

Doctor-patient communication

Time for humanity from doctors towards patients

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Health care professionals should aspire to making medicine the most humane of the sciences

It would not be difficult to support the claim that medical achievements during the 20th century rank as high, if not higher, than those in any other field of human endeavour.¹ Doctors have played a significant part in delivering the findings of science to patients in a variety of health care settings. Yet, the climate today in medicine and health care is not an optimistic one; indeed, it may never have been so gloomy. We are living in an era of frequent public inquiries into health professionals' conduct, sensational headlines about failed, inadequate or unethical care, constant surveillance of performance and outcomes, concerns about NHS funding, and growing criticism from user groups and patients. Criticism of the effectiveness and cost of the biomedical model has been growing for at least three decades. Some would say that medicine's efficacy has been overstated and that improvements in health have been largely due to improved nutrition and living conditions, hygiene, and changing patterns of reproduction.² Illich argued that medicine has deskilled people in caring for themselves and their families, by ignoring the contribution they can make to their own care and recovery and encouraging dependency on medical "experts".³ Another criticism is that medicine now tends to focus solely on pathology and fails to locate the person within his or her socioenvironmental context. Patterns of morbidity and mortality are related to factors other than biology including, gender, class, race, education, income, and age.⁴ By looking only at the biological changes within the body, doctors fail to appreciate the links between people's lifestyles, their domestic, cultural and social circumstances, and their illness.

While never before has so much been on offer to so many patients by way of pharmacological, surgical and psychosocial interventions, patients appear to be more dissatisfied than ever with how services are provided. Dobson estimates that approximately a quarter of people who suffer from life diminishing neurotic disorders don't seek medical help

either because they feel that their doctor has nothing to offer them, or through fear of being reprovved for taking up the doctor's valuable time.⁵ A perceived lack of humanity on the part of doctors results in large numbers of people, especially those with the most pressing health problems, not having their health care needs met.

Yet the evidence suggests that patients do not necessarily want more drugs or more interventions. What they do want is a partnership with their doctor in which they feel at ease to explain what their concerns are and discuss treatment options that fit into the context of their lives. In Beaver *et al's* study of 1012 women with a confirmed diagnosis of breast cancer, 22% wanted to select their own treatment and 44% wanted to select their treatment collaboratively with their doctors.⁶ Fewer than half the women felt that they had achieved the level of control over decision making that they preferred. Patients' preferences about choice of treatment were not well understood by doctors because doctors based their treatment decisions on intuitive rather than confirmed assumptions about patients' intelligence, age, or quality of life.

Sacks has said that patients need to tell their story in their own way in their own time, and that the doctor should seek to establish how the problems the patient has are affecting his/her life at that time.⁷ Yet in the general practitioner's surgery, doctors may feel that allowing the patient time to talk may prolong the consultation to the detriment of effectively processing a waiting room full of other patients. It has been observed that the average time between the patient starting his opening statement and the doctor interrupting is 18 seconds and that 94% of all interruptions result in the doctor obtaining the floor. Use of closed questions and technical language, which the patient does not understand, are used to control the consultation, but will almost certainly guarantee that s/he will quickly return for a further consultation either

with the same doctor or another in the practice. Use of open questions enables patients to reveal substantially more information than use of closed questions. More information enables the doctor to clarify the exact nature of the problem, to find out how the problem is affecting the patient's daily life, and to understand the patient's beliefs about his illness. He is also able to find out whether the problem first stated by the patient is the main problem or merely an introduction to something else that is in fact of greater importance to him.

Allowing the patient to complete his opening statement provides the basis for a "patient centred" consultation. Broody stated that patients are more likely to improve when the meanings of their experiences are altered in positive directions, when things are explained to them, when they feel cared for, and when they feel they have an enhanced degree of control over their symptoms.⁸ Mutual discussion of treatment options and goals leads to fewer referrals and fewer investigations as the patient feels in control of the course of action being taken and more satisfied by his care. The doctor is more likely to prescribe drugs or treatment regimens to which the patient will adhere. Non-adherence is a major issue in the management of scarce resources, and understanding the reasons for this is a priority. We know that approximately 50% of patients do not take their medication correctly or at all. This wastage costs the NHS millions of pounds a year. Patients are more likely to comply when they have information about their condition, and understand what to expect in terms of both the positive and negative effects of their medication. Yet the study of Makoul *et al* showed that doctors spent just one minute in a 20 minute consultation giving information, although they believed that they had spent approximately half the interview giving information.⁹

In a recent study of patients with migraine, 88% of participants stated that their first requirement of their medical practitioners was a willingness to answer questions.¹⁰ Secondly, they wanted doctors to teach them about the causes of migraine attacks, how to treat them, and how to avoid them. The doctors, on the other hand, thought that patients wanted them to be "experts", demonstrating extensive and complex medical knowledge. Patients preferred to be able to talk to their doctors and trust that they were being given the whole story. While doctors may consider that patients primarily want information about treatment and drug therapy, it may be that patients are more interested in information about

diagnosis, the impact of their condition on their lifestyle, and prognosis.

Information giving must be followed by exploration of the extent to which the patient has understood what he or she has been told. Those working in education know only too well that 90% of the content of a class is lost from the student's memory within an hour of the class's finishing.¹¹ How much more is this likely to be the case when the "student" is anxious and stressed as is the case of the patient in the consulting room? To find out what the patient has heard and processed, ask him to tell you what he now understands about his condition and the treatment plan. Finding out how little has been understood can enable doctors to reflect on better ways of communicating information in the future by categorisation, signposting, summarising, repeating, and using diagrams.¹²

Litigation, we know, is almost entirely the result of breakdowns in communication between doctors and patients. Beckman *et al* analysed a series of malpractice depositions and found that poor delivery of information was one of the four most common complaints brought by patients.¹³ The other three were deserting the patient, devaluing the patient's views, and failing to understand the patient's perspectives. In a recent visit to the United States, I was told that malpractice insurance companies have started awarding discounts on their premiums to medical practitioners who attend yearly training in communication skills.

Students enter medical training with high ideals about the kind of help they would like to provide for their patients. Yet can we assume that their education will help them develop the communication and relationship building skills which will result in their approaching patients in ways that the patient considers empathic? Are students trained in *authority* or *empathy* and by the end of their training, has it become necessary for them to break the mould of training in order to become skilled physicians taking a keen interest in people and their families and the context in which

they live their lives?¹⁴ Training for medical students in key interviewing skills could enable them not only to be perceived as more caring by their patients, but also to make more accurate diagnoses, utilising to the maximum the consultation time allowed.

In the postmodern era, it should be remembered that patients are no longer quite so certain that experts in science and technology can answer society's most complex problems. As medicine has become increasingly influenced by technology and science, it may be at risk of losing contact with basic human values of respect for the other person's beliefs and preferences. This is particularly so in psychiatry, where clinical neuroscience finds itself in service to a political agenda driven by distorted media coverage of "failures" of community care where both the patient and those in his vicinity have been hurt. Risk reduction and public safety rather than care and rehabilitation are now at the top of the agenda. The result is legislation forcing people to take medication and detaining them against their will, even in advance of their having proved themselves a danger. Psychiatry has always been deeply split between care and healing on the one hand, and government legislation, in shifting the balance in favour of control, is making this split ever deeper. No other medical specialty has spawned the equivalent of the psychiatric survivors' movement, confirmation of the perceived coercive nature of psychiatry.

In the developed world, the 21st century promises to be the era of depression and anxiety and of *lifestyle-killers*—diseases arising from smoking, poor diet, sexual behaviour, drug misuse, and stress. Patients will need to have real insight into their lives and to take responsibility for them if they are to recover. The greatest enemy of health and the least effective health care practitioner may be the paternalistic physician who takes decision making away from patients. Providing patient centred, compassionate care requires skills based education, excellent support systems to avoid doctor

burn-out, and clinical supervision. The rewards will be seen in terms of reduced costs for the NHS, better relationships between doctors and their patients leading to greater satisfaction on both sides, reduced litigation, and a redefinition of medicine that puts it back in touch with its aim of meeting the mental and physical health care needs of suffering humanity. The efforts of all doctors in conjunction with other health care professionals must now be towards realising the aspirations of medicine to become the most humane of the sciences as its founding fathers intended.

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