LETTERS TO THE EDITOR

1. Patients’ wishes during the diagnostic process:
—When their medical history is being recorded, patients want to feel as important as possible, so surgeons must convey the impression that they have the time necessary to listen to their patients and should avoid cutting short their explanations and interrupting them for details unrelated to their narration. It is preferable to move the interview on to the description of symptoms by asking direct questions, such as: Can you explain what is happening to you? Do you also notice...? Is all of this due to...? Did your doctor tell you that...? What is most important to you in regard to...? Patients perceive this approach as a sign of greater consideration of themselves and their problems.

—When a physical examination and complementary are performed, patients generally prefer a complete examination rather than a summary one or none at all. The surgeon must, however, take care that the first area investigated coincides with the patient’s wishes or clinical situation, and should not insist on investigations the patient is reluctant to accept, particularly if the patient indicates “Not that!” Before an exploration is performed, the physician should ascertain whether the patient is willing, and explain the aim of the procedure and what is involved. When a patient rejects a necessary test or procedure, the surgeon’s task is to explain all the reasons why it should be done and insist on the need to perform it for the good of the patient, without, however, concealing any drawbacks the procedure may have. If the patient still refuses, the physician should not go against their wishes, or reproach them for their conduct since this would automatically lead to a loss of confidence in the relationship. It is a good idea to explicitly accept the patient’s criterion and to offer other, alternative tests. This approach will tend to build mutual confidence and reinforce the patient’s faith in the doctor’s opinion.
—While the physician is working towards a diagnosis and evaluating the prognosis, everything should be explained to the patient in plain language. Informed consent is not merely a formality, but a matter of confidence and safety. The surgeon must, however, take care that the first area investigated coincides with the patient’s wishes or clinical situation, and should not insist on investigations the patient is reluctant to accept, particularly if the patient indicates “Not that!” Before an exploration is performed, the physician should ascertain whether the patient is willing, and explain the aim of the procedure and what is involved. When a patient rejects a necessary test or procedure, the surgeon’s task is to explain all the reasons why it should be done and insist on the need to perform it for the good of the patient, without, however, concealing any drawbacks the procedure may have. If the patient still refuses, the physician should not go against their wishes, or reproach them for their conduct since this would automatically lead to a loss of confidence in the relationship. It is a good idea to explicitly accept the patient’s criterion and to offer other, alternative tests. This approach will tend to build mutual confidence and reinforce the patient’s faith in the doctor’s opinion.

2. What patients want when they are undergoing surgery and during the postoperative period.
Some surgeons are surprised by what their patients want, probably because they have never realized that the ill person is going through a delicate and conflictive period in their life. More and more surgeons, however, are taking into account the psychological aspects of treatment, aspects that only a few years ago were not even considered or were relegated to other personnel. One example of this was the absence of any explanations complementary to those given in the informed consent document. One of the most common desires of people who have had surgery is that the surgeon should explain to them how the operation went and why they have drains or drips or other postoperative aids. This dialogue is, however, often cut short because the patients are being monitored by other doctors, who have not operated on them. The situation becomes more difficult if the surgeon on call, a doctor whom the patient has just met, decides that a second intervention is necessary. The operating surgeon should explain these circumstances to the patient in preoperative sessions. Moreover, it is very important that the patient be introduced to the surgical team and understand their different roles in relation to him or her case. Such communication serves the quest for excellence.

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4. Belloch A. Lo que el paciente espera que el médico le explique y lo que el médico cree que debe explicar. Arch Bronconeumol 2002;38(Supl 7):9-15.