QUALITY OF TREATMENT RELATIONSHIPS BETWEEN PHYSICIANS AND PATIENTS (CASE STUDY: POLYCLINIC OF GENERAL HOSPITAL AND PRIVATE CLINIC)

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Abstract: The studies and researches applied on the social medicine Mostly considered the role and position of organizational and macro elements in the treatment system: in return ,the relationship between physician and patient as a cultural issue has been focused lower. Due to lack of interaction between physician and patient, the treatment process has got into trouble in Iran . In this paper, in addition to Identification of physician and patients presence ,we intend to explain the pattern enforcing on the diagnosis and treatment flow in Iran by comparing two different environments of polyclinic and private clinic. The main question of this study is to investigate the quality of communication system between physician and patient : if the relationship between physician and patient is unilateral or interactive and continuous? The significance of interactive communication System is in patients collaboration in disease diagnosis and treatment process.

In this study , firstly by means of participant observation method , 60 samples of patients visit by physician and their conversation in the hospital and private clinic have been recorded and categorized in order to provide the requirements for conceptual analysis of findings. To analyze the data, considering the basic assumptions , Habermas communicative action theory and two main concepts of life world and system were used which have been declined to patient s life world and system (medical explanation) in the medical context.
The summary of this field study shows that the enforcement of biomedical and biologic view to the patient is yet continuing among the physician. This type of viewpoint affects the communication between physicians and patients and quality of conversation and counseling and even the diagnosis and treatment , and physicians single-dimensional and merely biological view to the patients leads to inefficiency of medical consultations.

Keywords: Communication patterns, relationship between physician and patient, life world, Medical Explanation, polyclinic, private clinic.

Introduction

Today, the health is deemed as an important topic in all societies and every year enormous costs are spent for prevention and treatment of patients in all countries. Considering the importance of health, increasing technology growth also has led to the extensive and comprehensive growth of health and treatment system in all societies. This increasing growth caused the expansion of health protection and supervision network of society individuals from the most central to the furthest spots and facilitated the society individuals' accessing to this widespread treatment system. On the other hand, the health orientation caused some of state budget to be spent for training the specialist physicians and production of drug, as well as purchasing and equipping the hospitals and health centers.

Despite the physician along with other elements of health and treatment organization is assumed as a partial part of great treatment system, but yet it is the most important one and has the pivotal role in the meanwhile, particularly for the patient that is in direct and immediate relationship with the physician and assumes it as the holder of technology and specialty in identification of disease and its treatment. Due to high expenses spent for training the physician and its central role in the health and treatment system, the quality of relationship and what happens in the consultations

and visits between physician and patient, and the physicians awareness of the quality of establishing a correct relationship with the patient and the effect of this treatment behavior on the formation trend of a correct and appropriate image of physician in the patient's mind and interesting in treatment continuation is important in the medical and health system and society. Consequently, this important and substantial relationship conceptually and theoretically as well as organizationally has been neglected in the health and treatment system and is ambiguous in the referrals of patients to the physicians.

Definition of problem

Whatever the medical system becomes more pivotal over time and upon development of technology and promotion of medical knowledge, the relationships between physician and patient become more sensitive. We believe that in the relationship between physician and patient, more than drug, the quality of physician's behavior and perception (of mental conditions and social and familial problems that is expressed as the physical illness) is effective on the diseases and its treatment. As Balin believes that "the disease is a biological phenomenon and to the same extent is a mental phenomenon and this perspective includes various implicit consequences for the role of general practitioner. The responsibility of practitioner is not to cure the biological disease but "organizing the unorganized disease", and its use has not the most effect on the patient's status but the human relations. Also, Balin states that "the drug means the physician has not been researched adequately: No one knows about the "doze" of physician to be given to the patient, and its addictive effects and side effects are unknown (Armstrong, Tavakol, 2008, 198). This subject has been assumed as an important scientific and experimental (in the context of diagnosis and treatment) issue and is raised as this question: "has been the treatment system-between physician and patient organized based on a specific communication system or not? If yes, is this communication system unilateral or interactional?" The question is propounded in experimental and health and treatment context in another form: "Does the mentioned communication system affect the results of diagnosis, treatment and improvement of patients?". To detect the mentioned communication system, it is necessary to apply an empirical research based on participant observation method. In this method, we intend to understand experimentally how is the relationship between physician and patient in physician room (private clinic or polyclinic)? Why the human relation instead of forming based on the mutual understanding of patient and its problems is formed based on a nominal relationship referred to a specific goal means examination, prescription, medication or referring to other physician and treatment centers? How the patients explain the pain and illness? Do they merely explain the disease symptoms or explain the effects of disease on their familial and social relationships as well?".

Theoretical framework

No consensus has been reached on the treatment mechanism. Some individuals assume it as a mechanical and technical mechanism therein the physician and technical medical system is the main principle, in return some others in addition to signifying the role of physician and technical medical system, emphasize on the major share and effectiveness of relationship between physician and patient. Focus on the pivotal relationship between physician and patient caused some experts such as Howard Becker to claim that the student in medicine learns more about the interaction with the patient and feeling responsibility thereto than study on the disease and its processes in vitro. Comparative continuation of such effectiveness and experience in the medical faculties and medical area leads to "non-personalization" of physician and growth of physician's "impersonal" moods to the patients, more than ever. Medical professors as the model have an important role in appearing such personality in student in medicine. Immersing in medical knowledge and technique particularly the patient's visit and treatment in an nonflexible and merely biophysical framework in the medical education may take this risk that the physician observes the patient only as an object and a merely material and consequently in his relationships with the patient behave indifferently and inattentively to the human and social factors. The true basis for the patients' particularly the uneducated and poor patients' perceptions and imaginations of the physicians' encounter to themselves should be explored at the same point.

Doubtless, the selection and training manner of students in medicine is effective on the results and consequences of this system; means the physicians and their characteristics and specifications. If the students in medicine are selected only among individuals who either only have scientific curiosity about the body and disease or only the material and credit motivations, and in both cases not the humanitarian motivations and attentions, then it is natural to have physicians who don't consider providing the health services to the people personally or use it just as a tool for achieving their goals including science or other materials. Various studies applied in the different advanced or underdeveloped countries demonstrate this bitter reality. Some medical criticizers commonly claim that the medical faculties are merely the "experience" schools that only train the human body technician and mechanic. Our medical

field study in the Iranian medical faculties implied that the expectation of a student in medicine from medicine as his future job and profession is to provide his high level welfare demands but never welcomed or even passed the "human resources plan" in the deprived state zones (Armstrong, Tavakol, 2008, 319).

By focusing on the role and position of relationship between physician and patient, we used the conceptual and theoretical perspective of Habermas under title of "communicative action theory". Mishler could diminish the communicative action theory of Habermas to the medical and therapeutic relationships and explain the existing relationships between physicians and patients. Communicative action theory of Habermas has several central concepts. The action is assumed as the most pivotal concept in this paper which is divided in two types as follows: Strategic action and communicative action; the first type includes the purposeful-rational action, whilst the second type that purpose of which is to achieve a perception is communicative action; in the following interpretations, communicative action is non-instrumental: an agreement reached communicatively has a rational basis, none of parties may impose it whether instrumentally or through direct invention in situation or strategically and through affecting the decisions of disagreed people (Ian Cripe, 2009).

The second element of this theory is differentiation between system and life world. His theory has been formed based on the moral attitude and warns about the risk of system's irregular growth and life world's surrounding by which. The life world has been situated in the value-oriented rationality and includes the person's experiences of the routine life events. This is the same referred to as normal behavior by Shatz. In the above context, the performances forward to the mutual understanding and are assessed as the moral criteria. On the other hand, the purpose-oriented rationality acts in the scientific contexts through specialized and technical methods therein the nonflexible and abstract regulations cause eliminating and ignoring the underlying issues and problems. In such state, the activity is advanced towards success achievement and the summary is evaluated by a technical factor instead of moral factors. The purpose-oriented rationality is performed by means of specific strategies. In this event, the conversation has instrumental nature and the speaker forwards to success achievement and for this purpose uses the dexterity and trick and even the falsified communications.

The third theory element is duality between system and life world. Habermans believes that in this process the system or in other word scientific specialized consciousness colonizes the life world and called this system systemic rationalization. To return to the balance and prevention of systemic rationalization progress (which is appeared in the falsified communications environment) an appropriate verbal interaction shall be established in order to realize the communicative rationality. The necessity of this process is going through mutual understanding (and not only with the purpose of achieving the individual success) which is possible through regulating the goals and talking about the individual situations without force.

Communicative action theory of Habermas due to its frequency has been used for perception of modern world and particularly in the psychiatrics and medicine. Jorge Olivet Mishler is a psychiatrist who uses the Habermas concepts in the medical world. In the medical the system is technologic medical system that strategic action is used towards its dominance and superiority. This strategic action has been falsified by powerful use of medical expression as the communicative patterns with the purpose of controlling the patient and reaching the respective final point means success-oriented action.

The extant paper is follows by basic referring to the communicative action theory of Habermas and its use by Mishler in the medical context. Mishler has interpreted the system and life world dual system in the medical context as medical explanation and life world explanation. He believes that the adaption between these two explanations provides the requirements for disease diagnosis and treatment. On the other side, conflict and non-adaption between these explanations is the origin of various challenges in the treatment context.

Relationship between Habermas and Mishler

Mishler in "Discourse of Medicine: Dialectics of Medical Interviews" relying on the communicative action theory of Habermas indicated that how the challenge between medicine and life world explanation may suppress the establishment of balanced communication for mutual understanding and active participation of patient in the conversations between physician and patient. Life world explanation is referred to the personal experience of life events and problems including the description and reports of routine life with a normal perspective and encounter. The events occurrence time is dependent to the individual's history and situation, whist medical explanation reflects the technical encounter and explains a scientific confronting. In this approach, the events are considered under abstract rules and are separated from their personal and social bed. As Habermas, the life world is a source, context, prerequisite and network that is obtained from separate interpretation of action participants. The life world is the

arena of free and equal conversation (gofteman) and basis of the worldview that as a collection of accepted concepts and duties leads and integrates the routine acts and relations of action participants.

Mishler for perception of communicative patterns between physicians and their patients in the hospitals and private clinics used the communicative action theory of Habermas for writing his dissertation "Discourse of Medicine: Dialectics of Medical Interviews" within mid-1970s in USA. He benefits from Habermas theories concerning the life world colonization by system and applies it for investigation of medical system, because he believes that in this process, system or in other word the specialized scientific consciousness colonizes the life world and calls this process as systemic rationalization. To return to the balance and prevention of systemic rationalization progress (which is appeared in the falsified communications environment) an appropriate verbal interaction shall be established in order to realize the communicative rationality. The necessity of this process is going through mutual understanding (and not only with the purpose of achieving the individual success) which is possible through regulating the goals and talking about the individual situations without force.

As Habermas, the life world is a source, context, prerequisite and network that is obtained from separate interpretation of a collection of accepted concepts and duties leads and integrates the routine acts and relations of action participants and provides the reasoning and discussions of actors. The action is a mean for achieving a goal and is a communication for reaching the communicative understanding. The purpose of both actions is dominating over the instrument. As Marx, the job is the most clear and comprehensive social phenomenon whilst Habermas assumes the "communicative action" as the most obvious human phenomenon and the ultimate point of evolution process of a rational society.

Social actions types:

Social action includes two types as follows:

1- Rational and purposeful action
2- Communicative action

Rational and purposeful action is divided in two types:

1- Direct actions
2- Strategic actions

Habermas focuses on communicative action and this type of communication is the basis for all his theories that is a non-falsified and forceless communication. In the communicative action, the action of involved individuals is consisted not through selfish ordination but through understanding actions. The individuals involved in communicative action are not seeking for their personal success but follow their goal in the conditions that can adapt their plans based on the definitions of common situation and in connection with the others.

Mishler uses the theories of Habermas concerning the life world's colonization by the system and benefits from his theory for investigation of medical system, because he believes that in this process, the system or in other word scientific specialized consciousness colonizes the life world and calls this system systemic rationalization. To return to the balance and prevention of systemic rationalization progress (which is appeared in the falsified communications environment) an appropriate verbal interaction shall be established in order to realize the communicative rationality. The necessity of this process is going through mutual understanding (and not only with the purpose of achieving the individual success) which is possible through regulating the goals and talking about the individual situations without force.

Life world explanation is referred to the personal experience of life events and problems including the description and reports of routine life with a normal perspective and encounter. The events occurrence time and importance is dependent to the individual's history and situation, whist medical explanation reflects the technical encounter and explains a scientific confronting. In this approach, the events are considered under abstract rules and are separated from their personal and social bed. Olivet Mishler for perception of communicative patterns between physicians and their patients in the hospitals and private clinics used the communicative action theory of Habermas for writing his dissertation "Discourse of Medicine: Dialectics of Medical Interviews" within mid-1970s in USA.

System System rationality	Life world
Value-oriented rationality - Routine events - Normal behaviors - Experienced	Purpose-oriented rationality - Technical instrument - Scientific encounters - Nonflexible and abstract regulations - Removal of experience
Communicative action Moral factors evaluate the result of work. (action referred to the mutual understanding)	Rational and purpose-oriented action Technical factors evaluate the result of work. (action referred to the success)
Balanced communication Ideal verbal interaction Achieving the mutual understanding without force	Falsified communication Strategic and falsified Along with dexterity and trick

Figure 1: Communicative action theory of Habermas

When the medical explanation is used in a mere scientific text may seem to be non-falsified but the science-based medicine in connection with the patients acts based on the hidden defaults that falsify the life world such as medicalizing the routine problems (Illich, 1976) or accepting the mind-body duality (Sampson, 1999) or the application of medical profession's power for dominating and controlling the communications.
Busbi (1999) explains that most of patients that are disappointed to the western treatment methods have tested the alternative methods such as chikong and acupuncture. These people recommend the treatment methods which are more compatible to their perception of their bodies and are closer to their life world. It shows that they have probably felt the said disorder.

The disordered and falsified pattern of medical explanation is adapted to the more normal and non-falsified pattern of life world. In medical explanation, the physicians control the conditions unequally. Consequently, a significant and proportional encounter is suppressed in the patient. Ultimately, these two completely different explanations have been challenged and cause the disruption of relationship. This challenge is sometimes invisible.
Mishler didn't mention one of strength points of Habermas theory; the said challenge is not necessarily the indicator of physician's moral inattention. Mishler theory helps the physicians to act honestly and meet the patient's needs, but still like as the most researches applied on the patients' satisfaction, the communications may be falsified systemically without parties' awareness.

Mishler claims that if the physicians can establish more appropriate verbal interactions, the obtained results will be more effective and moral. The actions he explained for aiming the said goal include listening to the patient, asking the descriptive questions, translating the scientific language to the life world language and speaking with balancing power. Mishler obtained these results from 25 cases of physician-patient relationship in 1984. These cases included the consultations in the hospital or private clinics in USA which had been collected by Harvard Vizkin et al within mid-1970s (ibid, 6).

In this research, Mishler achieved a stereotypic model and called it low-value conversation that in the event of absolute use of medical explanation, a united behavioral stereotype is repeated during the interview. This frame includes as follows:

1- Propounding a question by the physician
2- An answer by the patient
3- An evaluation after receiving the answer, sometimes implicitly) that is followed by another question
4- And probably another question for clearing the patient's answer.

System	*Habermas*	*Life world*
Medical explanation	*Mishler*	*Life world explanation*

Non-adaption causes the challenge in consultation and conversation's disorder and disruption

Mishler deems the low-value conversation between physician and patient as ineffective, because medical explanation is signified in a biomedical pattern completely (Mishler, 1981). This pattern than reflects the instrumental scientific structure of biological sciences takes away the social ground of events that may lead to the complete and appropriate understanding of patient and his problems, whilst effectiveness of medication requires such an understanding (Mishler, 1984, 192). Whereas Mishler has been a psychiatric, hence is deemed automatically as an experienced physician. He as a psychiatric tends mostly to emphasize on the mental aspects of medicine and need to encounter the patient as a collection and a whole. Although he as a physician don't ignore the modern medical benefits such as pain reduction by sedatives or mortality in children or reduction of epidemics, but by accepting these benefits as the initial achievements of medicine seems to focus on the improvement of medical status to the status quo. In fact, it is questioned if negligence of life world causes lower benefit medicine so that cannot meet the needs of the patient as a unique man. The witnesses prove that the patients' own suppose the ignorance of life world as a threat against their individual personality.

Straus et al believe that the medical explanation due to its specific organization is prioritized to the issues such as patient identity, biography, behavioral patterns and personal sensations (Straus et al, 1982). The medical explanation is a mean for acquiring the diagnosis, thus no case of treatment conversations may be found that therein medical explanation is not raised somewhat. As it is obvious, the medical explanation is not bad intrinsically and its problem begins when the technical and medical technology is used for the purpose of interview inhumanization.
Newly, Mishler emphasized on the story form structure of world life explanation and patients' need to narration about their problems so that cooperate with the therapist so required (Lokark & Mishler, 1992).
Mishler and other researchers act based on the Habermas theory prefer the holistic medicine to the pure biomedical encounter and recommend the mutual perception and communication without obligatory lead towards the therapist-client status, although there are some contrary ideas. The interpretations presented based on Foko's work for holistic cares emphasize on this fact that biomedicine has extended its control on the body to the personality.

Methodical observations

According to the above theoretical approach and particularly the medical explanation of Mishler, we intend to identify the communication between physician and patient in Iran and in addition to identifying the communicative process, explain the requirements for explanatory challenges formation and ultimately disruption of relationship between physician and patient. As a result, an empirical study has been designed for answering the research questions based on the experience of medical system and theoretical framework. This study has been applied in polyclinic and private clinics consisted of 60 samples. The method used in this study mostly focused on the observations and recording and analyzing the conversations between physicians and patients, as well as participant observation and questions designed for completion of observations of physicians and patients. The sample size included 20 visits for each physician which was selected based on reaching to theoretical saturation.

Methodological differences between Mishler and us

There are several differences between date collected in this study and data analyzed by Mishler; Mishler's data had been collected from outpatients referred to the hospitals and private clinics at mid-1970s, whilst our data has been collected from patients referred to the general practitioner, the physicians studied by Mishler were of white race men, whilst we used both woman and man doctors. 60 cases of counseling to the physician were selected including 40 cases in the polyclinic and 20 cases in the private clinic in order to understand the difference between his interaction and encounter to the patients in private clinic and polyclinic. As well as we could consider the place factor and its effect on the interaction and medical consultations.

Data description

At the first stage, we tried, regardless of any framework, only to observe and analyze the conversations between physicians and patients and during these observations and data collection process, we concluded that the relationships between physicians and patients are always placed in a range, for instance due to the presence of researcher at the physicians room, during research, the conversations between physicians and patients have been observed and recorded.

The conversations were investigated in five tables with respect to the primary data including gender, age, visit duration, disease type, quality of negotiation, quality of controlling conversation, talking about routine events,

patient's life world, quality of power dividing (sitting, looking, visit period, greeting, and quality of beginning to speak), and ultimately the result in table 6 (medical explanation and patient's life world explanation) were analyzed.
The summary of conversation analysis related to private clinic of Ms. X MD indicates that in all 20 cases, the physician talks to the patient with her medical explanation and the patient is obliged to speak by its closed and inflexible life world explanation that demonstrates the physicians behavior based on their stereotype pattern and their imagine of their profession. The average visit time was 6.6 min.
The summary of conversation analysis related to private clinic of Mr. X MD indicates that among 20 cases, the physician talks to 18 cases with his medical explanation and only in 2 cases, talks with their life world explanation. The average visit time was 3.8 min.

The summary of conversation analysis related to private clinic of Ms. X MD is more different from hospital's polyclinic. In private clinic, the physician uses the life world explanation in 18 cases out of 20 cases and the patient enters to its life world context as well and so the conversation between physician and patient exists from inflexible and formal state of clinic and the patients explain their routine events with better feeling and freely. In the meanwhile, in 4 cases out of 20, the inflexible and closed explanation of life world is flowed, but in the remaining 16 cases, this challenge is removed and the ideal conversational relationship is raised between the physician and patient. In fact, a lot of lateral factors such as easy access to the physician, having enough time for visit, discipline of clinic environment, long-term familiarity with the physician, peace and calm in the clinic, physician's freshly and friendly encounter and patient's comfort feeling in the clinic because of talking, expressing idea and opinion and asking various questions without feeling inattention of physician or non-listening to their talking or breaking their speech or his control over conversation. Indeed, the physician's art of good listening and patients' persuading to talk about themselves and disease, even their routine events, the communication established between medical context and patients' life world and humanitarian and friendly conduct, yet use of medical explanation and expressing the required explanations and therapies caused the patients to exit from doctor's room with lower stress and a smile indicating the satisfaction with this visit and so pay more attention to the therapy process and consequently achieve further improvement.

The average visit time was 6.9 min that was approximately two times more than average visit time in clinic of two above physicians. The most patients suffered from a chronic disease and had medical record and some of them were fixed patient of the physician and due to controlling their disease (diabetes, blood pressure etc.) referred to the doctor for two years or more. Consequently a friendly relationship beyond a physician-patient relationship had been formed.

The medical explanation includes the academic and specialized language of physician, objectivistic view to the patient and professional attitude to the medicine as a job, considering the humans as a disease case, atomistic perspective instead of holistic perspective to the human with social, biological and cultural dimensions and merely biological perspective to human, applying experimental, laboratorial and merely technical tools for treatment of ill element and organ, merely rational perspective and taking effort for achieving an appropriate result that is the same ill organ's treatment. In this process the physician assumes that the person entering in his room is a patient and demands the treatment, accordingly expresses a completely learned behavior, asks, diagnoses, treats and controls the whole relationship.

Some patients refer to the physician with extreme anxiety and provide a list of their diseases to the physician; the diseases that only because of stress resulted in physical disease or intensified it. The physician diagnoses the patient's anxiety well and tries to calm him, but in some cases the physicians without paying attention to the patient's anxiety that is arising out of the familial and financial problems only change the patient's medication but so the patient's confusion is increased and the own patient and its mental mood is disregarded whilst the patient may be relaxed by a little talking or referring to a psychiatric and upon reducing the anxiety, its physical illness will be obviated.

The obtained results indicated one-dimensional perspective (biomedical) to this physician-patient relationship supposing that the physician controls the conversation by its medical explanation and the patient and its life world is ignored and the physician by asking short questions and receiving short answers as yes/no doesn't allow the patient to speak. Although this perspective is the common pattern in the most visits of physicians but is not only the pattern and it was assumed that the patient intends by its life world explanation to establish the common relationship with the physician, but the physician by medical explanation leads the conversation progress, consequently the patient's speeches is not listened by the physician or in the event of listening are not considered, and the patient feels humiliation and disregard, and leaves the physician sadly and dissatisfied with the conversation. While, the

physician as per its pattern that the patient referring just for treatment, only pay attention to the ill organ of referred patient and by asking some questions tries to cure the disease, in the meantime the totality and existence of patient as a human is neglected. The physician acts in accordance with the training received during education and indeed uses the academic and specialized language.

Results

Mishler has drawn a two-dimensional classification of relationship between physicians and patients and claimed the physicians always by medical explanation and the patients by life world explanation converse to each other. The physicians by medical explanation control the life world explanation of patients and the patients' speeches are suppressed by medical explanation. In this field study that included recording and investigating 60 physician-patient conversations in polyclinic and private clinic, the obtained results in approved the theory of Mishler, moreover provided new forms of communication between physician and patient.
These findings have been obtained from reviewing and analyzing the conversations and on the other side, observation and participant observation.

The studies samples showed that only this unilateral pattern is applied in the conversation flow, but pattern of physician's medical explanation and patient's life world explanation which is suppressed and disregarded by the physician. Sometimes, life world by physician participates in conversation or sometime the physician allows the explanation and conversation of life world to the patient, so we can achieve a new classification of these conversations.

First morel: Pure medical explanation (the patient closes itself to the physician's medical explanation)

Medical explanation: The accepted and normal pattern supposed by the patients.
The physician's interaction to the patients is assumed normally and the patients adapt themselves to this imaginary predetermined mental frame. In fact, the patient before being limited by the physician, he/she own has limited itself and placed in the biomedical pattern. This type of interaction was observed among patients with the different social and economic classes and demonstrated that the pure medical perspective has no connection with class, education, age and gender and includes a range of patients. Also, the disease type (acute/chronic) in the clinic doesn't affect the determination of physician's interaction to the patient significantly and in both cases, the conversation is performed based on the pure medical interaction. Although the physician by asking some questions about the sporting, nutrition, sleep etc. becomes close to the patient's life world, but tries to pay attention only to the information in relation to the disease and by controlling the patient's speeches leads the conversation towards aiming the goal (diagnosis of disease). In these conversations, the physicians and patients the both exclusively communicate with the medical explanation. The pure medical explanation is equivalent to the low-value conversations in Mishler's researches. All patients have referred with physical symptoms and most of them were involved in individual acute problems and referred without prior appointment. Their problems included stomachache, cold, headache, hives, sinusitis and asthma. All these samples had been referred to the general practitioner for the first time and all visits were performed without prior appointment. It shows that the medical explanation is used as an intelligent strategy and is single in these simple problems and the physician needs to time economization extremely.

At first, the patient's individual and personal factors (e.g. the patient is not interested in establishing more communication with the physician or don't assume it necessary or due to respecting the physician censors himself) are raised but certainly a lot of social factors are involved in formation of this problem; how this unwritten law has been internalized in the society people (referred patients)? How this change has been made from human holistic perspective to the atomisttic and objectivistic medical perspective and elimination of life world agents? How this intensive rational and purpose-oriented perspective has involved the humans?

The researchers have raised several probabilities as follows:

- Rationality-orientation of society people (particularly the patients) which has been resulted from modernity.
- Change of society peoples' holistic perspective to atomistic and objectivistic perspective (and from soul to the body).
- Intensification of rationality factors by media (TV, radio, newspapers etc.);
- Internalization of an experience because of repeat (repeated referrals of patients to physicians and observing their interaction to themselves and other patients.
- Placing (patient-physician) in the therapy system framework such as following the hospital rules, mechanisms and laws (reception, visit, appointment etc.).

As a result, the own patients use the medical explanation and adapt to the medical explanation of physician and have no problem in this interaction. The both parties consider the purpose-oriented action. This type of interaction doesn't create any problem in the communication because is accepted by both parties.

Second model: Life world's resistance to medical explanation

Some patients were not ready to accept the physician's opinion and therapy method about their disease (denying groups) and try to cure their disease through traditional methods (traditional medicine) and suppose the traditional methods more effective than modern actions.

In such cases, still the patents' life world context and traditional medicine or a medicine originated from humans' life world context is active and growing. In such cases, the patients refuse the physician's speeches and believe that aiding their treatment actions available in their life world may cure the disease. The reasons of this relationship are as follows:

- The modern medicine disappoints the patient and has no response for its certain treatment;
- The patient still hopes to the traditional medicine and its effectiveness;
- The own patient is not ready to accept the truth.

Third model: The own physician closes itself to the patient's life world.

The language is a cultural factor and tool for explanation of life world and the life world of every human is formed by language. The different ethnicities with the different languages form the different life worlds. The language is a window to the life world of any individual, but how much this subject is important for the physicians particularly in Iran and how much is effective on the interaction to the patients. The patients with the different ethnicities and languages (Kurd, Turkish, Arab, Lor etc.) referred to the doctor, but some who had been referred from counties and villages and were not able to speak Farsi (the doctor was Fars) came accompanying one of their family members or friends to translate their conversation to the doctor. This lingual difference doubled the problem and avoided formation of a mutual understanding communication. The physician was a little familiar with some languages due to the repeated referrals of patients; for instance understood Arabic and Turkish but couldn't answer.

This sample of conversations revealed explicitly the elimination of patients' life world and placing in the medical explanation pattern so that despite the patient talked in its vernacular language, the physician didn't paid attention thereto and by repeated questions tried to control the patient's speeches by medical explanation. As well as, the observations in emergency indicted that the physicians with different ethnicities and talk to their same ethnic patients in vernacular language attract the patients' trust more and this is an important factor in physician's acceptance and expression of pain by the patient. So, it is concluded that the physician by closing its explanation (ethnic-academic language) to the patient's language, the life world explanation is intervened by the physician in the conversation. The result of this physician's behavior was interesting; some patients immediately and completely welcomed this mode of physician's encounter, means that a mutual and two-sided life world was formed. And some patients and their accompaniers firstly looked at the physician amazingly and perplexedly, perhaps they assumed this type of physician's behavior contrary to their default and subjective pattern (inflexible and formal and academic behavior of physician), but after a few moments, this problem was removed and ultimately they became satisfied with this visit.

Fourth model: Mutual life world (the physician signifies the patient's life world)

This model of conversation that included the conversations available in the clinic and in fact what explained in the polyclinic incompletely or didn't explained at all, a conversation out of medical framework therein the patient is allowed to talk freely in its life world's context, there is no time limitation, against the polyclinic, only one patient is present at the doctor room, the physician doesn't cut the patient's talking and persuades the patient to talking by explanatory and open questions and for this purpose makes medical explanation if required and performs the diagnostic and therapeutic measures for the patient. This method causes the patient to unconsciously mention the familial and individual agents intervened in the disease and accelerates the patient's diagnosis as well. This model was observed in the private clinic mostly. In this model, the both physician and patient use the life world explanation. In this model, the physicians used more normal communication styles such as propounding explanatory questions and active and without intervention listening, kindliness, questions directly related to the life world and explained in routine language and applying terms which certified and credited the patient's sensations. As a result, the patient assumes itself the partner and peer of physician. This conversation is very similar to the friendly conversation therein not only the sensations are allowed to be explained but are valued as one of important parts of routine and medical events. In this model, medical explanation is not intervened in any ways and purposeful efforts were not observed for controlling the conversations.

Fifth model: closeness of life world explanation to medical explanation by educated patients

The patient tries to close itself to the medical explanation and makes equal conversation.
The patients with high educational level that usually have academic and medical information about their disease (that obtain through reading books and articles on internet etc.) try to enter into equal conversation to the physician means instead of closeness of physician to the patient's life world, the educated patients close themselves to the medical explanation. It may be the victory style of methods that progress more than ever towards the society medicalization, or the patient tries to achieve the demanded equal conversation through this way in order to reduce the implicit violence of relationship.

Sixth model: Defected medical explanation (due to time shortage in polyclinic)

A lot patients and low time and simultaneous presence of several patients together with their accompaniers at the doctor room caused the doctor room to be changed to a stressful and crowded environment and consequently the physician became tired and impatient and the conversations were failed. Indeed, although low time and lot patients increased the quantity but reduced the work quality and the quantity superseded the relationship's quality. Although the physician in the polyclinic acts according to the trained mechanism (biomedical perspective) but the low time causes the same mechanism to be executed deficiently means a defected medical explanation.

Sample b (clinic of Mr. y MD, 3:25pm)

…..
A 45 years old patient enters into the doctor's room in chador and drugs bag.
The doctor is visiting another patient.
Patient: Hello
Doctor: Hello, sit down please
Patient: this is my tests result ….. I have received angiography.
Doctor: who?
Patient: Dr. Miri {cardiologist}…. my heart rate is so high that I cannot see the patients.
Patient: sit down {measures the blood pressure of patient and observe her drugs}.
Doctor: Have you any insurance book?
Patient: It is the insurance book of my daughter.
Doctor: Give me {takes the book}.
Patient: Did you see the pills?
Doctor: Yes.
Doctor: Did you receive the cardiography?
Patient: Yes I received.
Doctor: Go and bring it.
{the patient takes the cardiography report out of the test reports in her hand}
Doctor: Your cardiography report has changes but is old.
Doctor: I think your stress has been increased?
Patient: Yes, I take drug.
Doctor: You should change {the drugs}
Doctor empties the drugs bag on his table and checks them.
Doctor: You have no good and useful drugs and the patient introduces the drugs.
Doctor: I have to add one drug to your drugs.
Patient: I have this drug.
Doctor: Not having …. Means don't want to take?
Patient: Yes.
Doctor: I prescribe a drug. Take two times at morning and night … You have so much anxiety that went and told to provide angiography, but you have anxiety and should cure it.
{Short and indistinct conversation of doctor to patient}
Doctor: You come and say any problem you have.
Patient: I have a lot of problems.
Doctor: You have anxiety and will die of anxiety, should cure it.
Patient: {desperately} what should I do?
{the patient without saying goodbye goes to the room door and returns again}
Patient: Means you say I shouldn't go to the doctor?
Doctor: Go.

The patient exits from room.
Exit hour: 3:35.
……..
This conversation is finished within 10 min. The patient refers to the clinic with her angiography record and takes two appointments from general practitioner and cardiologist in order to get informed of the opinion of GP and cardiologist about her disease. The patient had anxiety and it was completely obvious in her behavior and confusion. But this visit was not ended here, the patient goes to the cardiologist and again returns to the GP.
The patient enters into the room while the physician is talking to another patient in order to show the drugs.
Patient: {with intensified anxiety} Dr. Miri has changed my drugs and prescribed these for me {shows the drug}
Doctor:{thinking}ok, take them.
After patient goes the doctor is complaining.
These drugs were similar to the drugs the patient had, why out colleagues regardless of patient change the drugs and so intensify her anxiety.
And when the researchers asks the doctor why he own has not paid attention to the patient's concern and anxiety,
Doctor answers: "I don't spend time for the patient who doesn't respect my words, this patient was expecting for visit of cardiologist and thought with herself until the appointment time, to go before GP".
But the main subject that is not revealed in the meanwhile despite of its clearness and obviousness is inattention to patient's anxiety and its causes and questions such as "have you anxiety?" or "you should cure your anxiety" that regardless of the main subject are challengeable, because the patient's anxiety doubtless is related to its life world what has not been considered by GP nor the cardiologist and have encountered the patient with medical explanation {observing the drugs, changing the drugs}, but the own patient doesn't take effort for breaking this type of encounter and her life world. Although the GP refers to the patient's anxiety but his short question "have you anxiety" in return for explanatory question "why do you have anxiety?" or "which agent caused your anxiety?" that could persuade the patient to talking about her life world causes this problem remains hidden and the patient after spending time and cost and exacerbation of her anxiety exits from the clinic with the new drugs whilst her main problems has not be resolved.
Note that life world explanation and asking about it is mostly considered by the psychiatrics and the patients visiting the psychiatric explain their life world conveniently and in fact the own psychiatric is aware of the importance of patient's life world in creation of its disease, therefore tries to cure the patient through asking the open and explanatory questions and good listening technique as well as allowing the patient to explain its life world. Hence, the patients referring to the GP, in the event of suffering from severe anxiety are referred to the psychiatric, because the patient's talking about its life world in a crowded area of clinic and inevitably low time the physician gives to each patient and sometimes simultaneous presence of 2 or 3 patients and their accompaniers in the doctor room don't provide the conditions for the physician.
But a part of the foregoing is related to the character, moral and attitude of the physician. Where the physician assumes the patient's visit merely as a job and profession and believes that the use of medical specialty is the patients' treatment way and not his behavior to the patient, consequently the disease is considered {as an independent subject that its only treatment way is use of specialty} and not the patient as a human that its illness has involved a part of its whole body and soul and the own humans are forgotten. The medicine has advanced in technology, tools and specialty so that the own human as the most important factor has been ignored.

Theoretical and methodical conclusion

Habermas drawing the communicative action theory attempted to show what important in the conversation is mutual perception and understanding. By this assumption, Mishler indicated that physician-patient conversation is not a relationship based on the patient's understanding and perception but is a deviated and purpose-based and inhuman relationship. The researcher by means of this theoretical and experimental background and reviewing 60 samples of conversation between physicians and patients and observing the physicians' performance and behavior with the patients concluded some results which demonstrated that this relationship is not merely a bipolar relationship of medical explanation and life world but the physician-patient relationship as regard to the interaction is placed in a spectrum, so that sometimes the patients close themselves to the medical explanation and sometimes the physicians close themselves to the patients' life world explanation. Although still the medical explanation is dominant in the conversations, but it is not the sole form of relationship.

Considering the theoretical viewpoint of Habermas in relation to the communicative action and its application in medical context and use of field methods, observation, record and analysis of conversations between patients and physicians and obtained information, it is concluded that treatment relationships are diminished in the most cases to the mere biological perspective to the patient and plenty of communications formed between physicians and patients is a deviated relationship therein the physicians try to separate the patient from life world context and control it and follow the conversation based on the systemic or medical explanation that demonstrates the rational and instrumental perspective to the relationship. In biomedical perspective (paying attention to the disease instead of the patient), the physicians only intend to cure the disease and not paying attention to the patient and it was dominant in all observations. Although the physician's duty is defined so, but inattention to the patient and its speeches and trying to control the relationship has inverse result, because establishes a relationship between a subject and an object and creates a rational and purpose-oriented relationship, whilst the patient needs to be understood correctly by the physician and failing to achieve such a result causes deviation and improper understanding of the patient by the physician. Merely rational and purpose-oriented perspective may not be prescribed and used for all patients.
Our analyses show that in this study the physicians change their conversation manner proportional to their patients referring with acute or chronic physical problems. When they use the pure medical explanation for encountering the acute physical problems, it seems they have adopted a successful method.

Conversation based on mutual life world was used for counseling to the patients and this method will be successful even if the patient suffers from physical symptoms. Essential problems are created in the conversations that the patient has referred for chronic physical diseases. These problems are referred to the life world. Although the physicians observe them as the physical problems and believe that it requires use of medical explanation and stopping and ignoring the inappropriate life world explanation. One of physicians used the both explanations; in the polyclinic due to the low time and lot patients used it limitedly but in the private clinic this conversation was observed more based on mutual life world particularly to the patients with chronic diseases (hypertension, diabetes, thyroid etc.). It shows that if the patients understand the significance of life world application encountering the chronic physical and mental diseases will provide better health cares to the patients.

Results

The applied studies indicated how the entry of physicians to the patients' life world may create the patient's trust to the physician, effective conversation, more human perspective to the patient and ultimately the useful and effective diagnosis and therapy process. In plenty of studied samples, where the physician allowed the patient to talk about its life world, the patient spoke conveniently and while patient's talking, the physician could extract its disease reasons out of factors existing in its life world and understand that the disease has been arising out of anxiety and stress or is a completely physiologic disease and it helped the therapy process (test, radiology etc.), costs and repeated referrals. In fact, a value-oriented conversation and spending a 10-15min time at most avoided the repeated referrals of the patient in the subsequent weeks and a more human relationship was formed as well. Ultimately, through studying on the selected samples, we tried to understand which one of communicative and interactional patterns is run between the physicians and patients and which one may be more useful to the patients.

As a result, communicative action comparing to the strategic action may have positive effects and results in medicine and therapy. Any behavior is the result of training, therefore the behavior of medical section to the society must be amended and through changing the physicians' attitude to the patients, the systemic policy is amended and life world is returned to the society at least to the medical context as an important section of the society.
The medical training system must pay attention to the biological and mental aspects of disease and change its positioning from the framework of merely physical and biological perspective to human to the holistic and more human perspective to the human and train the students whether academically or experimentally so.
The physicians instead of merely biological perspective to the patients must pay attention to the mental and social factors of disease and their perspective to be changed from disease to the patient.
Health centers must understand the importance of value-oriented communicative action that results in human perception and understanding until achieving the result and goal and replace the strategic action by communicative action.

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