

COMMUNICATION BETWEEN PHYSICIANS AND PATIENTS IN OUTPATIENT CLINICS

Social and Cultural Factors

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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 that develops between the doctor and his patient is governed by a vast network of rules of conduct which sets the standards of behavior. The substance and quality of this interpersonal contact is shaped by the perception that physician and patient have of each other and such perceptions are influenced in large part by the social and cultural forces that 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 clinics 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 Saunders, Stycos and Spiegel have pointed out that cutting across the lines of social class division within complex societies are the communication problems arising from value conflicts associated with differences in ethnic group membership. If a practitioner and a patient act within quite separate cultural frameworks disagreements may result 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, 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, Saunders and Larson⁶ have suggested that in practitioner-patient communication the possibility exists of misunderstanding or nonunderstanding on the part of the patient due to vocabulary deficiency. When the patient has little formal education, or is a member of an ethnic group that has preserved a language other than that used in local medical discourse, or is from a low-class environment, the probability of poor understanding or misunderstanding is increased.

Wilson indicates that of all the subcultural 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 that 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 separateness seems to be inherent in the very situation of professional practice:⁸

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 protracted 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.

The purpose here has not been to present a complete review of studies on the influence of social and cultural factors on physician-patient communication, but instead to illustrate the complexity of the problem and the resulting need to discriminate carefully before making assumptions about the variables that shape the physician-patient relationship. Social class position, ethnic group membership and deficiency in vocabulary knowledge influence the perception that physician and patient have of each other. The contrasts in values and the knowledge derived from differential group membership may contribute to interferences with the quality of communication required 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 based on a realistic view of the nature of physician-patient communication.⁹ The search for explanation of the factors influencing that relationship should lead 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 that 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 Samora's study on medical vocabulary knowledge among hospital patients.⁶ The present investigators were interested in learning the extent of the possibility of misunderstanding or nonunderstanding on the part of patients due to their inability to understand terms commonly used in medical discourse, and 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. Medical interviews were to be analyzed to assess the extent to which physician and patient understood each other during the interview. Of particular interest was 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 investigation it had been 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.

Also of interest was 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 a study could be made of the possible relationship between different manners of presentation of self and the adequacy of communication.¹⁰

With the identification of communication barriers that occur in the actual course of the medical interview, data could be gathered that would offer a comprehensive basis for an evaluation of problems in communication between physician and patient.

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 an individual possesses and therefore influences him.¹² These perceptions are, in part, a function of the social processes and cultural values governing the behavior of persons such as physicians and patients, as societal members and participants in the life of medical organizations.

The approach of the study 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 for which words stand—but also with its connotative aspects—that which words suggest. Thus terms may confuse patients 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 language¹⁵ 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 that is the basis of the doctor-patient relationship, which, as Meares has indicated, is an emotional relationship established by the extraverbal and nonverbal communication of emotion. The physician must learn to use nonverbal communication himself because some ideas can be effectively communicated only by that 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 physician-patient relationship in a clinic, such as the expression of authority relations and the responses to them.¹⁷ In these attempts to describe model ways in which patient and

physician encounter each other, it is assumed that the communicative patterns of a physician or of a patient cannot be viewed separate from each other, for doctors and patients communicate in terms of their perceptions of each other, the self definitions growing out of their mutual role conceptions in the interpersonal situation.

With emphasis on these concerns, it was hoped that the focus of the questions might offer an initial understanding of communication processes in clinical organizations, to complement the rural and public health oriented research efforts that 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 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 a half 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 great 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 in the analysis includes 43 women and 16 men, all of whom were attending the clinics for the first time.¹⁹ Forty-nine per cent of the population were in Clinic A, 38 per cent attended Clinic B and 13 per cent were seen in Clinic C.²⁰ All patients were informed that they had been chosen to participate in a special project to learn about their experiences so that services

could be improved. The choice of "new" clinic patients was to secure a population that would not have had the opportunity 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 urban²¹ 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.

Most of the patients selected were 20 to 45 years of age. That particular age group was chosen to prevent ignorance of terminology or medical principles due to youth or to memory lapses associated with advanced age or to emotional problems associated with the menopause. Seventy-one per cent of the patients fell within that bracket, and the others were divided between the older and younger age groups.

The sample represented a lower-class group, with unstable income or none at all. Most men were agricultural workers or unskilled laborers, while one-third of the women worked 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 17 physicians chosen for study were selected by the clinic administrators in consultation with the researchers. Although the sample cannot in any way be described as "representative," efforts were made to include a random group typical of the physicians in practice at each clinic. No one refused 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 per cent), fourth-year medical students (35 per cent) and residents (24 per cent). 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 interviewed by the research physician and the patient was interviewed by the anthropologist. Physicians were asked to identify 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 their problems and information on their general impressions of the physician and the clinic experience.

A number of unstructured interviews 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 provided data on the perceptions that 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 evaluating the effectiveness of literal verbal communication, the separate judgments of the patients, physicians and researchers were considered.²²

With regard to the vocabulary study and analysis, the investigators chose a list of ten terms that 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.²³

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 placed in sentences in the context judged to be meaningful for the particular patient interviewed.²⁴

The responses were filled in by the investigator in a regular form,

but the scoring was done by the researchers after the interview, with the help of the transcriptions from the tape recordings. The following four-fold scoring procedure, adapted from Samora's study,⁶ was used for evaluation:

1. Exact knowledge: when in the judgment of the researchers the patient showed an adequate understanding of the principle, even though his 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 sufficient 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, 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 pitch and tone of the voice, the manner of phrasing statements and patterns of communication of affect, such as the physician's communicating to the patient a sense of understanding his feelings and the meaning of life events to him.²⁵

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 differences found in the evaluation of the expression of empathy by physicians and the judgments made by the present investigators.

FINDINGS

Verbal Communication Analysis

Both the doctors and the patients tended to agree that few serious barriers interfered with their ability to understand each other at a verbal level. Thus, in 90 per cent of the cases, physicians indicated that they had understood the patients, three per cent expressed "serious problems" and seven per cent of the 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 that were difficult to interpret or those in which patients came with a diagnosis to be "confirmed" by the physician. A resident said:

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 . . . [Interviewer: But do you believe that she did understand your questions?] 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 per cent of the cases patients stated that they had understood the physician, while nine per cent felt that they experienced some problem in understanding him. In only five per cent of the cases did patients express serious problems in understanding the physician. Data were unknown for three per cent 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. When the data were analyzed by region, however, 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:

... 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 ... [Interviewer: ... What about the Doctor's questions? Were you able to understand them or were some of them not very clear?] 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 further measure the extent to which physician and patient communicated effectively with each other, an analysis was made of the vocabulary study material that 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 per cent 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 per cent of the respondents, while more than 45 per cent of the patients had "exact knowledge" of the terms "nausea," "lab exam" and "chronic." It is of interest to note that 43 per cent of the patients showed a "lack of knowledge" of these last three terms, the highest rate found in this category. With regard to the words most frequently judged as "erroneous," 13 per cent of the patients showed a mistaken understanding of the term "diarrhea," while nine per cent erred in their understanding of "colic."²⁶

Four factors were thought to be associated with vocabulary knowl-

TABLE 1. ADEQUATE AND INADEQUATE RESPONSES TO TEN MEDICAL TERMS.

<i>Medical Term</i>	<i>Correctness of Response</i>							
	<i>Exact Knowledge</i>		<i>Approximate Knowledge</i>		<i>Lack of Knowledge</i>		<i>Erroneous Knowledge</i>	
	<i>Number</i>	<i>Per Cent</i>	<i>Number</i>	<i>Per Cent</i>	<i>Number</i>	<i>Per Cent</i>	<i>Number</i>	<i>Per Cent</i>
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	0.0
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
Total	396	67.1	60	10.1	111	18.8	23	4.0

edge: sex, age, amount of formal education and origin. As Table 2 suggests, no significant differences were found 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 of urban origin. Patients between 31 and 40 years of age 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 per cent of the vocabulary, while the highest "exact knowledge" response of older or younger patients was 68.5 per cent (Table 3). As might be expected, with an increasing amount of elementary school education patients of both sexes tended 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.

TABLE 2. CORRECT AND INCORRECT RESPONSES TO TEN MEDICAL TERMS, BY ORIGIN AND SEX.

<i>Correctness of Response</i>	<i>Rural</i>			<i>Urban</i>			<i>Total</i>		
	<i>Female %</i>	<i>Male %</i>	<i>Total %</i>	<i>Female %</i>	<i>Male %</i>	<i>Total %</i>	<i>Female %</i>	<i>Male %</i>	<i>Total %</i>
Exact knowledge	57.06	69.09	61.79	71.92	72.90	71.20	66.05	70.00	67.22
Approximate 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

TABLE 3. CORRECT AND INCORRECT RESPONSES TO TEN MEDICAL TERMS, BY AGE.

<i>Ages</i>	<i>Correctness of Response</i>							
	<i>Exact Knowledge</i>		<i>Approximate Knowledge</i>		<i>Lack of Knowledge</i>		<i>Erroneous Knowledge</i>	
	<i>Number</i>	<i>Per Cent</i>	<i>Number</i>	<i>Per Cent</i>	<i>Number</i>	<i>Per Cent</i>	<i>Number</i>	<i>Per Cent</i>
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	81.0	11	11.0	5	5.0	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
Total	396	67.1	60	10.1	111	18.8	23	4.0

TABLE 4. CORRECT AND INCORRECT RESPONSES TO TEN MEDICAL TERMS, BY NUMBER OF YEARS OF SCHOOL COMPLETED BY RESPONDENTS.

<i>Education</i>	<i>Exact Knowledge</i>		<i>Approximate Knowledge</i>		<i>Lack of Knowledge</i>		<i>Erroneous Knowledge</i>	
	<i>Number</i>	<i>Per Cent</i>	<i>Number</i>	<i>Per Cent</i>	<i>Number</i>	<i>Per Cent</i>	<i>Number</i>	<i>Per Cent</i>
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
Total	396	67.1	60	10.1	111	18.8	23	4.0

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 less knowledge of medical vocabulary and who expressed problems in understanding the physician had attended one of the three clinics. It is of additional relevance that most of the women who referred to problems in understanding the physicians tended to have complaints of a sexual nature, such as menstruation or doubts about the possibility of pregnancy. As small as this group is, it 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 relatively few problems appeared in the doctor-patient communication at a verbal level. These findings might surprise researchers and other interested students. As was suggested in the review of the literature and in the introductory supposition, when social distance exists between physician and patient due to class membership, other subcultural variables or vocabulary deficiency, problems in verbal communication are likely.

The explanation for the present findings would appear to be associated with the general views of the personnel 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. Paramedical personnel such as aides were posted at strategic places to offer patients "information" and "clarification" in the setting. Physicians were attuned to the need to reword basic medical principles that were not immediately grasped by patients and they also depended on aides to interpret the prescriptive orders offered at the end of their interviews.

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

Patients exhibited few problems when talking with physicians in grasping the general meaning of the topics under discussion. If patients showed ignorance or misunderstanding of the "key" terms in a general subject of discussion, physicians reworded those terms. 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 records of previous illnesses or operations and they had few questions about subjects such as urination or defecation. On this denotative level relatively few communication problems existed. Patients could understand what the words denoted.

Problems were evident, however, in eliciting the more specific symptoms associated with the main topics under discussion because physicians tended to take for granted that patients could 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 of urine—the specific qualities that are a basis for diagnosis—were 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 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 the first example the physician began by assuming 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?

Pt. What? My urine? Is it bad?

Dr. Is it well, are you urinating daily?

Pt. 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 exchange, 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?

Pt. No, doctor, it does not come frequently.

Dr. How often is your cycle?

Pt. Sometimes it comes every six, sometimes seven, sometimes three months.

Dr. And how long does it last?

Pt. It lasts eight, eight days.

Dr. How long has it been that way?

Pt. No, doctor, ever since I began menstruating.

Dr. Since you began menstruating?

Pt. Yes, doctor.

Dr. Have you had any children?

Pt. Yes, doctor . . .

Dr. How do you know when you are pregnant?

Pt. No, doctor, when my stomach grows.

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

Pt. 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?

Pt. No, doctor.

Dr. Then how often?

Pt. 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?

Pt. Yes, doctor.

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

Pt. That is to say . . .

Dr. When did it come?

Pt. Yes, doctor, after my first menstruation it was eight months before the next menstruation occurred.

Dr. And after that?

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

Dr. And then?

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

Dr. And then?

Pt. Then in the . . . every three months.

Dr. Has it always been that way?

Pt. It has always been that way . . .

In the following situation the physician asked questions on the color of urine, a factor 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?

Pt. Yellowish?

Dr. Yellowish, has it ever been red?

Pt. No, doctor . . .

Dr. Has your urine ever been muddy colored? . . . as if it were dirty . . . ? As if it were . . . smelly?

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

Presentation of Self Analysis

The preceding discussion on verbal communication problems in evidence in the interaction between physicians and patients offered relevant material for the 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,²⁷ 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."

1. The "bureaucratic task-oriented" physician and the "matter-of-fact, collaborative" patient. In 55 per cent of the interviews physicians tended to present themselves in a "bureaucratic, task-oriented" manner.²⁸

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 ex-

pressed limited sensitivity toward the patients' feelings 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 about the direction in which the physician guided the interview. Thus, 80 per cent of the patients in this group responded in the complementary "matter-of-fact" fashion that appeared to be expected of them. Of the remaining patients, 16 per cent followed "miscellaneous" modes of communication, such as elusiveness and rambling, while one patient (four per cent), who showed collaboration with a greater degree 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 fashion similar to that of the physician. Analysis of the general content of the taped interview material as well as the researchers' observations on the behavior of 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 they believed were 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 regarding the patient who responded to him in a complementary fashion (see illustration, Appendix B).

2. The insecure and detailed physician and the "vague" and "matter-of-fact" patient. Contrasting with the "matter-of-fact" mode described above, in 20 per cent of the total number of inter-

views physicians tended to carry out very detailed and lengthy interviews. Numberless questions however, did not contribute 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 student physicians tended to be heavily represented in this group appeared to suggest that their limited experience, or their possible fear about participation in the research project shaped their manner of communication with patients.

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

3. The "self-assured" physician and the "matter-of-fact" or "miscellaneous" type patient. In 12 per cent 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 the interviews were conducted by the regular physicians, who had a longer period of employment in outpatient settings.

The physicians often asked questions and offered interpretations about "underlying" problems the patients had not volunteered, or were not included in the regular history questionnaire, such as poverty, problems in family relations or birth control. In their manner of dealing with issues that were obviously sensitive to patients, however, physicians offered little opportunity to patients to do more than to acknowledge the correctness of their interpretation.

Almost half (43 per cent) of the patients in this group 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).

4. The "amiable" person-oriented physician and the "matter-of-

fact" or "pleasantly collaborative" patient. Finally, in 11 per cent 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 that 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).

Presentation 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. Although 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.²⁹

In terms of the relationship between the 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 to make themselves understood to patients.

The modal bureaucratic pattern, however, 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 that 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 the pace is maintained, the physician finds 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 tends to lack empathetic understanding of the feelings of patients.³⁰ 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 pointed out in a study of outpatient care in an obstetrical clinic, the mode of organization of the clinic unwittingly frustrates even the staff member who recognizes the vital importance of emotional support:³¹

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.

Such observations point to the need to turn to an examination of the factors that influenced the bureaucratic manner in the clinics under study. It is important to examine not only the structural factors—the requirements of the clinic systems—but also the processes through which patient and physician acquired the typical compo-

nents of the bureaucratic self. Two questions appeared relevant for discussion: 1. In the first place, what mechanisms, cues or processes prepared patients and physicians to present themselves as “bureaucrats?” 2. secondly, is it possible to identify traces of the “traditional” patterns of communicative behavior associated with the differential class membership of patients and physicians, alongside the predominantly “bureaucratic” patterns?

Factors Accounting For The Bureaucratic Presentation of Self

The Patients. With regard to patient involvement with medical resources, patients were selected 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, only 16 per cent of the patients had 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.³² 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 toward conformity to bureaucratic patterns. To paramedical personnel, an ideal patient followed routines efficiently and he did not express overt dissatisfaction 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 cued the patient to the behavior expected in the doctor’s office. Thus, 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 dissatisfaction with the physician’s lack of empathy.³³

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 physi-

cian who was reputed to “shout” to patients or scold them for asking clarificatory questions. Although 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?

Pt. I would like . . . another one . . .

I. Another one?

Pt. 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 understand 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 people would feel less nervous when they come here?

Pt. 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?

Pt. Courtesy, Miss . . .

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 seemed that physicians emphasized that problem to satisfy the interest of the researchers rather than to express the most serious communications problems they felt. Indeed, when the content of the informal discussions with the physicians was examined, other communication problems, discussed with a much

greater feeling of intensity and concerns, clearly reflected the areas the physicians experienced as serious problems in communication.

Physicians most often suggested that they had difficulties in communication with verbose patients who presented vague symptoms that 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 medical vocabulary out of context.

In reference to their preferred modes of communication, physicians categorized 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 toward 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”)

I. . . . 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.

I. Was there any communication problem?

Dr. None.

(Physician blames the patient’s lack of “coherence” on his illness)

I. 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.

I. 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.

I. Are there any communication problems?

Dr. No, there are none . . .

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

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

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

I. How would you categorize this patient? Not very collaborative?

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

I. He does not have capacity? Intellectual capacity to communicate?

Dr. That's it, to communicate.

I. 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 . . ."

I. . . . 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 physicians showed that the pressures of inadequate time and heavy patient loads contribute to the "task-oriented" approach found prevalent among physicians. Preferences 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 subject of conflict with administrators, is in itself a source of frustration. The longer time requirements of initial interviews, as well as the possibility of losing 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 is aggravated by the tendency for physicians in teaching hospitals to view clinic service as a type of Siberia, in which tasks are to be undertaken by medical personnel of inferior levels.³⁴ 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:

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.

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. It is important to emphasize, however, 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 a distinguishable system of medical care is 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."³⁵ 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. Although physician and patient attempted to respond to each other according to the manifest requirements of their roles as doctor and patient, the social climate³⁶ 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 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 un verbalized policies in which the "less valued" paramedical personnel in a hospital were those assigned to clinic service.

Although discussion of these elements would appear to go beyond the present focus on the influence of social distance on communication at the patient-physician level, future, more extensive research on communication in clinical settings must give specific attention to the relationship of organizational goals to the interaction between medical personnel and 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 that extends beyond the patient physician dyad. In future, more detailed study it may be possible to move from the initial stage of identifying the 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 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 per cent of the patients and ten per cent 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. When the material for the three clinics was compared, however, 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 expresses a limited sense of empathy toward his patient maintains the question and answer pace required 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 influence of the relationship between the social background of the physician and patient, and the situational context of the clinic organization were discussed. Since the evidence suggests that the organizations within which patient or physician interact set the tone for the style of communication followed, more specific inquiries are needed into the processes within the broader organizational settings that socialize members for action.

With the increasing recognition that the Colombian physician of today tends to devote more time to work in bureaucratic settings rather than to solo practice,³⁷ information is needed on the organization of practice in large-scale bureaucratic settings to help identify the educational requirements to meet the demands of the contemporary medical world. In view of the rather limited knowledge of the processes of social behavior in large scale organizations in Colombia, or Latin America as a whole, social science research efforts can be turned increasingly in this direction.

In conclusion, final observations should be presented on some of the broader implications of the 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 stated:³⁸

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 demonstrated 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.

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. Thus, discussions of the implications of the present study or the development of a strategy to modify the climate of clinics, are guided by the belief that efforts must be made to relate findings to the realities of medical practice in large-scale organizations in Colombia. It is the responsibility of researchers to assist medical personnel such as clinic practitioners and medical educators to incorporate and sustain a system of scientific inquiry from the behavioral sciences that 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 ideas about the type of health agencies that 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 more dynamic use of the information that already exists in settings such as out-

patient 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 program. 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 sociocultural context of health problems, as well as to understand the influence of these same factors on patterns of interpersonal relationships.

Only limited attention has been paid to the type of learning required 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 to become "aware" of the social context influencing the patient. But with few exceptions do Latin America reports tell 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.³⁹

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 that yields only a minimum of "general information" 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 the organization of learning experience in his own "field" the student should be able to develop the flexibility necessary to use sociocultural knowledge

meaningfully in his relationships with patients and other medical personnel.

That 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 bearing on practice and establishing links for the feedback of findings that will relate to the mutual concerns of the physician and the behavioral scientist.

APPENDIX A

VOCABULARY

1. *Exact knowledge*

- I. Colic—have you heard that word? Have you ever met anyone who has had colic?
- Pt. Colic? Yes, Miss I had a period when I had colic. . . . And what . . . did you feel when you had colic?
- Pt. Ohhh I felt as if my “guts” . . . were being pierced or stabbed.
- I. That they were stabbed . . . where?
- Pt. This . . . that which is called . . .
- I. What is it called? What do you call it?
- Pt. Guts, Miss, (laughing).

2. *Approximate knowledge*

- I. Did they take you through x-rays? What exam did they do?
- Pt. The one from the body up.
- I. Had they ever done it to you before?
- Pt. No, Miss.
- I. What do they examine there?
- Pt. There? . . . Who knows what they examined, they made me undress from the waist up.

3. *Lack of knowledge*

- I. Have you had nausea?
- Pt. What? No, I don’t know anything about that.
- I. You don’t know anything about that?
- Pt. No, ma’am, I’ve never heard.

4. *Erroneous knowledge*

- I. And what happens to people when they get diarrhea?
- Pt. 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?

Pt. 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.

Pt. Headache doctor that doesn't go away.

Dr. What else?

Pt. 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?

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

Dr. Can you touch the lump?

Pt. No, doctor.

Dr. Then?

Pt. I feel . . .

Dr. What's the sensation like?

Pt. Yes, doctor, a lump that I seem to have there.

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

Pt. No, doctor.

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

Pt. Because that is what it feels like, doctor.

Dr. When do you feel the lump?

Pt. 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?
Pt. At night when I go to bed.
Dr. When you lie head up, on your side or . . . ?
Pt. When I lie on my side, doctor, on this side, the left side.
Dr. How long have you been suffering from that?
Pt. One year, doctor.
Dr. Does your stomach move every day?
Pt. Yes, doctor.
Dr. Do you have . . . ?
Pt. No, doctor, that is to say I don't 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?
Pt. Yes, doctor.
Dr. Do you get diarrhea?
Pt. No, doctor.
Dr. You do not get diarrhea?
Pt. No, doctor.

APPENDIX C

THE INSECURE DETAILED PHYSICIAN

The following excerpts of dialogue 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 is expected of her:

Dr. Good, you have to stay here for a few days so that you may get this blood exam: no, now when you go out to the cashier you ask about the exam. Good, to see how to continue with this, since you are going to return in 15 days, because I am going to give you a little card so that you may return in 15 days to 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 them thoroughly. Do you hear?

Can you read them?

Pt. . . . Yes Sir.

Dr. Good. You read them over and follow the diet that it says here. 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 weight; 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 legs thus, when you lie down, raise your legs thus, put two or three pillows or put two "adobes" under the bed 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.

Pt. 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.

Pt. 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 bandage—I have put it down here on the formula; don't put on a rubber or an elastic bandage: there are cloth or 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 your 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 breakfast 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.

- Pt. 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.
- Pt. 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.
- Pt. No, or otherwise, I don't lose weight, only one . . .
- Dr. Only one of all 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.
- Pt. 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.

Pt. 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.

Pt. Oh, different!

Dr. Yes.

Pt. 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 in between.

Pt. 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 20 days for example.

Pt. No, that's alright.

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

Pt. 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?

Dr. 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?

Pt. 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 . . .

- Pt. 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?
- Pt. The explanation of the . . . those certificates, that's what . . . I understand the least . . .
- I. That's what you don't understand?
- Pt. 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?
- Pt. All that is needed is a cure, and the rest, the doctor, well.
- I. As long as there is a cure?
- Pt. 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?
- Pt. Yes. . . . 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?

Pt. Olga de Peña (all patients' names have been changed.)

Dr. How old?

Pt. Thirty.

Dr. Married or single?

Pt. Married.

Dr. Children?

Pt. Two children.

Dr. Abortions?

Pt. One because I fell.

Dr. Sure?

Pt. Ja. Ja.

Dr. Have you been operated?

Pt. No, doctor, I have not been operated.

Dr. Why do you come here?

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

Dr. What else?

Pt. 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?

Pt. Good.

Dr. Does it come well?
Pt. From one date to the other.
Dr. How long does it last?
Pt. Three days, doctor.
Dr. When did you have your last birth?
Pt. The girl is two and a half.
Dr. Do you think you'll get pregnant again?
Pt. No, doctor.
Dr. Why?
Pt. Who knows?
Dr. What do you mean who knows?
Pt. 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 individual attention to the answers offered by the patient. His introductory manner of address to patients, "Alright, tell me what seems to be bothering you," and periodic summation 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?

Pt. In . . .

Dr. And where do you live?

Pt. I live in . . .

Dr. Are you married?

Pt. Yes, sir.

Dr. How many children?

Pt. There's been 14.

Dr. Eleven?

Pt. Fourteen.

Dr. Fourteen?

Pt. Yes.

Dr. How many are alive?

Pt. I have . . .

Dr. Fourteen were born?

Pt. 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?

Pt. I came here because Dr. T. sent me. He was doing 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?

Pt. 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?

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

Dr. Yes?

Pt. And it is painful to swallow.

Dr. When did that begin?

Pt. 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?

Pt. About a year and a half.

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

Pt. It began 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?

Pt. About two years.

Dr. For about two years?

Pt. 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?

Pt. No, sir after that “colerin” . . . I haven't had any other vomiting.

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

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

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

Pt. When? At 14.

Dr. At 14? You've had sexual intercourse haven't you?

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

Dr. Good. How long does the menstruation last?

Pt. Sometimes it last four to five days, others it stays eight to ten days.

Dr. Has it always been so irregular?

Pt. Yes.

Dr. Good, how often does your menstruation come?

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

Dr. When did you first get those disturbances?

Pt. About six months ago. . . . First I would get sick, every month.

Dr. Good . . .

Pt. 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?

Pt. 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?

Pt. Yes, sir.

Dr. Goiter?

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

APPENDIX F

PATIENT'S PERCEPTION OF THE CLINIC

- I. And how did it go here . . . ?
- Pt. 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?
- Pt. 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?
- Pt. Yes, Madam, he gave me an appointment for the fourth.
- I. Did you forget to tell him anything?
- Pt. No, I have 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?
- Pt. 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?
- Pt. Yes, Ma'am, to the same doctor, yes, Ma'am . . . he was very good, they had told me that no, that he was bad, but I thought he was good.
- I. How?
- Pt. 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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³ Koos, E. L., *THE HEALTH OF REGIONVILLE*, New York, Columbia University Press, 1954; Simmons, O. G., Implications of Social Class for Public Health, *Human Organization*, 16, 7-10; ———, Popular and Modern Medicine in Mestizo Communities of Coastal Peru and Chile, *Journal of American Folklore*, 68, 57-71.

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⁵ Foster, G., *PROBLEMS IN INTERCULTURAL HEALTH PROGRAMS*, New York, Social Science Research Council, 1958, pp. 29-35.

⁶ Samora, J., Saunders, L. and Larson, R. F., Medical Vocabulary Knowledge among Hospital Patients, *Journal of Health and Human Behavior*, 2, 92, Summer, 1961.

⁷ Wilson, R. N., Patient-Practitioner Relationships, in Freeman, H. E., *et al.* (Editors), *HANDBOOK OF MEDICAL SOCIOLOGY*, Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1963, p. 283.

⁸ Friedson, *op. cit.*, p. 175.

⁹ For further discussion, see Friedson, *op. cit.*, pp. 190-191.

¹⁰ The researchers hoped also 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, a socially mobile physician would perform differently from a physician of the upper class (status secure) regarding socially mobile patients or status secure patients. The choice of clinic settings used in the study, however, did not offer the conditions necessary to test the hypothesis. Nearly all patients belonged to a homogeneous group of rural and urban poor, and the physicians included both experienced and student physicians.

¹¹ Ruesch, J. and Bateson, G., *COMMUNICATION, THE SOCIAL MATRIX OF PSYCHIATRY*, New York, W. W. Norton & Company, Inc., 1951, as quoted in Kimball, S., *Communication Modalities as a Function of Social Relationships*, *Transactions of the New York Academy of Sciences*, pp. 459-460.

¹² Kimball, *op. cit.*, pp. 459-460.

¹³ *Ibid.*, p. 460.

¹⁴ King, *op. cit.*, pp. 227-231.

¹⁵ "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 statements 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:" Ruesch, J. and Kees, W., *NONVERBAL COMMUNICATION*, Berkeley, University of California Press, 1961, p. 189.

¹⁶ Meares, *op. cit.*, p. 667.

¹⁷ A more extensive discussion of the usefulness of the idea of social type in the study of organizational behavior may be found in Wheeler, S., *The Structure of Formally Organized Socialization Settings*, in Brim, O. G. and Wheeler, S., *SOCIALIZATION AFTER CHILDHOOD*, New York, John Wiley & Sons, Inc., 1966, pp. 76-77.

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¹⁹ The original plan was to include a random sample of 100 patients of rural and urban origin who were attending the clinic for the first time. After the initial period of research, however, 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 study is representative of the male-female ratio in the clinics. The higher proportion of women is probably due to the fact that in Colombia, medical coverage under National Social Security programs includes a greater number of men than women. Females not covered under government insurance would be likely to turn to medical facilities available to low-income or indigent patients, such as medical resources under private sponsorship, quasi-governmental organizations 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 categorizing 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 were used to define permanent residence in cities.

²² Answers were categorized as 1. Adequate; 2. Approximately adequate and 3. Inadequate. *Adequate* 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 interview. *Approximate understanding* referred to the evaluator's judgment that the physician or the patient had experienced some problems in communication, but which had not been of a large enough dimension to erect serious communication barriers. *Inadequate understanding* referred to the evaluator's judgment that the physician or the patient had experienced serious problems in understanding the other.

²³ Prior to this word selection in the hospital setting, the research physician inquired of a random group of 40 physicians asking them to suggest 20 terms they used frequently in their medical interviews. Twelve per cent of the group responded to the inquiry.

²⁴ Samora, *op. cit.*, p. 84. Samora presented the terms in simple standardized sentences typical of the form in which they might be used in hospital settings. The present researchers attempted rather to elicit the patient's notion of the meaning of the term.

²⁵ For helpful references on the subject see Bogdonoff, *op. cit.*, pp. 131-134; Goffman, E., *THE PRESENTATION OF SELF IN EVERYDAY LIFE*, New York, Anchor Books, Doubleday & Company, Inc., 1959; Greenson, R. R., Empathy and its Vicissitudes, *International Journal of Psychoanalysis*, 41, 418-424, July-October, 1960; Kutner *op. cit.*, pp. 258-273; Meares, *op. cit.*, pp. 663-667.

²⁶ A more detailed analysis of the response patterns to specific words will be offered in a future, more detailed article. For present purposes it will suffice to focus on possible relationships of vocabulary material to the general patterns of patient-physician communication patterns found in the study.

²⁷ Wheeler, *op. cit.*, p. 76.

²⁸ The total represented 63 per cent of the total number of interviews carried out by regular physicians and 48 per cent of the total number of interviews carried out by residents and students.

²⁹ Only two physicians, a student and an experienced doctor, conducted a proportionately larger number of interviews that were not of a "Bureaucratic" type. Seven physicians (41 per cent) followed bureaucratic as well as alternative forms of interviewing. The limited number of interviews recorded for each physician made it impossible to determine the circumstances under which physicians departed from the modal "matter-of-fact" patterns.

³⁰ In the judgment of the investigators, 82 per cent of the patients in this category were dissatisfied with the physician's lack of empathy.

³¹ Schlesinger, R. H., Davis, C. D. and Milliken, S. O., Out-Patient Care: The Influence of Interrelated Needs, *American Journal of Public Health*, 52, 1850, November, 1962.

³² The present research was not designed to study the types of medical problems that brought patients to clinics. Certainly, more detailed inquiry into those factors would offer a more dynamic context within which to interpret the data. 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 practitioners, and 2. the types of problems that patients take only to the lay or to the scientific practitioners.

³³ Of the matter-of-fact patients, 59 per cent expressed dissatisfaction with the physician's manner toward them; 32 per cent expressed satisfaction and nine per cent offered no judgment.

Care must be taken with these findings since cultural values reinforcing the suppression of negative or hostile feelings may lead some patients to present the physician in positive terms. In the judgment of investigators, 82 per cent of these patients were not satisfied with the physicians lack of empathy.

³⁴ Hayes, G. 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.

³⁵ Roemer, M. J., Medical Care and Social Class in Latin America, *Milbank Memorial Fund Quarterly*, 42, 54-64, July, 1964, Part 1. The present authors do not wish to imply that this pattern is common only to Latin America.

³⁶ Wheeler has pointed out that the idea of social climate "refers to a subjective attitudinal set rather than a condition effectively known by studying interaction patterns of personal characteristics." It is his belief that this idea 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, *op. cit.*, pp. 81-83.

³⁷ With regard to the type of practice followed by Colombian physicians, Paredes indicates that 14.5 per cent are in private practice only, 24.3 per cent in nonprivate work only and 61.2 per cent are in mixed private and nonprivate practice. Paredes, R., "Recursos Humanos y Educativos para la Salud y Educación Médica," Conferencia Nacional de Recursos Humanos, Bogotá, Agosto 9, 1967, p. 10.

³⁸ Samora, *op. cit.*, pp. 91-92.

³⁹ For an example of this approach, see Molina, G. and Jimeno, C., Teaching Social Science Concepts in a Clinical Setting in Preventive Medicine, in Badgley, *op. cit.*, pp. 211-225; and Badgley, R. F. and Schulte, M., Social Science Teaching Programs in Latin American Medical Schools, in Badgley, *op. cit.*, pp. 193-195.

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