medicinska revija
medical review

UDK: 614.253:159.9

José Antº Flórez Lozano Med Data Rev 2009;1(4): 43-48 MEDICAL DATA / Vol. 1 / Broj 4 Decembar 2009.

Aktuelne teme/
Current topics

FORMULAS FOR AVOIDING COMMUNICATION ERRORS: RECOMMENDATIONS FOR IMPROVING COMMUNICATION

FORMULE ZA IZBEGAVANJE GREŠAKA U KOMUNIKACIJI: PREPORUKE ZA POBOLJŠANJE KOMUNIKACIJE

Correspondence to:
E-mail: jaflorez@telefonica.net

José Antº Flórez Lozano

Šef katedre za nauku o ponašanju pri odseku za medicinu Univerziteta u Ovjedu, Španija/
Head of Department of Behavioral Science at the Medical Department of the University of Oviedo, Espana

Prevod na srpski: Snežana Mikić
Prevod na engleski: Vladimir Ristić

"Preciznost, kao i izvesnost, su lažni ideali.
Nemoguće ih je dostići i... trebalo bi se odreći i jednog i drugog.
Nikad ne treba pokušavati da se bude precizniji
Od onoga što zahteva stanje problema"
Karl Popper

UVOD

U komunikacionim procesima učestvuje veliki broj komponenata, od kojih su neke poznate, dok su druge potpuno nepoznate, i one u velikoj meri otežavaju ili ometaju sadržaje komunikacije, što dovodi do toga da se na kraju pojave greške, koje se prevode u psihičke disfunkcije pacijenta.

Različiti elementi komunikacije (držanje tela, pogled, ćutanje, reč, manuelni kontakt, ambijent, instrumentalni odnos, itd.), u ogromnoj meri uslovljavaju tok komunikacije, obzirom da svi faktori komunikacije generalno deluju u celosti. Ovi elementi nisu uvek od iste važnosti, već su samo neki od njih protagonisti u datom trenutku komunikacije; ostali faktori (ostatak tela) smeštaju se u drugi plan, i, najzad, takođe treba imati u vidu posebne i privremene okolnosti u kojima se odvija komunikacija.

Svaki fundamentalni element, kao što je, na primer pogled, ima višeznačne perspektive i značenja (srdačan, otvoren, zaštitnički, ispitivački, zahtevajući, izazivački, neodlučan, itd.). Naravno, lako je pomisliti da ukoliko kontrolišemo sve ove elemente komunikacije, mogućnost da se počini greška u prenosu poruke je veoma velika.

U određenim okolnostima, naročito kod onkoloških bolesnika, duševno stanje učestvuje u percepciji poruka i u isto vreme ova percepcija simultano utiče na emocionalno i osećajno stanje obolelog. Mnoge od ovih komunikacija imaju osnovni smisao da ublaže bol i poboljšaju kvalitet života pacijenta. Međutim, kao što smo već napomenuli, greške u prenosu poruka mogu imati upravo suprotan efekat.

"Precision, the same as certainty, is a false ideal.
It is impossible to reach them and... One should renounce both of them.
One should never intent to be more precise
Than the problem situation requires"
Karl Popper

INTRODUCTION

In the communication processes the significant number of components is taking part. Some of them are known, while others are completely unknown. They complicate and disturb the communication contents in great measure, which eventually leads to committing errors and translates into psychological dysfunctions of patients.

Different elements of communication (body language, look, silence, word, manual contact, ambience, instrumental relationship, etc.), are conditioning communication flow in great measure, bearing in mind that all the communication factors generally act in their wholeness. These elements are not always of equal importance; only a few of them are protagonists in a given moment of communication; other factors (rest of the body) are in the background, and finally, it is important to bare in mind special and temporary circumstances in which the communication is going on.

Every fundamental element- for example view - has ambiguous perspectives and meanings (cordial, open, protective, investigating, demanding, provoking, indecisive, etc.). Of course, it's easy to think that if we control all those communication elements, the possibility of committing error in message transmission is very high.

In certain circumstances, and especially in oncology patients, the state of soul participates in the perception of messages, and at the same time, this perception simultaneously influences the emotional and emotive state of a sick person. The primary function of most of these communications is to alleviate pain and improve patient's quality of

U situacijama u kojima se često nalaze ove osobe (bol, mučnina, suvoća usta, pospanost, itd.), mogućnosti "pravljenja greške" su ogromne, između ostalog, zato što anksioznost, odnosno teskoba, očigledno učestvuju u komunikaciji na taj način što iskrivljuju poruke. Pacijent čuje ono što kaže lekar, ali prihvata ono što želi da čuje. Često, pred ovakvim stepenom kompleksnosti, lekar želi da u potpunosti izbegne pitanja pacijenta, koristeći čisto akademski jezik. Tako, na primer, lekar kaže: "Videćete da biopsija ukazuje na prisustvo hepatokarcinoma koji kompromituje metaboličke funkcije, pa ćemo stoga nastaviti sa hemioterapijom da bismo uništili maligne ćelije". Naravno, ovakav veoma raširen jezik dovodi do skoro potpune blokade komunikacije.

U drugim prilikama, jednostavno može postojati emocionalna interferencija u ravni komunikacije. Lekar, odnosno medicinska sestra, nisu bili u stanju da uspostave ovako dubok nivo interakcije, na kome se bazira terapeutsko poverenje. Ovi emocionalni aspekti (koji su ponekad nesvesni; na primer, neprijateljstvo, osećanje krivice, itd.) imaju negativno dejstvo na ravan komunikacije. Zapravo, iza mnogih lekarskih grešaka, nalazi se neprijateljstvo (prema pacijentu ili prema samom sebi). Određeni pacijenti zbog svojih ličnih karakteristika (loše higijene, neprijatnih mirisa, zatim, ako su agresivni, nepoverljivi, zahtevni, popustljivi itd.) mogu da generišu takav stil komunikacije koji dovodi do mnogih grešaka. Možda je "neprijateljstvo" osećanje koje je najviše izdajničko za lekara, jer ni na koji način nije prihvatljivo. Priznajući ga, značilo bi suočiti nas sa idealima koji pretpostavljaju lekarski poziv (predavanje, vokacija, etika, razumevanje, itd.) Upravo se ova agresivnost može prevesti na smanjenje komunikacije svake vrste, u povećanje medijacije (da više ne bi zamarao), u slabu posvećenost, nedostatak brižljivosti kod nege, itd. Ali, osim toga, vrlo često nailazimo na paraverbalesne izraze, koji se nalaze između reči i gesta i koji izražavaju različite emocionalne situacije (uzdahe, isprekidane slogove, itd.), koji u veoma velikoj meri otežavaju komunikaciju.

S druge strane, obolela osoba suočena sa veoma zlosrećnom simptomatologijom, može naći pribežište u mehanizmu "negiranja" (uprkos očiglednim simptomima), u cilju neutralizovanja straha i anksioznosti. Ovakvo psihološko "prikrivanje" takođe može lako objasniti greške u komunikaciji.

Za mnoge lekare je odnos sa teškim ili umirućim pacijentima naročito težak; Ovakva situacija može pretpostavljati pretežak teret. Pa ipak, i samo njegovo prisustvo, znači prihvatanje i priznavanje u trenutku kada se oboleli oseća sam i napušten. Da bi se započela ovakva komunikacija, od fundamentalnog je značaja sesti pored pacijenta i pitati ga da li je voljan da priča. Može nas iznenaditi koliko mnogo pacijenata zahvaljuje na ovakvoj mogućnosti, na ovakvoj prilici za komunikaciju.

Na primer, može potražiti da mu pokaže album sa porodičnim fotografijama; ovo pacijentu daje mogućnost da sagleda svoj život i da se priseti svojih najsrećnijih dana. Ne osećaju svi pacijenti potrebu da pričaju, ali svi oni žele (i svima je potrebno) da komuniciraju kako bi izrazili svoje strahove, nade i verovanja. Iskrenost lekara, njegova samilost, njegovo poštovanje i velikodušnost, mogu biti najvažnije oružje za održavanje ovog dubokog nivoa socijalne interakcije.

life. But, as we already mentioned, errors in message transmission can have exactly the opposite effect.

Because of the situations in which these persons often find themselves in (pain, nausea, mouth dryness, sleepiness, etc.), the possibilities of "committing errors" are enormous, because anxiety, or angst, among other reasons, obviously participate in the communication in a way that they distort the messages. The patient hears what the doctor says, but accepts what he wants to hear. Many times, faced with such a grade of complexity, the doctor wants to avoid completely patient's questions, by using merely academic language. To give an example, the doctor says: "You will see that the biopsy indicates the presence of hepatocarcinoma which compromises metabolic functions. So, due to that fact, we will continue with chemotherapy, in order to destroy malignant cells." Certainly, such a language, which is very spread out, leads to the almost total blockade of communication.

In other occasions, there could be only emotional interference at the level of communication. A doctor, i.e. a nurse, was not able to establish such a deep level of communication, on which the therapeutical confidence is based. These emotional aspects (which are sometimes unconscious; for example, hostility, feeling of guilt, etc.) have negative effect on the level of communication. In fact, behind numerous medical errors is hostility (towards the patient or towards his own self). Certain patients, due to their personal characteristics (bad hygiene, unpleasant smells, or, if they are aggressive, distrustful, demanding, yielding, etc.) can generate such a communication style that could lead towards many errors. Perhaps "hostility" is the most betraying feeling for the doctor, since it is not acceptable in any way. To recognize it, would mean to face ourselves with ideals which are expected from medical professionals (dedication, vocation, ethics, understanding, etc.)

Exactly this aggressiveness could be translated to the reduction of communication of any kind, and an increase in mediation (so he could not bother anymore), in weak dedication, lack of attentiveness in the care, etc. But, besides, very often we are founding paraverbal expressions, which are somewhere in between of the word and the gesture, which express different emotional situations (sighs, broken syllabics, etc.), which difficult the communication in great measure.

On the other hand, a sick person faced with a very unfortunate symptomatology, can find refuge in the mechanism of "denial" (in spite of obvious symptoms), in order to neutralize fear and anxiety. Such psychological "cover" can easily explain the communication errors.

For a lot of doctors, the relationship with hard to work with or dying patients is especially hard; such a situation can be a heavy burden. However, only its presence means acceptance and acknowledgement in the moment in which a sick person feels alone and abandoned. To start such a communication, it is of fundamental importance to sit by the patient's side and ask him if he is willing to talk. We can be surprised how many patients express gratitude for giving them such an opportunity for communication.

For instance, the Doctor can ask the patient to share his family photo album; this is to offer the patient possibility to perceive his life over again and to recall his happier days. Not all the patients feel necessity to talk, but all of them want (and they all need) to communicate, in order to

U nekim slučajevima, "fatalistička" situacija i "stres" koje doživljava pacijent, očigledno utiču na komunikaciju. Isto tako, "mehanizmi odbrane ličnosti" sprečavaju da pacijent obavi lečenje i omogućavaju da "negira" da prihvati težinu svoje bolesti. Moguće je da pacijent i njegova porodica "koriste" bolest kako bi stabilizovali neki težak odnos. Svi ovi psihološki faktori, svesni i nesvesni, utiču na interakciju "lekar-pacijent", omogućavajući pojavu važnih "grešaka u komunikaciji".

Ponekad se, kod nekih pacijenata, susrećemo sa veoma značajnom patologijom u komunikaciji, čak više nego sa greškama. Zapravo, mogu se pojaviti delirantne ideje (gonjenja, grandioznosti, religiozne, itd.) kao posledica izvesnih oštećenja mozga. Ponekad je jezik potpuno dezorganizovan, uključujući neologizme koji očigledno narušavaju efikasnu komunikaciju. Kod organskih delirijuma, indukovanih metastazama na mozgu, pacijent generalno pati od vremensko-prostorne dezorijentacije, pogrešno tumači pitanja koja mu se postavljaju, ima sklonost ka brkanju osoba, i često pati od vizuelnih halucinacija i iluzija. Lekar može pogrešno tumačiti značenje izvesnih stavova ili može da ne razume značenje određenih reči, ili može bukvalno da shvati figurativne izraze, ili obrnuto. Verovatno nam lična analiza i autorefleksija omogućavaju da saznamo učestalost, poreklo i okolnosti pod kojima dolazi do grešaka u komunikaciji. Nije psihološki adekvatno verovanje "ja nikada ne grešim" jer čak i ovakvo razmišljanje realno nameće razmatranje, analiziranje i spoznavanje grešaka u komunikaciji a konsekventno tome, ne bismo mogli da dostignemo bolji nivo tretmana onkološkog pacijenta.

Aktivno slušanje je, besumnje, magistralna formula za izbegavanje većeg broja mogućih grešaka u komunikaciji. Ali, u isto vreme i u ovom smislu, želim da naglasim da se radi o jednoj suštinski humanoj tehnici koja utvrđuje osnovni princip terapije koncentrisane na ličnost (Rogers, 1980). Lekar, odnosno medicinska sestra, koji primenjuje ovu tehniku na kanceroznim pacijentima, može na istima da primeti veliko zadovoljstvo. Nažalost, mnogi zdravstveni radnici ne "informišu" svoje pacijente a još manje ih slušaju. Mclntosh (1974) je sproveo brojna istraživanja na polju ove problematike.

Što se tiče želje da se poseduje informacija o bolesti od koje pacijent boluje, potvrdilo se da oboleli žele da znaju; više vole da budu informisani nego da žive u neznanju (Mclntosh, 1974). Dakle, aktivno slušanje je takođe jedan vid komunikacije. Terapeuti koji primenjuju ovu tehniku, koncentrišu svoju pažnju na svesnu autopercepciju pacijenta, više nego na svoja sopstvena tumačenja kao terapeuta.

U ovom procesu "aktivnog slušanja" lekar i medicinska sestra "slušaju" bez prosuđivanja i tumačenja.

Osnovno je da se suzdrže od usmeravanja pacijenta prema određenim percepcijama. Ova terapija se naziva "nevođena terapija", upravo zato što se "fokusira" na ličnost i, na izvestan način, usmeravamo pacijenta prema određenim poljima njegovog psihološkog života. Pacijent, u ovom smislu, ima apsolutnu slobodu da se iskaže i da izrazi svoja osećanja, odnosno teskobu što na izvestan način dovodi do značajnog psihološkog olakšanja.

Kada lekar, odnosno medicinska sestra, omoguće da se pacijent oseti bezuslovno prihvaćenim, on im takođe pomaže u shvatanju samog sebe i u prihvatanju samog sebe.

express their fears, hopes and beliefs. The doctor's sincerity, compassion, respect and generosity, can be the most important tool for maintaining this deep level of social interaction.

In some cases, the defeatist mentality and "stress" experienced by the patient have obvious influence on the communication. Also, the "defense mechanisms of personality" impede that the patient carry out the treatment, and they permit that he "denies" accepting the burden of his disease. It is possible that the patient and his family "use" the disease in order to stabilize a difficult relationship. All those psychological factors, conscious and unconscious, influence on the interaction "doctor-patient", making possible the commitment of important "communication errors".

Sometimes, in some patients, we notice very significant pathology in communication, even more than we notice the communication errors. In fact, delirious ideas can appear (of persecution, grandiosity, religious, etc.) as a consequence of certain brain damages. Sometimes the language is totally disorganized, including the use of neologisms, which obviously disturb efficient communication. In case of organic deliria, induced by metastases to brain, the patient generally suffers the time-space disorientation, erroneously interprets the questions directed to him, has tendency to mix up persons, and often suffers visual hallucinations and illusions. The doctor can erroneously interpret the meaning of certain attitudes, or can not understand the meaning of certain words, or can understand literarily figurative expressions, or vice versa. Probably the personal analysis and autoreflection enable to find out the frequency, origin and circumstances under which the communication errors are made. "I never make mistakes" is a psychologically inadequate belief because such a way of thinking realistically imposes consideration, analysis and cognition of the communication errors, and consequently, we wouldn't be able to reach better level of treatment of the oncology patients.

The active listening is, without doubt, the magisterial formula for avoiding a great number of possible communication errors. At the same time I would like to emphasize that this is an essential human technique which determinates the basic principal of the therapy concentrated on personality (Rogers, 1980). The doctor, or nurse, who uses this technique on cancerous patients can notice greater content on them. Unfortunately, most of medical stuff doesn't "inform" their patients, and even less listen to them. Mclntosh (1974) made numerous studies in the sphere of this problem.

Concerning the patient's desire to have the information about the disease he or she has, it was confirmed that they do want to know; they prefer to be informed than to live in ignorance (Mclntosh, 1974). So, the active listening is also one aspect of communication. The therapists, who apply this technique, concentrate their attention on the conscious autoperception of the patient, more than on their own interpretations as therapist.

In this process of "active listening", the doctor and the nurse "listen" without judging and interpreting. They need to keep themselves from aspiring patient to have certain perceptions. This therapy is called the "unguided therapy," because it "focuses" on personality and, in some way, helps guide the patient towards certain parts of their psychological lives. Patient, in this sense, has the complete liberty to

Kada zaista slušam neku osobu ili nekog pacijenta, sintetišem značenja koja su važna, slušam ne samo njegove reči, već i samog čoveka (u njegovom psihičkom integritetu). Kada stavimo na znanje pacijentu da smo čuli njegova sopstvena i intimna lična značenja, dešava se mnogo toga. Pre svega, tu je zahvalan pogled, pacijent ponovo zadobija slobodu; on je autentični protagonista, jedini zaista odgovoran i, naravno, važniji od svoje bolesti.

Često možemo da primetimo da što pažljivije možemo da slušamo, više toga se dešava. Skoro uvek kada osoba primeti da je pažljivo slušana, ovlaže joj se oči; u realnom smislu, verovatno plače od radosti. To je kao da kaže: Konačno me je neko saslušao! Neko zna šta znači biti kao ja! Tada dolazi do dubokog sklada u svim procesima komunikacije, i postiže se uspostavljanje reda u svim poremećujućim elementima ljudske psihe. U isto vreme, lekar, odnosno medicinska sestra, može da oseti veliko lično zadovoljstvo, jer shvata da može da učini mnogo više od onoga što je uobičajeno, što rutina bolničkog postupka nemilosrdno nameće. Zdravstveni radnik se takođe susreće sa samim sobom.

S druge strane, aktivno slušanje pretpostavlja različite postupke koji uključuju ponavljanje, reformulisanje, traženje pojašnjenja onoga što pacijent izrazi i priznavanje iskazanih osećanja. Lekar sme da prekine pacijenta jedino da bi reformulisao i potvrdio osećanja pacijenta, da bi prihvatio ono što pacijent izražava, ili da bi potražio neku vrstu pojašnjenja. Lekar može da se oseti bezgranično strpljiv, i osim toga, da se uzdrži od davanja suda.

Imajući u vidu obavljenu psihološku analizu, izgleda da je lako razumeti zašto dolazi do mnogobrojnih grešaka u komunikaciji. Pre svega, neverbalni znaci mogu lako da indukuju mnogobrojne greške, odnosno teškoće; to znači da treba biti krajnje obazriv u izražavanju, putem koga, ishitreno čitamo mnoge poruke i donosimo mnoge pogrešne zaključke. Na drugom mestu, semantika takođe može lako da prouzrokuje teškoće u komunikaciji, obzirom da jedna reč ili rečenica može imati više od jednog značenja. Na primer, rečenica "Ovo je strašno", ne mora nužno da znači da se radi o ličnoj patnji koja ne može da se prevaziđe, već naprotiv, može da ima potpuno suprotno značenje. Na trećem mestu, nedostatak vremena je drugi fundamentalni element koji može da indukuje veoma bitne greške. Naravno, u kratkom vremenu ne možemo da uhvatimo poruku, različite kanale komunikacije i, kao posledica toga, dolazi do grešaka

Drugi faktor koji treba naglasiti je memorija. Analizom radova koji su se bavili ovim problemom, koju su sproveli Ley i Spielman (1976), pokazala je da je između 37% i 52% onoga što je rečeno pacijentu, zaboravljeno po isteku relativno kratkog vremenskog intrvala, između 10 i 80 minuta. Kao što je poznato, u bolničkom okruženju često dolazi do rupa u memoriji, veoma bitnih grešaka koje se duguju bolničkom okruženju, višestrukim informativnim podacima (uključujući i one kontradiktorne), farmakološkom lečenju, stresu, itd. U ovim okolnostima, memorija slabi i pacijent počinjava greške, isto kao i lekar. Na taj način su mnogi propusti u komunikaciji prouzrokovani jednostavnim problemima razumevanja i memorije. Što se tiče razumevnja pacijenta, Ley (1976) ukazuje na tri faktora koji imaju veze sa teškoćama u razumevanju poruke. Na prvom mestu, teškoća samog materijala; na drugom mestu, odsustvo znanja pacishow and express his or her feelings, or hardship that in a way leads to feeling a lot better psychologically.

When a doctor, or a nurse, gives the patient an opportunity to feel unconditionally accepted, the patient also helps them with understanding himself and with accepting himself. When I really listen to a person or a patient, I synthesize the important facts, listen to their words, the whole person (in their psychological integrity). A lot of things happen when we point out to the patient that we heard his own intimate and personal feelings. Above all else, there is a look of gratitude in the patient's eyes, and they feel that they gained more freedom. He or she is an authentic protagonist, the only one truly responsible and, of course, more important than the disease which they have.

Often we can notice that the more carefully we listen, more things happen. Almost always when a person notices that they are carefully listened to, their eyes become watery; perhaps because those are tears of joy. That's like if they are saying "Finally someone listened to me! Somebody understands how it feels to walk in my shoes!" That's when it all deeply comes together in all aspects of communication, and order is established in all disarraying elements of human psyche. At the same time, doctor, or nurse, can feel great personal pleasure because they understand that they can do much more than the usual cruel hospital routine. Health worker also becomes more in touch with himself.

On the other hand, active listening presumes different actions that include repetition, reformulating, asking for clarification from the patient, and acceptance of shared emotions. The doctor can interrupt the patient only to reformulate and confirm patient's emotions, to accept what the patient is expressing, or to look for some sort of clarification. Doctor can feel endlessly patient, and besides, to refrain himself from judging.

Having considered the completed psychological analysis it is easy to understand why it comes to multiple errors in communication. Above everything, nonverbal signs can easily induct multiple errors, or difficulties. That means that we need to be very careful in expressing ourselves over which we hastily read many messages and make a lot of bad conclusions. On second place, semantics can also easily create nuisance in communication, considering that one word or a sentence can have more than one meaning. For example, a sentence "This is horrible" does not necessarily mean personal suffering that cannot be overcome, au contraire, it can have a completely opposite meaning. In third place is the lack of time as another fundamental element that can induct serious mistakes. Naturally, in short period of time we can't fully comprehend the message, different channels of communication and, as a result, that leads to errors.

Second factor that needs to be mentioned is memory. Analyzing the studies of this problem, which were conducted by Ley and Spielman (1976), it was shown that between 37% and 52% of what is said to the patient is forgotten after relatively short period of time – between 10 and 80 minutes. It is familiar that holes in memory occur often in hospital environment, very important errors that are owed to hospital environment, multiple pieces of information (including the contradicting ones), pharmaceutical healing, stress, etc. Under these circumstances, memory is weakened and the patient commits errors, same goes for the doctor. Many

jenta, i najzad, stidljivost pacijenta. Ličnost konstituiše drugi faktor koji povlači mnoge probleme u međuljudskim odnosima, svakako, u efikasnosti komunikacije. "Stidljiva" osoba, što je veoma čest slučaj u odnosu lekar-pacijent, ima mnogo problema u mogućnosti razumevanja i shvatanja onoga što se kaže, ne postavlja pitanja, ne pravi primedbe, ne izražava osećanja, itd. Ovakav profil ličnosti nosi sa sobom nedostatak poverenja kod pacijenta, koji ga zapravo spečava da traži više informacija od lekara, odnosno medicinske sestre. Ovakva psihološka blokada pacijenta, takođe nosi sa sobom izvestan stepen straha koji se može objasniti, moguće, u disimetričnom odnosu koji je uspostavljen sa pacijentom.

Zbog toga je zapravo značajno izraziti ovakve crte ličnosti da bi moglo da se deluje korektno u odnosu na pacijenta.

Moguće je takođe da su problemi vezano za emocionalnu nestabilnost (tuga, inhibicija, agresivnost, bes, itd.), kako kod pacijenta, tako i kod lekara, uzrok brojnih grešaka, i da čak sprečavaju efikasnu komunikaciju. Isto tako, anksioznost prouzrokovana stanjem bolesti, obično je praćena neizvesnošću, što dovodi do toga da se traže indicije u sredini koja će mu pružiti smernice u pronalaženju načina kako treba da se oseća u ovakvoj situaciji. Zapravo, stanje anksioznosti pretpostavlja "hiper-upozorenje" u sistemu komunikacije i recepcije koja određuje poremećaje pažnje i koncentracije. Greške u komunikaciji u ovakvim posebnim psihofiziološkim okolnostima su veoma bitne; komunikacije praktično nema, jer u osnovi pacijentom vladaju uznemirenost, nervoza, hiperaktivnost, iritabilnost, muskularna tenzija, itd.

Naravno, u ovakvim uslovima autoimago, odnosno slika o samom sebi i samopoštovanje kod ovih pacijenata, obično su veoma poremećeni; zbog toga je veoma važno da lekar, odnosno medicinska sestra, može da poboljša pozitivne i adaptivne aspekte pacijenta, jačajući ovakvo ponašanje, kako bi ispoljio pozitivan stav prema lečenju i pokazao minimalne pomake u ovom pravcu

Kao što je poznato, značajan procenat onkoloških pacijenata ima prisilnu osećajnost na polu tuge, pokazujući takođe nedostatak interesovanja u svim delatnostima; u isto vreme, njihovo lice je tužno i sa velikim "podočnjacima", u trenucima kada imaju iscrpljujuću blokadu misli. Postoji mogućnost da se kod pacijenta pojave osećanja odvajanja, gubitka, raspadanja, nesposobnosti, odnosno napuštenosti, čime se greške u komunikaciji progresivno povećavaju.

Sa druge strane, suštinska komponenta u analizi ovog fenomena je sposobnost lekara, odnosno medicinske sestre, da može da ispita informaciju i da je sintetiše na razumljiv način. U nekim slučajevima, takođe može biti ugrožen terapeutski odnos i razumevanje, zbog nesvesnih projekcija lekara na pacijenta. Lekar, odnosno medicinska sestra, koji nije u potpunosti razrešio svoj odnos sa jednim od roditelja, može da doživi različita osećanja (privlačenje, nežnost, krivicu, srdžbu, itd.), koja mogu da otežaju ili poremete komunikaciju. Ovakva osećanja mogu da determinišu neadekvatno terapeutsko ponašanje; tako možemo da naiđemo na lekara koji se oseća "obaveznim" da "spasi" pacijenta, kao posledica neverovatne fizičke sličnosti ili sličnosti u ponašanja pacijenta i lekarevog oca; čak može da ostvari "nadkompenzaciju" tako što će ustanoviti slabo realistične terapeutske perspektive.

lapses in communication are committed this way because of the simple problems of understanding and memory. When it comes to understanding the patient, Ley (1976) points to three factors that have connection to difficulties in understanding the message. In the first place, the difficulty of the material itself; secondly, patient's lack of knowledge and finally, the shyness of the patient. Personality constitutes the second factor that attracts many problems in interpersonal relationships, especially in the efficiency of the communication. "Shy" person, which is a very common case in doctor-patient relation, has a lot of problems with the ability to understand and comprehend what is said, doesn't ask questions, doesn't make remarks, does not express emotions, etc. This kind of a patient personality profile carries with itself lack of trust, which is exactly the reason that prevents them from asking their doctor or nurse for more information. This kind of patient's psychological blockade also carries a certain level of fear that can be explained perhaps in dissymmetric relationship that was established with the patient.

This is exactly why it is important to express these personality characteristics in order to deal with the patient in a proficient, correct manner.

It is also possible that the problems related to emotional instability (sorrow, inhibition, aggressiveness, anger, etc.), in both patients and doctors, are a cause of multiple errors, and that they prevent effective communication. Same way, anxiousness cause by the condition of the disease is usually followed by uncertainty, which leads to seeking indications in the environment that will provide him with guidance in finding a way of how to feel in this situation. The state of anxiousness sets up a "hyper-warning" in the system of communication and reception that sets attention and concentration disorders. Errors in communication in these special psycho-physiological circumstances are very important; communication practically doesn't exist because the patient is guided by fear, nervousness, hyperactivity, irritability, muscular tension, etc.

Of course, in these kind of circumstances autoimage, or picture of yourself and self-respect amongst these patients, is usually very troubled. This is why it is important that a doctor, or a nurse, improve positive adaptive aspects of the patient, strengthening this behavior so positive attitude towards healing is exposed and so minimal improvements in this direction are made.

It is known that a serious percentage of oncology patients have forcing feelings on the pole of sorrow, also showing the lack of interest in all activities. At the same time, their face is sad, with big "eye bags," in the moments when they experience draining blockade of thoughts. There is a possibility that patients start to experience emotions of separation, loss, falling apart, incapability, and being abandoned with what the errors in communication are expanded.

On the other hand, core component in analyzing this phenomenon is the ability of the doctor, or nurse, to be able to explore the information and to synthesize it in a coherent manner. In some cases therapeutic relationship and understanding can also be endangered because of subconscious projections that doctors have on patients. Doctor, or nurse, that doesn't have a stable relationship with one of the parents can feel a lot of different emotions (attraction, kindness, guilt, rage, etc.) that can complicate communication.

Kao posledica toga, vidimo da postoje brojne greške u komunikaciji; zbog toga, realno je neophodno razviti strategiju koja treba da uključi tri faze, kako bi se umanjila ova problematika, intenzifikujući naročito "insight" sposobnost lekara.

Tri postupka, koja nisu nužno razdvojena, dozvoljavaju lekaru da osigura jasnoću informacije. Navedeni procesi pokušavaju da postignu sistematičnost u lečenju pacijenta. Tako na primer, u fazi verifikovanja, pokušavamo da verifikujemo i osporimo primljene poruke: "rekao si da", "zapravo želiš da kažeš da", "dakle, kažeš da"...

U pojašnjavanju, kao što i sama reč kaže, pokušavamo da još više pojasnimo dobijenu informaciju, dajući u tom cilju više informacija i više objašnjenja. Lekar treba da uspe da stimuliše pacijenta da mu postavlja onakva pitanja kakva želi vezano za sve sadržaje njegovog mentalnog života, striktno vezano za proces bolesti.

Najzad, u praćenju, pratimo ispunjenje odluka donetih u ličnim razgovorima, odnosno intervjuima. Radi se o odlukama vezano za lični život (ostavljanje pušenja, upražnjavanje fizičkih vežbi, slušanje muzike, itd.), porodični i poslovni. U ovom procesu praćenja, pravimo jednu autentičnu analizu ličnog ponašanja pacijenta u cilju ojačanja onih aspekata koji su najznačajniji za zdravlje i za sreću pacijenta.

Jedino na kraju, uz strpljenje, pripremu i izuzetan senzibilitet, moći ćemo da poboljšamo komunikaciju, da umanjimo greške i poboljšamo kvalitet pomoći koju pružamo pacijentu, što je najvažniji cilj naše zdravstveno-socijalne pomoći.

These kinds of feelings can determine inadequate therapeutic behavior. This is why we can run into a doctor that feels "obligated" to "save" the patient as a result of the patient's incredible physical or behavioral similarity to the doctor's father. This can even realize "overcompensation" by establishing almost unrealistic therapeutic perspectives.

As a consequence of that, we see that there are numerous mistakes in communication. In order to minimize this problem, it is necessary to develop a strategy that needs to include three phases that will intensify on "insight" of the doctor.

Three steps that are not necessarily separated allow doctor to make sure about the clarity of information. Mentioned processes are in place to try to achieve systematic in healing a patient. In verification phase, we try to verify and place in doubt received messages, for example "you said that … but you actually meant to say that…," "so you say that…"

In clarification stage we are simply clarifying the received information, and getting more information and more explanation. Doctor must succeed in stimulating the patient that he asks him the questions he wants that are strictly related to the contents of his emotional life, and the process of disease.

Finally, in the follow-up stage, we are evaluating how much did the patient actually do of what he said he was going to throughout the previous interviews and conversations. This is about the decisions related the personal (quitting smoking, doing physical activities, listening to music, etc.), family, and work lives. During the follow-up process we are creating an authentic analysis of personal behavior of the patient in order to strengthen those aspects that are the most important for health and happiness of the patient.

In the end, only with patience, preparation and remarkable sensibility we are able to improve communication, to minimize the mistakes and improve the quality of care that we are giving to the patient, which is the most important goal of our health-social care.

REFERENCES

1. Mcintosh J. *Process of communication, information seeking and control associated with cancer: a selective review of the literature.* Soc Sci Med (England) 1974;8(4):167-187.
2. Argyle M. *Psicología del comportamiento interpersonal*. Alianza Editorial, Madrid, 1978.
3. Blondis M, Jackson BE. *Non verbal communication between patients and medical practitioners*. J of Soc Issues 1979;35(1):82-99.
4. Knapp ML. *La comunicación no verbal.* Edit. Paidós, 1982.
5. Nogales Espert A. *La comunicación, una actividad fundamental en el trabajo de Enfermeria.* Notas de Enfermeria 1991;1(6):37-48.
6. Laín Entralgo P. *La relación "médico-enfermo".* Rev de Occidente. Madrid, 1964.
7. Rodrigo Alsina M. *Los modelos de comunicación.* Edit. Tecnos, Madrid, 1989.
8. Soria Murillo. *Relaciones humanas.* Limusa, México, 1986.
9. Urraca Martínez S. *El papel del médico y el paciente en la consulta*. Rev El Médico 1986;187:68-73.
10. Reig Ferrer A, Rodríguez Marín J. *Aspectos psicológicos del incumplimiento de las prescripciones terapéuticas y estrategias de modificación.* Enfermería Científica 1985;39:20-26.
11. Hauss K. *Fundamentos de psicología médica.* Edit. Herder, Barcelona, 1982.
12. Recalde V. *Enfermería y comunicación.* Rev Rol de Enfermería 1994;186:41-42.
13. González Felipe MA, Arribas C. *La comunicación no verbal y la investigación sobre la influencia de la misma en los cuidados de enfermería*. Enfermería Científica 1985;44:18-22.
14. Miquel y Suárez-Inclán R. *El tacto, psicoanálisis del quinto sentido*. Rev El Médico 1991;4(5):84-90.
15. Ricci PE, Cortest S. *Comportamiento no verbal y comunicación. Barcelona*. Gustavo Gili, 1980.
16. Davis F. *La comunicación no verbal.* Madrid, Alianza Editorial, 1973.
17. Corrace J. *Les communications non verbales.* Paris, P.U.F., 1980.
18. Flórez Lozano JA. *Aspectos psicopatológicos relacionados con el cansancio de la vida.* Medicina Integral 1994;24(4):184-187.
19. Flórez Lozano JA. *Medios de comunicación y psicopatología infantil*. Rev Medicina Integral 1995;25(6).
20. Flórez Lozano JA. *Aspectos psicológicos de la muerte*. Rev Medicina Integral 995;25(8):378-386.
21. Flórez Lozano JA y Pérez Fernández M. *El estrés en la adolescencia: Estilos de afrontamiento.* Rev. Medicina Integral 1995;26(6):274-279.

Rad po pozivu / Invited paper - Received 20.10.2009.