Russian Journal of Cardiology 2021;26(9):4679
doi:10.15829/1560-4071-2021-4679
https://russjcardiol.elpub.ru

ORIGINAL ARTICLES
ISSN 1560-4071 (print)
ISSN 2618-7620 (online)

Communicative competence of a cardiologist: ethical and psychological analysis

Schneider Ya. E., Pavlova E. K., Seleznev E. A., Belova M. V., Zaitsev N. V.

The article problematizes the issue behind the standard categories of psychosocial factors, informing a patient about disease, prognosis, treatment methods, etc. The issue of a doctor's role in interaction with a patient. Although psychological research methods are actively used in cardiology practice, and their results are quite transparent and demonstrate the specifics of patients experiencing the disease, affective states, soping skills, there are still questions about a physician not as a biomedical expert, but as a helping specialist. And although deontological imperatives require quite clear personal qualities from a doctor, the very realization of these qualities should be based on psychological approaches and cultural-psychological categories. As such, the way a doctor interacts with a patient can be described in terms of virtue ethics, which is an integral category that describes personal characteristics. Such characteristics, being implemented directly in clinical communication, could become a universal "recipe" for meaningful cooperation.

Keywords: risk factors, noncommunicable diseases, ethics, deontology, doctor-patient relationship, virtue ethics, person-centered approach, value-based healthcare.

Relationships and Activities: none.

Pirogov Russian National Research Medical University, Moscow, Russia.

Schneider Ya. E.* ORCID: 0000-0001-7139-560X, Pavlova E. K. ORCID: 0000-0002-7497-3660, Seleznev E. A. ORCID: 0000-0002-6010-2063, Belova M. V. ORCID: 0000-0003-1559-4908, Zaitsev N. V. ORCID: 0000-0002-7303-7213.

*Corresponding author: cardio03@list.ru

Received: 24.08.2021
Revision Received: 12.09.2021
Accepted: 24.09.2021

For citation: Schneider Ya. E., Pavlova E. K., Seleznev E. A., Belova M. V., Zaitsev N. V. Communicative competence of a cardiologist: ethical and psychological analysis. *Russian Journal of Cardiology*. 2021;26(9):4679. (In Russ.) doi:10.15829/1560-4071-2021-4679

Clinical medicine involves the interaction of two individuals, one of whom is a helper, while the second — one who needs help. The intensive development of medical science has made the biological disease substrate a priority. Working with a social person, one's experience of the disease faded into the background [1]. The advantages of biomedical approach are that it is based on natural scientific methods, which means that it provides certainty, predictability, verifiability and guarantees. The disadvantages of biomedical methods are overcome by increasing the sample and achieving a sufficient number of observations. It is also convenient from the standpoint of health care systems, whose task is to implement state guarantees. To give guarantees, you need to have verified tools for their implementation [2].

But in the definition of health, which was given by the World Health Organization and included in the Russian legislation, psychological and social well-being are also indicated along with physical health. This division should be considered conditional, since the psychological level of a person's structure is the physiology of his higher nervous activity, connecting the somatic and social components [3]. Interdisciplinary studies of psychosomatics, as well as the general idea of psychosocial risk factors, demonstrate almost the higher importance of cultural components in the development of noncommunicable diseases, in particular, cardiovascular pathology. Practical medicine, therefore, cannot exclude these factors from its field of vision. The difficulty of working with them lies in the fact that, unlike natural science, cultural factors cannot be counted and recorded. They are mobile, individual, context-dependent and are studied by humanitarian sciences. They require different fundamental skills from a health professional than biomedical ones. And although from the point of view of epidemiology and medical psychology, a deep understanding of the structure of psychosocial risk factors, their interrelationships and influence on specific pathological processes has been achieved, the question remains about the direct implementation of this knowledge in work with a specific patient [3].

It is obvious that in practice, despite the presence of many auxiliary tools (scales, protocols, algorithms), the main thing is the direct communication between doctor and patient. Its tasks include not only collecting history and informing about the diagnosis, but also a wide range of other issues. So, a doctor should inform a patient *about the goals, methods of care provision, the associated risk, possible options for intervention, its consequences, as well as about the expected results of care*. Together, this is part of the disease performance, and in the time perspective, it is part of illness narrative [4]. It is quite obvious that in addition to the aspects required by law, such communication has a clear goal — to provide a coping with the disease. Taking into account the whole range of approaches to prevention, treatment and rehabilitation in atherosclerotic cardiovascular diseases, objective, transparent, meaningful knowledge of the patient about his condition is not only constitutional right, but also a psychosomatic tool. A well-formed picture of the disease will further increase adherence to the doctor's prescriptions, contribute to lifestyle modification, and, in addition, relieve frustration caused by misunderstanding. From the point of view of patient-centered medicine, the patient is an *expert* in himself, while the doctor is an expert in the biomedical part of problem [5].

All of the above poses the question of what are the requirements for a doctor personality and how clinical communication should be built in order to implement both legal and deontological imperatives. A similar *issue* was considered in a number of studies on acute coronary syndrome and myocardial infarction (Semiokhina A.S. et al. (2017), Airapetyan M.A. et al. (2017)) [6, 7]. The first study included 100 patients (mean age, 63 years) with ST segment elevation myocardial infarction and incomplete myocardial revascularization. The groups were divided depending on revascularization strategy. The analysis found that in patients with delayed intervention, compared with those not received revascularization, the quality of life was significantly higher. This study, in addition to the biomedical aspects itself, raises following questions for clinical interaction: how a doctor should discuss a strategy with a patient, how to formulate risks and expected results, what position does the doctor take. The second work regarded non-ST-segment elevation acute coronary syndrome in 51 females (mean age, 50,5 years) and 50 males (mean age, 46,7 years). The groups differed depending on following outcomes: unstable angina or myocardial infarction. It was shown that the quality-of-life features can be distinguished both by sex and by the outcome. In particular, the following components of negative coping can be noted: "loss of meaning in life" — 4% of men and 7% of women; loss of interest in hobbies or activities — 22% and 13%, respectively. Taratukhin E.O. et al. (2017) used the so-called in-depth person-centered interview, surveying young men with the first myocardial infarction during hospitalization. A number of unspoken, but as a rule, unconscious components of experiencing a disease situation were identified as follows: serious life change; anxiety and fear of sudden death and repeat

Table 1

Categories of communication of a helping specialist (adapted from K. Rogers)

Skill	Description	Application
Empathy	Epistemic empathy, i.e. the process of perceiving the patient's inner world, taking into account the subtle shades of non-verbal communication, as well as the doctor's verbalization of the perceived information about a patient (emotions, feelings, motives, meanings, needs, etc.)	The ability to inform more adequately, to reveal hidden difficulties, joint decision-making, improvement of interaction, a more complete awareness by a patient of one's role in the disease and treatment
Non-judgment	Unconditional positive regard, i.e. absence of condemnation and other negative assessment, respect for the individuality of a patient and faith in one's capabilities. The conviction that everyone has an unconditional value, regardless of their behavior, state or feelings. A specialist enables patients to be themselves, in their manifestations, since it is a patient in this case who is a sick and suffering subject	Creating a healthy, comfortable psychological environment (a prerequisite for using empathy)
Congruence	Personal psychological work of a doctor, one's ability not to be sensitive to negative statements about yourself, as well as sincerity and correspondence of the internal picture of situation to what one speaks about it	More effective interaction due to the use of the doctor's psychological resource, promotes trust
Contact	The patient's trust in a doctor, a request for help — in this case, a psychological request for help in coping with the situation	Direct action of doctor's recommendations

of the event; discourage and confusion; puzzlement; disorientation in symptoms, misunderstanding; loss of perspective for better in life; stigmatization; self-image changes; feelings of guilt and resentment [8]. These data generally coincide with international and Russian studies [9, 10].

The results of three studies, obtained at the regional vascular center in Moscow (O. M. Filatov City Clinical Hospital № 15), are representative of some psychosocial and sociocultural aspects of a doctor's work. Being devoted to the assessment of psychological factors in the context of somatic noncommunicable disease, these studies raise the question of communicative skills of a doctor.

By itself, a patient-centered care implies the patient's direct participation in all decisions concerning one's management [11]. But the notorious question of patient incompetence in biomedical matters, lack of medical experience and experience of the disease (with the exception of patients with chronic disease, for example, asthma or diabetes) casts doubt on the usefulness this approach. The solution may be the special communicative competence of a doctor who is able to regard those parties of the patient's request that really play a key role both in coping and in providing sufficient adherence, in signing informed consents for treatment in general and for specific interventions.

The concept of *virtue ethics*, which was formulated in ancient Greek philosophy, stands somewhat apart from other metaethical theories (consequentialism, deontology, emotivism), because, unlike them, it refers not to decision-making methodology, but to the qualities of a person himself, making these decisions. The idea of such a holistic, fully functioning personality passes through culture, and of course, it makes up a significant part of usual deontological imperative — "requirements" for the doctor personality. The characteristics of a helper given by the American psychotherapist K. Rogers are very close to virtue ethics [12]. The situation of help, primarily psychotherapeutic, imposes the necessary and sufficient requirements as follows: empathy, unconditional positive regard and non-judgment, congruence, as well as psychological contact as such (Table 1). It should be added that empathy itself is studied by philosophers as a virtue, i.e. a special personality trait, and not just a skill [13]. Empathy allows you to implement the communicative mechanism of empathic listening. In addition, the situation of psychological help imposes "requirements" on a patient — the ability to contact with another person and to be able to perceive positive regard and empathy addressed to him.

If we combine all the categories mentioned above, namely the biomedical problem, psychosocial factors, a patient's coping with illness, the role of a doctor as a helper, then the clinical aspects of virtue ethics and psychology become obvious. Undoubtedly, it would be rather bold and unrealistic to impose *such* requirements on a doctor personality within the state guarantees and the health care system. Nevertheless, the qualities of deontological authorities illustrate and fill the indicated communicative and personal characteristics.

There are not many attempts to study this view in cardiology practice. In general, an attempt to "ethically measure" the cardiology practice was in

1990 (Parmley WW, et al. (1990)) within a working group on the study of general principles of ethics in cardiovascular medicine [14]. Noteworthy is the publication by de Hoyos A, et al. (2013), where the authors studied ethical deliberations in cardiology. The specialty was chosen due to the severity of conditions and the difficult moral choice of doctors, which requires reassessment of value-based medicine categories. The authors conclude on a number of communicative competencies and empathy that would contribute to building a more stable doctor-patient relationship and improve prognosis, treatment efficiency, and patient adherence [15]. Cook T, et al. (2015) pointed out that respect for patient autonomy is a medical virtue. The authors noted that in clinical practice, it is necessary not only to apply the interaction principles, which makes it possible to adequately sign informed consent, to make informed decisions, but it is necessary to introduce virtue within traditional Aristotelian ethics. This is achieved by educating the individual, including directly during work in the clinic [16].

Conclusion

Modern clinical "bedside" interactions with a patient vary widely: starting with the legal component and ending with the need to take into account the existential questions of a patient. The concept of P4 medicine, i.e. predictive, preventative, personalized, participatory [17], also forces one to seek the most complete interaction within the clinical situation. The demand for a special doctor-patient communication is obviously present in society, and it is necessary to look for rational solutions how to satisfy it. The combination of philosophical anthropology doctrine of virtue with the psychological concept of the helper personality, as has already been shown in empirical research, can be the solution that is required from health care systems.

Relationships and Activities: none.

References

1. Taratukhin EO. Patient's personality: an interdisciplinary approach to cardiovascular pathology. Russian Journal of Cardiology. 2014;(9):22-5. (In Russ.) doi:10.15829/1560-4071-2014-9-22-25.
2. Lehane E, Leahy-Warren P, O'Riordan C, et al. Evidence-based practice education for healthcare professions: an expert view. BMJ Evid Based Med. 2019;24(3):103-8. doi:10.1136/bmjebm-2018-111019.
3. Taratukhin EO. Biopsychosocial approach — a modern demand for interdisciplinarity. Russian Journal of Cardiology. 2015;(9):80-3. (In Russ.) doi:10.15829/1560-4071-2015-09-80-83.
4. Zaharias G. What is narrative-based medicine? Can Fam Physician. 2018;64(3):176-80.
5. Tattersall R. The expert patient: a new approach to chronic disease management for the twenty-first century. Clin Med (Lond). 2002;2(3):227-9.
6. Semiokhina AS, Taratukhin EO, Bayandin NL, et al. Life quality in one year after myocardial infraction with incomplete revascularization. Russian Journal of Cardiology. 2017;(1):102-5. (In Russ.) doi:10.15829/1560-4071-2017-1-102-105.
7. Ayrapetian MA, Luchinkina EE, Gordeev IG, et al. Life quality of patients according to gender and the form of non-ST-elevation acute coronary syndrome. Russian Journal of Cardiology. 2017;(8):31-5. (In Russ.) doi:10.15829/1560-4071-2017-8-31-35.
8. Taratukhin EO, Kudinova MA, Shaydyuk OYu, et al. Person-centered interview as a tool for clinical work in myocardial infarction setting. Cardiovascular Therapy and Prevention. 2017;16(1):34-9. (In Russ.) doi:10.15829/1728-8800-2017-1-34-39.
9. Kroemeke A. Changes in well-being after myocardial infarction: does coping matter? Qual Life Res. 2016;25(10):2593-601. doi:10.1007/s11136-016-1286-6.
10. Zhitkova RS, Khaliullina DR, Akhmetshina LA, et al. The importance of cardio rehabilitation combined with psychological correction for post myocardial infarction patients. The Bulletin of Contemporary Clinical Medicine. 2020;13(3):47-51. (In Russ.) doi:10.20969/VSKM.2020.13(3).47-51.
11. Taratukhin EO. Psychosomatic nature of myocardial infarction and patient-centered medicine. Silitsea. 2018. (In Russ.) ISBN: 9785990186002.
12. Rogers K. On becoming a person. Mariner Books. 1995. ISBN: 9780395755310.
13. Battaly HD. Is empathy a virtue? In: Coplan A, Goldie P. (eds.) Empathy: philosophical and psychological perspectives. Oxford: OUP. 2011. doi:10.1093/acprof:oso/9780199539956.003.017.
14. Parmley WW, Schlant RC, Crelinsten GL, et al. Ethics in cardiovascular medicine. Task force I: background and general principles. J Am Coll Cardiol. 1990;16(1):7-10. doi:10.1016/0735-1097(90)90447.
15. de Hoyos A, Nava-Diosdado R, Mendez J, et al. Cardiovascular medicine at face value: a qualitative pilot study on clinical axiology. Philos Ethics Humanit Med. 2013;8:3. doi:10.1186/1747-5341-8-3.
16. Cook T, Mavroudis CD, Jacobs JP, et al. Respect for patient autonomy as a medical virtue. Cardiology in the Young. 2015;25(8):1615-20. doi:10.1017/S1047951115002097.
17. Horne R. The human dimension: putting the Person into personalized medicine. New Bioeth. 2017;23(1):38-48. doi:10.1080/20502877.2017.1314894.