On Communication Analysis and Repair as an Alternative for Miscommunication

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Almost buried by the growing bureaucracy of the medical offices, we tend to be less patient, less concentrated, and less tolerant with our patients when engaging in dialogue. The result is often less than optimal. The patients, intimidated or self-centered, tend to forget the message of the doctor-patient dialogue, refuse to accept the facts or mandate a next of kin as a surrogate for a meaningful conversation.

The extent of the problem and the derived implications are important in figures. For instance, 80% of the litigations in a closed claim analysis in Japan were attributed to bad communication between patients and physicians [1]. Often the information from physician to patient is rather a monologue, where the individual is too intimidated, frustrated or emotional to be able to receive, understand, digest and accommodate with the information. Thus, it often appears that the information was encrypted or refrained from the beneficiary, although the physician is confident with acting in good faith and good practice.

Conversely, dialogue "is a foundational feature of social and political life and one that we often take for granted" [2]. It turns out from the research published in this issue and authored by Rita Kránicz et al, that we should not do such a thing [3]. In our uninhibited and permissive society, encounters are not only expressed by dialogue, but by a pro-active approach: sentence and reply. Reply and further dialogue are important to perform repair. This type of communication appears to be quite a complex one. The authors of the featured articles in this issue of our journal recorded the dialogues between a family doctor and a heart patient and a geography class between a hospital teacher and a student.

Conversation repairs were analyzed as to Schegloff's categorization of the repairs. Repair is defined as "the name given to periods of talk in everyday talk in which miscommunications rise, are noted and then resolved "[4]. Kránicz et al not only recorded the aforementioned conversations, but further classified the repairs in 6 categories according to the initiator and the repaired. When conversation analysis was applied to the lesson of a hospital teacher, 20 repairs were identified, 15 times the initiator being the teacher, who also corrected in over 50% of the cases [3]. Interesting enough, it was the student rather than the teacher who wanted to check the understanding. Repairs are a waste of time if not successful. The article emphasizes on the successful outcome of the repairs, regardless of the initiator. Still, the teacher preserved a dominant position, explained as being classical. Considering the vulnerability of the hospitalized young patients, this is no surprise. Multiple hospitalizations tend to accelerate maturation and the capacity to engage in a process of decision making. Moreover, usually conversations do not take place in a super controlled and friendly environment, but in rather stressful places: hospital waiting rooms, halls, wards, emergency departments, by the operating theaters. Recording conversations is monitoring them. If one is aware of this, one might better control oneself. But monitoring means losing privacy. It is unknown to what extent the outcome of a monitored dialogue would differ from a confidential one.

Due to the fact that conversation analysis is more a science than art, it should perhaps be taught and physicians be trained so as to avoid further misunderstandings as a result of a medical dialogue, be it between physician and patient. This article is a proof of the need of interdisciplinary communication and cooperation for the best interest of our patients and profession too. The authors, who concluded that the mistake analysis showed that they were most commonly non-syntactic by nature, observing that during repairs the syntactic structure applied could change, promised to further investigate the subject. We are waiting for.

References

1. Hamasaki T, Takehara T, Hagihara A. Physicians' communication skills with patients and legal liability in decided medical malpractice litigation cases in Japan. BMC Fam Pract. 2008;9:43.
2. Parsons J, Lavery JV. Brokered dialogue: new research method for controversial health and social issues. BMC Medical Research Methodology. 2012;19:92.
3. Kránicz R, Hambuch A, Hamar-Savay J, Rébék-Nagy G, Sárkány-Lőrinc A. Dominance Relations in the Light of Repair-mecanisms in Family-doctor-Patient and Hospital Teacher-Student Encounters. Acta Medica Marisiensis 2013;59(2):94-97.
4. Lind Ch, Okell E, Golab J. Conversation Analysis of Repair in Interaction with Adults who have Acquired HI, Chapter 16, in Hearing Care for Adults, 2009;157-164.

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