The patient-practitioner interaction is significant, as an effective patient-practitioner interaction results in a 'satisfied patient' returning from the healthcare.

Authors have analyzed the process of interaction between the patient-practitioners in different ways. The participant and non-participant observation technique in clinical setting was used extensively in social science research. Interaction process analysis technique was also developed in this regard. In this method, the researcher observes an instance and sets up a tally sheet to organize and enumerate the behavior he watches. A system for coding the behavior of a group is developed having some known or ready made set of categories into which one could fit in the observation.

Doctor-Patient Interaction Analysis (DPIA) was developed for observing the interaction between doctor and patient in clinical settings. Several categories were developed for coding the doctor-patient interaction based on the views expressed by the patient and doctors on what type of behaviour they expected from each other. Six categories for doctor talk and six categories for patient talk were developed. Three categories for coding the period spent in physical tests, non-verbal activities and distraction were retained. Some studies have tried to understand the patient practitioner
interaction based on the outcome of the patient-practitioner process, which includes the patient satisfaction.

Patient satisfaction is an important enabling factor for it facilitates the use of particular health serve and positively contributes for future use of the health services. Studies (Fiedler 1981) have revealed that various characteristics and practices of providers contribute to patient satisfaction. Patient have reported to be satisfied and inclined to utilize services when providers,

(a) gave more information
(b) counseled patients
(c) explained payment plans
(d) were happier and had a favorable attitude towards the patient
(e) spent more time with the patient

The different techniques of analysis for doctor-patient interaction reveals that the qualities of physician and the communication between the patient and practitioner form the backbone for the analysis of the Doctor-Patient interaction.

STUDIES RELATING TO PATIENT-PRACTITIONER INTERACTION

Studies reviewed here will include studies on both modern and traditional medicine. This is mainly due to the fact that studies revolving around patient-practitioner interaction in traditional medicine were limited and many studies compared the relationships between practitioner of
traditional medicine and their client vis-à-vis modern medicine men and their patients. So it was also felt by the researcher that the finding in the interaction process between the practitioner and patient in the realm of traditional medicine becomes relevant only when discussed in the context of modern medicine.

Chen C.Y. (1981) while studying the traditional and modern medicine in Malaysia reveals that in contrast to the practitioner of modern medicine, the traditional medicine man's approach to diagnosis and healing is very 'personal' and 'supportive'. The traditional medicine man tends to enquire in great detail into the patient's family and social background, requiring details of the patient's problems, life, family and enemies. According to Chen this is an important aspect of the cultural and historical forces that influence the development and acceptance of traditional medicine in Malaysia.

Wolinsky (1982) applied Andersons generic model and assessed the intent to which traditional practitioner of health service utilization are directly associated with individuals identification of the important factors in their choices of new doctor. The study revealed that 'doctors affective behaviours' i.e. 'doctors manner and personality' was the second highest recorded reason for selecting a new doctor. Although the data demonstrated that individuals seek affable physicians when choosing a new doctor, Wolinsky stated that it may be reasonably assumed that patients are more likely to maintain their liaison with or re choose affable rather non-affable physician. This supports the models of consumer satisfaction, which posit that the affective qualities of the physicians are more important than their
instrumental qualities in determining consumer satisfaction. Wolinsky et al goes on to suggest further policy changes based on these studies, which include modest changes in medical school curriculum which should focus on good communication and interaction skills rather than on information retrieval, as this permits the doctor to alleviate patients concerns and anxieties which in turn motivate patient compliance with treatment regimens and preventive behaviour.

Lasker J (1981) study in the Ivory Coast revealed that there was usually very little conversation during medical visits. Several young doctors indicated that it was not necessary to explain matter to patients. Several authors have put the responsibility for inadequate communication on the physical such as the use of 'inappropriate verbal consulting styles' or certain non-verbal behaviour.

Weisberg D.H. (1982) while studying the Northern Thai health care alternative revealed that the relationship between the healer and the patient and the family is crucial for choosing the healer. Healers of the 'locally sanctioned sphere' have to practise an understandable form of care and must approach patients and families in a polite and palatable manner.

Mathew (1983) pointed out certain problematic areas in clinician-patient communication, including incompatible frames of references as to what information should be shared, socio-linguistic differences between the two parties involved, the degree of shared knowledge (especially technical knowledge) between doctor and patient and the social distance between the
two given their difference in status and role and the constraints of the institution in which they interact.

According to Oyeneye. Y (1983) Traditional medicine has a fairly long history in Nigeria, traditional health care systems in popular due to its acceptability to a large proportion of rural and urban dwellers. This acceptance is not only due to its efficiency in the treatment of some health problems, but offer both social and mystical explanation for the cause of illness and due to its close proximately of people. African healers have been cited for their greater openness to patient and for their lesser social distance, when compared with hospital personnel.

Mathew remarks the extent to which patient and practitioners successfully exchange information is affected by the degree to which their realities are mutually compatible. Doctor ignorance of native illness concepts and an attitude of superior were reported by Lewis (Kroeger 1983) in a Mexican village and four Indian populations in Equador (1981), which results in communication problems.

Different authors point out that some of these differences are due to the differences between biomedical and lay definition of ill health, i.e. between disease and illness. According to Kleinman (1978) biomedicine views biological data as being more 'real' and clinically significant than either social or psychological data. Diseases are seen as abstract entities with a recurring identity in whatever socio-cultural setting they appear. Illness by contrast refers to the subjective response of the patient and those
around him their perception and origin of the event and how it effect them, unlike disease illness is a wider, more diffuse concept patterned by social, psychological and cultural factors.

Kleinman (1978) pointed out for successful diagnosis and treatment it is essential to understand the patient explanatory models of illness as these models are usually influenced by social and cultural factors. Their medical training largely influences physician interpretations of their patient ill health. In addition to their experiences, personality social background, subsequent training and rank in the medical hierarchy all play a part in what information is gathered from and communication to the patients they care for. Helman (1985) while trying to understand the clinician-patient communication in the context of primary care reveals the role of clinicians 'Health belief model' in communicating with patients. This model includes knowledge assumptions about how patients view their own ill health. This will serve as an indicator of the success of communication and a predictor for successful communication, compliance and patient satisfaction in the future.

According to Helman physicians should elicit their patients explanatory models and then compare these with their own health belief model. This will reveal evidence of 'typifications' or stereotyping, both of which may be barriers to successful communication.

But this approach advocated by Helman cannot be applied to large population, as the range of explanatory model for the patients will be many in number for a single disease. In utilization studies in clinical setting the
handicaps of facing patients with different illnesses results in larger number of explanatory models and corresponding health belief models.

If on one hand, one of the important reasons for abandoning modern medicine was the patients ignorance of the doctors paradigm which result into a communication gap, on the other hand studies report the mutual understanding between local healer and patient was based on shared knowledge and assumption.

Kroeger (1983) reports that in service based studies in traditional medicine (which focuses on the healer and his patient) congruence between healers and clients can be anticipated since this is the reason why people have resorted to those healers. This behaviour has been observed in India (1975) and Taiwan (1980).

In a study by Merzouk M. (1995) in Algeria reported that in a society that is predominantly religious and rural the 'kindness and warmth' of the care provider is the most important reason for use of providers.

Studies (Furnham et al 1993, 1996, 1988, 1996 et al) reported that traditional medicine clients were more dissatisfied with modern medicine for a variety of reasons related to doctor-patient interaction, including communication difficulties and perceived a lack of concern for their well being. The success of a satisfying personal relationship in traditional medicine is often considered to be one of the most important reasons for the use of traditional medicine.
In a study by Messerli et al (1999) in Switzerland it was reported that allocating sufficient time for consultation was one of the important reasons for utilisation of traditional therapy.

In a comparative study of Doctor-Patient interaction using DPIA (Doctor Patient Interaction Analysis) in small, medium and large hospitals revealed that the doctors conversed more in small and large hospitals than in medium hospitals where as the patient talk was little less in small hospitals. This happens because in the small hospital patients suffer from minor illness and they do not have much to explain about their illness. In small hospitals more time was spent by doctor in giving instruction regarding treatment and in medium hospital in enquiring about illness and in large hospitals in releasing the patient's tension and other talk.

Comparing the "patient-talk' it appears that in large hospitals the patients spent more time in seeking orientation, help and showing disagreement. In medium hospitals the patient spent more time in explaining their illness.

Behavioural components of doctor-patient relationship were identified as (1) patients need (2) effective medical care (3) professional ethics (4) normative behaviour. Different sub topics were outlined for each category. A behavioural scale was used to analyze the findings. The doctors rating revealed that they had high moral character and a sense of regard for patients. They had enough skill to treat the patients and they always gave instructions about treatment. But at the same time they were somewhat detached from the patient and the patients feel they were treated more like
cases. The patients rated doctors high on their behavior, medical attention, interest taken and treatment provided, but they rated them little low on communication of diagnosis.

Using the studies as a background the researcher developed a checklist after informal discussion with patient and practitioners as to what they expect from each other during the interaction.

**PATIENT EXPECTATIONS**

All patients reported that the practitioners should be pleasant, should have a sympathetic attitude, should enquire about the illness and collect the case history. The practitioners should clarify the doubts and queries and give a patient hearing.

**PRACTITIONERS EXPECTATION**

Practitioners expected the patient to explain the illness, without concealing any information should have confidence on the practitioner and treatment regimen and should clarify any doubts and queries.

**PATIENTS OBSERVATION**

Majority of the patients reported that the practitioner had a general talk with them. According to the patients this is usually done by the doctors to make the patients feel comfortable and ease out the 'tension' and 'anxiety' the patient feels. The general talk generally involves asking the
name, place of stay, occupation and about family attributes. This activity is undertaken by 'experienced' practitioner as they understand the importance of making the patient comfortable in an unfamiliar environment.

This behaviour is observed among the practitioner of traditional medicine and not among the doctors of modern medicine. The patients opine that practitioners of traditional medicine 'perfect the art of medicine' by years of practice which only comes through age in the process making them aware of the social responses to illness. But this does not seem to be valid in modern medicine. According to patients even young doctors can master modern medicine, by studying the various specializations and sub-specialization. This tendency is not exclusively attributed to the personal characteristic of the practitioner but also on the 'nature' of the system of traditional medicine. This prescribes that the illness and effected individual should be seen in 'totality' and not exclusive of each other. While in modern medicine the 'disease' is seen as a separate entity caused due to certain factors. The role of doctor is limited to explore the factors and try to control them thereby giving little importance to emotions of the patients.

According to patients the type of ailment decides the level of communication between 'patient and practitioner'. Majority of patients opined that for every illness whether minor or major, the symptoms and illness history is collected by the practitioner. But the level of information collected may vary, i.e. the history for minor ailment may be less compared to chronic ailments. The patients reveal that the practitioners of modern medicine do not ever bother to collect the history and symptom for minor
ailments. This behaviour reduces the interest among the patients as they feel 'delineated' from the treatment process.

The patients reveal that the level of information gathering on the illness is greater among the practitioner of traditional medicine when compared to their counterparts of modern medicine. Majority of the patients reveal that information rendered regarding the treatment, prevention and care for the illness is an important area in traditional medicine which differentiates it from modern medicine. According to the patient major part of the communication in the interaction process between a practitioner and patient in traditional medicine revolves around prevention and care in terms of dietary restriction and personal hygiene. According to patients this corresponds to the individual's own concepts of health care, which to a great extent is governed by food. The patients revealed that instructions are given to each individual based on his body constitution, which is not found in modern medicine.

Doubts and queries are encouraged by practitioner depending on the time available, which also depends on the experience of the practitioner. Majority of the patients reveal that when the practitioner is experienced he has not time to clear the doubts and queries.

More than three fourths of the respondents reported that the practitioner were 'pleasant' with them. But it was found there was 11.1% of Ayurveda patients and 12.1% of Unani patients who revealed that the

* 'pleasant' was described by patients as a behaviour of the practitioner, which make the patients feel important and the patient feel satisfied after the consultation.
practitioner they consulted were not 'pleasant' to them. The patients opined that the socio-economic background they belonged to influenced the behaviour of the practitioner towards them. This was reported by Pendleton et.al. (1980) while studying the patient-practitioner interaction.

Table 5.1: REASONS OPINED BY PATIENTS FOR THE PRACTITIONERS NOT BEING PLEASANT

<table>
<thead>
<tr>
<th>REASONS</th>
<th>AYURVEDIC PATIENTS</th>
<th>UNANI PATIENTS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NUMBER</td>
<td>%</td>
<td>NUMBER</td>
</tr>
<tr>
<td>Uneducated</td>
<td>1</td>
<td>5.8</td>
<td>1</td>
</tr>
<tr>
<td>Poor</td>
<td>15</td>
<td>88.3</td>
<td>10</td>
</tr>
<tr>
<td>Not important</td>
<td>1</td>
<td>5.8</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>100</td>
<td>12</td>
</tr>
</tbody>
</table>

34.3% Ayurvedic patients and 41.4% of Unani patients reported that they would approach the same practitioner even if he was 'practicing' some other system of medicine for the current problem. This reveals that the 'qualities' of physician overruled, the decision to select the practitioner based on the system of medicine practiced.

Affability of the practitioner was reported as an attribute for selection of practitioner for the current problem. But it is interesting to note that availing the services of the practitioner for all the health problems would not be influenced by the 'affability' of the physician, exclusively but also by the system of medicine he practiced. This was ascertained by a significant
percentage of patients who revealed that selection of the physician would depend on the system of practiced. This supports the fact that selection of practitioner also depends on the system of medicine they practice and illness classification the patient uphold.

PRACTITIONER'S OBSERVATIONS

The practitioners revealed that they expect their patients to be cooperative and should trust their doctors. A major area of concern shared by the practitioners of Ayurveda and Unani was that the significant percentage of educated patient doubts the diagnosis of the practitioner and thereby hesitate the treatment prescribed by the doctor. According to practitioner this is evident due to the number of 'questions', which precede the interaction process regarding the treatment.

According to the practitioner this behaviour 'stems' from the fact that 'traditional medicine' is an alternate form of medicine and the tendency to immediately compare the diagnosis and treatment regimen prescribed by the allopathic practitioner is high. This in turn affects the 'morale' of the doctor and the channel for 'disinterest' towards the patient creep in the practitioner. The practitioner feels 'the patient-practitioner' relationships should be based on mutual trust and respect towards each other.

Majority of the practitioners reveal that this behaviour is due to the 'huge importance' attached to allopahy. The practitioners feel the entire government, society, and the medical fraternity, which include the
practitioners of Allopathy, practitioners of traditional medicine are responsible for the trend.

Significant percentage of the practitioners opined that the patients should share all the information regarding the illness. The practitioners reveal that in some cases 'patient conceal information from them', which bring about mistrust and also hinder the process of treatment.

It was found that a majority of the practitioners had a general talk with the patient to make them comfortable and all the practitioners collected case histories from the patient. 26% of Ayurveda and 12.5% of Unani practitioners sighted communication problems. The nature of communication problem was majorly due to the lack of knowledge of the language spoken by patient. This was reported by a greater number of Ayurveda practitioners. This in turn affects the communication process and information shared becomes restricted. According to practitioner in most instances they can understand the problem but can't communicate in return, which is crucial for an effective patient-practitioner communication. This may in turn inhibit further use of the system of medicine. As has been stated earlier, this also explains the tendency of various ethnic groups availing the services of Unani practitioners as compared to Ayurvedic practitioner. It was found that Unani practitioner were fluent with three important languages spoken in Hyderabad i.e. Hindi/ Urdu/ Telugu which was not found among the Ayurvedic practitioner.

Thus, it can be concluded that an effective patient practitioner interaction depends on the qualities of the patient, practitioner and the nature
of the system of medicine, which in turn promotes the utilization of the system of medicine.