacted with had the availability to answer her questions, even though they expressed her anxiety as a patient. M.O., with a complex medical history (scleroderma, deep venous thrombosis) and with a personal history just as complicated (she comes from the social protection system), associates professional performance with personal qualities (empathy, warmth, patience), these being the ones having the most significant value for her.

“Many times, I even asked stupid things, and he, poor fellow, he answered. Yes, he answered. I asked him: what if die? I do not know how it came up. And I say: Doctor, is it possible that I die young? He says: “Don't be foolish, how can you die young!?”. If you have this thing that you will die, constantly thinking about that, you will die young. But if you will say: Oh, God, how will I look when I am old? Will I feel the same, will I be as thin and pretty as I am now? So, he is a doctor who knows how to make a joke, who knows how to make himself pleasant, to make you get out of that bad state. (...) If you are not educated as a doctor, you cannot be educated as a person, and vice versa; if one is not educated as a person, one cannot be educated as a doctor. (...) Firstly, I believe that the education he received at home is carried with him, in faculty, in everything. And if he keeps... first of all, I think that this doctor loves his parents very much. Because, by loving and respecting your parents, automatically... for example, he once associated me with his daughter, because we share the same name (M.O.).”

Affection towards fellow human beings emerges in several patients' discourses as a defining element of professional skills. It is a feature desired by the patient as prominent, even though not necessarily elaborately expressed. “Honesty,” “direct discourse,” “transparency,” “respect” are also included within the same sphere of desirable features. Patient L.D., who displays a more reserved attitude during the interview and is not very open for discussion, is pretty brisk in expressing herself and is unwilling to offer many details, refusing to answer the probing questions. The patient is asked to reminisce her childhood, and she mentions a small trick of the nurse that came to give her an injection. Her only mentioning this indicates that the patient retained what seemed back then as a scam from a very young age. “During childhood, when the nurse who was about to give me a shot told me that the injection is without a needle, and I believed her.” Even more, she points out the need for respect, punctuality, and honesty in the relationship with the doctor during our days at an adult age. Asked what the qualities of a doctor are, patient L.D. states as follows:

“Observing the schedule and reasonable waiting times; A thorough examination for providing a diagnostic; Explanation of the diagnostics, of possible consequences, of possible side effects as a result of the treatment”.

Even though this study is focused on the patient's discourse, for a balanced doctor-patient relationship, the doctor needs to be aware of his interlocutor's expectations, which sometimes also extend to his/her family or friends (Centor, 2007). “To be a good doctor, you must be acquainted with the entire story” points out Centor in his interview from 2007 and, by extrapolating, this means involving the patient's entire universe in this communication (Visser, Deliens and Houttekier, 2014), through real skills, acquired or activated during medical practice. According to Lipkin et al. (Lipkin et al., 1995), the act of anamnesis, of taking the medical history, stands at the basis of the doctor-patient communication relationship anamnesis technique is precisely the one inherently taught in the medical school.

The medical interview, Lipkin says, is the fundamental skill of medicine; it is how the doctor communicates with his/her patient, who is thus the only source of information available to the doctor. Consequently, the collaboration with the patient, which should offer valuable data, stands as the basis of their partnership (Lazare, Putnam, and Lipkin, 1995), and the partnership in itself a bidirectional concept (Joubert et al., 2006).

2) Extending the research perimeter to the other actors of the therapeutic act

This research predominantly explores the patient's voice as an actor in the doctor-patient relationship. On the other hand, we must not forget the doctor's capacity in this dialogue, even though the relationship is marked by asymmetry. The doctor's discourse deserves to be explored under the personal and medical set-up, considering the entire series of issues he is confronted with. As this research is based not only on the data obtained in the semi-structured interviews with the patients but also on the consultations room's participatory observation, how the doctor reacts to patients' problems is also noted. The observations obtained from the immersion into the study environment show that, sometimes, the doctor faces preconceptions, the patient's sometimes defective understanding of the therapeutic practice, the absence of compliance with the treatment, the patient's refusal, etc., for which he needs to activate individual communication skills (Maguire, 2002).

Patient M.O. narrates her husband's experience with a treatment prescription for diabetes, which he did not tolerate very well. The experience with the illness through which the family gathered medical information determined the spouses to make personal decisions regarding the insulin dose adjustment they considered inappropriate. Given that the said adjustment did not comfort the patient, the wife eventually advised him to resort to the doctor. Patient M.O. narrates how she got concerned about her husband's blood sugar values after starting the treatment with a new product.

“(…) these three months he did not cope well with that insulin, his blood sugar was still high, from 180 upwards. Moreover, when it exceeds 200, it already sweeps through the entire body. And I kept seeing him upset, worried. I tell him: "you will also get mentally ill due to this insulin, given that you keep seeing it high, mornings, evenings, you record your blood level, which continues to be high. Please call her (the physician) and tell her nicely on the phone that you give up this insulin and return to the old one (M.O.)”.

Taking over the initiative in changing the treatment, adjusting dosages, or gathering information from non-medical sources are only a few examples of the doctors' problems in their interaction with the patients. These could be noticed directly once the patients returned for consultation, in general, after a certain post-operative period or for prescribing new treatments.

It is not the object of this research to analyze these non-compliance situations, but we consider that investigating communication from the doctor's perspective would bring necessary supplementations for a full picture of the doctor-patient interactions. Following up this idea, how the doctor-patient relationship is calibrated

in the medical set-up may be insufficiently explored from a sociological viewpoint, meaning that interactions vary, as shown in the study "Breaking the ceremonial order: patients' and doctors' accounts of removal from a general practitioner's list" from a neutral relationship to one with violent notes towards the doctor (Stokes, Dixon-Woods and Williams, 2006). In this research, the topic is not present; the negative categories identified after coding the patient interviews are not showing such an escalation of the negative feeling. The studied sample group is maintained at the level of disappointment or disgust towards the Romanian medical system.

Nevertheless, it remains to be discussed what this feelings' impact on the doctor is as it can be estimated to produce a misbalance in the patient (Stokes, Dixon-Woods și Williams, 2006). The mentioned study comparatively brings the same "behavioral rules" for the doctor-patient binomial in a mirrored manner, from the two actors' perspectives. The study's authors show a perfect overlap between the patients' expectations from their doctors with the doctors' expectations, who wish for the same quality interaction with their patients.

The text also offers a theoretical basis for the mirrored analysis of the interaction between the two actors, the doctor and the patient, consisting in elements of interactionist theory, of the "behavioral code," which generate symmetry and reciprocity, or asymmetry and lack of reciprocity, in the latter case effecting the social "micro-policies" mentioned by Ditton (Ditton, 1980). Likewise, the authors also apply Goffman's proper order of the clinic theory, which suggests an entire social interaction ritual, especially in health services (Goffman, 1967).

Aside from the etiquette rules, the study confirms a system of similar identities, irrespective of the doctor's skills or the patient's cooperation. At the moment of interaction, it is departed from this complementarity premise.

Thus, for subsequent research, a more in-depth exploration of the doctor-patient relationship from both the social actors' perspective is of interest to identify how to correct the relationship. The purpose of such subsequent research may be declined in educational actions within the spirit of practicing narrative medicine, where the academic discipline can be taught and acquired, especially at the beginning of a career in medicine. Given the difficulty of reaching such a research field, we consider that the study must be extended both as an educational instrument and a research perimeter, upon other conditions and all the actors working in the medical services universe. We also asses for future research possible correction models of the patient-physician relationship to produce relevant information for the public policies' narrative in the cardiovascular field.

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