COMMUNICATION BETWEEN DOCTOR AND THE IMPRISONED PATIENT

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Abstract: *Based on the idea that, sending a message, encode but also decode a conduct, an attitude and a behavior, the communication is the answer to those mentioned above.*

So, the particularity of communication between the two (doctor - patient) depends on the patient`s identity which, in our case, is deprived of liberty, which determines knowledge and application of special strategies that can solve the health problems and not only that.

In this case, communication between the two players choose the efficiency method so our patient must remain patient and not an object and the Hippocratic Oath must be applied in all related cases.

Keywords*: communication, doctor, prisoner, specificity, efficiency*

1. INTRODUCTION

To start towards a definition of communication is a long road of knowledge and identity, as items implicated in the process, generates a series of metamorphoses that change the meaning and perception of the act itself. Thus, we choose to start our cnosological incursion from the following:

a) DEX - (1975) = defines communication as a process to make known, to let you know, to inform, to instruct, to say or talk;

b) Lohisse (2002) - communication conveys relationship with each other;

c) Prutianu (2000) - communication is what creates communion and community, ie a web of relationships rather than a quantity;

d) Lemeni and Miclea (after Pașca - 2012) - communication is defined as the process by which information are transmitted from a transmitter to a receiver, by application system of signs and symbols.

We will definitely get to a paradox at a first logical investigation, that communication is a game of mutual influences between people or between freedom and affection, according to Commarmond and Exiga (2005), remaining in expectation when choosing, Pruteanu St. (2000). Communication escapes attempts to define it, communication semantics of the term does not fit into a definition, but each definition captures something of what communication is.

Basically, communication is in fact a transaction between inhabitants: the transmitter and receiver are simultaneous, the transmitter being at the same time, receptor and transmitter, and then the receiver (mutual is also available). Therefore, communication is a social act, deliberately or unintentionally, consciously or not. It is in any case one of the acts underlying social bond, and you cannot live without communication, all these if we start from the idea of Watzla Wick (1972) - "If we admit that, in interaction, all conduct has the value of a message; in other words is communication that you cannot communicate, whether you like it or not".

Continuing the journey of identity, in terms of a psychosocial analysis, communication is a set of processes, which exchange information and meanings between individuals in a given social situation. By definition we can detach the item - exchange of information, meaning that falls within the communications processes are essentially social phenomena relying on the interaction determined by the actors.

In particular, the message communication between doctor and patient, the first must ensure (regarding the patient) if the second got the message; as it receives; what to expect, as is the whole approach, which is the feedback, so the next step to trigger active listening.

Active listening refers to understanding and receiving the message, which means encouraging the discussion partner through a series of gestures and behaviors aimed at clarification of uncertainties; demonstrating understanding of the conveyed message, interest in discussion so that the receiver (in our case, the patient) can express an opinion regarding the perception of the facts and the opportunity to change something at/in the situation during communication with the transmitter (doctor).

An important role between the two and how and for the choice of communication channel, is related to:

- strong connotations given to the social dimension of the situation;
- the way of sending the message (voice, writing, gesture) and physical conditions (their position in space, meeting place);
- two types of spatial arrangement that fosters communication, namely: face to face and side by side.

Basic pieces of communication are also included: doctor and patient vs. patient and doctor having two players in the role of communication Feertchak (1996) saying that any individual who communicates directly involved in the communication situation by engaging in it its personality and its own system of needs that determine motivations. The interlocutors, communication actors are best placed to:

- choose the language;
- think about the used words;
- knit words in the desired order;
- transmit words / information through a canal.

According to Blakar (1979), the transmitter is a creator through its message providing a whole set of data - signs on himself, his vision on the object communication or social situation that he wants or levy - which will be perceived and evaluated by the caller, determining reactions as commitment, responsiveness or blockage.

Basically, it is evident that communication between actors is necessary to have a purpose which has to:

- achieve certain objectives;
- avoid dangerous situations,

designed to develop a certain behavior to determine the normality of the act itself.

In this context, patient-physician communication, according to Tudose (2003), is a direct communication, face-to-face, unmediated and unofficial. Between the two subjects of information transfer, there is a continuous exchange of information, which leads each of the two partners to the specific aims of the meeting, namely:

- information about the health of the patient;
- proposed remedies and treatment;
- practical ways of action.

In another perspective, communication, according to Enătescu (2007), passed through an objective analysis, highlights, three stages defined by dominance, namely:

1) - the first stage with a very low dominance index which tends to zero, defines the first stage of communication, which exposes the patient, quasi-continuously streamed own history and symptoms that caused him to turn to the doctor; this stage generally occurs with very little dialogue from the doctor, his questions having only an overall aspect;

2) - second step is characterized by a balance of dialogue, with dominance index values around 0.5 which corresponds to managing dialogue by the physician through asking questions;

3) - the third stage is characterized by the dominance of the physician in the communication corresponding application i.e.: application diagnosis and therapeutic indications by the physician, or possibly applying specialized techniques "psychotherapy" (like suggestive therapies). The same authors mention that the ratio of the three stages depends on several factors as:

- the specialized area in which the test is performed;
- the psychological structure of the patient in his special situation of disease;
- medical psychology and affinity for communication.

Yet there are a number of factors that disrupt the communication process, which creates dysfunctions while running the medical act between doctor and patient. In this context, Tudose (2003) notes three factors, namely physical, internal and somatic.

These factors appear when the doctor does not appeal to patience or empathy (which represents the state in which you can feel as the other); as empathy with the patient is extremely important because it can create a state of incompatibility both for the doctor and for the patient, through barriers created to each other. According to Egner (1992), the most important barriers between doctor and patient are:

1) obstacles created by the physician:

- loose too much time;
- increased nervous consumption, especially when a tired doctor, after call or after a number of consultations, is overwhelmed by their own troubles;
- loss of control of biomedical problems of anamnesis;
- "not my job" - is a formula for dismissing the psychosocial issues that accompany any pathological or imagined suffering;
- the doctor cannot, objectively, put himself in the place of the patient;

2) obstacles created by the patient:

- attempt to hide his emotions in front of the doctor;
- fear of being put in an embarrassing situation;
- willingness to comply with the doctor's expectations, not to deviate from the presentation of the "technical" symptoms;
- fear of being sick;
- fear (possibly excessive respect) to the doctor.

but these empathetic gaps can be also found when future schemes of behavioral doctor-patient empathy, according to Cohen-Cole (1991) are based on:

- reflection;
- legitimating;
- respect;
- support;
- partnership.

Encountering communication barriers characterize both the effectiveness and efficiency, which causes cognitive new strategy in terms of communication, in this context, characterizing the doctor-patient relationship act.

Removing these shortcomings, we report, thus to Holdevici I. (2000) to communicate effectively with the following features:

- the subject express their feelings openly and directly;

- encourages his partner to do the same,

namely, the communication partner say what he feels and thinks and tries to understand what the interlocutor thinks and feels. However, effective communication involves listening and open expression, while ineffective communication is related to parties refusing to share their feelings openly and refusal to listen to what the other has to say.

Also, the patient's social role has triggered several concepts regarding its reporting to the community through new social role acquired for a limited time or not. IB Iamandescu (1997), based on the idea that the situation of a sick man is characterized by five main features such as:

- the marginal situation of the patient between health and disease, denying one or another, rendering it unstable, dominated by conflicting situations;
- the state of distress surrounding the patient and thereby to seek protective techniques for making threading situation;
- restricting horizons (concerns ambience);
- egocentrism;
- the long time perspective of a disease.

To these boundaries, we can add the idea of temporality or not, the role of sick person, which according to Parsons (1951) are characterized on four features, namely:

- relieving normal duties and responsibilities depending on the nature and severity of the disease;
- the patient can not recover alone, by an act of his own decision, therefore, he is not held responsible for his inability;
- the disease of the patient should be considered as undesirable and must be willing "to get well", which is a conditional legitimacy of its role;
- the obligation of the patient to seek competent help and cooperate with those responsible for his healthcare.

As a quintessential to the information mentioned above, the type of the patient's role in the community depends on a number of factors such as:

- the typology of the disease;
- the severity of the diseases.
- chronicity of the disease;
- the kind of treatment: ambulatory, hospital.

Basically, according to Lupu, Zanc, Săndulescu (2004), it legitimizes the social role of the patient, his vulnerable condition and his inability while obliging him to seek healing. It may be that the patient tries to profit from its status and considers the disease as a means to escape the responsibilities that cannot or will not take. The doctor must keep this balance between the two options to help the sick and refusing it. The therapeutic relationship to help overcome addiction caused by disease and deny him attempt to "manipulation by rewards" aimed at applications that do not arise from the illness.

We believe that, the cognitive sequence ranges include category of patients who come from a certain structure such as the prison being unique and specific turning to an attitude and conduct special communication with these patients assuming professional standards of high class. We are making such information because situation related to can appear:

- spirit of observation;
- acting;
- self-control;
- tolerance;
- acceptance of the situation;
- accountability;
- quickness in decisions;

- calm;
- security,

and the list can continue, giving successful doctor-patient communication endorsement in special situations mentioned above.

Deprivation of liberty involves restricting the right of movement, freedom of expression, the exercise of rights for a period of time or by a person. The doctor has at least minimum knowledge of the evolution of language in this compartment. Language demonstrates that the world in which they operate is different, if we look at the institution as such. In fact, the philosophy is that it: "Why punish? act or perpetrator? "so our perception, those outside incarceration must be fair and just, without putting force first.

In the same philosophical view Noica said: "There are three kinds of adversity: war - sports - dialogue". In the first one must defeat the other. In the second, the ideal is not to be winners and losers. In the third both can be losers, state which demonstrates the power of words and knowledge in communication and relationship between people.

It is necessary for the doctor to know that the state of deprivation of liberty, time and space, according to Gh. Florian (2001); especially because they are perceived implications in maintaining balance of the detainee's personality and his health in all aspects. Thus, there are various behavioral disorders that require prior knowledge of the patient pathogenic personality. In direct communication, the doctor will need to demonstrate:

- professionalism;
- balance;
- seriousness;
- respect;
- self-confidence;
- attitude,

without letting himself be caught in the slippery and ambiguous game of some prisoners for which the prison if is not their first home, or a safe place where "if you had where and who's good", I mean ... backup address.

Most often the doctor will be confronted with elements of personality restructuring (frustration, aggression, risk behaviors, etc.), according to Gh. Florian (2003) all prompting an attitude that is needed to get away from the fact that even if a person is incarcerated, first of all, he is a human being, and when his health is precarious, the aid requested will be granted immediately without any reluctance or unprofessional approach, trust capital from detainees being extremely important.

The doctor will have to look into the face of the person / patient who needs its services and not to see a criminal, offense (deed) or punishment, even if in the prison "detainees do not live in prison, but staying somewhere; they stay; while the free live".

At the same time the doctor is a man in the team, together with the: psychologist, educator, priest, social worker, being involved in terms of maintaining physical and mental health of the prisoner so that reintegration into the community to become as normal as possible, removing states isolation and marginalization that are usual in this situation.

Labeling it as "paria" is attributed to the failure of a inadequate communication, because "when you do not communicate, you communicate" and in our situation is conclusive, remembering that "Hippocratic oath" applies in all circumstances, the job having no prejudices and disease, pain and suffering ... have no choice after "glory, power and wealth" instead of its existence, even when talking about deprivation of liberty.

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