Reflections on the teaching-learning process of physician-patient relationship

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Abstract

The paper addresses the teaching/learning process of the physician-patient relationship considering the new medical education paradigm, the National Curriculum Guidelines. It argues about the need for extensive training, including related fields such as philosophy, bioethics, theology, and sociology. It points toward the necessity of teaching/learning, highlighting respect for otherness and autonomy, seeking to reflect on the theory/practice process related to this content into the living of medical students. It also aims to focus on explanatory models, laymen and physicians, discoursing about the need to deal harmoniously with differences. Finally, it presents the Balint's theory and its categories, which expand the understanding of patent's health/illness process, as well as it analyzes the needed development of medical students' emotional intelligence. The text attempts to observe the reflection of professionals who, somehow, influence the formation of future physicians.

Key words: Education, medical. Psychoanalytic therapy. Humanization of assistance.

Resumo

Reflexões sobre o processo ensino-aprendizagem na relação médico-paciente

O texto aborda o processo ensino-aprendizagem da relação médico-paciente considerando o novo paradigma do ensino médico, as Diretrizes Curriculares Nacionais. Argumenta a respeito da necessidade de formação ampla, que inclua áreas afins como filosofia, bioética, teologia e sociologia. Aponta para a necessidade do ensino-aprendizagem destacando o respeito à alteridade e à autonomia, procurando refletir sobre o processo teoria/prática em relação a esses conteúdos no viver dos estudantes de medicina. Também procura enfocar modelos explicativos, leigos e médicos, discorrendo a respeito da necessidade de lidar de forma harmoniosa com as diferenças. Por fim, apresenta a teoria de Balint e suas categorias, que ampliam a compreensão do processo saúde-doença do paciente, bem como examina o necessário desenvolvimento da inteligência emocional do estudante de medicina. O texto intenta pautar a reflexão dos profissionais que, de alguma forma, influenciam a formação de futuros médicos.

Palavras-chave: Educação médica. Terapia psicanalítica. Humanização da assistência.

Resumen

Reflexiones sobre el proceso de enseñanza-aprendizaje de la relación médico-paciente

El texto aborda el proceso enseñanza-aprendizaje de la relación médico paciente considerando el nuevo paradigma de la enseñanza médica: las Directrices Curriculares Nacionales. Argumenta respecto la necesidad de formación amplia, que incluya áreas afines como filosofía, bioética, teología y sociología. Apunta hacia la necesidad de la enseñanza/aprendizaje destacando el respeto a la alteridad y a la autonomía, buscando reflejar sobre el proceso teoría/práctica en relación a esos contenidos en la vivencia de los estudiantes de medicina. Asimismo, busca enfocar modelos explicativos, legos y médicos, disertando acerca de la necesidad de lidiar de forma armoniosa con las diferencias. Por fin, presenta la Teoría de Balint y sus categorías, que amplían la comprensión del proceso salud-enfermedad del paciente, así como examina el necesario desarrollo de la inteligencia emocional del estudiante de medicina. El texto intenta pautar la reflexión de los profesionales que, de alguna forma, influencian la formación de futuros médicos.

Palabras-clave: Educación médica. Terapia psicoanalítica. Humanización de la atención.

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Every Higher Education school should offer philosophy and history classes. Thus, we would be away from the figure of the specialist and we would gain empowered professionals capable of talking out about life.

Niemeyer, Oscar

The learning-teaching process of medicine asserts the development of knowledge, skills and technical-humanistic attitudes for the formative building-up of doctors, who are not only capable of treating diseases, but, above all, capable of knowing their patients, being contextualized in his/her living reality and, therefore, capable of developing the promotion of health in the community, preventing the worsening of collective health, as well as capable of treating people in stages of ongoing illnesses, being able to rehabilitate them for a new way of *being in the world*. This is the current view of the medical work, laid out in the National Circular Guidelines, for the graduation course of Medicine, proposed by the Ministry of Education (MEC).

The social transformations imposed on in this 21st century have modified the essence of the physician-patient relationship, formerly based only on polite attitudes, good manners and knowledge (not always deep knowledge) of the ethical principle. Along contemporaneity, the learning of the delicate relation between the professional and the patient entails basic knowledge of human sciences (sociology, anthropology, philosophy, psychology, etc.) and of theories that are a basis for the patient -patient relationship itself, as well as for the understanding and development of emotional intelligence of the medical student and his training in the communicative skills.

Basic knowledge of human sciences

The sociologist Paulo Henrique Martins[2], in the work 'Against Dehumanization of Medicine: sociological criticism of the modern medical practices', clearly points up the sociological understanding of unhealthiness: *the experience of suffering in the true relations of cure proves that medicine is typically an expression of socialness, which is revealed, in the meantime, in the symbolic and material sides, an expression that offers the benefit of healings and gives back the harmfulness of the disease. In fact, the idea of medicine as a total social phenomenon, grounded firstly in the circulation of talents among individuals (Exchange of suffering for cure benefits), allows for realizing that the ongoing changes, either as institutional or health management model levels, are preceded by changes in the practices of healing the disease*[3].

What Martins[2] states is that medicine is a social phenomenon, and it must be understood as such. History of medicine, since antiquity, shows that the care of healing another had originated in spiritual rituals, veering from philosophy to a new paradigm, in the 17th century: Science. The breach that comes out from the understanding of Science, by medicine, wears off the human relations which would permeate the contact between the patient (that who would solicit the healing for his/her ailment) and the physician (the healer).

Over the years, the stiff, pragmatic and positivistic science definitively set itself apart from the knowledge of the humanities field. Martins then analyses: *According to what the dominant medical canons preach, factors linked to the sick (family issues, or workplace problems, economic hardships, etc.) must not, absolutely not, contaminate the stages of diagnoses and prognoses. It is a belief of the anatomic clinical method, in which only the physical symptom should be considered*[4].

The perception that medical science alone, does not explain the process of human unhealthiness has lead professionals to re-think the physician-patient relationship, seeking to get back the human sciences knowledge. The Single Health System (SUS) itself has noticed the need of modifying physicians' work. The National Humanization Policy is today, a State policy which ensures the central treatment of the sick, seeking ways to understand them in their social realities.

Philosophy is one of the most important pillars of the physician -patient relations. Ethics, a philosophical field of knowledge is the building block of the relationship between the healer (doctor) and that one who looks for the cure (patient). From ethics, in the 20th century, a specific field of knowledge emerged, known as bioethics, that is, the living beings' ethics, very much specifically the ethics of human beings .Nowadays, one may not think anymore of the physician -patient relationship without heeding the bioethical references, especially the ones originated in the principles-driven

theory proposed by Beauchamp and Chidress[5]. Beneficence (always seeks to do well to the patient) and justice (do what is just, regardless of the socioeconomic, emotional factors, etc.) are allusive to medical actions. Besides these principles, which since Hippocrates, have guided medical practice; bioethics has added up respectfulness for autonomy (allows the patient to decide on this treatment, accepting it or not, after due clarification).

If beneficence and non-maleficence, as proposed by bioethics are perfectly understood in clinical practice, either in the purely technical dimension or in relational dimension, the idea of justice in bioethics is not, equally, easy to make out or to be put into practice, since it implies the consideration of social principles of justice in health access and in the service for patients. For Beauchamp and Chidress, justice is understood as distributive justice, which relates to the equal, equality-driven, and appropriate distribution in society[5].

Justice must be realized as a fundamental attitude for medical service. If on examining the patient, the professional needs to take into account the gender, skin color, moral and social issues, and in some cases even religious choice, it is extremely needed that these factors, so much determinant to medical diagnoses, be not taken as elements to discriminate him/her negatively. Treating the patient justly is, therefore, the exercise needed to ensure the future physician's ethical attitude and, above all, to allow that the students respect human dignity cogently with human rights.

Today, justice is a pillar of equalities, which, in turn becomes an epistemological basis for medical service. Although under the eyes of epistemology the word justness features closely to equality, there is a primary piece of data which distinguishes them. In fact, ideally, the service to the patient should be the same if people were equal. However, they are not exactly the same – anatomically or physiologically – due to gender, age and predispositions alluded to skin color and ethnicity.

Besides that, it is widely known that there are social inequalities, also, which play out as predisposition factors towards unhealthiness. For this reason, equality is seen as unequally giving out to the unequal individuals, in an attempt at offering similar opportunities for all society[6]. Although inequality is often discussed in public health reckoning (by means of SUS), such value must be part of the patients-driven services in any form of access, public, private, mediated or not by health insurance or medical unions.

Another fundamental bioethical principle in medical service is the understanding of patients' autonomy. Not long ago, physicians would act authoritatively claiming that, as doctor, they would know what was best for the patient and the latter ought to obey them. Presently, the respect for patient's autonomy places the physician at the position of one, who, in fact, wields the knowledge and so, must clarify to him/her about the best alternative for the treatment. Nonetheless, a physician may not force down the patient to accept the proposed treatment, since the patient's autonomy allows him/her the same legal rights to refuse it. Thus, the respect for autonomy is an attitude that must be understood since early on in the educational formation of medicine students. Besides these bioethical principles, other values are increasingly more necessary in the routine of professionals, such as the respect to dissimilarities (respect the differences of others) and secrecy (respect the secrets on patients' information).

The secrecy must be developed since the beginning of the medical educational course, guiding them through for not talking over patient's cases with relatives, boyfriends/girlfriends, friends at the university's cafeteria, or inclusive of social gatherings. Clinical cases, as discussed in specific consultancy sessions, must preserve the secrecy by means of the doctors' own deft maneuvers, such as utilizing only the initials instead of the patient's name or, even avoiding information which would allow for identification of the patients. One must bear in mind, always, that in a clinical case discussion, all the professionals taking part are subject to the duty of secrecy.

Dissimilarities are described as a fundamental bioethical value, for both the students and doctors must respect others with their diversities. Thus assuming one may not discriminate or rule out another one for his/her differences, nor can one equalize all, ignoring human diversity which compels a vast richness of possibilities of *one existing in the world*.

Assertive actions (actions of self-affirmation), such as movements by gay men, lesbians and the like, for instance, have gained focus from society for the respect to dissimilarities.

Theology, not in the catechetical sense, but in the spirituality sense, as well as anthropology, comes up to widen the field of knowledge of the patient-physician relationship in present days. Lately, there have been coming out several methods of treatment for the most diverse diseases. Some of them, originated from oriental medicine are accepted and regarded as scientific by the medical community; others are restricted to the field of life experience or spiritual experience (symbolic dimension) of each patient. Doctors, many of the times, see themselves in a situation of confrontation with dogmatic religious positions or even scientifically unexplained healings.

Religion science authors have pointed out the search for alternatives to traditional medical treatments as a social and anthropological phenomenon, which needs to be acknowledged by doctors in general. Martins[2] signals to the so called medical healing systems: *In medical healing systems, the main systems, installed or under installation, are classified, at this moment of transformations of modern medicine, as follows, the bioorganic systems, whose mostly known version is allopathy, which is the basis for the anatomic clinical physicians, adopted by official medicine; although we may not forget the other known bioorganic medicine version, homeopathy. A second set is that of the biopsychic systems, which receive focus through Freud's psychoanalysis. The popular systems are those which develop outside official medicine*[7].

The author cites, among the so called *popular healing systems*, the vulgarization and deliberate consumption of antibiotics (self-treatment), the use of teas and home remedies. And additionally, the shamanic systems, which partake in the process of societies' shaping, such systems characterized as magical-religious, seek healing by way of rituals and religious traditions. Respecting cultural diversities related to spirituality is one of today's primacies of physician-patient relationship.

Intending to achieve that respect, in the Family's Health Strategy, partnerships with community leaderships are being sought after, and mainly with religious ones. If the Family's Health Strategy team is able to count on collaboration from religious leaders of the campaigns for health promotion and illnesses prevention, the goals will surely be achieved more efficiently. The acceptance of the treatment must also be guaranteed, with due respect to patients' positions as for their religions' dogmas. Relevant examples, such as the presence of Jehovah's Witness members, in hospitals, has been considered a high leap forward in the field of professional health.

The continuous attainment of know-hows in the field of social sciences, will increasingly build students' and doctors' competence at understanding, in fact, their patients in a bio-psycho-social and spiritual fashion, and will so widen the relations with them and promote a medicine of social aspects, employing the proposals of the National Curricular Guidelines[1] for the teaching of medicine.

Theories that back up the physician-patient relationship

In order to discuss the theories which support the field of knowledge on the physician-patient relationship, it is necessary to perform a prior reflection on the health-disease process, because *what is at stake is a new understanding of diseases, not as an undesired abnormality which strikes the individual, but the disease as a total and needed symptom of a society under the move to complex and paradoxical roles organizations, a move which, in turn, reaches across the individuals and institutions which are part of it* [8].

Thus, there are not isolated illnesses, but people under the process of unhealthiness: people who are alive, within a historical context and who take part in a society. One who becomes ill, undergoes it along a true and full process of being alive, of being in the world; he/she becomes ill as in deep dive into his/her own routine. Ill-being is comprised of multiple questions which entail the individual in his several dimensions: his performance in the work front, his process of knowledge attainment (educational life), his true life and emotional experiences, his beliefs and myths[9].

This is not about disqualifying the knowledge of epidemiology, but above all, about broadening them in such a way to figure out the illness as an essential and historical-social movement and, therefore, a game changer of human beings in their life contexts. In this respect, one who gets ill must be understood in a systemic and complex manner: he/she is a historical, social, emotional, existential and biological being, for he/she is ultimately human.

Starting from this new and broad bio-psycho-social concept of the dialogue-driven health-unhealthiness

process, the World Health Organization (WHO) began considering health itself as one's balance, which refers to one's physical, psychic and social well-being.

Currently, the social surroundings in which a person is, is also a paramount factor in his/her process of unhealthiness, since *health has a lot to do with running water and treated water, sewage systems, pollution controls, human nutrition, housing, leisure, immunization against contagious diseases, epidemiology control, food surveillance and quality control, environmental condition overhauls,* etc[10].

In the meantime, becoming ill is also regarded as a life condition possibility in face of harsh conditions one faces day-to-day in a chaotic and globalized world, under constant transformations, which widens even more the socio-historical understanding of this complex process: *above all, as the outcome of formations of megalopolises, a great number of people has lost their roots and bonds, numerous-type families tend to disappear, and the individual sets himself/herself aside more and more and withdraws*[11]*. He/She sees himself/herself more and more pared down to their resources. Under disturbance conditions, especially if tension worsens, a possible and quite often escape mechanism is used, which consists of inquiring his/her doctor and regreting*[11].

Today, it is known that social and environmental upset yield psychic instability conditions (anxiety), which stir biological alterations, possibly producing pathological conditions (of diseases) such as chronic pain and mental illnesses. The physical experience itself has a connection with social and emotional disturbances, bringing about unhealthiness experiences and, many times, leading to physical aggression onto the person herself/himself, just as in the case of chemical dependency and abusive use of *piercings* and tattoos. The process of unhealthiness, and even of death, is mediated by chemical substances which have their production and distribution, within the body cells, broken out by psychosocial issues which take place far beyond pure and simple genetics. In a recent doctoral thesis, Nepomuceno[12] demonstrated the effects of free radicals in the process of aging and atherosclerosis formation, and therefore, of death, which point out the complexity which permeates the health-disease process and the social context. Hence, the need for bio-psycho-social balance, so that one can attain a healing process or a clinical picture betterment process.

Having knowledge on all this human complexity gets the medical professional in need to build competence towards developing a good relationship with his/her patient. Freud, through the extraordinary discovery of the unconscious introduces a new field of knowledge to doctors, bringing about deep knowledge of psychic life.

Upon describing the transferential movements, Freud made it clear what takes place with the patient (and with the doctor) at the clinical meeting. By meeting with the doctor, the patient develops feelings and emotions in relation to the doctor, which originates from his mostly intimate experiences, from long before (by and large in childhood) and which are unconscious. Such feelings and emotions, which he named transference, are determinant in the relations. According to Freud, knowing and understanding the transference that the patient performs during the meeting with his/her doctor may be a powerful therapeutic tool.

Psychoanalysts know really well how to utilize the transference in favor of the treatment or in favor of the patient's evolution. Doctors are responsible for learning how to do good use of these transferential mechanisms. Ferenczi, a Freud's disciple and later, the creator of the Hungarian School of Psychoanalysis, dealt the counter-transference (the feeling and emotions experienced by the doctor himself/herself in relation to his/her patient) very same value as that of transference along the therapeutic process. Other psychoanalysts contributed greatly to the understanding of the physician-patient relationship. Other lines of thought theorists, such as Moreno, for instance, have brought up new concepts which had been, gradually, aiding doctors to fathom their patients better as for ill people. Despite all these contributions, only Michael Balint has developed a specific theory on the physician-patient relationship. On the condition of a clinical practitioner and psychoanalyst, wielding experience in patient consultation services at the Berlin St. House's psychosomatic clinic, his theoretical contribution was to back up the basis for the understanding of this delicate relation and the process of unhealthiness.

Balint[11], while having been living in London since World War II, developed seminars, at the Tavistock Clinic, with Family doctors (general practitioners) in which he would discuss difficult cases under the perspective of understanding of what had happened between the doctor and the patient. So, he discovered that doctors, by prescribing a medicine, must investigate whether this medication might be good, doing well to the patient, or a truly poisonous one, causing stressful situations and anguish to that one who sought for him – this process Balint named "*the doctor as a drug*". It is necessary to point out that it is not about pegging the doctor as a medication, but as a drug, a substance which by penetrating the body provokes a pharmacological action, either medicinally or not.

A *doctor as a drug* has become the key category of his theory on the physician-patient relationship, but other theoretical categories were also described by him, such as the organization of diseases, the offer of the disease, the apostolic role, the anonymity agreement, the child as a sign of presentation and the *flash*.

The organization and the offer of the disease originates from the understanding that unhealthiness is a process and not a precise occurrence. A myocardium heart attack does not take place starting from the precordial pain and the myocardium necrosis ensued, but a heart attack takes place starting from life conditions (social, psychological, genetic, cultural, etc.) Balint makes it clear to what extent unhealthiness is an organization process, of people's life experiences. More and more, genetics points towards predisposition to certain unhealthiness issues, but it is also known that not all individuals, who are genetically susceptible, present such disease. There is a group of factors which, in a complex fashion, get in this pathological organization.

Once there is the presence of an organized disease or even one under process of organization, the patient needs to pass it on/offer it to someone else. The latter is usually a doctor, although at times it is some other health professional. The offer takes place when the patient delivers to the doctor all his/her regrets and, many of the times, he/she says clearly "*Doctor, I am in your hands*", or also "*God in heaven and you on earth to care for me*".

According to Balint, a doctor may accept the patient's offer while seeking to understand how the latter organized his/her unhealthiness condition and to manage to help him/her to disorganize the process and to find the cure, or, also, he may not accept the offer, he may not try to understand the case's complexity and wish for the patient's cure, regardless of his/her disease organization process. For this reason, it is important to wield theoretical knowledge in order to be able to recognize such processes.

The *apostolic role* is described as a necessity on the part of the doctor, to convince the patient to go along with his faith. Making it clearer, if the doctor believes, for instance, that split-up parents' children are troublesome and get involved with drugs, many times, advising his patient not to divorce the spouse, in the sense of protecting his/her children and perform a drug use prevention. As there are not enough meta-analyses which are able to demonstrate such correlation (children of split-up parents and drug abuse) it is feasible to say that the doctor, by acting this way, wants to convince the patient to advocate his faith in this situation, unproven scientifically. This attitude, according to Balint, is not therapeutic, but built around with the common sense – which he named as apostolic role.

The apostolic role may be interesting in some cases, but terribly disastrous in several others.

Another apostolic role which doctors generally carry out is that of giving punishment to patients. It is very common to see doctors who make it difficult for patients to have access to medical consultations (they create logjams in scheduling) when these patients do not advocate to the proposed treatment. An example is that of a patient who does not go along with the diet, does not lose weight, does not lay off smoking and does not use the medication correctly. The doctor, many times, unconsciously makes it hard to perform the patient's consultation scheduling, as an unwitting way of punishing him/her for being so disobedient.

The *anonymity agreement* is, currently, a widely observed category. It concerns the doctor who, by feeling insecure before the patient, appoints him to several experts, intending to better clarify his ailment. What characterizes the anonymity agreement and distinguishes it from the expert's conclusive opinion on the case is that none of the professionals involved - nor the general

practitioner nor the specialists – take responsibility for the patient. A cardiologist limits himself to the heart; a nephrologist only observes the kidneys, and so on, wherein the patient is helpless, not knowing who to follow and not having a doctor who would indeed guide him. Today, the anonymity agreement is so frequent that, to say it in fun, it is said that *one who has two doctors only has one, and one who has more than two doctors does not have any at all.*

Additionally, Balint described *the child as a sign of presentation* by observing that the third part of children taken to the doctors was not, in fact, ill, but their parents would show some sort of psychic or social upset; another third was ill, as well as their parents, and only the last third was ill with healthy and adequate parents. In face of such verifications, Balint proposed that the child may be taken as easing of their parents' ailment.

The *flash*, a category described at the end of Balint's life shows that when the doctor is well trained and much capable of working with the "Balint" theory within just six minutes, he is able to understand his patient's ailment, developing alongside with him an adequate relation. This category is a result a research work developed by Balint and his wife, Enid, also with London's Family Doctors who would regret for having only six minutes for each patient and, because of this, would not be able to conduct a good health consultation. The research showed that, with good training, in only six minutes, one is able to get an *insight* alongside with the patient, being able not only to understand what takes place but also to receive and support the patient properly. This ability to perform a set of *insights* lead to the name *flash*.

Currently, "Balint-driven" doctors from the United Kingdom have brought up to the discussion on the physician-patient relationship the issue of the mechanisms of doctors' defense. Salinsky and Sackin [15] carried out a research work which resulted in the book *Doctors with Emotions: identify and avoid defensive behavior in health consultations* and has shown the mechanisms, generally inadequate, which doctors give up on in the daily grind of professional stress.

Recent research works about medicine students and doctors show a greater predominance for burnout syndrome and other mental illnesses[16]. The harsh experience with stress related to the profession exposes the students and doctors to huge mental upset. The physician-patient relationship is a field of tension. Defense mechanisms are needed in order to preserve the mental health of students and doctors and to facilitate the relations of students and doctors. What Salinsky and Sackin [15] present as troublesome is that the mechanisms, often used in physician's routines are not adequate and end up jeopardizing the physician-patient relationship. Self-knowledge and the building-up of new proper mechanisms of defense are necessary, such as exaltation. Hence the need for basing the relations with patients on a theory that is able to back up the building of knowledge in this field.

Towards beyond the theory, Balint developed alongside with doctors from England's National Health System, seminars which later on were named as Balint groups. These groups make room for students and professionals to obtain a theoretical-practical learning of the doctor-patient relation. The technique consists of groups of 6 to 12 people, with a duly capable leader, wherein they discuss a certain case: a service provided or seen by a participant.

The leader starts out the activities by asking: *Who has a case?* One of the group participants tells of a case without any previous preparation. It is an essential condition that the case is passed on as it is gradually recalled by the reporting doctor or student. Next, the leader opens up space for questions to the reporting participant and, at the end, the group starts a discussion about the physician-patient relationship. At this moment, the reporting participant silences himself/herself and only hears the discussions.

The group must refrain from judgments and seek to understand the unconscious movements which permeate the case. At the end of 60 to 90 minutes, the group finishes off the activities with a final assessment of the reporter on how he/she felt with the discussion.

Balint groups' relevance has been described in the acquisition of knowledge, attitudes and skills to deal with patients and with th colleagues in multi-professional teams. The groups have yet been considered as a strategy for coping, before professional stress[17]. The term *coping*, currently widely used due to the concern with the diseases deriving from stressful life experiences such as, for instance, the burnout syndrome, is conceptualized as a set of strategies utilized by people, in a conscientious and intentional fashion in order to adapt to adverse or stressful circumstances[18].

In the medicine course at the Goiás' Pontifical Catholic University (PUC-Goiás) the theory and the Balint groups are laid out in the syllabus and permeate four semesters[19]. These groups stand out before the traditional groups because they are adapted to the techniques of the verbalization and observation groups (GV/GO). The observation group remains silent during all the Balint group ongoing activities and observes the "Balint" dynamics. It just gets into action after winding down the Balint group, detailing what has been observed. The verbalization group in turn, is comprised of the Balint group itself, following the international norms for such. Either traditionally or in the lines of GV/GO, the Balint groups represent moments of great learning for everyone.

Emotional Intelligence

Although it is a term that had been coined by Peter Salovey and John Mayer in 1990, the term emotional intelligence would only have become widely known since 1995, wherein the book by Daniel Goleman was published. And then various other theorists of psychology got the interest in the subject and several research works came up in this field of knowledge. According to Cobero, Primi and Muniz, *under the empirical-theoretical viewpoint, the term emotional intelligence was utilized for the first time by Mayer, DiPaolo and Salovey (1990), in an International Psychology scientific periodical, in a work that aimed at studying empirically one of its components, the ability of perception of affective contents. This research work mentioned the emotional intelligence as a subclass of social intelligence, whose abilities would be related to* "monitoring the feelings in oneself and in others, in the discrimination between either, and in the utilization of this information to guide the thought and the actions[20].

The concept of emotional intelligence may be thought of under the logic of the multiple intelligences by Gardner (linguistic intelligence; logical-mathematical intelligence; spatial intelligence, musical, bodily-kinesthetic, interpersonal and intrapersonal intelligence), and it is defined as an ability to perceive, assess and express emotions, yielding feelings which facilitate thought so as to be able to solve problems, besides understanding emotion and the emotional knowledge, controlling them and promoting the emotional and intellectual growth of one's own and others', through which one develops inter-relations.

Taking a doctor as a being driven to relations and the patient as that one who seeks the doctors in the form of sign and symptoms, *offering* all his/her emotions, it is noticed clearly how greatly necessary it is to carry out the development of the emotional intelligence in the teaching-learning process of medicine. This way, one may not talk about the physician-patient relationship without searching for such knowledge and skills.

The development of the emotional intelligence may be achieved through group activities, such as Learning Based on Problems (*Problem Based Learning – PBL)*, conversation circles for the solution of problems (problematizing methodology), research works developed in groups, movies discussions or theatrical plays discussions and Balint groups.

The cases studied in the PBL methodology must always, if possible, entail the emotional issues. They must not only contain just emotional issues related to the problem to be tackled with, covering a weekly goal, but must also bring along in its essence, emotional problems pertaining to the routines of medicine students.

By this, it is feasible to understand emotions as something intrinsic to human beings, both to the patient and to the doctor. At solving the students' cases, they will have an opportunity to perceive, assess and express emotions, leading to sentiments which facilitate thinking, so that it is possible to solve the problems at hand, besides facilitating the understanding of emotion and emotional knowledge, controlling them and promoting the emotional and intellectual growth of themselves and of the tutorial group colleagues'; with whom they develop inter-relations, while fully performing the concept of emotional intelligence previously mentioned.

The conversation circles or the case discussions under the perspective of the problemizing methodology are broader possibilities of this capacity development, for, contrary to the PBL cases, they are real case facts and not ones contrived by professors in order to cover certain goals. During such pedagogical activities, the following may be understood: the skills for identifying the emotions involved in the case (either the patients', the communities' or the

students'), for working out their own emotions aimed at solving problems, at responding to society and, ultimately, at developing social networks with their own colleagues and the community.

Another form of developing emotional intelligence is that of critical reflection of esthetic production. The analysis of famous artists' paintings expressing the relations between doctors and patients, of poems on human condition, of literary texts on life tragedies and above all, of movies and theatrical plays represent effective utility to the teaching-learning process of the physician-patient relationship in several medicine schools, under the perspective of emotional intelligence development. Esthetics has been relegated to second thought in the medical teaching, but, gradually, it has been recovered, pointing up a space still empty in the building of emotional intelligence. Being able to feel/capture the emotion that the author intended to pass on in his work is extremely relevant to the process. Movies discussions, for instance, has increasingly been studied and it is today, deemed a didactic methodology of vast possibilities.

The Balint group brings about, during the discussion, not only the perception of the patient's emotions and those of the reporter, but it also allows the participants to develop a critical eye, reaching out more, wherein he/she listens to the silence, being able to perform a reading of gestures, ways of looks, all in all, of the bodily mimics, thus understanding human behavior better.

Know-how, skills and attitudes for emotional intelligence

Whatever the selected didactical technique may be, it is important to bring about the learning of know-how, skills and attitudes which can support the emotional intelligence ramifications[20]. Such skills and attitudes, based on perception, understanding, analyses and reflective control of emotions once again get to promote communication between the doctor and the patient, improving the quality of the clinical meeting (consultation).

The perception, assessment and expression of emotion relate to the capability of identifying emotions in oneself and in other people, through drawings, objects and landscapes, by means of language, sounds, appearance and behavior. The latter embraces the competence of expressing emotions, needs related to feelings, as well as competences of distinguishing the difference between false expressions and the true ones.

As a facilitator of the act of thinking, the capacity of developing emotions prioritizes ideas so as to focus attention to mostly important information, contained in the previous emotive experiences in order to help the judgment of situations that they involve. The deployment of emotional know-how is the capacity of naming the emotions, interpreting the meanings which they bring up, about the interpersonal relationships. The reflexive control of emotions for promoting the emotional/intellectual growth is the capacity of one keeping himself/herself open to feelings, whether agreeable ones or not, administering the emotion in himself/herself and in others, by way of the balance / moderation of the negative ones and higher regard for the agreeable ones, without restraint or exaggeration of the psychological states which they may incite.

The training of the communicative skills is the building block of the clinical meeting / consultation. There is not a doctor-patient relation without communication. Basic theoretical concepts and proper techniques of communication must, therefore, be understood since the outset of the medical course. A doctor is an entity of relations. It is unfeasible to undertake a doctor role without interrelations with others, without the acknowledgement of inter-subjectivity. Not only for the patient, but also for his/her family, they will develop important spaces of communication with the professional. Having to give disagreeable news, for example, as letting the family know about a patient's death – may be extremely difficult for the medical professional.

In turn, the relationship within multi-professional team demands the ability of communication. Being able to talk it out with professionals of different medical/professional backgrounds, knowing how to respect their points of view, often laid out in a health team, is mostly important in medical day-to-day routines, because: *Inter-subjectivity is the primary element of social relations. "Life's world" has its ground creator of relations between individuals, heeded in their conscience perspective in mutual actions. The objective world of daily life, therefore, is the outcome of the tissue of all consciences at the same time. Inter-subjectivity is the builder and regulator of social spaces* [21].

Being able to acknowledge the relevance of inter-subjectivity highlights the need for attaining the theoretical knowledge of communication. Being able, yet, to understand the patient with his myths and cultural representations, and seek to, without disqualifying the knowledge which he/she presents, raise him out of common sense to becoming sensible, that is, acknowledge and put great store in their popular knowledge and being able to add up to it so as to teach him/her science, which is the greatest key element of promotion of health. And this competence, also, is developed by means of the communication field knowledge:

Any situation of communication develops at the same time in the inter-section of the poetic/esthetic spheres/realms of the Individual (Human Being). The communicative act's goal derives from the need to express something way beyond oneself. This expression is restricted to the necessity of naming the environment around oneself or to describing certain situations; to put it another way, the communicative act does not only target at identifying/taming symbols ("logos"), but also at the communication of affections, feelings and sensations. There is therefore, esthetics, all around the communicative act [22].

Therefore, communication is linked to emotions, that is, emotional intelligence. Communicating means to become emotional and to know how to deal with such emotions. The teaching-learning process of communication undergoes the development of emotional intelligence and esthetics, but must be widened so that the student is able to see for himself/herself at the moment he/she meets the patient.

Current skills laboratories in medical schools are equipped with mirror-filled rooms wherein the student is able to visualize a professor or even a colleague providing a service for a patient. Such patients, by and large, are theatrical actors who simulate the several ways that patients may show themselves, bringing to surface the several feelings and affections: sadness, empathy, anger, resistance to medical service, lack of mutual affection, etc. Filming the medical services, and their resulting analyses allows the patient to be able to see himself in the video and allows for discussions in respect to the service, seeking to overhaul the medical service to patients, which may base on any of the theories that support communication or even the physician-patient relationship – in case the Balint theory is utilized, there will be coherence with the Balint groups.

The constant observation and assessment of the students' capability of communication, in the tutorial groups and in other opportunities of case discussions must be carried out under the perspective of interaction with colleagues. Impersonal communication, which does not allow for a dialogue must be undermined, opening space for the competence of aggregating and warmly supporting another and other different positions. This capacity of aggregation, of communicating with people and of building up social networks must be always well valued in favor of a proper learning of the physician-patient relationship.

Along the teaching-learning process, one must constantly remember that: *The study of communication comprises in itself a theory of knowledge, ethics and esthetics. Human relations occur on the basis of mutual backgrounds of communications, and understanding by allows for a better assessment of the individual*[23] *himself.*

Final Considerations

In summary, the relevant teaching-learning process is one in which the doctor-patient relation is a scientific and humanistic field of knowledge. As such, it must be employed, researched on and attributed with theories, leaving behind the simplistic concept based off the common sense that the physician-patient relationship has an analogy with the personality of the student and with the values of his personal education.

The physician-patient relationship demand competences – knowledge, skills and attitudes which must (and can be) developed along the course of medicine, just as proposed in this article by means of the psychoanalytical theory by Balint.

As for the circumstance of the a field targeted at the promotion of dialogue between the fields of knowledge, bioethics will be capable of contributing so that such competences be, indeed, incorporated by learners of medicine, polishing up the professional practice. By attributing due value to the doctor-patient interrelations and by taking heed of ethics as a primary element of this relation, bioethics spurs on the trans-disciplinary dialogue so as to augment and foment human rights in the health front.

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