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Communicative culture of a physician

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Abstract

The article is focused on the problems of cultural competence and medical communication skills of physicians. Two basic approaches to professional communication - physician-centered and patient-centered - are described and characterized in the article.

Keywords: medical specialists, cultural competence, communication skills, physician-centered approach, patient-centered method

Studies concerning cultural competence and medical communication skills are based on examples of everyday medical practice. These modules do not focus on diagnosis and treatment. Instead, they focus on communication between health professionals and patients. These modules are not intended to show the only way to deal with a situation. Instead, they are intended to provide guidance on how to approach and reflect on these different scenarios.

The Communication and Cultural Competence Program is designed to illustrate communicative skills in medical context. There have been developed certain communication styles and techniques, as well as the standards expected of physicians in their daily practice. Applied with the modules, they may be useful in recognition and understanding of the difference between effective and less effective communication.

Like other people, physicians use communication skills in many different ways. A physician does the following during a typical day of practice:

- Makes rounds on hospitalized patients with other staff members;
- Calls colleagues about patients' referrals;
- E-mails notes about referrals;
- Sees new patients;
- Writes up charts, letters and reports (dictation, e-files, etc.);
- Takes calls from a ward nurse or other health professionals about the in-patients;
- Consults guidelines relevant to a patient;
- Attends committee meetings;
- Sees follow-up patients;
- Returns his patients' (and their relatives') phone calls;
- Reads the latest journal issues, and etc.

Thus, a physician's day involves four kinds of communication: (1) listening; (2) speaking; (3) reading; (4) writing. These components are the essential parts of communication. They are contextual, and the type and level of skill required depends on the setting, for example speaking to a patient as opposed to speaking to a colleague, or communicating with a friend. People adjust their behavior depending on the situation.

Selection of a communication technique and our expectations of a conversation depend on our cultural background. There are two major cultural systems at work in medical communication: the medical culture in which we are trained and/or practice, and the non-medical society in which we were raised and/or now live.

The requirements of physicians with regard to medical communication differ from those needed in other parts of life, such as socializing with friends, shopping, etc. Physicians must consider and process a large amount of information while selecting and interpreting input from patients and colleagues through active listening and observation. This information must then be integrated and summarized in the physician's mind and in oral and written formats.

The part of medical communication that many physicians, especially international medical graduates (IMGs), tend to find most different from their previous experience is usually the physician-patient encounter. All physicians have learned certain professional behaviors regarding the physician-patient relationship. These behaviors are culturally and historically determined, depending upon where and how the physician was trained. The basic approaches to physician-patient communication in medicine which have been constantly changing over the past 100 years are as follows: (1) the physician-centered model [the medical experience], and (2) the patient-centered model [the illness experience].

There are now many different models for physician-patient communication in the literature. These range from checklists of skills and techniques, to books on the functions of interviewing or the strategies to be employed. Most of them emphasize an understanding that the patient's context – his or her social, physical and psychological environment – is equally as important as the biomedical information the physician requires in diagnosing disease.

Why are communication skills felt to be so important? It is now recognized that better communication leads to being more patient-centered. While continuing to exercise medical reasoning, the physician gathers specific information not only about the patient's symptoms, but also the meaning of these symptoms to the patient. The closer a physician can come to an understanding of the patient's illness experience, the better he can fulfill his professional obligation to care for the patient. This obligation is to exercise medical expertise in a specific and unique patient context. For many physicians accustomed primarily to the biomedical model, this means that the kind of information considered clinically relevant must change.

These are some historical facts concerning physician-patient communication. The following is a short listing of some major trends. There have been and continue to be physicians who practice a variety of models of communication. Physician-centered approach was a predominant approach during the pre-World War II period:

- Physicians were highly regarded, paternalistic, and patients trusted them to behave in their best interests.
- Physicians were disease-oriented (physician-centered).
- There were few effective treatments to offer patients.
- Most physicians were generalists and knew their patients well.

During the post-World War II period (1950-1975) within the framework of physician-centered approach, physicians became even more overtly disease- oriented as:

- More effective therapy became available (e.g., antibiotics).
- There was an explosion of diagnostic and therapeutic technology.
- Specialization and research increased, which tended to distance the physician from their patient.

The physician-patient relationship was still strongly paternalistic, not because the physician knew the patient well enough to know what was best, but because the physician now had a much larger store of effective knowledge and treatments, resulting in:

- An even greater separation of the physician and patient, in terms of communication.
- Increasing dissatisfaction with visits to physicians.
- Patients felt they were neither heard nor understood.
- Increasing distrust of physicians, who were thought to be more interested in money and fame in the case of researchers and specialists.
- In some societies, a contractual, consumer model of the physician-patient relationship emerged. Physicians would show their wares and patients, with access to more knowledge, could shop around.

Medical training reflected the advances in biomedical knowledge, focusing on disease and the increasingly complex technology of medical practice. The dissatisfaction of patients was largely ignored as being irrelevant to patient care. Most physicians who are now practicing were trained in this biomedicine-focused, physician-centered system. History taking was the type of patient communication that was taught. In other words, physicians were taught to have a dialogue that was focused on asking questions to find out what kind of disease or abnormality was sitting in the office.

By the mid-1980s, the call for change in physicians' behaviors was insistent, driven in part by the rights' movement, the consumer movement and the appearance of the field of bioethics, which emphasized patient autonomy as a goal of care. In the last 15-20 years, many medical schools recognized the need to revise their curriculum to include communication skills. They began to look to those professionals whose approach to the physician-patient relationship recognized the importance of the patient's role in the dialogue. Among them were:

- Balint, who started group discussions to talk about "difficult patients".
- Engel, whose bio-psychosocial model was one of the first models of holistic medicine.
- Cassell, who described the difference between disease and illness, and language as a critical tool of medicine.
- Kleinman, who expanded patient-centered attitudes to all cultures.
- Stewart, Levenstein and McWhinney, developers of the Patient-Centered Clinical Method.

Physician-centered approach means that the physician's mind is focused on disease, the categories and locations of pathology. Communication with the patient is intended to provide information to assist the physician in locating and naming the disease, so that appropriate therapy can be administered. In this situation, it is the physician's experience and interpretation of the patient's distress that is important. Because the physician is thinking in terms of categories of biomedical pathology, the individual patient's context may not be heard. An individual patient's experience of and interaction with a disease process is not considered helpful to the physician, hence the frequent use of the term "subjective" for the patient's illness experience.

Focused on classificatory patterns and categories rather than on the specific individual patients, the doctor risks not understanding the particular interactions between this patient and the basic pathologic mechanisms that constitute just this person with just this disease. Thus, the doctor risks finding out what he or she already knows and missing precisely what the individual patient actually presents for diagnosis and therapy.

While the patient-centered clinical method described in the literature does have implementation strategies, no written material can ever show the true uniqueness and variability of physician-patient dialogue. It is difficult to capture on paper the many ways in which real interviews are developed. The use of video scenarios makes this more possible. Also, the focus in on communication itself: the verbal and non-verbal language of both physician and patient, and how this shapes the encounter. The principles are those of any patient-centered model, but the level of attention is more detailed.

Patient-centered approach means that the physician values the individual patient's understanding and meaning of illness as well as the biomedical information needed to manage the disease. Both are required. Further, it means that such information is valued because it contributes to the ability of the physician to provide high quality care for the patient. Patient-centered care has been shown to lead to better outcomes.

However, being physician-centered does not mean being a bad physician. Application of biomedical expertise is necessary, but not sufficient in clinical care. Being patient-centered does not mean complying and giving patients everything they request. This approach means being respectful of the patient's point of view and arriving at management plan that is acceptable to both the patient and physician. Nevertheless, patient-centered interviewing requires some special skills of the physician, which include: understanding the importance of context, of both the physician and patient; self-awareness in the interviewer; flexibility.

Patient-centered care presupposes several changes in the mindset of the clinician. First, the hierarchial notion of the professional being in charge and the patient being passive does not hold here. To be patient-centered, the practitioner must be able to empower the patient, share the power in the relationship, and this means renouncing control which traditionally has been in the hands of the professional. This is the moral imperative of the patient-centered practice.

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How does one acquire such skills and attitudes? It is necessary that medical students must be taught interviewing patients in order to understand the patient-centered method at all levels and to develop their language and communication skills. The entire complex of patient-centered approach includes mastering of techniques, styles and attitudes.

Techniques (specific tools used by physicians to express styles and attitudes) include: addressing disagreements, asking permission, bridging, clarifying, explaining why questions are being asked, facilitating, linking, negotiating, normalizing, paraphrasing, prioritizing, qualifying, quantifying, reflecting, reiterating, repeating, summarizing, using the patient's language, validating.

Styles (behaviors of physicians or how their attitudes are expressed) are as follows: (1) listening style: active (the physician responds to verbal and non-verbal cues, uses silence and interruptions appropriately, checks in); (2) questioning style: appropriate (open-ended, close-ended, directive, multiple); (3) non-verbal style: appropriate (facial expression, eye contact, body language); (4) speech patterns (the physician adjusts to patient's level of understanding, pacing is appropriate to context, vocabulary is appropriate to context, jargon is appropriate to context); (5) organization (flexibility – the physician follows patient's cues not rigidly bound to predetermined plan, appropriate focus and use of time, gathering adequate quality/quantity of biomedical information, gathering adequate quality/quantity of psycho-social information, active integration of biomedical and psycho-social information to create a complete context).

Attitudes (point of view, values, culture and environment of physicians) include: (1) being emphatic (understanding the patient's experience, acknowledging this understanding to the patient, checking in with the patient to clarify understanding); (2) being honest (always telling the truth, admitting a lack of knowledge); (3) having self-awareness (being non-judgemental, being aware of assumptions, being open-minded); (4) professional dialogue (encouraging discussion and feedback, seeking common ground, respecting the patient's viewpoint, seeking to put the patient at ease).

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