

## INFORMATIVITY AND EFFECTIVITY OF VERBAL CONTACT BETWEEN PHYSICIAN AND PATIENT

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Great achievements of the scientific-technical progress in recent decades enabled the introduction of numerous new technical devices in medical practice. Verbal contact between physician and patient which performed a basic role in the diagnostic and therapeutic process in the past, now begun to retire into the background accepting often a formal, non-professional character. Physicians began to treat first of all the objectified by technical means disease, not the patient himself with his numerous psychological and not seldom psychopathological experiences and problems. This circumstance gave rise to a justified patients' discontent that their illness and experiences remained uncomprehended, on the one hand, and on the other one — to physicians' dissatisfaction that rapidly increasing possibilities of modern medical science do not bring corresponding results in practice. The general feeling is that the undoubtedly more successful management of disease does not reduce sufferings of ill people.

One way out of this situation begins more and more persistently to be looked for in recognition and reinterpretation of the verbal communication «physician-patient» (4, 6, 7, 9, 13 — 16). Verbal contact has to bear obligatorily the signs of a dialogue\* (3, 5, 11). The necessity for the physician to master the art to incite, orientate and guide (but not to determine directly) the conversation with the patient.

Verbal relation between physician and patient seems nowadays to correspond not only to diagnostic purposes but also to other purposes which are important at the moment:

1. To enable the patient presenting his disease to rationalize his illness and thus to obtain a psychological catharsis by reporting of his own complaints.

2. To reduce naturally appeared in the course of the disease pathological mechanisms of psychological defence and to allow patient's activation for corresponding attack together with the physician of the present illness.

3. To form a corresponding patient's motivation to accept the therapy administered by the physician.

It should not be forgotten that by means of verbal contact with the patient the physician can obtain even that information which cannot be reached by any other means, e. g. the «intrinsic picture of the disease» (2), the experience of the disease as psychotrauma in relation to patient's social realization, etc.

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\* A dialogue verbal contact consists of several «dialogue units». Every «dialogue unit» contains in dialectically mediated appearance the previous own and processed foreign thought»

In the present work we aimed to study the present state of the verbal contact between physician and patient under polyclinic conditions in public health institutions in the city of Varna.

### Material and methods

A total of 87 conversation records carried out between physicians (21) and patients were analyzed in our study. 50 conversations were conducted by psychiatrists. There were primary physician's examinations and conversations between physician and patient, respectively, in 62 per cent of the cases. The average duration of a conversation conducted by a psychiatrist is 9.5 min and of that conducted by a physician with another medical speciality — 7.8 min. Physician's verbal reactions are evaluated according to the scheme proposed by Schwäbisch-Siems (1974). Besides we analyze the information received according to our own (Boncheva, 1986) table. It means that we give one point for information value in a given field to a pair of remarks (question and answer) each and 0 points when there is no information value.

### Results and discussion

Our results are demonstrated on tables 1, 2 and 3.

It is established that the first regulation for dialogue verbal contact — its dialectic character is not adhered to. Our physician has not the understanding

Table 1

Mean values and percentage ratios of verbal reactions of the physician

Nr.	Kind	State at «A»	State at «B»	Mean values
1.	% verbal reactions of the physician	52	51	51.5
2.	% ratio reactions (phys.)	1.09	1.03	1.06
	reactions (patient)			
3.	Ratio (+) reactions (phys.)			
	(-) reactions (phys.)			
	a) objective finding	0.78	2.08*	1.43
	b) theoretical finding	5.40**	11.70**	8.55**
4.	% ratio $\frac{a}{b}$	11.4	17.7	16.7**

«A» — somatic questionnaire «B» — psychiatric questionnaire

\* —  $p \leq 0.01$  \*\* —  $p \leq 0.001$

Table 2  
Mean values of the frequency of appearance of physician's positive and negative reactions

N	Kind of reaction	State at «A»	State at «B»	Mean values
1.	open question	0.80	1.40	1.10*
2.	activation	0.13	0.85	0.49
3.	«feeling» understanding	0.16**	0.05**	0.04**
4.	confrontation	0.10	0.45	0.29
5.	reflexia	0.03**	0.90**	0.47**
6.	interpretation	0.03**	0.85*	0.45*
7.	generalization	0.06*	0.15*	0.11*
8.	catalogue questions	0.30	1.50	0.90
9.	direct questions	1.77**	5.20**	3.49**
10.	sondage questions	0.93*	3.85**	2.39**
11.	alternative questions	3.16*	5.50**	4.33**
12.	suggestive questions	0.20	0.50	0.35
13.	antagonistic questions	0.43	0.45	0.44
14.	«why» — questions	0.13	0.05	0.09
15.	iatrogenic questions	0.33	0.50	0.42
I.	giving an advice	2.37**	1.30*	1.84*
II.	informational	3.76**	3.80**	2.84**

«A» — somatic questionnaire «B» — psychiatric questionnaire

\*\* —  $p < 0.001$  \* —  $p < 0.01$

Table 3  
Informativity of conversation (mean percentage ratios)

Nr.	Informativity concerning	At state «A» in %	At state «B» in %	Mean %
1.	Actual pathological picture	16.7	55.0*	32.0*
2.	Confidence ratio between physician and patient	26.7	45.0	34.0*
3.	Understanding patient's personality	6.7	15.0	10.0**
4.	Understanding of the disease by the patient	13.3	30.0*	20.0**
5.	Acceptance of the therapy by the patient	10.0	10.0*	10.0**

«A» — somatic questionnaire

«B» — psychiatric questionnaire

\* —  $p < 0.01$  \*\* —  $p > 0.001$

that is rather well characterized by Pascal (8): «If you want to improve somebody and to persuade him of his mistakes you must try to understand from which aspect he considers the question, because he is commonly right from this viewpoint. You must give him credit for his opinion. However, you must reveal also the other aspect where he is wrong. He will be satisfied because he will realize that he did not make a mistake but he did not simply see all the aspects of the problem».

Conversation turns into the so-called «collective monologue» (10) in 38 per cent of the cases most frequently because of directiveness of the physician. The following statements argue for that: 1) there is a disturbed logical relation between patient's answer and physician's successive question; 2) there are two parallel lines of association processes of both physician and patient which often causes repetition of physician's questions; 3) long talking of physician does not find any reaction in patient's verbal behaviour, and 4) patient's behaviour is not reflected in physician's verbal reaction.

In most cases the performed conversation informs the physician only (anamnesis, psychiatric status) and patient is ignored as an equivalent verbal partner. Patient is «the affected» who is only asked but who most frequently remains not understood. Patient's perception is shown by his own remarks, displeasure of what is said by the physician, amazement and desire for specifying questions (in 68 per cent of conversations recorded).

Although physician presumes most on objective findings he is in fact the person who conducts actively the conversation (table 1). Verbal reactions most frequently used by him are directives — direct, alternative and sounding questions, giving advices of general type which are not accepted as a rule by the patient, as well as numerous data about medical service and treatment which can be obtained also by other medical staff. The ratio between positive and negative verbal reactions of the physicians indicates the more frequent usage of negative ones. This is the case in 58 per cent of all the conversations. Mean raw value for the whole group accounts for 1.43 and thus presents only 16.7 per cent ( $p < 0.001$ ) of the expected raw value for one positive conversation i. e. only one fifth of the conversation is adequate, indeed. The rest is either reiteration of the already said, or remark exchange which is not necessary from the viewpoint of purposes of investigation.

Patient's relation to his disease and therapy administered does not become visible in the conversation between physician and patient conducted by this manner in most cases. Most conversations make in the patient an impression that he is a thing to be influenced on. One does not pay attention to personal feelings and experiences of the patient. In some cases a directive form of the type «... Ah, it hurts but is there anybody who is not in pain. . .» or «Eh, who has no neurosis now» is used. As result of this, patient's distrust concerning physician and therapy administered surely increases being a defence reaction. Patient wishes to change both physician and medicinals. In the last reckoning, all that influences unfavourably upon the effectivity of the whole treatment.

We would like to conclude that contemporarily conducted verbal contact «physician-patient» requires professional reconsideration in some aspects. It should be performed on the basis of dialogue which should be determined by patient's experiences and perceptions but not by physician's arrangements, expectations and prognostic schedules.

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ИЗВЛ

## ИНФОРМАТИВНОСТ И ЭФФЕКТИВНОСТ РЕЧЕВОГО КОНТАКТА МЕЖДУ ВРАЧОМ И БОЛЬНЫМ

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### РЕЗЮМЕ

Изучено 87 записей диалогов между врачом (21 врач) и пациентами. 50 из этих диалогов велись психиатрами. Все разговоры проводились в амбулаторных условиях.

Внимание исследователей было направлено на изучение характера и эффективности вербального поведения врачей. Оно оценивалось по схеме Schwäbisch/Siemens (1974 г.) с формально-содержательной стороны и по таблице И. Бончевой (1986 г.) с информативной стороны отношения врача к пациенту.

Результаты исследования приводят к заключению, что проводимый ныне речевой контакт между врачом и пациентом нуждается в профессиональном переосмыслении. Необходимо чтобы он имел в более высокой степени диалогический характер. Речевой контакт должен отражать не только объективную симптоматику, но указывать также на «внутреннюю картину болезни», т. е. на субъективные переживания больного.