DOCTOR-PATIENT DIALOGUE – BASIC ASPECT OF MEDICAL CONSULTATION

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(Abstract): Family medicine is the specialty that provides ongoing primary medical care and improves the health status of the individual, of the family and of the community through preventive, educational, therapeutic and rehabilitation measures. The family doctor often makes the interdisciplinary synthesis, in a flexible manner, either alone or in most cases with interdisciplinary consultation. In the latter case, the family doctor initiates the team work and makes the final evaluation by using the longitudinal follow-up of the disease. The doctor-patient encounter represents the “confrontation” with the greatest moral weight, due to the complexity of the values involved, the status of the doctor in a society, and patient’s involvement in decision making. The patient is a person who should be treated with respect, honesty, professionalism and loyalty, whatever the clinical status, severity of illness, mental competence or incompetence. A focus, on an international scale, is represented by the characteristics of a good doctor, family physician included, as the latter is the first link in the network of health services. Each model of consultation varies in a more or less subtle way in priorities assignment, and suggests slight differences regarding the role played by doctor and patient in their collaboration. The qualities of a good family physician include not only the strictly professional competences, that also apply to other medical specialties, but also duties, such as, clearly explaining to patients issues concerning their health, informing them about all the possible preventive measures of diseases, making a diagnosis, initiating and supervising a therapy. Medical responsibility lies at the crossroads between medical science and the conscience of the doctor. Keywords: DOCTOR-PATIENT DIALOGUE, MEDICAL CONSULTATION, THERAPEUTIC ACT, PREVENTIVE MEASURES, ANAMNESIS, ENQUIRY.

IMPORTANCE OF THE PROBLEM
The disease represents an unfortunate episode in everyone's life, and it has often many negative effects on the entire body. Patient’s concern, the fear induced by the disease, but also inappropriately by the family and entourage, sometimes leads to a deep depressive state. In such circumstanc-
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gration into family and social life. Respect for the person, as behavior and attitude, represents the fundamental value of the doctor-patient relationship and the essential condition of therapeutic success.

Family medicine brings a global and concise view of the man, represented in a close relationship with his social, existential, and family environment (1).

As the family doctor is the first step into the medical system, he has to be easy to find and approach by patients. The family doctor does not address a specific organ of the body or age group, but the entire person, the interconnections between different systems or organs and the external environment, the general manifestations of diseases, the associated and interdisciplinary pathology (2,3).

Also, family medicine has a nonspecific object of activity shared with other specialties, namely the early diagnosis of diseases, secondary prevention, community-based care in chronic diseases (tertiary prevention), continuous medical care, palliative medical care (4,5).

The family doctor is the only doctor that combines therapy and prevention activities (primary, secondary and tertiary prevention), both on an individual basis and at community level. Through the measures of prevention and health preservation, he is the guarantor of health (5,6).

Primary prevention measures may be effective if they target the individual, the family and the environment through concurrent actions of the family doctor and hygienist (e.g. vaccinations, health education, fighting the internal risk factors by acting on the environment through direct observation). Secondary prevention involves the perception of changes in the individual’s health status and early diagnostisis during common medical investigations and periodical examination. Tertiary prevention represents the prevention of complications and disease progression (5,6).

The main object of study for the family doctor is the individual, his family, his surrounding community and environment, all these exerting a positive or negative influence on the individual, with which the family doctor must be acquainted.

Family medicine distinguishes itself through the medical care given to healthy persons, primary prevention, and the holistic approach of the patient within the context of his environment, family, and living and working community, respectively (7).

This means that unlike other specialties that have in many cases analytic research methods of certain pathological conditions, that are exhaustively investigated, family medicine is solely based on methods that require synthesis, as the diagnosis is based on the synthesis of data collected through observation, history taking and physical examination of the patient.

Therefore, the research methods of family medicine are influenced by the following aspects: the family medicine is mostly communicative, mostly clinical, and mostly based on synthesis.

The activity of the family doctor mostly pursues clinical and diagnostic objectives, such as providing a diagnostic and therapeutic synthesis, therapeutical and prophylactic measures, as well as maintaining the health status of the healthy individual (7,8). The improvement of clinical methods resulted in the progress of family medicine.

The diagnostic and therapeutic synthesis is essential due to the fact that the encountered medical conditions are complex and that the patient should always be monitored (9).
In order to make and confirm a diagnosis, laboratory tests are required. This method of making the diagnosis is specific to all the other specialties, but cannot be ignored by the family doctor (9).

The family doctor should have basic knowledge of laboratory tests, based on which an initial diagnosis is possible. Based on this initial diagnosis the patient is either referred to a specialist or is recommended a first intention treatment. These methods of laboratory examination help the family doctor analyze and understand the diagnostic methods of other specialties, both at admission and upon discharge, in order to move the patient to community based care.

Due to the fact that global clinical laboratory testing uses the results provided by various specialties, where the patient was investigated, we come to the inevitable domain of interdisciplinarity.

**DOCTOR-PATIENT DIALOGUE**

The doctor-patient dialogue should take place in a relaxed atmosphere. The warm friendly tone, the optimistic attitude of the doctor, the solicitude, the comprehension towards patient's suffering, the kindness, the politeness and the patience with the person in illness, the interest that was proved by the doctor represent not only a real moral support, a source of security, of protection against the aggression affecting the patient. On the other hand, the patient becomes responsive, cooperative, understanding towards the efforts made by the family doctor in order to alleviate his suffering (1,7).

The patient becomes for the doctor a subject of research and of medical practice, but also a rational and social being, with a spiritual life and interest in his own health. Therefore, the doctor must be acquainted with the psychological peculiarities of the patient, irrespective of his disease.

As a good psychologist, the doctor shall make a close interhuman relationship with the patient, for the benefit of the latter. The doctor's emotional openness to the patient represents “the keystone of medical psychology”, as it lessens anxiety and insecurities and it humanizes the medical assistance.

The medical consultation begins with the report of the patient on the signs that were noticed at the onset of his disease. The report of the patient, based on recollection of pathological phenomena is known in the medical terminology as anamnesis or history. In quest of a thorough comprehension of data, the doctor asks questions, in order to set out some aspects. In other words, the doctor performs the medical enquiry (9,10).

The doctor-patient dialogue becomes more and more important, as the doctor helps not only treat the disease, but also solves the problems caused by diseases. In many chronic diseases, the communication is theoretically the only form of treatment. The advice, the support, the information are essential in helping patients adjust to a more limited lifestyle imposed by the disease.

**ANAMNESIS COMPLEMENTED WITH INQUIRY**

Anamnesis, complemented with inquiry, allows the doctor to gain extensive knowledge of patient’s symptoms. Thus, he has the opportunity to make an evaluation of his/her personality, level of intelligence, and general education, all these providing implicitly more nuanced criteria for evaluating the disturbances of the patient.
The adequate realistic description of symptoms, their succession have a great significance for the medical judgment based on a preliminary diagnostic hypothesis, whose accuracy shall be verified by clinical and laboratory investigations, but also by the results of the applied treatment (10).

The doctor-patient dialogue should be permanent, throughout the whole period of patient care. If the expected results do not occur, the doctor should do history again in order to gain new information that may lead to a reconsideration of the diagnosis (9).

The family doctor often makes the interdisciplinary synthesis in a flexible manner, either alone or in most cases with interdisciplinary consultation. In the latter case, the family doctor initiates the teamwork and makes the final evaluation by using the longitudinal follow-up. The onset of the disease may be suggestive for the nature and location of the pathological process.

The diseases with sudden onset and loud symptoms stand for acute pathological processes that allow an accurate diagnosis, based on the characteristic signs. An accurate diagnosis can even be made based on history alone. However, diseases such as cancer show progressive and silent clinical manifestations. The various locations of the neoplastic disease may have in early stages uncharacteristic, irrelevant clinical signs, common to other diseases of the affected individual (12). But it is a known fact that in cancer the symptoms are persistent, do not respond to common treatments, and the clinical picture adds further clinical manifestations (13).

In many cases, the description by the patient of the initial clinical symptoms is relevant for certain organs, such as lungs, heart, kidneys, and the presumptive diagnosis is verified through physical examination and laboratory tests. The subjective signs are common to various diseases of the respiratory system but take various forms and aspects, both at disease onset and during its progression, and the inquiry should focus on this problem (9). The infectious and contagious diseases are also important, because they weaken the body resistance and favor diseases of the respiratory system. In heart conditions, the patients complain of suggestive symptoms: pain in the region of the heart (precardial pains) with various characteristics, such as the typical constrictive claw-like pain that irradiates to the left shoulder, left arm and hand, and is common in angina pectoris or in myocardial infarction (7). Another common symptom is the lack of air or the difficulty of breathing that may frequently occur during exercise or even at rest.

The patients with high blood pressure may report such symptoms as seeing dark spots in the eyes or hearing various noises, headaches, and dizziness or sleep disorders. In diseases of the digestive system, the patients describe pains of different location and duration, depending on the affected area (stomach, duodenum, bowel, gallbladder), burning sensation behind the sternum or in the upper abdominal region, bloating.

In the diseases of the urinary system, the described symptoms include pain and alterations in urine elimination. Some patients report spontaneous urine leakage, that may suggest urinary incontinence, and in other cases urine retention. The qualitative changes in urine are medically significant and always alarming for the patients, when pus or blood is found in urine.

Very important is also that the doctor to
know the collateral genetic antecedents, because many diseases have a genetic basis (9).

During history taking, the patient should give information about age, sex, living and working conditions, conflicting events in the family or at work, if any, climate and geographical features of his neighborhood, unhealthy practices (use and abuse of alcohol and tobacco), treatments administered since disease onset, previous physical examinations and laboratory tests. The patients that received surgery should show the surgical protocol, needed in evaluating the acute disease each of these pieces of information may contribute to a more realistic approach of the investigated disease (14).

An as thorough as possible anamnesis and a correct inquiry represent "the art of interrogating the patients" and "the art of listening the patients". Anamneses that are incomplete and incorrectly recorded may be a source of errors, such as the unnecessary prescription of laboratory procedures, as well as of ineffective treatments. Thus, in some cases of pneumonia, the patients may report abdominal pain, that, as a result of a superficial and inaccurate anamnesis, may lead to a false diagnosis of appendicitis, cholecystitis or ulcer. Atypical clinical forms of severe disorders such as myocardial infarction may result in misdiagnosis and serious therapeutic errors (9). Some forms of myocardial infarctions are associated with digestive disturbances that include epigastric pain, meteorism, regurgitations, eructation that may induce a diagnosis of gastric or duodenal ulcer. In case of myocardial infarction, the treatment requires absolute bed rest, and if the diagnosis is false, this requirement will not be certainly satisfied and the outcome may be fatal (15, 16).

Anamnesis provides 50% of the information needed for a diagnosis. The rest comes from the clinical and laboratory examinations (17). It is common that the family doctor himself treat various diseases, such as, digestive, cardiac, dermatological, opthalmic disorders, when the patient cannot receive the consultation of a specialist doctor or laboratory examinations, due to objective reasons.

Some medical or surgical specialties may change or event disappear, but in our opinion this is absolutely certain: in all ages, as Hippocrates specified almost two thousand five hundred years ago, the family doctor will be always present with his patients by word and deed and with heart and soul (10).

**CONCLUSIONS**

The profession of family doctor is a noble one. The family doctor has difficult tasks to undertake, many financial disadvantages, but, on the other hand, he has great satisfactions.

The continuing medical education is essential for the life of a family doctor. The profession of doctor is one of the occupations that necessarily require lifelong education. Moreover, the health education of the population should represent the main aim of the national health policy, along with objectives such as medical preventive measures. The improvement of the level of health education in the general population may be achieved through large educative programs of public health.

Based on the duties of a family doctor, we can conclude that the family medicine represents the most important branch of medicine, because it provides the primary care and differentiates between the truly severe cases, that require hospital admission and the cases that require outpatient
care, under modern and efficient conditions.

What the family doctor does is essential, because he has a holistic view of the patient.

The family doctor should be regarded as "the hub of the world", because he deserves that. But until his status will be acknowledged, the family doctor may be still compared with an armed infantryman, who enters minefields, investigates the enemy, fights successfully or unsuccessfully, while on duty, and watches the sky full of specialists who look at him from aircrafts. However, when brought down to earth and put in the front line, these specialists behave just like untrained infantrymen.

REFERENCES