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EDITORIAL
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# Risk communication: ethics, psychology, law

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When communicating with a patient, a doctor is within a certain cultural practice (science-based medicine and state health care system), falling outside the limits of which is not legal. However, a broader understanding of medicine as a cultural phenomenon with a focus on health also requires a more varied perspective on patient care. The patient's problem can be more complex than looking at it from science- and evidence-based point of view. Therefore, in risk communication as an element of work with adherence or as part of signing informed consent, different ways are needed to consider a patient's situation. An ethical and psychological perspective on clinical interactions allows for a more holistic view of the disease.

**Keywords:** risk factors, algorithms, clinical guidelines, medical ethics, bioethics, adherence, patient-centered care, doctor-patient relationship.

**Relationships and Activities:** none.

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The subject of medicine is health. And although the practice of health service provision clearly demonstrates a different perspective of the medicine subject (treatment of diseases), the health care areas related to primary prevention, habilitation, predicting and individualizing risk allow for positive health in medicine.

In the reference frame, where a person is a biosocial subject, health is defined as physical, mental and social well-being. The social one is somatized, while the somatic influences the interaction of a person with the social environment [1]. Work within the prevention is mainly aimed at the psychosocial component of a person, until functional disorders lead to pathomorphological abnormalities, fixing the impaired function in the structure.

Risk communication is about informing society and individuals about the dangers they face. In medicine, risk communication can be of a public nature (promotion of healthy diet, smoking cessation, vaccination) or individual. The risks of a particular patient are discussed, firstly, when it is necessary to inform and obtain voluntary informed consent (or refusal), and secondly, when it is necessary to form adherence to the doctor's prescriptions, and more broadly, to form a constructive attitude to the situation [2]. Medical risk communication is based on knowledge about pathogenetic mechanisms and ways to correct pathophysiological changes. This knowledge is the content of medicine.

Medicine, in turn, has existed for several millennia. Its habitual model, which forms the modern social system, scientific and evidence-based, has only tens of years of its existence. Nevertheless, thanks to science as an institution of cognition and an economic system that depends on scientific achievements, medicine is embedded in social relations in such a way as to be in the center between the four components (Figure 1): biomedical knowledge, psychology communication, legal framework, ethics (more broadly — philosophy). Legal issues should be distinguished from ethics, since law as a state institution is endowed with essential features and functions. It should also be noted that systems other than the western scientific worldview, for example, traditional Chinese medicine, would be built into the institution of society and state in a completely different way. The goals of such "other medicines" would be as different as the approaches to achieving these goals. For example, Chinese medicine, which considers external environment factors ("wind", "cold", "dampness", etc.) as a semiotic and heuristic base, influencing on human homeostasis [3], a separate medical service would mean something else. And it would not give security, since the patient himself and his psychosomatic state play a significant role in its function.

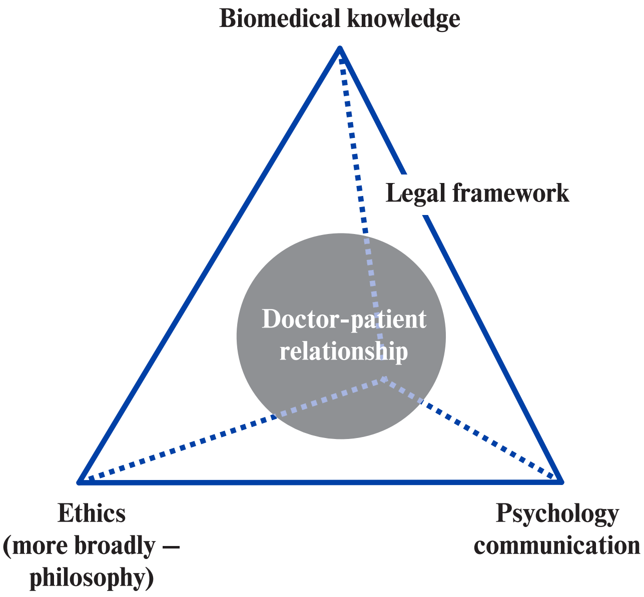

**Figure 1.** The four components of doctor-patient relationship.

The Western model was formed due to the rapid development of biology and chemistry in the context of commodity-money economy, as well as the creation of regulatory legal institutions. The tasks, operating techniques, and relations themselves within the Western model of medicine are outlined by this context, highlighting its certain, necessary, and appropriate aspects.

A doctor, as an actor of medical knowledge of a certain kind, is placed within the health service provision (within the broader concept of health care). This service includes 1) a biomedical basis, statistically proven by natural sciences, 2) the psychology of communication and psychological aspects of the patient's experience of the situation, 3) the interaction ethics (medical ethics), and 4) a number of legal service features and the doctor-patient relationship generally. Given the biosocial nature of human [4], ethics and psychology can influence the biomedical component, although such an influence, being a subject of humanitarian knowledge, is difficult to algorithmize.

Risk communication, i.e. informing a patient of possible negative situation scenarios, can be considered in a similar "tetrahedron":

— clinical (biomedical) side assumes *knowledge* of a doctor and institute of medicine as a whole about the typical course of a particular pathology, adjusted for the individual biomedical characteristics of the patient's body;

— psychological side includes *goals* for developing a constructive attitude (or coping) with the situation, for motivating for healthy behavior change or for following the doctor's prescriptions (adherence);

— legal side brings the situation of interaction in *accordance* with the values of a particular society and state, including, for example, requirements for voluntary informed consent;

— ethical side raises *questions* related to the very aims of interaction with a patient, ranging from the measure of truth that can (must) be reported, ending with the financial component of health service provision.

All these attributes are implicitly present in a concrete "here and now" situation of doctor-patient interaction, as a rule, not manifesting themselves until the communication stumbles upon a contradiction.

The four key concepts highlighted above outline the specifics of risk communication in a particular model of medicine. In the Western model, the knowledge of a doctor is absolute, since it is based on empirical data and large samples, allowing to achieve significance that claims to be axiomatic. The phenomenon of doctor's power lies in the fact that a doctor knows exactly about risks and possible options for event development [5]. The goal that is set in the doctor-patient communication is based on the relationship of etiology, pathogenesis, and outcomes, proven in the experience of fundamental and clinical medicine. Compliance with algorithms and other regulatory documents is required when it comes to licensed health care practices. The regulatory acts themselves represent a meta-level of the same fundamental knowledge, only even more alienated from the uniqueness of a particular patient. Here ethical questions arise.

It is most interesting to look at risk communication from the point of view of a doctor as an expert in the biological part of the issue, and a patient as an expert in himself. Considering that the biosocial nature of a person and his psychosomatic structure (as well as cultural and psychological) directly depend on the situation formed in consciousness (in the psyche, experience), the patient's knowledge about himself cannot be taken outside the interaction [1]. On the contrary, the new that a patient learns about himself as a sufferer falls on his picture of himself, transferring him to a different personal or even a different existential status. The feedback received by a doctor during communication modulates his further actions and speech, however, each action and statement also includes a doctor as a representative of medicine, health care, as a person, a helping specialist, and so on — i.e. the social role of a doctor. And there is still biomedical knowledge behind it all.

An example is the communication goal-setting about a modifiable risk factor for atherosclerosis based on cardiovascular risk stratification scales SCORE or SCORE-2. The risks in this case are ischemic events and other complications of atherosclerosis. The task of communication: to make a patient's idea of his condition adequate to the danger severity, so that he becomes motivated to modify the diet, lifestyle and can maintain this motivation, as well as to take lipid-lowering therapy. In this case, the doctor's knowledge is quite simple: there is an unconditional evidence base for the relationship between dyslipoproteinemia and coronary artery disease development. It is noteworthy that in the SCORE-2, additional stratification was made by country [6]. For example, a 72-year-old nonsmoking woman living in France with a non-high-density lipoprotein cholesterol level of 5,2 mmol/L and controlled hypertension (systolic blood pressure of 126 mm Hg) would have a ten-year risk of developing a cardiovascular event of approximately 8%, while a Russian woman with same *biological* characteristics has a risk of 31%, which is four times higher. In fact, such a serious risk increase occurs due to the introduction of additional factors that cannot be taken into account as follows: psychosocial stability, social security, economic well-being, health care system status, meal quality, cultural stereotypes of food or alcohol consumption, etc. At the same time, such a fundamental complication of the risk scale is symptomatic for the health care system to recognize the potential dead end of any stratification and the prospects of returning to work with the uniqueness of a particular patient. It is also obvious that 8% and 31% are some average values, and a resident of France with a low income and level of education, with family problems, living in a disadvantaged area may have a higher risk than a Russian woman who is a pensioner with wealthy children and grandchildren, living with them in an elite cottage village. How will risk communication between a cardiologist and these two women be arranged? Of course, there will be a turn from the epidemiological view to the individualization of specific conditions.

A significant unit in risk communication is a concept, behind which there are many attributes and prerequisites, one way or another included in it, but cannot be borne out separately due to their insufficient weight. For example, the concept of smoking may include data on current status (current/former/never-smoker) and quantity (pack per day; half pack per day, etc.), but does not include the *reasons* why the patient smokes, his psychological state during smoking or physiological changes caused by nicotine. In the example mentioned above, smoking as a component of scale in a French woman would be caused by social distress, while smoking in a Russian woman would rather due to aesthetic reasons. These and other significant units are incorporated by default into the concept of smoking due to the generalized knowledge of smoking effect on the development of biomedical pathology in. The idea of a causal relationship between pathogenetic factors allows us not to ask the question that, perhaps, the pathological effect of a risk factor is associated not so much with itself as with its prerequisites.

Such questions can be important for risk communication, but importance can be acquired if the vector of communication. In other words, if the interaction conditions allow us to make it more individualized, patient-oriented, then the approach will become less universal. This can lead to a departure from the legal basis of such interaction, namely from the formally necessary aspects, such as guidelines and algorithms. At the population level, such a situation is difficult to imagine, if only due to the legal responsibility of decision-makers at the population level. At the level of an individual doctor's appointment, it can also be fraught with responsibility if damage is caused. On the other hand, in the case of refusal of individualization, the assessment of the resulting damage is more likely to be in favor of the doctor's innocence, since he acted in accordance with the regulatory framework.

## Conclusion

The central conclusion that can be drawn from a brief consideration of the clinical situation, where the risk and prognosis options are explained, and the task is to obtain voluntary consent (refusal) or increase adherence to prescriptions, is as follows. The semantic system linking scientific biomedical knowledge with a real patient has developed in certain economic, social, and cultural conditions. Relationships within health care today are clearly defined and instrumentalized, since they occur within the state guarantee (if not for care provision, then at least for its quality control). As a result, the side of patient's condition that fits the care tools is given primary or even sole attention. Other ways of dealing with the patient's medical problem are marginalized.

**Relationships and Activities:** none.

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