Medicon Medical Sciences
Volume 7 Issue 1 July 2024
Article Type: Editorial
ISSN: 2972-2721

Colloquial Conversation with the Patient: Key in the Humanist Training of The Medical Student

Humberto Correa-Rivero*

Professor of Medical Humanism and Emeritus Dean of the Faculty of Medicine of the CLAEH University. Punta del Este - Uruguay

***Corresponding Author:** Humberto Correa-Rivero.

Received: June 18, 2024; **Published:** June 27, 2024

DOI: 10.55162/MCMS.07.221

The curriculum of our medical career proposes a humanistic training model for medical students that includes as objectives: increasing their self-knowledge, personal emotional growth, cognitive and critical development, fostering the spirit of solidarity, encouraging enthusiasm and balance in their academic and then professional life (and in their entire life), and an empathetic and compassionate behavior with patients.

Different authors and scholars dedicated to humanistic training in medicine have proposed various educational models. William Branch, who can be considered a pioneer of the inclusion of humanism in undergraduate medicine, and his proposals, along with those of other authors who emphasize the value of narrative, reflection, and humanistic development integrated into clinical training, have been powerful inspirations for our program.

Among the various educational tools and instances that we use in humanistic education, we especially privilege the colloquial, open and sincere individual encounter (conversation or dialogue) of each student with a patient. It is one of the main training tools, inspired in part by the publications of Branch and other authors, and the result of our experience and the collaboration of expert psychoanalysts. In this case, the meeting with the patient does not consist of a classic clinical survey or a structured interview, but rather a conversation between two people that is intended to flow naturally.

The colloquial, individual and open-minded conversation of a student with a patient admitted to care centers is one of the most important field tasks of our humanistic training program in the undergraduate Medicine course at CLAEH University (Punta del Este - Uruguay).

This activity, which is repeated during all Medical Humanism courses (from 1st to 4th year) and is carried out by all students, consists of a student/patient meeting in which the topic discussed does not include the clinical, diagnostic or therapeutic details of the patient's condition (only mentioned if the patient brings them up) but rather deals with his emotions and feelings, affective changes, worries, interests, anxieties, fears and hopes that have been provoked or accentuated by his illness. This should arise as spontaneously as possible since the patient is never forced to "answer a questionnaire" but rather the aim is to create the atmosphere of a conversation between two human beings.

The student must identify, be able to describe and interpret the psycho-affective state of the patient, his loneliness or the support he has and the way in which this influences his mood, his family relationship, (if the patient mentions it) and his relationship with the health team that takes care of him.

At the same time, the student must observe, identify and explain his own emotions and feelings during the encounter, arising in his affective world as a consequence of what the patient is discovering about his life and the emotional manifestations that he presents during the conversation.

Subsequently, the student must prepare a reflective narrative of the interview, deliver it to his teachers so that they can consider it, discuss it with him and provide all the feedback and support that is necessary.

This training mode has three objectives:

1. First, students should understand patients as people. They must know and learn that they have a complex life, full of various painful or pleasurable events, with varied relationships that can be very rewarding or extraordinarily painful and traumatic, with happy events and deaths, and above all with a life project that is threatened by the state of illness that has led him to be treated in a care center.
2. Secondly, it is aimed at helping students become aware, identify and analyze their affective reactions (generally truncated in traditional medical and clinical education), manage them well and experience a degree of real empathy. We believe that it is one of the few ways to make people change their paradigms of relationship with others (paradigms that have been modulated by a dehumanized and excessively materialistic society) and to incorporate into their posture towards patients an attitude that includes their whole being (with cognition and affectivity) and not only the role of expert technicians in curing disorders of human viscera. It is expected that in this way they will develop cognitive/affective mental patterns that allow them, every time they are in front of a patient, not only to consider the altered viscera -and diagnose their illness- but simultaneously, in a spontaneous way, to realize that these biological alterations belong to an integral person: a holistic human entity, with a life and a history, just like themselves.
3. The third objective is that they incorporate into the capital of their definitive memory the enormous diversity of human situations that exist behind each pneumonia and each peritonitis, and keep, together with their mental file of diagnostic patterns, the complexity and diversity of people's lives. Diversity in personality and mental health, forms of relationships, capacity for resilience, life projects, and social, economic, housing, environmental and educational situations. It is well known that all these factors also have a very important influence, determining or conditioning variants, on all their visceral somatic or systems pathological clinical pictures and on the response of these organisms to the doctor's therapeutic proposals.

Very Important Clarification: we want to achieve a behavioral change that makes empathy, respect and compassion towards the sick spontaneous.

It is imperative that we expressly clarify that this type of personal interview (which is intimate, emotional and of long duration) does not replace -nor do we in any way intend to replace - the usual professional clinical meeting that they will have thousands of times in the coming years as doctors. During the doctor/patient encounter, these future doctors will systematically collect signs and symptoms, think about syndromes, imagine diagnoses, select essential paraclinical examinations and consider a treatment.

The time for regular clinical consultations is limited. Patients come in thousands and institutions generally impose limited minutes for each patient. On the other hand, sometimes the emergency is overflowing with queries and time pressure imposes itself.

Then the question arises: Why do we train our humanism students in this type of individual interview and relaxed intersubjective contact if they are not going to practice it routinely?

We reply

The expected future behavior is not that they maintain a personal encounter, as described above, with each and all patients. They will only be able to do so, or the need will arise, with a special patient from time to time. In those cases, they will have to extend the interview, but it won't be common.

The valuable result that we expect in the future doctor who has received this human formation is a real change of attitude. We believe that this change will be largely generated by emotional and reflective colloquial conversations with patients and feedback from their teachers. A change in attitude that will manifest itself in a mental openness towards the holistic conception of the human being, a greater sensitivity towards the suffering of people, the deep recognition of their need for cordiality and affection, and their desire to be heard (even if it is just for 5 minutes). Sick human beings have a pressing need to feel that those who are going to care for and treat them consider and see them as another worthy human being. If the future doctor has developed a degree of empathy and sensitivity, the patient will be able to read in his eyes, in his voice and in his attitude that the one who comes to treat him really cares about him. Or in other words, the patient will "read his whole attitude" and he will feel that the doctor really cares about him, considers him a person and appreciates him as a human being.

References

1. Branch W., et al. "The patient-physician relationship. Teaching the human dimensions of care in clinical settings". JAMA 286.9 (2001): 1067-1074.
2. Branch WT. "Teaching professional and humanistic values: suggestion for a practical and theoretical model". Patient Educ Couns 98.2 (2015): 162-7.
3. Charon R. "The patient-physician relationship. Narrative medicine: a model for empathy, reflection, profession, and trust". JAMA 286.15 (2001): 1897-1902.
4. Cohen LG and Sherif YA. "Twelve tips on teaching and learning humanism in medical education". Med Teach 36.8 (2014): 680-4.
5. Correa H. Medical Humanism. Fin de Siglo Editorial and CLAEH. Chap. 5: Training in Medical Humanism of students (91-101) Montevideo (2016).
6. Plack MM and Greenberg L. "The reflective practitioner: reaching for excellence in practice". Pediatrics 116.6 (2005): 1546-52.
7. Lönn A., et al. "The impact of emotionally challenging situations on medical students' professional identity formation". Adv Health Sci Educ Theory Pract 28.5 (2023): 1557-1578.

Volume 7 Issue 1 July 2024