DOCTOR-PATIENT COMMUNICATION: A EUROPEAN PERSPECTIVE

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Key Words: Cancer patients, communication patterns, doctor-patient communication, Japanese and Dutch physicians, medical curricula, oncological care.

Abstract

This essay is on doctor-patient communication. It will specially focus on doctor-patient communication in oncological care. In this paper there are 4 models of doctor-patient communication presented, and a number of suggestions for using these different models are put forward. The paper compares a number of studies on Japanese and Dutch physicians' communication patterns with cancer patients. It concludes that between these groups of physicians similarities are more prominent than differences. The paper also discusses the implications of these findings. Finally, it presents some new developments in medical curricula, especially regarding doctor-patient communication.

Introduction

"The patient-physician relationship is the center of medicine"

(Glass, 1996, p. 148)

A recent European report on medical education on the subject of cancer analyzed the extent to which various topics regarding cancer are being taught (Bender, Haagendoorn and Oltöff, 1994). The subjects of the study rated 'epidemiology',...
‘screening’, and ‘tumour biology’ as ‘excellent’ based on the number of courses and the teaching material. Issues such as ‘complementary medicine’ and ‘patient organizations’ were judged to be quite neglected. ‘Patient-physician communication’ and ‘psychosocial support’ scored in the average to poor range. Empirical evidence also supports the claim that communication with physicians which is perceived by patients to be supportive, helps improve the outcome of medical treatment (Ong et al., 2000).

In this paper we will discuss a number of issues regarding patient-physician communication as they pertain to patients with cancer. We will briefly outline two major components of doctor-patient communication. We will also review some studies on patients’ views on physicians’ ability to communicate. Moreover, we will discuss the relationships between adequate patient-physician communication and outcome in cancer treatment. This paper will also review empirical studies on similarities and differences concerning Japanese and European physicians where it comes to caring for patients with cancer. Finally, there will be some suggestions for research and clinical care.

1. Physician-patient communication

Studies on physician-patient communication in the clinical encounter usually distinguish two major characteristics: instrumental behaviour and affective behaviour (Ford, Fallowfield and Lewis, 1996; Ong, De Haes, Hoos, and Lammes, 1995). Instrumental behaviour pertains to exchanging information on symptoms and signs in order to facilitate the diagnostic and therapeutic process. Physicians ask questions, patients give answers: their patterns of communication aim at defining medical-technical actions. Affective behaviour pertains to efforts on the part of physicians and patients to establish a good interpersonal relationship in order to facilitate adequate medical management. It involves listening and sharing empathy, expressing concern, warmth and interest (Boon and Stewart, 1998; Roter, 2000).

Emanuel and Emanuel (1992) outlined four models of physician-patient relationship:

- the paternalistic model,
- the informative model,
- the interpretive model,
- the deliberative model.
In the *paternalistic* model, the physician and patient share the goal of medical care: the physician defines the goal, and the patient agrees with this goal. The physician also does his utmost to promote the patient’s well being, independent of the patient’s views. The patient complies with the goal defined by the physician, whose role is that of a guardian. The *informative* model entails a more pronounced role for the views of the patients about what to expect of medical care. The physician provides the patient with relevant information, the patient filters this information and mixes it with his/her own views about what s/he wants. Here, the physician is the competent technical expert. In the *interpretive* model, the physician elucidates the patient’s values, provides the patient with relevant medical information, the patient decides in the end what type of medical care will follow. The physician here is a counsellor or advisor to the patient. In the *deliberative* model, the physician and patient deliberate on what the various consequences of a certain medical treatment may be. The patient defines his/her own values, the physician is a friend or teacher.

The issues which these four models of physician-patient relationships raise, reflect not just an academic exercise. The approaches which underlie these models have many ramifications: political and cultural, clinical and emotional. It is evident that the four models manifest a continuum of ‘power to the patient − power to the physician’. The issue of the balance of power also reflects a cultural shift. In North American and European cultures many physicians, patients, governments and medical societies have moved from the paternalistic to the interpretive and deliberative model over the past years (AAMC, 1998). Recently, a provocative and brilliant paper by Sullivan (2003) analysed backgrounds and implications of this move. Sullivan maintains that in the future, subjective views about health and illness will be the determinants of the structure and content of medical care.

The empirical evidence for the positive effects of the change in the physician-patient relationship towards more empowerment of patients, particularly in patients with chronic illnesses such as cancer, is quite convincing (Kaptein et al., 2003; Petrie et al., 2002; Roter, 2000). Providing patients with information about aspects of diagnosis (i.e. medical procedures), interventions and long term management, including adhering to
medication and life style changes, leads to reductions in stress, pain and anxiety, and to improvements in function and mood (Barlow et al., 2002). Involving patients in the medical management of a chronic condition by exploring patients' concerns, worries, and questions and by sharing decision-making, results in similar positive consequences (Weinman, 2001). The same conclusions can be drawn about the positive effects of partnership building, rapport-building, and emotionally-responsive talk (Glimelius et al., 1997).

2. Physician-patient interaction in Japan

The literature on physician-patient communication in Japanese health care shows that the issue of 'disclosure' (i.e. telling the diagnosis of cancer to the patient) is a very important one (Elwyn et al., 1998). It also indicates that Japanese oncologists are moving towards the view which is increasingly more prevalent in Western oncology: patients are being told more about the nature of their complaints, symptoms and ailments. The diagnosis 'cancer' is not a taboo any longer. Given this observation we wanted to throw some light upon the question as to whether Japanese and Western oncologists differ in their patterns of physician-patient interaction.

An exhaustive review of this topic is beyond the scope of this paper. So we will focus our attention on three recent papers which appear to be very relevant in examining communication styles and patient satisfaction in Japanese cancer consultations (Ishikawa et al., 2002a; Ishikawa et al., 2002b; Takayama et al., 2001). Ishikawa and his colleagues applied the Roter Interaction Analysis System (RIAS) to assess physician-patient interaction. The RIAS encompasses both instrumental and affective behaviour (see paragraph 1). Physician-patient interactions were studied in a sample of out-patients with cancer (Takayama et al., 2001). The use of the RIAS allowed comparison of physician-patient interaction patterns between Japanese and Western physicians. Audiotaped consultations formed the basis for this comparison. Examples of characteristics of the communications are: open-ended vs. closed-questions, information giving, positive and negative talks. The Japanese physicians' most frequent utterances in the consultations were 'exchanging information' (35%) and 'social behaviour' (34%) (Ishikawa et al., 2002a, table 3). Comparing these data with two studies in the UK and in the Netherlands respectively, the authors observed a striking result: 'In general the interactions were quite
similar' (Ishikawa et al., 2002a, p. 306). Physicians in Japan and in the Netherlands (Ong et al., 1998) devoted most time to ‘exchanging information’ and ‘social behaviour’ (Table I).

**TABLE I**

Physician-patient interaction elements, a comparison between Japanese and Dutch physicians in oncology consultations (Ishikawa et al., 2002a; Ong et al., 1998).

<table>
<thead>
<tr>
<th></th>
<th>Japan</th>
<th>Holland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exchanging information</td>
<td>35%</td>
<td>36%</td>
</tr>
<tr>
<td>Asking questions</td>
<td>14%</td>
<td>13%</td>
</tr>
<tr>
<td>Counselling</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>Social behaviour</td>
<td>34%</td>
<td>35%</td>
</tr>
<tr>
<td>Other</td>
<td>11%</td>
<td>14%</td>
</tr>
</tbody>
</table>

3. Psychological interventions in patients with cancer

Patient-physician communication in oncological care is important in its own right because it raises valid moral and ethical considerations. Reducing anxiety in patients and respecting the integrity of human beings are important goals in medicine (Cassell, 1991). However there are additional issues: what are the effects of psychological interventions in patients with cancer? Do psychological interventions, which include optimal patient-physician communication, improve quality of life, and maybe even survival (Cella et al., 2003; Cook-Gotay et al., 2002)?

Although an exhaustive discussion of this fascinating and controversial topic is outside the scope of this paper, a few remarks seem in order. Meyer and Mark (1995) published a meta-analysis of studies on this questions, and concluded that “it would be an inefficient use of research resources to conduct more studies (...) on the simple question: Is there an effect of behavioral, educational, social support, and nonbehavioral counseling and therapy interventions on the emotional adjustment, functional adjustment, and treatment- and disease-related symptoms of cancer patients?” The answer is that “These interventions have a consistent beneficial effect on all three areas” (p. 106). Two very recent studies in major medical journals (Fawzy et al., 2003; Goodwin et al., 2001) also support the claim made by Meyer and Mark: psychological interventions in patients with
cancer do positively impact on quality of life and even survival. Incorporating quality of life in studies on patients with cancer is therefore a worthwhile goal (e.g. Kaptein et al., 2000; Scharloo et al., 1998; Yamaoka et al., 1998).

4. Implications for educating medical students and young physicians
   
   Our line of reasoning is not unique. Many others have emphasized how changes in our conceptions of morbidity and mortality, prevalence of chronic disorders, and societal changes, necessitate changes in how young physicians are educated (Jones et al., 2001). Table 2 outlines some of these major changes.

   | TABLE II |
   | Changes in medical curricula |
   | From cure to care |
   | From the individual to family and community |
   | From paternalistic to partnership |
   | From anecdotal to evidence based |

   (Jones et al., 2001, p. 700)

   In essence, all four changes in Table 2 are related to physician-patient interaction, some directly and some more indirectly. It goes without saying that some physicians and other health care providers may object to some, if not all, implications. It is difficult to give up autonomy or to share responsibility. It remains to be seen whether societal changes will be reflected in how physicians and patients will cooperate in the future. Empirical evidence, however, strongly supports the beneficial effects of these changes for the patients involved.

Acknowledgment

Presented in part at the meeting of the Japanese Society of Cancer Research and Therapy, Tokyo, 9 November 2002.

References


12


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