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Report Number 2

Communication in the Doctor-Patient Relationship

FINAL REPORT

By. Antonio Ordoñez-Plaja

December 1967

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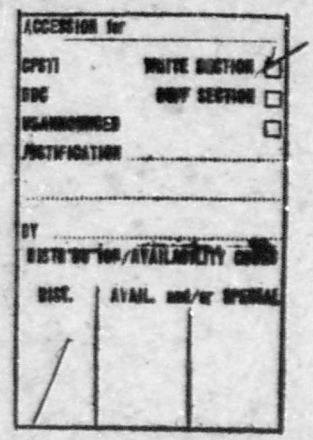
Facultad de Artes Y Ciencias, Universidad de los Andes
Bogotá, Colombia

U. S. Army Element
Defense Research Office, Latin America
Rio de Janeiro, Brazil



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Introduction

A number of studies in medical settings suggest that the process of communication in the doctor-patient relationship is an important factor in the adequacy of medical care. (1) If one begins with the premise that the patient must be able to communicate symptoms, feelings, beliefs, values, and changes in his condition in such a way that they are understandable to the physician, and that the physician must in turn be able to communicate instructions and a sense of understanding, as well as to ask pertinent questions, it becomes obvious that the adequacy of communication is related to the adequacy of medical care, as viewed by either of the participants.

The relationship which develops between the doctor and his patient is governed by a vast network of rules of conduct which sets their standards of behavior. The substance and quality of this interpersonal contact is shaped by the perception which physician and patient have of each other and such perceptions are influenced in large part by the social and cultural forces which form the matrix for communication. (2)

The present research focuses on the relationship of social class distance and vocabulary knowledge to the patterns of doctor patient communication found in three outpatient clinic settings in Colombia.

Related Studies

In recent years the study of the influence of membership in

certain social groups on patient physician interaction has assumed an ever increasing importance.

Studies by Koos in Regionville and Simmons in Chile and Peru suggest that the greater the social class distance between patients and physicians the more difficult it is to establish a relationship of mutual trust. (3) Writers such as Saunders, Stycos and Spiegel have pointed out that cutting across the lines of social class division within complex societies are the communication problems which arise from value conflicts associated with differences in ethnic group membership. If a practitioner and a patient act within quite separate cultural frameworks there may be disagreements over the most general definitions of the roles of patient and practitioner, basic value orientations, and beliefs about the nature of illness itself. (4) Foster further discusses the problem by indicating that when practitioners are from an upper class, caste, or ethnic group, and patients are from lower classes, forces such as mutual suspicion and lack of respect between medical practitioner and patient, the values associated with divisions in the social structure, and religious beliefs may interfere with effective communication and the adoption of new medical practices. (5)

In addition to these factors, Samora et. al. have suggested that in practitioner-patient communication there is the possibility of misunderstanding or non-understanding on the part of the patient due to vocabulary deficiency. When the patient is one with little formal education, or a member of an ethnic group that has preserved a language other than that used in local medi-

cal discourse, or a person who can be identified as coming from a low class environment, the probability of poor understanding or misunderstanding is increased. (6)

Wilson indicates that of all the sub-cultural differences that may divide practitioner from patient within a given society, the subculture of the medical profession itself may be the most critical. (7) Friedson supports his view by suggesting that the separate worlds of experience and reference of the layman and the professional worker are always in potential conflict with each other. He indicates that this separatness seems to be inherent in the very situation of professional practice.

"The practitioner, looking from the vantage point, perceives his detachment by seeing the patient as a case to which he applies the general rules and categories learned during his protacted professional training. The client, being personally involved in what happens, feels obliged to try to judge and control what is happening to him. Since he does not have the same perspective as the practitioner, he must judge what is being done from other than a professional point of view. While both professional worker and client are theoretically in accord with the end of their relationship -solving the client's problems- the means by which this solution is to be accomplished and the definitions of the problem itself are sources of potential difference." (8)

While we have not attempted to present a complete review of studies on the influence of social and cultural factors on physician patient communication, our purpose has been to illustrate the complexity of the problem and the resulting need to discriminate carefully before making assumptions about the variables which shape the physician patient relationship. Social class position, ethnic group membership and deficiency in vocabulary knowledge influence the perception which physician and patient have of each other. The con

trasts in values and the knowledge derived from differential group member - ship may contribute to interferences with the quality of communication requir ed for adequate medical practice.

The problem of the "clash of perspectives" associated with the very nature of the position of the patient as layman and the practitioner's position as a professional points to the need to keep in mind, in any assessment of communication, a model which is based on a realistic view of the nature of physician patient communication. (9) The search for explanation of the factors influencing this relationship should lead us then to a more meaningful understanding of the way in which certain sociocultural dimensions may influence the doctor patient relationship, and it should help medical practitioners to deal more effectively with the therapeutic relationship which constitutes the basis for treatment.

Present Study

The present research was concerned with examining the process of Doctor-Patient communication at two levels and in making an assessment as to its adequacy.

The first level was to be an adaptation of the study on medical vocabulary knowledge among hospital patients carried out by Samora et, al. The present investigators were interested in learning the extent to which there was the possibility of misunderstanding or non-understanding on the part of pa - tients due to deficiency in their ability to understand terms commonly used in

medical discourse. We hoped to study the extent to which factors such as educational level and origin might be associated with the patient's ability to understand the vocabulary used.

The second level of research was to be more extensive. We proposed to make an analysis of medical interviews in order to assess the extent to which physician and patient understood each other during the interview. We were particularly interested in learning about the extent to which the patients' and the physicians' expectations and reactions toward each other influenced their mutual ability to communicate effectively.

At the outset of the investigation we had hypothesized that the greater the social distance between physician and patient, the greater would be the distortion or lack of understanding of the communication between the two.

We were also interested in studying the extent to which the manner of presentation of self followed by the patient and the physician in the interview situation might influence their mutual patterns of communication. It was hoped that we could study the possible relationship between different manners of presentation of self and the adequacy of communication. (10)

With this identification of communication barriers which occur in the actual course of the medical interview we hoped to gather data which could offer a comprehensive basis for an evaluation of problems in communication between physician and patient.

The focus of our specific concerns grew out of the recognition expressed by Ruesch and Bateson that communication does not refer to verbal, explicit, and intentional transmission of messages alone but to all those processes by which people influence one another. (11) As Kimball has indicated, this definition is based upon the premise that all actions and events have communicative aspects as soon as they are perceived by a human being; it implies, furthermore, that such perception changes the information which an individual possesses and therefore influences him. (12) These perceptions are, in part, a function of the social processes and cultural values which govern the behavior of persons such as physicians and patients, as societal members and participants in the life of medical organizations.

Our approach followed the framework suggested by Kimball and others who have indicated that one useful way to analyze mechanisms of communication is to separate the verbal and nonverbal. (13) The effectiveness of the spoken language is associated not only with its denotative aspects - that which words stand for- but its connotative aspects- that which words suggest. Thus terms may lead patients to confusion because of the different meanings attached to them by the physician and the patient. (14)

The study of nonverbal aspects of communication such as sign language, action language, and object language (15) complements the analysis of comprehension at a verbal level. The analysis of nonverbal communication is relevant in medical interviews because therapeutic communication with the patient includes the establishment of rapport which is the basis of the doctor pa-

tient relationship. As Meares has indicated this is an emotional relationship and it is established by the extraverbal and nonverbal communication of emotion. The physician must learn to use non-verbal communication himself because some ideas can be effectively communicated only by this means. (16)

When taken together, the study of verbal and nonverbal communication in medical interviews offers a basis for describing typical manners in which physicians and patients present themselves before each other. The delineation of "social types" to show differential response patterns between physicians and patients can assist the student of social behavior to identify some of the dominant themes underlying the patient physician relationship in a clinic, such as the expression of authority relations, and the responses to them. (17) In these attempts to describe modal ways in which patient and physician encounter each other, we assume that the communicative patterns of a physician or of a patient cannot be viewed separate of each other, for doctors and patients communicate in terms of their perceptions of each other, the self definitions which grow out of their mutual role conceptions in the interpersonal situation.

With emphasis on these concerns, it was hoped that the focus of our questions might offer an initial understanding of communication processes in clinical organizations, to complement the rural and public health oriented research efforts which have been the focus of much of the social science investigation in medicine in Colombia. (18)

It was expected that research findings could contribute to the theoretical issues of relevance in patient physician communication, but it was also hoped that the ideas emerging in the course of the investigation, as well as the specific findings would offer a basis for continued more extensive study.

Research Situation

Research was carried out by the investigators, a physician and an anthropologist, in the outpatient clinics of three general hospitals that are used by medical schools for training purposes. The clinics were located in three Colombian cities, with a population of more than half a million each, located in three contrasting geographic and cultural regions of the country. The opportunity to conduct research in these sites was felt to offer potential material for purposes of comparison and contrast. Administrators and educators in the settings showed a strong interest in making their facilities available for investigation, and in having the research findings related to medical practice.

Patient Sample

The total of 59 patients used for the present analysis included 43 women and 16 men, all of whom were attending the clinics for the first time(19). Forty-nine percent of the population were in Clinic A; thirty-eight percent had attended Clinic B, while thirteen percent were seen in Clinic C.(20) All patients were informed that they had been chosen to participate in a special project in which we hoped to learn about their experiences, in order to offer better services. The choice of "new" clinic patients was made in order to secure a popu

lation that would not have had opportunities to learn the clinic vocabulary through participation in activities in these settings, or through direct contact with medical personnel.

The group was almost equally divided between urban (21) and rural patients. The majority of urban respondents resided in the three cities where the selected clinics were located, while most of the rural patients were peasants who came from agricultural communities or villages located in the same cultural region within which the hospital was located.

With regard to age, we tried to choose patients within the twenty to forty-five age category, in order to prevent ignorance of terminology or medical concepts due to youth or to memory lapses associated with advanced age or emotional problems associated with the menopause. Seventy-one percent of the patients fell within this bracket while most of the others were divided between the older and younger age groups

The sample represented a lower class group, with unstable or no income at all. Most men were agricultural workers or unskilled laborers, while one third of the women worked largely as domestics or in self employed capacities, such as seamstresses. Almost all of the patients had a limited elementary school education, but women tended to have received more schooling than men.

Physician sample

The seventeen physicians chosen for study were selected by the

Clinic Administrators, in consultation with the researchers. While it cannot be claimed that the sample was in any way "representative", efforts were made to include a random group typical of the physicians in practice at each clinic. There were no refusals to participate in the research.

The three clinics relied on physicians at different levels of training. The sample was thus comprised of staff physicians (41 percent), fourth year medical students (35 percent), and residents (24 percent). An average of 3.5 interviews, was recorded at separate intervals for each physician.

Method

All interviews between physician and patient were tape recorded. Immediately after these contacts, the doctor was seen by the research physician, while the patient was seen by the anthropologist. Physicians were asked to offer comments such as the identification of possible problems in communication with the patient, and to give some general impression of the patient as a person. The interviews held with patients included data related to their sociocultural background, patterns followed in seeking help for the presenting problem, and information on their general impressions of the physician and the clinic experience.

A number of unstructured interviews held with hospital personnel at different hierarchical and occupational levels provided additional understanding of physician and patient communication, as viewed by other members of the medical organization. These contacts also offered data on the percep-

tions which medical personnel have of their own roles and of the roles of other members of the medical team. Observations on the cycle of activity followed by new clinic patients and by the personnel offering services to them contributed to a general understanding of their relations in the clinic setting.

Evaluation Procedures

In the evaluation of the effectiveness of literal verbal communication, the separate judgments of the patients, physicians, and researchers were considered. *

With regard to the vocabulary study and analysis, the investigators chose a list of ten terms which appeared to be in frequent use with patients, in one of the outpatient clinics studied. This selected vocabulary was chosen on the basis of suggestions made by medical personnel, as well as the researchers' observations in the clinic context. (22)

The words were presented to the patients during the course of the interview with the researcher, which was after their initial visit with the clinic physicians. Most of the words were place in sentences, in the context judged to be meaningful for the particular patient interviewed. (23)

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* Answers were categorized as 1) Adequate, 2) Approximately Adequate and 3) Inadequate. 1) Adequate understanding referred to the evaluator's judgment regarding the physicians and the patients ability to communicate and understand each other effectively in the context of the whole interview. 2) Approximate understanding referred to the evaluator's judgment that the physician or the patient had experienced some problems in communication but these problems had not been of a large enough dimension to erect serious communication barriers in the interview. 3) Inadequate understanding referred to the evaluator's judgement that the physician or the patient had experienced serious problems in understanding the other.

The responses were filled in by the investigator in a regular form but the scoring was done by the researchers after the interview, and with the help of the transcriptions from the tape recordings. The following four fold scoring procedure, adapted from Samora's study was used for evaluation :

1) Exact knowledge.- when in the judgment of the researchers the patient showed an adequate understanding of the concept, even though this identification did not coincide exactly with the technical definition of the term. (See Appendix A)

2) Approximate knowledge.- when in the judgment of the researchers the patient showed a working understanding which was adequate enough so that in the context of the medical interview he did not suffer from errors in interpretation.

3) Lack of knowledge.- when in the judgment of the researchers, the patient was ignorant of the meaning of the word, or of its use in medical discourse context; or when this knowledge was so vague as to be equivalent to ignorance.

4) Erroneous knowledge.- when in the judgment of the researchers the patient expressed an erroneous understanding of the term.

In the assessment of the modes of presentation of self, an evaluation was made of verbal and nonverbal components judged to influence the manner in which physician and patient encountered each other. These included the following factors: 1) pitch and tone of the voice, 2) the manner of phrasing statements, and 3) patterns of communication of affect, such as the physician's com

municating to the patient a sense of understanding his feelings and the meaning of life events to him. (24)

A panel of seven judges -a sociologist, two anthropologists, a psychologist, a psychoanalyst, an endocrinologist, and a surgeon- were asked to listen to an average of three taped interviews, chosen at random, from the total universe. Only in two cases were there differences in their evaluation of the expression of empathy by physicians, and the judgments made by the present investigators.

Findings : A. Verbal Communication Analysis

Both the doctors and the patients tended to agree in judgments that there were few serious barriers in their ability to understand each other at a verbal level. Thus, in 90 percent of the cases, physicians indicated that they had understood the patients. Three percent expressed "serious problems" while in seven percent of the cases physicians referred to a mediocre understanding of the verbal communication of their respective patients.

The cases that presented recognized communication problems to physicians were those in which patients presented "vague" symptoms which were difficult to pin down, or those in which patients came with a diagnosis to be "confirmed" by the physician. A resident tells us :

M.D. "The interview with this patient is one of the difficult ones because they are , . . patients with a number of psychosomatic problems so that they have problems at almost all somatic spheres . . . abdominal nervous,

muscular . . . and another of their characteristics is that they tend toward details . . . so that . . . one may cut her off and then she immediately loses spontaneity or one has to guide the interview and then this will also result in a partial loss of spontaneity . . . In this interview I could not get to the root of the problem with her . . . It looks as if she tries to cover herself . . . she emphasizes that she has no problem . . .

I. But do you believe that she did understands your questions?

M.D. From that point of view, from the somatic point of view she presented minute details, but many more interviews will be needed in order to get to the heart of the problem."

In 83 percent of the cases, patients stated that they had understood the physician, while 9 percent felt that they experienced some problem in understanding him. Only in 5 percent of the cases did patients express serious problems in understanding the physician. Data were unknown for 3 percent of the population.

Factors associated with differences in formal education, age, origin, or sex, did not appear to have a significant influence on the ability of patients to understand the physician. However, when the data were analyzed by region, it was noted that with one exception, patients who expressed problems with understanding the physician had all attended one of the clinics. Almost all of these patients were of rural origin. Women in the group tended to focus on problems in understanding the physician's questions on menstruation, or related

sexual areas. A rural woman says :

P. ". . . I hardly understood him Miss. I was told . . . The Aide told me . . . that I should return in March, I don't know . . . in May . . . the Doctor didn't tell me anything, other than to return to an exam. What kind of an exam? Of that? (neurology?) No Miss, I don't know what that is . . .

I. . . . What about the Doctor's questions? Were you able to understand them or were some of them not very clear?

P. He asked me whether I fought with my husband and all of that. I told him that I did not . . . who knows what that was about . . . I wondered whether the sickness was related to fights with him . . . Who knows what it was about . . ."

To measure further the extent to which physician and patient communicated effectively with each other, an analysis was made of the vocabulary study material which was judged to represent typical words used in medical discourse.

The median number of "exact knowledge" responses was 7.3 words. As Table 1 shows, no respondent has "exact knowledge" of all the words, and no single word was adequately defined by all patients. More than 83 percent of the respondents has "exact knowledge" of the four words "formula," "drug or remedy," "vomit," and "colic," the terms "diarrhea" and "X rays " were adequately understood by more than 71 percent of the respondents while more than 45 percent of the patients had "exact knowledge" of the terms "nausea"

"lab exam" and "chronic." It is of interest to note that 43 percent of the pa - tients showed a "lack of knowledge" of these last three terms, the highest rate found in this category. With regard to the words most frequently judge as "erroneous," 13 percent of the patients showed a mistaken understanding of the term "diarrhea" while 9 percent erred in their understanding of the concept "colic." (25)

There were four factors thought to have an association with vocabulary knowledge: sex, age, amount of formal education and origin. As Table 2 suggests, there were no significant differences in the total response patterns according to origin or sex. However, an analysis of the specific response patterns of the patients with the highest "exact knowledge" responses of eight or nine words, showed a tendency for these respondents to be urban origin. With regard to age, patients in the 31 - 40 categories had a higher "exact" response rate than patients in the younger or older age groups. Thus, these patients had "exact knowledge" of more than 76 percent of the vocabulary, while the highest "exact knowledge" response of older or younger patients was 68.5 percent. (Table 3). As it might be expected, with an increasing amount of elementary school education there was a tendency for patients of both sexes to have an increasing number of "exact" knowledge responses. (Table 4)

With regard to the possible association between vocabulary responses and the patient's ability to understand the physician, it is of interest to note that patients who had expressed some problem in understanding the physician had a median number of 5.5. "exact knowledge" responses in the vocabulary

study, which contrasted with the previously mentioned "exact knowledge" median response of 7.3 for the total population.

Verbal Communication Discussion

The relative percentage of cases in which physicians and patients expressed recognition of problems in understanding the other was low, but these cases do offer clues of possible importance for future more detailed study. It is important to note that the rural patients with a lower medical vocabulary knowledge who expressed problems in understanding the physician had attended one of the three clinics. It is of additional relevance to observe that most of the women who referred to problems in understanding the physicians tended to have complaints associated with sexual areas, such as menstruation, or doubts about the possibility of pregnancy. As small as this group is, it poses dimensions which cannot be overlooked in a more extensive search for the sources of communication problems in clinic settings. Rural origin and vocabulary knowledge appear to offer a more serious problem in communication depending on the nature of the problem and on the orientation of the particular clinic organization toward patients.

Turning to the findings of the larger proportion of the population, it was noted that there appeared to be relatively few problems in doctor patient communication at a verbal level. These findings might surprise researchers and other interested students. For as we suggested in the review of the literature and in our own introductory supposition when social distance exists between physician and patient due to class membership, other subcultural vari -

ables , or vocabulary deficiency, problems in verbal communication are likely to emerge.

Our explanation for the present findings would appear to be associated with the general recognition held in the clinics that their patients were likely to show communication problems. Thus medical personnel worked with the assumption that their lower class patients were ignorant of scientific medical knowledge, the procedures, and the terminology associated with "modern" medical practice. The use of paramedical personnel such as aides or special men posted at strategic places was designed to offer patients "information" and "clarification" in the setting. Physicians were attuned to the need to "reword" basic medical concepts which were not immediately grasped by patients and they also depended on aides to interpret the prescriptive orders offered at the end of their interviews.

However, our own observations in the clinic settings offered an alternative relevant dimension of the problem which cannot be overlooked. Even though paramedical and orientation personnel were expected to present verbal material in terms which could be understood by patients, there were other indications to suggest that verbal communication problems continued to exist. The marked tendency for patients to consult with each other, or to use passersby for clarification of concepts as well as for general orientation to the setting pointed to the existence of communication hiatuses between patient and paramedical personnel.

With regard to physician patient communication at the verbal level there were, as we stated, few apparent problems in having patients grasp the general meaning of the topics under discussion. If patients showed ignorance or misunderstanding of the "key" terms which opened a general subject of discussion, physicians "reworded" concepts. Thus, requests for information on the subjects included in routine history interviews such as the "presenting problems," history of other illnesses, operations, menstruation, urination or defecation were generally understood by patients. Respondents could offer record of previous illnesses or operations, and they had few questions about subjects such as urination or defecation. On this denotative level, judgments were offered that there were relatively few communication problems. Patients could understand what words stood for.

However, problems were evident in the elicitation of the more specific symtoms associated with the main topics under discussion because physicians tended to take it for granted that patients could just as easily offer the range of specific symptoms necessary for diagnosis. Patients could clearly communicate that they menstruated or urinated, but that of course, is not the limit of the diagnostic inquiry. Communication on the diagnostic indicators such as menstrual regularity and timing, or the color or urine -the specific qualities which offer a basis for diagnosis- offered a source of frequent problems in communication between the physician and patient. The typical physician who made efforts to have his patient understand the "general"subject of

discussion often failed to maintain this same sensitivity to communication problems once he started to "break down" his inquiry into the component elements necessary to obtain a full diagnostic picture.

The following three illustrations serve to highlight these types of problems. It might be noted that all physicians and patients do not react similarly to the communication gap. The first and third cases point to the "corrective" steps which a physician or a patient take when they recognize openly that communication problems exist. Case two, typical of situations in which physician and patient do not openly identify their mutual problems in communication offers an illustration of a "problem" case.

In this first example, the physician began by taking it for granted that the patient was knowledgeable about "problem" signs associated with urination; as the dialogue suggests, the physician eventually identified the patient's difficulty in understanding him, and he proceeded to ask more specific questions.

Dr. How is your urine?

P. What? My urine? is it bad?

Dr. Is it well, are you urinating daily?

P. Oh, yes . . .

In the second case, the physician attempted to elicit information about the regularity of menstruation. The patient's comments suggest that she had limited "scientific" knowledge of the relationship of menstruation to other processes such as pregnancy. As they both continued in a straightforward ex-

chage, the doctor began to offer possible alternative answers, in response to which the patient gave the perceived "expected" answers :

Dr. How does your cycle come ?

P. No doctor, it does not come frequently

Dr. How often is your cycle ?

P. Sometimes it comes every 6 sometimes 7, sometimes 3 months.

Dr. And how long does it last ?

P. It lasts eight, eight days.

Dr. How long has it been that way ?

P. No doctor, ever since I began menstruating.

Dr. Since you began menstruating ?

P. Yes Dr.

Dr. Have you had any children ?

P. Yes Doctor . . .

Dr. How do you know when you are pregnant ?

P. No doctor, when my stomach grows.

Dr. You tell me that it comes every three, four, five months ?

P. Yes doctor, but sometimes it does not come, with the two girls it did not come but I learned that I was pregnant when I was already.

Dr. That's why I ask, have you always menstruated every three, four, five months ?

P. No doctor.

Dr. Then how often?

P. That is to say, it doesn't have a fixed date.

Dr. But tell me more or less how often do you menstruate in general, is it every month and a half, one month, eight days, six months, five months?

P. Yes doctor.

Dr. That is to say when you first began to menstruate how often did it come?

P. That is to say . . .

Dr. When did it come?

P. Yes doctor, after my first menstruation it was eight months before the next menstruation occured.

Dr. And after that?

P. After that it was three months before it came.

Dr. And then?

P. Then it took six months and it came back.

Dr. And then?

P. Then in the . . . every three months.

Dr. Has it always been that way?

P. It has always been that way. . .

In this last situation, the physician asked questions on the color of urine, a factor which was not meaningful to the patient. Rather than to guess at the "expected" answer, however, the patient vividly let the physician know

that due to her own life situation she has not been conscious of the color of her urine:

Dr. How is your urine ? Have you noticed any change, an increase in the quantity of urine, or a change in color ?

P. Yellowish ?

Dr. Yellowish, has it ever been red ?

P. No doctor . . .

Dr. Has your urine ever been muddy colored ?

. . . as if it were dirty . . . ? as if it were . . . smelly ?

P. Well you see since I live in the country one has to urinate on the ground . so that one hardly notices.

B. Presentation of self analysis

The preceding discussion on verbal communication problems in evidence in the interaction between physicians and patients offered relevant material for our field of inquiry. In addition it was felt that the identification of dominant styles of interaction between physician and patient could complement the more detailed analysis of verbal communication. Focus on the typical modes of communication between physician and patient could move the investigator in the direction of defining what Wheeler has aptly described as the differential responses of persons in formally organized settings to the problems found in these organizations, (Wheeler, op. cit., p. 76) and it could assist in the investigations of the possible relationships between the styles of interaction and communication problems.

Turning to an examination of the characteristic manner in which patients and physicians presented themselves in clinical interviews, four distinct patterns were evident. Physicians presented themselves as: 1) "bureaucratic task oriented," 2) "insecure and detailed," 3) "self-assured," and 4) "amiable-expressive oriented." Patients presented themselves as: 1) "matter of fact collaborators," 2) "vague or difficult to pin down," 3) "pleasantly collaborative," and 4) "miscellaneous types."

a) The "Bureaucratic Task Oriented" physician and the "Matter of Fact," Collaborative Patient. In 55 percent of the total number of interviews, physicians tended to present themselves in a "bureaucratic, task oriented" manner. (26)

Concerned with their immediate tasks of arriving at a diagnosis and making decisions as to the disposition of the case, these physicians covered the necessary history material. However, they expressed limited sensitivity toward the feelings which patients had about the problems brought to the consultation room. In their mode of approach and communication, the efficient "bureaucrats" wanted to get their job done. They asked standardized questions and in most cases they received direct answers.

In their interaction with this type of physician, patients presented themselves most often as "matter of fact collaborators" who answered questions in the order presented, and who expressed little initiative or overt concern over the direction which the physician gave to the interview. Thus, 80 percent of the patients in this group responded in the complementary "matter

of fact" fashion which appeared to be expected of them. Of the remaining patients, 16 percent followed "miscellaneous" modes of communication, such as elusiveness and rambling, while one patient (4 percent) who showed collaboration with a greaterdegree of spontaneity in the expression of positive feeling toward the physician, was categorized as "pleasantly collaborative."

It is of importance to note that the "matter of fact" patient was not at all "passive." He answered questions in a similar routine fashion as that which was folowed by the physician. Analysis of the general content of the taped interview material as well as the researchers' observations on the behavior followed by patients outside of the physician's office suggested that a number of patients would have been able to openly express their feelings about illness, or other areas which they perceived as associated with their general state of health. A "matter of fact" patient, however, was successfully able to "turn off" his own spontaneous expression of symptoms and feelings to follow the routine of the questions asked by the physician.

Seen as a two way process then, the "bureaucrat" was successful in following a specific communicative mode, vis a vis the patient who responded to him in a complementary fashion. (See illustration, Appendix B)

b) The Insecure Detailed physician and the "Vague" and "matter of fact" patient.

Contrasting with the "matter of fact" mode described above, in 20 percent of the total number of interviews physicians tended to carry out very detailed and lengthy interviews. Numberless questions however, did not con-

tribute to a more detailed or meaningful understanding of the issues under discussion, nor did prolonged explanations appear to lead to the establishment of positive rapport between physician and patient. The fact that this manner of communication represented 31 percent of the total number of interviews undertaken by regular physicians appeared to suggest that the limited experience of students as well as their sensitivity to participate in the project shaped their manner of communication with patients.

In response to this approach, 59 percent of the patients in the group responded with a lack of precision, and with minutely detailed answers. In 33 percent of these cases patients answered in the characteristic "matter of fact" fashion, while one patient (8 percent) answered in a "pleasantly collaborative" fashion. (See Illustration Appendix C)

c) The "Self Assured" physician and the "Matter of fact" or "Miscellaneous" type patient.

In 12 percent of the total number of interviews, physicians had a tendency to communicate, above all, a sense of "self-assurance" and correctness" about the questions asked, as well as the interpretations offered. With one exception, these interviews were conducted by the regular physicians, with a longer period of employment in outpatient settings.

These physicians often asked questions and offered interpretations about "underlying" problems which the patients had not volunteered, or which were not included in the regular history questionnaire, such as poverty, problems in family relations, or birth control. However, in their manner of deal-

ing with issues which were obviously sensitive to patients, physicians offered little opportunity to patients to do more than to acknowledge the correctness of their interpretation.

Almost half of the patients in this group (43 percent) responded in the matter of fact fashion, while the rest were characterized by miscellaneous modes of response such as elusiveness, spontaneity, self-assuredness, and slow responses due to apparent retardation. (See illustration Appendix D)

d) The "Amiable" Person Oriented Physician and the "Matter of Fact" or "Pleasantly Collaborative"Patient.

Finally, in 11 percent of the total number of interviews, a distinct pattern of communication was classified as "amiable" or "expressive oriented" because of the greater extent to which the physicians individualized their approach with the particular patients in the office. With one exception, these interviewers were students.

Physicians in this group expressed empathy toward the feelings experienced by patients and they asked and summarized questions at various intervals in the interview. The social factors which influenced the patient's behavior were recognized and used for diagnostic purposes. In contrast with the "self assured" type who identified "underlying" problems and offered interpretations as to the cause of problems, the "amiable" type showed an awareness of the feelings of patients and of the need to "time" sensitive questions or interpretations. The "self assured" type showed an ability to diagnose or identify the sociopsychological factors influencing the patient, but he appeared to

have less insight or flexibility as to the appropriate use of this knowledge in promoting a positive therapeutic relationship.

In response to the "amiable" mode, one half of the patients related in the matter of fact fashion while the others were pleasantly collaborative in their answers. One patient was characterized by marked rambling. (See Illustration Appendix E)

Presentantion of Self - Discussion

Analysis of the types of presentation of self in evidence showed that the "matter of fact" mode predominated for both physicians and patients. When not following this bureaucratic approach to patients, students and residents tended to present themselves as "amiable" person oriented types, or as "detailed, insecure" interviewers. The most frequent alternative communication modality found among experienced physicians was the "self-assured" approach toward patients. While age and experience appear to exert a limited influence on the approach toward physicians, the prevalence of the "bureaucratic" manner points to the strength of the organizational influence on behavior. (27)

In terms of the relationship between this modal "bureaucratic" pattern and the effectiveness of verbal communication, it is important to indicate that the bureaucratic roles do allow for "corrections" when general terms are not grasped by patients. Bureaucratic type physicians often "reworded" general terms in order to make themselves understood to patients.

However, this modal bureaucratic pattern, with its pressures to "get the job done" appears to make it more difficult for physicians to maintain alertness or sensitivity to the subtle but important gaps in communication which occur, for example, when a physician asks "How is your urine? and the patient feels obliged to "guess" at an "expected" answer. The bureaucratic form of interaction requires a continued question and answer rhythm and as long as this pace is maintained, the physician tends to find few comprehension problems.

It should be of little surprise to investigators who have analyzed doctor patient relations in outpatient clinic settings to learn that the bureaucratic physician had a tendency to show lack of empathetic understanding of the feelings of patients. (28) Certainly, it has generally been recognized that the "ideal" model in which the "personal" touch is shown toward patients is not typical of interaction in outpatient clinics. As Schlesinger et. al. have pointed out in their study of outpatient care in an obstetrical clinic, the mode of organization of the clinic unwittingly frustrates even the staff member who recognizes the importance of emotional support:

"Problems arise from the fact that a teaching clinic must serve all patients eligible for the clinic who apply for care. As the patient load increases, the available time, space, and staff personnel which of necessity remain relatively constant, must be spread more thinly. The result is all too often a sacrifice of the patient's individual needs and those of the staff as well" (29)

Such observations point to the need to turn to an examination of the factors which influenced the bureaucratic manner in the clinics under study. We find it important to examine not only the structural factors -the requirements of the clinic systems- but the processes through which patient and phy

sician acquired the typical components of the bureaucratic self. Two questions appeared relevant for discussion: a) In the first place, what mechanisms, cues, or processes prepared patients and physicians to present themselves as "bureaucrats" ? b) Secondly, was it possible to identify traces of the "traditional" patterns of communicative behavior associated with the differential class membership of patients and physicians, alongside with the predominantly "bureaucratic" patterns ?

C. Factors which Account For The "Bureaucratic" Presentation of Self

a) The Patients .-

With regard to patient involvement with medical resources, we selected patients who were attending the outpatient clinics for the first time, in an effort to obtain a study population who would not be "experienced" in communication with scientific health personnel. However, for very few patients was the clinic visit a "first" experience in contact with modern medicine.

Only two rural patients had never consulted a physician at all. In addition, in only 16 percent of the total groups did patients come directly to the clinics for initial consultation for their medical problem. The rest of the patients had followed a pattern of using home remedies, lay practitioners and health personnel for their specific medical problem, before actually approaching the Clinic.

Patients of rural origin tended to seek Clinic service because of personal dissatisfaction with the effectiveness of lay and scientific resources

in their places of residence, referral by their local physicians for more extensive consultation, or , for the use of equipment not available in local public health centers. In a rural woman's words :

"My problem began a year and a half ago. . . The first time I went to a doctor he gave me a formula and I improved a great deal; now the pain returned for the second time . . . it attacked me here at the "swallower" ("tragadero"). . . The Doctor told me that it was better for me to come here because what I needed was an X ray because he didn't know what it was, nor what to do."

Patients living in urban areas referred to their lack of financial resources or their loss of medical insurance privileges (I.E. medical coverage under social security) as the reasons for seeking Clinic care. (30) An urban man said :

"I have seen Doctors, herbmen, rootmen: Don Juan, Don Emilio . . . My friends have prescribed warm baths . . . Dr. Benicio gave me five formulas - it was good for nothing - ; he told me, Sir, I can no longer help you, the remedies themselves aren't even worth anything -here, take this note, go and give it to the Head of the Hospital in the Outpatient Clinic- tell him that I sent you- that you are a very poor man- , that you have a very large family . . . and so I came and I showed the note and right then and there they began to fill out my papers . . . "

In addition, observations on the course of events followed by the patients from the time of their arrival at the clinic, to the actual entrance in the physician's office pointed to the pressures of the organizational context to

ward conformity to bureaucratic patterns. To paramedical personnel, an ideal patient followed routines efficiently and he did not express overt disatisfaction over the hospital procedures or the personal manner of any clinic members. Contacts with an average of five members of the clinic team prior to the medical interview set the clues for the behavior which was expected in the doctor's office. Thus, we are suggesting that the previous experience with medical resources as well as the immediate demands of the clinic setting to have patients follow bureaucratic behavior set the climate for interaction with the physician.

These observations do not suggest that the successful adaptation of behavior to the perceived requirements of the clinic systems necessarily carried the approval of patients. Thus, an analysis of the evaluation offered by patients about the physician's manner of communication with them revealed a tendency to express disatisfaction with the physician's lack of empathy. (31)

The patients who described the ideal qualities of physicians referred to "proper" treatment, through which physicians showed "respeto" (respect) and "amabilidad" (amiable behavior or courtesy). These qualities led to the establishment of trust in the physician- "para que inspiren confianza." Patients disliked the physician who was reputed to "shout" to patients or "scold" them for asking clarificatory questions. While some patients acknowledge that the large volume of persons in clinics made physicians want to "get rid" of patients quickly, they indicated that such pressures did not allay their own fears about the possible effects of illness, or feelings of disorientation about the "proper" behavior to follow in interviews with the physician. An urban woman

spoke with the researcher :

I. Would you like the same doctor or would you like to have another one ?

P. I would like . . . another one . . .

I. Another one . . . ?

P. I don't know. Since one gets so nervous. . . The doctor seems to be so angry . . . I get so nervous . . . Of course now with the worry of the sickness . . . One goes in so nervous, one doesn't undestand what they are saying . . . Sometimes one gets the feeling that they did not understand what one said . . . One goes in, but one doesn't even know where to sit . . . if they tell you sit down one sits down, but if they don't tell you anything, well one waits . . .

I. What should we do so that people would feel less nervous when they come here ?

P. I don't know Miss . . . You know that one . . . that is to say, anyway one is afraid of a stranger; secondly: when one is sick one gets worried because . . . thinking about that only, one doesn't know it might be serious.

I. And what would you believe would serve to calm a patient under those circumstances ?

P. Courtesy, Miss . . .

b) The Physicians.

A number of physicians first made informal remarks about difficulties they encountered in communication with the very "rural" patient who had never had experience with medical settings. However, it was our impression that physicians emphasized this problem to satisfy the interest of the researchers rather than to express the most serious communications problems they felt. Indeed, when we examined the content of our informal discussions with the physicians, other communication problems, discussed with a much greater feeling of intensity and concerns, clearly reflected the areas which the physicians themselves experienced as serious problems in communication.

Physicians most often suggested that they had difficulties in communication with verbose patients who presented vague symptoms which were difficult to pin down, and in the communication of directions accompanying the prescription of medication or other medical orders. Physicians also disliked communicating with patients who came with a diagnosis to be "confirmed" by the physician, or with patients who used "scientific" medical vocabulary "out of context."

In reference to their preferred modes of communication, physicians categorised patients as good collaborators when they answered questions simply and directly. A valued patient had a good capacity to express himself well and to describe symptomatology clearly. Little concern was shown over problems in expressing empathy towards patients for communication problems were associated with terminology difficulties or with the patient's capacities,

rather than with the physician's own manner. The following dialogues between the research physician and the clinic doctor express these concerns :

(Physician associates satisfactory communication with the patient's ability to present material "concretely")

Researcher . . . There was no problem ?

Dr. None, she is quite concrete . . . A pain in the left breast which began two and a half years ago; she says it began to suppurate. There is blood coming out; it looks like a carcinoma.

Researcher Was there any communication problem ?

Dr. None.

(Physician blames the patient's lack of "coherence" on his illness)

Researcher How does the patient communicate ?

Dr. There is a certain incoherence, this character is not agile (ágil) possibly because of his state of undernourishment (estado carencial) . . . well we'll dig out the data.

Researcher What are you going to do to him ?

Dr. No, lab exams, in the first place to take down these facts in his history . . . and in accordance with that I'll send him over there so that they may check him.

Researcher Are there any communication problems ?

Dr. No, there are none . . .

(Physician associates the patient's pattern of collaboration with limited intellectual capacity)

Researcher . . . How is he, was there any communication problem ?

Dr. As far as terminology . . . well, I understood him, and I believe that he understood me.

Researcher How would you categorize this patient? Not very collaborative?

Dr. He tries to collaborate but he lacks the capacity to do so.

Researcher He does not have capacity? Intellectual capacity to communicate?

Dr. That's it, to communicate.

Researcher Did he use strange terms or a lot of words?

Dr. He used some of the terms common among the people . . . Well, the only thing that needs to be clarified are his movements; he did a lot of acting with his hands . . . "It hurt here . . ." "It moved this way . . ."

Researcher . . . As far as your own communication with him, do you believe that you communicated easily with him? that he understood you easily?

Dr. I would ask counterquestions to see whether he had understood me, and he had.

An examination of the organizational demands placed upon physi - cians showed that the pressures of inadequate time and heavy patient loads con tribute to the "task oriented" approach found prevalent among physicians. Pre ferences for follow-up rather than initial interviews were also well in evidence. The number of intake contacts per work period, which has often become the sub ject of conflict with administrators, is in itself a source of frustration. The longer time requirements of initial interviews, as well as the possibility of los- ing contact with the patient through referral to other specialists all contribute to the physician's less valued interest in new patients.

Hayes has indicated that the overwhelming demand for services mentioned above, is aggravated by the tendency in teaching hospitals to have

physicians view clinic service as a type of Siberia in which tasks are to be undertaken by medical personnel of inferior levels. (32) Certainly, the comments by one of the clinic directors point to the possible influence of administrative expectations on the modalities of communication between physician and patient:

(clinic administrator)

"Obviously, an outpatient clinic fulfills a very important social function for the community. As you know we have numbers of people who consult us . . . It would be impossible to hospitalize all patients and so we must make attempts to limit entrance only for persons with urgent problems.

We cannot work perfectly for fear of having experiences such as those of Dr. . . . ., our former Assistant Director. He tried to have physicians take a "good" history but as a result, many patients were left without service. . the patients stoned the hospital . . .

Most of the clinic patients do not have serious problems . . . We must have personnel to select out and eliminate this type of patient."

D. Bureaucratic Patterns and Social Class Distance ?

Questions may be raised about the relative influence of the social class membership of physician and patient on their patterns of communication. Did the prevalent "bureaucratic" mode becloud the social background of physicians and patients, so that social distance exerted a minimal influence on communication modes? Or, did the group of experienced physicians, residents and medical students, as members of the middle or upper classes, demonstrate

communication problems with their lower class patients, which could be associated with the social distance between them?

The present findings pointed to the prevalence of "bureaucratic" forms of communication between the physicians and patients which appeared to be associated largely with the functional demands of the clinic settings. However, it is important to emphasize that if the analysis of communication at the patient-physician level did not in itself suggest communication problems associated with social distance, the conclusion cannot be drawn that this variable did not influence the behavior found in the general clinic setting.

Roemer has observed that in most Latin American countries there is a distinguishable system of medical care associated with each of the social classes, a pattern of social and economic organization by which medical personnel and facilities are applied to the diagnosis and treatment of sickness. "One could readily identify a person's social class . . . by examining the way he obtained medical care" (33) In the present study it was evident that the "rational" demands for efficient and task oriented service shaped the "bureaucratic" behavior of doctor and patient toward each other. But while physician and patient made efforts to respond to each other according to the "manifest" requirements of their roles as doctor and patient, the social climate (34) or the general "feeling tone" of the clinic communicated the responses of the medical organizations toward the "latent" identity of the patients served, their low socioeconomic status. (See, for example, Appendix F)

Elements such as financial eligibility procedures, long waiting lines, drab wooden benches, or the relative lack of privacy in medical offices, all expressed the values held toward poverty stricken populations, as well as the problems faced by the larger society in the delivery of services to the needy. In some cases, the marginal position of the patients was reinforced through unverbalised policies in which the "less valued" paramedical personnel in a hospital were those assigned to clinic service.

While discussion of these elements would appear to take us beyond our present focus on the influence of social distance on communication at the patient-physician level, we would like to indicate that in future more extensive research on communication in clinical settings, specific attention needs to be paid to this relationship of organizational goals on the relations of medical personnel with patients. Certainly, social class distance between patients and physicians may make it difficult to establish a relationship of mutual trust. However, if a number of patients use a particular type of medical organization such as a clinic when other medical and financial resources have been exhausted, or if medical services for the poor can be clearly differentiated from those offered in other socioeconomic groups, the question of social distance and trust clearly must be studied in a framework which extends beyond the patient physician dyad. The present investigators hope that in future more detailed study it may be possible to move from the initial stage of identifying this latent social climate to the more specific and dynamic analysis of the ways in which manifest and latent forces shape each other.

Summary and Conclusions

The present study was undertaken in order to explore the processes of communication between physician and patient in outpatient clinics and to evaluate the relative influence of social class distance and medical vocabulary knowledge on their mutual patterns of interaction. In summary:

1. Only 14 percent of the patients and 10 percent of the physicians referred to problems in understanding each other at a verbal level. Physicians expressed problems with "vague" patients or those who sought medical "confirmation" of a diagnosis while almost all of the communication problems identified by women patients were associated with understanding material in sexual areas.

In terms of the vocabulary knowledge of terms judged to be in frequent use in the clinics, patients had a median "exact knowledge" of 7.3 words. Patients who had expressed some problems in understanding the physician, had a lower median "exact knowledge" of 5.5 words, suggesting an association between knowledge of medical vocabulary and the ability to understand the physician. However, it is important to note that when the material for the three clinics was compared, it was found that with one exception all of the patients with comprehension problems were found in only one of the three clinics. It was found further that almost all of these patients were of rural origin.

2. The relationship between the modal bureaucratic presentation of self and comprehension at a verbal level merits more detailed study. A bureaucrat who express a limited sense of empathy toward his patient maintains

the question and answer pace required in order to complete diagnostic tasks. If the patient does not understand a general topic of discussion, the physician is quick to correct his vocabulary. It was noted however that the pressure of the question and answer routine appears to make it more difficult for doctors to uncover the diagnostic "details" of a subject.

Some patients recognize and verbalize problems in understanding the physician. However, what type of physician evokes "expected" answers ? What characteristic ways of dealing with illness on the part of patients lead physicians to fail to recognize, or to deny the existence of comprehension problems ? The investigation of such questions should lead to a more meaningful understanding of physician patient communication problems.

3. The present researchers discussed the influence of the relations between the social background of the physician and patient, and the situational context of the clinic organization. Since the present evidence suggests that the organizations within which patient or physician interact set the tone for the style of communication followed, there is a need to undertake more specific inquiries into the processes within the broader organizational settings which socialize members for action.

With the increasing recognition that the Colombian Physician of today tends to denote more time to work in bureaucratic settings rather than in solo practice, (35) there is a further need to obtain information on the organization of practice in large scale bureaucratic settings in order to help us to identify the educational requirements to meet the demands of the contemporary

medical world. Given our rather limited knowledge of the processes of social behavior in large scale organizations in Colombia, or Latin America as a whole, we would hope that social science research efforts can be turned increasingly in this direction.

In conclusion, we would like to make final observations on some of the broader implications of this exploratory research for medical practice and education. Effective communication between physician and patient at verbal and nonverbal levels is a basic tool for treatment. As Samora et. al. have stated :

> A question could be raised about the necessity of adequate communication between patients and those who treat them in hospital and clinic. Certainly no one has demostrated that those patients who understand everything that is said to them, get well faster or more certainly than those who do not. Perhaps if the goal of medicine is the diagnosis and treatment of disease, the quality of communication between practitioner and patient makes little difference so long as an adequate medical history can be obtained and the necessary cooperation of the patient in doing or refraining from doing certain things can be assured. But if the goal is more broadly interpreted, if the concern is with the person who is sick and the purpose is to relieve, reassure, and restore him -as would seem to be increasingly the case the quality of communication assumes instrumental importance and anything that interferes with it needs to be noted, and if possible, removed. (36)

Research on the identification of problems in communication between physicians and patients certainly does not insure that such knowledge will be used automatically by administrators or practitioners to improve the adequacy of medical care in clinics. And thus, in discussions of the implications of the present study or in the development of a strategy to modify the climate of clinics, we are guided by the belief that we must make efforts to relate findings to the realities of medical practice in large scale organizations in Colom-

bia. We also believe that as researchers it is our responsibility to assist medical personnel such as clinic practitioners and medical educators to incorporate and sustain a system of scientific inquiry from the behavioral sciences which offers knowledge pertinent to the focus and direction required by contemporary medical education and practice needs in Colombia. Two factors can be singled out for discussion:

1. The development of an effective "social climate" in clinics, geared toward the introduction of change, rather than the reinforcement of the marginal social conditions of patients can offer a positive contribution among needy sectors of a population. However, without concerned efforts on the part of hospital administrators to develop new philosophies of service and to clarify their own conceptions about the type of health agencies which can best meet the health needs in a given area, efforts to modify communication patterns would be short sighted indeed.

With a recognition of these problems the researcher who participates in health organization research must turn his attention to the establishment of "feedback" mechanisms or to the development of collaborative relationships through which to apply research findings so that the administrator and his practitioners might be assisted to develop new approaches to the delivery of health services.

One way to initiate such collaboration is through a more dynamic use of the information which already exists in settings such as outpatient clinics. Thus, the systematic analysis and use of data on the types of problems

brought to clinics should offer a meaningful framework to understand the relationship between specific medical problems and communication gaps with medical personnel. The priority of this goal would appear to be indicated by its potential as a source of data for the development of realistic health service policies, as well as for organization of an effective service training programs. Indeed this knowledge becomes more important if agencies such as clinics are to become the vital organs, rather than the appendages of the system of health organizations of a region.

2. It has been assumed that the introduction of behavioral science content in the medical school curriculum can help the future physician to become sensitive to the socio-cultural context of health problems, as well as to understand the influence of these same factors on patterns of interpersonal relationships.

However limited attention has been paid to the type of learning which is required in order for the practice oriented physician to integrate social science knowledge meaningfully with the demands of practice. Medical students may participate in field experiences in the community, in order to become "aware" of the social context which influences the patient. But with few exceptions do we find in Latin America reports of efforts to help the student physician to integrate his knowledge in the clinical setting, under the supervision of a social scientist or qualified medical educators. (37)

If medical education is geared to the provision of information as well as to the development of skills and attitudes necessary to understand and

treat patients, behavioral science teaching content which gives only a minimum "general information" requirement will not offer the medical student the opportunity to relate abstract knowledge to practice. The medical ward, the outpatient clinic, or the social security office -the future fields of the student- should become the training ground where he learns, through supervised experience, to analyze his own performance. Through this organization of learning experience in his own "field", the student should be able to develop the flexibility necessary to use socio-cultural knowledge meaningfully, in his relationships with patients and other medical personnel.

This approach requires shifts in the traditional position of the academically based social scientist. Thus, the combination of teaching functions in the classroom and in the hospital should offer a more effective basis for helping medical students to learn to use information. For the behavioral scientist himself, this approach should help him to identify problems and to design research which has bearing on practice and which establishes links for the feedback of findings which will relate to the mutual concerns of the physician and the behavioral scientist.

Appendix A (Vocabulary)

i.e. 1. Exact knowledge

I. Alright and colic ? have you heard that word ?

Have you ever me: anyone who has had colics ?

P. Colic, yes Miss I had a period when I had colic.....

I. And what.... did you feel when you had colic ?

P. Ohhh I felt as if my " guts" .. were being pierced or stabbed.

I. That they were stabbed.... where ?

P. This... that which is called ....

I. What is it called? What do you call it ?

P. "Guts Miss, (laughing)

---

i.e. 2. Approximate knowledge

I Did they take you through X Rays? What exam did they do ?

P. The one from the body up.

I. Had they ever done it to you before?

P. No Miss

I What do they examine there?

P. There?... Who knows what they examined, they made me undress from the waist up.

---

i.e. 3. Lack of knowledge

I. Have you had nausea ?

P. What? No I don't know anything about that

I. You don't know anything about that ?

P. No m'am, I've never heard.

Appendix A , (Vocabulary)

i.e. 4. Erroneous knowledge

I. And what happens to people when they get Diarrhea ?

P. One gets the feelings of daily wanting to go to sit and I wouldn't "do anything" Miss.

Appendix B - The Bureaucrat

The bureaucratic mode of communication is best illustrated in the following excerpts from an interview between an experienced physician and a married woman of urban origin :

Dr. Sit down there señora; tell us why, why do you come to the hospital ?

P. Because of a headache I suffer doctor and a pain under the left rib.

Dr. Speak a little louder because you can't be heard.

P. Headache doctor that doesn't go away.

Dr. What else ?

P. A pain in the brain, I feel a pain and a lump here in this rib, I can't . . I can't lie on that side.

Dr. Do you feel the lump permanently ?

P. Doctor when I lie on that side it is as if they poked me . . . a piercing pain. . .

Dr. Can you touch the lump ?

P. No doctor.

Dr. Then ?

P. I feel . . .

Dr. What's the sensation like ?

P. Yes doctor a lump that I seem to have there.

Dr. But you can't touch it or anything ?

P. No doctor.

Dr. And why do you say that you have something like a lump ?

P. Because that is what it feels like doctor.

Dr. When do you feel the lump?

P. Doctor not during the day, during the day I feel sharp pains rather, on this side.

Dr. When do you feel the lump there then?

P. At night when I go to bed.

Dr. When you lie head up, on your side or . . .

P. When I lie on my side doctor, on this side, the left side.

Dr. How long have you been suffering from that.

P. One year doctor.

Dr. Does your stomach move every day?

P. Yes doctor.

Dr. Do you have . . .

P. No doctor, that is to say I dont have any appetite but a feeling of wanting to vomit, I feel a great deal of pain in my legs.

Dr. Do you feel bloated? after you eat?

P. Yes doctor.

Dr. Do you get diarreas?

P. No doctor.

Dr. You do not get diarrea?

P. No doctor.

Appendix C - The Insecure Detailed **Physician**

The following excerpts between a medical student and a married woman of rural origin point to the student's attempts to clarify medical orders through detailed explanations. The patient responds in the collaborative fashion which she perceives as expected of her .

Dr. Good, you have to stay here for a few days so that may get this blood exam, no now when you go out to the cashier you ask about that exam. Good, to see how to continue with this, since you are going to return in fifteen days, because I am going to give you a little card so that you may return in fifteen days you may tell me how your menstrual problem is doing; the other problem is with that varicose ulcer; there are two things in the first place you are very fat, very much so, and if you don't reduce, that will never get cured, and it will not only not get cured but it will get worse, it will get larger, and then that will really be worse, then you must reduce at least 20 to 30 kilos, because otherwise it will get worse. Good, then to reduce I am going to give you this . . . these papers so that you may read then thoroughly do you hear ?

Can you read them ?

P. . . . Yes Sir.

Dr. Good you read them over and follow the diet that it says here, with that if you follow what it says here, with that you will reduce and you will improve that . . . your general well being will improve, the menstrual problem will improve because it is in part due to your . . . fatness,

which upsets the whole organism and the weight problem is harmful for those veins, imagine two legs only to support all that weigh; good, then the ulcer problem cures itself only by losing weight. Secondly, by resting, you must rest, I don't know how, but you must rest, at noon lie down for a while, raise your leg thus. when you lie down, raise your legs thus, put two or three pillows or put two "adobes" under the bed to so that the legs may be raised and then the blood that is there filling those veins may move, may empty; then leave some time free and you may thus get cured little by little; good, outside of the rest and the diet to reduce weight for the ulcers I am going to do the following: here is a little formula that you must get prepared, a paste that you may get in a pharmacy to put on the ulcers every four days, every four days.

P. Do I put on the ointment every four days?

Dr. Yes, the ointment, you put on a thick layer, very thick, not thin to cover the whole area, well covered everything real thick.

P. All this purple area, all this?

Dr. Everything, everything, everything well covered with a thick layer, after four days you wash that well . . . you begin to wash, you dampen it, you begin to wash it until it becomes completely clean, right; now I shall explain how to wash it, then after you have washed it well and the ulcer is clean, you put on another thick layer, every four days, every four days and on top of that thick layer you put on a cloth or a gauze band age -I have put it down here on the formula; don't put on a rubber or an

elastic bandage: there are cloth or a gauze bandages that are sold especially for that in a pharmacy: then without tightening it very much, you put it on to cover the whole area and to keep it clean. Good, now here it also says to get boric acid, that is to prepare the wash hear? Remember how you are going to wash it, you boil a liter of water, a liter of water, you put it in a container, and when it begins to cool you put in the boric acid, you mix it well, so that the powder is well mixed, it's a powder, see, then when it is done, you let it get cool, it must be cool, so that it won't burn you leg, completely cool, then with regular tap water you first wash off the paste you put on, you wash it, it falls, it falls and the skin is clean once again, then you wash it with the water solution that you boiled, you wash well, well washed with a . . . with gauze or cotton without rubbing hard because with that water all remains clean, right; that is the last wash, after washing with that solution, then you put the paste on and the bandage over the paste. Now this injection it says here is an intramuscular injection. . . this strong "dorvilon" one intramuscular injection, then this: the paste, the boric acid, and then the bandage. Now about these sheets look: this is the diet that you must follow, here . . . it says: "forbidden foods," that which you cannot eat, so that you may be able to reduce, you must read this well; here: the food which is permitted in moderate quantity . . . that which you can eat and here are the foods which you are allowed to eat as you wish more or less but don't exaggerate the quantities, hear? And here are some examples, for example, a break-

fast sample, what you can eat at breakfast, here is what you can eat at breakfast more or less, they are all things that you eat normally but in less quantity and above all you cannot use sugar anymore or "panela" in any meal which is sweet.

P. Doctor and some pills that I have, Saccharine, may I . . .

Dr. Oh, those are the ones, then you can continue with Saccharine, those are the ones I was going to prescribe.

P. I've been taking those for the last two months only once or twice have I had a little black coffee, with "panela" (brown sugar).

Dr. Good, then see, it's well explained here, then there is a sample of the luncheon how you can . . . what you can eat at lunch for example and it will help you to reduce; now note well, it says here for example : eat : half a banana or a large papaya slice, half a grapefruit, a "lima" or a tangerine, or an orange, all those things only one of those things; orange juice or a "lima" but not the orange juice and the "lima" and the banana, but not all together.

P. No, or otherwise, I don't lose weight, only one . . .

Dr. Only one of all of that and it says so here right: a small pineapple slice; instead of that you can take : a "granadilla" or a "guayaba" or strawberries or papaya right? it is one thing that you can substitute for another, but always only one . . . only one thing.

P. Only one . . .

Dr. Yes. Then look, here it is, this is the diet so that you may read it well

and this is the formula and you already know how to take all the remedies.

P. And this . . . this blood thing?

Dr. No, that is not a transfusion, this they take out a little blood for an exam, different from the one they already did.

P. Oh, different!

Dr. Yes.

P. In the same lab?

Dr. Yes, but you must get that stamped now when you go by the cashier's here? . . . this blood exam, this, you must have it done before leaving, now before leaving, and with this card ask for an appointment for two weeks from today. Now, if you want to delay the appointment longer, I can leave more time inbetween.

P. No, the faster the treatment, the better.

Dr. Now then, if it is easier for you to return from. . . well then return in two weeks, if it is easier, otherwise you can get an appointment to return in twenty days for example.

P. No that 's alright.

Dr. Ah, good, then good. Good then everything is ready.

P. Good, thank you.

Dr. Good bye Señora. Follow the diet, hear!

In his post interview comments, the physician points to his believed success

in communication with the patient:

I. With this señora . . . was there any communication problem with her?

M. No. This is one of the classic examples of the type of patient that comes to these offices, they are patients who are rural, completely rural; they are not urban patients; they occupy a "middle position" and understand the words one uses with them perfectly, the vocabulary one uses, and sometimes one adapts to their vocabulary, then communication is easy . . .

In her post interview comments, the patient indicates that it is the "cure" that is important:

I. How did things go with you today in your interview?

P. How did it go with me in the interview?

I. How did it go with you in the interview? were you able to tell the doctor all that you had to tell him, did you forget anything or . . .

P. I remember . . . ah! I forgot to tell him that I think that I have a back pain.

I. But . . . outside of that were you able to tell him all that you wanted to tell?

P. The explanation of the . . . those certificates, that's what . . . I understand the least . . .

I. That's what you don't understand?

P. The other things are difficult, the veins that's what's worse with me.

I. Yes? Would you still like to return to the same Doctor or would you like another one?

P. All that is needed is a cure, and the rest, the doctor, well,

I. As long as there is a cure?

P. Because it is terrible, to be full of aches . . . or to put it differently It's because I have to take care of the Miss from the rural school . . .

I. Does she board in your home?

P. Yes.

I. Hmm.

P. . . . I prepare meals for her because she lives in our house with board and room and everything; then, the Priest comes, or she comes; one has to take care of whomever comes to the house . . .

Appendix D - The Self Assured Physician

In the following excerpts between an experienced physician and a married woman of urban origin, the physician very early suggests to her that he is aware of her attempts to limit the size of her family. He is direct and he is sure that questions on subjects which are not verbalized directly by the patient are relevant and representative of her actual practices :

Dr. What is your name ?

P. Olga de Peña *

Dr. How old ?

P. Thirty .

M. Married or single ?

P. Married.

M. Children ?

P. Two children .

Dr. Abortions ?

P. One because I fell .

Dr. Sure ?

P. Ja. Ja.

Dr. Have you been operated ?

P. No doctor, I have not been operated .

Dr. Why do you come here ?

P. Because of an ovary, I believe it is an ovary because I have a pain here and my leg hurts.

Dr. What else ?

P. And a pain I've had for about four months in a row and sometimes it's very strong in the mornings.

Dr. How are your menstrual cycles ?

* Note: All names have been changed.

P. Good.

Dr. Does it come well ?

P. From one date to the other.

Dr. How long does it last ?

P. Three days Doctor.

Dr. When did you have your last birth ?

P. The girl is two and a half.

Dr. Do you think you'll get pregnant again ?

P. No Doctor.

Dr. Why ?

P. Who knows.

Dr. What do you mean who knows ?

P. Since the girl is already two and a half . . .

Appendix E. - The Amiable Expressive Oriented Type

In the following excerpts of an interview between a medical student and a married woman of rural origin, the student shows a characteristic pattern of asking the necessary routine questions. He pays individualized attention to the answers offered by the patient. His introductory manner of address to patients, "Allright, tell me what seems to be bothering you," and periodic summarization of the problems presented, differentiate his manner from that followed by the routine man whose interview is characterized by an impersonal straightforward question and answer mode.

Dr. Where were you born doña Helena?

P. In . . .

Dr. And where do you live?

P. I live in . . .

Dr. Are you married?

P. Yes Sir.

Dr. How many children?

P. There's been fourteen.

Dr. Eleven?

P. Fourteen.

Dr. Fourteen?

P. Yes.

Dr. How many are alive?

P. I have . . .

Dr. Fourteen were born?

P. Yes sir . . . I have six alive.

Dr. Well, now tell me what is the matter with you Helena, Why did you come here to the Hospital?

P. I came here because Dr. T. sent me, he was doing some . . . some . . . here are the formulas, do you need them?

Dr. No, not right now, tell me what is the matter with you now, what do you feel?

P. I feel a pain from here on up, yesterday he told me that he could do nothing because he did not know what I had.

Dr. Yes?

P. Sometimes the pain attacks me . . . it thickens inside.

Dr. Yes?

P. And it is painful to swallow

Dr. When did that begin?

P. It's been more than a year since I first felt that, the first time I went to Dr. T. and he gave me a formula and I improved a great deal; now, for the second time the pain returned, and it attacked here - my "swallower" ("tragadero"). A lot of pain here, it swells, I had fevers, then I returned to Dr. T. and he gave me another formula and he told me that it was better that I come here because I needed an X ray that he did not know what it was, what to do, what I had here.

Dr. Good, how long did you tell me that you've had that?

P. About a year and a half.

Dr. About a year and a half? how did it begin?

P. It begin with a small pain here when I swallowed.

Dr. A pain when you swallowed? you don't shake much, you don't shake much?

Dr. Good, now tell me something; how long has it been since you shake and since you have that little lump here on the neck?

P. For about two years.

Dr. For about two years?

P. Yes.

Dr. Very cold? Good. Tell me what else have you felt, outside of the little pain here, the nervousness here, the pain here, the fatigue. vomiting . . . you vomited again right?

P. No sir after that "colerin" . . . . I haven't had any other vomitting.

Dr. Good, you haven't had anything else after that?

P. No, only that, that headache that accompanies me.

Dr. Good, when did you have the first menstruation?

P. When? at fourteen.

Dr. At fourteen? You've had sexual intercourse haven't you?

P. No sir, not yet because I had my last menstruation now this week.

Dr. Good. How long does the menstruation last?

P. Sometimes it lasts four to five days, others it stays eight to ten days.

Dr. Has it always been so irregular ?

P. Yes.

Dr. Good, how often does your menstruation come ?

P. Look, now recently I've been two to three months or even four without having it.

Dr. When did you first get those disturbances ?

P. About six months ago.

P. First I would get sick, every month.

Dr. Good. . .

P. But for the past six months I've been like that.

Dr. Good. So for the past six months you have been so irregular ? Good . . . Everything was normal before, right?

P. Yes sir every month and about six months ago I've become this way.

Dr. In your family what other relatives have had something to do with the thyroid . . . have any of them had goiters . . . do you know what goiter is ?

P. Yes sir.

Dr. Goiter ?

P. No, in my family no one has that . . .

Appendix F. - Patient's Perception of the Clinic

I. And how did it go here . . .

P. All well, very well, the Doctor was very good, he took care of me and my mother quickly.

I. You say that the Doctor took care of you quickly?

P. Yes Madam very good very approachable and the Doctor that took me there; I don't even know his name.

I. And did you understand his explanations and those things?

P. Yes Madam, he gave me an appointment for the fourth.

I. Did you forget to tell him anything?

P. No I gave told him everything and I told him about the strong cough I get.

I. Is there anything you would have liked him to explain better?

P. No Madam I understood him, the Doctor told me about the varicose vein; I also told him that I had many varicose veins, whether I should get treatment for them.

I. Would you like to return to the same Doctor?

P. Yes M'am, to the same Doctor, yes M'am. . .
he was very good, they had told me that no, that he was bad
but I thought he was good.

I. How?

P. In the sense that they treat you very well, no one has shouted at me yet, there's people that say that they shout at you . . .

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(7)

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(8)

Friedson, p. 175.

(9)

For further discussion of this point, see Friedson, pp. 190-191.

(10)

The researchers had also hoped to study the extent to which the degree of social mobility on the part of both the physician and the patient would have its effect on the communication process. That is, that a socially mobile physician would perform differently from a physician of the upper class (status secure), vis a vis socially mobile patients or status secure patients. However, the subsequent choice of the clinic settings for research did not offer the necessary

conditions to test this hypothesis. Almost all patients belonged to a homogeneous group of rural and urban poor, while the physician group included both experienced and student physicians.

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Ruesch, J; Bateson, G., Communication: The Social Matrix of Psychiatry, Norton Co., N. Y., 1951, as quoted in Kimball, Solon, "Communication Modalities as a Function of Social Relationships", Transactions of the New York Academy of Sciences, pp. 459-460.

(12)
Kimbal, op. cit., pp. 459-460.

(13)
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(14)
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(15)
According to J. Ruesch and W. Kees, "sign language includes all those forms of codification in which words, numbers, and punctuation signs have been supplanted by gestures; action language embraces all movements that are not used exclusively as signals. (The acts of walking and drinking have the dual function of serving personal needs, and constituting stements to those who may perceive them). Object language comprises all intentional and nonintentional display of material things, such as implements, art objects, the human body and whatever clothes or covers it." (Nonverbal Communication, Berkeley: University of California Press, 1961, p. 189.

(16)
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(19)
We had initially planned to include a random sample of 100 patients of rural and urban origin who were attending the clinic for the first time. However, after the initial period of research it was decided to undertake a more intensive study of interviews between physicians and patients in the selected outpatient clinic settings;

The patient sex ratio in the present study is considered representative of the male-female patient ratio in the clinics. The higher proportion of women to men in the clinics is probably due to the fact that in Colombia, medical coverage under National Social Security programs includes a greater number of men

than women. The needy feminine segments of the population, not covered under government insurance programs would be likely to turn to medical facilities available for low income or indigent patients, such as medical resources under private sponsorship, quasi-governmental organization, such as "Beneficencia" facilities, or public health centers. The clinics in this study were located in hospitals sponsored by combined Beneficencia and public funds.

(20)
These differences in proportion were related to the investigator's availability of time in the region.

(21)
The researchers are aware of the problems involved in categorising persons of rural origin as "urban". Factors such as the retention of practices associated with rural origin may influence expected "urbane" qualities of a group of subjects. In the present study, the urban criteria was used to define permanent residence in cities.

(22)
Prior to this word selection in the hospital setting, the research physician had sent a letter to a random group of 40 physicians asking them to suggest twenty terms which they used with frequency in their medical interviews. Twelve per cent of the group responded to this inquiry.

(23)
Note: Samora et. al. presented the terms in simple standardized sentences, typical of the form in which they might be used in the hospital settings studied, (Samora, p. 84) The present researchers attempted rather to elicit the patient's concept of the meaning of the term.

(24)
For helpful references on the subject, see for instance:
Bogdonoff, M.D., pp. 131-134;

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(25)
A more detailed analysis of the response patterns to specific words will be offered in a future more detailed article. For present purposes we shall focus on possible relationships of vocabulary material to the general patterns of patient -physician communication patterns found in the study.

(26)
This total represented 63 percent of the total number of interviews carried out by regular physicians and 48 percent of the total number of interviews carried out by residents and students.

(27)
Only two physicians, a student and an experienced doctor conducted a proportionately larger number of interviews that was not of a "Bureaucratic" type. Seven physicians (41 percent) followed bureaucratic as well as alternative forms of interviewing. Due to the limited number of interviews recorded for each physician, it was not possible to determine the circumstances under which physicians departed from the modal "matter of fact" patterns.

(28)
In the judgment of investigators, 82 percent of the patients in this category were disatisfied with the physician's lack of empathy.

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Schlesinger, R. H., Davis, C.D., and Milliken, S.O., "Out-Patient Care-The Influence of Interrelated needs," American Journal of Public Health, Vol. 52, No. 11, Nov. 1962, p.1850.

(30)
The present research was not designed to study the types of medical problems which brought patients to clinics. Certainly, more detailed inquiry into these factors would offer a more dynamic context within which to interpret the data on the factors which bring patients to clinics. For example, it would be of value to have material on 1) the types of medical problems for which patients make the "rounds" of lay and scientific practioners and 2) the types of problems which patients take only to the lay or to the scientific practitioners.

(31)
Of the sample of "matter of fact" patients, 59 percent expressed disatisfaction with the physician's manner toward them; thirty-two percent expressed satisfaction, while no judgment was offered in 9 percent of the cases;

Care must be taken with these findings, since it was felt that cultural values reinforcing the suppression of negative or hostile feelings led some patients

to present the physician in positive terms. In the judgment of investigators 82 percent of these patients were disatisfied with the physician's lack of empathy.

(32)
Hayes, Guy, "La Consulta Externa del Hospital y su Proyección a la Comunidad, "Medicina y Desarrollo Social, Bogotá Asociación Colombiana de Facultades de Medicina, 1964, p. 100.

(33)
Roemer, Milton J., "Medical Care and Social Class in Latin America" Milbank Memorial Fund Quarterly, July 1964, Vol. XLII, No. 3, Pt. 1, p.55. (Note: The present authors do not want to imply that this pattern is common only for Latin America)

(34)
Wheeler has pointed out that the concept of social climate "refers to a subjective attitudinal set rather than a condition effectively known by studying interaction patterns or personal characteristics. It is his belief that this concept is "crucial to an understanding of organizations that process people, especially since the dominant social climate tends to symbolize so many different concrete elements in the setting.

Wheeler, Stanton, "The Structure of Formally Organized Socialization Settings", in Socialization after Childhood, pp. 81-83.

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With regard to the type of practice followed by Colombian physicians, Paredes indicates that 14.5 percent are in private practice only, 24.3 percent in non private work only, while 61.2 percent are in mixed private and non private practice. (Paredes Raul "Recursos Humanos y Educativos para la Salud y Educación Médica", Conferencia Nacional de Recursos Humanos, Bogotá, Agosto 9, 1967, p.10)

(36)
Samora, pp. 91-92.

(37)
For an example of this approach see, Molina, Gustavo and Jimeno Claudio, "Teaching Social Science Concepts in a Clinical Setting in Preventive Medicine" pp. 211-225, and Badgley, R.F. and Schulte, M., "Social Science Teaching Programs in Latin American Medical Schools," pp. 193-195, both in Behavioral Science and Medical Education in Latin America, Badgley, R. (ed.) Vol. XLIV, No. 2, April 1966, pt. 2.

T A B L E 1

Number and Percentage of Adequate and Inadequate Responses to Ten Medical Terms

Number of Patients Responding to each Terms - 59

Medical Term	Correctness of Response							
	Exact knowledge		Aproximate knowledge		Lack of knowledge		Erroneous knowledge	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Formula	56	94.9	0	0.0	3	5.1	0	0.0
Drug or Remedy	56	94.9	0	0.0	3	5.1	0	0.0
Vomit	53	89.8	1	1.7	2	3.4	3	5.1
Colic	49	83.0	2	3.4	3	5.1	5	8.5
Diarrhea	47	79.8	2	3.4	2	3.4	8	13.4
X Rays	42	71.2	7	11.8	10	17	0	0.0
Nausea	33	55.9	0	0.0	23	39.0	0	5.1
Lab Exam	32	54.2	0	0.0	25	42.4	2	3.4
Chronic	27	45.8	4	6.7	27	45.8	1	1.7
Cancer	1	1.7	44	74.6	13	22.0	1	1.7
T o t a l	396	67.1	60	10.1	111	18.8	23	4.0

T A B L E 2

Percentage of Correct and Incorrect Responses to Ten Medical Terms by Origin and Sex.

Correctness of Response	RURAL			URBAN			TOTAL		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Exact Knowledge	57.06	69.09	61.79	71.92	72.90	71.20	66.05	70.00	67.22
Approx. Knowledge	8.82	10.91	9.64	11.15	10.0	10.80	10.23	10.00	10.17
Lack of Knowledge	27.65	18.18	23.93	13.08	14.19	14.19	18.89	18.75	18.81
Erroneous Knowledge	6.47	7.89	4.64	3.85	3.01	3.81	4.83	1.25	3.90

T A B L E 3

Number and Percentage of Correct and Incorrect Responses to Ten Medical ...ers by Age.

Ages	Correctness of Response							
	Exact Knowledge		Approximate knowledge		Lack of knowledge		Erroneous knowledge	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
19 - or less	37	52.8	9	12.8	22	31.4	2	3.0
20 - 25	39	65.0	6	10.0	13	21.7	2	3.3
26 - 30	31	62.0	5	10.0	14	28.0	0	
31 - 35	81	81	11	11.0	5	5	3	3.0
36 - 40	46	76.7	5	8.3	7	11.7	2	3.3
41 - 45	59	65.5	8	8.9	15	16.7	8	8.9
46 - and over	89	68.5	12	9.2	26	20.0	3	2.3
No Data	14	46.7	4	13.3	9	30.0	3	10.0
T o t a l	396	67.1	60	10.1	111	18.8	23	4.0

T A B L E 4

Number and Percentage of Correct and Incorrect Responses to Ten Medical Terms by Number of Years of School Completed by Respondents.

Education	Exact knowledge Number	Per Cent	Approximate knowledge Number	Per Cent	Lack of knowledge Number	Per Cent	Erroneous knowledge Number	Percent
Illiterate	79	56.4	12	8 6	40	28.6	9	6.4
1 to 2 years, elementary	131	65.5	18	9.0	45	22.5	6	3.0
3 to 5 years, elementary	156	74.3	26	12.4	22	10.4	6	2.9
Above elementary	24	80.0	3	10.0	1	3.3	2	6.7
No data	6	60.0	1	10.0	3	30.0	0	0.0
T o t a l	396	67.1	60	10.1	111	18.8	23	4.0

Unclassified
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DOCUMENT CONTROL DATA - R&D

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3 REPORT TITLE

COMMUNICATION IN THE DOCTOR-PATIENT RELATIONSHIP

4 DESCRIPTIVE NOTES (Type of report and inclusive dates)

Final Technical Report

5 AUTHOR(S) (Last name, first name, initial)

Ordeñez-Plaja, Antonio
Cohen, Lucy M.
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6 REPORT DATE	7a TOTAL NO OF PAGES	7b NO OF REFS
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8a CONTRACT OR GRANT NO.	9a ORIGINATOR'S REPORT NUMBER(S)
DA-ARO-49-092-66-G110 b PROJECT NO. 2NO14501B71D 00 018 LA c d	None 9b OTHER REPORT NO(S) (Any other numbers that may be assigned this report) None

10 AVAILABILITY/LIMITATION NOTICES

Unlimited

11 SUPPLEMENTARY NOTES	12 SPONSORING MILITARY ACTIVITY
None	U.S. Army Element Defense Research Office, Latin America U. S. Embassy, APO New York 09676

13 ABSTRACT This is a pathfinding study to identify problems which interfere in communication between doctor and patient. This was accomplished by interview techniques including: tape recording of actual clinical interviews, questionnaire, and post consultation discussions by researchers with the doctor and the patient. These were 59 adult, first visit, outpatient clinic encounters, randomly selected at three clinics in major cities of Colombia. Patients were from urban and rural populations. Doctors were staff physicians, residents, and fourth year medical students. Only 14% of patients and 10% of doctors referred to verbal communication problems. Observation, however, indicated a larger problem with patients questioning paramedical personnel and other patients after the interview with the doctor. Patients showed moderate understanding of clinical terms. Understanding was dependent on sex, age, formal education, and origin. The doctors and patients grouped themselves into certain broad categories (ex., doctors -- Bureaucratic Task Oriented; Insecure Detailed; Self Assured; Amiable, Person Oriented). Categories, interactions with patient categories, and organizational enviornment effects are discussed.

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14 KEY WORDS	LINK A		LINK B		LINK C	
	ROLE	WT	ROLE	WT	ROLE	WT
Psychology Sociology Verbal communication Medical care Patient evaluation Diagnosis						

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