Zeszyty Naukowe KUL 59 (2016), nr 3 (235)

KATARZYNA DROP*, BARTŁOMIEJ DROP**

PHYSICIAN–PATIENT COMMUNICATON IN HEALTHCARE FACILITIES

INTRODUCTION

Shaping the right communication strategies for relationships between doctors and patients is not only desired but even essential. A good physician is a one that does not only provide quick and correct diagnoses, but also is capable of communicating in a clear and effective manner with the patient. Currently, there is a wide and easy availability of information, which is why it is important to provide patients with clear information about their health condition, possible side effects of both taking certain medicine and disease-related complications, as well as the latest therapeutic and diagnostic solutions. Patients are looking to be informed by doctors about the reasons for their diseases, how to cope with them, reasons for hospital admission or for choosing that certain treatment method, as well as possible side effects of certain medication, etc. The information should be provided in plain language, devoid of medical terminology.

Lack of communication and understanding between the healthcare professional and the patient is often the reason for the failure of the diagnostic and therapeutic process, even though both the physician and the patient have the same purpose, which is patient's recovery and minimizing the risk of any complications.

This is why the importance of relationship and communications should be emphasized upon. Both inexperienced young physicians and Medicine students should be taught about how to shape and maintain closer relationships with patients. Mutual understanding and respect ensure a quick and full recovery – if the patient-physician relationships are devoid of that, there is a risk of errors or misunderstandings.

Currently, the impact of the right relationships and communication is often undermined. A bigger picture is needed in order to understand the relations between the patient and doctor, with the following questions to be asked:

* KATARZYNA DROP – Katolicki Uniwersytet Lubelski Jana Pawła II, Instytut Dziennikarstwa i Komunikacji Społecznej, Katedra Teorii i Zastosowań Tekstu, e-mail: drop.katarzyna@gmail.com.
** BARTŁOMIEJ DROP – Uniwersytet Medyczny w Lublinie, Katedra I Zakład Zdrowia Publicznego.

- What does the patient expect from the physician?
- How would the patient like to be treated?
- What are physicians' real attitudes toward patients?
- What are the reasons for such attitudes?
- Is it possible to improve mutual relationships?
- If so, how to do it? In addition – would patient-physician communications seminars improve the relationships between the two sides?

COMMUNICATION

Communication is a process of conveying information from one entity to another. These entities are referred to as the receiver and the sender. Apart from words, communication can take the form of gestures, sounds, pictures and texts or even radio waves and electric signals. Mutual understanding on the side of the sender and receiver is the most important feature of communication. This is due to the fact that this is a mutual process. Upon receiving information, the receiver reacts in a certain way, which conveys a message to the sender. Communication is the basis for any interactions, both on the personal and social level. It serves a regulatory function in human relations[1].

The act of communication happens only when the conditions described below are fulfilled. The language used for exchanging information should be understandable for both sides. Furthermore, both individuals have to use a certain medium which allows for transferring the information from the sender to the receiver. The content of the message should be free of any sound distortions that might be referred to as *communication noise*[2]. The noise hugely affects the perception of the content of the message. Such noises might either be physical (huge distance, other noises), as well as psychological (tiredness, concentration disorders.) Some communication problems might be caused by cultural and linguistic differences, various actions taken during the communication process or even emotions appearing during the process[3]. Other factors essential for successful encoding and decoding of the message include: addressing the information to the particular receiver and the receiver's willingness to understand the message. Research studies have shown that verbal communication (words) constitutes only some 7% of the overall human communication. Non-verbal communication methods (voice tone, gestures, mimics)

[1] P. R o g a l i ń s k i, „Komunikacja werbalna i niewerbalna", 20 wrzesień 2012.

[2] A. P e a s e, *Mowa ciała. Jak odczytać myśli innych ludzi z ich gestów?*, Jedność, Kielce 2001.

[3] J. S t e w a r t, *Mosty zamiast murów Podręcznik komunikacji interpersonalnej*, PWN, Warszawa 2008.

are responsible for 38% of human communication. Researchers have noticed that it is the paraverbal communication that humans most often resort to (body language, voice tone and timbre, grunting) – 55%.[4]

There are also other factors affecting communication. In order for that activity to happen, some 4 elements of communication need to be present. They are: the sender (conveying the information), the receiver (receiving information), the right message (the way in which the information should be conveyed and interpreted) and the channel, through which the message travels from one person to another. Every channel has its own bandwidth and capacity. Due to that, various channels have different data transmission speed[5]. The following channels can be mentioned here: audio channel that allows people to receive messages through hearing, like in radio commercials. There is also the audio-visual channel allowing to receive messages both through the sight and hearing, active when watching television or participating in any event (like election rallies). The third channel is the visual one which allows for receiving information through sight: reading leaflets, books or press articles[6].

1. THE COMMUNICATION PROCESS

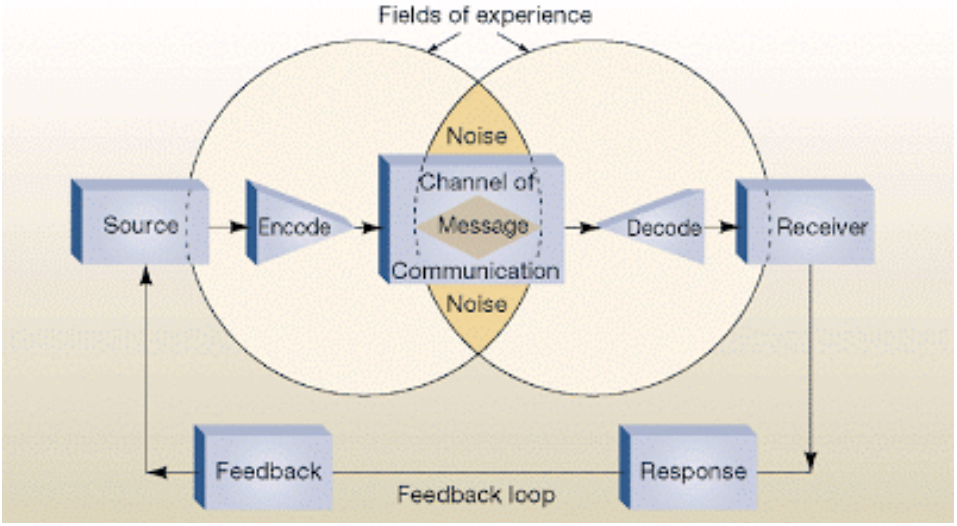

Figure 1. Communication process diagram

Source: http://marketingcommunique.blogspot.com/2012/11/the-communication-process.html

[4] A. P e a s e, *Mowa ciała. Jak odczytać myśli innych ludzi z ich gestów.*

[5] A. A u g u s t y n e k, *Psychologia. Jak ślimak piął się pod górę*, Diffin, Warszawa 2008.

[6] W. C w a l i n a, A. F a l k o w s k i, *Marketing polityczny. Perspektywa psychologiczna*, Gdańskie Wydawnictwo Psychologiczne, Gdańsk 2005.

Communication occurs between two parties, one of which is the sender (source of the message) and the receiver (the individual that receives the message). In formalized settings, these roles are strictly set which means they cannot be changed. Every participant is influenced by their own experiences, feelings, mood or ideas, which means that both the received and sent message can have different meanings. One's personal opinions about other people surrounding them always affect their attitude toward their thoughts and feelings. Coding is a process of creating a message through the use of a certain form. It is a system of signs that communication participants have no impact over and becomes known to them upon beginning of the communication process. These codes might either be verbal (spoken, written) and non-verbal. Another part of it is the message, which is the information that one looks to convey to their interlocutors. This is a complex structure made of different meanings. It consists of symbols (sounds, actions, words) through which the meaning of the message is being conveyed to other people participating in the act. The symbols have to be comprehensible for both entities. The message is subject to processes like coding (done by the sender) and decoding (done by the receiver). Noise is one of the most important parts of both human and marketing communication. The idea of noise refers to any disruptions in receiving the message that was conveyed (as it was said before). Regarding marketing communication, the noise might be divided into three groups, varied by their character, source and the cause. Semantic noise is due to incorrect conveying of the message. It might be regarded as a misunderstanding or lack of a "common ground" with the target group. Another group is the internal noise, which roots from the current mood of both the sender and the receiver. This is related to their personality traits, perception of the world, as well as stereotypes and superstitions that they believe in. External noise in communication is the last group – it is related to the environment in which the communication process takes place. There is a whole range of distractions to the message, like misprints, server failures, noise and competitors' actions. Unlike it is the case with semantic noise, people have no influence whatsoever over the external noise. Obviously, people have to attempt at removing any negligence that might affect the communication process. Noise is an integral part of the communication process, which is why it appears in other situations, like feedback. This is a receiver's reaction to the message that was previously sent by the sender, its clarity and quality. Feedback can happen in a variety of ways, throughout a larger time span. For instance, when looking at providing medical advice, it happens instantaneously, while in case of information from the media, it is analyzed in a larger time span. The context, which is the circumstances in which the communication process happens, is another part of the communication scheme.

Interpersonal communication remains an important part of the physician-patient relationships. It is a process in which one person elicits information from another, through means of direct contact. The interpersonal communication process has its certain dynamics. Mimics, words and gestures are all the stimuli that cause certain thoughts to appear, as well as certain feelings or emotions.

In order for the communication process to be effective, both sides have to be able to feel, speak and listen. Good listening skills are important for communication. Hearing is an involuntary process that happens through perception. The hearing activity happens through the organ of hearing and receptor cells located in there, as well as the interpretation of hearing stimuli reaching the ear. It is based on correct coding of the stimuli and transforming them into various words, sentences or messages.

Interpersonal communication can be classified as either verbal or non-verbal. Verbal communication is based on words, which are then transformed into whole sentences (using certain grammar rules). Non-verbal communication is based on body language (mimics, gestures, etc.).

In order for the communication process to be fully effective, without any misunderstandings, both sides have to be able to listen actively. This is achieved through a few techniques:

a) reflecting – showing the way that the words, feelings or intentions were understood

b) paraphrasing – using different words to show that one is attempting at understanding what has been said

c) clarification – asking the interlocutor to explain the unclear message and focus on one aspect only

d) confirmation – in order to show interest in the speaker's message, the listener should always add some words from themselves while receiving information[7]

2. COMMUNICATION MISTAKES

The relationship between the patient and the physician is of asymmetrical type. This is why a physician is responsible for the keeping the interactions at the right level. It is physician's responsibility to build natural, stress-free relations for both sides. In order for the relations to be good and happen in the intended way, the physician should fulfill patient's expectations both in the informative and emotional sphere. Many a time, the relationship is limited to diagnostics only and doctors ask incorrect questions.

Physicians should avoid some mistakes when building the relationship:

a. Patients should not be held responsible for their disease – physicians tend to do it either by asking too many *why* questions or moralizing the patients. At the same time, the patient may consider this an accusation, which leads to the feeling of guilt that triggers the defense mechanisms[8].

[7] E. G r i f f i n, *Podstawy komunikacji społecznej*, GWP, Gdańsk 2003.

[8] J.G. B r a d l e y, M.A. Edinberg, *Communication in the Nursing Context*, Appleton – Century – Croffs, Norwolk, Connecticut 1982.

b. false sympathy. It might appear as a way of reducing the mental burden but it can have some totally different consequences[9].

c. False sympathy might take the form of
- Promising impossible things
- Lying[10].

d. Providing information in an unclear way. Physicians should avoid long and complex sentences, as well as the medical jargon when talking to the patient[11].

PATIENT–PHYSICIAN COMMUNICATION BARRIERS

1. BASIC COMMUNICATION BARRIERS

The communication skills of physicians should be analyzed along with the patients' behavior[12]. This is a larger process and no single part of it can be analyzed separately from the other one. Both the physician and the patient are fully responsible for shaping the relations and interactions[13], Doctor and patient are at opposite poles in their mutual relations. For both sides, completely different kinds of information are the most important regarding the current problems. In addition, both sides play completely different roles in this context. The patient is looking to receive medical advice and care, while the physician is responsible for providing it. They use different language as well. The patient uses the vernacular, while physicians stick to the professional jargon. They have different expectations – psychosocial (patient's viewpoint) and biomedical (physician's viewpoint). These differences can affect symmetrical communication, which means a situation where both the sender and the receiver have the same status and rights[14].

[9] M. Sokołowska, *Socjologia Medycyny*, PZWL, Warszawa 1986.

[10] Taż, *Badania socjologiczne w medycynie*, Książka i Wiedza, Warszawa 1969.

[11] J.G. Bradley, M.A. Edinberg, *Communication in the Nursing Context*.

[12] N.K. Arora, *Interacting with Cancer Patients: the Significance of Physicians' Communication Behavior*, "Social Science & Medicine" 2003, 57, s. 791–806.

[13] D.J. Cegala, *Patient Communication Skills Training: a Review with Implications for Cancer Patient*, "Patient Educaction and Counseling" 2003, 50, s. 91–94; J.A. Hall, A. Visser, *Health Communication in the Century of the Patient*, "Patient Education and Counseling" 2000, 41, s. 115–116; R.L. Street, *Information−Giving in Medical Consultations: the Influence of Patients'Communicative Styles and Personal Characteristics*, "Social Science & Medicine" 1991, 32, s. 541–548.

[14] A.M. Dulmen, *Different Perspectives of Doctor and Patient in Communication*, "International Congress Series" 2002, 1241, s. 243–248.

2. COMMUNICATION BARRIERS FOR THE PHYSICIAN

Physicians also face some issues when it comes to building relationships with a patient: avoiding deeper relations with patients, working under time pressure, anxiety, lack of communication skills, lack of real support from their colleagues, and personal problems.

Visits to the doctor are too short, so that no real discussion concerning the existing problems can happen. Physicians are considered as too busy to respond to patients' questions about the disease. This is why patients look for other sources of knowledge, like the Internet, popular science books or nurses advice. And that is the reason why they often fail to receive reliable information based on scientific research.

Talking to nurses about the diseases may prove problematic as well. They are rarely prepared to provide psychological or/and medical advice. Many a time, physicians fail to inform them what exactly they should be telling to the patient. In situations where the patients are being transferred to another healthcare unit, there is a risk that they are going to receive completely different information. Physicians have different opinions about what can be said to the patient[15].

Physicians tend to avoid questions concerning their own feelings about the diagnosis or treatment methods. They rarely answer the questions about the influence that diseases have over their everyday life, human relationships or mood. Instead, they resort to questions that would not reveal the difficult emotions that the patient feels[16]. This leads the patient to feel as if the physician were not interested in what they think[17].

Most physicians confirm that they do not want to let the patients reveal their emotions. They do so since they are afraid that touching upon the patient's psychological condition may lead to a negative emotional spiral that they would be unable to cope with. They consider the patients as both delicate and fragile. They are also afraid that they would do them harm, instead of offering help. Physicians fear difficult questions that they might be unable to answer – e.g. What are my chances of survival? They tend to think that medical advice should be provided in a safe way, in order to avoid forming too close a relationship with patients or their families and avoid emotional costs.

Lack of communication skills is the main problem. Physicians often do not know what details about a certain disease they can disclose to the patient. This

---

[15] P.R. Mayerscough, M. Ford, *Jak rozmawiać z pacjentem*, GWP, Gdańsk 2001, s. 13–18; C. De Valck, K.P. Van De Woestijne, *Communications Problems on an Oncology Ward*, "Patient Education and Counseling" 1996, 29, s. 131–136.

[16] P. Maguire, *Barriers to the Care of the Dying*, "British Medical Journal" 1985, 291, s. 1711–1713.

[17] Tenże, *Improving Communication with Cancer Patient*, "European Journal of Cancer" 1999, 35 (10), s. 1415–1422.

becomes particularly important in case of bad news. Furthermore, they are unable to deal with negative emotions among patients and the difficult questions they ask[18]. While talking to the patients, physicians tend to use medical jargon, which is why their advice becomes incomprehensible[19].

In a research study looking at 97 women suffering from breast cancer, some 49.5% of the subjects reported problems understanding the information that physicians had provided. At the same time, healthcare professionals were convinced that patients clearly understand the provided information. This proves that doctors tend to provide information in a way that was understandable by people with similar intelligence or educational level[20]. The support received from coworkers or superiors is an important part of shaping the patient-physician relationships as well. Those healthcare employees who do not receive support are more likely to discourage patients to express their fears related to the disease or the recovery process[21].

3. COMMUNICATION BARRIERS IN PATIENTS

Patients are very uneager to reveal any psychological problems. They consider them as inevitably linked to the disease and regard both the fear and depression as a natural consequence of the disease, which leads them to believe that there is no need to talk about it as that will not change anything. They are afraid to talk about these feelings, as they think that physicians would consider them as neurotic or ungrateful.

Patients regard physicians as very busy and due to the respect they feel toward doctors they do not want to put any additional burden on them. They also notice that physicians are not too eager to refer to any emotion-related difficulties that they mention. Research has shown that physicians deal with physical aspects of the diseases, without revealing any emotional difficulties[22].

GENERAL RULES ABOUT PHYSICIAN–PATIENT RELATIONSHIPS

1. Patient is number one; always place the interests of the patient first.

a. Choose the patient's comfort and safety over anyone else's.

---

[18] C. De Valck, K.P. Van De Woestijne, *Communications Problems on an Oncology Ward*; P. Maguire, *Barriers to the Care of the Dying.*

[19] G.L. Kreps, N.K. Arora, D.E. Nelson, *Consumer/provider Communication Research: Directions for Development*, "Patient Education and Counseling" 2003, 50, s. 3–4.

[20] P. Salmon, *Psychologia w medycynie*, GWP, Gdańsk 2002, s. 16–140.

[21] P. Maguire, *Improving Communication with Cancer Patient*, s. 1415–1422.

[22] Tamże.

b. The goal is to serve the patient, not to worry about legal protection for the physician.

2. Always respond to the patient.

a. Answer any question that is asked.

b. Respond to the emotional as well as the factual content of questions.

3. Tell the patient everything. even if he or she does not ask.

a. Do not force a patient to hear bad news if he does not want it at that moment, but do try to discuss it with him or her as soon as possible.

b. Information should flow through the patient to the family, not the reverse.

c. If you have only partial information, say that it is partial, and tell what you know.

4. Work on long-term relationships with patients, not just short-term problems.

a. Make eye contact.

b. Defined touch: tell him or her what you are doing.

c. Talk to patient, not colleagues: patient is always the focus.

d. Arrange seating for comfortable, close communication.

e. Shy away from large desks and tables.

f. Both patient and physician should both be sitting if at all possible.

5. Listening is better than talking.

a. Getting the patient to talk is generally better than having the physician talk.

b. Take time to listen to the patient before you, even if other patients or colleagues are waiting.

6. Negotiate rather than order.

a. Treatment choices are the result of agreement, not commands by the physician.

b. Remember, the patient makes medical decisions from the choices provided by the physician.

7.Trust must be built. not assumed.

a. Don't assume that the patient likes or trusts you.

b. Treat difficult or suspicious patients in a friendly, open manner.

8. Admit to the patient when you make a mistake.

a. Take responsibility. Don't blame it on the nursing staff or on a medical student.

b. Admit the mistake even if it was corrected and the patient is fine.

9. Never "pass off" your patient to someone else.

a. Refer to psychiatrist or other specialist when beyond your expertise (but usually not the case).

b. Refer only for ophthalmology or related subspecialties.

c. Provide instruction in aspects of care, e.g., nutrition, use of medications.

10.Express empathy, then give control: "I'm sorry, what would you like to do?"

a. Important when faced with a patient who is grieving or is angry.

b. Important when faced with angry or upset family members.

11. Agree on problem before moving to solution.

a. Tell the patient your perceptions and conclusions about the condition before moving to treatment recommendations.

b. Informed consent requires the patient to fully understand what is wrong.

c. Offering a correct treatment before the patient understands his or her condition is wrong.

12. Be sure you understand what the patient is talking about before intervening.

a. Seek information before acting.

b. When presented with a problem, get some details before offering a solution.

c. Begin with open-ended questions, then move to closed-ended questions.

13. Patients do not get to select inappropriate treatments.

a. Patients select treatments, but only from presented, appropriate choices.

b. If a patient asks for an inappropriate medication that he heard advertised, explain why it is not indicated and suggest an alternative.

14. Be sure who your patient is.

a. Is it the injured child, or the mother who brings him in? (the child)

b. Is it your long-term patient who is now in a coma, or her husband? (the patient)

15. Never lie.

a. Not to patients, their families, or insurance companies.

b. Do not deceive to protect a colleague.

16. Accept the health beliefs of patients.

a. Be accepting of benign folk medicine practices. Expect them. Diagnoses need to be explained in the way patients can understand, even if not technically precise.

c. Be careful about having young family members translate for elderly patients.

17. Accept patients' religious beliefs and participate if possible.

a. Your goal is to make the patient comfortable. Religion is a source of comfort to many.

b. A growing body of research suggests that patients who pray and are prayed for have better outcomes.

c. Ask about a patient's religious beliefs if you are not sure (but not as a prelude to passing off to the chaplain!).

d. Of course, you are not expected to do anything against your own religious or moral beliefs.

18. Anything that increases communication is good.

a. Take the time to talk with patients, even if others are waiting.

b. Ask "why?".

c. Seek information about the patient beyond the disease.

19. Be an advocate for the patient.

a. Work to get the patient what he or she needs.

b. Never refuse to treat a patient because he or she cannot pay.

20. The key is not so much what you do. but how you do it.

a. The right choices are those that are humane and sensitive, and put the interests of the patient first.

b. Treat family members with courtesy and tact, but the wishes and interests of the patient come first.

The key is not what physicians *actually do, but what the most ideal physician should do*[23].

PATIENT'S RIGHTS

1. The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.

2. The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.

4. The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

5. The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements for care.

6. The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians

[23] Dostępny w Internecie: <http://www.usmlestudentdoctor.com/2014/01/general-rules-for-exam--questions-about.html> (dostęp: 10.08.2016).

should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care[24].

PHYSICIAN–PATIENT RELATIONSHIP

The relationship between the physician and patient is an important part of communication. Here, the patient is at risk of a disease that can be a difficult or even traumatic experience. The contact between the physician and a single patient, a family or a certain group (e.g. parents with children) creates a certain social bond that is essential for fulfilling the needs important for life and health. Both sides in this relationship affect each other, paying attention to common values. Lack of the right relations between the physician and patient can result in destroying their relation, while caring for the relationship can lead to achieving the desired goals. Shaping this specific relationship has to be based on mutual understanding and cooperation.[25] If the physician-patient relationships are shaped in a wrong way, it might lead to a negative ending - the problems that arise in this relation would only deteriorate. Due to that, neither the patient nor the physician would be willing to cooperate. This might be a huge problem in the recovery process – as it is often a battle for health or even life of the patient. In order for the process to work both entities have to adhere by the roles assigned to them in the socialization process. The patient admitted to a physician is often angry or even anxious. They expect empathy and understanding. Doctors are often considered a social authority, so patients really want to trust them, even subconsciously. Yet, there is the fear of losing health, which is why the patients are so careful about believing in everything that physicians say. This pertains both to individual patients and caregivers visiting the physician with their children (as they are responsible for their health). At the same time, the healthcare professional expects the patient to cooperate and submit to their orders. A physician should not be dominated by the patient when it comes to medication or choosing a certain recovery process. They should be trying to build a paternalistic relationship, yet not devoid of attempts at partnership, so that the patient would feel they are treated as another human being, not a medical case. This mutual relationship should be based around a language understandable for the patient. In case a physician is using too much professional jargon, there is a risk that the patient will not obey to his orders, as they are incomprehensible. This may

[24] D.B. P r o c t o r, A.P. A d a m s, *Kinn's The Medical Assistant: An Applied Learning Approach 11th Edition*, "Elsevier Health Sciences" 27.03.2014, 1376.

[25] M. M a k a r a - S t u d z i ń s k a, *Komunikacja z pacjentem*, Wydawnictwo Czelej, Lublin 2012.

lead to lack of mutual trust, patient's aversion and lack of a proper relationship between the two entities[26].

CONCLUSION

Communication is an indispensable part of human life. It is not only about words but also gestures, sounds, images and texts, as well as radio waves or electronic signals. It is usually a two-sided process in which both the sender and the receiver should be transferring information in a mutually intelligible way. The relationship between a physician and a patient is a special form of communication. It is based on eliciting information from the other person through a means of direct contact. Hence, it might be said that communication in this case is responsible for shaping the relationships between the two entities. It is a special, asymmetrical relationship, where the patient is totally dependent on physician's knowledge, experience and skills. For that communication to be effective, both entities have to feel, speak and listen to the other individual. This is why good listening skills in doctors are important for shaping the relationships with patients. Various research studies have found huge deficits in listening skills. The patient comes for an appointment and hopes to receive more detailed information about their disease: either how to treat it or what was the reason for it, as well as how to live their life with the disease. The patient wants to understand the reasons for hospital admission and for choosing that particular treatment method. In addition, patients want to learn more about the medication they take – whether they have any side effects or affect the healing process. The physician-patient relationships are very important for the recovery process, as both entities have one common goal – which is patient's recovery or minimizing the consequences of the disease.

BIBLIOGRAPHY

Arora N.K., *Interacting with ancer Patients: the Significance of Physicians' Communication Behavior*, "Social Science & Medicine" 2003, 57, s. 791–806.

Augustynek A., *Psychologia. Jak ślimak piął się pod górę*, Diffin, Warszawa 2008.

Bradley J.G., Edinberg M.A., *Communication in the Nursing Context*, Appleton - Century - Croffs, Norwolk, Connecticut 1982.

Cegala D.J., *Patient Communication Skills Training: a Review with Implications for Cancer Patient*, "Patient Education and Counseling" 2003, 50, s. 91–94.

[26] T. S o b i e r a j s k i, *Jak skutecznie rozmawiać z* pacjentem, „Medycyna Praktyczna Szczepienia" 2012/01

Cwalina W., Falkowski A., *Marketing polityczny. Perspektywa psychologiczna*, GWP, Gdańsk 2005.
De Valck C., Van De Woestijne K.P., *Communications Problems on an Oncology Ward*, "Patient Education and Counseling" 1996, 29, s.131–136.
Proctor D.B., Adams A.P., *Kinn's The Medical Assistant: An Applied Learning Approach 11th Edition*, "Elsevier Health Sciences" 27.03.2014, 1376.
Dulmen A.M., *Different Perspectives of Doctor and Patient in Communication*, "International Congress Series" 2002, 1241, s. 243–248.
Griffin E., *Podstawy komunikacji społecznej*, GWP, Gdańsk 2003.
Hall J.A., Visser A., *Health Communication in the Century of the Patient*, "Patient Education and Counseling" 2000, 41, s. 115–116.
http://www.usmlestudentdoctor.com/2014/01/general-rules-for-exam-questions-about.html (dostęp: 10.08.2016).
Kreps G.L., Arora N.K., Nelson D.E., *Consumer/provider Communication Research: Directions for Development*, "Patient Education and Counseling" 2003, 50, s. 3–4.
Maguire P., *Barriers to the Care of the Dying*, "British Medical Journal" 1985, 291, s. 1711–1713.
Maguire P., *Improving communication with cancer patient*, "European Journam of Cancer" 1999, 35 (10), s. 1415–1422.
Makara-Studzińska M., *Komunikacja z pacjentem*, Wydawnictwo Czelej, Lublin 2012.
Mayerscough P.R., Ford M., *Jak rozmawiać z pacjentem*, GWP, Gdańsk 2001.
Pease A., *Mowa ciała. Jak odczytać myśli innych ludzi z ich gestów*, Jedność, Kielce 2001.
Rogaliński P., *Komunikacja werbalna i niewerbalna*, 20 wrzesień 2012,
Salmon P., *Psychologia w medycynie*, GWP, Gdańsk 2002.
Sobierajski T., *Jak skutecznie rozmawiać z pacjentem*, „Medycyna Praktyczna Szczepienia" 2012/01.
Sokołowska M, *Badania socjologiczne w medycynie*, Książka i Wiedza, Warszawa 1969.
Sokołowska M., *Socjologia Medycyny*, PZWL, Warszawa, 1986.
Stewart J., *Mosty zamiast murów Podręcznik komunikacji interpersonalnej*, PWN, Warszawa 2008.
Street R.L., *Information−giving in Medical Consultations: the Influence of Patients'Communicative Styles and Personal Characteristics*, "Social Science & Medicine" 1991, 32, s. 541–548.

KOMUNIKACJA LEKARZ–PACJENT W PLACÓWKACH SŁUŻBY ZDROWIA

Streszczenie

„Komunikacja" to termin trudny do jednoznacznego zdefiniowania, ponieważ odnosi się do wielu pojęć i różnych dziedzin życia. W poniższej pracy została ona scharakteryzowana jako proces, w którym następuje wymiana informacji pomiędzy jej uczestnikami – nadawcą i odbiorcą. Szczególną jej formą jest komunikacja interpersonalna, wśród której niezwykle istotna jest komunikacja pacjent–lekarz. To właśnie od relacji pomiędzy wspomnianym stronami zależeć będzie, czy proces leczenia przebiegnie, sprawnie i skutecznie. Dobry lekarz to ten, który szybko i poprawnie zdiagnozuje pacjenta i ustali odpowiedni proces terapeutyczny, ale także ten, który w odpowiedni sposób będzie umiał przekazać pacjentowi złe informacje dotyczące jego stanu zdrowia, będzie umiał przekazać zalecenia dotyczące dawkowania leków czy też wytłumaczy z jakiego powodu pacjent został przyjęty na oddział do szpitala lub jakie mogą być skutki uboczne przyjmowania konkretnych medykamentów.

Celem pracy jest próba wyjaśnienia i przedstawienia relacji pomiędzy pacjentami a lekarzami występującymi w placówkach ochrony zdrowia. W związku z tym, zostały w niej omówione podstawowe pojęcia takie jak: komunikacja (schemat komunikacji), błędy popełniane w komunikacji, bariery w komunikacji lekarz–pacjent, główne zasady relacji lekarz–pacjent, prawa pacjenta, relacja pacjent–lekarz.

Przedstawiona praca jest częścią pierwszą – teoretyczną, omawiającą szczegółowo wymienione zagadnienia. W kolejnej części – doświadczalnej – zostaną przedstawione i omówione wyniki badań uzyskane na podstawie ankiety przeprowadzonej wśród pacjentów lubelskich jednostek ochrony zdrowia, co będzie podstawą do dalszych rozważań na temat relacji między lekarzem a pacjentem.

Słowa kluczowe: komunikacja, komunikacja interpersonalna, relacja pacjent-lekarz, błędy w komunikacji, prawa pacjenta

Summary

It is very hard to clearly define the term of communication, because it relates to many notions and different fields of life. In this publication the authors tried to characterized it as a process of information changing between its participants – a sender and a receiver. Interpersonal communication is one of the specific forms of communication, in which doctor-patient communication is the most important in the field of medicine. Relation between mentioned participants is very crucial because the effects of the process of healing and getting better depends on how the doctor and the patient cooperate with each other. The best doctor seems to diagnose patient and prepare proper methods of treating as quick as possible. That type of person seems to be responsible for breaking the bad news to the patients, giving advice how to dose different medicines he/she prescribed, explaining the purpose of hospital admission and defining the adverse effects of specific medicines the patient has to take.

The aim of this paper is to explain, define and describe the relation between doctor and patient in medical units. This is why the authors discussed such basic terms as: communication (scheme of communication), communication mistakes, barriers between doctor and patient, general rules about physician-patient relationships, patient rights, doctor-patient relationship.

This publication is the first - theoretic part in which the authors precisely defined the terms mentioned above. The next part of this paper is the study, in which the results of survey will be shown. A group of Lublin medical units patients fill in the questionnaire and asked the questions about their observations of doctor-patient relationship. The next part will be the base to discuss and think how the mentioned relations should look like.

Keywords: communication, interpersonal communication, doctor-patient relationship, communication mistakes, patient rights