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Editorial

25 YEARS OF ABCD
SURGEON-PATIENT RELATIONSHIP IN THE PAST AND PRESENT

25 anos de ABCD - Relação cirurgião-paciente no passado e no presente

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PATIENT-SURGEON RELATIONSHIP

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Industrialization brought about by scientific and technological advancement resulted in the concentration of population in metropolitan centers of various sizes. Contrary to the inhabitants of rural areas, this urban population always had easier access to education, culture and medical assistance. Social progress stimulated the government to found medical schools and turn out a growing number of professionals to handle the demand for health care. The result in most European and South American countries is that many doctors flood the market place and they are not always professionally well-prepared. Therefore, in order to survive, the doctor thrown into the intensely competitive field, complies with poor salaries, debasing the dignity of the profession. Technically ill-prepared, and with little incentive, he lacks the motivation to care for his patients. To make matters worse, because of his poor preparation he does not have the over-all knowledge to treat the patient. Often he only has a partial view and is unable to integrate the information provided by the patient within the precise clinical reasoning. The result is that the patient is sent to other specialists so that he winds up being examined by parts and superficially. This type of management prolongs the patient's suffering, increases expenses and diminishes efficiency. Under these circumstances the patient-doctor relationship is non-existent. On the other hand, except for a few countries we have seen, the international medical assistance has a somewhat chaotic organization, for patient care is centralized and not regionalized and hierarchical. To make matters worse, the doctor is often poorly paid and has little incentive to perform his task. In highly industrialized nations with abundant resources, especially plentiful and sophisticated diagnostic equipment, the patient often submits to diagnostic tests with little participation by the attending physician. The doctor's relationship with his patient is mainly through the realization of complementary exams. In the last two examples of either poverty or wealth, the doctor-patient relationship is essentially weak. The worker is the major financier of the health system by contributing with his salary, and he winds up the loser.

Therefore, in many modern societies, in spite of scientific, technical, cultural and social progress, the doctor-patient relationship is still far from being ideal. Besides being a science, Medicine should also be practiced as an "art", by this we mean the concept and rules to do anything well. In the practice of surgery, the concept is sufficiently clear. There are 2 "arts", the "art" that is implicitly involved in the doctor-patient relationship, and the "art" directly connected to the Surgery itself. The latter "art" is the skill or ability to execute something. The patient-doctor relationship is an art that elicits feelings that cannot be produced by scientific processes. Positive feelings emerge from the patient due to the personal interrelationship with the physician and reactions of sympathy, admiration, enthusiasm and confidence are evoked. In gastrointestinal Surgery, the sources of anxiety and psychological suffering can be diminished by means of the patient-surgeon relationship. These feelings are caused by depression when the patient must face the diagnosis of his illness, especially if it is a malignant neoplasm. Another important aspect is the Surgery itself, involving the anesthesia, the loss of blood, the level, extent and consequences of the incision. But unquestionably, what most mobilizes the patient's feelings is the problem of the organ to be operated on. There are always doubts about the possibility of leading a normal life. Doubts involving alimentation, work, social and sexual activities. The psychological feeling of mutilation and castration manifest themselves under these circumstances when the partial or complete removal of an organ is contemplated.

If the body is thought of as a set of the individual's characteristics, surgical interventions may be looked upon as a threat. In cosmetic and reconstructive surgery, if the patient seeks the surgeon to correct physical defects and repair psychological changes caused by them, then in gastrointestinal Surgery, resections such as wide gastrectomies, large pancreatic resections or

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extensive resections of the small bowel, can cause malnutrition with secondary effects on the body, interfering with professional and social adaptation. Likewise, surgical "ostomies" such as esophagostomies, gastrostomies and especially colostomies and ileostomies provoke intense negative psychological responses. As part of the surgeon-patient relationship, attention should be given to the patient during his hospital stay, endeavoring to reduce the hostile environment produced by the technical jargon, discussions at the bedside, etc., all producers of tension and anxiety. Fundamentally, management should be humanized to avoid depersonalization of the patient by calling him by name and not by bed or room number. This same psychological support should be present in other hospital sectors such as the emergency room and intensive care units, which are also places of extreme anxiety, fear and threat.

The patient-doctor relationship is based on relatively simple actions, without any mystery. When the patient seeks the surgeon and places his confience in him, a commitment with the patient is established. This commitment forms a bond whose objective it is to cure the patient, and for it to succeed, some basic resources are essential. These consist primarily of the knowledge of the patient's psychological reactions. They should include 3 things: the quality and intensity of the patient's psychological responses; the sensitivity and insight to perceive and analyze them, and dedication including a good dose of patience.

It is in this situation that the doctor should be patient, listening and helping with the patient's emotional needs. Particularly in the field of gastrointestinal Surgery, two fundamental approaches can be followed. The first is the care of patients with benign lesions with good chance of cure and social and professional adaptation. The surgeon-patient bond is concerned with short-term emotional problems which are solved with the surgical cure. However, patients with serious lesions especially malignancies that require organ resections sometimes resulting in changes in bodily image such as colostomies and ileostomies, things are more complex. Under these circumstances, a medical team of many disciplines should provide assistance with the objective of having the patient accept and adapt himself to the new social condition imposed by the illness-operation. In order to take advantage of the patient-doctor bond as a powerful therapeutic tool with healing and prophylactic effects, integrated sessions with the cooperation of the psychology department were begun.

Outstanding within the management of the surgical patient is applied surgical psychotherapy at the group as well as individual levels. A multidisciplinary team consisting of a doctor, nurse, social worker, psychologist and nutritionist participate in the groups. Weekly sessions with the hospitalized patients provide information about the illness, the methods of treatment, the prognosis and even the hospital routine. This approach reduces the patients' fears and anxieties, in addition to preventing psychophysiologic and psychopathologic imbulances. An exchange of experiences is made possible for the professionals involved.

A second approach is on an out patient level available to colostomized patients by an interdisciplinary team. Its objectives are prevention and reabilitation of patients with significant mutilation of the digestive system. This same approach is used for alcoholic patients with liver diseases as well as their families.

Another approach, called interconsult, is underway in the Department, conducted jointly by an internist and a psychologist. The objective of this collaborative work is to develop insight both the patient's and the doctor's psychological reactions to one another and through an exchange of information, help the doctor deal with these factors.

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PATIENT - SURGEON RELATIONSHIP: WHAT HAS CHANGED?

Although the previous text was written 25 years ago representing the first article of ABCD Brazilian Archives of Digestive Surgery, the concepts on it are still very current.

In recent years occurred important advances in medicine and gastrointestinal surgery, both in diagnostic techniques (CT, MRI, PET-scan, endoscopy and interventional imaging) and surgical procedures (laparoscopic surgery, robotic surgery and transplants of organs) that are differed from the past. There was also great progress in medical therapy with the discovery of new drugs. Currently the training of the surgeon is longer, requiring complete two years of residency in general surgery and then another two or three on the specialty. Considering all these aspects, medicine has become more burdensome to the patient. The number of medical schools has tripled in the country and increased the number of doctors looking for job in the same market.

Nowadays, patients have easier access to various aspects of their diseases and treatment

methods, obtaining valuable information on the Internet. This new time allows patients to ask questions and discuss with the surgeon the best way to treat them.

Despite these advances, the surgeon-patient relationship remains indispensable to reach the ultimate goal of the human being, i.e., to have good care, best treatment and better opportunity to recover both physically and emotionally. Therein lies the binomial complex: heart and surgical art, that permits to provide high quality in most cases of health care.

Patient dissatisfaction - and many of their complaints - is due to the poor doctor-patient relationship. Although we are in a new century and these facts have been known for decades, doctors tend to underestimate their ability to communicate.

The surgeon-patient interaction is a complex process; lack of proper communication is potential pitfall, especially in understanding the goals of patients, care, outcomes and prognosis of neoplastic diseases, very common in digestive disorders. Surgeons good communications allow patients to participate in all discussions, and important questions for them are answered before surgery is done. Empathy is one of the most important ways of providing care and support, reducing feelings of insecurity, isolation and distress.

A good surgeon-patient relationship facilitates the understanding of medical information, and allows better identification of their needs, expectations and emotions regulation. They feel, through a good communication with the surgeon, satisfied with their care. Better information related to the diagnosis and its consequences, permit joining and agreeing to the suggested treatments and, at the same time, stimulates the need for follow-up. Collaborative good communication will provide dynamic and reciprocal relationship.

The ideal way is surgeon collaboration in diminishing anxiety of their patients, giving them the best care, avoid making decisions based on quick assessments without detailed understanding of the situation that the case requires, missing opportunities to offer and discuss treatment options, sharing responsibilities and exchanging balanced and safe information. Following this approach, the doctor must discuss treatment options - especially if surgical treatment is required -, and the care needs to have better outcome. The risk level, family involvement, the understanding of cost and benefit, maximizes adherence of the patient and ensures the best results.

Doctors are not born with communication skills, as they have different interests and backgrounds. It is necessary to practice a lot during medical school, residency and expertise acquired over years, understanding the patient feelings. Some experts argue that medical education must go beyond training skills only in medical practice. They found that communication skills tend to diminish with the advance of the students in medical field; over time doctors in training tend to lose their focus on the patient. In addition, difficulties, barriers and the need for longer time to their medical training - especially during the internship and residency -, suppress empathy, diverting their attention to the purely technical, diagnostic, therapeutic and surgical involvement. There are many barriers to good patient-surgeon communication, and the surgeon's responsibility is to jump over them, especially in regard to anxiety, fear of litigation and uncertainty.

Most complaints about surgeons are related to communication issues, not competence. Patients want surgeons who can expertly diagnose and treat their illnesses, as well as communicate with them effectively. Physicians with better communication and interpersonal skills are able to detect problems earlier and provide better support to their patients, leading to greater satisfaction, reducing costs and getting better treatment adherence. The joint decision between surgeons and patients to attain the agreed objectives and favorable results, can lead to better quality of life.

A good surgeon-patient communication can be an effective source of motivation, encouragement, confidence and important component of the health care. Also, a good relationship can increase job satisfaction by increasing self-confidence, with direct influence in the final evolution of the treatment.

In summary, only few things changed in 25 years of medical care, when man is focused; the needs of human race are the same as they were in the past and, certainly, will continue as they are in the far future.