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# What is a Good Consultation for the Patient and the Doctor?

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Certainly, in the daily practice of the general practitioner (GP), he or she continually has to decide what is best for the patient. But how do we define and identify the concept of "good"? What are good and bad health behaviors? Where are the "gold standards" of good clinical practice? [1].

The "good" consultation and decision would be that which achieves patient satisfaction. Satisfaction from thoughtful and humane help. What helps people has nothing to do with the theories used. When a person feels seen, and we feel that they feel seen, and we feel seen by them, then, in that precise moment, a touch of the spirit takes place. And that's it, that's it. The "good" consultation or decision works the way life works: without a road map, without instruction manuals. What makes it "good" is what makes a good relationship work: feeling understood by the other. Achieving a situation of interconnectedness. Perhaps together—patient and doctor—understand the problem. What is on the table in the consultation is not the doctor or the patient, but both together. The doctor's task is to achieve and maintain a connection with the patient. To use our experience with suffering beings to connect with those who have crossed the border of what we call normality and try to draw them back into the flow of humanity. Taking what seems foreign to a given individual and seeing it as native. That's healing. That's what good doctors do. Being with people at the crucial moments of their lives [2]. Being there when it mattered and truly understanding the patient's feelings [3].

The healthcare provider-patient encounter is an expressive framework for relationships, and there are two types of interventions: technical and expressive, which are mutually interrelated [4,5]. A "good consultation" for the patient does not mean eliminating the differences between both parties, but rather reaching an agreement on what to do. This is true even if there is no cultural consensus on the "why" to do it. A "good" decision is based on an awareness of the emotion. Emotional experiences should not be viewed as unwelcome intrusions, but rather should become a fundamental guide for understanding and developing the therapeutic process. The clinician's accessibility to diverse feelings is the key to the situation. In the end, all decisions are emotional [6,7]. As Mahatma Gandhi said: "Everyday decisions should be made with the head, but the really important ones should be made by the heart."

Medicine has been defined in predominantly biological and technical-scientific terms. The dualism between mind and body tends to relegate the psychosocial, spiritual, and humanistic aspects that are always present in suffering. Frequently, the data recorded in medical records do not reflect the richness of narrative information expressed by sick people. Although general medicine consultations offer a favorable space for emotions to surface, little information is available on how they are identified and assisted by GPs [8].

The purpose of reflecting on decision-making is to promote "good decisions." Traditionally, clinical reasoning has been understood from the perspective that human cognition operates on two levels: an automatic and intuitive process that is unconscious, rapid, and highly dependent on pattern recognition; or a slow, deliberate, systematic, and analytical thinking process that is activated when faced with unfamiliar problems. Within this framework, "biases" (defined as structured, predictable, and systematic errors in thinking) have been identified as the main cause of cognitive errors. Likewise, it has been suggested that "noise" (defined as undesirable variability in human judgments) is a very important source of error in human decision-making [9].

Although the idea that the quality of decision-making is defined by reference to evidence-based medicine seems to hold true, this approach is not sufficient in actual practice. Patients seen in general medicine are complex because their health problems do not usually depend on a single, dominant element, as is the case in secondary care—to use a musical analogy, these would be melodic patients—but rather present several intertwined elements—symphonic patients—which can be subordinated to a primary element, whether evident or veiled [10].

To make "good" decisions, it is necessary to encourage our emotional reaction to follow the "right path": a clinical decision is good if it opens the way to a new decision (i.e., if it unblocks the path to the problem). This involves assuming that uncertainty for decision-making will always exist, even if its limits could be reduced [11].

A "good" decision and a "good" consultation for the patient also imply "empowerment," and mean that marginalized people can take charge of their own affairs and improve their situation. From this, a positive sense of control over one's life develops. This feeling can be more than individual satisfaction, self-esteem, or personal confidence, and can lead to ideas of responsibility and social justice.

Of course, healthcare professionals and patients have different perceptions about what they find most useful in making clinical decisions, and what patients want rarely coincides with what clinicians think those patients need. But the main determinant of the ultimate success of a consultation is the agreement between doctor and patient on the main problem at hand. A "bad" decision occurs when professionals make decisions based only on their narrow range of evidence while ignoring the evidence from patients and their families. For healthcare professionals and patients to relate to each other as co-producers rather than providers and consumers, decisions must be based on both sources of evidence [12,13].

Decision-making, and thus the "good" decision, becomes more complicated in complex systems, compared to the mathematical model approach of positivist science. When the context is turbulent, unstable, and unpredictable, the professional, in order to achieve what is "good" for the patient, must be more flexible, autonomous, with more decentralized decision-making, involving other stakeholders, and facilitating broad participation. Often, there is not a single "good decision" for the patient, but rather several options, and the skills of contextualization, decentralization, and strategic planning must be used to select the best one. Thus, the collective construction of decisions would be a core competency of the physician [14-16].

Ultimately, a good consultation would be one where the physician finds things that are meaningful for him or herself and helps the patient also find things that are meaningful for themselves [17,18].

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