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Talking with patients from Howlong to the Himalayas

Do all our patients want us to be patient centred?

Patient centred communication is an important feature of general practice training. It is cited by general practitioners as one of the defining features of our specialty. However, many doctors are not convinced that this approach is always suitable. This article highlights the range of expectations that patients have toward communication styles. The experience of researching this topic in Nepal has confirmed this diversity for me. We need to have various communication styles at our disposal so that we can engage as many of our patients as possible.

If you work in a group practice, there is nothing like a colleague going on holidays to remind you of how different patients can be. When Dr Brown goes away his patients come into my office and settle into their chair as if they are expecting to spend all day with me. When Dr Jones is away, his patients are almost on their feet before I have finished signing the prescription. Patients of both doctors mostly think that their doctor is great.

Just two days travel away, I am sitting in a clinic in eastern Nepal supervising junior doctors and medical students. There are two doctors consulting from one desk and two medical students are interviewing patients on the edges. Occasionally a patient will make a suggestion about the ailment of the person opposite them. I am not able to ask the patients what they think of the doctors but there is consensus among junior medical staff that they are seen as 'second only to a god'. Is there a model of patient centred communication (PCC) that can accommodate all patients across all continents?

Patient centred communication

There has been increasing interest in concepts of patient centredness since Edith Balint defined patient centred medicine as 'understanding the patient as a unique human being'.¹ This movement has grown in contrast to the traditional biomedical model of health and disease. Henbest and Fehrsen² speak of 'putting the patient at the centre of the consultation' and shifting from 'thinking and responding in terms of disease and pathology toward understanding and caring for people and their problems'.²

Many general practitioners are familiar with the patient centred clinical method (PCCM), a model of patient centred consultation developed by Stewart³ and others. It consists of six components:

- exploring both the disease and the illness experience
- understanding the whole person
- finding common ground regarding management
- incorporating prevention and health promotion
- enhancing the doctor-patient relationship (including power sharing and therapeutic alliance), and
- being realistic (regarding time, resources and team building).

Most models of PCC share these components, although some (such as the PCCM) are more clinically based, recognising issues such as time pressure and the need for preventive activities. They all assume that the doctor is thinking far more broadly than the patient's physical pathology and is willing to share power and control.

The measurement of PCC is a complex process that requires surveying patients or observing consultations. Several observational methods have been developed in which tapes of consultations are analysed and an objective 'patient centredness' score calculated. This requires consultation behaviours to be classified into those that are more patient centred and those that are doctor centred. For example, one observational method of rating PCC determines that an increased amount of 'doctors' biomedical information giving' produces a less patient centred score. Another method determines that 'all doctors' talk about nonmedical matters' produces a more patient centred score.⁴ Increased 'power sharing' behaviours are universally defined as more patient centred.

All of these models have been developed in western countries.

What does the research show?

Research shows that patients have varying expectations about communication styles across demographic, racial and cultural groups. Younger patients, the better educated, those with less severe disease, and women, generally prefer more patient centred styles.⁵⁻⁷ There are subjects in all studies who prefer a directive, biomedical style.

The discussion about attitudes to PCC becomes more complex when we look across cultures. A literature review looked at different styles of communication across ethnic groups.⁸ It found major differences in physician behaviour when interacting with caucasian patients compared to ethnic minority patients. Doctors behaved more 'affectively' with caucasian patients. Patients from ethnic minorities were less assertive. These behaviours are clearly affected by complex issues of language and beliefs.

What about Nepal?

There have been studies in the developing world that measure patient satisfaction with medical services and the relative value that they place on good communication. I have identified no studies that measured attitudes to the various aspects of PCC.

On a recent working trip to Nepal I researched this topic by surveying attitudes of patients and doctors. Detailed description of this research is beyond the scope of this article, however, suffice to say that Nepalese patients share similarities with western patients in wanting good information and respectful relationships. However, they were generally happy for the doctor to control the consultation and be the sole information source. These findings did not vary across age, gender and education groups. The research instrument scored Nepalese patients as significantly less patient centred than patients in western studies.

Are we more patient centred than our patients?

Previous western studies have shown higher levels of patient centred attitudes in doctors

than their patients.⁵ The preliminary results from Nepal show this difference to be even greater. Surely it is absurd to state that doctors are more patient centred than their patients! This highlights the problems of definition and terminology. Activities that a doctor defines as patient centred may not seem that way to all patients. We have seen that some observational methods rate increased amounts of 'doctors' biomedical information giving' and less 'doctors' talk about nonmedical matters' as reducing patient centredness scores. Similarly, in my survey patients who give control to the doctor are rated as less patient centred. However, in Nepal these things were exactly what many patients wanted.

These issues show the complexity of the task of measuring PCC. Stewart recognises the difficulties of measurement in saying that 'the best way of measuring patient centredness is an assessment made by the patients themselves'.⁹ However, it should be noted that the PCCM is partly based on observational research methods and a codified tool for its measurement has been developed. The different attitudes that patients hold toward patient centred activities may be part of the explanation for the variable results in research that links PCC and medical outcomes.

What are the implications for practice?

There is a pragmatic approach in the literature that defines the tasks of the consultation rather than defining the specific outcomes of those tasks. In the PCCM, items 3 and 5 are more concerned with finding out what the patient's expectations are rather than pushing for a particular result, although most doctors will want to encourage their patients into partnership. In doing this we should avoid a new type of paternalism whereby a doctor pushes a patient into a power sharing role – even if the patient wants a different style at that time.

Doctors need to have various styles available in order to treat all of their patients effectively. This will accommodate variations between ethnic groups – and individuals – depending on time and circumstances. It is not that some patients want 'less patient centredness'. A doctor can appropriately adopt a very directive style in some circumstances and this can still

be understood as patient centred. 'Patient centred medicine means that the doctor... has the communication skills to handle the different types of consultations that result from that position'.¹⁰

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References

1. Balint E. The possibilities of patient centred medicine. *J R Coll Gen Pract* 1969;17:269–76.
2. Henbest R, Fehrsen G. Patient centredness: is it applicable outside the west? Its measurement and effect on outcomes. *Fam Pract* 1992;9:311–7.
3. Stewart M, Brown JB, Weston W, McWhinney I, McWilliam C, Freeman T. Patient centered medicine: transforming the clinical method. 2nd ed. Abingdon UK: Radcliffe Medical Press, 2003.
4. Mead N, Bower P. Patient centredness: a conceptual framework and review of the empirical literature. *Soc Sci Med* 2000;51:1087–110.
5. Krupat E, Rosenkranz S, Yeager C, Barnard K, Putnam S, Inui T. The practice orientations of physicians and patients: the effect of doctor-patient congruence on satisfaction. *Patient Educ Couns* 2000;39:49–59.
6. Levinson W, Kao A, Kuby A, Thisted RA. Not all patients want to participate in decision making. *J Gen Intern Med* 2005;20:531–5.
7. Swenson SL, Buell S, Zettler P, White M, Ruston DC, Lo B. Patient centered communication: do patients really prefer it? *J Gen Intern Med* 2004;19:1069–79.
8. Schouten BC, Meeuwesen L. Cultural differences in medical communication: a review of the literature. *Patient Educ Couns* 2006, [epub ahead of print].
9. Stewart M. Towards a global definition of patient centred care. *BMJ* 2001;322:444–5.
10. Bensing J. Bridging the gap. The separate worlds of evidence based medicine and patient centered medicine. *Patient Educ Couns* 2000;39:17–25.