

## INTERROGATIVE STRATEGIES OF DOCTOR - PATIENT COMMUNICATION

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### Abstract

The doctor-patient communication as the basis of health communication matrix, regardless the level at which it takes place - national, international or global - has a diversified, inhomogeneous base. This disparate legacy led to a development of health communication types of communication patterns taken from other sciences (psychology, computer science, anthropology, sociology, public policy, etc.) applied in particular contexts. The direct consequence of this fact has led to the proliferation of communication patterns based on medical schools, successful personalities in health, cultural values, moral, social, political of the various communities. In recent research in this field, that see in communication an end in itself, reducing communication theories as more structured models adopt a bottom-up perspective on specific issues facing today's society (poverty, human rights, health) but with wider applicability (Jon Christianson) has been tried to be applied. Another perspective in health communication is the overall approach (Obregon and Waisbord) that tried a strengthening of health communication through the convergence of communication theories. The paradigm in which we have outlined these tests is a common communication development. In this paper I will try an approach to doctor-patient communication starting from the communicational paradigm, supporting the possibility of convergence of communication theories based on interrogative strategies essential to any kind of communication. As methodology for addressing this problem, of pragmatic reasons I will outline first the current directions of development of communication intended to provide an overview of the doctor-patient communication as an integral part of global health communication. In the second stage, the research will focus on interrogative strategies, questions types and ways to use. The pragmatic aim of this paper would be to outline an effective tool easy to adapt to complex situations involved in the doctor-patient communication.

**Keywords:** *doctor-patient communication, health communication, participatory model, questioning strategy*

### 1. STRUCTURAL ELEMENTS OF DOCTOR - PATIENT COMMUNICATION AND APPLIED MODELS IN HEALTH COMMUNICATION

Regarded from the perspective of the doctor, the doctor - patient communication aims to clarify the diagnosis. To arrive at a more accurate diagnosis as a proper treatment of the patient's positive response (Treatment compliance), analyzes and laboratory investigations are not only enough, but also the way in which the doctor has the ability to directly communicate with the patient and maintain the communication relationship. The doctor, even from the very first meeting with his patient is placed in a position to discuss how patient develops his/her professional activity, personal life, to describe his condition, his problems facing the suffering that accuses. For this reason, but not only for this, the doctor-patient communication doesn't have a rigid, fixed form, but it changes during the process of communication. Specialists, especially psychologists, draw attention to the changing nature of communication as patient access different states, attitudes and behaviors or the vary social or intimate area under review "to make a case history between doctor and the patient a conversation as an interview will be hosted, which then must turn into a free, uncontrolled open and honest story to the patient (disease clinical narration)".<sup>1</sup>

The case history is, from the medical point of view, "all information obtained about the history of a disease and the circumstances that preceded it"<sup>2</sup>. The communication between the doctor and patient should not be limited to obtaining relevant information to establish a diagnosis but

it should focus on equal terms, on building a safe, trust environment that the patient is able to perform. The doctor has at hand<sup>3</sup> at least two ways to achieve the case history in terms of verbal and nonverbal communication<sup>4</sup>, query and systematic and detailed observation of signs and symptoms.

The physician should ask the patient questions to an empathic manner and avoid administrative query. Empathy targets an intellectual understanding of patient's experiences while sympathy is identification with the patient at an emotional level. Empathy "indicates the ability to immerse yourself in the other's subjective world, to participate in the experience as far as verbal and nonverbal allow (...) to capture the personal significance of the words spoken to each other rather than to meet their intellectual content (alto-centric sensitivity) (...) and remaining perfectly independent at an emotional level"<sup>5</sup>. Empathy becomes a very important element in communication with a negative charge, which is why the doctor-patient communication occupies about the same position with the ability<sup>6</sup> and according to The Kalamazoo Consensus Statement as essential elements must be included "...allowing the patient to complete an *opening statement*, eliciting concerns and establishing a rapport with the patient; using open and closed - ended questions to gather and clarify information, along with different listening techniques to solicit information; identifying and responding to the patient's personal situation, beliefs, and values; using language the patient can understand to explain the diagnosis and treatment plan; checking for patient understanding; encouraging patients to participate in decision and exploring the patient's willingness and ability to follow the care plan; and asking for other concerns the patient might have and discussing follow-up activities expected of the patient, before closing the visit."<sup>7</sup> All these essential elements of doctor-patient communication, with each performed act of communication, according to participants in the act of communication and communication context, they come into contact with a number of variables<sup>8</sup>: doctor's characteristics (age, sex, personality type, ethnicity, communication skills) patient's characteristics (age, sex,

education, income, health insurance, health status, personality and communication skills with the doctor), environmental features (health insurance system, health services). Because of these variables, the model structure of communication becomes extremely loose, difficult to control and requires a doctor's ability to adapt and instruments as flexible in structure as well.

However, health communication remains indebted and divided between three models of communication: information / media effects and participatory / critical theories. The information, a primary communication model is designed specifically to carry information from the issuer to the receiver, change beliefs, knowledge, and health behaviors. Media effects and participatory model involving the community in decision making, enables groups to problematize issues of health and disease and to establish priorities for action. The third perspective: the critical theories of communication emphasize the individual reason more than the group or community. Rationality is defined in this context according to "social expectations, norms and attitudes."<sup>9</sup> Obregon and Waisbord tried to strengthen health communication through the convergence of the three models of communication. The paradigm in which they sought common points is the development of communication in an attempt to find a standardized model able to answer and solve global problems. Obregon and Waisbord insisted on the difference in level between "global" and "international / national" stressing that: „*Global* refers to health communication issues that affect the world as a whole and, concomitantly, to approaches that analyze them as phenomena with planetary dimensions and implications. Examples of such global framework are theories about the role of communication in addressing health risks and challenges that transcend geographical and cultural borders, whether the spread of infectious diseases or the impact of climate change. Conversely, „*international*” alludes to the intersection between health and communication in specific local, regional, and national cases throughout the world. Examples are the analysis of the role of communication in immunization campaigns in a given country or strategies to

promote care and treatment of people living with HIV/AIDS in a community.”<sup>10</sup> The difference between the two global approaches – international / national / regional health communication induces the need for methodologies to reabsorb the distance between them and at the same time to restore relations as mentioned by Obregon and Waisbord, of critical dimensions (sense-making processes, cultural difference, and dialogue) and the socio-economic and political conditions of health systems around the world. In their approach, Obregon and Waisbord fragment the fundamental elements of communication theories, in fact a process of instrumental rationality, indicating the differences in level as health communication anomalies „Theories start from different epistemological premises, are interested in different dimensions of the intersection between health and communication, and are driven by different questions. Not surprisingly, then they have produced quite different explanations, propositions, and predictions.”<sup>11</sup> Despite all these differences, one element is found in all the approaches, each party assumes theory with different epistemological foundations and own methodologies to answer a set of questions. Starting from this observation we find a doctor-patient communication approach which supports the possibility of convergence of communication theories based on interrogative strategies essential to any type of communication by highlighting the use of questions.

## **2. INTERROGATIVE STRATEGIES IN DOCTOR-PATIENT COMMUNICATION: FROM QUESTIONING TO LISTENING**

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At the onset of the process of communication a series of standard questions occurs and the doctor is forced to ask questions of “form” type.<sup>12</sup> In order to lessen the formality questions and create a safer environment the doctor will interleave between these questions a number of elements to balance the communication.<sup>13</sup> Requesting administrative manner<sup>14</sup> should be avoided and used a query based on empathy.<sup>15</sup>

From a logical perspective<sup>16</sup>, their questions are perceived as speech acts that require a

response, a clarification. Questions are dependent on the context in which they appear and are formulated based on assumptions. The existence of the assumptions implies, on the one hand, the possibility of questions and, on the other hand, the responses to the questions. Question and answer form a unit that is consistent with assumptions and takes the difference between the questions and answer.<sup>17</sup> Primarily, this uneven segregation between question and answer provides a clear distinction of what is a problem in relation to the answers, solutions. Secondly, this makes a clear tie between answers that can be asked in relation to one and the same problem, i.e. the problematologic equivalence. Within the doctor-patient communication, the discourse created around a problem – the patient’s suffering – is nothing but a thematization of questions and answers, solutions around it. Within the doctor-patient communication asking a single question in relation to more answers without those answers to contradict, means in terms of participatory communication model, that the problem facing the patient can be solved by two or more methods, treatment regimes, and at the same level, that decision to follow a version or another is shared by those who participate in the act of communication, namely doctor and patient. As an alternative, the question arises how the communication process, if we consider the assumptions<sup>18</sup>, leads to the occurrence of neuronal responses. Depending on how the assumptions affect the questions, they will be direct and immediate or indirect. Among the direct assumptions the existence, possibility, or method can be also mentioned.

For example: “He took all his drugs at 20” involves existential presupposition: there is a person. This assumption mediates other assumptions, the fact that the person has health problems that he has received adequate treatment at and he was prescribed medication. The fact that it would be a person who avoids his medication after a rigorous schedule and he does not take them all, or that, at least, there were times when he made exception, another assumption would be that there is a person who observes what does the person do while taking his medication.

In short, it could be stated that before a question there is a situation, a context that creates it through presuppositions, and this context must always be brought to the attention of the other party if you wish to receive an appropriate response to the question or at least to be understood.

The Romanian logician, Petre Botezatu, based on erotetic calculations determined the relations between questions aimed purely pragmatic to achieve more efficient questioning strategies. The classification of questions proposed by Petre Botezatu<sup>19</sup> is based on distinct criteria of selection:

- 1) *the value of truth*, according to the standard, the questions are: *absolute, qualified, conditional*;
- 2) *according to the existence of some alternative*, the questions will be: a) *of complete list*, b) *non-exclusive* c) *direct* d) *semi-direct* e) *indirect*
- 3) *according to questioning strategy*: a) *general* b) *strict* c) *decisional* – the answer is given by replacing the unknown question with the name of a concept; d) *disjunctive* e) *“why” questions* – several meanings, for cause, reason, purpose, principle, f) *semantic* – is like the name of an object or meaning of a name;
- 4) *according to the form and function*, interrogations can be: a) *Hint* – the answer is looming the question; b) *rhetorical* – they have the function of questions but they do not act as proper questions; c) *apparent* – keep the questioning form but the function can be a statement, command or exclamation.

From this perspective, of classifying the questions, the problematologic theory simplifies things. The only criterion at stake will be the nature of answers that the questions ask them. In this context, interrogations can only be:

- 1) *Binary* – it requires at least two answers. If a question does not meet this requirement then we are dealing with a disguise answer. For example: “Did you take prescribed medications?” Requests as response either yes or no;
- 2) *Categorical* – questions that supports multiple opportunities to respond. The question: “When will you take the medication?” may receive as an answer either “today at 9”, “after lunch”, “evening”, “I do not take them” etc.

The doctor not only puts questions, he is often put in a position to answer various questions

that patients address him. If the doctor is encouraged, so as the communication process not to come to a deadlock, to use with predilection the categorical questions, on the other hand, the patient, may ask the doctor the questions that directly targets him. The patient may be suspicious, and he can have the feeling that the doctor’s hiding the truth: according to this belief, the doctor will address the patient a question that apparently does not seek anything but to put the caller in trouble and to confirm the answer, to know the “truth” which is hidden. How to use questions? Most of the questions that the doctor addresses to the patient should be categorical. Binary questions can only be used when searching a dichotomous answer and when an alternative response is ruled out. This type of questions must be interspersed among the categorical questions. Questions formulated by the doctor should be clear, in words that the patient understands, and as a general rule, two questions should not be put at once. If case of the interview, as a method in the case history, the doctor should avoid the apparent questions in the communication with the patient. Through these false questions the doctor can determine the patient to say what is expected of him.<sup>20</sup>

Within the doctor-patient communication, the obedience becomes the pendant of the question. Listening does not mean just hearing, even in the explanation of the term, the obedience includes verbs such as to understand, to question, to subject or as a self-induced attitude, to obey. The act of listening involves intentionality and focuses a visible attention (participation) in the non-verbal communication of the interlocutor, while hearing relates only to the position of receiving sounds, even those you do not want to hear them, they occupy a defined space in the communication patterns and they are seen as elements that disrupt communication: the background noise. From this point of view “obedience is not a perception, but a dialogue.” The basic principle of a dialogue is to listen carefully to each other, through dialogue different perspectives on the same issue are placed in front of and integrated into a wider vision. In accordance with the principles of dialogue, silence is equivalent to listening<sup>21</sup>. Silence, in this perspective, is for: a) scoring element (the patient

is allowed to express his/her own point of view in relation to a relevant aspect); b) time of reflection; c) transition to another topic. A prolonged silence may be considered as: a) expression of the reserved listener, in this case, the doctor stresses his superior role within the communication relationship (biomedical approaches); b) a form of pressure on the speaker; the patient may feel compelled, when silence is prolonged, to talk more. The listening centered on dialogue requires balance between the other's attention and that of him, the other's expression and his own expression.

### 3. CONCLUSION

The doctor-patient communication strategies based on interrogative questions as a way to use communication flow takes into account a broader perspective on the structure of the question and integrates not only what is essential in the question itself, but also the elements that complete the answer / answers and what becomes specific to this type of communication, namely the listening. The interrogative communicative action type creates a reductionist effect: the questions, the answers agglutinate forming problems. In this context, the problem must be understood not as obstacles to overcome, but as "messages that convey information, promote values and forms the spirit of proposed rules of their knowledge and induce performative attitudes"<sup>22</sup>.

Philosophical, problematologic foundation of this approach provides the possibility of the communication theories based on interrogative strategies that are found to converge without exception, in all the communication patterns.

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**Endnotes:**

1. Rules prescribed by C. Enăchescu, *Tratat de psihopatologie*, ed.IV., Polirom, 2007, p.128.
2. A. Muchielli, *Arta de a comunica*, Polirom, 2005, p. 217.
3. Ovid Fontaine, Philippe Fontaine (eds.), *Ghid clinic de terapie comportamentală și cognitivă*, Polirom, 2008, p.71.
4. The paradox of communication would be that we, before saying something using words, if we are dealing with a face to face, unmediated communication, of the type that establishes between doctor and patient, we communicate nonverbally. Prior to communicate a thought, an emotion, a nonverbal state-level we say something about ourselves through clothing, jewelry, hair, posture, facial expression, as we speak, the gestures that accompany our words, tone of voice, pace, intensity of speech, the way we look at the speaker, the distance at which we stand to it, touching, simple clamping a hand, all these factors influence the way in which information is received. In the logic of communication, the nonverbal communication is the preceding verbal communication and at the same time, the very act of speaking out. However, specialists in communication sciences not only prefer to reverse the order but also to analyze separately the two different types of communication, both on methodological reasons and as a result of the communication model that gives the addressed communication, mainly, the role of transmitting the information only to relationships structure. Systematizing these elements of communication, according to the traditional dichotomy, it can be argued that if verbal communication is the foundation of words, then the issuer selects and arranges them in large units of speech. On the other hand, the nonverbal communication incorporates the context in which communication occurs, the style and the way information is communicated to the other.
5. C. Rogers, M.G. Kinget, *Psychotherapie et relations humaines*, ed a III-a, Ed. Universite de Louvain, 1966, pp. 105-108.
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7. Ibidem, p. 391.
8. Christianson, Jon, Warrick, Louise, H. In the work, *Physician Communication with Patients: Research Findings and Challenges* University of Michigan Press, 2012, p. 6, includes the doctor’s characteristics, those of the patient and environment in a logical model of communication.
9. Obregon, Rafael, Waisbord, Silvio, *Handbook of Global Health Communication*, Wiley-Blackwell, 2012, p. 34.
10. Ibidem.
11. Ibidem.
12. The “type form” questions of in the daily flow of patient-physician communication could have the following form: doctor - your name, please ...; Patient - Popescu Ion, doctor - age?; Patient - 53 ...
13. Among the elements capable of absorbing a part of rigidity and the doctor-patient communication formalism, the greetings, self-presentation and polite behavior can be considered. For example: Oh - Hello! I’m Dr. Elvira Pavelescu, your name, please ...; Patient - Hello Mrs. Dr.! Ion Popescu ...; Doctor - I have to ask you to answer a series of questions about your health problem. If some of the questions you will find them embarrassing ... please intervene; Patient - Let’s get started, it does not bother me, that’s why I’m here...
14. The administrative questioning may have the following query structure: doctor - What problem do you have?; Patient - It hurts on the right side here ...; Doctor - when did the pain occur?; patient - Oh! There was for a long time ...; Doctor - is there a cause, a trigger pain more recent?; Patient - I do not know ... Asked in this way, the doctor gets increasingly less information and he can lose the collaboration with the patient.
15. The empathic manner of querying could be played by the following structure: Oh - I understand that you have a pain, how is this manifested?; Patient - it hurts me on the right, right here ... Before, the pains were shorter, but now they have stepped up and the pain is stronger and they occur about half an hour, maybe an hour after you eat... The doctor determines his patient to provide more information.
16. Laura Ciubotarașu-Priscop, „Rolul principiilor logicii clasice în procesul chestionării”, *Symposion*, Tom, VII, Nr.1 (13), 2009, pp. 114 – 123.
17. The question-answer difference is seen in this context as the concept of *problematologic difference* introduced in the discourse of philosophy of Michel Meyer is what “makes the question as being a *question*, which necessarily implies that it (the question) has made a *contrario*, or to decide when we do not, or do not have a question.” M. Meyer, *De la problematologie. Philosophie, science et langage*, Pierre Mardaga, 1986, p. 53.
18. The perspective on the assumptions takes into account the theory developed by R.G. Collingwood in the paper, *An Essay on Metaphysical Study. Function of Metaphysics in Civilisation, Notes for an Essay on Logic*, Calderon Press, Oxford, 1998, pp. 30 – 35.
19. Petre Botezatu, „Erotetica - Logica întrebărilor” in Constantin Grecu (ed.), *Logica interogativă și aplicațiile ei*, Editura Științifică și Enciclopedică, București, 1982, pp. 25 – 35.
20. Using the apparent questioning may receive, for example, this form too: “Oh -Do you have a backache?; Patient - yes, I find this normal, I have an

- age...; Doctor -Is still hurting you?...; Patient - A little bit".
21. C. Rogers, *La relation d" aide et la psychotherapie*, ESF, 1970, as cited in Andre de Peretti, Jean - Andre Legrand, Jean Boniface, *Tehnici de comunicare*, trad. Gabriela Sandu, Iași, Polirom, 2001, pp. 317 - 327.
22. Balahur, P. , *Problematologie și comunicare*, Iași, Editura Performantica, 2006, p. 55.