Challenges in Interpersonal, Intercultural and Technology Aspect in Doctor and Patient Relationship

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ABSTRACT

Primary care was the main function of primary health care, and towards this goal, doctor-patient relationship was important for the health prevention and promotion component. Effective communication is essential for delivering quality patient care and building patient-doctor relationships with compassions and shared respect. Effective doctor-patient communication is the heart of medicine. This is important in the delivery of high-quality health care. Though communication between doctor and patient is complicated but it is a window of understanding the patient's perspective on the impact of illness. Through good interpersonal communication patient can make their doctor understand how to understand patient feeling about the treatment they want. Through good interpersonal communication doctor can educate patients about their care, including disease evaluation, diagnosis, and prognosis. Unfortunately, this sometimes sacrificed with the intrusion of business into the patient-doctor relationship, the pressures of limited time to office visits, and the sometimes all-consuming focus on technology. The using of technology can be very helpful for doctor and also patient. But technology need to be used carefully. Patient can be very defensive and make the doctor failed in doing his/her job because patient highly believe in medical information that he/she get from internet. Another barrier to achieve effective communication between doctor and patient in Indonesia is hierarchical social culture. In this type of culture, doctor and patient practice one-way communication style. The current situation satisfies neither doctors nor patients. So, we can see that there are challenges related to interpersonal communication, intercultural communication and communication technology in doctor and patient interaction. Through this article I want to offer a recommendation from communication science perspective about what the doctor and patient can do about their communication skill, especially in interpersonal communication, intercultural communication, and the use of technology in communication.

Keywords: *interpersonal communication, internet, intercultural communication, communication skill*

1. BACKGROUND

One of media in Indonesia, The Jakarta Post, wrote *"Before the AEC policy many Indonesians went to other countries to seek better healthcare services. According to the Health Ministry, in 2014 more than 600,000 Indonesians went abroad to seek medical assistance, especially to Singapore and Malaysia. Indonesian patients have contributed more than US$600 million to those countries every year since 2003. Next year, many foreign physicians are expected to open practices in Indonesia."* Some doctors, the pessimists type, afraid that they will lose their patients, assuming Indonesians trust foreign doctors. Some doctor understand about this condition and willing to learn more in order to upgrade their capability so they can provide better quality aid, hospitality and professionalism. But some of the doctor not. They prefer to put the blame on patient.

Lack of time to communicate with the patient and practicing in many places are two reasons why hospitality and professionalism of Indonesian doctors has decreased. Many of our physicians practice late into the night with many patients and at several places. To prevent Indonesian doctors from practicing in multiple places, government and the private sector should raise their pay.

In article "Introducing a Partnership Doctor-Patient communication Guide for teachers in the culturally Hierarchical context of Indonesia" Mora Claramita et.al, based on their research revealed a need for regular and proper communication skills training in medicine in postgraduate setting in Southeast Asia, they point to the lack of training in socio-behavioral sciences, including doctor–patient interaction, communication, and professionalism, in current undergraduate and postgraduate education programs.

2. Concepts in Doctor and Patient Communication

2.1. The Nature of Interpersonal Communication

If we talk about the communication between doctor and patient, we can see it as a communication in interpersonal context. A simple definition of interpersonal communication is the verbal and nonverbal interaction between two (or sometimes more than two) interdependent people. De Vito explain in his book that there are several nature of interpersonal communication.

First, interpersonal communication involves interdependent individuals. Interpersonal communication is the communication that takes place between people who are in some way "connected". A doctor connected to his/her patient and so does the patient connected to his/her doctor. Not only the doctor and patient simply "connected" - they are also interdependent: what one person does has an impact on the other person. The actions of doctor have consequences for the patient, and vice versa. A patient who does not trust or like the doctor will not disclose complete information efficiently. A patient who is anxious will not comprehend information clearly. The relationship therefore directly determines the quality and completeness of information elicited and understood by his/her doctor.

Second, interpersonal communication is essentially relational. Because of this interdependency, interpersonal communication is inevitably and fundamentally relational in nature; interpersonal communication takes place within a relationship - it impacts the relationship, it defines the relationship. The communication that takes place in relationship is in part function of that relationship. Most of the medical encounter spent in discussion between doctor and patient. Goold and Lipkin explain about the function and elements of medical interview. The interview has three functions and 14 structural elements. The three functions are gathering information, developing and maintaining a therapeutic relationship, and communicating information. So, we assume that, instead of we call the relation between doctor and patient as a interpersonal relationship, we prefer to call it therapeutic relationship.

Third, interpersonal communication exists on a continuum. Interpersonal communication exist along a continuum that ranges from relatively impersonal to highly personal. At the impersonal end of the spectrum, you have simple conversation between people who really don't know each other. At the highly personal end is the communication that takes place between people who are intimately interconnected. A few characteristics distinguish the impersonal from the personal forms of communication.

a. Role versus personal information.
b. Societal versus personal rules.
c. Social versus personal messages.

Before, we already explain about our preferences to call the relationship between doctor and patient as a therapeutic relationship instead of interpersonal relationship. But it doesn't mean that interpersonal communication doesn't exist. But we believe that it is not easy to achieve the ideal form of interpersonal communication. For example. In medical encounter, doctor always play his/her role as a person who has power to help the patient. On the other side, patient play role as a person who needs help. So equality is never usually happened in this kind of relationship. Especially in Indonesia that hold high cultural-context of communication.

Forth, interpersonal communication involves verbal and nonverbal messages. Interpersonal interactions involves the exchange of both verbal and nonverbal messages. The words you use as well as your facial expressions, your eye contact, and your body posture-in face-to-face interaction- and your online text, photos, and videos send interpersonal messages. Doctor have to be mindful in using verbal and nonverbal language. It is important because the complexity of high cultural-context communication that most of Indonesian people embrace. The ambiguity can be worst by the use of medical and technical term that not every patient understand and the culture not to questioning what the superior (doctor) say or do.

Fifth, interpersonal communication takes place in varied forms. Interpersonal communication often takes place face-to-face, as when patient talk with his/her doctor. And, interpersonal communication often takes place over some kind of computer network, through texting, e-mailing, posting to social media, phoning, and tweeting. Some of these forms are synchronous; they allow people to communicate in real time; the messages are sent and received at the same time as in face-to-face and phone messages. Other forms are largely asynchronous; they do not take place in real time.

Sixth, interpersonal communication involves choices. The interpersonal messages that you communicate are the result of choices you make. In some situations, some choices work better than others. Throughout your interpersonal life and in each interpersonal interaction, you're presented with choice points- moments when you have to make a choice as to who you communicate with, what you say, what you don't say, how you phrase what you want to say, and so on. This is why doctor and patient have to be mindful in their communication. Especially if doctor and patient understand that communication process is inevitable, unrepeatable, and irreversible.

About how doctor should communicate with his/her patient, a meeting, named Meeting of Experts on Doctor-Patient Relationship held by WHO-SEARO in New Delhi, 15-16 February 2011 come up with idea about the Strategic Framework for Further Strengthening Doctor- Patient Relationship. It was pointed out that the relationship between patients and their doctor was fundamental to the practice of medicine and was essential to the delivery of quality health care in terms of diagnosis and treatment of diseases. This was often viewed by patients and doctor alike as a "long-term personal relationship". Such a relationship was a key component of patient-oriented care which could result in positive health outcomes for the patient.

The framework explained that the doctor-patient relationship starts with an interview, which involves (1) gathering of details about the patient's complaint, (2) developing a therapeutic regime and (3) communicating information and advice. These three functions interact inextricably. A patient must feel confident about the competency of his/her doctor and must trust the doctor fully in order to confide in him/her. Here, confidence, mutual respect, trust, shared values and perspectives about disease and good health foster a better doctor-patient relationship. Adequate time and attention devoted by the doctor in this interaction would result in accurate diagnosis and substantially increase the patient's trust in the doctor while at the same time would increase his/her knowledge about the illness and the preventive and promotive measures that could be taken for self-care. Data increasingly suggest that in medical encounters conducted in such a congenial environment, patients feel encouraged to ask questions and participate more actively in their own treatment and care, resulting in higher levels of satisfaction and cure. We think it is clear that communication between doctor and patient is all about for therapeutic function, as well as therapeutic relationship.

2.2. Elements of Interpersonal Communication

That strategic framework to strengthen doctor-patient relationship model are embedded in model of interpersonal communication. As we know, the model presented in Figure 1.2 is designed to reflect the circular nature of interpersonal communication; both persons send messages simultaneously rather than in a linear sequence where communication goes from person 1 to person 2 to person 1 to person 2 and on and on. Each of the concepts identified in the model and discussed here may be thought of as a universal of interpersonal communication, in that it is present in all interpersonal interactions: (1) source-receiver, (2) encoding-decoding, (3) messages (and the meta messages of feedback and feed forward), (4) channels, (5) noise, (6) contexts, and – though not indicated in the diagram but an overriding consideration in all interpersonal communication, (7) ethics.

Source-Receiver

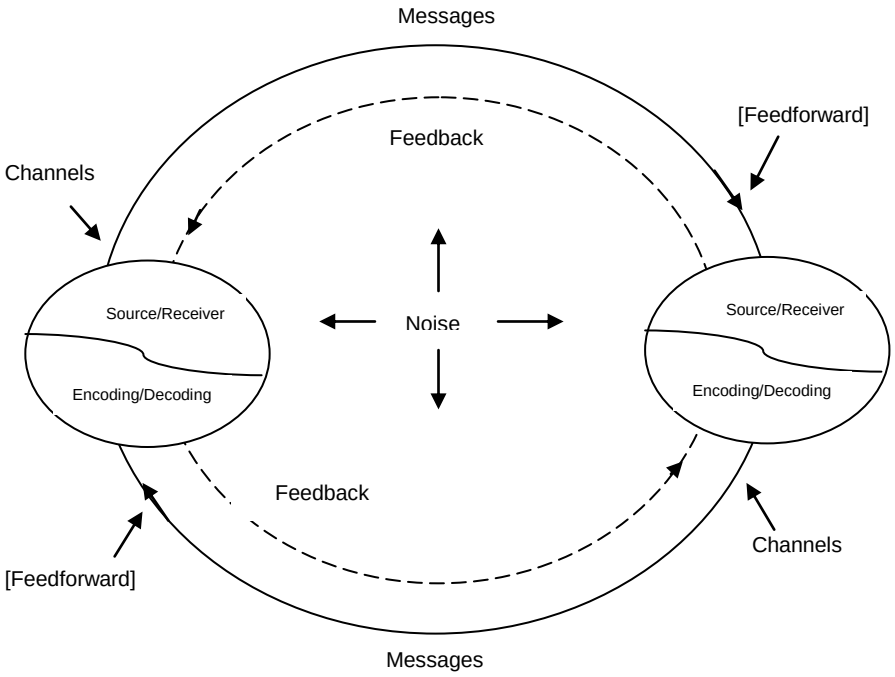
Interpersonal communication involves at least two people. Each individual performs source functions (formulates and sends messages) and also performs receiver functions (perceives and comprehends messages). The term source-receiver emphasizes that both functions are performed by each individual in interpersonal communication. In medical interview, at the same time, doctor become source and receiver. When he/she become a source, he/she asking how the patient feel or condition about his/her illness. When doctor become receiver, he/she have to be actively listening to the patient's information.

Who you are, what you believe, what you value, what you want, what you have been told, and what your attitudes are all influence what you say it, what your ability to communicate effectively (as source and receiver) is your interpersonal competence (Spitzberg & Cupach, 1989; Wilson & Sabee, 2003). Your competence includes, for example, the knowledge that in certain context and with certain listeners one topic is appropriate and another isn't. Your knowledge about the rules of nonverbal behavior example, the appropriateness of touching, vocal volume, and physical closeness- is also part of your competence. Doctor's or patient's interpersonal competence includes knowing how to adjust communication according to the context of the interaction, the person with whom they're interacting, and a host of other factors discussed throughout this text.

Based on articles written by Jennifer Hong Ha and Nancy Longnecker (2010), it has been observed that communication skills tend to decline as medical students progress through their medical education, and over

time doctors in training tent to lose their focus on holistic patient care. Furthermore, the emotional and physical brutality of medical training, particularly during internship and residency, suppresses empathy, substitutes techniques and procedures for talk, and may even result in derision of patients.

Figure 2.1
A Model of Interpersonal Communication



Encoding – Decoding

Encoding refers to the act of producing messages-for example, speaking or writing. Decoding is the refers to the act of understanding messages. The term encoding-decoding is used to emphasize that the two activities are performed in combination by each participant. For interpersonal communication to occur, messages must be encoded and decoded. Encoding and decoding process in medical interview can be very difficult since not every patient can be a good decoder and encoder. Doctors have been found to discourage patients from voicing their concerns and their expectations as well as requests for more information. This negative influence of the doctors' behavior and the resultant nature of the doctor-patient communication deterred their health goals. Lack of sufficient explanation results in poor patient understanding, and a lack of consensus between doctor and patient may lead to therapeutic failure.

Messages

Messages are signals that serve as stimuli for a receiver and are received by one of our senses – auditory (hearing), visual (seeing), tactile (touching), olfactory (smelling), gustatory (tasting), or any combination of these senses. You communicates interpersonally by gesture and touch as well as by words and sentences.

Messages may be intentional or unintentional. They may result from the most carefully planned strategy as well as from unintentional slip of the tongue, lingering body odor, or nervous twitch.

Messages may refer to world, people, and events as well as to other messages (DeVito, 2003a).

The doctor-patient interaction is a complex process, and serious miscommunication is a potential pitfall, especially in terms of patients' understanding of their prognosis, purpose of care, expectations, and involvement in treatment. These important factors may effect the choices patients make regarding their treatment and end-of-life care, which can have a significant influence on the disease. Good communication skills practiced by doctors allowed patients to perceive themselves as a full participant during discussions relating to their health.

Channel

The communication is the medium through which messages pass. Its a kind of bridge connecting source and receiver communication rarely takes place over only one channel; two, three, or four channels are often used simultaneously. For example, in face to face interaction, you speak and listen (vocal-auditory

channel), but you also gesture and receive signals visually (gestural-visual channel). Often you communication through touch (coetaneous-tactile channel), you emit odors and smell those of others (chemical-olfactory channel). In doctor and patient communication usually taking place in face to face communication. Doctor need to see patient face to face to achieve good diagnose.

Noise

A Technical noise is anything that disturbs a message-anything that prevents the receiver from receiver the message. At one extreme, noise may prevent a message from getting from source to receiver, A roaring noise or line static can easily entire message from getting through to your telephone receiver. At the other extreme, with virtually no noise interference, the message of the source and the message received are almost identical. Most often, however, noise, distorts some portion of the message a source sends as it travels to receiver.

Four types of noise are especially relevant. Its important to identify these types of noise, when possible, to reduce their effect.

- Physical noise is interference that is external to both speaker and listener; it impedes the physical transmission of the signal or message.
- Physiological noise is created by barriers within the sender or receiver, such as visual impairments, hearing loss, articulation problems, and memory loss.
- Psychological noise is mental interference in speaker or listener and includes preconceived ideas wandering thoughts, biases and prejudices, closed-mindedness, and extreme emotionalism. You are likely to run into psychological noise when you talk with someone who is closed-minded or who refuses to listen to anything he or she doesn't already believe. Some doctors choose to avoid discussion of the emotional and social impact of patients' problems because it distressed them when they could not handle these issues of they did not have the time to do so adequately. This situation negatively affected doctors emotionally and tended to increase patients' distress. This avoidance behavior may result in patients being unwilling to disclose problems, which could delay and adversely impact their recovery.
- Semantic noise is interference that occur when the speaker and listener have different meaning systems; examples include language or dialectical differences, the use of jargon or overly complex terms, and ambiguous or overly abstract terms whose meanings can be easily misinterpreted. You see this type of noise regularly in the medical doctor who uses "medicals" without explanation.

As you can see from these example, noise is anything that hinders your receiving the messages of others or their receiving your messages.

All communications contain noise. Noise cannot be totally eliminated, but its effects can be reduced. Making your language more precise, sharpening your skill for sending and receiving nonverbal messages, and improving your listening and feedback skills are some ways to combat the influence of noise.

Context

Communication always takes place in a context, or environment, that influences the form and content of your messages. At times this context isn't obvious or intrusive; it seems so natural that it's ignored-like background music. At other times the context dominates, and the ways in which it restricts or stimulates your messages are obvious.

- Physical Dimension
  The physical dimension is the tangible or concrete environment in which communication takes place. The size of the space, its temperature, and the number of people present in the physical dimension. Communication between doctor and patient takes place at hospital or clinic.
- Temporal Dimension
  The temporal dimension has to do not only with the time of day and moment in history but also with where a particular message fits into the sequence of communication events. For example, a joke about illness told immediately after the disclosure of a friend's sickness will be received differently than the same joke told in response to a series of similar jokes. Also, some channels (for example, face-to-face, chat rooms, and instant messaging) allow for synchronous communication in which messages are sent and received simultaneously. Other channels (for example, letter writing, e-mail, and social networking postings) are asynchronous; messages are sent and received at different times.
- Social-Psychological Dimension
  The social-psychological dimension includes, for, example, status relationships among the participants, roles and games that people play, norms of the society or group, and the friendliness, formality, or gravity of the situation.
- Cultural Dimension
  The cultural context includes the cultural beliefs and customs of the people communicating. When doctor interact with patient from different cultures, doctor may each follow different rules of communication. This

can result in confusion, unintentional insult, inaccurate judgments, and a host of other miscommunications. Similarly, communication strategies or techniques that prove satisfying to members of one culture may prove disturbing or offensive to members of another.

Today, patients have recognized that they are not passive recipients and are able to resist the power and expert authority that society grants doctors. They can implicitly and explicitly resist the monologue of information transfer from doctors by actively reconstructing expert information to assert their own perspectives, integrate with their knowledge of their own bodies and experiences, as well as the social realities of their lives. Being attentive to social relationships and contexts will ensure that this information is received, and most importantly, acted on. Inequality, social relations, and structural constraints may be the most influential factors in health care.

2.3. A Recommendation Model of Communication

A meeting, named Meeting of Experts on Doctor-Patient Relationship held by WHO-SEARO in New Delhi, 15-16 February 2011 come up with idea about the Strategic Framework for Further Strengthening Doctor- Patient Relationship. It was pointed out that the relationship between patients and their doctor was fundamental to the practice of medicine and was essential to the delivery of quality health care in terms of diagnosis and treatment of diseases. This was often viewed by patients and doctor alike as a "long-term personal relationship". Such a relationship was a key component of patient-oriented care which could result in positive health outcomes for the patient.

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Taking into account the background to the issue and the factors affecting it, a model was proposed as a strategic framework to strengthen doctor-patient relationship. It focused on the following domains:

- Patient-related factors.
  A person's religion, culture, traditions and beliefs carried a strong influence on his/her attitudes and behaviour, which could significantly influence and affect his/her relationship with the doctor. Culture, tradition and religious practices could also have restrictions on or preferences for a specific health system or practice and also about seeking care at all. The educational status and access to health information of a person as well as his/her experience with health care services will also affect his/her decision while selecting a particular doctor or health care system. The financial status of the patient and peer influence and related factors would decide the choice of the care provider.
- Doctor-related factors.
  A patient seeks care to get cured of immediate illness and also be free of future illness if possible. He/she seeks care from a doctor who is considered to be capable and competent. Such skills would depend on the medical education and training the doctor would have received and the clinical experience he/she had gained. A doctor's attitude towards the patient and the empathy and bedside manners shown during an encounter would build a long-term relationship between the two. The doctor would be guided in this humane approach by the ethics and standards learnt at the medical school guided and governed by the medical council and the legal framework of a country. Professional medical bodies such as medical associations also have a major influence over the doctors and how they treat their patients.
- Doctor-patient encounter.
  Availability, access and affordability to medical services are important considerations for a patient when seeking care. Once the decision is made and when the patients report at the health care centre, the attention and treatment received and the personal care offered are very important in building trust and a sound and long-term relationship. The interaction with the doctor is important for the exchange of information that is required for a correct diagnosis and a successful outcome. A doctor needs to spend sufficient time with the patient in order to understand his/her condition correctly.

Continuity of care in an illness and its follow-up were important to the patient. How the services were organized to respond to patients' needs and how support services like referral systems functioned were important issues at the first level of doctor-patient contact.

The draft strategic framework which rise on the Meeting of Experts on Doctor-Patient Relationship held by WHO-SEARO in New Delhi, 15-16 February 2011 suggested the following areas for intervention in order to strengthen the doctor-patient relationship. It stated that these interventions will necessarily have to focus on several domains, of which the major ones were listed as follows:

- Strengthening medical education by the teaching of :
    - Ethics
    - Sociology: cultural sensitivity, empathy, dignity

According to Article"Introducing a Partnership Doctor-Patient communication Guide for teachers in the culturally Hierarchical context of Indonesia" in Journal Education for Health, Volume 26, Issue 3 (December 2013) , Original Research Article, wrote by Mora Claramita et.all, Southeast Asian culture is characterized by a hierarchical social structure. A large power distance between people of higher and lower social status is combined with a collective rather than an individual orientation. This results in less autonomy for individuals in making decisions, and for patients, strong involvement of their family in medical decisions. High value is placed on nonverbal expressions of etiquettes of politeness. Recent studies in a Southeast Asian showed that doctors, patients, and medical students prefer a partnership style in doctor–patient communications. However, doctors in this region use mostly the one-way communication style in practice. Consequently, the current situation satisfies neither doctors nor patients.

    - Legal aspects of medical practice
    - Standards of medical practice
    - Continuing medical education.
- Recognizing patients as consumers with rights
    - Patient education and empowerment
    - Strengthening consumer protection (confidentiality and personal data protection, protection when patients are subjects in clinical research)
    - Health literacy: demystification of health knowledge.
- Health system issues
    - Health service organization for universal coverage and continuity of care
    - Grievance redressal mechanisms
    - Patient-friendly systems audits.

2.4. Principles of Power and Influence

Power is the ability of one person to influence what another person thinks or does. You have power over another person to the extent that you can influence what this person thinks or what this person does. And conversely, another person has power over you to the extent that he or she can influence what you think or do. Perhaps, the most important aspect of power to recognize is that power is asymmetrical; If one person has greater power, the other person must have less. There are some principles of power and influence according to DeVito :

1. Some people are more powerful than others.
2. Power can be shared.
3. Power can be increased or decreased.
   Although people differ greatly in the amount of power they wield in any time and in any specific area, everyone can increase their power in some ways. Power can also be decreased. Probably the most common way to lose power is by unsuccessfully trying to control another's behavior.
4. Power follows the principle of less interest.
   In any interpersonal relationship, the person who holds the power is the one less interested in and less dependent on the rewards and punishments controlled by the other person. The more a person needs a relationship, the less power that person has in it. The less a person needs a relationship, the greater is that person's power. If you perceive your partner as having greater power than you, you will probably be more likely to avoid confrontation and to refrain from criticism.
5. Power generates privilege.
   When one person has power over another person, the person with power is generally assumed to have certain privileges-many of which are communication privileges. And the greater the power difference, the greater is the license of the more powerful individual. Sometimes we're mindful of the privilege or license

that comes with power. Most often, however, we seem to operate mindlessly, with no one questioning the power structure.

6. Power has a cultural dimension.
   In his book, De Vito quote Hofstede idea about culture and power. Hosftede said that cultures differ in the amount of power distance or discrepancy that exists between people and in the attitudes that people have about power, its legitimacy, and its desirability. According to DeVito the bases of relationship power, research shows, can be conveniently classified into six types :
   1. Referent power.
   2. Legitimate power.
   3. Expert power.
   4. Information of persuasion power.
   5. Reward and coercive powers.

2.5. Barriers to effective communication between patient and doctor

Based on articles written by Jennifer Hong Ha and Nancy Longnecker (2010), there are several barriers in communication and patient and doctor. There are :

- Deterioration of Doctors' Communication Skills.
  It has been observed that communication skills tend to decline as medical students progress through their medical education, and over time doctors in training tent to lose their focus on holistic patient care. Furthermore, the emotional and physical brutality of medical training, particulary during internship and residency, suppresses emphaty, substitutes techniques and procedures for talk, and may even result in derision of patients.
- Nondisclosure of Information.
  The doctor-patient interaction is a complex process, and serious miscommunication is a potential pitfall, especially in terms of patients' understanding of their prognosis, purpose of care, expectations, and involvement in treatment. These important factors may effect the choises patients make regarding their treatment and end-of-life care, which can have a significant influence on the disease. Good communication skills practiced by doctors allowed patients to perceive themselves as a full participant during discussions relating to their health. This subjective experience that influences patient bioogy is the "biology of self-confidence" described by Sobel, which emphasized the critical role of patients' perception in their healing process.
- Doctors' Avoidance Behavior.
  Some doctors choose to avoid discussion of the emotional and social impact of patients' problems because it distressed them when they could not handle these issues of they did not have the time to do so adequately. This situation negatively affected doctors emotionally and tended to increase patients' distress. This avoidance behavior may result in patients being unwilling to dislose problems, which could delay and adversely impact their recovery.
- Discouragement of Collaboration.
  Doctors have been found to discourage patients from voicing their concerns and their expectations as well as requests for more information. This negative influence of the doctors' behavior and the resultant nature of the doctor-patient communication deterred their health goals. Lack of sufficient explanation results in poor patient understanding, and a lack of consensus between doctor and patient may lead to therapeutic failure.
- Resistance by Patients.
  Today, patients have recognized that they are not passive recipients and are able to resist the power and expert authority that society grants doctors. They can implicitly and explicitly resist the monologue of information transfer from doctors by actively reconstructing expert information to assert their own perspectives, integrate with their knowledge of their own bodies and experiences, as well as the social realities of their lives. Being attentive to social relationships and contexts will ensure that this information is received, and most importantly, acted on. Inequality, social relations, and structural constraints may be the most influential factors in health care.

3. CONCLUSION

- Gaps in communication related to gender, culture, and health literacy can lead to an inferior standart of patient care. The well-attuned doctor can adapt communication styles to different clinical setting and patient character. To become well-atunned a doctor must have active listening skill.

- Barriers frequently develop in physician-patient encounters. If they go unrecognized, they can severely limit the therapeutic potential of the doctor-patient relationship. Because barriers are not always explicit, a strategy must present for recognizing implicit signs such as verbal-nonverbal mismatch, cognitive dissonance, unexpected resistance, and physician discomfort. Once a potential barrier is identified, its source can be defined and explored using standard clinical reasoning techniques such as hypothesis generation and testing. Patients can often share in the process of generating hypotheses about the nature and sources of barriers. Once defined and understood, most barriers can be lessened and sometimes resolved using the basic communication skills of acknowledgment, exploration, empathy, and legitimation.
- When conflict exists, common interests and differences must be clarified. Conflict might involve disagreement about the presence of a barrier, its nature or source, its relevance to the physician-patient relationship, or about strategies for approaching it. Negotiation need not be limited to the initial positions, but can include creative solutions whereby both parties gain. The decision to confront a barrier depends on both doctor and patient readiness, as well as how critical the barrier is to the therapeutic process, and how amenable it is to change. By effectively uncovering and addressing barriers, the physician can often turn roadblocks to effective communication into means for enhancing the therapeutic relationship.
- People should be put at the centre of all health care efforts. For this to be achieved, quality human resource was of the utmost importance. Primary care was the main function of primary health care, and towards this goal, doctor-patient relationship was important for the health prevention and promotion component.

4. REFERENCES

Books :

Devito, Joseph A. (2013). " *The Interpersonal Communication Book 13th edition"*. New York : Pearson.

Griffin. (2013)." *A First Look At Communication 8th edition*". McGraw-Hill.

Turner, Lynn H. and West, Richard. (2004). "*Introduction Communication Theory : Analysis and Apllication 2nd edition".*

Journals :

Anthony L. suchman, Kathryn Markakis, Howard B. Beckham, Richard Frankel. A Model of Emphatic Communication in the Medical Interview. The Jounal of the American Medical Association, Feb 26, 1997 vol. 277.

Debra L. Roter, and Judith A. Hall (1989). Studies Of Doctor-Patient Interaction. Annual Review Public Health Journal. 1989 vol. 10:168-80.

Jennifer Hong Ha and Nancy Longnecker (2010) Doctor-Patient Communication: A Review. The Ochsner Journal: Spring 2010, Vol. 10, No. 1, pp. 38-43.

Mora Claramita, Astrid Pratidina Susilo, Manik Kharismayekti, Jan van Dalen, Cees van der Vleuten. Article in Journal Education for Health, Original Research Article, "Introducing a Partnership Doctor-Patient communication Guide for teachers in the culturally Hierarchical context of Indonesia" . • Volume 26 • Issue 3 (December 2013) [Downloaded free from http://www.educationforhealth.net on Tuesday, April 21, 2015, IP: 137.120.181.231]

Siti Aisah Boediardja. Komunikasi dengan Empati, Informasi dan Edukasi : Citra Profesionalisme Kedokteran. Majalah Kedokteran Indonesia Vo;. 57, no. 4 : April 2009.

Susan Dorr Goold and Mack Lipkin Jr. The Doctor-Patient Relationship : Challenges, Opportunities, and strategies. The SGIM Symposium on Managed Care, Washington D.C. May 1997.

Warren J. Ferguson, and Lucy M. Candib (2002). Culture, Language, and the Doctor-patient relationship. Family Medicine and Community Health Journal UMMS.

Others :

KONSIL Kedokteran Indonesia (2012) : Standar Kompetensi Dokter Indonesia.

http://www.thejakartapost.com/news/2014/12/06/are-indonesian-physicians-ready-asean-economic-community.html#sthash.XoSmf0xi.dpuf

Proceeding :

Proceeding of Meeting of Experts on Doctor-Patient Relationship WHO-SEARO, New Delhi, 15-16 February 2011, World Health Organization 2011, India.

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