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Different perspectives of doctor and patient in communication

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ABSTRACT
In the past decades, medical health care has gradually shifted its emphasis from the disease to the patient. Presumably, this has resulted in a more egalitarian relationship in which doctor and patient participate in a balanced way in terms of their relative contribution as well as the content of their interaction. Still, a meeting between a patient and a doctor is a meeting between two extremes. Patient and doctor may have different roles, language, expectations and perspectives. These differences might prevent a balanced communication. The purpose of the present study was to examine in what respect the communication between doctor and patient could be considered balanced in terms of equality of their attention to affective, biomedical and psychosocial factors. Using findings from studies in different clinical settings, e.g. internal medicine (n = 85), paediatrics (n = 846) and gynaecology (n = 526), it was furthermore examined whether this balance differed by setting. Results showed that, regardless of the nature of the clinical setting, doctor and patients showed almost the same amount of affectivity in their conversation. They differed remarkably, however, in their attention to biomedical and psychosocial issues.

1. INTRODUCTION

Until recently, doctors were considered to be the sole experts on medical issues, whose advice one followed without questioning. In those days, doctors' work was centred around the disease; the patient behind the disease was less important. In the last decades, this limited biomedical model is abandoned more and more. One of the reasons for this apparent change is the fact that nowadays, patients have plenty of access to various sources of medical information and often demand every available cure. To meet the patients' expectations and reassure them effectively, a patient-centred attitude is urgently advocated [1]. Using a patient-centred consulting style one acknowledges that, apart from biomedical factors, emotional and psychosocial factors are worthwhile considering as well, resulting in the application of a biopsychosocial model. By looking after the patient instead of the disease, patients' need for reassurance and support (affective need) as well as their need for information and advice (instrumental need) are more likely to be met. In addition, new legislation, such as the Medical Treatment Agreement in the Netherlands, dictates patients' right to understandable information. Besides, decisions regarding treatment or life style changes should be taken in consultation. No doubt, these changes must have turned the medical visit into a meeting between two parties who contribute to the discussion more equally. However, it is unknown whether this ideal picture is really reflected in actual medical practice. Besides, can we really expect doctors and patients to communicate on the same level? After all, despite good intentions or new legislation, a meeting between a patient and a

doctor is still a meeting between two extremes. Patient and doctor may differ in roles (health care seeker vs. health care provider), language (lay talk vs. medical jargon), expectations (more diagnostic tests vs. wait and see) and perspectives of the complaints (biomedical vs. psychosocial attributions). In addition, they differ in the way they perceive the presented problem and accompanying emotions, thereby focusing on either biomedical or psychosocial aspects. Both viewpoints, the one of an egalitarian relationship, the other of a collusion of two inherently different perspectives, are expected to influence the communication between the doctor and the patient. It is, however, unknown which of these viewpoints dominates and whether this depends on the nature of the clinical setting or type of health problem. The purpose of this study was twofold: (1) to examine whether or not the communication between doctors and patients proceeds in a balanced way, and (2) to examine to what extent this depends on the nature of the clinical setting.

2. METHODS

The communication between doctors and patients was examined by means of observations of videotaped medical visits in three different outpatient settings, i.e. internal medicine (n = 85), paediatrics (n = 846) and gynaecology (n = 526). For this purpose, the videotaped medical visits were coded for verbal communication using the Roter Interaction Analysis System (RIAS) [2]. RIAS distinguishes affective reactions (e.g. exchanging social talk, showing empathy, concern and reassurance) and instrumental communication behaviours (e.g. asking questions, providing information and advice on biomedical or psychosocial issues) on the part of both the doctor and the patient. Affective communication is needed to establish a therapeutical relationship, to show respect and make the patient feel at ease. Instrumental communication indicates the content of the conversation between doctor and patient which might differ in the extent to which it is biomedically or psychosocially oriented. For the purpose of this study, some communication categories were joined together. Doctor–patient communication was considered balanced when they contributed to the conversation almost equally and they each spent about the same number of utterances on biomedical issues, psychosocial issues and patients' feelings. Differences between the communicative behaviours of the doctors and the patients were tested by means of the paired-samples t-test.

3. RESULTS

3.1. Internal medicine visits

All internal medicine visits examined concerned patients with type 2 diabetes who had been referred to the internist as a result of secondary failure to oral anti-diabetic agents [3]. During these visits, patients had to be convinced about the necessity of complying with a new medical treatment (usually insulin therapy) by means of evidence-based information (biomedical communication). In addition, they needed to be reassured about the frightening aspects of injecting oneself (affective communication) and informed about how to adapt their lifestyle to the new treatment (psychosocial communication). The communication during the outpatient visits can be characterized on the basis of the frequencies of the different communication behaviours depicted in Table 1.

[TABLE 1]

The frequency of the most important indicator of the affective component of the communication process (showing empathy and reassurance) showed that the affective communication between the internists and the patients was quite balanced, i.e. the doctors and the patients expressed an equal number of emotional statements. However, the amount of conversation dedicated to either biomedical or psychosocial topics appeared to differ substantially between the internists and the patients; whereas the internists focused almost exclusively on biomedical aspects of the disease, the patients appeared to be bothered about psychosocial issues as well. In fact, compared to the internists, the patients talked almost three times as much about psychosocial issues. Overall, patients' conversational contribution is 43% of the total amount of utterances.

3.2. Paediatric visits

Paediatric visits differ from other outpatient visits by the fact that there are three persons involved, i.e. it is a meeting between two adults, usually the doctor and the mother, and one child-patient. A consequence of this inequality may be that the paediatrician and the adult engage in an alliance from which the child is being excluded. A recent study shows that in conversations with a child-patient, the child is frequently ignored by both the doctor and the parent [4]. As a result of the alliance, paediatricians and parents might be expected to communicate quite similarly.

Again, the communication process (Table 2) was affectively balanced; the paediatricians and the parents showed an equal amount of empathic talk, which is indicative of a balanced interaction. In addition, although the instrumental conversation between the paediatricians and the parents seemed rather balanced as well, parents still talked almost twice as much about psychosocial issues. Similar to internal medicine visits, parents talked less than the paediatricians.

[TABLE 2]

3.3. Gynaecological visits

Gynaecological disorders often coincide with emotional or marital problems. These concomitant problems appear to predict clinic attendance more than organic factors [5] and also explain why patients experience physical complaints and disorders differently. Patients like their gynaecologist to take notice of personal and family conditions and to initiate communication about these subjects [6]. More specifically, patients would welcome a gynaecologist's exploration of their ideas about the illness and how the illness affects patients' functioning.

In accordance with the picture that emerges from visits in internal medicine and paediatrics, visits to the gynaecologists proceeded balanced only in terms of affective communication (Table 3). An exploration of the content of the interaction showed that the gynaecologists primarily focused on biomedical issues, whereas the patients more often talked about psychosocial issues. Overall, the patient's conversational contribution was small.

[TABLE 3]

4. DISCUSSION

The present study showed that in affective respect, medical visits may be considered quite balanced. The internists, paediatricians and gynaecologists, all seemed to acknowledge patients' feelings as they communicate in an equally affective way. By doing so, they fulfilled one of the needs patients have when visiting a medical doctor, i.e. the need to feel known and understood [7]. Besides, this balance offers a firm basis for establishing a therapeutical relationship. However, a lot of patients also want information on biomedical as well as psychosocial issues. Present findings suggest that the medical specialists have difficulty fulfilling this instrumental need, at least with respect to psychosocial aspects. Although the patients frequently talked about psychosocial issues, the consultants did not appear to react accordingly. Differences in the way doctor and patient communicated about the presented problem were apparent regardless of the nature of the clinical discipline. Doctors probably either neglected the psychosocial concerns or transformed them into biomedical issues. Similar findings were recently reported by Detmar et al. [8], who found that in communicating with palliative-treated cancer patients, doctors devoted 64% of their conversation to biomedical issues and only 23% to psychosocial issues. Patients' communication was divided more equally between these topics.

The imbalance in the content of the medical visits indicates that doctors and patients still differ a lot in what they consider to be important regarding the presented problem. However, one might wonder whether it is necessary to solve this difference. The main reason to do so is that different perspectives may cause a lot of problems. A patient whose questions have not been answered is more likely to become dissatisfied, seek a second opinion or use medication incorrectly. A recent ethnographic study of terminal patients with small cell lung cancer showed that different perspectives may even lead to false optimism about recovery, preventing appropriate end of life care [9].

TABLES

Table 1

Frequencies of communication behaviours observed in 85 internal medicine visits

Communication categories	Internist	Patient
Affective		
Social conversation*	7.59	10.53
Agreements/paraphrases*	32.53	42.18
Empathy/reassurance	6.67	6.55
Instrumental		
Clarification*	9.26	2.49
Biomedical conversation[a,*]	97.52	63.21
Psychosocial conversation[a,*]	2.81	8.76
No. of utterances*	175	139
Length of visit	14.6 min	

* Significant difference between doctor and patient (paired-samples *t*-test).
[a] Biomedical and psychosocial conversation includes questions, information and advice.

Table 2

Frequencies of communication behaviours observed in 846 paediatric visits

Communication categories	Paediatrician	Parent
Affective		
Social conversation*	10.43	11.62
Agreements/paraphrases*	34.52	40.18
Empathy/reassurance	5.96	6.33
Instrumental		
Clarification*	8.07	2.33
Biomedical conversation[a,*]	68.97	51.42
Psychosocial conversation[a,*]	7.51	14.21
No. of utterances*	156	131
Length of visit	14.1 min	

* Significant difference between doctor and parent (paired-samples *t*-test).
[a] Biomedical and psychosocial conversation includes questions, information and advice.

Table 3

Frequencies of communication behaviours observed in 526 gynaecological visits

Communication categories	Gynaecologist	Patient
Affective		
Social conversation*	9.19	11.31
Agreements/paraphrases*	26.28	42.64
Empathy/reassurance	4.37	4.66
Instrumental		
Clarification*	8.74	2.36
Biomedical conversation[a,*]	76.97	45.66
Psychosocial conversation[a,*]	3.60	8.49
No. of utterances*	159	121
Length of visit	13.3 min	

* Significant difference between doctor and patient (paired-samples *t*-test).
[a] Biomedical and psychosocial conversation includes questions, information and advice.

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