

## THE DOCTOR PATIENT RELATIONSHIP; WHAT IF COMMUNICATION SKILLS ARE NOT USED? A MALTESE STORY

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### SUMMARY

*The doctor patient relationship is fundamental to the practice of medicine. In the UK, much work has been carried out to develop training in communication skills for both doctors and medical students. Whereas it is true that controlled trials of communication skills are now beginning to emerge in the primary care literature, it is also true that there is need for studies of communication skills on the hospital ward. One alternative form of evidence for the need of communication skills is that of anthropological studies of hospital wards. We here summarise the observations made in one such anthropological study which was carried out in a renal unit in Malta. The conclusion of these observations is that the inability of the doctors to utilise communication skills is that patients develop meaningful relationships with other groups of professionals, to the extent that they consider them as part of an extended family. Doctors remain isolated from all these relationships and only relate to patients from a position of power.*

**Key words:** communication skills - doctor patient relationship - anthropological studies

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*“The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it.”*

Sir James Spence, 1960, Professor of Paediatrics, Newcastle-upon-Tyne

The doctor-patient relationship is now a major issue in the international literature on the delivery of health. This doctor-patient relationship has been studied in medical, anthropological and social science terms and has now entered the basic teaching of general practice. The consultation has been described as central to medicine and Michael Balint (1964) speaking from a psychodynamic perspective, has suggested that the most important drug that the physician prescribes is himself. Boardman et al. (2009) have suggested that such ideas should also be applied to nurses and others in the treatment team. Such concepts have led to the introduction, at the insistence of the General Medical Council, of communication skills training in medical schools and GP training. Such communication skills are now part of the medical final exams in medical schools such as Cambridge. This is not necessarily so in all countries. In Malta, which is quoted in this paper, some Communication skills training is given to medical students by the department of Psychiatry (Cassar 2009).

### The importance of communication

In the United Kingdom, both General Practice and Psychiatry have developed the idea of the doctor-patient relationship into becoming the central tenet of medical practice (Agius 2008). The consultation facilitates this relationship and communication underscores its deve-

lopment. It is this consultation which is the central moment in the relationship between two persons; one of whom may have a problem, but also much life experience, whilst the other, who has also had years of life experience and study of the art of medicine, is believed by the first to have the knowledge and skills to help find a solution (Agius 2008).

At the beginning of a consultation, a patient arrives with ideas, concerns and expectations which they expect to be discussed and understood by the practitioner. If, in particular, their expectations of the consultation are not met, the consultation is unlikely to have been successful from the patient's point of view. Effective communication can therefore improve both patient and doctor satisfaction. Observational studies by Little et al. (Little 2015), investigated verbal and non-verbal behaviour in the context of patient perceptions. The results suggest that patients may respond to non-verbal behaviours and non-specific verbal behaviours, such as social talk, more than traditional verbal behaviours. A doctor's skill as a communicator extends past conventional aspects of patient-centred care. Knowledge of a patient's personal life and their history serves to reinforce the patient's sense of a personal relationship. A subsequent randomised control trial by Little et al. (Little 2015), demonstrates the importance of reflection in the development of effective doctor-patient communication. The trial finds that GPs briefly trained in non-verbal and non-specific verbal elements of communication improve a patient's perception of satisfaction, distress, a partnership approach and health promotion. This is further enhanced by reflecting on consultation videotapes, a form of consultation analysis as discussed later in this paper.

Good communication should be considered as a creative art that can be developed throughout a medical career (Warnecke 2014). Communication with a patient should not purely involve the doctor asking questions and getting answers. This would cause problems in the balance of power in the doctor-patient relationship. Power is an inescapable aspect of all social relationships, and inherently is neither good nor evil (Goodyear-Smith 2001). A doctor must acknowledge that they have a position of power but that this must not be misused, particularly in the setting of a consultation. The patient must be allowed time to express themselves and offered cues allowing not just for the exchange of relevant information but also for the development of trust and empathy.

The words of Hippocrates, 'Cure sometimes, treat often and comfort always' can be related to the modern day doctor-patient relationship. Medicine is often seen primarily in terms of the interventions that can be performed. However, the increase in mental health disorders and chronic disease means that the final words 'comfort always' ring more true than ever. It is easy for a doctor to have their own agenda and focus on what they can and can't do for a patient. However, real comfort can only be offered when a doctor considers a holistic range outside their normal scope which may involve for example therapeutic, palliative or hospice care in the case of terminal illnesses.

### **Concepts of communication skills in the United Kingdom; consultation models and analysis**

Medical students are taught to diagnose disease with the basic template of history, examination and investigation, but analysis of the consultation takes a much more profound view of why the patient came and what has been achieved within the consultation (patient.info 2015). Consultation analysis has developed as part of doctor's training in order to emphasise how this mutual understanding can be brought about in the consultation (Agius 2014). The objective of consultation analysis is to closely scrutinise the consultation and identify verbal and non-verbal behaviours that helped or hindered the patient during the consultation. Through this it is possible to improve consultation outcomes with the main intention being to develop communication skills and enhance doctor-patient relationships. Several important consultation models and styles are discussed below.

Michael Balint's book, 'The doctor, the patient and his illness' (Balint 1957) became an essential text in the renaissance of British General Practice in the 1960s. He emphasised the importance of considering a patient's psychological state when a patient presents with a primarily psychological problem or with a physical complaint. Balint also acknowledged the important role that doctors own feelings play in the consultation. Balint had group discussions with 14 GPs on using 'brief practical psychotherapy' in consultations, explaining the importance of looking at patients from a bio-psycho-

social view. His book looks in depth at patients 'who for some reason or other, find it difficult to cope with the problems of their lives resort to becoming ill.' He describes how in these cases the doctor acts as a 'drug' and their actions are therefore fundamental in how a patient responds to their illness and treatment. However, there is 'no pharmacology of this important drug exists yet. To put this discovery in terms familiar to doctors, no guidance whatever is contained in any textbook as to the dosage in which the doctor should prescribe himself, in what form, how frequently, what his curative and maintenance doses should be'. One of the most important communication devices that Balint describes is 'active listening', where the doctor responds to patient cues, follows up ideas and re-states what the patient has said to make sure they have understood correctly. This serves to enhance the doctor-patient relationship by building trust and means that the doctor does not just 'ask questions only to get you answers'. Balint's approach exists to heighten a doctor's self-awareness, both consciously and unconsciously in order to improve the consultation dynamic.

In 1972, the Royal College of General Practitioners released 'The Future General Practitioner' which marked the start of work by many within the Royal College of General Practitioners (RCGP 1972) which helped define the characteristics of modern general practice in the united Kingdom, in particular ensuring appropriate consideration of the physical, psychological and social condition of the patient.

Byrne and Long wrote 'Doctors talking to patients' in 1976 which analysed tape-recordings of 2500 patients in order to determine the verbal behaviours used (Byrne 1976). This provided 'a set of instruments with which the solo learner could provide himself with feedback to facilitate his self-learning'. They found that the doctor was 'both a product and prisoner of his medical education' and that many consultation approaches reflected a doctor-centred authoritarian style where the doctor is a passive listener. Byrne and Long describe six stages to the consultation which are as follows:

- The doctor establishes a relationship with the patient.
- The doctor attempts to discover the reason why the patient attended. This might not be as transparent as first it seems. What is the patient's agenda? What are their fears and concerns?
- History and possibly examination occurs.
- The doctor, in consultation with the patient, considers the condition.
- Treatment or further investigations are discussed.
- The doctor brings the consultation to a close.

These stages are not in a particular chronological order and should not be used as a sequential checklist, which would lead to a rigid inflexible consulting style (Pawlikowska). Both Balint's book and this text are considered to be quite doctor-centred and do not entirely fit the patient-centred style that is stressed today.

In 1984, David Pendleton released his PhD thesis on consultation analysis building on the approaches mentioned above (Pendleton 1984). He set out seven tasks for a doctor to achieve in a consultation. These are as follows:

- Define reasons for attendance.
- To consider other problems.
- To choose an appropriate action for each problem.
- To achieve a shared understanding of the problem.
- To involve the patient in the management and enable him or her to accept responsibility.
- To use time and resources appropriately.
- To establish or maintain a relationship with the patient.

The model emphasised the importance of both doctor and patient involvement and cooperation. It is a patient-centred and partnership model which facilitates a balance of power in the consultation. Pendleton was also a pioneer of the use of video recording for analysis of consultations. This is now used in the training of registrars and is a component of several medical examinations. It encourages doctors to reflect on their communication skills and consultation styles to make appropriate adjustments to progress as practitioners. Peter Tate (1996) worked with Pendleton and developed on this idea in 'The Doctors Communication Handbook'. He introduced a video consultation analysis module into the MRCGP exams in 1996 and came up with the famous acronym ICE (ideas, concerns and expectations).

The use of recording in consultation analysis was used to great success by Stewart and Roter as described in 'Communication patterns of primary care physicians' published in 1997 (Roter 1997). They analysed consultations with 537 patients and 127 physicians recorded on audiotape and therefore focussed on verbal communication. The verbal communication patterns varied from being narrowly biomedical to consumerist and had varying degrees of patient satisfaction. Communication patterns closer to consumerist were generally more satisfactory for both physician and patient. There are two parallel pathways in the gathering of information, one following the illness framework (patient's agenda) and one following a disease framework (the doctor's agenda) (patient.info 2015). These should be brought together in the consultation so that both parties have a shared understanding and form an appropriate plan of action together.

John Launer wrote 'Narrative-Based Primary Care' published in 2002, which describes how we construct our view of reality by telling stories (Launer 2002). In order to understand a patient's story, Launer recommends that a doctor should use several techniques. There should be a focus on active listening and circular questioning to aid the development of the story. Physicians have the potential to take on an important supportive role in the creation of the illness narrative: to

create and to formulate new stories, and thus help patients in their coping process and even contributing to their personal growth (Kalitzkus 2009). This is particularly useful in consultations dealing with a patient's mental health.

Lewis Walker describes neuro-linguistic programming techniques in his book, 'Consulting with NLP' written in 2002. NLP is similar to a patient-centred approach. Patients have a unique 'internal map' which causes them to interpret experiences differently. NLP hones the ability of a doctor to 'read' the patient and therefore understand and affect the patient's thinking patterns (Walker 2002).

Consultations have been described in British literature using various methods with each one having different stages and aims. 'The Exceptional Potential in each Primary Care Consultation' was written in 1979 by Stott and Davies and describes a four point framework that should be systemically explored (Stott 1979):

- Management of the patient's presenting problem.
- Modification of help-seeking behaviours.
- Management of continuing problems.
- Opportunistic health promotion.

Management of both the presenting problem and continuing problems tend to be attended to well by doctors and this is what the patient focuses on. Modification of help-seeking behaviour and opportunistic health promotion is often neglected perhaps because these need to be addressed over several consultations. However, it is important that doctors consider them as they seek to improve long-term patient care. Modification of help-seeking behaviour is important for patient behaviour in future consultations. This area seeks to educate patients on self-help strategies and prevent over-use of medical services. Opportunistic health promotion 'ensures that the patient leaves better able to make informed choices.' This simple model provides targets for both the doctor and patient to attempt to influence the patient's health, from initial presentation and into the future.

The model that is described by Roger Neighbour in 'The Inner Consultation' (Neighbour 1987) includes five stages. It is an instinctive model that focuses on maintaining a positive consultation dynamic. The doctor must firstly connect with the patient and develop a rapport. This initial development of empathy for the patient affects the success of the next stage. The second stage is 'summarising' of the patients' reasons for attending, their ideas, expectations and concerns. This is followed by 'handing over' an agreed management plan to ensure there is a balance of power in the doctor-patient relationship. 'Safety netting' is a way in which the doctor can then make follow up plans and discuss risks and potential outcomes. Finally, 'house-keeping' ensures that the doctor is in a good state of mind ready for the next patient.

One of the most well-known and most-used methods of consultation is 'The Calgary Cambridge Method' (2000) as described by Silverman et al. This provides evidence based-guidelines and outlines the skills required for communication (Silverman 2000). The aim is to establish and maintain a positive doctor-patient relationship with the patient at the heart of the consultation. The Calgary Cambridge Method is a five stage model designed to facilitate patient involvement and enablement, and is fairly similar to Neighbour's model described above. The session is initiated by establishing rapport and a shared agenda. Information about the patient is gathered and relevant questions are asked, initially starting with open questions and then moving on to more closed questions. Both verbal and non-verbal cues should be noted by the doctor and relevant findings followed up. It is then important to build on the doctor-patient relationship by developing the rapport and going over information that the patient has provided in order to demonstrate understanding, empathy and support. The doctor should then explain their thoughts and make a plan together with the patient ensuring that they understand and allowing them to clarify any misunderstandings before the session is closed.

British literature on consultation models and analysis is constantly evolving and there are wide-ranging techniques used to explore consultation styles. However, the overriding theme focuses on the importance of reflection and good communication. Although the literature reflects little change in what are considered to be effective communication skills, there have been changes over the years to reflect a shift to patient-centred care and partnership. This discourages an authoritarian approach and ensures a balance of power during the consultation. Doctors are taught to look more closely at the psychosocial aspect of illness and use this to develop a positive patient-doctor relationship when considering the biomedical aspects of the disease. The doctor-patient relationship is very dependent on the adoption of a consultation style which leads to an open discussion between doctor and patient which continues with the sharing of information by both parties, so as to arrive at a mutually agreed solution to the problem which the patient has presented for discussion and which is to be implemented by a mutually agreed plan (Agius 2014). Consultation analysis is a well-studied area and plays a vital role in the learning and teaching of communication skills.

### **When communication skills are not utilised by a doctor, what are the consequences?**

Although there is a vast amount of information in British literature on the use of communication in the consultation, what has never been described is what happens when there is no attempt by the doctor to use communication skills?

It ought to be pointed out that whereas most of the literature on consultation analysis in the UK comes from general practice, (Pendleton 1984, Tate 1996, Launer 2002, Byrne 1984) in fact, the present medical student training also covers junior doctor work in the wards (Silverman 2000). Furthermore, in Cambridge, there also exists a 'professionalism course', in which one of us, an experienced teacher on the professionalism course, has observed that students have frequently raised issues regarding problems of communication skills which arise on ward rounds. Hence it does appear that difficulties in communication skills do occur in hospitals in the UK.

One approach to understanding communication skills, and the consequence of their neglect is to use an anthropological study in order to observe what happens if communication skills are not valued by the doctor. One such unpublished study has been carried out by one of us in the renal unit in St Luke's hospital and Mater Dei hospital in Malta.

In summary, it appears from this anthropological, descriptive research, that if patients feel that they do not relate to their doctor, then they develop strong relationships with other professionals, in the case of the Renal Unit the nurses.

What arises from the anthropological study which we are quoting is that within communication skills in general, body language becomes extremely important when establishing the relationship.

Furthermore, body language include at one level posture, active listening, facial expression, but at a wider level, it also includes the arrangement of the room, how the doctor and patient are oriented to each other (sitting, lying or standing), how the doctor is dressed, and on a ward round, who the consultant addresses, whether the patient is given time to speak, whether the patient is allowed to have an explanation of what is being discussed between members of the team, and so on.

For example It has been repeatedly observed in General Practice in the UK that sitting with a desk between a doctor and patient puts the doctor in a position of overwhelming authority and is not conducive to good doctor-patient communication. Sitting with the patient to the side of the desk, closer to the doctor, is believed to improve doctor-patient communication (Cassar 2009). If the seating organisation between doctor and patient in the consultation room is considerably different with a table separate the parties concerned on opposing sides. Having the doctor talking across the table to the patient carries the undercurrent of power with the table almost acting as a boundary to any potential doctor-patient relationship. One party is the authority; the other is the subject.

A structure, be it cultural or not, which does not put doctors and patients on a level plane gives a general

perception of an authoritarian approach, and this cannot provide patient enablement. This kind of approach would make any medical system rather unsympathetic.

It needs to be added that, in the study, it is not just a lack of communication skills during a ward round which is a barrier to communication between doctor and patient in the Renal Unit, but also other symbolism relating to doctors and their position in society as communicated to the patient. Thus, doctor's clothing (White Coat), their carrying a stethoscope, etc are all symbols which put doctors apart, and therefore are part of unconscious negative communication between doctor and patient. We below quote verbatim from the unpublished study.

Medicine needs to directly connect with the people who are in need of it, which is achieved through the medical practitioners themselves. Nurses commented that, due to the situation in which these patients with chronic renal failure find themselves, contact with medical professionals is crucial. On the Renal Unit this occurs at many levels, with both doctors and specialised nurses being posted to this ward. Once admitted, patients attend regularly and, with the exception of deaths and the referral of new patients, faces become familiar. The treatment requires that patients spend a good part of their day, three to four times weekly, in the ward. This means that patients and nurses in particular have the chance to establish positive relationships and become accustomed to each other. One nurse commented that they inevitably become part of each other's lives. Evidently, nurses here get to know their patients on a very personal level. This is seen to happen on at least two levels: firstly and foremost, the regularity of attendance serves to encourage mutual friendship; secondly, nurses have to keep detailed and up to date records of the patient's medical history. In the setting of the Renal Unit, a patient's medical history can be seen as almost equivalent to a patient's social history. This flow of personal information seems to create a distinctive relationship between patients and staff. This could be the reason why a feeling of family really pervades the unit.

Both patients and nurses commented on various occasions that 'hawnekk qisna familja' ('here, we are like a family') or 'il-familja ta l-isptar' ('the family at hospital'). This kind of contact seems to overcome those difficult boundaries that patients in health-care often experience. Patients with chronic renal failure have to learn to cope with and accept several realities. The insidious, incurable chronicity of the disease ultimately intrudes into the patient's life and affects their whole sense of self. Their physical entity is changed forever; and worst of all, it slowly degrades with the passing of time. A nurse reported that referral to the renal unit is in reality a first port of call towards death. End stage renal failure is after all a silent death. Therefore, it comes as no surprise then that talk about this issue is avoided on all accounts. A patient's death is the real wakeup call to the remaining living patients.

In a situation filled with insecurities and pain inflicted by chronic renal failure, patients need to feel secure, taken care of and esteemed by and within the medical establishment, in particular by their immediate care givers. Nurses at the Renal Unit partly fulfil this role and make patients feel that they have value and are cared for. A healthy platform for consistency in the form of peace of mind and regard is present. These are good grounds for the maintenance of stability beyond chronic renal failure where stability cannot be guaranteed. Having achieved this platform, patients can build a way to self-actualisation and see themselves with worth and as a separate entity to their disease. All patients must feel that they belong within the 'family at hospital'. This family is security, equity and a place where various relationships and affiliations can be formed. However, what is interesting in this discussion is the lack of mention of doctors and their seeming detachment from the 'hospital family'. *this is so because of his apparel and his behaviour on the ward....*

Categories that are perceptually acknowledged in a hospital's setting are 'care takers' in the form of ill or temporary malfunctioning individuals and 'care givers' in the form of doctors, nurses and consultants. These individuals have their own designated spaces and distinguishable attire which is seemingly indicative and representative of their associated behaviour. Attire seems to play a crucial role in hospital. Sartorial images or representations are quite symbolically charged. Generally medical students are spotted doing their rounds in their white lab coats. Housemen, doctors and consultants present themselves in very smart dress, many with a stethoscope around their neck as their trade mark. The latter are seen flashing by in hospital corridors. Patients of course have a very different look about themselves; which seems to reinforce the distinction between provider and receiver. When patients were being received in consultation rooms, the general assortment of people would be such that medical staff would be behind one side of a desk and patients on the other. Indeed inside the ward, doctors had a tendency to deliver their diagnosis, or otherwise communicate with the patients, standing beside the patient's bed. The placing of the doctor and patient places power in the hands of the doctor before verbal communication has even begun. This goes against patient-centred care models and doctor-patient partnership as described in the British studies above.

This greatly contrasted with how non-medical staff, such as chaplains, interacted with patients. They were generally observed to stand closer to the patient, sometimes even sit down, and physical contact between them, such as an amicable rub or holding hands, was common. There was observed to be less discrepancy between the roles of patient and chaplain. For patients who accepted the chaplain's visit, the mood seemed lighter and more personal. This is no criticism or judgment towards doctors but simply an observation of the difference of attitudes towards patients and the

varying dynamics in the hospital. The hierarchal structures within the local medical system seem to have patriarchal tendencies, usually from those professionals belonging to the upper ranks over those of lower ranking such as nurses, and including patients. This discrepancy is also brought about by differences in medical language that doctors and nurses utilise. Nurses do not generally use as much technical jargon as doctors, making the language of nurses more 'popular' and accessible for patients. It is true that nurses spend more time with patients than doctors; 'popular' is what the patient understands, or can begin to comprehend.

Doctors seem to be set apart by their overtly medical background and presumed position in society. In contrast nurses have a tendency to act as mediators between patient and doctor, and unconsciously make the patients' experience of hospitalisation less oppressive. This is the difference in attitude of doctors and nurses towards the patient, albeit they are both being medical professionals and both administering medical care. In the medical hierarchy in Malta, nurses are 'underneath' ('taht') the doctors, who in turn, are 'underneath' (in this case, understudy) consultants. The outcome is that the patient develops distinct relationships relevant to the appropriate professional even though the patient is equally dependant on both doctor and nurse for treatment and support. For patients inside the renal unit those 3 to 4 hours of dialysis time would be a lot worse if these mediators (nurses) are absent. They also seem to be mediators between the patient's chronic illness and the machine: they attach the patients to the machine, and meanwhile are there to support and talk to the patients while the treatment is carried out. Amongst patients at the Renal Unit, nurses were considered as the ultimate consultants, since they were constantly present giving advice and becoming a bearer of hope.

The issue of Apparela as illustrated in the Anthropological Study is further illustrated by the comments by one of the hospital chaplains reported below.

A member of the chaplaincy describes the situation where he believes that the medical system in Malta seems to be "more sacred than the Church". It is seen to have just as much power over the individual: medicine is an ultimate. These situations ultimately have significant effect on patients' lived experience of medicine and their disease. For patients, sartorial symbolisms are a point of reference. The visual prominence of clothing sets off a variety of perceptions. This was apparent after a meeting with one of the resident chaplains at the hospital whose uniform is a distinguishable brown tunic. One particular chaplain explained how he chose to denude himself of any religious symbolism (with the exclusion of a cross-shaped pin), including his tunic. In his experience he deduced that some patients felt threatened when a religious person approached them. The chaplain explained that the immediate reaction of patients towards him were that he was either a harbinger of death or an extorter of forced conversions. This creates

a great deal of tension within the patient, particularly in those of a resistant disposition. This seems to hinder the real purpose of the chaplain. It is neither their responsibility to give any medical information to the patient or their relatives; nor is it their aim to impose faith or conversion on the sufferer. As was explained to me, by the various chaplains who were interviewed, the main purpose of their role in hospital is to help patients in their healing process – whichever kind of help they may need. The patient is at liberty to refuse them. Their role is more of an active participation in comforting the individual – be it patient, relative and even staff. In view of this drastic reaction toward the perceived oppressive religiosity, this particular chaplain had resorted to normal casual attire. In this way, he believes that he can reach out to patients, or rather that the patient is more accepting of him. This, he is convinced, has aided his pastoral mission. It is indeed true then, within Maltese society, that the dress proclaims (or does not proclaim, as the case may be, for the patient) the man – *l'abito non fa il Monaco* (Italian proverb).

## CONCLUSIONS

It needs to be said that the data which we have described above is simply data based on one anthropological study of a small number of doctors observed in a small number of wardrounds, which were observed some years before the writing of this article. It is not by any means meant to be a criticism of doctors in general, and it should be noted that one of us does, during the professionalism courses which he runs, hear similar comments on ward rounds in UK, while also hearing about many excellent examples of the Doctor-Patient Relationship. However it is true that the situation discussed in the anthropological study does reflect general problems within the doctor patient relationship in many hospitals in my countries which one of us (MA) has visited.

The conclusion of these observations is that the ineffectiveness of doctors to utilise communication skills is that patients develop meaningful relationships with other groups of professionals, to the extent that they consider them as part of an extended family. Doctors remain isolated from all these relationships and only relate to patients from a position of power. This is reinforced particularly by the hierarchical dress code we have described which creates an invisible barrier to meaningful consultation of patients' conditions and treatment plans. Doctors remain outside of the 'extended family' of nursing staff which may in part be explained by societal expectations ...

It is our opinion that the anthropological study described above sheds important light on the need for effective relationships between doctors and patients. Further anthropological studies, including comparative studies between different healthcare systems and countries/cultures are necessary to give further evidence on the need for effective relationships between doctors and patients.

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