

► MEDICAL REVIEW

Communication in the Clinical Encounter: Dealing with the Disparities

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ABSTRACT

Despite basing its foundation upon the ideals of Hippocrates, Western medicine, especially in the last century, has shifted from a holistic to a more reductionist approach to understanding and treating patients. These changes are primarily a result of widespread acceptance of the biomedical model in modern medicine. Consequently, there are now significant differences in physician and patient explanatory models for the same ailment. Cancer, for example, is interpreted as primarily a physiological process by the medical community, or more simply, as a disease. The patient, on the other hand, interprets cancer as an illness, a more subjective response, covering all aspects of the patient's life experience, including emotional, psychological, social, and cultural realms, in addition to physiological aspects. These differences in explanatory models result in disparities between physicians and patients when it comes to defining the condition, managing the condition and even defining successful outcomes. These incongruencies must be addressed through effective communication in the clinical encounter, an aspect of patient care that has proven beneficial effects on patient health outcomes. The shared treatment decision-making model best addresses these communication problems. By providing a framework for both the physician and patient to negotiate their respective explanatory models en route to a mutually agreeable treatment decision, this model is a compromise between the two extremes of patient-physician models of communication: paternalism and informed decision-making. Ultimately, the shared treatment decision-making model establishes a clinical relationship that is no longer characterized by an inability to effectively negotiate and consolidate differing values due to unbalanced informational and power dynamics in a social context. By incorporating this model of communication into medical practice, physicians and patients will better understand each other, bridging the disparities apparent in current practice and allow Western medicine to once again approximate the Hippocratic ideal.

INTRODUCTION

The set of beliefs that define one's approach to an illness is formally termed an explanatory model.

Hippocrates, the father of medicine, was the first to suggest that through the physician-patient relationship, the physician must define this approach to ill-health by understanding the whole person, considering biomedical, psychological, familial, and environmental contexts in order to address the effects of a disease. In the last century, despite what Hippocrates suggested and the formal agreement each physician makes with the Hippocratic Oath, Western medicine has seen a distinction develop between the physician's interpretation of cancer, for example, as a 'disease,' and the patient's interpretation as an 'illness.' Ultimately, due to these differing explanatory models, the patient and physician arrive at fundamentally different concepts of not only the disease, but also the method by which each would approach its treatment. This represents a crucial aspect of the physician-patient relationship that, if not addressed through strategies of effective communication, will undoubtedly lead to problems for both the physician and patient.

DEFINITION DISPARITY

Explanatory models are "used by individuals to explain, organize, and manage particular episodes of impaired well-being" (Helman, 1994). Through the Biomedical Model, the physician is able to conceptualize cancer as a 'disease.' This refers to the malfunctioning of the physiological and/or psychological processes of an individual (Helman, 1994). In this light, the modern Western physician "assumes that biologic concerns are more basic, 'real,' clinically significant, and interesting than psychological and sociocultural issues" (Kleinman, 1980). Patients, on the other hand, view the cancer as an 'illness,' which is the subjective response of the patient to cancer. This refers to how the patient perceives the origin and significance of the cancer, how it affects her emotional state, behavior, or relationships with other people, and how she will manage the cancer (Helman, 1985). For the patient, the explanatory model tends to be idiosyncratic and changeable, heavily influenced by the specific cultural and individual values. 'Illness,' unlike 'disease,' is a more diffuse concept, defined by more broad factors. The oncologist is trained to objectively interpret the cancer, emphasizing the biological significance of the diagnosis, while the patient who is living with the cancer undergoes a subjective, internal experience that adds a social, cultural, and psychological

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dimension to the physician's concept. This fundamental difference between the lay and physician perception of what constitutes the ill-health episode, termed definition disparity, can be attributed to the difference in 'cultures' between the physician and the patient (Bochner, 1983).

Due to different explanatory models of cancer, physicians and patients may also have different approaches to managing cancer. For physicians, the diagnosis of cancer is generally followed by disease staging then an immediate application of a treatment protocol specific to that particular type of cancer. The treatment itself consists of any or all of the following: chemotherapy, radiation, surgery, hormones, or immunotherapy. Since this approach focuses more on the physical dimensions of cancer, factors such as personality, religious belief, family, culture, and socio-economic status of the patient, all of which affect the individual patient's cancer experience, are often considered irrelevant in making the diagnosis or prescribing treatment. This is a fundamental difference between patients and physicians in the approach to cancer.

GOAL DISPARITY

The physician and patient undoubtedly agree on the mutual desire to achieve clinical success as an outcome of the relationship. The definition of successful health outcomes, however, also varies between the two parties based on the misaligned approaches to management resulting from the conflicting explanatory models. This difference is known as a goal disparity (Bochner, 1983). Physicians define success as a positive clinical outcome for the patient, ultimately in the form of a cure with reduced somatic symptoms. This definition is evident by analyzing the content of cancer care practice guidelines and treatment policies. These policies, of provincial, national, and even international institutions, incorporate the best possible evidence available reflecting the increasing importance of evidence-based medicine in providing optimal care for patients. Most of these guidelines are based on treatments for malignancies rather than treatment for individuals. Success, according to these policies and the physicians that follow them, is defined as complete remission or the absence of all signs of malignancy. These definitions are assumed, often inaccurately, to be the same definitions of successful therapy for the patient as well. When caring for patients, the physician relies on somatic symptoms as the most important piece of information. This includes primarily physicochemical data obtained through reductionist investigation and analysis in addition to a report by the patient of how she is feeling. Interestingly, though, it has been reported that patients' reports of their somatic symptoms are more a reflection of their social and emotional distress rather than the actual health status as defined and determined by their physicians (Koller et al, 1996). This evidence emphasizes the

differing notions of success, or a goal disparity, between patients and physicians.

Additionally, much of the effort in cancer management is focussed around establishing a certain quality of life (since the persisting malignancy often leads invariably to death). The fact that few physicians admit to using the extremely limited selection of tools that measure quality of life (Walsh and Emrich, 1988), and the subsequent failure for physicians to accurately assess their patients' quality of life (according to the patient's broader, more psychosocial definition), indicates that conventional medicine has not yet been able to depart from its reliance on the Biomedical Model when applying medical care to realms that clearly can not be addressed by the reductionist mentality. Ultimately, one must focus on the method of communication amidst the clinical encounter in order to address the obvious and potentially harmful problems that result from an inability to effectively bridge the disparities that present themselves in the physician-patient relationship.

COMMUNICATION

Helman suggests that one of the ways to improve communication in the clinical encounter is for the physician's diagnosis and treatment to "make sense" to the patients, in terms of their lay view of ill-health, and "should acknowledge and respect the patients' experience and interpretation of their own condition" (Helman, 1994). Primarily, this can be achieved by getting the physician to understand and treat the 'illness' as well as the 'disease.' In theory, the clinical encounter is supposed to be a negotiation between the explanatory models of the physician and the patient, however, in actuality what happens is a clear dominance of one over the other. The nature of cancer and illness in general, and its subsequent effects on the expectations of treatment as well as the expectations of each other in the clinical encounter, leads to a situation where the patient has an 'illness' that is forced into the physician's explanatory model of 'disease.' Conversely, one can also say that the explanatory model of the physician is almost forced into the lay context. Thus, communication in the conventional clinical encounter neither leaves opportunity for values of the physician to 'make sense' in the patient's mind, nor allows the patient's values and subsequent explanatory model fuse with those of the physician. Treatment and management of the 'illness,' which should be the ultimate goal of such an interaction, is subsequently rendered problematic.

The importance of effective communication should not be understated. There is evidence to suggest that improved communication between patients and physicians leads to improved clinical outcomes. Improved

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clinical outcomes may mean improved patient compliance with treatment regimens, the ability for physicians to make a more appropriate diagnosis, recommend more appropriate treatment, or better recognize signs of social and emotional distress (which as mentioned above, were found to be the main factors influencing patients' self reports of their somatic symptoms) (King, 1983). In general, improved communication also establishes a more supportive environment: one that considers and respects the values and beliefs of the patient amidst their illness. For example, support groups for breast cancer survivors have been recognized as environments where women are empowered to become more active in their treatment decisions. This kind of psychosocial context provides the ideal environment for women to share their information and fears regarding treatments and even the illness itself. It is an opportunity to expose the components of one's explanatory model in a health care context. Primarily, the positive outcomes that arise from this type of interaction are an increase in quality of life (Meyer and Mark, 1995). One study even suggests that these environments also result in a potential increase in survival (Spiegel et al., 1989). Empowering patients to actively participate in decision making has been associated with beneficial outcomes in several other chronic ailments. In patients with diabetes, hypertension, and peptic ulcer disease, it was shown that pilot programs aimed at increasing patient participation in medical care resulted in improved function and health outcomes (Greenfield et al., 1988). More recently, Stewart et al. (2000) found that health outcome parameters such as level of discomfort, level of concern, and mental health showed significant improvements when patients perceived themselves as being full participants in discussions regarding their care. In light of this evidence, it is important to establish a model of patient-physician communication that genuinely accommodates negotiation of the explanatory models of physicians and patients. Through this negotiation, the subsequent health understandings and associated fears, beliefs and expectations can also be revealed.

SHARED TREATMENT DECISION-MAKING MODEL

The last several years has witnessed a rise in a specific model of communication that seems to address this need. Shared treatment decision making in the clinical encounter is widely seen as the ideal model for the patient-physician interaction. This model, formally developed by Charles et al. (1997), falls in between the two extremes of patient-physician models of communication: the paternalistic model and the informed decision-making model. These two latter models fall short of alleviating the problems associated with inadequate negotiation of values amidst the clinical encounter, whereas the shared treatment decision-making model provides the most appropriate framework for addressing those concerns.

Up until the 1970s, the physician-patient interaction in Western medicine could be classified as primarily authoritarian or paternalistic. The patient as well as the physician would both assume their stereotypical roles. The patient simply needed to "follow the doctor's orders." This was generally accepted by the medical community and the society as the best way to approach patient care in a clinical relationship (Pellissier and Venta, 1996). It also reinforced the heavily skewed distribution of power between the physician and power that is still evident in much of conventional clinical encounters today. The main problem with this type of relationship is that it only reflects the values and explanatory model of the physician. The physician clearly dominates the encounter establishing a one-way flow of information from the physician to the patient. This information is predominantly medical in nature, which, of course, is derived from the biomedical explanatory model. There is also very little scope for negotiation of the meaning of the illness and the values that define it, since deliberation en route to a treatment decision is done by the physician alone or with her colleagues (Charles et al., 1997).

The informed treatment decision-making model (often referred to as the consumer-sovereignty model), on the other hand, emerged in the last several decades as a preferred method of giving the patient (or consumer) more control. This control, something generally lacking for patients amidst the illness experience, is established by limiting the role of the physician to one of primarily information provision. The physician is essentially expected to remain silent "about anything other than data" (Pellissier and Venta, 1996). The nature of the information exchanged, though, is devoid of non-biomedically oriented values. The information is primarily medical. Thus, the patient is given the power to use her own values in arriving at a treatment decision, however, the treatments are primarily formulated through an explanatory model that does not view the patients predicament, cancer in this case, as an 'illness.'

The shared treatment decision-making model seems to address the main problems associated with ineffective communication in the clinical encounter. First, the two-way flow of both medical and personal information characteristic of this model ensures that the previously incompatible frames of reference in the clinical encounter, that of a disease and illness, are at the least mutually recognized. The negotiation of the physician and the patient's explanatory models are facilitated through communicating information that is a combination of medical and personal nature. Also, the nature of the deliberation, between both the patient and the physician, is a process that results in a treatment decision agreed upon by both and contributes to further genuine negotiation of explanatory models. Lastly, shared decision making is "seen as a mechanism to decrease informational and power asymmetry between

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doctors and patients by increasing patients' information, sense of autonomy and/or control over treatment decision that affect their well-being" (Charles et al., 1997). Thus, this model of patient-physician communication eliminates the definition and goal disparities intrinsic between the respective explanatory models of patients and physicians. It does so by establishing a clinical relationship that is no longer characterized by an inability to effectively negotiate and consolidate differing values due to unbalanced power dynamics in a social context.

CONCLUSION

Although society and the medical community are becoming increasingly aware of the merits of shared treatment decision-making, the practice of this method of communication has not diffused widely enough. In fact, close to one quarter of patients still leave the clinical encounter with unmet expectations (Charles et al. 1997). This is a function of more than a century of reliance on the biomedical explanatory model as the stamp of approval for methods of obtaining and applying knowledge in the context of health care. To reverse these ingrained attitudes, young physicians require more explicit and practical training which focuses on addressing the patient's unique illness experience as an avenue to effective patient care. Specifically, medical curriculum must incorporate both real and standardized patients early in the curriculum, allowing students to practice obtaining and imparting information, addressing the personal needs and desires of each patient and negotiating their respective explanatory models. Eventually, more physicians will recognize and promote shared treatment decision-making as a means to achieve patient satisfaction, physician satisfaction and ultimately patient health.

Until recently, unquestioned faith in the Biomedical Explanatory Model rendered society largely unable to recognize how the resulting behavior and communication dynamics within a clinical encounter failed to approach the complete concept patient care, as proposed by Hippocrates. Again, this concept considers the psychological, social, cultural, as well as physiological contexts. In arriving at a method of communication

where explanatory models, which span those broad contexts, are exposed, conventional Western medicine will become closer to the Hippocratic ideal.

NOTE

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