

Ernest E. Boesch, Saarbrücken

Doctors and Patients: Reflexions on the Problem of  
Social Change

Social change, it is often said, has two sources: one being the internal dynamism of a group, power struggles, technical innovations, pressures by restricting customs, to give but a few main examples. The second source lies in external influences: commercial imports, studies abroad, tourists, conquests would be examples for such external stimuli of social change.

These two sources, in practice, are not exclusive; they join forces, although in most cases not equally. We might say, however, that in developing countries during the colonial and post-colonial periods, external stimuli have been of particular importance for social change. Social change, for these cultures, often did not consist in developing or in gradually transforming existing patterns of life, but in the abrupt introduction of alien ones.

Being interested in social change, we thought that two main problems would be, first, along which channels new information traveled into a culture, and, second, how they were selected for adoption. The following assumptions may be made:



- 1) Innovation follows a "slope": groups having easy access to new information will accept it more readily and will transmit it to less educated or informed groups. This implies a gradual process of diffusion from the widely informed "elite groups", over to their different interacting or "target-groups".
  
- 2) No group readily accepts new information: mostly, a group-specific selection process occurs.

This selection applies to transmitting as well as to perceiving new information and is likely to be governed by the following variables:

- a) the perceived "valence" of the new information, i.e. its attractiveness with relation to a "felt need"; in more simple words, frustrations, privations on the one hand, curiosity, wishes for stimulation or consumption, etc., would increase the likelihood of accepting new forms of behaviour.
  
- b) The perceived "difficulty" of the new information; this means, the costs, the difficulty of learning, the sacrifices which it might require will all reduce the tendency to accept an innovation.



c) Social rewards, barriers or licences; if "public opinion" is felt to be adverse, the likelihood of acceptance is lowered; on the other hand, the anticipation of an increase in status or in otherwise satisfactory social relationships will rise the readiness to accept an innovation. Some innovations may fall into an area not controlled by social rules and thus can be accepted without particular regard to the group.

These variables, obviously, act in conjunction; furthermore, their perception follows a time- and a system-dimension: an individual may anticipate imminent rewards but long-range punishments, or vice-versa; the individual might also anticipate gains in one area of behaviour, but losses in another, and will weigh these one against the other.

4) Such complex processes will mostly not consist of conscious decisions. It is far more likely that new information exercises a kind of attraction/repulsion, coupled with a diffuse awareness of possibly complex consequences which the adoption might imply. Individuals (and groups) therefore tend to develop strategies for dealing with innovative perceptions. One of the main (although not the only one) strategies consists in looking for models. Indeed, being able to observe on somebody else the effects of any type of innovation greatly reduces uncertainty and risk for the



subsequent adopter. Material, social and personal results as well as side effects can thus be evaluated. This strategy is obviously important for social change. However, it leads to two main difficulties; the first one being that the person, the social situation and the material conditions of the early adopter may influence the perception of the innovation. To mention but two extremes: what a member of nobility in Thailand does would by this very fact be something some people might tend to consider unsuited to themselves, wanting to avoid the appearance of undue social pretention; or, fashion adopted by prostitutes might for this very reason be declined by women of a different social standing.

The second difficulty lies in the fact that observation alone generally does not sufficiently clarify neither immediate profits or risks of an innovation, nor its side or long-range effects, unless one lives in very close contact with the adopter. Asking him directly, might often not appear feasible, which introduces the necessity of additional information from second hand, with all the problems it brings along.

- 5) We decided to study these problems in Thailand, a country with whose culture and language I am somewhat familiar and which thus offers fewer barriers to investigation than others.



We started from the modeling-assumption, that educated elites who, by their public function, are in continuous and close contact with other social groups, would play a key role in promoting social change. Indeed, these "service elites" were familiar with modern ways of thinking and behaving, by reasons of their education and other western contacts. They would, we expected, in their relations with "target groups" - i.g. students, farmers, patients - demonstrate new ways of acting and behaving; they would thus constitute "existential models", easy to observe, and socially not so distant as to inhibit imitation. We decided to concentrate our investigation on the relationships between doctors and patients. Indeed, doctors are in possession of an "item" of high value to patients: knowledge concerning health and curing its disturbances; they would provide opportunities for explanation and discussion during their consultations, and they would be able to control the adopting of new health behaviour on the occasion of subsequent visits by their patients. On the other hand, the patient is highly motivated, by the experience of his illness, to adopt innovations demonstrated or recommended by the doctor, wishing to improve his health and to prevent further illness. Patients would not perceive nocive, threatening secondary effects of modified health behaviour (such as through drug side-effects); we could, therefore, expect an optimum impact of the doctor as a model of change. Our hope was not only



to gather data directly useful to health promotion and medical training, but also to gather some more concrete evidence on the flow of innovation from elites to their clients.

- 6) I shall not go into a detailed description of the research done in Thailand. Be it sufficient, for the present purpose, to say that we worked in out-patient-clinics of hospitals in Central Thailand, during two major field stays in 1966 and in 1970/71. Altogether we visited 16 hospitals and taperecorded 94 medical consultation sessions of half a day each, including 72 doctors and over 2600 patients. In addition, doctors and patients were interviewed individually. A general survey of the research can be found in the German Journal of Psychology, Vol. 1, No. 1, 1977 (BOESCH, "The medical Interaction; a study in Thailand").

There is no doubt that the two groups, doctors and patients corresponded to the conditions we wanted to study. Doctors had all received a complete medical training according to western standards; almost half of them had undergone some additional training abroad. They constituted, thus, a group of highly informed and innovated persons. Patients, on their side, mostly were poor and uneducated. 70-75% of them had only four - and sometimes less - years of schooling and worked in correspondingly low income brackets. They were



tradition minded with a strong tendency to superstitious beliefs in matters which affected their health and destiny in general.

- 7) What were our findings? Again, let me give just a short summary of some aspects relevant to our problem. First, consultations in our hospitals were quite short. The total average of the 1970/71 sample was three and a half minutes, 2 minutes 15" of which presented the average speaking time, the major part of it being taken up for asking the questions basically required for the doctor's conclusions. Explanations concerning diagnosis, treatment and prevention lasted on the average only 40 seconds.

There are variations, though. Thus, the first ten patients of a consultation session get about 35% more time than the last ten patients (4 minutes : 21/2 minutes). Doctors in crowded hospitals, understandingly, spend less than the average time per patient, while the less burdened ones spend more. There appears, however, a somewhat puzzling fact: out of an official 180 minutes available for the consultation time, the doctors with many patients (on the average about 38 persons per morning) spend only around 51% of the possible time with their patients; doctors in less crowded hospitals (on the average about 18 persons per morning) spend up to 72% of the their time with the



patients. We would rather expect the opposite: the more patients per session, the more a doctor should relatively use of the available time for seeing each patient. We have made allowance, in these calculations, for half an hour's break for the doctor between consultations; we might also guess, that, the more patients, the more a doctor would relatively have to inquire with colleagues or to take notes. The fact, however, remains that by far not all the available time is given to the patient, and that the low proportion of time utilized is not entirely dependent upon number of patients: thus, in the two groups averaging around 18 patients per session, the one uses 72%, the other only 56% of the available time.

An additional intriguing fact appears: if we count the "messages" given by doctors to the patients, i.e. each different item of information included in their interaction, we get a distribution ranging from 10 and less up to 110. The majority of doctors (over 94%) offer more than 10, two thirds of the doctor (over 66%) provide more than 20 information items. No patient, however, remembered more than 15, and almost 80% less than 8 items. If in addition we consider the accuracy of recall by the patient, it appears that accurate recall reaches only 40% of those messages which relate to the explanation of treatment (such as "take one red pill three times a day"), while the diagnosis and additional advice are accurately recalled in barely one third



of the cases. Since this data stems from interrogations immediately after the consultation, it is likely that even more will be forgotten after some time has passed.

Initially, we had planned to follow the "destiny of information", i.e. to control the behaviour of patients in their homes after the visit to the doctor. The technical problems, though, were too great, so that we had to abandon this intention. We may, however, guess its results already on the available evidence. The innovation impact of doctors on their patients appears to be minimal.

The doctors are aware of this; they frequently complain about the lack of education, of understanding, of intelligence or of "good will" on the part of their patients. Patients are in their own ways not less aware of something wrong in the medical relationship: they complain about impatient doctors, their unwillingness to give explanations or their lack of concern. Looking at the patients' behaviour, one is struck by their submissiveness, their absence of probing questions, the lack of asking for explanations. They are, to put it very simply, often afraid of the doctor.

The simple assumption of elites as transmitters of new information, thus, appears not to hold true. Doctors do not communicate adequately with patients for imparting new health behaviour;



patients, although likely to be highly motivated by their suffering, do not inquire sufficiently for obtaining insight into the causes of their disease and the conditions for its cure. The reasons for this lack of communication appear to be obvious: doctor and patient belong to different "loyalty-groups" and do meet only under exceptional circumstances - which at least the patient also desires to remain exceptional. The patient is, indeed, motivated to be cured, but not involved in the situation in a way which would guarantee adaptation, i.e. understanding and acceptance of its requirements.

However, inspite of these limitations, certain changes occur. It is true that the patient does not learn much about the causes and the nature of his disease, but he might at least grasp that it is (or could be considered) a natural and not a supernatural phenomenon. He learns, in addition, that something like taking red, round shaped average sized pills three times a day would cure his ailment. So, when falling ill again - from the same or some other illness - he might not go to see the doctor but simply ask at the drug store for "those red round pills you gave me last time". The magic of the red pill thus has been established and will produce its good or ill effects according to the circumstandes. Druggists, who only too often are not very much more knowledgeable than the patients will profit from these beliefs in the pill (or in the injection) in their ways: thus, the "small cure" for venereal disease, sold



over the counter and consisting of a dose of penicillin barely sufficient for reducing the acute symptoms, obviously did a lot of harm.

What we witness here, is a distorting acceptance not of the rationale, but of the pragmatics of an innovation, i.e. of the simple surface aspects of doing. This simplistic and incomplete formula of action, however, now is handed on to others, since communication between patients in the village is much more intensive than the one with their doctors. The "red pill" will be bought not only by the patient, but also by his friends and neighbours. Others will profit from it as shown e.g. by the spread of quacks, or "injection doctors", whose popularity is due to the high value Thai patients attach to injections. It is not unlikely, by the way, that this estimate given to injections relates to the formerly wide spread belief in the "buried needle" (Radjadhon, Textor), a magical procedure in which one acquires protection against harm through the imbedding of a needle under ones skin. The pragmatic formula borrowed from the doctor makes use of existing rationales for explanation and credibility.

Pragmatic acceptance, in our case, thus implies distortion both through ignorance of function and causation and through assimilation to existing patterns of behaviour. But the doctor's messages not only foster new ways of doing (however inappropriate they be), but also new forms of social connections. Healing,



in traditional Thailand was done by a person with high "bun" (moral merit from previous lives) - otherwise he would not have got the required power; but healing was also exercised in order to gain additional merit and therefore was an unselfish activity, rewarded only by presents and not by payments from the patient. Doctors, however, require payment, and mostly are aliens to the culture of the patient's group. Patients, therefore, not only find it difficult to communicate with them, but also to understand their motives. The doctor, thus, is often suspected of being selfish; he might withhold "good", or "strong" medicine, in order to "nurse the disease", to stretch the duration of treatment and thereby to increase his income. Modern healing, therefore, establishes a new form of dependence: it is in the hands of persons who hold - medical as well as social - power, whose intentions are not transparent and over whom the patient himself feels to have no means of control. While helping others, in Thai tradition, was mainly based either on the principle of reciprocity, amongst equals, or of kindness (meetaa) in dealing with inferior or weaker persons, it here gains an entirely new aspect: impersonality, power and profit begin to be related with it. The social-ideological consequences of this would be worth to be followed.

We would therefore tend to conclude this brief and only summary presentation by saying that elites, as exemplified by doctors, are less transmitters than instigators of innovation.



They provide models which only very fractionally are apt to be imitated. Since they tend to shorten the communication process they increase the likelihood of distorted reception of their messages. The patients, on their side, accept the pragmatic aspects of the doctor's messages, introducing much distortion not only through lack of understanding but also by the effort to integrate the new behaviour into existing rationales. This holds true for practical behaviour as well as for its evaluation and interpretation. It is obvious that by this token the existing rationales will undergo transformations, too.

Thus, social innovation appears less to be a process of transmission (as "item-adoption-research" seems to imply), than a process of inducing continuous and complex assimilation, implying distortion, transformation and building of new structures. It is this active transformation which makes the spread and the effects of innovation difficult to predict. Further research will have to concentrate on such processes of transformation rather than on rates of successful imitation. Which places research on social change on the problem level of individual action in a specific cultural setting.