

How doctors talk to patients and why

- Asking questions only gets you answers.
- It is not whether the communication between doctor and patient is good or bad that matters, it is whether it is more or less effective.

For over 5000 years now the basic style of doctoring can be described in the modern ethical jargon as beneficent paternalism. The medical profession has thus adopted a well-meaning parental role in most patient encounters. Doctors have acted on behalf of, and for the good of, their patients. They have also wielded power over them. This role, which is taken for granted by our society, produces recognisable patterns of behaviour, which are disease-orientated with a strong tendency towards authoritarianism. It has become clear in recent years that this behaviour affords the doctor some emotional protection – in fact often more perceived than real – and is one of the most important reasons why many doctors find a more sharing approach so difficult.

AGENDAS

One way to think about the ways in which doctors communicate is to consider the *agendas* for both doctor and patient. Figure 2.1 demonstrates diagrammatically the possible spectrum of doctor communication behaviour with patients.

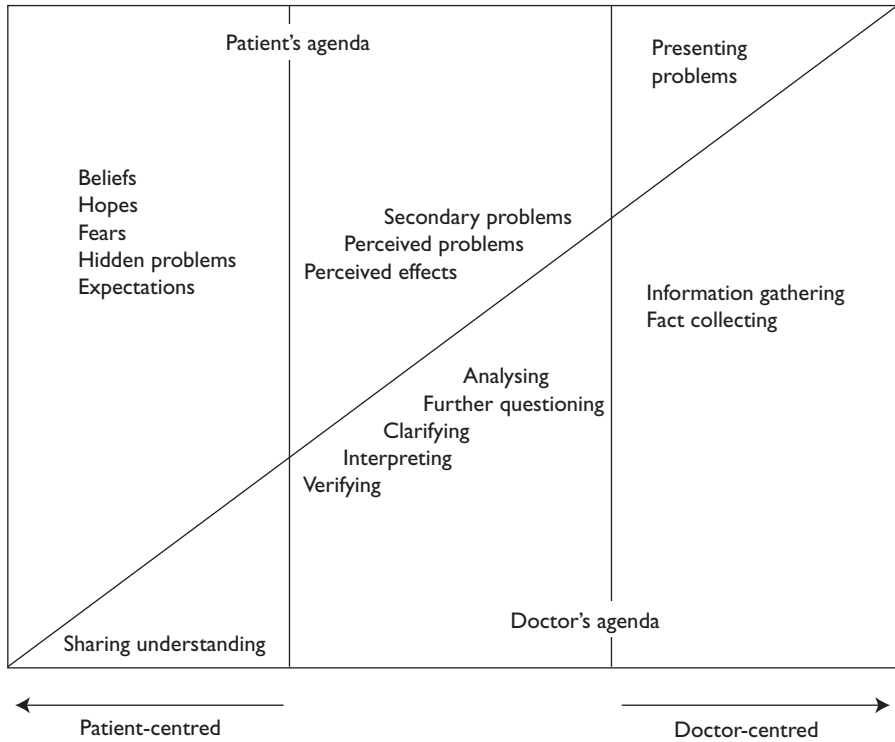


FIGURE 2.1 A power-shift model of styles of consultation.

The right-hand side of the graph is nearly all doctor's agenda, with only the presenting complaint coming from the patient. As the doctor's style moves to the left, more and more of the patient's agenda is taken on board, until at the left-hand end of the graph it is nearly all patient's agenda. Most hospital doctors and still the majority of GPs tend towards the right-hand end of this model. This is not too surprising, as it is the way we are taught. For GPs working in the UK it is also the way we are

paid, the Quality and Outcomes Framework (QOF) being a centrally set medical agenda. The whole act of *taking* a history is doctor-centred, and not necessarily bad in itself. Medical thoroughness and good pattern recognition are a hallmark of this style when practised well.

As an example of doctor-centred behaviour, imagine Mrs Arthur's first outpatient appointment. It could go something like this:

Dr: Good morning, Mrs Arthur. Your GP says you seem to have a problem with your thyroid gland. Tell me, have you lost weight?
Mrs A: No.
Dr: Any hot flushes?
Mrs A: No.
Dr: Feeling tired or slowed up?
Mrs A: Er, well, maybe a little, doctor.
Dr: Bowels OK? Not constipated are you?
Mrs A: Not really, doctor, I was wondering ...
Dr: I think I should examine you now. Would you take your blouse off ...?

Mrs Arthur's agenda has not figured in the conversation so far – only the doctor's agenda is being addressed.

Here is an example of a more patient-centred style, using the same scenario:

Dr: Good morning, Mrs Arthur. Your GP says you have a problem with your thyroid gland. Would you tell me about it?
Mrs A: Oh, er, well yes, I first noticed the swelling a few months ago, but I didn't do anything about it for a while.
Dr: Why not?
Mrs A: Oh, you know, I hoped it would go away while fearing the worst.
Dr: The worst?

Mrs A: Cancer, what else.

Dr: That's a frightening thought. Do you still think it may be cancer?

Mrs A: Well, yes, but I'm hoping you will be able to tell me, doctor.

In this example the patient's agenda figures highly to start with, and the doctor has not yet started on his agenda.

The totally patient-centred doctor is probably a dangerous creature. Patients do after all come for medical advice and considered professional opinions. They don't expect the doctor to let them do all the talking, planning and managing.

However, the first chapter may have got you thinking that the doctor should more often than not take on board some of the patient's belief systems. An ideal doctor might perhaps lie around the middle of this spectrum, changing their behaviour one way or the other depending on the needs of the patient and the situation.

The problem as shown by experience and research work is that doctors *do not change*. Audio and visual recordings of multiple consultations by the same doctor show a remarkable consistency of style. A simple analogy likens us to the traditional Englishman abroad. We don't act differently – we just talk more loudly or slowly. Thus doctors say and do things in much the same way with an anxious 16-year-old coming for a termination as with a 50-year-old woman with menorrhagia or an 80-year-old woman with vulval carcinoma. It appears that we do not regularly adapt to meet the needs of the patient. You could say that this does not matter so long as we have an effective set of behaviours with which we can cope with most patients. However, Chapter 3 will demonstrate that different patients need different types of communication. We need to be flexible, and it appears that most of us are not.

The most basic communication need is to discover why our patient has come to see us. This seems almost too obvious to state, but much research work suggests that doctors are not very good at it. In many consultations, doctors and patients do not appear to be talking about the same thing. Many years ago one of the truly great academic GPs, Professor Pat Byrne, gave this type of consultation the deliberately ugly name of *dysfunctional*.

In this sort of consultation the doctor and the patient are each pursuing their own quite separate agendas.

Doctors are good at diagnosis (i.e. establishing in the medical sense why a patient has come to see them). We discover the nature and history of the problem and the likely cause, but we tend not to be good at searching out our patients' beliefs and expectations. These are the real reasons why patients come to see us, and not discovering them can lead to a mismatch of agendas.

For example, a gloomy 64-year-old man comes to his GP for a sick note. The doctor knows this person to be a somewhat aggressive, paranoid depressive with a long history of repeated admissions to a psychiatric hospital. The man says that he has been in hospital recently, and asks for a certificate. The doctor, seeing no record of the latest admission, but assuming that the usual has occurred, acquiesces quickly. He wants to avoid any difficult confrontation, and therefore fills in a certificate stating 'depression.' The doctor and patient briefly discuss convalescence and returning to work, and the patient leaves.

What is wrong with this scenario? Almost everything! The whole consultation was based on a false premise. The patient had in fact been admitted to hospital with a myocardial infarction. The doctor's original assumption was false, and nothing in the ensuing communication put it right. The doctor had failed to discover why his patient was there, and the patient did not realise this.

Dysfunctional consultations are common in general practice because the patient's reason for coming to see their doctor is often unclear, but major misunderstandings do occur regularly in hospital. Consider the case of Mrs Arthur again. Let us carry on with the doctor-centred example given earlier in this chapter. Assume that the doctor has examined Mrs Arthur and completed the history taking in the form of a series of staccato questions. Mrs Arthur has therefore contributed none of her own thoughts and feelings. The time for explanation and management has come:

Dr: Well, Mrs Arthur, there is nothing to worry about. You have multinodular goitre, but this is a benign condition. There are a

couple more tests we need to do just to be on the safe side. I will arrange for a special scan and a biopsy of that biggish lump. Is that OK?

Mrs A: So you are sure it is not serious, doctor?

Dr: Oh yes. Speak to the nurse about the arrangements for the tests and I will see you in a month. Goodbye.

Mrs A: Well, goodbye doctor, er, thank you.

This is deficient communication. The patient has not had any of her agenda addressed. Consider her ideas in Chapter 1. She has not been reassured about her future. She will probably attend for the tests out of fear, but she may default. She is not sure what the words ‘multinodular’, ‘goitre’, ‘benign’, ‘special scan’ or ‘biopsy’ mean, and she will go home feeling frustrated and afraid. The doctor, in turn, has focused his attention on the thyroid gland to the exclusion of everything else. He knows little about Mrs Arthur and nothing about her specific fears or reasons for consulting. This consultation is truly dysfunctional.

POWER

Look at Figure 2.1 again and think about *power*. This type of diagram is known as a power-shift model. The doctor is much more in control on the right-hand side, and his power slips away as the agenda increasingly becomes that of the patient. This is not to say that the totally patient-centred doctor does not have power. They simply have less direct control and are much less authoritarian. It is worth stopping here to consider the nature of doctor power.

Patients expect and often want a powerful doctor – that is, a doctor who has reassuring authority, who is apparently capable and whose pronouncements can reduce anxiety. One definition of medical or ‘Aesculapean’ authority divides it into three parts – *sapiental*, *moral* and *charismatic*. These words are somewhat offputting at first meeting, but bear with me.

Sapiential authority

This can be defined as the right to be heard, based on knowledge or expertise, and it means that doctors must know, or at least appear to know, more about medicine than their patients. However, this can only be one part of the doctor's authority, as a biochemist may know more about a particular branch of medicine, but it is to a physician that a patient turns when they are in need. Moreover, as we discussed at the beginning of the book, this knowledge is now much more freely available, thus reducing the intrinsic sapiential power of modern doctors.

Moral authority

This is the right to control and direct patients significantly, based on doing what society expects of us as doctors. In order to retain their moral authority, doctors must always act with the good of the patient as their paramount concern. This is derived from the Hippocratic credo. In addition, societies generally revere doctors, which means that doctors' behaviour is seen as socially right as well as individually good. This is a powerful combination.

Charismatic authority

This is the most difficult of the three concepts, and is similar to the anthropological definition of magic. It stems from the original unity between medicine and religion. In Western culture it is related to the possibility of death, and the magnitude of the issues with which the doctor deals. Many patients want doctors to be a little magical. For most of us when we are ill there is a need to supplement sapiential and moral authority with an ineffable factor, which might just hold out hope against the odds. Many doctors go out of their way to cultivate this. They develop a priestly mien, use complicated and obscure rituals, and act more like bishops than physicians.

The three forms of authority are present in all doctors, although some doctors go out of their way to develop particular sapiential, moral and charismatic elements in their behaviour towards patients and others.

Think about some of the powerful doctors you have met and the nature of their power.

Here is an example. A partially patient-centred doctor, like that shown in Figure 2.1, has the same moral authority as their doctor-centred colleague, but they may reduce some of their sapiential authority by sharing more information with their patients. This highlights a fundamental truth. *Controlling information increases doctor power and restricts patient involvement.* Many doctors still become very uneasy with knowledgeable and inquisitive patients, as such patients decrease the doctor's control. The partially patient-centred doctor will also be more likely to attempt to demystify the nature of medical diagnosis and treatment, reducing their charismatic authority and thus their power to control the interview. This requires a degree of bravery, particularly when first trying such strategies.

Most doctors, perhaps especially when they are training, are afraid of losing control – of exposing too much of their patient's pain and fear. You may find yourself not asking the important question due to fear of opening an emotional Pandora's Box and becoming overwhelmed. Such doctors use their power over their patient to keep the box shut and emotions at a non-threatening level. This style of behaviour can then become fixed and persist throughout a career. Don't let this happen to you, or you will lose much more than you will gain.

Doctors can increase their charismatic power, should they wish to do so, in many different ways. The trappings of power are the most obvious – for example, white coats, impressive mysterious gadgetry, attached (subservient) staff, a large desk with a big chair placed firmly behind it, grandiose-looking certificates on the wall, and computers with unintelligible displays or pointing away from the patient. Such doctors may communicate by means of cryptic oracle-like pronouncements, shrouded in 'medico-speak.' This can then be wrapped up with dire warnings of the fearsome consequences of not following the treatment properly, in order to complete the effect. Powerful rituals such as examining and prescribing are more charismatic in the absence of adequate explanations.

The problem with this contrived exercising of medical authority is that the overwhelming evidence suggests that *it is not very effective.* It

quite obviously does not increase patient understanding, because that is not what is motivating the doctor. The often quoted reason for this style of communication is that it will make patients do what is good for them. However, the sad fact of the matter seems to be that more often than not they don't. The literature on compliance or what is now more hopefully called *concordance* with medical advice reflects rather badly on doctors.

The *rule of one-thirds* describes this. It is easy to remember and is well authenticated.

- One-third of patients take medical advice and act in accordance with it sufficient for the advice to be effective.
- One-third take heed of some of the advice, but not enough for it to be effective. Imagine the way that many doctors take pills for a sore throat – a few one day when it is sore, forget for a day or so, and then start again when the throat gets sore again.
- One-third just don't bother.

For the sixth edition of this handbook it would be encouraging to report that recent evidence has shown this trend to be improving. Sadly, this is still not so. In many cases, especially in psychiatry, the rule of one-thirds appears to err greatly on the optimistic side.

Take the common life-threatening condition of maturity-onset diabetes, an illness that leads to blindness, terrible circulatory problems and considerable morbidity. Many patients need at least two drugs to control their blood-sugar level adequately. The modern rash of protocols usually assumes 100% adherence to prescribing regimes. So what are the facts? In a careful and thorough study of 1000 diabetic patients from Tayside in Scotland, reported in early 2000, the authors showed that adherence to a one-drug regime did indeed fit with the rule of thirds, with 33% of patients taking the medication as prescribed. However, when two drugs were prescribed the adherence fell to 13%! A review of the literature in 2005 revealed that long-term adherence to drug treatment decreased over time, and that 50% was an average figure after 3 years.

Think about this long and hard. You want to be the finest doctor in the land – to be able to recognise a yellow nail syndrome at 20 feet, to

restore ailing people to full vigour with your hard-earned expertise – but in some cases more than two-thirds of your patients don't follow your advice. If your patients are really like that, how much use are you? How can you make sure that this fate won't befall you? Do you have to be in absolute control?

There is now a healthy debate about the very word 'compliance', which implies a subservient relationship. As previously mentioned, many experts are now advocating the use of the word 'concordance' instead, and some prefer the word 'adherence.' What is clear is that the slavish following of medical advice by patients is not only an unusual behaviour, but appears to be so uncommon in many cases as to be regarded as deviant.

Now think about this. I repeat that you are living through a time of historic change in the role of doctors. You are no longer the keeper of occult secrets, you are not the fount of all medical wisdom, and many of your patients will know more about their individual disease than you carry in your head. Your job has changed so that you are now your patient's medical interpreter. The Internet has torn up the rules, old-fashioned communication strategies are no longer viable, shared decision making is a must, and concordance rules. Read on.