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Taking a history (anamnesis) – a communication strategy in the medical clinic

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Taking a history (anamnesis)

- It is the first and often one of the most important examinations in a series of clinical examinations to put the correct diagnosis.
- Research in the medical clinic is divided into: physical, functional, noninvasive and invasive and is done through various techniques, instruments and apparatuses.
- When we take a history the only instrument is the natural human language and the techniques are based on the participants' speech and communication skills.
- There may be some similarity between taking a history and physical examinations – inspections, percussion, palpation, and auscultation because all of them are based on the innate natural phenomena.

Taking a history in terms of linguistic sciences

- In the process of social and professional development, the physician develops his/her own communication skills, applicable to the anamnestic discourse.

-They are a set of different verbal and nonverbal techniques. The successful application of them largely determines the outcome of the diagnostic and healing process.

- In connection with the leading role of the human language and the socially committed language behavior of the physician in taking a medical history, it is appropriate to discuss this clinical practice in terms of a number of linguistic sciences:

- **structural linguistics**,
- **sociolinguistics**,
- **linguistic pragmatism** and others.

Communication strategies

- They are known to emerge in the relations between the speaker and the listener, in which the speaker's attitudes to achieve certain communicative-pragmatic goals through speech are embodied in certain patterns of verbal and non-verbal behavior *(*Dimitrova 2009: 182).
- In taking a history the relationship is between the communicative subjects socialized as a doctor and a patient. In the process of discourse they consistently exchange their roles as speakers and listeners, and each of them conducts his/her communication strategy.
- This is the general philosophy of discourse, directed at the speech act as a whole, related to the willingness of the speaker to conduct its course.

Cooperative or Confrontational strategies

- Prof. Stefana Dimitrova points out that the relations between the speaker and the listener "can be divided into relations where the speaker wants to be honest with the listener, and the relations where the speaker is deliberately inaccurate with the listener."
- Using the terms of P. Grice (Grice 1975), the author points out that in the first case the speaker carries out a co-operative communication strategy, and in the second one – a non-cooperative or confrontational communication strategy (Dimitrova 2009: 182).

The communication strategy of a doctor who has taken the oath of Hippocrates

- It is considered a priori to be honest (cooperative).
- In the anamnestic discours it is aimed at a clear ultimate pragmatic goal -- obtaining complete reliable information from the patient about his current complaints and related past events of a medical and social nature.
- In the context of discourse, the physician applies various interrelated and complementary verbal and nonverbal strategies that can be related to two groups:
  - 1. Strategies for introducing the patient into anamnestic discourse (Introduction);
  - 2. Patient questioning strategies (Poll)

The introduction of the patient into anamnestic discourse is important because

- It is related to the overcoming of a number of psychological barriers - fear, shame, worry about the upcoming conversation with the doctor, etc.
- It begins in the waiting room of the doctor's office where the material environment plays a strategic role for the success of anamnesis.
- Upon crossing the door of the Doctor's office, the patient enters the situation of the speech. Right now, the doctor starts his strategy of winning the patient's confidence.
- It is believed that the first quarter of an hour often determines the relationship between the physician and the patient (Zingler 1988: 2.2.)

Formal or informal speech in the conversation with the patient???

- In Bulgarian there are morphological markers for speech in formal and informal environment. They are included in so-called forms:

ВИЕ-форма (VIE form) (formal speech**) & ТИ-форма (TI form) (**informal speech**)** .

- In Bulgarian sociolinguistics it is stated that formal or informal language markers are a sign of social status (Videnov 1998: 129-132). That's why the correct solution to the problem is in conformity with some of the patient's social and demographic characteristics, such as :

-level of education & profession

-origin from a particular place (city or village),

- place of residence,

- age, etc.

In view of these characteristics, VIE-communication is more appropriate for some patients, and for others, the communication with TI is preferred.

Body language by Introduction

First of all this is the choice of pose - symmetrical mirror position in the sitting position of a physician and a patient (quoted by Tacheva 2014: 141-142). (Tacheva 2014: 141-142)

Patient questioning strategies (poll)

are a subject to a specific scheme - Plan for Taking a History

1. A description of the current complaints;
2. Data on past illnesses;
3. Family history;
4. Systematic examination (Zeollner & Hadorn 1995: 5)

Regarding the part arrangement : there is only one hard rule -- to be started with the leading complaining (quoted by Sigentaler 1993: 2.2).

The rest of the anamnesis can be shifted according to the medical case (quoted by Marchev 1994: 50).

It can be concluded that the arrangement of the anamnesis parts is a strategic task of the physician, which is decided according to the specificity of the particular medical case.

The doctor's language
from a physical point of view

- The qustions must be pronounced sufficiently loudly with clear articulation and face facing the patient so that he can monitor the movements of the lips, mimicking muscles and the doctor's eyes.

The doctor's language
from a point of view of logic and meaning

- The **logic** of a history of current complaints and past illness is:

from the more general issues (problem identification) →

→ to the more specific questions (problem characterization) (see the report by S. Marchev 1994: 43 et seq.)

- About the **meaning** -- the questions must be brief, clear, unambiguous and not manipulative. They should not create a sense of curiosity or criticism.
- Questions should not contain medical terms.

The doctor's language
from a structural linguistic point of view

- The physician should be aware of the information nature of the different question sentences.
  - question sentences with full question marks: **Какво?** (What?) **Кога?** (When?) **Как?** (How?) **Къде?** (Where?) **Колко?** (How much?) **Каква е причината?** (What is the reason?).

  They perform a function of complete open questions and suggest an exhaustive answer.

  - question sentences with a **ЛИ** particle (question particle) . They perform a closed-ended function with two alternative answers - YES or NO.
  - questions with other questioning particles such as **ДАЛИ ('whether'), НАЛИ ('right'), НИМА ('wonder and question') , ДА НЕ БИ ('do not you mean that')** etc., should be avoided in the history because of their connotative meanings and the ability to manipulate responses).

The doctor's language and the phenomenon of Diglossia

- **Diglossia is a linguistic situation in where non-equal high-prestige and low-prestige formations function to provide the means of communication for certain communities (…) (Videnov 2005: 61).**
- The socio-demographic characteristics of participants in the anamnestic discourse (education, profession, background, ethnicity, etc.) and their role-based relationships affect the use of one or other language code in the situation of diglossia:

  (e.g. - literary language code,
  - dialect code,
  - intermediate code,
  - ethnological code etc.).

The doctor's language and the phenomenon of Bilingualism

- **Bilingualism is a language situation where the individual uses more than one language (Bell 1980). In such a situation, languages are equal in terms of social prestige.**
- Specific (but common nowadays) is the anamnestic discourse with participants of different nationalities, in which different languages can be used. This discourse corresponds to bilingualism.In such cases, an advantage is given to the patient and the communication is done in the native (or more convenient) patient language.
- In order to realize this principle, the foreign students in medicine and dental medicine in Bulgaria pass an obligatory detailed course in Bulgarian with final part Clinical Bulgarian for communicating with the patients.

Conclusions about the physician's role in choosing or managing the language code

- It should be highlighted.
- Properly selected linguistic code is part of the strategy for taking a history. The physician is this participant in the discourse, which must ensure unimpeded communication.
- In addition the doctors' speech must not leave the boundaries of the literary language.
- The doctor must speak literally language code (see Daliho 2000: 23).

The doctor's "body language”
has strategic meaning during the questioning

- There are a number of rules regarding:
  - **sitting position,**
  - **gestures,**
  - **eyescontacts** etc**.**

The patient's discursive communication strategy is most often cooperative

- The cooperative communication strategy is conducted from the point of sincerity. Patient sincerity depends to a large extent on the success of physician communication strategies for expressing support, patience, warmth, etc., which are steps to build confidence (Dahmer 2005: 12).
- Feeling full confidence in the physician, the patient is relieved of a number of concerns and makes it easier to speak in the sense of catharsis - a possibility that anamnesis gives to every patient in general(Gross 1965 on Dahmer 2005: 13)

Non-cooperative (or confrontational) patient's strategies

- They are conducted from the position of insincerity.
- Different cases of intentional or unintentional non-cooperative communication strategies have been noticed:
  - Some patients have a preliminary opinion about their illness and are trying to direct the doctor in a certain direction;
  - Other patients deliberately report wrong complaints or fictitious complaints (in criminal or expert cases)

  (see Zoellner & Hadorn 1995: 5).

In conclusion:

- 1. Communication strategies arise in the relationship between the speaker and the listener. They can be cooperative or non-cooperative (confrontational)
- 2. The general communication strategy of the physician is a priori honest (cooperative).
- 3. The patient's general communication strategy is most often cooperative , but cases of intentional or unintentional non-cooperative strategies are known and analyzed.

In conclusion:

- 4. Successfully achieved communicative goals at the stage of anamnesis are a base for the success of the next stage - the diagnostic-healing process and the successful resolution of the medical case.
- 5. The knowledge and achievements of more and more humanities and social sciences such as general linguistics, sociolinguistics, linguistic pragmatics, theory of communication, psychology, social psychology, etc. have been taken into account today to improve the anamnesis of the past.

Bibliography

- Belle 1980: Bell, R.T. Sociolinguistics. Publishing house Science, Moscow, 1980
- Dalicho 2000. Dalicho, A.H.W. Die allgemeinearztliche Unterzuchung (a Bulgarian translation, Bulgarian Translation, Sharov Publishing House, 2000.
- Dahmer 2005. Dahmer, Jurgen. Anamnese und Befund. Stuttgart: Georg Thieme Verlag, 2002 (Bulgarian translation: Anamnesa and Finding, Sofia, Medicine and Physical Education, 2005.)
- Dimitrova 2009. Dimitrova, Stefana. Lingvistic pragmatics. Veles Publishing House. Sofia 2009.
- Grace 1975. Grise, H.P. Logic and Conversation // Syntax and Semantics, v. 3, ed. by P. Cole and J. L. Morgan, N.Y. Acad. Press, 1975:41-58.
- Marchev 1994. Marchev, S. The Way to Diagnosis. Sofia 1994
- Propedeutics 2016: Propedeutics of Modern Studies of Internal Diseases. Volume 1. Under the edits of G. Mileva, G. Neshev, A. Shinkov. Sofia: ARSO Medical Publishing House, 2016.
- Sigenthaler 1993.Sigenthaler, W. Differenzialdiagnose innerer Krankenheiten. Stuttgart 1988 (Bulgarian translation Publishing Medicine and Physical Education 1993)
- Tacheva 2014.Tacheva, Violeta. Communication Skills in Medical Practice, STENO Publishing House, Varna 2014.
- Videnov, 1998. Videnov, M .. The sociolinguistic marker. Delphi Publishing House Sofia 1998.
- Videnov 2000. Videnov, M. Introduction to Sociolinguistics. Delphi Publishing House Sofia 2000.
- Videnov, Videnov, M. Dilogossia in view of the Bulgarian language situation. Academic Publishing House "Marin Drinov", Sofia 2005.
- Zoellner & Hadorn 1995. Zoellner, N., Hadorn, W. Vom Symptom zur Diagnose 1986 (Bulgarian Translation, Publishing "Medicine and Physical Culture", Sofia 1995.)
- https://www.google.bg/search?q=%D0%B8%D0%B7%D0%BE%D0%B1%D1%80%D0%B0%D0%B6%D0%B5%D0%BD%D0%B8%D1%8F+%D0%BD%D0%B0+%D0%BB%D0%B5%D0%BA%D0%B0%D1%80+%D0%B8+%D0%BF%D0%B0%D1%86%D0%B8%D0%B5%D0%BD%D1%82&rlz=1C1AOHY_bgBG710BG710&oq=%D0%B8%D0%B7%D0%BE%D0%B1%D1%80%D0%B0%D0%B6%D0%B5%D0%BD%D0%B8%D1%8F&aqs=chrome.1.69i57j69i59l3j0l2.47392j0j8&sourceid=chrome&ie=UTF-8, visited on 16.06.2018

THANK YOU

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