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EDITORIAL

Consent form versus doctor - patient relationship☆

Termo de consentimento versus relação médico-paciente

In a not so distant past, the most important person in the doctor-patient relationship was the doctor. The latter exercised total control of the actions and the patient was completely dependent and submissive: the doctor “knew what was best” for the patient. This situation has changed radically. The principle of autonomy has allowed patients to make their own decisions about their bodies and treatment and current laws have put the bioethics’ viewpoint on the list of the basic laws regarding the rights of the human person. The asymmetry of the relationship, although still uneven, has acquired greater balance. We physicians are still learning to live with these paradigmatic changes and the approach to avoid and minimize conflicts seems to indicate the search for ways to improve the doctor-patient relationship.

Our current reality is that this relationship has been corroded and needs to be re-established, taking into account the abovementioned facts, and also that the medical-scientific knowledge is no longer limited to the physician. Information is disseminated and has easily accessible sources, allowing patients to even know things that their doctors do not know yet. To minimize or disregard this reality, even when one acknowledges that many of these sources lack credibility or scientific acuity, does not solve any problems. The fact is that, at least, the patient brings questions and doubts that were previously unthinkable. One needs to deal with this new situation in a mature and sensible way. This is the challenge of this new era.

The power of the physician has decreased in order to respect the patient’s autonomy, so that decisions are taken by both doctor and patient. Thus the paternalistic-authoritarian image of the past had to be replaced by the informed consent of the person being cared for. This new situation cannot be transformed into a mere document with technical terms for physicians to protect themselves in legal circumstances (which, in fact, does not protect them), but must entail the dialectical discussion in search for clarity and solidarity of the patient at all stages of treatment.

The poor results that were previously seen as something natural (“I’m sorry it did not work out”) are no longer

passively accepted and have been piling up at the Medical Councils and Courts of civil and criminal justice. The dialogue and the construction of clear communication between the physician and the patient could do much to prevent visits to the Courts and Councils. Records from Cremeb (Regional Medical Council of the state of Bahia) indicate that complaints against doctors have increased five-fold when the periods of 1996/2000 and 2001/2005 are compared. More recent figures are not encouraging...

The major problems to be overcome to attain an adequate doctor-patient relationship are imperfect or blocked communication and medical training that needs to be rethought. We learn, during medical school, to look at the patient and recognize the signs of disease, but we do not learn to listen to the patient. We use our senses to search for signs and symptoms of the disease until we achieve a conclusive diagnosis, but unfortunately we do not establish good communication with the people under our care. We are saved at this stage of learning from the uncertainty of knowledge that makes us spend more time with patients. If some of our academic delay could persist together with an increasing curiosity for what affects the patient, we might have greater success and fewer lawsuits.

Apparently, however, after learning the diagnostic method, the physician will minimize what patients say or manifest in several ways. They neglect to listen to them, to look at them and, amazingly, to touch them! We lose a crucial opportunity to have a closer access to each of them, for not being able to spend some time getting to know them and learn more of their “circumstances”. Sometimes little is said and much less is heard. How much of a therapeutic effort is wasted by not understanding the patients’ life reality?

We must provide compassionate and friendly treatment, calling individuals by their names, acknowledging them and not the disease, considering what they do professionally and, above all, giving them the opportunity to have an opinion on the impact of disease on their lives. An old aphorism says that “the biggest pain is the one we feel.” Hence, it is

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not correct to say that rhinitis, for instance, is an insignificant disease to someone who works with the public and has to scratch and wipe their nose all the time.

What do you do? This is a basic question to understand the burden that the disease has on the lives of those who are under our care. Knowledge of the professional activity and the patient's life should not be mere information for the epidemiology of the disease. It should be used to evaluate all the consequences of the disease that affects the patient and those around him.

The "Free and Informed Consent Form" does not solve the problems of a poor doctor-patient relationship and thus, the physician must learn to communicate better to establish an adequate relationship. By doing so, the doctor will build bridges and strengthen the trust between the doctor and the patient. It will open the doors of the heart and soul of the patient, allowing greater therapy amplitude, minimizing the impact of any undesired results, and when there is no more chance of successful treatment, will allow the physician to act in the quintessence of the medical condition:

to be himself, if not a healer any more, a bringer of comfort and safety for his patient.

When the professional achieves this condition, a signed and lawful document becomes little significant. The doctor will have been successful in **caring** for the person under their care and will have their recognition, as well as of all around them.

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