

The Power of Talk – Creating a Healing Environment

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### **THE POWER OF TALK – CREATING A HEALING ENVIRONMENT**

*I wouldn't demand a lot of my doctor's time. I just wish he would brood on my situation for perhaps five minutes, that he would give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh to get at my illness, for each man is ill in his own way...Just as he orders blood tests and bone scans of my body, I'd like my doctor to scan me, to grope for my spirit as well as my prostate. Without such recognition, I am nothing but my illness.*

(Words of Late Anatole Broyard, Professor at Columbia University, who wrote this to his doctor shortly before his death from prostate cancer in 1990).

The failure of conventional medical practice in meeting patients' perceived needs and expectations is well documented in academic literature (Myerscough & Ford, 1996; Starr, 1992). What is less well known is that inadequate clinical communication can lead to serious problems such as noncompliance, medical complications and litigation (Prounis, 2005; Shapiro, 1989). The purpose of this study is to review aspects of medical interviewing which promote a positive patient-centered approach. The paper attempts to provide insight into the integrated understanding of a patient's reason for a medical visit and his or her expectations out of it. At the same time it looks at doctors' approach to patients and analyzes communication aspects which promote an open and empathic dialogue and foster long-term relationship building in order to improve patient satisfaction and compliance with therapy. Although this review will touch on some aspects of communication and relate to the relevant theories, it is not meant to be an 'anatomy of the talk', in other words, it is not a detailed linguistic analysis of the communicative

aspect of medical interviewing. It rather emphasizes more the ‘power of talk’, that is, the creation of a secure and problem solving environment in doctor-patient communication which will produce a conducive environment for the healing to take place.

Most of the health communication research cited in this review paper has come from varied academic disciplines of sociology, psychology and medicine. It is a difficult literature to review since patient-centered communication appears to be disorganized without much theoretical cohesiveness. This has led to a proliferation of terms such as patient-centric, relationship-centered and others, without agreement on the basic definitions. In fact, the literature appears so disparate that twenty years ago, even when the studies on the subject were limited, a reviewer described it as a Rorschach test (Inui, 1985), in which the interpretations reveal as much about the reader as the literature itself. The situation does not seem to have improved much. The presented literature is limited to primarily American and British writings. Most of the research in the realm has investigated physician’s communication aspects and very few have looked at patient’s communication process. Having been trained in medicine myself, I acknowledge that to a certain degree this review may be skewed by my personal experiences in medical practice.

## **NEED FOR THIS STUDY**

*The history is everything. Think about the classic description of diseases that were written before the guys with the CAT scans. (Apker & Eggly, 2004, pp.420)*

More than twenty years ago, Flaherty (1985) observed that with the advancement in medical technology, the basic tools of Western medicine such as history taking and physical examination, are being neglected more and more in medical practice. This notion seems to have

become more widespread over the past two decades. Stewart et al. (2003) contends that patients notice and resent when biotechnology takes over the agenda of the medical visit between a doctor and a patient which then minimizes the importance of patient's unique personal story. Although biomedical technology has developed exponentially (Mauksch, 1980), the basic premise of the doctor patient interaction, which is to take care of the unique patient has remained the same. In fact, Stewart et al., (2003) point out that modern medical genetics studies, strongly support treating each patient distinctively with a tailored management plan. Patient care and medical genetics go hand in hand in recognizing that a patient-centric approach is essential.

It is well documented that medical interviewing still remains the most important diagnostic tool (Hasnain, 1997; Peterson, 1992) and consequently are the ultimate determinant of the treatment modality of the patient. Hales et al., (1994) has noted that the single most important method of arriving at an understanding of the patient is by medical interviewing; the effectiveness of which depends on the physician's ability and willingness to communicate. Unfortunately, there is considerable literature suggesting widespread patient dissatisfaction due to the poor quality of patient-physician communication (Harrigan & Rosenthal, 1986; Hulka, 1979). The quality of dialogue often determines the future doctor-patient interaction and patient compliance with the treatment regimen (Ley, 1979). Harlem (1977), in a comprehensive review of communication in medicine described a significant discrepancy between patients' and doctors' interpretations of common and popular medical terms and suggested that many of the patients do not really understand what the doctor tells them even when they think they do. In the same review Harlem also notes that better communication is indispensable to the practicing health professional and that most fundamentally of all, better communication is essential to the

consumer of health services. It seems that such communication problems start taking root in medical school since various studies have found that medical students frequently use jargon and medical terms in medical history taking, which are not easily comprehensible to most patients (Irwin, 1989). Walker (1973) therefore advised that the communication area needs to turn its best effort towards an understanding of communication problems peculiar to the health care area. Unfortunately, it seems that this is not what has been happening. For instance a study by Stewart (1979) showed that 54% of patient complaints and 45% of a patient concerns are not elicited by their physicians during medical interview. Similarly, although doctors come across psychosocial and psychiatric problems commonly in general medical practice, but these diagnoses are missed in up to 50% of cases (Schulberg, 1988). Hence while analyzing the challenges of the doctor-patient encounter, Barnlund (1976) suggests the need for research to elucidate the mechanisms that sometimes distort the meaning of the communication exchange. Fuller and Quesada (1973) have shown that the effectiveness of communication between the participants in the therapeutic system is a major determinant that the therapy may succeed. It has been noted that patients' satisfaction in consultation is increased when physicians communicate in simple language (Evans et al., 1987) and allow patients to openly express their beliefs and ideas (Korsch, 1972). The rapport between a patient and physician determines the extent and quality with which the doctor is able to transmit relevant information to the patient (Dimatteo, 1979).

There is no denying that the edifice of medical practice exists because of the patients and therefore they need to be put back in the center of health care. There however does not seem to

be widespread research on positive medical interviewing techniques employed by the physicians, despite the fact that a majority of the complaints by the general public about doctors deal not with their clinical competency but rather with communication problems (Richards, 1990). This study is an effort to review the important research that has been conducted in the realm.

## **EVOLUTION OF DOCTOR-PATIENT INTERACTIVE RELATIONSHIP**

From the time that Hippocrates instructed his students on how to communicate with patients, doctor-patient communication has been a subject matter of interest in medical teaching and practice. Bulger & Barbato (2000) contend that Hippocratic medicine was committed to understanding of the whole person. Thus it can be inferred that the emphasis of Hippocrates was not on the disease but on the patient. With the passage of time the roles of the patient and the physician were defined by sociologists. The conception of professional and patient roles in terms of privatized and proximal relationship is evident in the analysis of medicine in *The Social System* by Parson (1951). According to Parson it is up to the physician to direct and set the boundaries of the clinical encounter. The roots of such doctor dominated and disease centered approach can in fact be traced back to Rene Descartes. Foss (2002) narrates that in 1634, Descartes wrote that “the body is a machine, so built-up and composed of nerves, muscles, veins, blood and skin, that even though there were no mind in it at all, would not cease to have the same function” (p. 37). Descartes conceptualization of body as a machine had far reaching impact and laid the foundation of modern day medicine with its emphasis on the body physiology rather than the patient as a whole. The later successes in the eighteenth century firmly established this ontological model of disease in medicine, according to which the disease is located in the body and is separable from the sick person (Dubos, 1980). This model prevails even today.

The prominence of medical communication in clinical encounters waned sharply with the professionalization of medicine (Shorter, 1985). Edward Shorter (1985) categorizes Post World War I as crucial era for modern medicine. During this time, Sulfa drugs and Penicillin revolutionized medicine leading to the development of chemistry oriented sciences such as biochemistry, pharmacology, microbiology and immunology. This led medicine to concentrate mainly at the organic picture of the disease which could be countered with drugs (Roter, 2006). This then heralded the start of the 'biomedical' model of medicine, with a consequent decrease in interest in the patient's experiences of illness. The advances in medical technology added to this trend (Novack, 1981). According to Shorter (1985) this depersonalization of medicine downgraded the importance of history taking and greater emphasis was placed on more structured questioning and interpretation of laboratory data. Roter (2006) contends that it is then not coincidental that the practice of interviewing patients around a series of closed ended questions developed around this time. This remodeled the medical interview as wholly scientific and objective and left no room for the catharsis that the patient felt by telling their story to the physician.

However since the past twenty five years in which a call for a more humane form of medicine has been made, there has been a renewed interest in doctor-patient communication (Baron, 1985). Lain Entralgo (1969) contends that communication relationship between doctor and patient had presented no serious problems until the twentieth century. He attributes this fairly recent friction to four modern developments: the increasing importance of medical technology and its potentially depersonalizing effects; the popularization of psycho therapy and the consequent widespread interest in all interpersonal relationship; the socialization of health

care; and modern Western culture's changing effects on patient perceptions of illness and wellness. This has led to the introduction of the interviewing and interpersonal skills courses in medical teaching (Lipkin et. al., 1984). In parallel with this trend in medical education, has come the increased sociological interest in doctor patient communicative aspects over the last two decades. Thus studies in late 1960s coded statements and compared for instance the frequencies with which doctors and patients gave and received information (Korsch et al., 1968).

Balint and colleagues (1970) introduced the concept of patient-centered medicine. In the 1970s and early 1980s when patient-centered medicine was in the initial stages of conceptualization it was viewed by scholars and researchers as a soft-science. Caring and empathy were acknowledged to be traits of the care-giver but few people gave credence to potential crucial role of patient-centered communication in modern scientific medicine (Stewart, 2005). It however gained more authenticity once Byrne and Long (1976) developed a method to categorize a consultation as either doctor-centered or patient-centered. Value addition to patient-centeredness was made when family-centered approach to patient care was introduced (Doherty & Baird, 1987). Recently the focus in patient centeredness has been on the structure of the discourse such as the ways that medical dialogue is organized (Mishler, 1984) and to describe the particular discourse structures which either facilitate or hamper the expression of patients' viewpoints and expectations. It is evident from the flurry of recent academic research that the patient-centered method portends to bring patient back to the center stage of healthcare by restoring the Hippocratic ideal of friendship between the doctor and the patient (Stewart, 2003).

## MODELS OF MEDICAL INTERVIEWING

Physicians exhibit differing styles of communication with their patients, which range from doctor-centered (or disease oriented) at one extreme to patient-centered at the other (Laine, 1996). The disease-oriented model is doctor led in which the physician concentrates on his/her own agenda and where the doctor essentially seeks to reach a clear diagnosis of the problem through direct inquiries (Levenstein, 1986). The term patient-centered approach refers to the understanding of the complaint offered by the patient not only in terms of illness but also as expression of patient's unique individuality, tension, conflicts and problems (Balint et al., 1970). The dominant model in medical practice has been the doctor-centered approach (Novack, 1981) (also referred to as the biomedical approach) and can be categorized as part of the conventional medical model. Criticizing this conventional medical model, Engel (1977) noted that it left no room within its framework for the social, psychological, and behavioral dimensions of illness. He asserted that the conventional biomedical model not only requires that disease be dealt with as an entity independent of social behavior, but it also demands that behavioral aberrations be explained on the basis of disordered somatic (biochemical or neurophysiologic) processes. This dominant ideology espouses value neutrality, objectivity and social control through authority and technical expertise (Waitzkin, 1991). This model oversimplifies the complexities of sickness. Stewart (2003) contends that the biomedical model is a conceptual framework for understanding the biological dimensions of sickness which reduces sickness to disease. The focus is on the body not the person.

On the other hand in the patient-centered model the doctor uses less of the direct inquiry method and approaches the patient with a more empathic attitude. The focus is the person and not the disease, because illness and disease may not always co-exist. For instance people who are worried or grieving may feel ill but have no disease (Stewart, 2003). The physician creates the secure space to enable the patient to express his/her feelings, ideas and expectations (Henbest, 1989). Reaching a correct diagnosis is not the sole goal of the physician in such an approach. Stewart (2003) has described patient-centered care as a process which (a) explores the patient's main reason for the visit, concerns and need for information (b) seeks an integrated understanding of the patients' world – that is, their whole person, emotional needs and life issues (c) finds common ground on what the problem is and mutually agrees on management issues (d) enhances prevention and health promotion and (e) enhances the continuing relationship between the patient and doctor. Patient-centeredness is therefore a framework encompassing both abstract concepts, such as humanism, empathy, and self-awareness, and concrete concepts, such as rational organization of a medical interview (Roter, 2000).

In summary, the doctor-centered model embodies the classic paternalistic doctor patient relationship in which the disease is the main concern, the doctor is relatively dominant and the patient is expected to defer to the doctor's judgment. The patient-centered model, however, is characterized by a physician's desire for a relationship in which the patient is involved in the decision making process, and the person rather than the disease is the focus of treatment (Krupat, 2000). No wonder then patients typically like doctors who listen attentively, are genuinely concerned about them, and acknowledge their feelings (Williams, 1997).

## **ILLNESS AND DISEASE FRAMEWORKS**

In order to appreciate the patient-centered approach it is essential to firstly recognize the distinction between the two conceptualizations of ill health, that is, disease and illness. Twaddle (1994) defines disease as a health problem that consists of a physiological malfunction that results in an actual or a potential reduction in physical capacities or a reduced life expectancy. Ontologically, Twaddle (1994) characterizes disease as an organic phenomenon independent of the subjective experience or social conventions. Epistemologically disease is measurable by objective means. Stewart (2003) explains this by noting that disease is diagnosed by objective observation; it is a category, the 'thing' that is wrong with the body-as-machine or the mind-as-computer. She considers disease as a theoretical construct by which physicians' attempt to explain patients' problems in terms of abnormalities of structure or functions of body systems or organs and includes both physical and mental disorders. Twaddle (1994) identifies illness on the other hand as a subjectively interpreted undesirable state of health. Ontologically, it is the subjective feeling of the individual, which is referred to in the medical terminology as a symptom. Thus it is the personal experience of the feelings, the thoughts and altered behavior of someone who feels unwell. Epistemologically, this feeling can only be directly observed by the subject and indirectly through her/his reports and by eliciting of signs during physical examination. In support of the above mentioned definitions by Twaddle, Hoffman (2002) contends that disease calls for action by the medical profession towards actively identifying and treating the occurrence and taking care of the problem. Illness on the other hand alters the actions of the individuals and the patient himself/herself communicates his or her personal experiences to others in the form of symptom. Hoffman (2002) argues that those instances where a patient is ill and has subjective symptoms, but no disease has been found, pose an epistemic as well as a

normative challenge. Epistemologically it is a challenge for the medical profession to find a cause for the symptoms. Normatively it is a challenge to know what to do in such situations.

## **THE TWO CONTRASTING VOICES OF MEDICAL INTERVIEWING**

A useful way of looking at the doctor patient communication is through Mishler's (1984) theoretical concepts of two contrasting dialectic frameworks which characterize medical discourse. In a typical medical interview setting, the doctor and the patient talk to each other with different voices. Mishler terms these as the Voice of medicine, representing the technical and scientific assumptions of medicine and the Voice of Lifeworld, representing the natural attitude of everyday life.

The voice of medicine is characterized by medical terminology, objective descriptions of physical symptoms, and the classification of these within a biomedical model (Mishler, 1984). In the standard medical interview of the prevailing biomedical model, the voice of medicine dominates. In this the physician tends to control the content and form of the interview by unilaterally defining what is and what is not relevant through the questions he or she asks. Distorted medical communication is many a times the outcome when the doctor employs a technical, diagnosis focused, Voice of medicine; since it is incompatible with the natural, everyday Voice of the ordinary or lifeworld, employed by the patient (Lyons, 2006). According to Mishler (1984), The Voice of medicine manifests a technical interest and signals a scientific attitude. He further elucidates this by adding that "the meanings of events are provided through abstract rules that serve to decontextualize events, to remove them from particular personal and social contexts" (p.104). Stewart (2003) contends that the Voice of medicine produces a scientific, detached attitude and uses questions such as "When did it start? Where does it hurt?"

How long does it last? What makes it better or worse?” (p.36). On the other hand the Voice of the Lifeworld directly relates to patient’s lived experiences of life. Such patients’ voice is characterized by non-technical discourse about the subjective experience of illness within the context of social patient’s everyday life and social relationships. Typical questions that explore the lifeworld include: “What are you most concerned about/ How does it disrupt your life? What do you think it is? How do you think I can help you?” (Stewart, 2003, p.36). A tension exists between a lifeworld perspective, in which illness is perceived as having many causes based in daily life, and a technical perspective, in which the one correct biomedical answer is sought (Apker, 2004). Mishler (1984) observes that generally physicians tend to consider the voice of the lifeworld as irrelevant and not medically significant. That the Voice of lifeworld needs to be heard is borne out by Cassell (1985). He posits that patients are not objective observers who can report about their diseases mechanically, rather they narrate things that have happened to them and they assign meaning, interpretations and casual explanation to their narration. When the physician attends to the Voice of the lifeworld, the contextual narration of the story by the patient is facilitated.

Figure 1 illustrates that the Voice of medicine acts as a tool of biomedical medicine. The interaction is predominantly technology driven. Typically, doctors have considerably more power than patients to structure the nature of interaction between them. Consequently, patients may feel that their voice is being silenced, or stripped of personal meaning and social context (Alam, 2007). Due to the hegemonic power enjoyed by the physician (Brody, 1992) the patient’s voice is suppressed. Doctors who adopt a paternalistic approach are more likely to want short descriptions of physical symptoms that they can then transform into diagnostic categories (Gafni, 2000). The Voice of medicine has the potential to lead to tension between the patient and the

doctor. Where the Voice of lifeworld is used, it can lead to a humane interaction. In such a scenario the physician is willing to share power and listen to what the patient has to say. With the power differential gone, a more meaningful dialogue between the two can take place, resulting in a comparatively effective encounter. However for this to happen the Voice of lifeworld should ideally be used by both the parties, for if only one uses it then it has the potential to create a disruption of the consulting process.

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Stewart (2003) puts forth Mishler's argument that typical interactions between doctors and patients are doctor-centered and are dominated by the biomedical perspective. Since in such medical interviews the primary task is to make a diagnosis therefore the doctor selectively attends to the voice of medicine, often not hearing patient's attempts to make sense of the suffering. This is perhaps so because communication as taught in medical schools functions to construct a professional identity of the doctors which is grounded in the principles of the biomedical model (Apker, 2004).

Mishler's (1984) seminal study was based on 25 interactions between doctors and patients. He found that if physicians were to use the Voice of the lifeworld, then it would result in more effective health outcomes and at the same time the care would be more humane. The

ideal doctor dialogue should include attentive listening, posing more open ended questions, sharing power with the patient and avoid using medical jargons.

The concept propounded by Mishler (1984) has been criticized by Silverman (1987). According to him Mishler theory lies on the faulty assumption that doctors always speak with a medical voice and that patients always speak in Lifeworld voice and that if both speak in the same lifeworld voice then it would be more liberating and effective. Silverman theorizes that actually in doctor-patient relationship there should exist a plurality of voices. Thus both the doctor and the patient should intersperse their consultation with the voice of medicine and that of the lifeworld. Furthermore there is no guarantee that if both speak with social voices then the outcomes would be improved. This last point has however been disproved by the study of Barry et al. (2001).

Mishler's conceptualization has been further proved and elaborated recently by the study conducted by Barry et al. (2001). They inform that while the two studies evaluate similar constructs, but there were differences in the sample population. Mishler's data collection in the 1970s consisted of a total of 25 cases from both outpatient departments of hospitals as well as private practices, while Barry et al.'s study consisted of a total of 35 cases from private practice only. The doctors in Mishler's sample were all White American males but Barry et al.'s study had better gender composition with 50% female doctors and had around 10% Asian doctors. Barry et al.'s research was also more nuanced since they further categorized the Voice of Lifeworld concept into three parts. Thus the four group labels in their study include Strictly Medicine, Lifeworld blocked, Lifeworld ignored and Mutual lifeworld. In the strictly Medicine

cases, both the physicians and the patients spoke entirely in the Voice of medicine. In the Lifeworld blocked cases, there were brief moments of lifeworld in the interactions but they got quickly suppressed due to physician's close ended mode of structured inquiry. In the Lifeworld ignored group, the patient spoke entirely in the Voice of lifeworld, this was however completely ignored by the doctor who conducted the entire consultation in the Voice of medicine. In the Mutual lifeworld group both the physicians and the patients used the Voice of the Lifeworld throughout their consultation. In the results, Barry et al. found that the categories of Lifeworld blocked and Lifeworld ignored had the poorest outcomes in terms of satisfaction and effectiveness. Both the other two, that is Mutual lifeworld and Strictly medicine, did equally good. This came as a surprise to the investigators. On further analysis, it was revealed that the Strictly Medicine cases comprised of patients with relatively straightforward medical issues, such as tonsillitis and ear infection. Most of the cases in the Mutual lifeworld group were more complex health issues with patients presenting with multiple problems. Thus it can be concluded from this particular study that while Mutual lifeworld approach works best with patients with complicated issues but the more acute organic illness benefits from the traditional biomedical approach.

## **COMMUNICATION THEORIES FOR DOCTOR PATIENT INTERACTION AS RELATED TO PATIENT CENTEREDNESS**

The complex communicative interaction of a doctor-patient interview presents a difficult task for the theorists. Thus studies have used sociolinguistic, behavioral and clinical approaches to explain this consultative process. However there is no widely accepted theoretical framework which encompasses all aspects of the medical interviewing phenomenon. My review of literature has revealed two relevant theories which could best explain patient-centeredness in a medical interview. These are Habermas' theory of Communicative Action and Bathkin's theory.

### **1. HABERMAS' THEORY OF COMMUNICATIVE ACTION**

Habermas' theory of Communicative Action is a dialectical struggle between two types of rationality (Habermas, 1984). Habermas posits a discourse that focuses on the importance of morals, feasibility and attractiveness in rational communication in order to find solutions. His ethical (moral) discourse can be utilized to outline the manner in which patient-centeredness can be achieved in medical interviewing.

Barry et al. (2001) have given an illustrative explanation of Habermas' Theory of Communicative Action.

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According to Barry et al. (2001), Habermas divides rationality into Value rationality and Purposive rationality. Value rationality involves experiences of everyday events as seen in their social contexts. Habermas' (1984) contends that Value rationality can be achieved through Ideal or Convivial speech which is defined by feasible, attractive and moral considerations. Barry et al., suggest that it is the moral consideration which is at the core of the Communicative Action process. In medical communication setting an ideal speech creates an atmosphere where problems can be discussed in a fair, open and uncoerced manner. Such a communication leads to a condition which Habermas terms as 'Lifeworld'. Barry et al. (2001) enunciate that Purposive rationality (as opposed to Value rationality) involves expression of a technical attitude. Here an effort is made to decontextualize the dialogue and focus on organic problems. Since the purpose is to achieve a quick diagnosis so the speech is strategized by the doctor to achieve this end. The authors go to the extreme when they suggest that the physician may even use manipulative or deceitful language to get to the diagnosis. Habermas terms such a condition as the 'System'.

Habermas suggests that the technocratic consciousness of the System seems to be encroaching on the Lifeworld. He calls this process of colonization as 'System rationalization'. Barry et al. posit that in medical interviewing the system could be held back from colonizing the lifeworld by focusing on Value rationality through Ideal Speech interaction. For this to happen, the communication should be based on mutual respect, trust, empathy, long-term partnership building and shared decision making.

Mishler labeled the typical medical interviews as the Unremarkable Interview. This

interview is wholly based on Purposive rationality. It has a completely technical focus. It is characterized by frequent interruptions by the physician who is in total control of the communicative process. Mishler has termed such a communication pattern as the 'Voice of medicine'. In contrast, Mishler terms the interview in which the previously explained Value rationality was used as 'Voice of Lifeworld'. Mishler (1984) in applying Habermas' Theory of Communicative Action suggests that if physicians use more of the Ideal speech in interviews with their patients, then it could result in a greater humane and effective interaction. In such interviews the patients are viewed as unique and autonomous whole persons, and are treated with warmth and empathy. The patient in such cases is also involved in decision making and enjoys an egalitarian and equal relationship with the physician.

The contention of Mishler that any medical encounter that does not have the Voice of the lifeworld is ineffective and inhumane, has been criticized by Strauss et al. (1982). They suggest that no consultation with a physician can proceed without relying on the Voice of medicine. This is so because the Voice of medicine is the basic tool through which the diagnosis can be reached. It is also possible that certain patients may actually like to interact in the Voice of medicine, through the use of technical language in medical encounters. (Coupland et al., 1994).

## **BATHKIN'S THEORY**

Corresponding to Mishler's argument about the two Voices in medical communication, is Bathkin's distinction of Monologic and Polyphonic narrative. Bathkin's theory gives the conceptual framework to study doctor-patient medical interaction as a socio-cultural phenomenon. Bathkin terms the expression of one's consciousness in a dialogue, as 'voice'

(Bathkin, 1984). He contends that since person's consciousness is socially produced through interaction with others, therefore the voices of other people also constitute a part of one's own voice. Thus according to Bathkin when a patient speaks he/she airs a voice which includes voices of those related to the patient. Similarly the physician's dialogue with the patient is also moderated by the medical training and experience of the doctor. Bathkin's terms this plurality of voices, such as in a medical interaction, as 'polyphony'. Eulogizing the use of polyphony Bathkin terms it as a way of visualizing aspects of human as they appear. Bathkin suggests that the single best method for verbally expressing human life is through open-ended dialogue (Bathkin, 1984). He contends that the more such open interactions take place, the more meanings are gathered. Thus an open ended interaction in medical interviewing seems very compatible with Bathkin's polyphonic perspective. The antithesis of polyphony in human interactions has been termed 'monology' by Bathkin. Defining monology Bathkin notes that "monologue is finalized and deaf to others response, does not expect it and does not acknowledge it in any decisive force. Monologue manages without the other and therefore to some degree materializes all reality. Monologue pretends to be the ultimate world. It closes the represented world and the represented persons"(Bathkin, 1984, pp. 292-293). Thus the typical medical interview which is technological and disease centered exemplifies Bathkin's description of a monologue. It focuses on the biomedical aspects of the disease to the exclusion of the patient who harbors the disease. This then denies the patient to be heard as a person. In other words applying the Bathkin's monologic principle in a disease-centered approach transforms the patient to a voiceless entity during a doctor-centered medical interview.

## ESSENTIAL ELEMENTS OF PATIENT-CENTEREDNESS

In keeping with the nature of the disparate literature in the field, it was found that various authors emphasized on different dimensions of patient-centered communication. Thus Mead & Bower (2000) delineate the dimensions as (1) Biopsychosocial perspective (2) Patient-as-a-person (3) Sharing power and responsibility (4) Therapeutic alliance (5) Doctor-as-person. The important variables put forward by Northouse (1998) include (1) empathy (2) Control (3) Trust (4) self-disclosure (4) Confirmation.

Two major conferences were held in Toronto (1991) and Kalamzoo, Michigan (1999) to discuss patient–physician communication. The Toronto and Kalamazoo consensus statements (Buyck & Lang, 2002) identified the following essential elements of communication in a medical encounter which have been consistently found to be the central theme in patient-centered communication.

Information Exchange

Rapport and Relationship building

Trust

Empathy

Decision making

### 1. INFORMATION EXCHANGE

Exchange of relevant information between the patient and the doctor remains the cornerstone of interview taking (Inui, 1985). Various studies have investigated doctors' and patients' level of information provision and information seeking communication process during

medical consultations. The doctor seeks information so as to reach the correct diagnosis and to help formulate a treatment plan. The patient on the other hand seeks information from doctor so as to understand the nature of the illness and to get relief from the symptom and to some extent to get catharsis by verbalizing the problems. This understanding of the felt need for compassion is an integral part of the patient-centered approach. Whereas it has been found that the provision of information by doctors has been positively related to patient satisfaction (Pegg, 2003; Williams & Calnan, 1992), it is a general observation that physicians do not seem to be cognizant of the patients' need for information. Studies have found that when the patients are given a chance to describe their illness and circumstances in their own words, it leads to a greater degree of patient satisfaction (Stiles et al., 1979). It has also been shown that greater patient participative role in the medical encounter improves satisfaction, compliance and outcome of treatment (Fallowfield, 1990). Various studies have revealed that the information seeking desire by patients is especially great when suffering from chronic illnesses like cancer (Molleman, 1984). Thus Blanchard et al. in a study in 1988 found that more than 92 % of the cancer patients desire to get complete information about the carcinoma they are suffering from. It has also been reported that the patient wants to know from the oncologists about things which will personally affect him/her, such as information about the associated pain and prognosis (Chaitchik, 1992). The level of anxiety in patients with chronic serious illness is mitigated if they perceive that they have received adequate information from their physician (Fallowfield, 1990). It is therefore imperative that doctors should encourage the patients to speak up about the aspects of the disease that they want to be communicated about (Weston, 1989). Patient-centered interview takes this

into account and allows for the patient to openly discuss their feelings about the problems that they are encountering.

Patients actually get better more quickly if they perceive their doctor listened and fully discussed the problem with them. In 1986 in a study conducted by the Headache Study Group of the University of Western Ontario Canada, two hundred and seventy two patients in London, Canada, who sought help for headaches. It was found that the recovery of the patient was statistically related to whether they felt their doctor had fully discussed the problem with them at the first visit. Similarly a U.S. study of high blood pressure and diabetes found that blood pressure and blood sugar levels improved in patients who asked their doctor questions and received satisfactory answers, while levels stayed the same in the patients who didn't fully participate in their visits (Orth, 1987).

One criticism that is made about trying to enhance the amount of information exchange between the doctor and the patient is the increased time duration that it will take in such a dialogue. Considering that medicine in the west is now a 'business' and controlled by business interests, with the constant pressure on physicians to see more and more patients, this might seem like a valid concern. However, research has shown that it is not necessarily so. Studies have found that useful clinical communication is possible in routine clinical practice. This can be achieved during the average time duration of clinical encounters, without overly prolonging them, if the clinician has learnt the relevant techniques to do so (Stewart, 1989).

## 2. RAPPORT AND RELATIONSHIP BUILDING

A strong therapeutic relationship is considered the ideal outcome of a patient physician interaction (Safran, 1998). The Kalamazoo consensus statement of 1999 endorsed patient-centered approach to relationship building as the fundamental communication element between the doctor and the patient (Makoul, 2001). Relationship building is found to be an oft mentioned yet inconsistently operationalized construct in the medical communication literature. Researchers have been generally unable to define its measurable components. Rapport building has however been shown to lead to relation building. While discussing rapport Grahe and Bernieri (1999) mention that when one comes away from a conversation feeling invigorated, then one has experienced an interaction high in rapport. They mention that terms like engrossing, friendly, harmonious, involving, and worthwhile are used to describe rapport. Thus the feeling of intense involvement helps relation building in a doctor-patient encounter. Roter & Hall (1989) specifically showed that patient satisfaction was related to conversation which promoted building of partnership. Roter (2000) suggested that strong relationship building occurs when both the doctor and the physician explicitly convey emotional content. Radwin (2000) found that knowing personal information about health providers, made the patients feel closer to them. The presence of high quality relationship also leads to advantageous physiological changes in the human body (Heaphy & Dutton, 2008). The authors assert that such relationship between individuals has the potential to positively impact the cardiovascular, immune as well as the neuroendocrine systems of the body.

Cegala et al. (1996) have shown in their study that the physician has a major role and is responsible in the promotion for relational communication in the doctor-patient interaction. Strong relations can lead to concordance between doctors and patients (Bass et al., 1986). Their

study found that concordance between doctors and patients greatly helps in identifying the probable treatment modalities for the presenting problem of the patient.

### **3. TRUST**

Patients go to the physician because they trust that the physician is the best person to take care of their medical problem. Thom & Campbell (1997) found that both technical competence and interpersonal behavior contribute to patient's trust in the physician. This means that although the patient cannot objectively assess a physician's competence but they do make a subjective assessment of it. At the same time the patients also assess from an emotional perspective whether the physician can be trusted. Hall et al. (2001) have defined trust as "an optimistic acceptance of a vulnerable situation in which the trustor believes the trustee will care for the the trustor's interests" (p.615). Giddens (1990) however does not consider trust to be a cognitive understanding but rather considers trust to be more like faith.

Anderson & Dedrick (1990) have recognized patient's trust in the physician as a crucial feature of doctor-patient relationship. Davies & Rundall (2000) contends that trust lies at the core of doctor-patient relationship. Trust has been shown to be directly related to the success of treatment (Mechanic, 1998). According to Dimatteo et al. (1985), trust is essentially a principal concern of the patient due to the chasm that exists between patients and physicians with regard to medical knowledge and power.

There are not many empirical studies suggesting positive outcomes of a high trust relationship. However the study by Davies and Rundell (2000) suggested that the benefits of a high trust therapeutic relationship include patient loyalty, a more enriched information exchange, better compliance, reduced patient anxiety and potentially less litigation.

#### 4. EMPATHY

It is a common observation that a patient often needs moral and emotional support from the healthcare provider. This is especially true when an emotional situation occurs, such as a physician disclosing to a patient the diagnosis of a terminal illness. No wonder then empathy is increasingly being considered as the foundation of ethical medical practice (Emanuel & Dubler, 1995).

Historically however there has been a controversy over defining whether empathy is an affective or cognitive construct or both. Thus Hogan (1969) emphasizes on the cognitive process of empathy whereas Mehrabian & Epstein (1972) consider it to be a primarily affective construct. The current view in medical literature however holds that empathy entails both cognitive and affective components (Squier, 1990) Thus Squier has defined empathy to consist of a cognitive informational aspect and an affective motivational component. He contends that both these component enhance patient compliance.

In medical literature although there is a general acceptance that empathy is an important variable in doctor-patient communication, but there have been relatively few studies which have made the direct linkage. A study by Macleod (1991) found out that understanding patient concerns, even when they could not be resolved, resulted in a significantly diminished patient anxiety. Crawford (1997) showed that physician compassion played a positive role in reducing apprehension in communication with patients of prostatic cancer. Another study found that breast cancer patients who found physicians to be more empathic during doctor-patient communication were much more psychologically stable after mastectomy (Blanchard et al., 1988). An interesting study conducted by Carl Marci (2007), measuring skin concordance, shows

that perception of physician empathy by the patient, leads to enhanced social and emotional patient-physician interaction. On the other hand the expression of negative affect by either the patient or the doctor has been found to be negatively associated with patient satisfaction (Carter et al., 1982).

Perhaps the most extreme form of empathy seeking behavior is depicted in persons who are labeled to have Munchausen's syndrome. It is a disorder in which the individual fabricates an illness to receive medical care. Cameron (2001) stresses the need to distinguish Munchausen's syndrome from malingering, in which the subject has a motive for secondary gain, such as insurance money or drugs. Whereas in Munchausen's syndrome, the only thing the patient craves for is the attention and emotional understanding of the medical personnel. Such individuals are willing to endure even unnecessary surgery just to receive attention, understanding and empathy from the medical staff.

## **5. DECISION MAKING**

Decision making is one of the core objectives of the medical interviewing process. In the traditional paternalistic model of decision making process, the doctor commands the patient to follow certain treatment modality, based on the diagnosis he/she has made. Geist and Dreyer (1993) in their study of physician-patient interactions have maintained that traditional medical communication system advances hegemony that "establishes a system of values, attitudes, and beliefs that restricts the layperson's participation in scientific decision making" and also "suppresses the types of dialogue that facilitate understanding in provider-patient relationships" (p. 233). No wonder then a high proportion of patients do not even remember what their doctors inform them about diagnosis and treatment (Lay, 1988). This trend has however somewhat

changed since the past two decades with the advent of the concept of shared decision making (Brock, 1990), in which both the physician and the patient jointly decide as to the appropriate treatment regimen tailored to the specific patient need. However this ideal may actually differ depending on the kind of illness. For example surprisingly Siminoff (1991) and Owens (1993) found that women diagnosed with breast cancer preferred to delegate the authority of deciding the treatment modality for breast cancer to the physician. However irrespective of the fact whether the patients decide to participate in the decision making process or not, in a patient-centered medical interviewing approach, the physician is expected to offer to the patient the option to partake in the decision making process. Taylor (1987) in his study categorizes doctors on the basis of such an approach into therapists and experimenters. The therapists tend to retain the control of the decision making process with themselves while the experimenters tend to share the decision making authority with their patients. This study showed that 71 % of the doctors fall within the category of therapists; which is a negation of the aspect of patient-centered interview approach.

Shared decision making benefits health care outcomes. A number of research studies have shown that patients are more likely to comply with medical advice when they participate in decision-making (Frankel & Beckman, 1989). This is important considering that compliance with treatment regimen is quite low. For instance, Ringel (1997) in a study found that only 50% to 60% of patients comply with medical advice most of the time. Thus negotiating a treatment plan with the patients is an important clinical skill to be learnt (Ricardi, 1987). It is also proposed that if patients are involved in decision making then there will be less chances of litigation.

## **ATTACHMENT THEORY AND PATIENT-PHYSICIAN RELATIONSHIP – AN INTIMATE LIASION**

The recent studies by sociologists and psychologists linking the construct of Attachment theory to patient–physician relationship, provide an interesting lens to look at this interactive process. (Eells, 2001). Attachment may be defined as an emotional connection between two persons, in which it is expected that one or both the individuals in the pair will provide protection and care in times of need (Goldberg, 2000). Attachment is said to result when a more vulnerable member bonds with a stronger or wiser person (Bowlby, 1979). Thus the more vulnerable patient and a wiser physician, fit well into this model. Relationships are considered to be a mutual system for regulation of emotions; where parental responsiveness shapes formation of secure attachments (Tronick, 1999). It has been suggested that individuals who are able to form secure attachments are more likely to value intimate relationships (Goldberg, 2000). Health care providers can provide a secure base for affective and cognitive exploration of a patient (Adshhead, 1998). A secure environment allows patients to better communicate emotions openly which helps foster building a strong relationship (Fosha, 2000). Such emotional information provision could help in diagnosis. Thus in a doctor patient interaction the physician would do well by embedding clinically relevant questions which would evoke the affective side of the patient. This would help establish an environment where optimal dyadic regulation of emotion can take place (Fosha, 2001). Fosha contends that in such cases, feelings of safety are produced, such that the partners remain engaged even if things get difficult. This could be of much help in medical interviewing of complex problems.

Research has shown that attachment behavior becomes activated when there is stress (Bowlby, 1979) such as in a therapeutic setting. It is contended that differences in styles of attachment effects the extent to which one can accept or be soothed by health care providers (Hunter, 2001). Quantitative research clearly suggests that there exists a relationship between attachment styles to that of collaborative relationship in a healthcare setting (Thompson & Chiechenowski, 2003).

Based on empirical research, Griffin and Bartholomew (1994) have identified four dimensions of attachment in adults (1) secure (2) preoccupied (3) dismissing (4) fearful. These may be considered to be along a continuum and a person may show varying degrees of each. However for conceptualization purposes it is more useful to categorize individuals in terms of their predominant attachment style. Thus adults who have experienced responsive care giving exhibit a secure attachment style (Ainsworth et al., 1978). They generally exhibit a relaxed demeanor and are easily comforted by others. Researchers have shown that people with secure attachment styles are generally more satisfied with medical care as compared to people with insecure attachments styles (Riggs, 2001). Adults, who have an emotionally unresponsive early care giving experience, develop a dismissing attachment and although they have a positive view of their own self but are uncomfortable trusting others (Bowlby, 1977). A study of patients with dismissive attachment style showed that they were least expected to seek psychotherapeutic support (Riggs, Jacobovitz & Hazen, 2002). Adults who have experienced inconsistently responsive care giving develop a preoccupied attachment style (Bartholomew, 1990). They have a positive model of others and exaggerate behaviors to attract their support (Mikulincer, Shaver & Pereg, 2003). Such individuals present themselves as vulnerable and have a high expectation

of being taking care of (Dozier, Stevenson, Lee & Velligan, 1991). Adults, who have had a harsh and rejecting early care giving experience, develop a fearful attachment style (Bartholomew, 1990). They have a negative view of self as well as others. Although they desire intimacy, they tend to avoid close relationships because of the fear of rejection (Bartholomew, 1993). Such an attachment style can lead to potential problems with compliance. Thus studies have shown that diabetic patients with a fearful attachment style have higher blood glucose because of poor compliance with treatment regimen (Chiechanowski, Russo et al., 2004).

Thus we see that while most theoretical concepts related to the doctor-patient relationship help explain the overall interactive process, Attachment Theory portends to establish a sound theoretical approach to the understanding of this relationship at the individual level. More than any other construct, Attachment theory brings us closer to the need for a 'Good Fit' in medical interactions. This then brings us one step closer to truly customized care in medical practice.

## **CONCLUSION AND FUTURE COURSE**

There is sufficient data to prove that problems in physician-patient communication are common which adversely affect patient management. Overall the studies carried out on the doctor-patient communication overwhelmingly support a patient-centered approach to medical interviewing. This in itself is powerful as patient-centered philosophy transcends the conventional medical dichotomy between the body and mind, which heralds the larger societal transformation to a post modern era (Stewart, 2003). The good message is that this can be done with moderate changes in the doctors and patients communicative and behavioral approach. However it has been documented that traditional medical education, either at medical school or higher levels is ineffective in teaching effective clinical communication (Kern, 1989). Weston

and Brown (1995) and Hafferty and Franks (1994) have found that medical school education actually erodes the ability of physicians' to develop social relationships with patients effectively. Even though the medical profession values and endorses patient-centered approach (Stewart, 2003) it remains unclear what the ultimate outcome of medical education reform will be, when the language of scientific medicine continues to dominate. Thus there is a need to bring a change in the medical school curricula to overcome this shortcoming. It is posited that if patient-centered medical interviewing is made an integral part of medical education and practice, then it will help to improve the relationship between patients and physicians.

Useful additions to the existing literature in the field could include looking at doctor-patient communication and patient understanding of medical advice, patient memory recall and follow-up visits. It also remains to be researched if the words used in the medical interview, and the way the medical interview questions are framed, have a direct bearing on the transfer of information between the physician and the patient, and the relationship that develops between the two. A comprehensive theory still eludes academics to more fully explain the communicative interaction in a medical interview. Medical profession still relies on instruments to evaluate different medical conditions, in which the inquiry applies a disease centered approach. Research is now required for the formulation of instruments for different medical conditions, in which questions are framed in patient-centered manner.

In the emerging literature a few studies have conducted linking patient's attachment style with the outcomes of medical interaction. However studies taking into account doctor's attachment styles are almost non-existent. Thus the field is wide open for such interesting research.

Although a review of literature shows that patient-centered medicine is being practiced more in the family medicine and psychiatry/psychology field but it remains to be seen if there is a place for it in other areas of medicine too. This will help us evaluate if its messages are relevant to other specialties of medicine such as General Surgery, Ophthalmology and others or if it is only suited to specific fields. It therefore remains to be seen how researchers could help rationalize its expansion to other domains.

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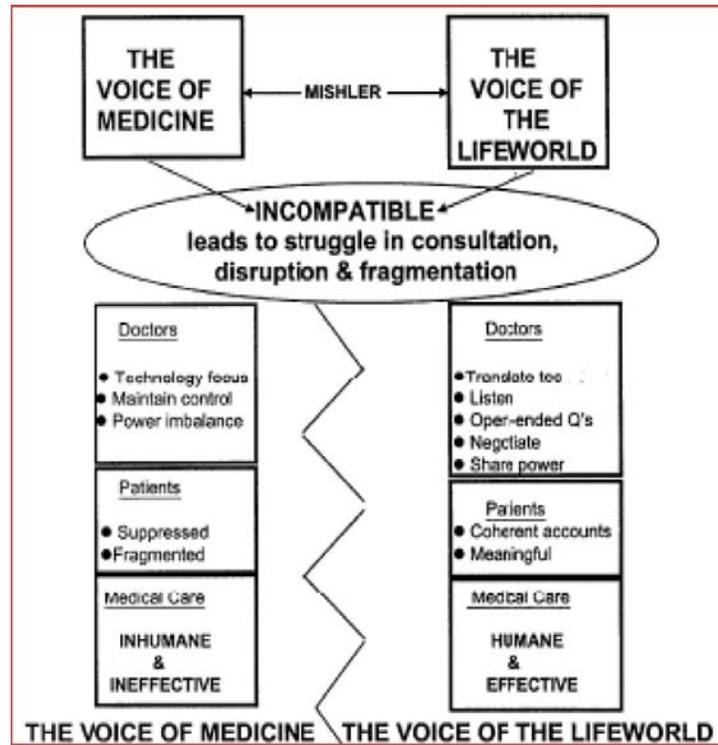


Figure 1. Mishler's Two Contrasting Voices

(Adapted from Barry et. al, 2001)

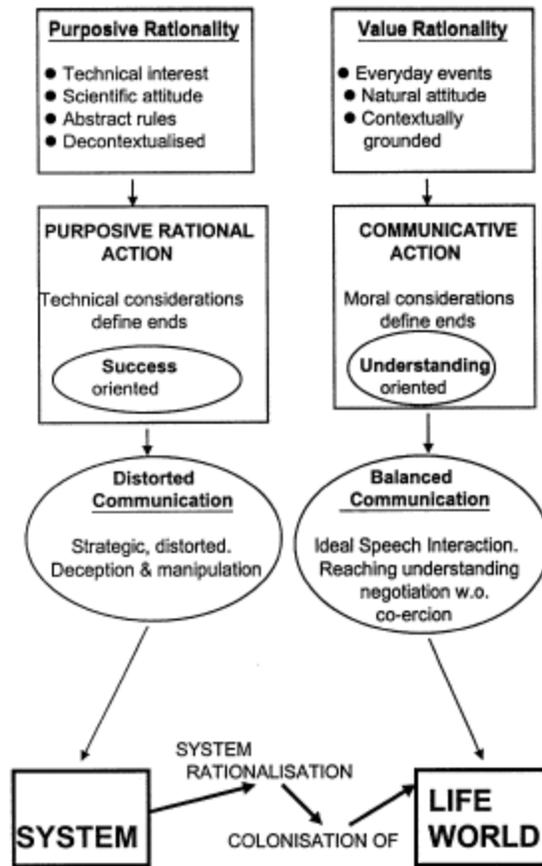


Figure 2. Habermas' Theory of Communicative Action (Barry et al., 2001)