Grounding Patient Care Decisions: A Discourse Analysis of Doctor-Patient Interactions in Private Clinics

VENUS PAPILOTA-DIAZ
vpapilota@gmail.com
WEST VISAYAS STATE UNIVERSITY, ILOILO CITY

GLORY FE B. SALMINGO
WEST VISAYAS STATE UNIVERSITY, ILOILO CITY

APRIL ROSE C. VALENCIANA
WEST VISAYAS STATE UNIVERSITY, ILOILO CITY

Abstract

This study draws from Grice's conversational implicatures and uses Discourse Analysis to explore interactions of doctors and patients during consultations in private clinics. It advances the claim that effective use of communication strategies facilitates common ground as participants get involved in mutual discussion of treatment options, goals, and roles in health management. Extracts from eight transcripts of the audio-recorded interactions serve as data. Results show that communicative strategies of doctors include instances of bureaucratic negotiation and casual inserts, frequent repetitions and explanations, and codeswitching while patients preferred brief answers, asking for confirmation, and giving more information than requested. These strategies promote effective doctor-patient interaction and communication—central to doctors' clinical competence and patients'health status, satisfaction and health care.

Keywords: doctor-patient interaction, patient-centeredness, communicative strategies

Introduction

According to Universal Health Care, "Every Filipino has the right to the provision of the highest possible quality of health care," (Department of Health 9). In order to meet this need, medical and healthcare professionals are expected to provide suitable treatments to patients who seek satisfactory medical attention. These treatments need to be rooted in the thoroughly-deliberated decisions regarding patient care, for decisions may affect the patients' health status.

Majority of Filipinos, specifically the low-income households, prefer to seek treatment in a government hospital if a family member needs confinement (DOH 9). Affordability is the main reason for going to a government medical facility, while excellent service is the main reason for going to a private medical facility (9). When patient needs are not satisfactorily addressed, malpractice suits are filed against the medical practitioner because the patients' right to high quality health care is not appropriately served. The Professional Regulatory Commission (cited in an explanatory note of The Senate of the Philippines) says over a hundred malpractice suits have been reported to them as early as 1993. The Center for People's Health Watch, a Cebu-based non-governmentalorganization has documented 53 cases of medical malpractice from 1992 to 1996 in Visayas alone.

With this high number of medical malpractice cases, it is an immediate concern to know and address the critical factors leading to malpractice litigation. According to Levinson, breakdown in communication between doctors and patients is one of the factors that lead to medical malpractice (1619). An estimated 70% to 80% of medical litigation involves relationship or communication problems (Lussier and Richard 37). Moreover, Beckman et al. (cited in Levinson 1365–70) also identified four problematic relationship issues in 71% of malpractice depositions: deserting the patient (32%), devaluing patient and/or family views (29%), delivering information poorly (26%), and failing to understand the patient and/or family perspective (13%). However, doctors are not the only cause of communication breakdown;

patients, too, contribute by being uninformative or untruthful and irrelevant in answering the doctor's questions (Niedziałek 94).

Exploring doctor-patient interactions in private clinics and guided by Grice's theory of conversational implicatures, this study highlights the importance of communicative strategies of both doctors and patients as they go about health matters and decisions regarding patient care. It posits that effective communication strategies can facilitate common ground as doctors and patients get involved in mutual discussion of treatment options, goals, androles in health management.

Understanding Patient Centered-Approach in Decision Making

Patient-centeredness was coined by Balint in 1969 to express the belief that each patient has to be understood as a unique human-being (Saha et al. 1275). Henbest and Stewart defines patient-centeredness in terms of doctors' responses which enable patients to express all their reasons for coming, including symptoms, thoughts, feelings, and expectations (250). These responses call for conscious use of language to communicate emotional concerns of their patients (Levinson 823). Studies have since provided explanations and descriptions of how doctors should communicate with patients.

Henbest and Stewary investigated the relationship between doctors' patient-centered behaviors and patient satisfaction (249). Results show that consultations with patient-centered scores in the highest quartile had the greatest percentage of patients highly satisfied.These findings coincide with the results obtained by Like and Zyzanski who found that when patients' requests are met, it increases their satisfaction with the medical encounter (351). Patients who are encouraged to voice their own ideas and concerns in consultations are more likely to be satisfied with their medical care than patients who are treated by more traditional doctor-directed methods.

According to The National Health Care Disparities Report 2010, the patient-centered approach improves patients' health status, lessens patients' symptom burden, encourages patients to comply with treatment regimens, and reduces the chance of misdiagnosis due to poor communication (DiMatteo 332). According to Stewart, patients perceived that they found common ground with their doctors in the decision-making process, and patients who do are with significantly less referrals and diagnostic tests (Stewart et al. 799). Finding common ground also means that the doctor adheres to a patient-centered approach in dealing with his patient. Finding common ground focuses on three key areas: defining the problem, establishing the goals of treatment and/or management, and identifying the roles assumed by the doctor and the patient. Communicative strategies according to Valero-Garces can facilitate finding common ground among doctors and patients as they define problems, establish goals of treatment and/or management, and eventually identify participant roles. Discussion of these strategies in this study is guided by Grice's conversational implicatures (implications derived from discourse based on principles and assumptions, 67). According to Grice, "to work out that a conversational implicature is present, the hearer will rely on the conventional meaning of the words, the Cooperative Principles and its maxims, contextof the utterance, background knowledge, and availability of all these to all participants (71–72).

Method

Discourse analysis (DA), as one of the discourse-analytic approaches to text and talk and popular among linguists and social scientists, recognizes that there is orderliness, logic, and meaningfulness to linguistic performance drawn from recordings of informal spoken interviews among participants in various settings (Baxter cited in Litosseliti1 24–26). It works from a social constructionist stance, which promotes variability in the interpretation of data resulting to various versions of social reality. The study employs DA since it has a clear focus on language use for various functions to construct aspects of realities of how doctor-patient interactionstake place.

Several studies on doctor-patient interactions used DA. Adegbite and Odebunmi (515–16) used DA to analyze discourse tactics of doctors and found that they predominantly initiate the interaction, elicit and confirm information, and give directives to patients. The patients give information and attempt to respond appropriately to the doctors' moves. Conversation maxims were flouted and politeness maxims were exploited in order to enhance successful diagnosis in the interaction. Haiyan (2011) also used DA to pragmatic functions of hedges and found that doctors in major hospitals in China used hedges to achieve politeness, increase credibility, and enhance self-protection.

This study aims to contribute to literature by highlighting the importance of communicative strategies in facilitating decision making on patient treatment and care using DA to analyze data from the eight (8) transcripts of the audio-recorded patient-doctor interactions during the medical consultations. As regards methodology, informed consent was a primary concern of the study. It followed the principles of volunteerism, confidentiality, anonymity, and justice. When participants agreed to the terms, audio recording and transcribing of interactions transpired. Extracts from the transcripts were classified according to the communicative strategies of Borrelli Carrio (cited in Valero-Garcés 469–95), and analyzed in the framework of Grice's conversational implicatures.

Summary and Findings

Communicative Strategies in Achieving Patient-Centered Decision Making

Results show that when doctors and patients define health problems, set goals of treatment, and assume roles during consultations, communicative strategies are employed. In this discussion of results, five communicative strategies of doctors and three of patients are presented here as means to achieving patient-centered decision making.

Higher percentage of bureaucratic negotiation. In a bureaucratic country like the Philippines, the patients develop abilities to make appointments and to obtain the appropriate services from one office to another in an efficient way through the attending doctors' help (Valero-Garcés 473–74).

Extract 1

Doctor:	Maliban ... Tiwaay man na infection so indikokahatag antibiotics. So i-evaluate ta anay kung anonasyadason may additional konga laboratories ipakwa. Amonaangmedyomahal-mahalpero ...
Patient:	Mga pila doc?
Doctor:	Indi nasya emergency ah. You can have it taken next year, January, kag dal-on modiri.
Patient:	Hmm. Mga pila doc angamona?
Doctor:	Uhh, angsabulongngaginapa-ano ... ah, bulong ... sa laboratory ngaisamalibansa ultrasound dawmgaP1,500 nasya.
Patient:	Aranaangtanan?
Doctor:	Wala pa. Angsadugolangna. Sa ultrasound mo is lain pa gid.
Patient:	Ahh.
Doctor:	Dirinanga price ha? Sa public hospital. Pero kung outside kamagpakwa OK lang man saakon, walagidproblema.
Patient:	Kung sin-o langang less eh ah.
Doctor:	Dependesaimo ah. Oo.
Patient:	Huo.

1. Doctor: Besides ... There's no infection so I cannot prescribe antibiotics. So we will do the evaluation to know what that is, then I'll request for additional laboratories. It costs more though.
2. Patient: How much, doc?
3. Doctor: This is not emergency (urgent). You can have it taken next year, January, and bring me the results.
4. Patient: Hmm. How much is that one, doc?
5. Doctor: Uhh, the medicine that is ... ah, medicine... for the laboratory aside from the ultrasound, that costs around P1,500.

6. Patient: Is everything included?
7. Doctor: No. That is only for the blood test. There is a separate one for your ultrasound.
8. Patient: Ahh.
9. Doctor: That's the price here huh? In a public hospital. I won't mind if you'll have it taken outside (the hospital).
10. Patient: Whichever costs less, then.
11. Doctor: It's up to you. Yes.
12. Patient: Yes. (DPI4:117-128)

When doctors help patients solve bureaucratic tasks, the doctors use sequences of bureaucratic negotiation as in Extract 1 when an ENT doctor discusses with the patien t(suspected to have goiter) relevant information about where the latter can get an ultrasound, what other laboratory tests are needed, which tests comes first andthe costs. The doctor needs to have the results evaluated so she could give appropriate diagnosis and treatment plan for the patient.

In utterance 3 (U3), the doctor flouts the maxim of relevance because she did not answer the patient's inquiry about the cost of the laboratory tests the first time she was asked. According to Niedzialek (2001), for patients to become well-informed consumers, they need to actively seek out relevant information from their doctors. The doctor informs the patient that some of the tests can be done later but the patient, not getting the exact information that she needs, asks again how much the test costs (U4), implying how much the amount concerns her. The doctor recognizes this, finally giving the patient a more definite answer in utterance 5. The patient answers "ahh", expressing satisfaction. In the subsequent exchanges, the doctor flouts the maxim of quantity by being overinformative. As the primary source of reliable information about the services offered by the hospital, doctors are expected to be as informative as possible even though patients do not ask for explanations

directly because this negotiation is more favorable to the patient. By flouting the maxim of quantity during bureaucratic negotiation, common ground was achieved, and confirmed by the patient assenting to all suggestions.

Casual inserts. A casual insert according to Frankel (cited in Valero-Garcés 473), is a strategy to distract the patient's attention while the doctor performs a technical action during the physical exam; such strategy performs social functions (Diaz cited in Valero-Garcés 473).

Extract 2

Doctor:	Diinka nag-graduate ya?
Patient:	Naka (school)ko, Nursing Doc, pero nag graduate kosa Mindanao gid.
Doctor:	Ah, tuod?
Patient:	Cruise Ship.
Doctor:	Ah … tihuo, huo. Tidiinkanaga practice subong?
Patient:	Ga Med Rep ko Doc (laughs).
Doctor:	Ah OK …

1. Doctor: Where did you graduate?
2. Patient: I went to(school)), Nursing Doc, but I really graduated in Mindanao.
3. Doctor: Ah, really?
4. Patient: Cruise Ship.
5. Doctor: Ah … Yes, yes. So where do you practice now?
6. Patient: I'm a Med Rep Doc (laughs).
7. Doctor: Ah OK … **(DPI2:5-11)**

In extract 2, the ENT doctor casually inserts a non-medical-related question directed to the patient while he is doing the physical examination and writing on the medical chart. Díaz (cited in Valero-Garcés 473) said that the content of casual inserts is neither incidental nor irrelevant for the doctor-patient talk-

in-interaction. Here, the casual insert strategy performs some social function such as to build rapport and to keep the patient engaged when the doctor is doing something else. Asking about personal information (school graduated from) allows a window for the patient to talk freely, flouting quantity, because the conversation led by the doctor is turned casual.

Frequent repetitions. Doctors use repetitions to make patients remember important information during the interactions: how to take the prescribed medication, what to do next after the consultation, what tests are further required, and where they can be availed.

Extract 3

Doctor:	Tan-awonkoanayimongatutunlanha? Angimoliog. Huo.
Patient:	Aw ah.
Doctor:	Tutunlanmokaronlantawonkoman.Waayka man gakadunlanmagkaun?
Patient:	Dawwala man.

1. Doctor: We will check your throat first ha? Your neck. Yes.
2. Patient: Aw ah.
3. Doctor: I will check your throat, too. Do you choke when you eat?
4. Patient: I don't think so.(DPI1:29-32)

In this extract, the ENT doctor conducts a physical examination to his patient who recently had a throat operation. The doctor intends to check the throat, and the patient points his finger to his neck perhaps to signify that the status of his throat is not ready for prognosis. However, the doctor asserts that his throat needs to be checked by repeating "will check your throat," but this time using "I" replacing the inclusive "We" to display his authority and adding subtleness with the use of "too". Understanding the doctor's authority, the patient gives in by answering subsequent questions well and realizing that he needs honest patient-care.

Frequent explanations. This strategy makes the patients understand their current medical problem.

Extract 4

Doctor:	Ti avoid mogidna. High in fiber, avoid mo man. High in fiber, naga ... budlayankamagtunawsinamo so you need to secrete damonga acid satiyan para tunawunmona.
Patient:	Huo.
Doctor:	Mgaanobala, vegetables ngagrabegidang fibers yanabala.
Patient:	Mgakamotenga ran huh?
Doctor:	Hhhmmm ... Kinahanglanmonai-digest gid no. So anganotanisubong is, assessment ta saimo is ang AR. Kung matulog, angulo is taassatiyan kay ang tendency kung flat kagidgatulog, ahhmm, imonga gastric acid nagabalikdirisa throat so ma soak ang acid dirisa throat. Soma elevate monis'ya, so isaka manifestation, kaisasapasyente is amonapagpalanghugot ...

1. Doctor: You must avoid that. High in fiber, avoid too. High in fiber, makes ... you will have a hard time digesting so you need to secrete enough acid in the stomach to digest that.
2. Patient: Yes.
3. Doctor: Those vegetables rich in fiber.
4. Patient: Just like sweet potato?
5. Doctor: Hhhmm. You need to really digest that. So supposedly right now, our assessment is AR (Acid reflux). When you sleep, your head should be higher than your stomach because when you lie flat, the tendency is ahmmyour gastric acid creeps up into the throat so acid will soak in the throat. So you can elevate. So one manifestation, sometimes in a patient is tightness.(DPI3-TARC3:127-131)

In extract 4, the ENT doctor discusses with her patient some of the triggers of gastroesophageal reflux disease. Frequent explanations strategy helps the patient understand her condition better and retain important information such as prescription instructions. In line 5, the doctor flouts the maxim of quantity in order to explain drawbacks of wrong sleeping positions and suggests better and more helpful ways.

Preference for brief answers. Patients, on the other hand, prefer brief and straightforward answers to agree with the doctors in a satisfactory way. This allows doctors to take much of the talk time to explain or elaborate patient-care matters.

Extract 8

Doctor:	Huo, huo. So ini may anti-fungal kag may antibiotic man s'ya. Four drops, three times a day gid.
Patient:	OK.
Doctor:	Kaya mo man guro mag three times ah.
Patient:	OK.

1. Doctor: Yes, yes. So this has anti-fungal and antibiotic (properties). Four drops, three times a day.
2. Patient: OK.
3. Doctor: I'm sure you can do it three times.
4. Patient: OK. (DPI2-TARC2: 75-78)

Code-switching. Code-switching is a process of shifting from one linguistic code (a language or dialect) to another, depending on the social context or conversational setting (Holmes 35). In the extracts that follow, lexical code-switching serves as communication strategy of doctors when English verbs were put before or next to common Hiligaynon inflections that express futurity. Aside from the doctor's immense use of accessible medical terms—assessment, tendency, gastric acid, throat, and manifestation in a stretch of a sentence, samples of inflections in code-switching are the use of i- or ipa-, ma-, ka-, and pa-+-un with English verbs – digest, elevate, soak, start, and gurgle.

Extract 5

Doctor:	HhhmmmKinahanglanmonai-digest gid no. So anganotanisubong is, assessment ta saimo is ang PR. Kung matulog, angulo is taassatiyan kay ang tendency kung flat kagidgatulog, ahhmm, imonga gastric acid nagabalikdirisa throat so ma-soak ang acid dirisa throat. So ma-elevate

monis'ya, so isaka manifestation, isa, sapasyente is amonapagpalanghugot ...

1. Doctor: Hhhmm. You have to really digest it. So now our, assessment about you is the PR. When you sleep, the head is higher than the stomach because the tendency is if you sleep flat, ahhmm, your gastric acid will flow to your throat so the acid will be soaked in your throat. So if you elevate this, so one manifestation, first, in patients is the tightening (DPI3:131-132)

Previous research on code-switching has confirmed that code- switching is common in multilingual contexts just as when the doctor uses affixations, particularly prefixes such as i- in i-digest and ma- in ma-elevate. Most of the verbs when used to express futurity in Hiligaynon start in i- as in ipakita (to show), i-palapnag (to spread) and ma- as in makadto (to go), makaon (to eat). Another way of code-switching that expresses futurity and coverting a noun Multivet (a brand of a multivitamin) to a verb by affixing i- is in the term i-Multivet during the doctor's interaction with a mother as patient.

Extract 6

Doctor: So bali ... (clears throat) I-Multivet ta langsyaanaynga inhalation, 8 hours for three doses lang.

1. Doctor: So ... (clears throat) We will give her Multivet inhalation, every 8 hours for only three doses. (DPI6:67-70)

In a specific instance, the doctor uses circumfix in the case of the verb "gargle" when code-switched with Hiligaynon affixes pa- and -un, as in pa-gargle-un to mean "to hold a liquid in the mouth or throat and agitate with air from the lungs," (https://www.merriam-webster.com).

Extract 7

Doctor: Tapos after the chocolate syempreindi ta gidna ma ano, makaungidnasila. Paimnunmogidtubig or pa gargle-lun kay basiangdasun ta bala ma tonsillitis.

1. Doctor: After the chocolate we cannot really make sure, they will really eat. Make her drink water or gargle because maybe our next problem would be tonsillitis. (DPI8:117-118)

This mixing of Hiligaynon prefixes with English terms in this doctor-patient interaction shows that code switching is an "everyday" phenomenon in multilingual societies (Appel and Muysken 213). The doctors draw from the notion that patients need to be given directions—what to do with medications and how to manage the self to avoid further health threats. Directions or instructions for doing something bears aspects of futurity as the doctors attempt to get patients to carry out an action after the consultations. In doctor-patient interactions, even simple and often taken for granted things such as eye contact can have a big impact on healthcare system (White, 2013); code-switching can also have a fundamental influence on health care delivery.

Giving more information than requested. This strategy is the patients' way of offering expressions of emotion and distress and to save the doctors' effort in asking questions that elicit information about the nature of the problem presented.

Extract 9

Doctor:	Waayka man hilanat?
Patient:	*Waay man. Masakitsasuloddaw may gamaylangnga pain bala haw.*
Doctor:	Makatol? Medyo?
Patient:	*Huo. Kis-a makatolsaginaanoko … Pero matyaganko, may tubig or dawano man …*

1. Doctor: Don't you have a fever?
2. Patient: *No, I don't have. It hurts inside like there is a bit of pain.*
3. Doctor: Is it itchy? A little bit?
4. Patient: Yes. Sometimes if it is itchy I … But I think, there is fluid or I don't know … (DPI2-TARC2: 37-40)

Extract 9, a conversation between an ENT doctor and a male patient who experiences symptoms of ear infection, reveals how a patient flouts the maxim of quantity by giving information more than required. The doctor uses yes-no questions in the event that the patient may just be clipped about his answers; however, the patient extends his responses primarily because he wants the doctor to know possible symptoms of an impending infection such as having fluids in his ears.Yet, the patient expresses his doubt about the symptom by saying, "I don't know," and leaves the diagnosis to the expert—the doctor. Most doctors prefer patients who are vocal about symptoms or feelings associated to pain because it is through communicating these can the doctor suggest treatment or management.

Asking for confirmation. To make sure that they take in, understand and remember all the important information explained by the doctor, patients ask for confirmation.

Extract 10

Doctor:	Taposindipag pa-anadonsalutgot.
Mother:	*Tianona Doc man?*
Doctor:	Every time ngaibutang …
Mother:	*Kwaonnalang?*
Doctor:	Ipa-anadonngahukson. Kay actually anomalangnanilamo, pattern nanila. So kadabutangkwaongid kay eventually mabitbitnila mag dalagkosilabala.

1. Doctor: Then do not let (him) get accustomed with thumb sucking.
2. Patient's Mother: *So what will that be Doc?*
3. Doctor: Every time (he) puts (his thumb) …
4. Patient's Mother: *I have to get it?*
5. Doctor: Let (him) get accustomed to taking it. Actually, they are usual pattern (of behavior). So every time (he) puts it in,(you) have to take it (the thumb) out because if you will not do this, eventually, they (children) carry it on until they are older. (DPI7-TARC7: 98-102)

In this last extract, the mother of a six-month old baby does not pre-empt or complete the utterance of the pediatric doctor to show that she knows better; instead, she asks for confirmation whether her knowledge of a simple strategy—that is taking off the thumb from the mouth of her child, is the right approach to stop the thumb sucking of her child. The doctor confirms this to be the right approach and elaborates why thumb sucking is not a good behavior for children. Patient-centeredness transpires in this interaction because both the mother and the doctor agree on what is best for the baby.

Summary of Findings

The study confirms the findings of Adegbite and Odebunmi (2006) on the role of the doctor as predominantly initiator of the interaction, and that doctors elicit information and patients respond appropriately. Mostly, doctors give directives to patients because they also take the role of an expert. Communicative strategies employed by doctors and patients during medical consultation are considered to be patient-centered especially when they tackle treatment or management of illness, that they even flout maxims in order to express patient-centeredness.

This study emphasizes the crucial role that language and communication play in medical consultations. It is vital that doctors learn how to use language and employ appropriate communicative strategies to be able to provide quality healthcare services to patients. Traditionally, in doctor-patient interactions, paternalistic approach is used—the doctor is usually the one who makes the final decision about what to do with the patient's medical condition. This study, on the other hand, posits that doctors use patient-centered communicative strategies during medical consultations to achieve better and more positive patient outcomes. This patient-centered approach expects doctors to involve patients in grounding patient care decisions, allowing them to participate in establishing the treatment plan and respecting the patients' preferences regarding their own care. The communicative strategies described in this study may be helpful to doctors and other medical practitioners in managing medical

consultations and other medical encounters in such a way that breakdown in communication may be avoided and malpractice cases be prevented.

Works Cited

Adegbite, Wale andAkinOdebunmi. "Discourse Tact in Doctor-Patient Interactions in English: An Analysis of Diagnosis in Medical Communication in Nigeria."*Nordic Journal of African Studies*, *15*(4), 499–519. http://www.njas.helsinki.fi/pdf.

Appel, Rene and Pieter Muysken.*Language Contact and Bilingualism*. London and Baltimore,MD: Edward Arnold. 1987. doi.org/10.1017/S0047404500014573. https://www.cambridge.org/core/journals/language-in-society/article/bilingualism.

Baxter, Judith. "Discourse-analytic Approaches to Text and Talk" in Litosseliti, Lia. Research Methods in Linguistics. London:Continuum. 2010, pp 117–137.

Beckman, Howard B., et al. "The Doctor-Patient Relationship and Malpractice: Lessons from Plaintiff Depositions." *Archives of Internal Medicine*, vol. 154, no. 12, pp. 1365–70. www.ncbi.nlm.nih.gov/pubmed/8002688.

DiMatteo, M. Robin. "The Role of the Physician in the Emerging Health Care Environment." *West J Med*, vol. 168, no. 5, 1988, pp. 328–33.www.ncbi.nlm.nih.gov/pmc/articles/PMC1304975/?page=5.

Grice, Paul Herbert. "Logic and Conversation." In Jaworski, Adam and Nikolas Coupland. *The Discourse Reader.* Routledge, 2006, pp. 67–22.

Haiyan, Zhoa. "The Pragmatic Functions of Hedges by Doctors in Doctor-Patient conversations. Retrieved from http://www.dissertationtopic.net/doc/433759.

Henbest, Ronald J., and Moira A. Stewart. "Patient-centeredness in the Consultation. 1: A Method for Measurement." *Family Practice*, vol. 6, no.4, Dec. 1989, pp. 249–54. www.pingpong.ki.se/public/pp/public_courses/course05589

Holmes, Janet. *An Introduction to Sociolinguistics*. 3rd Ed. Longman, 2008.

Levinson, Wendy. "Patient-centred Communication: a Sophisticated Procedure." *BMJ QualSaf*, vol. 11, no. 20, 2011, pp. 823–25. www.qualitysafety.bmj.com/20/10/823.extract

Levinson, Wendy. "Physician–Patient Communication: A Key to Malpractice Prevention." *Journal of the American Medical Association*, vol. 272, 1994, pp. 1619–20. jamanetwork.com/journals/jama/article-abstract/383201

Like, Robert, and Stephen J. Zyzanski. "Patient Satisfaction with the Clinical Encounter: Social Psychological Determinants." *Soc. Sci. Med*., vol. 24, no. 4, 1987, pp. 351–57. doi:10.1016/0277-9536(87)90153-5.

Lussier, Marie-Thérèse, and Claude Richard. "Complaints and Legal Actions: Role of Doctor-Patient Communication." *Canadian Family Physician*, vol. 51, no.1, 2005, pp. 37–39. www.ncbi.nlm.nih.gov/pmc/articles/PMC1479583/pdf/jCFP_v051_pg37.pdf.

"National Objectives for Health 2011-2016." *Department of Health*, 8 Dec. 2015, p. 9. www.doh.gov.ph/sites/default/files/publications/noh2016.pdf.

Niedzialek, Marta P. "A Pragmatic Approach to Doctor-Patient Communication: A Contrastive View." 2001, pp. 85-96. www.ur.edu.pl/file/1213/sar_v2_09.pdf.

Ong, Lucille M., et al. "Doctor-Patient Communication: A Review of the Literature." *Soc. Sci. Med*., vol. 40, no. 7, 1995, pp. 903–918. www.dissertationtopic.net/doc/433759.

Roter, Debra L., et al. "Patient-physician Communication: A Descriptive Summary of the Literature." *Patient Education and Counseling*, vol. 12, no. 2, 1988, pp. 99–119. doi:10.1016/0738-3991(88)90057-2.

Saha, Somnath, et al. "Patient centeredness, Cultural Competence and Healthcare Quality." *J Natl Med Assoc*., vol. 100, no. 11, 2008, pp. 1275–85.

Stewart, Moira A. "What is a Successful doctor-patient interview? A Study of Interactions and Outcomes [Abstract]. *Soc. Sci. Med*., vol. 19, no. 2, 1984. doi: 10.1016/0277-9536(84)90284-3.

"Senate Series No. 588." *Senate of the Philippines*, www.senate.gov.ph/listdata/17431133!.pdf. Accessed 8 Dec. 2015.

Stewart, Moira A., et al. "The Impact of Patient-Centered Care on Outcomes." *The Journal of Family Practice*, vol. 49, no. 9, Sept. 2000, pp. 796–804. www.ncbi.nlm.nih.gov/pubmed/11032203.

"UHC to Address Inequity in the Health System." *Department of Health*, www.doh.gov.ph/universal-health-care. Accessed 8 Dec. 2015.

Valero-Garces, Carmen. "Interaction and Conversational Constrictions in the Relationships between Suppliers of Services and Immigrant Users." *Pragmatics*, vol. 12, no. 4, 2002, pp. 469–495. doi:10.1075/prag.12.4.04val.