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Editorial

Narrative Medicine: the modern communication between patient and doctor

S. Coaccioli

Dept. of Internal Medicine and Rheumatology, Perugia University School of Medicine, District of Terni, Italy

Abstract

In Modern Medicine the ability to communicate represents a true and unique operative methodology which is the basis of Narrative Medicine. This type of approach does not represent an alternative to the traditional model, but rather expands its boundaries while preserving its scientific base; where the feelings, expectations, and desires of the Patient and his interpretation of the disease, more or less obvious, are read in the broad context in which the Patient himself exhibits. Two principle themes in medical training have by now been clearly identified and can be summarized as follows: the ability to understand and to explain (*what to say to the patient*) and the ability to listen and to comprehend (*how to speak to the patient*). In this regard the modern Narrative Medicine is a holistic approach to the complexity of the method known as the most effective and most efficient – not only in patient-centered medicine, but also in the improvement of services rendered to both the individual and society at large. ***Clin Ter 2011; 162(2):91-92***

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The patient-doctor relationship constitutes, qualifies and represents one of the highest points in human communication. Ever since the times of Hippocratic Medicine, the act of communication between the sufferers and their caregivers plays a fundamental part, not only in medical conduct and therapeutic outcomes, but also actualize and depicts the most significant ethical moment in the entire clinical history of a patient (see *Il Mestiere di Medico* by G. Cosmacini; R. Cortina, 2000 and *Filosofia della Medicina* by G. Federspil *et al.*; R. Cortina, 2008).

In the Modern Medicine, where Complexity is the framework in which there is an alliance between Physicians and their Patients, the ability to communicate represents a true and unique operative methodology which is the basis of Narrative Medicine, and the end-product of Medical Humanities (see *Medical humanities e medicina narrativa* di L. Zannini; R. Cortina, 2008).

Communication is made up of a combination of psychological and physical processes through which an individual's ability and manner of communicating influences others. In this context, the contents of communication are given by the message and the information; the way in which two people form a relationship, is representative of the *communicative relationship*. Lastly, there are two substantial means through which we use to communicate (and which occurs at the same time) from the moment we start to speak (*verbal communication*), we simultaneously communicate with our body (*non-verbal communication*). Furthermore, the basis of therapeutic communication is based on the fact that the presence of an illness represents, for the individuals, an experience as a whole, while at the same time completely single and all-absorbing. Thus, there is a significant potential for a substantial change with respect to their previous state. Change, then, is connected to the meaning that each of us attributes to life, survival, suffering, death – and this is already a therapeutic process in itself.

It can be pragmatically affirmed that the most effective method for approaching those who are suffering is to embrace their anxiety, responding to it by lending an ear – by listening not only openly and passively, but above all to listen actively and with interest.

Two principle themes in medical training have by now been clearly identified and can be summarized as follows: the ability to understand and to explain (*what to say to the patient*) and the ability to listen and to comprehend (*how to speak to the patient*). This trend has been acknowledged by the Ministerial Decree of 1966 which states that - … *training must be distinguished by a holistic approach to the medical problems of both healthy and sick individuals, also in relation to the social, physical and cultural environment which surrounds them*. Consequently, very specific aspects of medical training and competences have been defined in the *core curriculum* of health care professionals: a) to be able to recognize and regulate the cognitive and emotional processes associated with the illness, stress and pain; b) to develop an adequate awareness of the emotive and motivational implications which has led to the choice of entering the medical profession and to be able to exploit them in the clinical relation; c) to be able to communicate clearly and effectively with the patients and their family members, both in the diagnostic

Correspondence: Prof. Stefano Coaccioli. Dept. of Internal Medicine and Rheumatology, Perugia University School of Medicine, District of Terni "Santa Maria" General Hospital 1, Tel./Fax: +39.0744.205.365, Mob.: +39.339.8923.923. E-mail: scoaccioli@tin.it; stefano.coaccioli@med.unipg.it

stage and in the communication of the diagnosis, with details concerning serious and disabling illnesses, with reference also to their social and cultural dimensions.

The exergue of this editorial covers the Complexity – understood as the framework within which a Doctor-Patient alliance is formed – where the ability to communicate represents a true and unique operative methodology which is the basis of Narrative Medicine, and the end product of Medical Humanities. In the late 60's, von Bertalanffy defined a *Complex System* in terms of – level of organization consisting of different parts which interact to form an organizational unit with specific functions; features which cannot be carried out independently by any single part – (see *La sfida della complessità* by G.Bocchi and M.Ceruti; B.Mondadori, 2007; *La teoria della complessità* by R. Benkirane; Bollati Boringhieri, 2007; *La logica della complessità* by V. DeAngelis; B. Mondadori, 1996; *Teoria della Complessità* by Morin and Prigogine – first work).

In this regard, we can now conclude that Modern Medicine is a holistic approach to the complexity of the method known as the most effective and most efficient – not only in patient-centered medicine, but also in the improvement of services rendered to both the individual and society at large (Coaccioli S. *Medicine of Complexity: the Modern Internal Medicine* Clin Ter 2010: 161(1):9-11 – which states that : *Complexity bears its methodological and doctrinal contribution to the general health and medical assistance management, as well as to the clinical context and medical training. The science of complexity has suggested as alternative model in which the disease, as well as the patient's general well-being, are the results of a complex interaction between various elements of the entire system, dynamic and unique, of the individual*).

Going back to the communication between Doctor and Patient, the primary contribution introduced in the mid-70's is as much doctrinal as it is pragmatic (see *Medico Paziente e Malattia* by M. Balint; Feltrinelli, 1990) when Balint set the stage for a Patient-centered Medicine: … *if the Physician is expected to continuously have more specific interests, he must also be called upon – in the interest of the Patient – not to lose sight of the psychosomatic unity... even though some pathological forms are prevalently clinical, in any case he must make every effort to react to the patient's illness with his whole personality*. This issue was later excellently resumed by Moja and Vegni, stressing that this type of approach (see *La visita medica centrata sul paziente* di E.A. Moja and E. Vegni; R. Cortina, 2000) does not represent an alternative to the traditional model, but rather expands its boundaries while preserving its scientific base; where the feelings, expectations, and desires of the Patient and his interpretation of the disease, more or less obvious, are read in the broad context in which the Patient himself exhibits.

We cannot overlook what Watzlawick postulated forty years ago (see Watzlawick P., Beavin J.H., Jackson D.D. *Pragmatica della Comunicazione Umana*; Astrolabio, 1971) in terms of *codes of communication* (duty, relation, information, feedback and redundancy), of *systems of communication* (interaction, tolerance, retroaction) and of *theory of communication* (the knowledge of things – in terms of awareness conveyed through the senses; and the knowledge of things – in terms of elaborate knowledge): Epitteto, in the 1st century A.D., had already affirmed that these: "…*are not things in themselves to worry about, but the views that we have of them*."

Therefore, a Doctor must bring about a change – within himself and on his surrounding – that is as much substantial as it is pragmatic, and as methodological as cultural. And here again, Watzlawick proposes this change (see Watzlawick P. *et al. Change*; Astrolabio, 1974) as the keystone for a new type of analysis of reality; as a way to describe the relationship between people and as a tool to optimize their communication. And here, I would like to quote a thought by Lao Tse which says: *"Thirty spokes meet in a hub, but the empty space between them is the essence of the wheel. Pots are formed from clay, but the empty space between it is the essence of the pot. Walls with windows and doors form a house, but the empty space within it is the essence of the house. The principle: Matter represents the usefulness, non-matter the essence of things."*

An element of fact concerning the approval ratings by Italians on their National Health Service was revealed about 10 years ago: apart from the excessive bureaucracy, the endemic disorganization of services, and the long waiting lists and queues at the clinic, the main reason for discontentment was the *lack of information* (see Mapelli V., *Il Servizio Sanitario Nazionale*; Il Mulino, 1999). As a result, relationship-based care (*from "care" to "take care of"*), relational professionalism (*knowledge, know-how, interpersonal skills*), the question of language (*the ability to communicate: how, what, to whom*), communication and the promotion of health (interdisciplinary communication and inter-institutional communication) are all seen as essential and considered a priority (see Beccastrini S. *Competenze Comunicative per gli Operatori della Salute*. Centro Scientifico Editore, 2000).

The Physician must acquire appropriate skills and expertise, especially when dealing with communication of diagnosis – the first step in relationship-based care: there is no "*if you tell,*" but rather "*how to tell*" (see *La comunicazione della diagnosi* di R. Buckman; R. Cortina, 1992).

Medicine has never before exhibited a more technological power than now, and never until now has it revealed such a profound crisis in credibility from the patients. The Physician "*must not, and cannot, run the risk of imposing his rationality and categorizing the opinions of the patients as 'superstition' or 'beliefs and myths,' because by doing so, he would impede himself from understanding the Patients' narrative, their deepest reasons, their fears, their hopes*" (see *Narrare la malattia* di BJ. Good; Ed. di Comunità, 1999).

In closing, Narrative Medicine and Medical Humanities can be portrayed as cultural, methodological and instrumental, which are essential for the integration of *narrative-based* and *evidence-based medicine* (see L. Zannini, *cit.*).

A few parting thoughts to enliven a never-ending discussion: *Why are Medical Humanities necessary?* to learn to understand the patient; to learn to understand the context; to learn how to shape the importance of the experience of the illness. *How do you teach Medical Humanities?* With an ethical approach, or the capacity for moral reflection; with an aesthetic approach, or literary skills (capacity in literature/interpretation); with an empathetic approach, namely the capacity to understand the experiences, emotions and values of others.