

5 Clinical Dances: The Doctor-Patient Relationship in Different Infectious Diseases. Chapter 4. Gastrointestinal Infections (The Charleston)

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Abstract

The importance of the doctor-patient relationship is evident in its proven influence on healthcare outcomes. A good doctor-patient relationship is a process of alliance building: a process in which the doctor adapts to the patient's pace and can gradually help them achieve better results; that is, detecting 'what style of care the patient is following.' But there is no single 'good' or 'appropriate' type of doctor-patient relationship; there is no single style of care for all patients. Using this metaphor, the main concepts of 'clinical care' are explained with patients presenting with infectious diseases: 1. HIV/AIDS (Contact/Improvisation), 2. Urinary Tract Infection (Fast Rock & Roll), 3. Respiratory Infections (Twist), 4. Gastrointestinal Infections (The Charleston), and 5. Sexually Transmitted Infections - STIs (Ravel's Bolero/Crescendo Dance). Assigning a style of care to the doctor-patient relationship in different clinical scenarios illustrates the flexibility, pace, and attitude that the practitioner must adopt. To apply patient-centered communication techniques to each of the five clinical "dances," the physician must adapt their verbal and nonverbal skills to the rhythm of each infectious disease. To put this metaphor into practice or use it in teaching, a specific dialogue script or role-playing exercise is presented for each of the five dances, illustrating the critical moment in the consultation when the physician applies the patient-centered communication technique to adapt to the patient's pace. Here, a case study of a doctor-patient interview with Gastrointestinal Infections is presented using the "The Charleston" metaphor: the technique is empathetic directivity.

Keywords: Doctor-Patient Communication and Relationship; Patient-Centred; Infectious Diseases; Gastrointestinal Infections; Metaphor; Medical Education; General Practice

Introduction

The importance of the doctor-patient relationship is evident in its proven influence on the outcomes of medical care. Within the doctor-patient relationship, there exists a form of psychotherapy where the doctor and patient work together to improve psychopathological conditions (1). The doctor-patient relationship can vary depending on the pathology (2-4). In chronic illness, there is a prolonged course with the appearance of less obvious, more subtle symptoms, with less clinical resonance than in acute illness. The person with a chronic illness has a different experience of illness and a different pathological-biographical content than the experience of illness in an acute patient (5). Likewise, it depends on multiple conditions, some related to the doctor, others to the patient as an individual or as a person, and others to the situation (6). Given that these concepts of doctor-patient relationship and patient-centered consultation have multiple facets, they are complex to understand and teach. The use of a metaphor is a tool that can be helpful. A "good" doctor-patient relationship is a process -

of creating an "alliance": a process in which the doctor adapts to the patient's pace and can gradually help them move toward healthier scenarios. This means detecting "what dance the patient is dancing" and, like a good dancer, taking a step back, then a step forward, dancing and keeping time with the patient (7).

But there isn't just one type of "appropriate" doctor-patient relationship; there isn't "just one dance the patient dances." To apply patient-centered communication techniques to each of the 5 clinical "dances" the doctor must fine-tune their verbal and nonverbal skills to the rhythm of each of these different infectious diseases.

Here, a case study of a doctor-patient interview with Gastrointestinal Infection is presented using the "The Charleston" metaphor.

SPECIFIC DIALOGUE SCRIPT (ROLE-PLAYING) IN GASTROINTESTINAL INFECTION

Charles, 34, a salesman. He's been suffering from watery diarrhea, severe cramps, and nausea for 48 hours. He arrives sweaty, exhausted, and visibly distressed by the urgency of his symptoms.

Patient: "Doctor, I'm sorry to be so direct, but I need you to give me something right now to stop this. I've been running to the bathroom every half hour for two days, I can't even sit down comfortably because of the pain, and I have a crucial sales presentation tomorrow. Give me a strong antibiotic intravenously if you have to, but stop this."

Doctor: "Charles, I completely understand your desperation and how exhausting it is to be constantly running to the bathroom; a situation like this completely throws you off. Before thinking about stopping it abruptly with pills or antibiotics-which, if it's a virus, could worsen your intestinal condition-our absolute medical priority is to replace the water and salts your body is losing so rapidly. We're going to slow the impact gradually with oral rehydration solution. Tell me, have you been able to keep any fluids down in the last three hours?"

DISCUSSION

The doctor and patient dance a "Charleston": an extremely fast-paced, frenetic dance with comically jerky and spasmodic leg and arm movements. It perfectly reflects the uncontrollable urgency, sudden cramps, frantic trips to the bathroom, and the overall "jiggling" physical discomfort of an acute gastrointestinal condition. A strong doctor-patient relationship is vital in managing gastrointestinal infections. Effective communication reduces patient anxiety, improves treatment adherence, and directly influences clinical outcomes (8-11).

Acute gastrointestinal infections impose a fast-paced and chaotic rhythm that abruptly disrupts the patient's routine. The physician must adapt to this urgency (the rapid rhythm of the Charleston), but act as the stabilizing force that curbs the patient's spasmodic movements of anxiety, redirecting the misguided demand for medication toward the true priority (hydration). The doctor-patient relationship in acute infectious gastroenteritis centers involves rapid clinical evaluation, clear communication regarding self-limiting symptoms, and joint decision-making on whether supportive care or diagnostic testing is required (12). Trust and dialogue help prevent unnecessary antibiotic use while ensuring high-risk patients are identified early (13).

The Charleston is a dance of jumps and turns where it seems the dancer is about to lose their balance at any moment. Clinically, gastroenteritis destabilizes the patient's body at an alarming rate due to the massive loss of fluids and electrolytes. Dehydration causes weakness, dizziness, and physical prostration, throwing the patient off their usual balance in a matter of hours. On the Charleston dance floor, there is much chaos and movement. In the consultation room, the patient arrives exhausted, frightened by the intensity of the outbreak, and demanding magic solutions (such as unnecessary antibiotics) to halt the process immediately. The physician must adapt to this rapid pace, but with a clear purpose. The action is to synchronize the urgency and guide the dynamic rebalancing. The technique is empathetic direction. The professional doesn't rigidly halt the flow, but rather assertively takes the patient by the hand to guide them toward safe movements: prioritizing controlled oral rehydration step by step and calming anxiety, restoring stability to the body. The physician immediately acknowledges the exhaustion and implicit humiliation of the symptoms, but assertively takes control of the consultation. They steer the patient away from the false solution (demanding antibiotics) through clear, simple, and biologically prioritized instructions.

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