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Freely Available Online

JOURNAL OF FAMILY MEDICINE
ISSN NO: 2640-690X

Short Communication

DOI : 10.14302/issn.2640-690X.jfm-18-2485

Doctor-Patient Relationship as Dancing a Dance

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Abstract

The transcendence of the doctor-patient relationship is given by the confirmed fact of its influence on the results of health care. Several models of doctor-patient relationship can be described, but evidence of improved compliance, satisfaction and recall of physician information has been found in patient-centered consultations. Since these concepts of doctor-patient relationship and patient-centered consultation have multiple facets, they are complex to understand and teach. Using a metaphor is a tool that can be useful in these situations. We could say that the "good" doctor-patient relationship is a process where an "alliance" is created: a process in which the doctor adapts to the rhythm of the patient and little by little can help him move towards healthier scenarios; that is, detect "what dance the patient dances and like a good dancer, take a step back, another forward, dancing and pacing with the patient. But there is not a single type of "good" or "adequate" doctor-patient relationship; there is not "a single dance that the patient dances". If "the doctor has to dance with the patient", he has to know that there are many types of dance! The doctor will have to dance dances such as Cha-Cha (which has to be slow or very fast to dance), the Mambo (where the music is faster and the rhythm more complicated - the relationship with an urgent patient); the Merengue (which is danced like walking - informal doctor-patient relationship); el Pasodoble (that you have to dance with a haughty air, but not with rigidity -synchronizing assertiveness and empathy); The Salsa (where you have to learn the basic step separately - discontinuity of the doctor-patient relationship), among others.

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Citation: Jose Luis Turabian (2018) Doctor-Patient Relationship as Dancing a Dance. Journal of Family Medicine - 1(2):1-6. https://doi.org/10.14302/issn.2640-690X.jfm-18-2485

Keywords: Physician-Patient Communication; General Practice; Framework; Physician-Patient Relations; Communication Training; Metaphor; Qualitative research

Received: Nov 19, 2018 **Accepted:** Nov 29, 2018 **Published:** Nov 29, 2018

Editor: Alaa Ali Mohamed Elzohry, Lecturer of Anesthesiology & Pain Management South Egypt Cancer Institute Assiut University, China

Introduction

The doctor-patient relationship is a complex phenomenon conformed by several aspects, among which we can point out the doctor-patient communication, the patient's participation in decision-making and the patient's satisfaction. These characteristics have been associated with the physician's communication behavior and the patient's autonomy in medical care. The transcendence of the doctor-patient relationship is given by the confirmed fact of its influence on the results of health care [1, 2].

Thus, we could break down the various benefits that have been described in the literature on the interpersonal continuity of the doctor-patient relationship, such as: it builds trust and improves the doctor-patient relationship; It has clinical advantages: by increasing knowledge about the patient so facilitates diagnosis and treatment; presents the unique opportunity to study the natural history of the disease; allows to see that the presence of a problem in a family member can be a marker of conflict in another or other members of the same; facilitates the monitoring of the chronically ill; facilitates the implementation of preventive elements; continuity has an impact on public health, since it allows transforming actions on populations into actions on individuals, families and communities; contributes to the quality of assistance; favors satisfaction with the service; saves costs to the health system (better use of services, fewer hospitalizations, etc.) [3]; and evidence of improved compliance, satisfaction and recall of patient information has been found in patient-centered consultations: a trusting patient-provider relationship, shared decision-making support, full disclosure of side effects and cost sensitivity are attributes that might enhance primary adherent; patients reporting more engagement and autonomy have been found to be more adherent to therapy. Doctors who establish a good, trusting relationship with patients may be able to help improve adherence to prescriptions [4,5,6].

Because the doctor-patient relationship can vary according to the different trajectories of the diseases, the presence or not of multimorbidity, the mechanisms of transfer and counter-transfer, social class, gender, race, age, ideology, the mechanisms of social control, and the different types of health and care systems, the term "doctor-patient relationship" is nowadays an imprecise term, and it is probably preferable to speak of "interaction between health care actors" [3].

Several models of doctor-patient relationship can be described, but evidence of improved compliance, satisfaction, and recall of physician information has been found in patient-centered consultations [7]. In any case, this patient-centered relationship has several dimensions (such as biopsychosocial perspective, the value of the patient as a person and the personal meaning of illness, the sharing of power and responsibility and recognition of the needs and preferences of patients, the therapeutic alliance, the doctor as a person, a trusting patient-provider relationship, and a shared decision-making support), and so it requires continuous verification, feedback and a triangulation of the points of view of each actor involved. As a summary, it can be said that the bio-psycho-social model and the patient-centered medicine overlap [4].

Since the concept of doctor-patient relationship and patient-centered consultation have multiple facets, they are complex to understand and teach, the resource of using a metaphor (that is, making a transference or transposition of concepts -"metaphor" etymologically indicates the position of one thing instead of another) is a tool that can be useful in this situation. Metaphors allow us to understand something unknown in terms of something more familiar. For that reason they are a habitual resource in all the sciences that use common words to name complex realities. The reflexive analysis of metaphors allows making accessible the expert thought on the clinical reasoning. In this scenario we propose the metaphor of "dancing" to reflect on the doctor-patient relationship [8,9,10,11].

Discussion

In the professional interaction between the patient and physician, the existence of an effective communication and the satisfaction of the patient with this relationship take on considerable importance. This is especially relevant in general medicine, where the general practitioner (GP) maintains a continuous interpersonal relationship with the patient and their family, sometimes for many years. We could say that the "good" doctor-patient relationship is a process where

an "alliance" is created: a process in which the doctor adapts to the rhythm of the patient and little by little can help him move towards healthier scenarios; a careful and active listening process so that the doctor can understand that rhythm of the patient -his bio-psycho-social meanings of the symptom and the disease. That is, detect "what dance the patient dances" and like a good dancer -a step back another forward- be able to dancing at pacing with the patient.

But there is not a single type of "good" or "adequate" doctor-patient relationship. There is not a single dance that the patient dances. Several types of doctor-patient relationship have been described that are frequently used with the patient ("active-passive" relationship, "guided cooperation" relationship, and "mutual participation" relationship), and several models of relationship "creators of context" (doctor creates contexts of social relationship according to his behavior: unidirectional information strategy, persuasive or consultative strategy, and participatory strategy-cooperative with empowerment) [12].

In addition, on the other hand the doctor-patient relationship has different nuances in general medicine, or in relation to pharmacological treatment, or in gynecology, or in surgery, and in different diseases (with the cardiovascular patient, the hypertensive patient, the asthmatic, the digestive, psychiatric, endocrinological, incurable, with cancer or AIDS, etc.) [13, 14].

And last, but not least, the doctor-patient relationship also shows differences according to the patient's personal characteristics: Safe, worried, fearful, etc., patients independent of the doctor or dependents, patients according to their emotional characteristics and personality traits (people who perceive situations as dangerous or threatening, cautious people, tenses, easily fatigable, timid, apprehensive, pessimistic, etc., or if the patient is a person with depressive personality -individuals that are characterized by particularly serious, unable to have fun or relax and humourless, with negative thoughts, pessimistic, etc., even without there being an identifiable mental illness such as anxiety and / or depression-, and, of course, according to ages (child, adult, elderly) [12].

In short, if "the doctor has to dance with the patient" (useful doctor-patient relationship), he has to know that there are many types of dance!

The doctor will have to dance the Cha-Cha, who has to dance it either very slowly or very quickly, like when we want to listen to someone to be able to understand the meaning of what he says, with calm exterior and a type of comforting tranquility that inspires trust [15]; or the Mambo, where the music is faster and the rhythm more complicated; everyone goes crazy when he dances, as if they were on hot coals (relationship with an urgent patient) [16, 17]; or the Merengue, which is danced as if walking, one step is taken with each beat of the music and it is considered an asymmetric dance, since in the basic step, the same leg is used at the beginning of each new dancing compass (an informal relationship between doctor-patient) [18]; or Pasodoble that you have to dance it by pulling out your chest and putting your stomach in, with a haughty air, with elegance and temperament, but not with rigidity (doctor-patient relationship with coordination and synchronization between assertiveness and empathy) [19]; or the Salsa, where you have to forget the couple dances and spend time learning the basic step separately (discontinuity of the doctor-patient relationship [20].

But maybe, you have some patients who dance the Tango, like walking but with a certain Freudian resistance against one another [21]; or Claque or Tap with the characteristic sound of the feet, which has no partner (without true doctor-patient relationship) [20]; or the Arab Dance, with its smooth and fluid movements, dissociating and coordinating at the same time the different parts of the body (bio-psycho-social approach) [22]; or the Classical Dance, whose technique of this dance has an important difficulty, since it requires a concentration to dominate the whole body, adding in addition a training in flexibility, coordination and musical rhythm (relation with the difficult patient) [23]; or the Modern Dance, where there can be free steps, where each dancer does a different thing, that can be invented beforehand or improvised at the moment (strategic interview, which moves according to what can be, from the strong points) [24].

of course, the doctor will have to master the dance of the Lyric Dance, where we must emphasize the

control of emotions, musicality, balance and emotional expression (relationship and communication with cancer patients and give bad news) [25, 26]; or the Funky, with its strongly accented rhythm, where the expression is very important through movements that accompany it, trying above all to draw attention with its street style (relationship and communication with the psychosomatic patient) [27]; Hip-Hop, with the volume of the music high enough, and taking one foot forward so that it looks like you are "stuck" and leaning in the opposite direction, and repeat the step with the other leg (relationship and communication with adolescents) [28]; Flamenco, with its beating of the feet and the furious passion that it entails (relationship with the patient hostile, aggressive, demanding, threatening, "difficult") [29].

And I have no doubt that the GP, during the hundreds of thousands of interviews he will carry out during his 40 years of professional life, will Rock & Roll dance more than once, which is a fast and complicated dance, in which is necessary to be physically and psychically prepared enough to can practice it correctly, because it can become pure acrobatics (relationship and communication with special patients - the foreign patient, the insane, the psychotic, the patient with visual or auditory impairment) [14]; And the Waltz, which is danced with an elegant and erect pose, being completely straight, and trying not to move either the shoulders, the arms, or the hips, with the gentleman's right hand on the lady's back (to the height of the left scapula), and the left hand of the gentleman subject to the left hand of the lady, who rests her arm on the gentleman's (doctor-patient communication according to the patient's educational level, where lower educated participants prefer aspects related to the affective / emotional area of the medical consultation, and middle and higher educated participants prefer communication oriented on the problem) [30]; or the Samba, with its joy that leads us to practice the ability to identify imaginatively with the subjective experience of the other to provide genuine recognition and validation of that experience [31]; etc.

And how can GPs learn such amount of dancing? How can they adapt the doctor-patient relationship to the different rhythms of diseases, scenarios and personal characteristics of patients?

The way in which most teachers teach dance resembles that of traditional dance schools: "put your right foot here and the left there, and then bring them together." Now drop your weight on your left foot, and change, etc." It is the learning model considering communication and doctor-patient relationship a structured process, or semi-structured. However, this it is a slow and difficult method (although the instructions are not very complicated). The clinical interview, which is the technique or channel and place of communication, where the doctor-patient relationship is produced and developed, must avoid its decontextualized structuring [24].

Observe the way of dancing of a normal boy or girl of 12 years in any of the modern rhythms; He knows how to dance them all, and the instructions are more complex than the classic dances. Imagine the size of the instruction manual of all those dances. It will need the time of a doctorate university course! And so, how does he do it? First, he simply observes. He does not think much about what he is seeing. Then he feels like imitating him. Repeat the process several times, and get to dance effortlessly. When asked how that rhythm is danced, he can say "I do not know ... something like this ... look". Ironically he says he does not know because he can not express it in words. In this scenario, probably, the research practices on the doctor-patient relationship in general medicine should be art-based and performative research [32], since this way it would be possible to have an idea of the experiences lived, of "listening to the beats" of other people, and of the "mental movement" or "mental dancing" in the course of that relationship [33].

The function of GP is also to allow patients to express themselves. This requires addressing situations from the consultations they make their feelings, their experiences, and their findings and find answers and solve the questions with them. This means that GPs are trained to work in context, not to apply principles or structured rules, which may be biased or fallacious in that particular case. It takes two to tango [34]. The GP must discover what dance the patient dances and dancing with him: discover what is meaningful for the patient, and seek with them -"to dancing with

them"- what can clarify everything they seek to understand and do.

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