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ABSTRACT

Current medical practice expects the minority patient to bend his linguistic and cultural background to that of the physician, a situation which interferes with effective doctor/patient communication. This study examines the problems in doctor/patient communication in the cross-cultural medical interview, with a special focus on the black, inner-city patient. Three types of investigation were followed. Evaluative questionnaires were administered to patients and doctors to determine subjective evidence for or against communication breakdown in the medical history interview; actual verbal exchanges between doctor and patient were observed, recorded, and typescripted; and extant automated routines for eliciting medical histories by means of a computerized console were examined. On a continuum with doctors speaking doctor language on one end, and patients speaking patient language on the other, the breakdown appears at either end. Communication appears to take place successfully at the center of the continuum. Since the burden for communication has traditionally been placed on the patient, it is suggested that the medical profession assume a more responsible attitude to this problem. One suggestion entails exposing medical students to minority languages and cultures. Two sample questionnaires are appended. (Author/AM)

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Problems of Communication in the Cross-Cultural Medical Interview

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Problems of Communication in the Cross-Cultural Medical Interview[1]

It is a well known presupposition in sociolinguistics that any social relationship or event tends to develop an organization of verbal means specific to itself (Hymes 1971). This presupposition implies that language use is organized into speech acts and speech events with discoverable underlying structures, and that the users of language select from available choices in both novel and familiar situations with both novel and familiar utterances. The medical interview provides an interesting example of a speech event which has been little studied by sociolinguists. Some preliminary work has been done on the ethnographic taxonomy of medical history taking by Beverly Stoeltje (1971), who has examined actual medical interviews of nurses with pre-natal patients at Brackenridge Hospital in Austin, Texas. Her interesting research has focused on the formulae for openings, closings, leave takings, etc. within this well-defined context. The preliminary and therefore cautious findings of Stoeltje's work are tempered by her realization that frequently in her research different cultural groups are involved in the speech situation and quite different views on what is appropriate (or even possible) to ask may be held by the interviewer and interviewee at different points in the event.

It is precisely this area of cross-cultural communication upon which the present research is being conducted. The situation of a Black, inner-city patient being interviewed by a middle-class, medical professional is one focus of our concerns here. The medical history was selected as the speech event largely because of its cruciality (estimates are that 95% of the success of the treatment hinges on an accurate assessment of the history) and accessibility. It is probably the most structured

aspect of the medical care involving the language and culture of the patient. The perspective will involve a rather inconsistent view of several academic fields at the same time. That is, this paper is not an ethnography of communication, a study of social interaction, an examination of attitudes nor a treatise on linguistic behavior but rather an admixture of these areas of academic study on the problem of medical history taking in a cross-cultural context. I am, quite frankly, more interested in addressing myself to this problem than I am to verifying the assumptions or claims of any of the fields which provide theoretical or methodological suggestions or procedures.

Interference Factors in Patient-Doctor Communication.

Elsewhere I have identified some of the factors which bear heavily on interfering with effective communication between patient and doctor in the medical interview (Shuy to appear). The speech event itself is shrouded with emotion, on the part of the patient at least, and is often carried out in language which has been described by several members of the medical profession as a peculiar and technical jargon. The following is one such recent observation.

> The Physician speaks a strange and often unintelligible dialect. He calls everyday common objects by absurd and antiquated terms. He speaks of mitral commissurotomies, pituitary insufficiency, and reality feedback. This world is peopled with cirrhotics, greensticks, and hebephrenics. The professional dialect creates a communication gap between physician and patient that is generally acknowledged by neither.
>
> ...Increased specialization refines the physician's particular dialect, and he becomes much like the computer, tolerating only the imprint of words that fit into the programmed languages (Kimball 1971:137-138).

A third factor leading to interference in the effective communication between patient and doctor stems from the socio-economic reality of our

society. Medicine, as a profession, is a strictly middle-class phenomenon. Of this, Kimball points out:

> Although medicine has traditionally been the most accessible of the professions in terms of providing for upward social mobility, it has recruited most of its manpower from the middle-class, especially the upper middle class. These groups display life styles, thought processes, and a dialect far removed from those of most patients (1971:138).

This situation obtains equally for psychoanalysts as Hollingshead and Redlich clearly indicated in 1958 when they pointed out that money commands attention from psychiatrists (Hollingshead and Redlich 1958). Those who are relatively poor or uneducated are given little or no attention and it has been estimated by one prominent psychoanalyst that an overwhelming majority of presumed successes in psychotherapy are with middle-class patients (Harley Shands personal communication). A suitable patient, in fact, might well be defined as one who is comfortable with the language and culture of the therapist, which is by definition, middle-class.

An obvious suggestion to overcome this middle-class bias of medicine and psychotherapy is to recruit more doctors from the working classes in order to reduce this mismatch of language and culture from patient to doctor. As hopeful as this might sound, past experience has shown that there is something in the acquisition of medical knowledge which seems to wipe out former ties and culture. Casual observation of many physicians who came from the working classes has revealed a relative lack of sympathy toward patients of working-class status. Apparently the same assimilative phenomenon is at work in medicine that already has been observed in school teachers. Perhaps you can't really go home again, as Thomas Wolfe once said.

As a remedy to this mismatch of the doctor's difficulties with dialect, both with his own professional jargon and with the social and cultural dialect of the patient, Kimball suggests a refocused medical education:

> Medical schools have the opportunity to sharpen the student's hearing and to broaden his understanding of disease and illness patterns at an early and sensitive stage in his development. Unfortunately, interviewing, as a diagnostic and therapeutic skill, is ignored and underestimated by many medical faculties. Departments of medicine often reduce interviewing to history taking. Although some emphasis is placed on past, family, and social history, the focus is directed toward disease specificity rather than the illness and its relationship to the patient, his family, and his community (1971:139).

Kimball suggests that one way to enlarge the medical students' experience with the dialects of the working-class community is to expose them to such groups during their training.

One medical school in the Southwest has planned a training session in clinical medicine in a neighborhood health clinic--learning interviewing techniques in the real world. In this case, the program requires that the medical students learn Spanish since most families enrolled in the neighborhood health clinic speak only that language. Obviously not much information is communicated unless the doctor learns to understand the patient in his own tongue. Not satisfied with this, Kimball further suggests: "In many of our urban medical schools physicians-in-training could use special courses in culture and language of subgroups, whether or not they speak English" (1971:139).

In an important study of the ways in which cognitive and linguistic and conversational elements are basic to the medical history interview, Aaron V. Cicourel laments that the fixed choice questionnaire typically used by the physician obscures for analysis the reasoning processes of

the interviewer. Several observations are possible nonetheless. The interview problems are treated as technical issues. Physicians give little or no credence to the possibility of training in interviewing techniques:

> The physician relies on powerful theories from biology, biochemistry and the neurosciences to justify his diagnosis and treatment; he tends to ignore the difficult interface between common sense talk to the patient, and the translation of the question-answer format into clinical science terms (Cicourel MS).

Cicourel continues:

> How stored information is organized and how access is to be made is not defined as a serious problem. The researcher assumes the respondent will be presented with 'normal'speaking intonation, standardized syntactic structures, and standardized topics as indexed by the same lexical items. Open-ended questions that encourage spontaneous responses are not encouraged because this complicates the coding of responses and the achievement of a standardized format (MS).

Before such a program were to be developed, one would want to be sure that adequate knowledge exists concerning the language and culture of such subgroups. Recent research in the distinctive language patterns of Blacks, Puerto Ricans, isolated Appalachians and minorities of other types, for example, has enlarged our potential for designating areas of communication breakdown in a number of settings. Previous research at Georgetown University, The University of Pennsylvania, The Center For Applied Linguistics and other places has repeatedly pointed out the consistent, systematic linguistic contrasts between minority speech and the language of the middle classes. Such information is useful both as a predictor of potential communication breakdown and as a critical measurement point for remediation. In the past these linguistic descriptions have been helpful to classroom teachers in that they specify the exact nature of the problem and they enable the teacher to adhere to

the long cherished (but seldom followed) notion starting with the student where he is. That is, teaching materials can be built more efficiently after it is clearly established where the learner is on the education continuum.

As things now stand, the typical minority group patient is in a similar position to the minority group student in the schools. Much has been said about compensatory education in recent years. In reality, what this means is that the institution (the school) does not feel that certain minority group children are culturally, socially or linguistically ready for education. To make them ready, a program is devised that will change their culture, their social behavior and their language to conform to the expectations of the school. Compensatory education argues essentially that the child must be like the school in order for the school to be able to teach him and all that rhetoric about starting with the child where he is is only so much verbiage. Current medical practice utilizes a similar communications mode. The patient must adjust to the language and culture of the physician or psychoanalyst. The medical profession does no better job of starting with the patient <u>where he is</u> than does the teaching profession. If the various medical specialists cited earlier are correct in their assessment of current practices in doctor-patient relationships, a great deal of miscommunication is currently taking place not simply because of the emotionally charged nature of the interaction, not simply because of the doctor's inconsiderate use of medical jargon, but because of a critical lack of awareness concerning the linguistic and cultural systems which some patients bring with them to their first meeting with the person to whom they entrust their health.

Of the more obvious and predictable interference factors in effective doctor-patient communication, then, we have noted three: the fact that the event may be laden with patient emotion, the myopic perspective of the doctor with respect to the language of his specialty, and the obvious class-contrast between doctor and working-class patient. All of these factors have been noted in the literature, by the medical profession as well as by outsiders to the profession. Still, relatively little hard data are available to verify or reject these assumptions. This situation results partially from the tendencies toward self-preservation by the medical profession itself, where presumed high standards of ethics have all but eliminated internal criticism and where a lack of openness about the relative certainty or uncertainty of diagnosis or treatment is masked by the assumed aura of infallibility. There are increasing evidences, however, that the status of high priest, so long enjoyed by the medical profession, is beginning to crumble. For one thing, it runs counter to the way we do things. Our space science ventures are open for public inspection. The life blood of our legal system involves challenging an expert and questioning his expertise. Our academic professionals are subject to attack in almost everything they write. Our artists, musicians and writers are reviewed skeptically and critically. Only the medical profession has put itself above such analysis, spurning the process of peer review and making a general muddle of the medical evaluation. Psychiatry is probably the extreme example of this, as David Brazelon (1973:7) observes, where "...there are no commonly accepted standards of good work or ways to prove that changes in a patient's life are due in fact to his clinical sessions. Success can always be imputed to the psychiatrist's impact and failure can always be attributed to the patient." Considerable effort

is being made today to get psychiatry to open its doors, a pressure brought about largely by growing public suspicion and distruct. Medicine cannot be far behind for the National Hospital Association has been studying doctor-patient relationships and has compiled a list of the ten questions most often asked by patients. Leading the list is the question: "Why don't doctors explain a medical problem in simple language that a patient can understand?". In answer to this question, the famous heart surgeon Michael E. DeBakey replied: "Most doctors don't want their patients to understand them! They prefer to keep their work a mystery. If patients don't understand what a doctor is talking about, they won't ask him questions. Then the doctor won't have to be bothered answering them." (Robinson 1973:9-12).

One purpose of this current study was to examine the extent of this behavior, to examine how much patients feel or are led to feel that they must communicate with doctors in doctor language. Conversely, we were also interested in those occasions in which doctors showed a need to try to communicate with their patients in patient language. One might hypothesize a continuum such as the following:

Doctors talking Doctor language	Doctors talking Patient language	Doctors understanding Patient language	Patients understanding Doctor language	Patients speaking Doctor language	Patients speaking Patient language

Among issues of concern to us in this aspect of the study were:

1. What evidence can be noted to determine that patients are either understanding or not understanding doctor talk?
2. What evidence can be noted to determine that doctors are either understanding or not understanding patient talk?
3. What failures and/or successes can be determined in the efforts of patients to talk doctor language?
4. What failures and/or successes can be determined in the efforts of doctors to talk patient language?

5. How can all of the above evidences, successes and failures be accounted for in terms of the known facts of language and culture?

In an effort to tackle the topic in as many ways as seemed potentially valuable for discovering and describing problems that might later prove to be significant in assessing the subject, three types of investigation were followed:

a. Evaluative questionnaires were administered to patients and doctors in order to determine subjective evidence for or against communication breakdown in the medical history interview.

b. Actual verbal exchanges between doctor and patient were observed, tape recorded and typescripted for objective evidence for or against communication breakdown in the medical interview.

c. Extant automated routines for eliciting medical histories by means of a computerized console were examined for such evidence.

The Evaluative Questionnaire.

Probably the most basic question we could ask in such a study is whether a communication problem between doctors and patients really exists. Since our work was to be done largely at Georgetown University Hospital, it seemed useful to get a rather broad survey of patient reactions to their care and treatment there. Considerable effort was made to design a set of questions in the clearest possible language to avoid ambiguities and confusion. Fourteen such questions were constructed, worded and arranged so that some points would be evaluated twice.[2] Five of the questions were directed at addressing the nature of the vocabulary problems between medical people and patients (#1, 3, 6, 10 and 11). Two questions attempted to assess whether or not there was something in the medical person's attitude which discouraged free communication by the

patient (#2 and 7). Answers to questions relating to the time element and the doctor's real or apparent personal interest were sought in five questions (#4, 5, 8, 9 and 13). One question asked for the patient's overall assessment of satisfaction (#14) and one explored the possibility of undue secrecy on the part of the doctor (#12).

The questionnaire was administered randomly to 86 patients in the waiting rooms of the various clinics and private medical practices during a two-week period at the hospital. The results demonstrate clear evidence of how widespead the problem is.

On the matter of vocabulary, 41% of the people (a wide age range with race and sex variation was achieved) said that they sometimes felt the doctor did not understand the patient's problem (#10). Replying to this question with a positive answer does not relate the percentage unique to linguistic problems, of course, because other factors could be involved such as the doctor's inattention to the patient's minor or continuous complaints.

Other percentages for vocabulary problems come close to this, however; 38% thought that doctors, nurses or interns sometimes use words that are difficult to understand (#1) while an equal 38% thought it was sometimes difficult for the patient to explain himself to the doctor (#3). Thirty-eight percent would prefer the doctor to speak in simpler language (#11). However, only 16% would say that the doctor usually expects you to know medical words (#6), possibly indicating that this just happens to be the way doctors talk and that the patients are not directly blamed for not being able to understand the doctor. They would like it if the doctor could modify his language to be more easily and fully comprehended. The problem does not sit solely with the doctor

as the only cause because patients admit to an equal share of the problem (#3).

The doctor's attitude was assessed negatively by 39% and 43% of the interviewees. Thirty-nine percent felt that the doctor's attitude is sometimes unfriendly (#2). This may stem, of course, from a large variety of causes, but the general feeling of "unfriendliness" includes most anything. Forty-one percent fe' inhibited by the doctor's attitude, personality or style (#7).

The inhibition seems to occur through the patient's recognition of a major difference in intellectual levels between himself and the doctor. We might infer that many patients credit the doctor with so much intelligence nd preoccupation with "important matters" that they cannot bother him with minor or irrelevant questions. This is a potentially critical factor in communication because some problems, no matter how superfluous for the doctor, may be deep-seated sources of worry and discomfort for the patient. If the patient holds back on these things his anxiety is not alleviated.

The medical profession is one where time seems an exceedingly valuable item. Patients see doctors as very busy people. The questionnaire reveals, though, that a sizable number of patients think more time should be spent with them. It has been a basic assumption in our research that time is not in reality what some patients feel is lacking, but more often a larger degree of active interest and attention should be accorded them when they are with the doctor. This attention is extended through oral-linguistic means--communication. It is not so important how much time is spent with the patient but how much and what kind of transfer occurs during that time.

Thirty percent of the interviewees thought the doctor does not spend adequate time talking with the patient during appointments (#4) while 53% would like the doctor to spend more time talking with them (#9). There is a range of 23% between the two statistics. It may be partially explained by pointing out that number 4 pertained specifically to appointments and that this may constitute fewer of the doctor-patient contact situations than we suspected. Question number 5 was designed with the aim of comparison with numbers 4 and 9 to establish whether patients feel the doctor in particular does not pay enough (the right kind of) attention to patients or whether other medical personnel such as nurses and hospital attendants are also involved. Unfortunately, we cannot make the comparison because in analyzing the content of the question, it was discovered that number 5 asked about adequate attention to medical needs. This covers non-linguistic domains which we are trying to steer clear of. The question would have been better worded, "enough attention to you when you are in the hospital."

It was asked (#12) whether patients sometimes feel the doctor withholds information they think they should know. This was an attempt to tackle the communication problem from another angle. Fully 70% believed this was true. The reasons for this will not yet be surmised but we will note that over two-thirds of the interviewees felt a void in communication where information was either not willingly offered or not furnished (not forthcoming).

The remaining questions sought to measure the general evaluation of medical service--including the linguistic element without setting it apart. Fifty-three percent said they get their money's worth out of medical services (#13), but 57% felt doctors are overpaid. When compared

with the 25% who are in general dissatisfied with the situation (excluding all consideration for operations, medications and prescriptions--#14), we note, however, that a quarter of the interviewees feel they should be content with what they get even though they do not like the situation as it now stands, while an additonal quarter are still not appeased by the benefits of their medical attention at all. Seventy-five percent are satisfied with the medical attention they receive, but of this group, one-third (therefore one quarter of the total interviewees) are not altogether pleased.

To contrast this general survey of subjective responses of hospital patients to their medical treatment, we have also begun to assess the feelings of university medical personnel, on these same issues. Two obvious methodologies suggested themselves. ... is the questionnaire-survey and the other is by means of direct observation of the medical history taking.

At the time of writing, only seven university physicians had returned the questionnaire and, of course, the results are, at best, fragmentary.[3] All seven express the belief that there is a communication problem between doctor and patient. When asked where the difficulty comes from, no particular pattern seems to emerge. The answers are rather evenly distributed between the way the patient speaks, the way the doctor speaks, the patient's general attitude, the doctor's general attitude, the lack of time and fear. Interestingly enough the younger physicians suggested time as a major factor much more than the older doctors.

On the other hand, when the doctors were asked to check off the factors which best describe physicians, they used busy most frequently, followed by over-uses technical terms and reserved. In general, negative terms (brusk, impatient, impersonal, etc.) were used to describe the profession over positive terms (sympathetic, friendly, relaxed, etc.)

by a ratio of three to one. Overwhelmingly the factors physicians would not like to find in their profession were impersonality, impatience and an over-use of technical language to patients.

When asked to check-off factors which best describe patients, negative terms dominated at the ratio of five to one, despite the fact that an equal number of positive and negative alternatives were available for selection. Only the youngest physicians considered patients generally friendly. The most common attributes were fearful, imprecise, nervous, tense, reserved and, strangely enough, talkative. All generally agreed that good patients are relaxed, at ease, and clear or explicit, while bad patients are impatient, imprecise and aggressive. All seven doctors agree that problems can arise because of the different cultural backgrounds between themselves and the patients but only the oldest two physicians admitted that this came to them as a surprise after they had set up practice. Only one physician was able to cite any specific examples of this mismatch of culture (one was a malapropism for fibroids in the uterus--fireballs in the useless, and the other a street-corner synonym for have a chancre--get a haircut).

Tape Recorded Medical Histories.

One of the major difficulties in carrying out research of this type quite naturally involves invasion of privacy of the patient, the doctor, the hospital and the medical profession. It would be nice to think that the processes of the profession might be studied in some kind of impersonal isolation but the simple fact is that the medical history is usually conducted by a human being upon a human being. Even in the case of the more impersonal automated medical history routing (which will be discussed later) the array of questions was developed by human doctors for human

patients. In short, there seemed to be no way to study this situation without invading people's privacy. This fact led to an enormous set of problems involving authorization for the research at every level of hospital administration and private involvement. Each patient whose medical history was tape recorded signed a release form.[4]

Once all arrangements were made for the researcher's physical presence at the consultation, we had to resolve problems in the actual recording of information. These centered around physical-mechanical difficulties and planning of strategies. The ideal data form would have been an audio-visual taped record of the entire interview from which all the physical and environmental elements could be studied in addition to the linguistic and non-linguistic communication signals. Failing this, for obvious reasons of lack of space as well as equipment and financial resources, the second best situation was to tape record the interview and to take notes on various factors accompanying the dialogue such as gestures, speaking distance and visual orientation of the interlocutors. Although we were able to use tape recorders for consultations at a hospital clinic, conversation was often difficult to typescript because of the heavy, constant, background sound effects provided by ventilation fans, opening and closing doors, moving chairs and metal medical instruments.

The recording quality itself also suffers from improper distancing of the microphone. The researcher cannot permit himself the arrogance of establishing himself in appropriate proximity and ideal position for recording the communication exchange. To do so would not only interfere with the doctor's movements but could also create undue stress on the situation, leading to embarrassment for the patient. Greater improprieties

have already resulted in a critical rebuke for scientific research and need not be repeated. Furthermore, the consequent doctor-patient communication becomes at least modified by the presence of a third party. The researcher's presence almost loses its passive character by inhibiting the patient's communication with the doctor in an already special and intimate situation.

The data gathered so far is from a total of fifteen full or partial medical history interviews. Five were conducted in the hospital's community medicine clinic, four in the hospital office of a private physician and six in the emergency room. It was sincerely hoped that by this time it would have been possible to have gathered more data in all three settings as well as in the family planning office of the hospital. We have been stymied in the latter case by a natural hesitancy on the part of patients to permit a third party, especially a male, into the intimacy of their treatment. In many instances our tape recording in the community medicine clinic has been short-circuited by our being pressed into service at the hospital to translate for doctors who speak no Spanish and patients who speak no English. In this we feel that we have offered something useful in exchange for our constant request for data but it has, nevertheless, worked against our research goal.

Earlier we stated that we were interested in determining the extent to which the medical history is conducted on a continuum from doctor language to patient language. By far the largest parts of the medical histories were conducted in doctor language and the patients tried very hard to operate in as close a version of doctor language as they could muster. Most serious breakdowns came when patients could (or would) not speak doctor language and doctors could (or would) not understand patient

language. Our data, though still brief and fragmentary, display evidences of success and failure at all points on the continuum.

Learning to Speak Doctor Talk:

Some patients apparently spoke or tried to speak doctor language in order to be accepted as a legitimate member of the speech event or to establish some sort of status with the doctor. A person who can use the terms mesial or distal to his dentist, for example, can feel that he is almost an insider to the dentistry business, even legitimizing his presence in the chair. Some of our patients made very clear and conscientious efforts to speak a language which they judged appropriate for the medical interview. The fact that all the patients were Black women from inner-city Washington, D.C., would suggest that their gearing-up for the interview would cause them to produce their best formal English, as free as possible from stigmatized grammatical features. The patients generally guarded against the use of vernacular English by offering relatively short and formal responses, slipping only in utterances which might be considered non-medical or near social, such as:

D: Does Mr. Jones work?
P: He work manually. He work at the courthouse downtown.

or in hypercorrections such as:

P: Well, I just had infection, you know--a kidneys infection.

or in emotional circumstances such as the description of intense pain as follows:

D: And what's, what's the chest pain like?
P: They don't really stay in one place. They comes right up in here, then it goes round the side, then, you know, just up and down and round the side.
D: Ever under your arm?
P: Yes, in this arm here and it, and like when I wake up, I can't hardly hold it, you know, it go to sleep. It's all pain here--

hurts--and then when I wake up I can't hardly close my joints--so stiff.

D: Is this--does it hurt?

P: Yeah, and then I, you know, when I try to use it, it feel like it goes dead and don't have no feeling in it.

The shorter emergency room interviews tended to be more fraught with frantic emotion, yielding little guarding against vernacular such as:

P: Look, I ain't gonna sign...

D: Is this your first or last (name)?
P: That my last. Arnold my first.

D: Your nose stuffed up?
P: Not my nose. It my body.

P: I tell you where I comes from it never rain.

Most generally during the major portions of the medical interview, however, very little vernacular Black English was employed by the patients, despite every indication that such a vernacular is habitual in more formal contexts. This suggests that they were putting on their best English for the occasion, a fact which in itself suggests that they were attempting to speak doctor talk.

Occasionally doctor talk was actually learned during the interview:

D: And have you ever had any accidents, breaking an arm, break a leg...?

P: Not broken, but, I, when your arm is in a sling that means it's not broken. It's not always knocked out of place, but this was when I was a child.

D: It was dislocated.

P: Well, right, dislocated, OK? (nervous laughter)

Another instance of this learning can be seen on another occasion when a woman who had had six previous pregnancies learned the sequence and language of responding very quickly:

D: OK, now your second child?
P: 1959, Georgetown, normal pregnancy.
D: And how about the, uh, duration of labor?
P: I'd say it was 1:00 when I came here that night and my son was born at 5:30 in the morning--5:30 a.m.--so I guess it must have been around 4 hours.

D: And...
P: Normal. They were all six pound babies.

This anticipatory response continued through the descriptions of the other four deliveries as well:

D: And your fourth child?
P: 1961.
D: Where was she born?
P: Here, the same, and I don't remember.
D: (Laughs) We're getting this down pat now, aren't we?

In addition to the direct teaching of medical terms (as in the case of dislocated arm) and cumulative experience (as in learning the predicted medical history question sequence [immediately preceeding]), patients also learn to talk doctor language in a rather dangerous manner as a result of intimidation:

D: You are drinking a lot of milk, aren't you?
P: Oh, yes, I drink a lot of milk.

Upon completion of the interview, we overheard the nurse ask the patient the same question and the patient answered, this time truthfully, that she hated milk and never touched it. Why would she lie to the doctor? Probably because the question was asked in such a way that the patient was afraid to answer truthfully.

Another level of intimidation seems to derive less from the doctor's manner than from the obviousness of the question. Somehow we expect ourselves to have perfect memory for certain things like our own telephone numbers, our family's birthdates and other such matters. Our data reveal several examples of patient embarrassment at such lapses in memory:

D: Now, your first child...what year was he born?
P: She was born in 1957.
D: 1957?
P: This is terrible! I have to think

Equally embarrassing is the patient's general inability to pronounce the names of drugs properly or, in some cases, even to remember them:

D: Chest pains? OK. Do you use any medications?
P: I was on, uh, what you call it? Diagrens--they call Diagr... Diagrens, like little pink pills.
D: Hmmm. Have you ha..., have you taken them during this pregnancy?
P: No.
D: Anything that you've taken during this pregnancy?
P: I had some Dia...They gave me some vitamins, some green pills and I had some little, bitty white pills and some red pills.

This interlude was particularly tender because of the patient's complete failure at speaking doctor talk. She got no reinforcement from the doctor, who may not know what Diagren is either, and, lacking support and realizing defeat, the patient resorted to the total layman, even childish, language of red, green and white pills.

In some cases, clear evidence of a patient's ability to talk doctor language seems apparent:

D: Were there any complications as far as you were concerned?
P: Well, I did have excessive weight gain as I have now and, uh, that was toward the end of the pregnancy and they put me on a salt-free diet.

This exchange came at the very end of the interview, and perhaps evidences the patient's language learning skills, even to the extent of impersonalizing her pregnancy to the pregnancy and sprinkling lightly with hospital lingo.

Learning to Understand Doctor Talk:

Doctors do not always make it easy for patients to understand them. Occasionally this stems from inexperience or a simple inability to ask questions well. Surprisingly, patients are frequently able to guess at the intention of the question even when it is inelegantly stated:

D: Now did he have any problems during the pregnancy of the child?
P: No.

This question follows a discussion of the delivery of the patient's second child during which no antecedent for the he exists. It can only be assumed that the doctor meant you for he. Likewise, the doctor obviously

means your pregnancy for pregnancy of the child. This was a terribly garbled sentence, yet the patient answered without the slightest hesitation, apparently disambiguating as she went along.

Patients in these interviews were also very consistent in answering multiple questions put forth by the doctors. The following multiple questions will serve as examples:

D: Well, how do you feel? Did you have a fever?
P: No.

D: How long have you had that? All your life?
P: Yes.

D: Where do you get short of breath? Do you ever wake up short of breath?
P: No.

D: And in your family, was there any heart problems?--any heart disease? Do you talk to your parents a lot?
P: Yes.

D: Did you ever have rheumatic fever? Break out in a rash?
P: No.

It can be assumed that the consistency of the patients here in answering only the last of a multiple question series is transported from their same question answering strategies used in other contexts. In the last two examples, the yes and no may well relate to the entire series of questions. That is, it is conceivable that the patient's family has a history of heart disease and that she talks to her parents a lot. But for the first three examples this could not be the case for yes and no cannot answer the first questions in those examples. This transportation of regular question answering strategies to the medical history interview is not surprising from the patient's perspective but it casts considerable question on the interpretation of the answers. What indeed will the doctor do with an answer of yes to his question, "How long have you had that?"? What will he do with an answer of no to his inquiry, "Where do you get short of breath?"?

On some occasions the doctor's questions are simply not understood by the patient:

D: Have you ever had a history of cardiac arrest in your family?
P: We never had no trouble with the police.

D: What's your name?
P: Betty Groff.
D: How do you spell that?
P: B-e-t-t-y.

D: How about varicose veins?
P: Well, I have veins, but I don't know if they're close or not.

In the analysis of the taped medical histories, however, we were only infrequently given such clear examples of misunderstanding. There are many other occasions in which one might seriously question the understanding of the patient on technical language. In several instances, when the doctor appeared to be hurrying through his list of diseases and illnesses, we noted what we are calling negative weakening, as illustrated by the following:

D: ...Is there any incidence of high blood pressure?
P: No.
D: Tuberculosis?
P: No.
D: Epilepsy?
P: No.
D: Neurological or psychological problems?
P: (Nods no)
D: Allergies?
P: (Nods no)

That is, the series of technical terms has triggered a negative series in which the response is at first strong (perhaps because the questions are more familiar) but gradually weakens acoustically and finally devoices into negative head shaking. Even stronger evidence for the incomprehensibility of this series of questions can be observed in the very next response in this same interview:

D: Multiple births?
P: (Pause) I had a retarded child myself.

Later in the same interview the patient responded with a stong no to German measels, a weak no to chronic problems and a head-shaking negation to both vaginitis and cervicitis.

Naturally, some doctors are more sensitive than others to their patients' lack of knowledge of doctor talk. Some attempt to determine what the layman needs to know is made:

Relative: Is he gonna live?
D: Well, are you his wife?
R: Yes.
D: Well, he's had a cardiac arrest. Do you understand what this is?
R: Yeah.
D: Well, he's in very critical condition. We have a tube in him and he has some pressure of his own. So, we'll see him in about a half-hour if there's been any change.

It is doubtful, in this emergency room setting, that the relative would have asked the doctor for an explanation of cardiac arrest. But he might have tried to do a better job than he did. The implication seems to be clear and consistent. Patients and relatives of patients should play the doctor game in the doctor setting, similar to the way Americans expect all foreigners to speak English in our country.

In stark contrast, one hospital doctor actually began his history in the following way:

D: I want to know if you have any questions you might want to ask.
P: No, nothing I can think of.
D: OK, we'll go on from there.

The question undoubtedly took the patient by surprise, for almost everyone has questions to ask about his health if he is given the opportunity and freedom to ask them. This doctor opened the door but it may take patients a while to get used to their new role in his office.

As an adjunct to the study of the tape recorded medical histories, we might call upon the data recently extracted from attempts at automated techniques for acquiring medical information. One such application involves the condensation of several basic medical tests into one functional unit called a multiphasic testing facility (or multitest clinic). The particular series of tests and procedures employed emphasize the differentiation of a general population into two major subgroups: (1) the apparently healthy who require little more than reassurance and periodic status checking and (2) the probably ill who require further evaluation and, in all likelihood, treatment.

A prime discriminator in such a differentiation is the interpretation of the medical history. The patient answers a self-administered series of questions by pressing various buttons on a console. The written questions appear on an illuminated screen and the patient selects from the multiple choice answers. He can take as long as he wants, go back to earlier questions, change answers, leave blanks or call for the nurse to help him interpret a question. All of his answers are recorded electronically within seconds and are organized into a convenient print-out for the physician to interpret at his convenience.

Several things may be criticized in this procedure and it is my intention neither to defend it nor attack it here. Of greater interest to me is the fact that the questions asked were devised by physicians on the basis of their past experience in face-to-face medical interviewing. The content and wording of the questions may be assumed to be representative of the more individualized and time-consuming, patient-doctor communication. The concepts and the language of such questions are clearly middle-class, uninvolved and jargonish and, as such, they offer further

evidence of the requirement of patients to learn to talk like doctors. They are seldom close to the inner-city patient's point of view or experience level. Even the briefest over-view of such questions will yield areas of concern such as the question-answer categories offered in the answers and the instructions.

The Question-Answer Categories. In an effort to obtain background information on the kinds of physical activities in which a patient engages, the medical profession takes a clearly middle-class stance. Questions which ask for data on the amount of time spent exercising, for example, have a distinct bourgeois ring to them (jogging, tennis, skiing). Most inner-city residents walk at least 20 minuces a day and would find the question unnecessary. It may be possible to eliminate this sort of question for certain audiences but, at least, the alternative should be modified to activities which are more real to them. Such a question is culturally equivalent to asking them whether they read The Wall Street Journal, The New York Times or Atlantic.

The Range of Choice Offered in Answers. Occasionally wording is potentially unclear to any audience. For example, "How do you feel about your work?". This is very close to what linguists might call a stereotype question. That is, if asked, "How are you?", most people will answer, "Fine.", regardless of their present state of health. The temptation is to answer a stereotype question with a stereotype answer. The whole interchange performs a social function rather than an intellectual one. A question about work is made even muddier, however, by the word feel, which could trigger any number of possible responses. If such a question

is to be preserved in the examination, care must be taken to find cultural equivalents to the rather middle-class responses.

In one question, a male patient was asked what his main reason was for seeing the doctor. There are few working-class men who will admit to having an emotional problem. However accurate the term might be, it is not likely to be employed by a man whose status and livelihood are dependent on his masculinity. Emotional problems indicate weakness. It is easier to admit being injured than sick and it is easier to admit being physically sick than emotionally sick. Again, research will have to determine the best wording to trigger the desired response. At this time, it is difficult to tell.

Not only is patient-doctor communication affected by the language and culture of the doctor, but also by the culture of the patient. Zborowski studied the reactions to pain of various New York City ethnic groups and concluded that while Jewish and Italian-Americans responded to pain quite emotionally, more assimilated Americans were more objective and stoical, and Irish-Americans more frequently even denied the existence of pain (1952). Furthermore, Italian-Americans were usually satisfied when relief from pain was obtained while Jewish patients were mainly concerned about the underlying meaning of the pain and its potential consequences for their future well-being. Mechanic (1972) notes that this study and others of the same type do not clarify whether such ethnic differences are a result of the fact that children with specific previous experiences and upbringing have more symptoms, interpret the same symptoms differently, express their problems more willingly, more eagerly seek help or use a different vocabulary for expressing distress. It is important that such distinctions be researched.

The effect of social learning on the language system (lexicon, in particular) of ill or probably ill people is carefully observed by Zborowski (1952), who points out that in "old American" families, the mother teaches her children to endure pain "like a man" and to avoid crying. If a doctor is consulted, it should be for physical, not psychological distress. Likewise, Zola (1963) studied the evaluations by doctors of patients from various ethnic groups for whom no medical disease was found. Within relatively constant SES and life-difficulty groupings, he found that Italians, who were more emotional in the presentation of symptoms and gave more attention to the expression of pain and stress, were more likely to be diagnosed as suffering from a psychogenic condition than were members of other ethnic groups. Similarly, Bart (1968) observed that women who entered for neurology service and were diagnosed as psychiatric cases were less educated, more rural, of lower socio-economic status and less likely to be Jewish than women who entered a hospital for psychiatric help directly. Bart further noted that the two groups of women were differentiated by their vocabularies of complaint, which obviously affected the manner in which they presented themselves. The ultimate consequences of expressing psychologic distress through physical attribution can be seen in Bart's follow-up study in which 52% of the psychiatric patients on the neurology service had hysterectomies while only 21% of the women who went directly to psychiatric treatment had such surgery, suggesting that patients who express psychologic distress through physical attributions expose themselves to apparently unnecessary medical procedures.

The general impression resulting from such studies as those of Zborowski, Mechanic and Bart is that at least two major patterns of patient behavior may mislead the physician as he attempts to obtain verbal information

relating to their medical history.

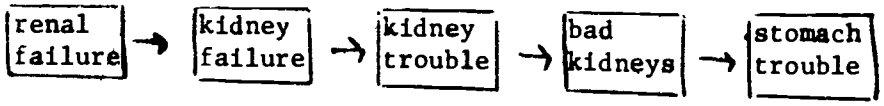
1. The patient who is willing to use the vocabulary of physical and psychologic distress, complaining openly and admitting frustration and unhappiness. Such a patient may seem hypochondriacal but he is at least not culture bound to distort or hide his symptoms or problems.

2. The more difficult (and more common) patient who, for whatever reason (including cultural background), has a different vocabulary for reporting distress from that of the physician.

Of these two patterns, Mechanic observes that the second group

> ...present the doctor with a variety of diffuse physical complaints for which he can find no clear-cut explanation, but he cannot be sure that they do not indeed suffer from some physical disorder that he has failed to diagnose. Patients who express psychologic distress through a physical language tend to be uneducated or come from cultural groups where the expression of emotional distress is either inhibited or different from middle class norms. Such patients frequently face serious life difficulties and social stress, but the subculture within which they function does not allow legitimate expression of their suffering nor are others attentive to their pleas for support when they are made. Because of their experiences these patients frequently feel...that expression of their difficulties is a sign of weakness and will be deprecated. They thus dwell on bodily complaints...(1972: 1136)

Other problems of wording involve the translation of medical terms into everyday language. One important research question will involve the difference between receptive knowledge of such terms and productive knowledge. In probes about what a working-class patient's father died of, the term stroke may not be as likely to be understood as high blood pressure, a term in common use in the ghetto community (and in most working-class communities, regardless of race). An important research question will involve the degree to which technical accuracy can be gambled for patient understanding. In some cases the chance of error will be slight (T.B., for example, is more widely understood than tuberculosis). A semantic continuum for investigation may appear to be somewhat along the following lines.



It might be pointless to expect a ghetto resident to understand renal failure but the other end of the continuum may be too vague to be helpful to the analyst. On the other hand, if stomach trouble is as sophisticated as the patient can get, we will have to learn to use this information.

In other questions, medical specialists will need to learn that questions involving expressions such as an infection like pneumonia or blood poisoning are middle-class analogies. Many people do not think of pneumonia as an infection. Likewise for many people, diabetes is less likely to be understood than sugar or sugar diabetes, and heart disease is more likely to be recognized as heart trouble. In such cases as the latter, it may be true that patients can respond to the stimulus heart disease even though they use the term heart trouble. But we do not know, as yet, if even this is true. In any case, problems involving the heart are not generally thought of as disease in the working-class community. It has been hypothesized that heart attack is recognized as that which kills a person who may or may not have a history of problems with his heart while heart trouble indicates a history of the disease. Such information, if true, could be helpful in a technical way which is, at present, untapped by the medical profession. There are, in addition, many other everyday terms used by ghetto residents which could be employed in such a questionnaire. Consumption, for example, in Washington is used in reference to a person who drinks himself to death. Diarrhea is more commonly known as runny bowels or running off at the bowels.

The doctor's over-use of his technical language tends to estrange him from the patient by setting himself on a much higher intellectual level. This may inhibit the patient in his communication--e.g. fear of asking questions that the doctor might consider stupid or superfluous. One patient received the following typed physician's report from the clinic where she was examined. It was the only information she received on her medical condition:

> BARIUM ENEMA WITH AIR CONTRAST: There is normal filling evacuation of the colon. There is reflux into the terminal ileum which appears normal. There are multiple nontender diverticula, predominantly involving the descending colon and sigmoid portion of the colon. No other abnormalities are identified. Incidentally noted is calcification within the uterine fibroids in the true pelvis.

This was the only information she received on her medical condition.

Learning to Understand Patient Talk:

It will take considerably more data than are now available for us to catalogue the types of misunderstandings doctors have of patient language, primarily because the patient says so little during the medical history, following a strategy so successfully used by minority school children who learn very early that the name of the game is to be right as often as possible and wrong as seldom as possible and that the best way to avoid being wrong is to keep one's mouth shut. Another reason why we have so few examples of doctor's misunderstanding of patient language stems from the social structure of the speech event. The doctor is simply not to be wrong. If anyone is wrong, it is the patient. Still a third reason for the paucity of evidence on doctors' misunderstanding of patient talk stems from the feedback system. There seems to be no immediate way to determine how he has actually misassessed the validity of the patient's

no when, in truth, the answer is yes. We have already cited a fortuitous example of two of such evidence, but such proof is hard to come by.

We have recorded one instance, however, in which clear acquisition of patient talk by a doctor seems to have taken place:

P: Oh, he did, uh, in last April he had a little touch of sugar when...
D: He has a little what?
P: You know, diabetic...
D: Oh, he had some sugar.

A more serious example occurred during an early observation during which the doctor asked the patient if she had ever had an abortion. She denied that she had, even though her chart clearly indicated two previous abortions. In the doctor's mind, the patient had chosen to tell a lie for the evidence was clearly before him. After the doctor had left, the patient was asked by a linguist whether or not she had ever lost a baby. She readily admitted to having lost two. In the ensuing conversation it was determined that the patient was defining abortion as self-induced while the doctor was using the term to refer to a wider range of possibilities. It seems obvious here that the doctor has not learned patient language either.

Learning to Speak Patient Talk:

If evidence from our research and from the accounts in medical journals is accurate, few doctors have mastered the ability to speak the language of the working-class, minority or foreign-language-speaking patient. Severe problems can result from miscommunication on all levels, particularly for the non-English speaker. In fact, the clearest mandate seems to be for hospitals, clinics and other medical facilities to gear up for medical services for speakers of foreign languages.

A more cautious note must be sounded, however, for the need for doctors to attempt to speak patient dialect, a practice which can lead to serious problems. For example, one conscientious doctor, sensitive to the fact that his patient was Black and poor, assumed that she would be more comfortable with "homey" expressions, despite the fact that she had already passed through such fine distinctions as phlebitis, rheumatic fever, transfusions and epilepsy. He was doing very well in his history taking, giving the appearance of casual yet professional ease. He was friendly and interested in the patient as a person. And then he blew it with his liberal enthusiasm:

D: What about belly pain?
P: (pause, followed by recovery) No.
D: (unperturbed and growing more dramatic) Have you had a problem with burning when you urinate or do you find you're running to the john every five minutes?
P: (slowly) No.
D: (rising to crescendo) Or do you have an extreme urgency, like do you feel when you have to go urinate that, oh, the urge is just tremendous that you have to run and get there or else you'll wet your pants?

If these questions seem ludicrous to us, how much more ludicrous must they have seemed to the patient. Here she was, working desperately to speak doctor talk, with medical terminology and a minimum of vernacular grammar and he uses words like belly, john and wet your pants. The effect must be similar to that of a fifty-five year old youth worker trying to talk teen-age slang. It is also akin to the problem some of us have who grew up speaking a non-standard dialect but, having gotten educated, are no longer allowed to use it by the people we grew up with and love. Their expectation of us simply won't allow it even though they may continue to use it themselves.

The Language of the Medical History.

As noted earlier, by far the largest part of the medical history, from the data available to us so far, indicates a doctor dominance in language and perspective. It is, in one sense at least, his native country, his home grounds. The patient is the foreigner or intruder. A great deal has been said in recent years about a similar situation in education. For a long time we have made noises about starting with the child where he is and yet, as mentioned earlier, massive programs have been mounted to remake children in the eyes of the school norm so that they can benefit from the teaching perspective. Such programs are saying, in effect, that the child is simply not good enough, and that in order to be taught he must become like the school, especially in matters of language and culture. It appears that a similar situation obtains in medicine. Our limited data show that almost 40% of the patients surveyed feel extremely uncomfortable about understanding what doctors are telling them and about making themselves clear to doctors. An equal number feel that doctors are generally unfriendly and intimidating. Our tape recorded data reveal startling instances to verify the communication breakdown and call to question the efficiency of the medical history in cross-cultural settings. Add to this the fact that it is the patient who is at the disadvantage. He is either in need of medical attention or thinks he has such a need. Just as one might expect a person with education to adjust to the needs of the person being taught, so might one expect the healthy to adjust to the needs of the sick. And yet, strong indication exists that such an adjustment is only infrequently made. With the exceptions of the histories taken by the private physicians in our study, we can safely generalize that the doctors do not speak patient language and, much more seriously, that they often give little evidence of understanding it. They are not

friendly, not very good at making the patient comfortable and generally lack expertise at question-asking. The patient generally adjusts to the doctor perspective, offering medical terms whenever possible. When the patient cannot do this well, the history is slowed and made less efficient. In short, the general expectation is for the patient to learn doctor talk.

A great deal could be learned by the clinic doctors from the contrastive technique of one private physician whose demeanor was relaxed, congenial and enthusiastic. Some random quotations from his histories will serve as examples:

...Here's an illustration of what I mean.

...Great! It'll probably work out fine for you.

...Let's watch that but don't worry too much about it.

...You look like a million dollars.

...Mrs. M, are there any questions I can answer for you?

...No problems here. And your last labor was much too easy.

...So what I'd like to say is that everything that's going on is quite normal.

It may take a long time for this doctor's patients to learn to take advantage of the openings he regularly provides them to ask any question they want. One of his patients confided:

> I thought he was too busy so I didn't ask a lot of things until I was in my ninth month. Then Dr. G realized that I, you know, had been holding back. But we got everything straightened out in time.

This same doctor evidenced a clear appreciation of the language needs of his patients. Although he never attempted to speak Vernacular Black English himself (fully realizing how ludicrous it might sound), he was sensitive to his obligation to help the patient understand his language,

without being patronizing or stuffy. For example, to a sixteen year old patient he said:

> It might be advisable to induce forced bleeding. Incidentally, Ann, you might have noticed that you have a lot of mucus in your flow and that's normal...and it's called lucorbea.

The approach was not, "You have lucorbea." Such a statement would either require the patient to ask what the term means, thus lowering her status even further or to retreat to fearful and ignorant silence, a strategy which I suspect to be frequent in our data.

In summary, of the general points on the doctor-patient, medical history language continuum

Doctors talking Doctor language	Doctors talking Patient language	Doctors understanding Patient language	Patients understanding Doctor language	Patients speaking Doctor language	Patients speaking Patient language

the major breakdowns occur at the extremes. Some patients cannot or will not speak doctor language. Likewise, some doctors cannot or will not speak patient language. It has been suggested, in fact, that it is probably disastrous for them to try. The obvious area of hope lies in the central portions of the continuum. Historically, we have expected patients to carry all the burden here. Either they learn to understand doctors or they remain ignorant. Naturally this is a gross generalization but one which is generally supportable from our data. One would hope for considerably more from the medical profession.

At the very minimum one would hope that the medical profession would give some attention to the matters in the ethnography of interrogation. It is strange that of all professions, both teaching and medicine rely so heavily on the answers of their clients but pay so little attention to the vast complexities of question-asking.

Secondly, one would hope that the medical profession would give some attention to the matter of receptive competence of patient language on the part of their practitioners. It is patently absurd to run the risk of getting inaccurate information in the medical interview simply because the patient does not want to admit ignorance of the question or because the question was indelicately asked. There is far too much at stake for such a situation to be maintained. Despite the extant crowding in the medical school curriculum this situation is serious enough to merit change. Focus and time must be given to the language and culture of minorities in medicine.

This paper has presented a rather impassioned plea for a significant reorganization in the attitude and practice of doctor-patient relationships in the cross-cultural medical interview based on rather limited and extremely difficult-to-obtain data. It has barely scratched the surface in terms of its concerns from the major field upon which it is based--sociolinguistics. It is hoped, however, that the continuation of the research will enable us to delve deeper into theoretical issues in sociolinguistics while, at the same time, providing practical assistance in an area of human need.

NOTES:

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[2]See Appendix A: DOCPAT Questionnaire #1.

[3]See Appendix B: DOCPAT Questionnaire #2.

[4]This form reads as follows:
I give my permission for the doctor's consultation with me to be tape recorded. This recording will be used only for research studies on communication between doctors and patients.

Signed _____ Date _____

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APPENDIX A: DOCPAT QUESTIONNAIRE #1

Medical Survey--Questionnaire
(DOCPAT Studies)

	yes	no
1) Do you ever feel that when doctors, nurses or interns ask you questions they sometimes use words that are hard to understand?	___	___
2) Do you ever find the doctor's attitude unfriendly?	___	___
3) Do you ever find it hard to make the doctor understand what a pain is like or where it is?	___	___
4) Do you think the doctor spends enough time talking with you during an appointment?	___	___
before an operation?	___	___
after an operation?	___	___
5) Do you think nurses or hospital assistants pay enough attention to your needs when you are in the hospital?	___	___
6) Do you think that medical people expect you to know too many medical words?	___	___
7) Do you ever feel that sometimes you do not want to ask a doctor a question because he might think it is stupid?	___	___
8) Do you think doctors get too much money for what they do?	___	___
9) Do you think that doctors should spend more time talking with you than they do?	___	___
10) Do you ever think that the doctor does not understand your problem?	___	___
11) Do you think sometimes that doctors should speak in more simple language?	___	___
12) Do you ever feel that doctors do not tell you everything you should know about a problem, condition or an operation?	___	___
13) Do you think you get your money's worth when you go for medical advice, checkups or other medical problems?	___	___
14) In general, are you satisfied with the kind of medical attention you get besides actual operations, medications and prescriptions?	___	___

APPENDIX B: DOCPAT QUESTIONNAIRE #2

As part of the Georgetown University Communication Research Project, we are examining the patterns of communication between doctors (and other medical personnel) and their patients.

We would appreciate your help in this study by taking a few minutes to fill in this questionnaire.

Gerogetown University Communication Research Project

1. Do you feel that sometimes there is difficulty in communication between doctor and patient?

Yes	No
___	___

2. Does difficulty in communication come from: (Arrange in order of importance by giving a 1, 2, 3 to your first three choices.)

		In what way is this so?
a.	How a patient speaks ___	_____
b.	How a doctor speaks ___	_____
c.	The patient's attutide ___	_____
d.	The doctor's attitude ___	_____
e.	Lack of time ___	_____
f.	Fear ___	_____

3. Below are some things that have often been said of doctors.

Doctors are:

a. Very busy	g. Open	m. Patient
b. Friendly	h. Brisk	n. Business-like
c. Clear	i. Understanding	o. Good-listeners
d. Reserved	j. Impatient	p. Use too many technical words
e. Relaxed	k. Gentle	
f. Sympathetic	l. Impersonal	

Of these (i) What are the things most often found in doctors?
(ii) What would you most like to find in a doctor?
(iii) What would you least like to find in a doctor?

	i. Most often found	ii. Would like to find	iii. Would NOT like to find
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

4. Below are some things that have often been said of patients.

Patients are:

a. talkative	g. tense	m. impatient
b. relaxed	h. imprecise	n. at ease
c. clear or explicit	i. fearful	o. self-centered
d. calm	j. overimaginative	p. timid
e. reserved	k. friendly	
f. aggressive	l. nervous	

Of these (i) What are the things most often found in patients?
(ii) What should a patient be? What would make a good patient?
(iii) What would make a bad patient?

i. Most often found	ii. A good patient is:	iii. A bad patient is:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please feel free to add your comments to any of the above questions.

To be filled out by informant:

Sex: M___ F___

Place of Birth: _____ Date of Birth: _____

Citizenship: U.S._____ Other _____

Education: (Please circle highest grade completed.)

Elementary	High School	College	Graduate
1 2 3 4 5 6 7 8	9 10 11 12	1 2 3 4	1 2 3 4

Occupation: _____