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NUEVAS NECESIDADES COMUNICATIVAS DEL PACIENTE Y SU RELACIÓN CON EL *COACHING* PARA PACIENTES

New patient communication needs and its relationship with coaching for patients

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Resumen

A lo largo de la historia, las necesidades de los pacientes han ido evolucionando, y con ellas, los aspectos comunicativos y relacionales que definen la relación médico-paciente. Este artículo analiza los modelos relacionales de diferentes autores y sus características comunicativas, explorando las habilidades de comunicación necesarias en cada caso para, a partir de ahí, profundizar en el perfil del paciente del siglo XXI, caracterizado por su deseo de empoderarse y adquirir herramientas que le permitan tomar las riendas de su proceso y decidir con criterio. En una segunda parte, se presenta el *coaching* como nuevo modelo relacional. La confusión en torno al *coaching* de salud tanto desde el punto de vista de la metodología de trabajo como de los objetivos que persigue en su trato con el paciente deja un vacío en cuanto a la aproximación hacia el paciente. Por este motivo, y apoyándose en la investigación realizada con pacientes de cáncer de mama, se propone el *coaching* para pacientes como nuevo modelo relacional, un tipo de *coaching* con características propias y específicas que dirige su mirada hacia el futuro y que permite al individuo, por medio de herramientas prácticas, recuperar la confianza y dedicarse un espacio de autorreflexión y crecimiento.

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Palabras clave: Empoderamiento; comunicación; salud; cáncer; paciente; *coaching*; desarrollo personal

Abstract

Throughout history, patients' needs have evolved, and with them, the communication and relational aspects that define the doctor-patient relationship. This article analyzes the relational models from different authors and their communicative characteristics, analyzing the communication skills necessary in each case to, from there, delve into the profile of the 21st century patient, characterized by their desire to feel empowered and acquire tools that allow them to take control of their process and decide wisely. As a second step, *coaching* is presented as a new relational model. The confusion surrounding *health coaching,* both from its working methodology perspective as for its objectives when dealing with the patient, leaves a void in terms of the approach to be used. This is why, and based on the research carried out with breast cancer patients, this article proposes *coaching for patients* as a new relationship model and a new type of *coaching* with its own and specific characteristics, that puts on the spotlight the patients' future possibilities and allows the individual, through practical tools, to regain confidence and dedicate a space for self-reflection and growth.

Keywords: Empowerment; communication; healt; cancer; patient; coaching; personal development

1. INTRODUCTION

The patient profile has evolved over the years, as has the patient's relationship with the healthcare professional. Today, health-related organisations in both the public and private spheres, as well as the patient himself, refer to a profile of an empowered and active person, who wishes to take control of his situation and make decisions with knowledge and judgement. The best-known models of doctor-patient relationships cited to date reflect the different personalities and often expectations of each of the interlocutors, without assessing how to create active patients. Training and subsequent retraining for professional development (Barrientos-Báez et al., 2019) in medicine is essential for the doctor-patient relationship.

The research conducted in this study shows that the methodologies used so far in the training of empowered patients do not entirely respond to the patient's own need to take control of their illness and life. The academy has also taken action and is proposing new training plans to address special medical situations (Carretero-Díaz and Barrientos-Báez, 2019) and, more broadly, multimedia training for social work (López Meneses et al., 2019).

This article presents a review of the different models of relationships and the type of communication prevailing in each of them. Starting from the classical models, it delves

into the use of the discipline of professional coaching to achieve the goal of patient empowerment, something that already existed avant la lettre in cases of motivation for specific audiences (Odor Hurtado, 2020). His analysis also shows confusion and shortcomings with regard to health coaching and its patient empowerment process.

Therefore, this article concludes with the recent work carried out by Ferreiro (2021) with breast cancer patients, which presents a new model of relationship with the patient (Cofré Soto, 2020), coaching for patients, focused on providing these people with tools to empower and authorise themselves to make decisions, through a process of personal work and the search for answers carried out in collaboration with a coaching professional, rather than through an educational process carried out by health professionals. This need for a paradigm shift in doctor-patient communication is already a constant in many areas of health, as is the case in the management of serious (Cofré Soto, 2020), chronic (Compte-Pujol et al., 2020), psychological (Vargas Delgado, 2020) or disability (Lucas Moreno, 2020) illnesses. We leave at this point an open front for future research but of crucial interest: the management of emotional intelligence (EI). A term that Barrientos-Báez (2019a) defines as the ability to control and positively manage one's own and others' emotions, in any given scenario, where experiences and changes occur as part of the personal learning process. From this follows the importance of EI in nursing professionals by competences and geographical scope (Veliz et al., 2018).

2. OBJECTIVES AND METHODOLOGY

Based on a review of the types of relationship that exist between doctor and patient, the initial aim of this study is to analyse the communicative and relational needs of 21st century patients, especially those that help them in their process of empowerment.

Based on this analysis, a second objective of the article is to delve deeper into the communication skills necessary in the relationship with the patient, including some which, although not strictly communicative but derived from professional coaching, do contribute to improving the relationship with the patient and their empowerment process.

The ultimate aim of this study is to explore and support the use of the discipline of professional coaching in the relationship between doctor and patient, proposing coaching for patients as a new model for the relationship between the two. The review of coaching, and more specifically, health coaching, reveals a number of shortcomings in addressing the new communicative needs of the patient. For this reason, coaching for patients is proposed, a model with specific characteristics aimed at accompanying the patient and providing them with tools on their path towards empowerment.

The methodology used was a literature review of specialised sources from both the health and communication sectors. The starting point for the documentation process was the article by Emanuel and Emanuel (1999, pp. 109-126), which establishes four relational models in order to, based on their classification, go deeper into their evolution and learn about the new proposals of later authors. As for the sources related to coaching, as this discipline is very recent (it has been in existence for about 30 years), it

has been less dealt with in the academic literature, so we have resorted to the bibliography of prestigious coaches and online publications.

3. THE PATIENT AND THE DIFFERENT RELATIONAL AND COMMUNICATION MODELS

3.1. Different models of doctor-patient relationships

There are numerous models of doctor-patient relationships that have coexisted over the years. Although some of them may occur more frequently in certain historical periods, their existence is not necessarily determined by the historical moment. In his work The Laws (pp. 720-857), Plato already differentiated between the doctor-patient relationship when the latter was a slave and when he was a free man.

In line with the development of the different models -technological most of the time (Rando Cueto et al., 2021; Sancho Escrivá et al., 2020)- that currently coexist in different medical settings -including hospitals (Barquero Cabrero et al., 2018), the way in which patients have positioned themselves in relation to their health has evolved from a passive position to one in which the patient acquires responsibility and commitment to their decisions (Barrientos-Báez, 2019b), even if the sources of information are not truthful, as in the case of anti-vaccine campaigns (Piqueiras Conlledo et al., 2020). This is the case of empowered, or competent, patients, although with sometimes dubious sources of information that generate stereotypes, which makes the work of professionals with patients difficult (Lara Martínez and Lara Martínez, 2019) as they are overtaken by those who manage the networks, as has been the case of the recent pandemic during its first period (García-Manso, 2021; López del Castillo Wilderbeek, 2021).

Emanuel and Emanuel (1999, pp. 109-126) describe at least four models of the doctor-patient relationship:

- **Paternalistic model:** Once the diagnosis is established, the doctor determines what is best for the patient and his health. He or she gives the patient selected information on the treatments that he or she considers to be suitable for his or her health, directing the patient to where, in his or her judgement, he or she should go. This doctor, who acts as the patient's guardian, also has obligations, such as putting the patient's interests above his or her own. *"The patient's autonomy is conceived as an assent (...) to what the physician considers to be best"* (Emanuel and Emanuel, 1999).
- **Informational model:** This is a technical model, characterised by the use of a large amount of scientific information. The physician provides the patient with data concerning his or her disease, different treatments, with the risks and benefits that each entails. In this model, the patient's values are present, apart from the relationship with the doctor. Patient autonomy is conceived *"as the patient's control over medical decision-making""* (Emanuel and Emanuel, 1999).
- **Interpretive model:** In this case, *"the goal of the patient-physician relationship is to determine the patient's values and what he or she really wants (...) and thus to help the patient choose from among all available medical interventions those that*

meet his or her values" (Emanuel and Emanuel, 1999). That is, the patient's values may be ill-defined or in conflict with his or her experience, and it is the role of the physician to help the patient understand them, as a counsellor, without judgement. *"The patient comes to know more clearly who he or she is and how different medical choices affect his or her identity"* (Emanuel and Emanuel, 1999).

- **Deliberative model:** In this model, the doctor-patient relationship helps the patient to choose, from among his or her health-related values, those that are most important to consider at the moment he or she is in. The doctor acts as a teacher or friend, indicating what the patient could do and what he or she thinks best suits the patient, but leaving the final decision to the patient. *"Patient autonomy is conceived as moral self-development. The patient is enabled, not only to follow unreflective preferences (...) but also to analyse, through dialogue, the different values related to health, their importance, and their implications for treatment"* (Emanuel and Emanuel, 1999).

These four models coexist in space and time. The same doctor may opt for one or the other depending on the situation. For example, the paternalistic model is most commonly used in cases of extreme urgency, where important decisions need to be made in a very short time.

As we progress through each of these four models, we see an evolution in the roles of doctor and patient. From an initial paternalistic, rigid model in which the relationship between doctor and patient is asymmetrical and deprives the latter of autonomy and choice, there is a shift towards more egalitarian models, in which concepts such as autonomy, freedom, respect, trust and confidentiality come into play. From the middle of the 20th century onwards, the doctor acquired a more human dimension, without losing his or her technical capacity, and the patient gained power and recognition in the eyes of the professional. The patient also becomes a key player during his or her illness and in the healing process.

> A doctor must possess not only technical knowledge and skills, but also an understanding of human nature. The patient is not just a collection of symptoms, damaged organs and disturbed emotions. The patient is a human being, both concerned and hopeful, seeking relief, help and reassurance. The importance of an intimate relationship between patient and caregiver can never be overstated, because in most cases, both a proper diagnosis and its effective treatment depend on the quality of this relationship *(Hellín, 2002, pp. 450-454).*

In addition to Emanuel's classification of the models, the authors Kabaa and Sooriakumaran (2007, pp. 57-65) take up the three basic models of the doctor-patient relationship as presented by Szasz and Hollender (1956, pp. 585-592):

- **Activity - passivity:** The patient is perceived as incapable and in need of the doctor's expertise. Treatment is carried out regardless of the patient's contribution and outcome. This approach is justified in acute cases.
- **Guiding cooperation:** Aware of their suffering and seeking relief, the patient is able and willing to participate, placing the doctor in a position of power in which the patient obeys without question. Occurs in less acutely ill cases.

- **Mutual participation:** This is based on the idea of equality between human beings. In this model, the physician may admit that he or she does not know exactly what is best for the patient. The interaction between the two is based on equality of power, mutual independence and a common quest for satisfaction, through a relationship of empathic collaboration and close friendship. This is the ideal model in chronic diseases.

Both Emanuel's interpretive and deliberative model and Szasz and Hollender's mutual participation model point the way towards a patient-centred model (Mead and Bower, 2000, pp. 1087-1110). From the analysis of conceptual and empirical literature, Mead and Bower (2000) identify five dimensions in this new model (Kabaa and Sooriakumaran, 2007):

- **Biopsychosocial perspective:** This refers to the desire to engage with the difficulties patients bring to the consultation, and not just their biomedical problems.
- The patient as a person: To understand the illness and alleviate the patient's suffering, physicians first need to understand the meaning of that illness for that particular patient.
- **Shared power and responsibility:** A relationship of equals in which the patient has a voice and is involved in his or her treatment, encouraged by the physician.
- **Therapeutic alliance:** Great importance is given to the personal relationship between doctor and patient, which can increase, among other things, adherence to treatment and be instrumental in the process of improvement and healing (Pinto et al., 2012, pp. 77-87).
- **The doctor as a person:** The patient and the doctor influence each other, giving space to the emotions of the professional as part of the relational aspects between the two.

The patient-centred model has been around for about 30 years and has been the subject of countless academic studies. This model, which puts the patient at the centre and determines the issues of importance to them through direct consultation and dialogue (Yeoman et al., 2017, pp. 76-83), sets the trend for institutional and social bodies, which focus their research on how to achieve the implementation of this model in an environment increasingly characterised by the impact of technology on the one hand (including aspects such as the dissemination of information through the internet, new and increasingly sophisticated machines, the impact of artificial intelligence, digital disruption, etc.), and by a search for profitability of the system that brings with it a reduction in the time that the doctor can dedicate to each patient, which makes it difficult to build a human relationship between both actors, making it highly recommendable to work on spiritual intelligence as a resource that optimises this time (Alarcón-Orozco, 2020).

3.2. Historical evolution of the patient and its typologies

Historically, the patient has been a passive subject who conformed to the paternalistic model. They went to the doctor's surgery to listen to his recommendations as to what

they had to do to be cured, without getting involved in the healing process. In the 19th century, with the advent of psychology and the theories of Freud, the patient began to be perceived as a person. Therefore, it is essential to listen to the patient carefully, creating a sincere rapport and reintroducing the patient into the consultation as an active participant (Kabaa and Sooriakumaran, 2007).

When, in the mid-20th century, eminently humanistic concepts such as autonomy, freedom, respect, trust and confidentiality gain weight, the strengths of doctor and patient tend to become equal. The year 1973 was a key year in this historical evolution of the patient, as it was then that the American Hospital Association approved the first Patients' Bill of Rights, which entailed official recognition of the patient's right to receive full information about his or her clinical situation and to decide between the possible options, as the autonomous and free adult that he or she is (Lázaro and Gracia, 2006, pp. 7-17). Since then, the figure of the patient has been evolving and consolidating, to the point of becoming a patient who is more committed to his or her health, more responsible and active.

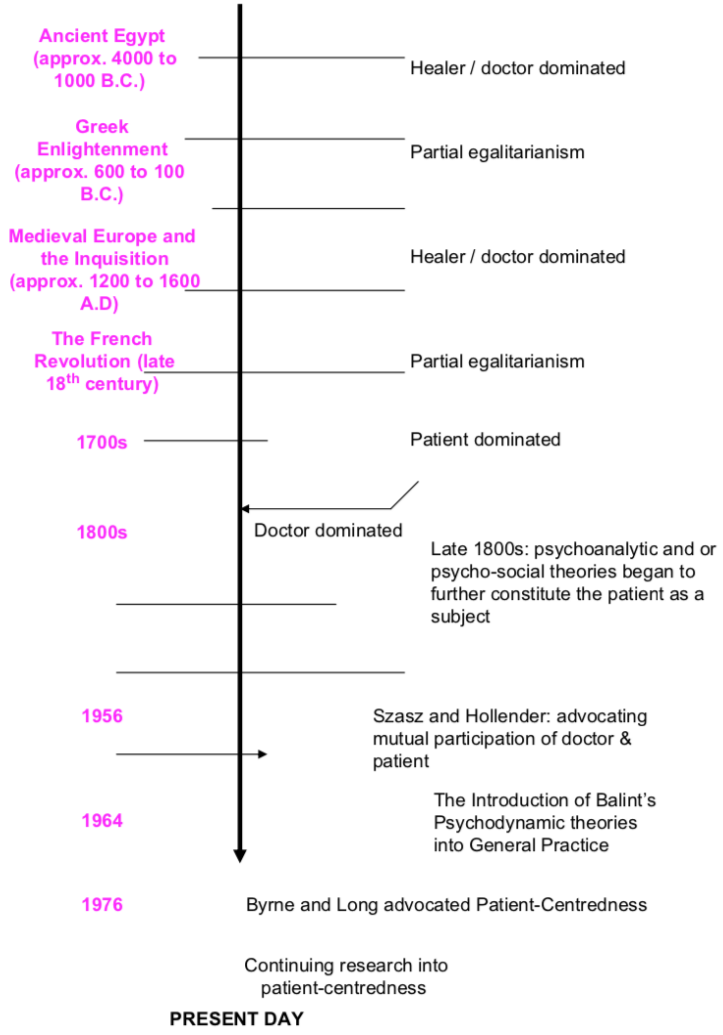

Figure 1: Evolution of the figure of the patient
Source: Kabaa and Sooriakumaran, 2007.

The development of the internet has introduced major changes in the doctor-patient relationship. Ferguson coined the term e-patient in 2017 to describe equipped, empowered, enabled and engaged individuals who use the Internet to seek information about a health topic both for themselves and for someone around them (Ferguson and e-Patients Scholars Working Group, 2007). With the information they obtain through the Internet, e-patients have the opportunity to better understand their illness and ask relevant questions of their doctors. Moreover, they understand that their doctors cannot keep up with all developments and offer ideas and solutions. Today the term has fallen into disuse and the definition corresponds to that of the active patient.

3.3. The 21st century patient

This evolution in the patient's attitude and needs brings with it the need for the doctor-patient relationship to change as well. The 21st century patient does not look to physicians as a paternalistic person, but as *“"fellow travellers, counsellors who help them to interpret their own wishes, needs and values, and who help them to make free and informed decisions"”* (Emanuel and Emanuel, 1999).

In his analysis of the evolution of the type of patient, Simón quotes Jadad et al. (2006) to explain that *"the key role of the health professional of the future will not be to provide scientific information, but to give advice and support in the clinical decision-making process"* (Simón, 2006, pp. 29-40).

Since the beginning of the 21st century, there has been the figure of the expert patient, who *"transmits knowledge and shares experiences with other people suffering from the same health problem" (Expert Pacient Programme Catalunya, 2013). It is "a person affected by a chronic disease who is able to take responsibility and care for themselves, knowing how to identify the symptoms, responding to them appropriately and acquiring the skills that help them to manage the physical, emotional and social impact of the pathology, thus improving their quality of life (Mestre, 2015)"*

3.4. Communication in different relational models

The four models of the doctor-patient relationship are accompanied by an evolution in the way in which the two protagonists of this relationship communicate.

In the paternalistic model, communication is practically unidirectional. The expert doctor speaks and the patient merely listens and carries out the expert's commands. The information provided by the doctor to the patient is biased, as the aim is to make the patient accept the doctor's decision (Kabaa and Sooriakumaran, 2007). The patient empowers the doctor. In his or her role as guardian, the practitioner may use resources such as a condescending tone, warmth or firmness.

The informative model is characterised by fact-focused communication. Emotions are neutralised and the doctor is positioned as a channel transmitting truthful information, leaving the patient with the power to make the final decision.

The type of communication used in the interpretative model is more philosophical. By means of questions and the selection of the information he/she considers most appropriate for the patient, the doctor accompanies the patient in his/her search for an answer, through questions and advice. The tone is warm and friendly.

In the deliberative model, the physician uses communication to transform his role into that of a friend who is also a teacher. Both actors are on the same level in the pursuit of an ultimate goal shared by both.

Nowadays there is more and more talk of the doctor-coach. The term is inspired by the business environment, where the leader-coach defines a leadership style characterised by the ability to inspire the team and to enhance the skills of its members. Thus, the doctor-coach is a professional who engages in dialogue and empathy, who trusts in his patient's resources and helps him to maximise his possibilities, in a climate of trust that allows the patient to be aware of his abilities and believe in them. The doctor-coach's communication is open to respect. It is two-way and open, and is established in a situation between equals in which both feel able to express their needs and opinions.

3.5. Communication, a key element in the doctor-patient relationship

A good relationship and good communication between doctor and patient has very positive results on the evolution of the disease. A study conducted in 2002 among 110 patients showed that patient-centred communication significantly improved the patient's state of health, both in terms of anxiety levels and pain intensity (Muñoz et al., 2002, pp. 23-31). More recent authors state emphatically that "the effectiveness of a medical treatment depends on the quality of the doctor-patient relationship" (McCabe and Healey, 2018, pp. 409-424). This relationship is based on trust (Pellegrini, 2017, pp. 95-102), and trust is built through good communication between interlocutors facilitated by a set of skills that professionals can acquire (Honavar, 2018, pp. 1527-1528).

Asnani, adds that "research has abundantly demonstrated that no matter how profound a doctor's knowledge is, if he or she cannot open a good channel of communication with the patient, he or she cannot be of any help to the patient" (Asnani, 2009, pp. 357-361). However, doctors may not be aware of how patients experience their communication style (Burt et al., 2018, pp.330-337).

On the other hand, it is commonly accepted that many doctors have difficulties communicating with their patients (Asnani, 2009). It is especially interesting to see how doctors' communication skills decline as their medical school training progresses (DiMatteo, 1998). Moreover, the physical and emotional hardship of training, especially

during speciality and residency training, eliminates empathy and replaces conversation with the use of techniques and procedures (DiMatteo, 1998).

3.6. Effective communication skills in the patient relationship

Among the communication skills considered most important in the academic literature for good patient communication are active listening, the use of open-ended questions, and the ability to empathise (Fong Ha and Longnecker, 2010), in order to create collaborative communication that ensures real information exchange. To do this, the physician will also need to be able to facilitate an honest discussion in which the patient feels listened to, often using negotiation skills. By putting these skills into practice, the physician focuses his or her communication on the patient, thus participating in a patient-centred model of the patient-physician relationship. The gaze also plays an important role both in communicating and in creating the context that allows patients' emotions to surface.

- **Active listening**

One of the fundamental pillars of communication is listening. Active listening refers to the ability to listen by allowing the other person to express him/herself fully. Active listening pays attention to words, gestures and emotions. When practised by doctors, it satisfies patients' need to feel that they are known and understood (Karora, 2003, pp. 38-43), listened to and valued, and the evolution of their illness is more positive (DiMatteo, 1998).

From a coaching point of view, good listening facilitates people's openness (Kimsey-House et al., 2011), because they perceive the other person's interest and presence. Listening helps to build an environment of trust and security, in which people feel respected and valued.

Listening is not a passive act, but an active one. Active listening is one in which the receiver is present and available to the other person, engaging in the process and using tools to in many cases help the sender connect with what is important, removing the layers of "noise" that interfere.

- **Empathy**

While it is not a communication skill in itself, it is one of the key skills that will shape the development of the doctor-patient relationship. Empathy is the ability to put oneself in the other person's shoes and understand what the other person is feeling. In the case of the doctor-patient relationship, when the doctor recognises that he or she understands the patient's perspective, the patient feels more listened to and supported.

When Goleman defined interpersonal skills (Goleman, 1996), he differentiated empathy (emotional skill) from other relational skills based on communication. Based on this definition, an empathic person uses non-verbal communication to convey this

empathy. This is why we include empathy as one of the skills necessary for a successful relationship.

Broadly speaking, empathy consists of perceiving what others feel and think without being told. Or being able to understand the other person's feelings and put ourselves in their shoes. We speak of empathic communication when some of the qualities of empathy are put at the service of communication with the aim of opening new paths and exchanging feelings, attitudes and emotions, without judgement. Marshall Rosenberg, a well-known pacifist, used the term in 1998, in an article dealing with aspects of communication in the field of health (Rosenberg and Molho, 1998, pp. 335-340). He has since gone on to publish books on non-violent communication and empathy (Rosenberg and Chopra, 2015). Other authors also refer to empathic communication in books and articles (Servellen, 2009; Belles, 2018, pp. 10-11). In describing his emotional-rational model of the clinical interview, Borrell (2004) talks about a series of qualities of great importance for the health professional (warmth, respect, cordiality and empathy among others), when welcoming the patient and laying the foundations of the relationship with him/her.

- **Open questions**

As opposed to closed questions, which include a series of response options (for example: "Do you like films? Yes/no") and do not facilitate the development of dialogue, open questions are answered in an elaborated way, with sentences that facilitate access to arguments, elaborations and opinions of a broader development. By using them with patients, they force them to verbalise (Borrell, 2004). In this way, these questions allow access to the person, their history and concerns, and from there establish a relationship of dialogue and trust based on a common objective. Open-ended questions are shown to be one of the elements that help the patient to express his or her concerns (Maguire, 1999, pp. 1415-1422). Some authors (Lichstein, 1990, pp. 29-36) propose to use these questions and let the patient talk before starting with detailed questions.

- **The gaze**

Gaze is a fundamental element of non-verbal communication. In his book, Nonverbal Communication, Knapp (1980) builds on the four functions of gaze to present the following functions:

- Regulation of the communication stream: That is, gaze opens and closes the communication channel.
- Feedback by monitoring the reactions of the interlocutor: It allows us to obtain information about how our interlocutor is receiving information.
- Expression of emotions: Gaze provides a lot of information about the emotions being expressed.
- Communication of the nature of the interpersonal relationship: This tells us about the type of relationship that exists between the interlocutors. According to Knapp, closely related to looking at people is the positive or negative attitude factor. We seem to look more at people we like.

Building on the fourth function of gaze, it contributes to creating an environment of intimacy, which facilitates communication. Seeing the other person as they are, taking time and allowing them to express themselves and to fail, helps to create that space of accompaniment and security that encourages the person to explore and take risks, trusting. We refer to the attentive gaze. A look, as defined by Esquirol (2006), which is born from respect: "The movement of attention is not only to rescue the other or the other, but also oneself (...) attention becomes the task of the one who must start again, of the one who knows he is the subject of responsibility and called to be oneself". Learning to look means learning to pay attention, to direct the focus and avoid dispersion. Attention connects us with the world. (Esquirol, 2021)

3.7. Active patient - empowered patient

The World Health Organisation defines "patient empowerment" as "a process in which patients understand their role, and in which health professionals equip them with the knowledge and skills to carry out their task, in an environment that recognises cultural and community differences and encourages patient participation" (WHO, 2009).

An empowered patient is one who is able to take charge of his or her situation, make decisions, solve problems and take control of his or her life. Thus, empowering patients involves not only educating them about their illness by providing them with the information and knowledge they need to be as autonomous as possible, but also equipping them with the resources they need to feel emotionally capable of making their own decisions and relying on their own judgement (Huffman, 2009, pp. 490-498). Authors such as Timmermans refer to this type of patient as the "engaged patient", and relate their active attitude to the rise of the Internet as an alternative source of information (Timmermans, 2020, pp. 259-273).

Much of the literature that delves into patient empowerment and the needs of the sick does so from the field of medicine and health sciences, not so much from the disciplines of communication and/or coaching. From the point of view of coaching, empowerment takes on a broader dimension, because in addition to taking into account the person's relationship with the illness, it enables them to manage their emotions and control their life in such a way that they can turn it into what they want to live. These emotions include the patient's relationship with their illness and the place they want it to occupy. Several studies that have evaluated the impact of empowerment on patient satisfaction or adherence to treatment suggest that active patient involvement is associated with improved recovery (Roberts, 1999, pp. 82-92). Moreover, regaining control of their lives becomes for patients one of the pillars of their recovery (Gray et al., 1991, pp. 33-45).

Other fields, such as sports, demonstrate the usefulness of coaching for managing emotions (Correia et al., 2016; Davis and Davis, 2016, pp. 285-306), although in this case the figure of the coach is oriented towards the personal trainer and his or her ability to help the athlete manage his or her emotions, or the professional (Cox and Patrick, 2012, pp. 34-51).

For the doctor-patient relationship to be at its highest level, the patient needs to know and practice a series of skills that are described below:

Active: An active patient takes the initiative, asks questions, searches and has an open attitude towards his or her situation.

Curious: They want to know and understand their illness in order to be able to take charge of the situation. To this end, they are open to research, learn from new sources of information apart from their doctor, read, listen and ask questions related to their illness to help them acquire this knowledge.

Responsible: The active patient knows that the evolution of his or her health depends to a large extent on his or her commitment to his or her own healing. There will be times when he/she will need to make decisions or carry out actions or behaviours that may largely determine the course of his/her disease. Using the capacity to make decisions in a conscious way implies knowing the possible consequences of their decisions and accepting responsibility for them. From a role in which the patient is positioned as a victim, he/she moves to a role in which he/she becomes the conductor of the orchestra.

Consciousness: The patient is aware of his or her real situation and knows the repercussions of the treatments or his or her attitude. Moreover, he/she knows and accepts the consequences of the decisions he/she makes, even opting for a different path to the one proposed by the doctor, which is better adapted to his/her person, values and beliefs.

Committed: The active patient is committed to following a treatment, a lifestyle, indications that help them with their illness. This commitment is usually with themselves and/or with other people (doctor, family members, etc.).

Autonomous: He/she makes decisions for him/herself, according to his/her condition, needs and environment. They know what is best for them and have the scope to act on their illness without the need to consult the doctor on any small aspect.

Informed: They know their illness, the treatments they are following and why. Sometimes they are more up to date than the doctor himself (Ferguson and e-Patients Scholars Working Group, 2007).

Judgement: The decisions made by the active patient, the options he chooses, the behaviours he adopts, are born of his discernment. Each person has his or her own judgement, which deserves to be respected. It is based on his or her values and experiences. In the face of any discrepancies that may exist between doctor and patient, the doctor's role is to accept the active patient's judgement and to accompany him in his decision.

4. COACHING AS A MODEL FOR COMMUNICATION AND PATIENT EMPOWERMENT

The *International Coach Federation* (ICF)[2] defines professional coaching as "a partnership with clients in a process of reflective and creative accompaniment that inspires them to maximise their personal and professional potential". (ICF, 2018).

- **A partnership with clients:** That is, the coach works with clients (as opposed to psychologists, for example, who work with patients). This is a peer-to-peer relationship. For coaching to work, it is essential that all participants are protagonists in the process. In no case does the coach position him/herself as knowing the solutions to the problems or situations that are put on the table over the person with whom he/she is working.
- **In a process of reflective and creative accompaniment:** The coach helps the person, through questions, conversations, reflections and various tools, to find their own answers.
- **Inspires them to maximise their personal and professional potential:** One of the principles of coaching is that everyone has the ability to choose how they want to live their life and to make the most of themselves and their experiences. Thus, through coaching, clients are empowered to go beyond their self-imposed, often limiting, possibilities. This new perspective they gain on themselves is inspiring because it opens up new ways of positioning themselves in life and living their experiences.

Leonard, considered one of the fathers of coaching, believed that everyone is a coach (2001). In his opinion, we all have a mentor inside us who needs to be trained in coaching tools, which he defined as advanced communication skills (Brock, 2017). To this concept, Whitmore further adds that coaching focuses on future possibilities, not past mistakes" (2010).

4.1. The different meanings of health coaching

An analysis of coaching applied to health and patients reveals some confusion, both in terms of the way it works, the objectives pursued and the practitioners who practise it.

With regard to the relationship established with patients, the literature often describes a directive type of action, in which the practitioner acts as a guide or mentor to the client. In the field of medicine, this figure is even more evident. Many articles refer to the health coach as a person who informs and takes the client by the hand throughout his or her treatment in pursuit of a cure. The objectives of this coaching may be similar to those of the coaching we recognise in this paper, although the method differs (Clark and

[2] ICF: an international regulatory body for coaching and the professionals who practise it. Its main objective is to ensure the development of this discipline in a rigorous manner. ICF is the organisation responsible for accrediting professional coaching qualifications. It has also designed a code of ethics that provides the framework and binding standards of conduct for ICF members and credential holders.

Douglas, 2014, pp. 1537-1544). A clear example of this methodology in which the coach guides the patient is cancer coaching as it is understood in America. In this case, the coach informs the patient about what to expect with the treatments, gives guidelines on diet, physical and mental exercise, side effects, but does not offer the professional accompaniment of a certified coach, as he or she has not received adequate training (CBC, 2018).

Furthermore, the terminology used to refer to this type of coaching can also be confusing. There is talk of health coaching, wellness coaching, health coaching and wellness coaching, without these different expressions offering clear differences in meaning (Clark and Douglas, 2014).

Bennet defines health coaching as a process used to "help patients gain the knowledge, tools and confidence to become active participants in their care and achieve self-determined health goals" (Bennet et al., 2010, pp. 24-29).

Molins, a physician by profession, defines health coaching as "facilitating the individual to achieve their health goals in a more effective way. Coaching is based on a special conversation that we call an enabler of change between the client or patient who wishes to improve, and the health coach who uses communication skills to help them achieve it" (Molins, 2011, pp. 6-7).

With regard to the issues addressed by health coaching, the term is usually a catch-all that encompasses both disease prevention coaching and coaching for people who want to lose weight, i.e. coaching that helps them to achieve health goals, or coaching for patients undergoing treatment or who need follow-up. Indeed, Bonal et al. (2012) describe how coaching can empower patients by co-designing an action plan where the patient is the protagonist of the tasks (Bonal et al., 2012).

When using the coaching practitioner as a defining element of this type of coaching working with patients, there is also a lack of agreement on the role of the coaching practitioner.

According to Bennet et al. (2010), a health coach can be a person with or without clinical training (nurse, patient or social worker who has attended at least two training sessions related to mostly medical topics). Kreisberg (2015) made a distinction between a health coach and a wellness coach. The former works with people with often chronic health problems, while the latter is more oriented towards prevention and wellness. Building on this definition, Huffman (2016, pp. 490-498) gives the ultimate responsibility for the patient's health to the professional, who, according to the guidelines of the National Society of Health Coaches, should have clinical education and training.

Shearsmith (2011, pp. 120-138) suggests that both life coaches, i.e. those with specific coaching training, and health coaches, those with both clinical and coaching training, could carry out the type of coaching referred to in this section (Caldwell et al.,

2013), for their part, focus the education of coaches on integrative health coaching training, without mentioning the need for clinical training.

In addition to the health coach, the expert patient has found a place in the healthcare system in recent years. Their role can vary from one who is able to take care of themselves, to one who trains and accompanies other patients on their journey. Sometimes patient experts become patient advocates, having the possibility to train and improve their skills and capabilities (Hunter, et al., 2018, p. 270) in order to be involved in the whole process of medical research and development (Klingmann et al., 2018, p. 251). In some cases, the role of patient experts has become professionalised, although in the vast majority they remain volunteers. In none of these cases does the training acquired by the patient expert resemble that of a professional coach.

4.2. Coaching for patients

Based on the communication and relationship needs of today's patients and taking into account the ambiguity surrounding the concept of health coaching, and supported by the results of the research carried out by Ferreiro (2021) with breast cancer patients, a new type of coaching is proposed, designed specifically for patients, characterised by the following objectives, which in some cases have already been described by other authors:

- To obtain tools that help patients in their day-to-day life, both to manage their emotions, their situation and their life (Taleghani et al., 2014).
- Dedicate a safe space and time of one's own that favours personal exploration and reflection (Mok and Martinson, 2000, pp. 2016-213).
- Regaining self-confidence and learning to occupy the space they deserve (Carpenter et al., 1999, pp. 1402-1411).
- Renewing energy, regaining enthusiasm for the future and leaving behind the fear of illness or of what might happen.

On the other hand, based on the type of professional responsible for accompanying patients, it is proposed to include as an important attribute to strengthen the relationship between the two, both training in professional coaching and experience as a patient who has undergone the same experience.

Therefore, the ideal profile of the coach working with patients is a professional in whom professional coaching training and patient status converge, characterised by the following aspects:

- The patient coach does not belong to the medical team, but as in any other coaching relationship, he/she positions him/herself as an equal to the other patients. Therefore, no medical training is required.
- The patient coach is a professional coach who has acquired the knowledge and mastery of coaching tools and techniques and is able to perform spontaneous

coaching interventions with some of the participants throughout the implementation of the model.

- The coach shares the same diagnosis with the patients. Having lived through similar experiences helps to build trust and empathy in the group because, as patients who have collaborated in the study have indicated, *"in addition to her professional skills, the coach knows what she is talking about because she has been through what we have been through"*. Aware of the limitations of this requirement, patient coaches could be coaches who, although they do not share the diagnosis, have experienced it very closely (family member or close friend).
- The patient coach is not responsible for the patient's health. Their role is to make the patient take responsibility for themselves.

5. CONCLUSIONS

Both from a communicative and relational point of view, the patient's position vis-à-vis health professionals, as well as his or her needs, have evolved over the years. While until the mid-20th century the relationship between the two was asymmetrical, from that time onwards the patient began to gain power, acquiring more autonomy and choice.

The 21st century patient is an active patient, seeking tools that allow him to make decisions related to his illness and his life, based on his own criteria. Among the skills that are necessary in the communication process between the patient and the medical team are active listening, which facilitates the opening up of people, empathy, which helps the patient to feel accompanied, open questions, which help to establish a relationship of trust based on a common objective, and an attentive gaze, which is born of respect and helps to create a safe environment.

Although the discipline of professional coaching combines these skills in its practice and opens the door to a new model of relationship with the patient, in the interests of patient empowerment, the analysis of the different modalities of health coaching and its practitioners reveals a gap that the coaching for patients proposed in this article and defined on the basis of the research with patients presented in Ferreiro's thesis, aims to fill.

Patient coaching is a new way of communicating and relating to patients, which aims to provide them with what they need for their empowerment, in line with the demands of the 21st century patient. It is characterised by a number of elements that patients describe as key to this new relationship:

- It is a model designed specifically for patients and their specific needs.
- The professional coach practising patient coaching does not belong to the medical team.
- The coach shares diagnosis with the patient.
- The patient acquires responsibility in the relationship with his or her condition.
- The patient obtains tools that help them in their day-to-day life.

- The objectives of the relationship are focused on the present and the future, with a view to regaining hope and leaving behind the fear of what might happen.

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Degree in Information Sciences from the Complutense University of Madrid. Teresa combines work on her thesis at the same faculty (expected publication date in June 2021) with her professional activity as a professional coach certified by ICF. With more than ten years of experience working with breast cancer patients from the moment of their diagnosis as affected, author of the book Un bulto en la mama, tú eliges cómo abordarlo (2012) and regular speaker at events aimed at both patients and professionals in the health sector, around the theme of patient empowerment. In 2019, EyeforPharma recognised her career and work by presenting her with the European Patient Champion Award. Teresa is also the founder of Baby Beatles, a non-profit organisation that helps women who have had breast cancer to become mothers, and is currently working on Soul Reconnect, an innovative patient empowerment project through patient coaching, a term she coined based on her doctoral thesis research. Leadership coach at the prestigious Swiss business school IMD.
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