# General Aspects on the Communication between Healthcare Provider and Patient

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**Abstract:** In this paper we propose to analyze the relationship of communication between healthcare provider and patient, based on the fact that this type of interaction interrelate with the information appearance, with the regulations, which is at a stake relational positioning. Medical Communication is complex and represents a basic element of the doctor-patient relationship; it involves certain techniques capable of efficient communicative behaviors of both the healthcare professional and the patient. Significant communication are effective medical knowledge, skills, and appropriate medical self-attitudes, which must take into account age, sex, physical and psychological conditions of each patient sociocultural level. Also, we aim at highlighting techniques verbal and nonverbal communication as a means of limiting possible errors and conscious or unconscious that you can make the medicine. It is also important to identify the causes of a communication incomplete or distorted, ambiguous and assess possible consequences of communication errors.

**Keywords:** verbal communication; nonverbal communication; patient; healthcare Provider; message; communication obstacle

## 1. Introduction

The communication expresses the relation of the man with the world and it represents a concomitant verbal, gestures, attitude and behavioral system which needs to be studied globally (Arsith, 2010, p. 13). Communication involves adjustment and adaptation processes and it takes place at two levels: informational and relational, the second level providing interpretative guidance for the former. To communicate means to inform; this is the first existing way of communicating. The

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essential character of information is to bring a new element and surprise. When a relationship with others is initiated, the risk of being accepted or rejected, appreciated or criticized is assumed. One of the fundamental feature of communication is to see an acknowledged image of yourself confirmed. "*Respect for territories and image plays the role of identity and relational defense*" (Picard, 2010, p. 128). At the social level, it is impossible to imagine an interpersonal communication that goes beyond the rules, that is outside the communication models.

The actors involved in the exchange strive to define the default situation and the implicit rules of communication. Communication cannot exist without the quality of the emerging relationship. As the exchange unfolds, the relationship takes shape. The relational "techniques" need to be adapted to the situation and it must be consistent with what can be done in the given situation (Mucchielli, 2002, p. 127). These procedures are in part of the implicit, nonverbal, paralanguage.

## 2. The Communication Behavior in the Health Provider-Patient Relationship

Communication is not possible without a minimum system of shared rules. The schematics of the most frequent communication situations become "cultural models of communication". Each model is associated with a form of communication, a certain attitude. Here are some examples (Mucchielli, 2002, p. 131):

(a) the "communication with the authority" model, which is currently centered on the "democratic" values of dialogue and negotiation;

(b) the pattern of communication with a "counselor" - physician, psychologist, priest;

(c) the model of love communication;

(d) the pattern of the request for administrative information;

(e) the school model of traditional education;

(f) the "friendly communication" model, involving exchanges of views and preferences, listening to the other and formulating personal comments.

In communication, the relationship is from subject to subject, sending to the idea of relationship with the other. The main types of attitudes of locators in the communication process are as follows (Arsith, 2010, pp. 23-24):

a. *The attitude of interpretation*, which consists in expressing and verbalizing for the other the meanings of his words and deeds; this attitude indicates a difference in status between locators: one transmits and knows more than the other, and in addition, it is the actor who interprets for the other;

b. *the attitude of evaluation*, consisting of positive or negative judgments about what the other person says or does;

c. *the attitude of counseling*, which expresses itself through proposals and solutions offered to the other;

d. *the attitude of the questionnaire*, which means asking the other questions to allow it to express itself. It is important to stimulate the expression of the other's point of view, to know and to listen to him, by limiting the ostentatious questioning;

e. *comprehensive attitude*, which is to show the other interest, understanding, and evidence of obedience; it is a way of valuing the other.

**2.1. Verbal Communication**

Verbal and intentional communication is only the "tip of a giant iceberg, which closes in a unit the whole behavior of an organic integrated individual in a totality comprising other ways of behavior: tone, posture, contextual etc." (Pârvu, 2000, p. 65). An important part of interpersonal communication is stimulated by the desire to produce a certain self-image and to validate it through the other. The image we want to build must be confirmed.

An important part of interpersonal communication is stimulated by the desire to produce a certain self-image and to validate it through the other. The image we want to build must be confirmed, and if the interlocutor does not confirm it, then there is a discomfort and a sense of identity insecurity. The quest for recognition underlying the majority of communication acts is subject to a fundamental motivation, the search for valorization: to exist in the other's eyes, to be appreciated, to be accepted as a reliable interlocutor, to be recognized as an individuality, etc.

Doctor-patient communication is a specialized and unequal interaction that belongs to the consultation, where one of the protagonists possesses a specialized, socially recognized knowledge. The specialist is in a high position; he has the authority conferred on him by science and power (Vion, 2000, p. 130).

The intrusion between the doctor and the patient begins with the face-to-face encounter of two people with significant differences (Iandolo, 2006, p. 87):

| **Health provider** | **Patient** |
|---|---|
| Is calm | is concerned |
| Doing routine work | is experiencing an unusual event |
| did not choose the patient | chose the doctor |
| Is not put in the situation to wait | probably waited before coming to the doctor |
| Has an obligation to give help | came to ask for help |

**Figure 1. The premises of doctor-patient meeting**

Often, the patient would like to start talking, but he has doubts about how to say and how to go silent. He is also afraid he will not be able to explain what bothers him or does not know how to start. For these reasons, the physician should open the dialogue by asking some general questions before addressing the disease problem. At the end of this first phase of communicational interaction that is the meeting, the doctor and the patient come to have a mutual perception of their personalities and roles and unconsciously set up the directions of conduct for the next stages of the interaction.

In the next phase, the patient exposes to the doctor his or her troubles, needs and concerns. The physician obtains from the patient the information and data needed for diagnosis and treatment. At the same time, it develops another competence required for medical staff, the ability to listen to the sick. This capacity refers not only to assigning meaning to words spoken by the interlocutor, but also to assessing how to speak, the tone, the fluidity of the speech, and the way of choosing the words.

## 2. Non-verbal Communication

Nonverbal communication is a set of body manifestations by which interpretation there are relevant the psychological states of communication actors. Through this type of communication, the trust of the interlocutors is strengthened, the status of

the interlocutors is legitimated and communication positioning is displayed, without the need for expressing this positioning.

The word is not the main support of communication (Marsille, 2013, p. 6). It joins the attitudes, the manner of occupying space, silences, facial expressions, gestures, all of which allow for proper interpretation by the interlocutors. "We speak with our vocal organs, but we talk with our whole body" (Abercrombie, apud Iandolo, 2006, p. 61). The many signs transmitted through non-verbal communication are almost never isolated. Face expressions, postures, gestures are emitted in various combinations that precede, accompany or follow the verbal expression (Iandolo, 2006, p. 41).

Receptors react to what it is said to them in different ways: they can approve or disapprove of what there are told; through the expressions of their faces they can manifest feelings such as understanding, perplexity, pleasure, sadness, amusement or surprise. These attitudes, also called "mute answers" (Iandolo, 2006, p. 47), are captured by the speaker and the feedback that complements the communication process.

Significant non-verbal signals are (Cook, apud Iandolo, 2006, p. 40):

- *static:* face, physical conformation, voice, clothes, makeup, etc.

- *dynamic*: distance orientation, posture, body movements and gestures, face expression, direction of sight, voice tone, rhythm and speed of speech.

The attention that the health provider employs in listening to the patient activates four elements (Ivey, apud Iandolo, 2006, p. 151):

(a) contact, less than one meter;

(b) the health provider's posture, slightly inclined towards the patient;

(c) the physician's calm attitude, without being distracted or hurried;

(d) the verbal comment of the health provider, confirming hearing without interrupting the patient or changing the subject.

The non-verbal communication of the doctor allows him to interpret the mimic and gestural behavior of the patient and to formulate rather important conclusions. Observing the patient and decoding his non-verbal language contributes to a great extent to the first impression on him (Iandolo, 2006, p. 145).

Observing patient's non-verbal behavior should not be confused with its physical examination, which is part of the clinical assessment. It is necessary to observe the patient from the moment he enters the cabinet or in the dispensary in order to be able to formulate opinions on his or her personality, emotional status or interpersonal behaviors.

Non-verbal communication contributes in a decisive way to the formulation of valuable judgments by the patient, but also by the physician on understanding of the status, personality of each person, emotional state, attitude, and dynamics of communicative interaction. Communication must be undertaken and directed by the physician. It must have the ability to overcome the obstacles that may interfere with an optimal communication with the patient.

## 3. Obstacles and Errors in Doctor-Patient Communication

Communicating with the patient may be inadequate when the message is not sent or received in full. It may also be defective or deformed when the words transmitted by the transmitter are incorrectly interpreted by the receiver. And when one or more of the communication goals are not reached, this is unsatisfactory. Anxiety, depression and fear can diminish the recipient's ability to receive the message.

The factors that disrupt the communication between the doctor and the patient, giving him an incomplete or deformed feature, may be: unidirectional communication, ambiguity of language, unconscious behavior of the physician, time pressure, patient's condition, etc. Incomplete or deformed communication between doctor and patient is a consequence of misunderstandings and ambiguities that may arise in diagnosis and treatment. It is possible for the two interlocutors - the doctor and the patient - to give different meanings to the same word.

Some physicians do not realize that through their non-verbal behavior they can transmit messages that are not always positive, but it can be decoded perfectly by the patients who look at them and notice them:

- a posture that indicates dominance or lack of interest;
- the conversation with the patient at the doorstep and not near the bed;
- frequent looking at the watch;
- hurried talks with the patient;
- superficial answers to the questions posed by the medically evaluated ones, etc.

It is very important for the doctor to give his patient: time to explain; time to listen; time to dispel the patient's fears; time for the patient to accept the disturbing aspects of his illness; time to enter the existential world of another person who is his patient (Barnlund; apud Iandolo, 2006, p. 171).

A problem that may arise in the interaction between medical staff and patients when doctors, for example, speak during the visit in the hospital room, for example, in very specialized terms, ignoring the patient; he feels excluded and insulted, as doctors underestimate his intelligence, his ability to understand. The patient prefers to receive explanations when undergoing an examination, when performing various analyzes or a radiological examination. Otherwise, they fall prey to anxiety in fear of the unknown, because they come to believe that they are seriously ill, and this is silenced.

Many patients do not understand the scientific terms but do not ask for explanations either, as they may seem ridiculous and uninstructed in front of the doctor and other patients who are present and can listen to the conversation with the medical assessor. And if he asks questions, he may have the impression that he is ridiculed by overly general and superficial answers. That is why in the medical communication it is very important the respect for the patient and cultivation of the patient's trust in the doctor whio is examining him.

Another reason for the difficulties of communicating between the doctor and the patient is the emotional state of the latter. Fear is one of the most common emotional reactions to the disease. Fear is the most constraining emotion. It can give rise to a "tunnel" perception (Iandolo, 2006, p. 162) when the affected one becomes blind with respect to much of his perceptual field. The thinking of the person concerned becomes slower and more limited, and the behavior is simplified. This state of fear and anxiety is exacerbated by many hospitalized patients, especially when they are visited by their chief doctor or well-known medical professors. They become reluctant to formulate precise questions at the right time. Exceeding this situation would be possible if the patients could ask the doctors about their illness before their visit.

Refutation and repression as psychological defense mechanisms are other obstacles in medical communication. Their essence lies in the refusal of a disagreeable information (Iandolo, 2006, p. 162) Refutation is a psychological mechanism that most often occurs when the individual is in the face of a painful situation or in the face of objectives considered being unrealistic or faced with a reality that is

considered to be intolerable. In this situation, the individual unconsciously removes the content that damages them from the consciousness field. Repression is a form of minor evasion; the element that affects is removed, consciously.

## 4. Conclusions

We believe that for the successful completion of the medical act, the professional training of medical students must be obligatory accompanied by the formation of a communication competence with patients. An important aspect is the motivation of future doctors to achieve a high level of this type of competence. Significant is the formation of the belief that it is necessary to provide information and time to the patient to help him get rid of anxiety and uncertainty.

Also, it is not enough for the doctor to have full knowledge of his domain or to apply it correctly; it is necessary for him to acquire a series of attitudes, behaviors and to cultivate feelings indispensable to good communication: respect for human values, devotion, acceptance of the patient as a partner in the medical act, patience and tolerance.

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