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General Practice and Medical Anthropology: Partners in the Study of the Doctor – Patient Relationship within the Mediterranean Setting

Christos Lionis[1], Gabriella E. Aspraki[2]

[1]Associate Professor of Social and Family Medicine, [2]Research Associate, Clinic of Social and Family Medicine, Medical School, University of Crete

Abstract

It is well documented that the doctor–patient relationship is one of the keys to successful patient treatment. The importance of this relationship appears to be more pronounced in General Practice due to the long term, personal relationship developed within the context of primary care. In the present paper we discuss a number of parameters, which are crucial to the doctor–patient relationship. A special emphasis is placed on the Southern European and Mediterranean settings.

Keywords: Doctor-patient, communication, Primary Care, Mediterranean

Introduction

The doctor–patient encounter has attracted growing interest in the current literature. It is now well documented and widely accepted that one of the keys to successful treatment of the patient is a good working relationship with the doctor. [i-ii] In General Practice/Family Medicine (GP/FM), furthermore, where the relationship between doctor and patient is more personal and long lasting, effective communication seems to be vital in establishing rapport with the patient and enhancing the doctor's effectiveness; however, further study is needed in this direction. Despite the above, doctor–patient issues have received little attention in certain Southern European countries, including Greece.[iii-iv] This can be partly explained by the absence of relevant training courses in Medical Schools.

Corresponding Author:
Dr Christos Lionis, Associate Professor, University of Crete, School of Medicine, P.O.Box 2208, Heraklion, Crete, GR 71003 Greece
Tel. No: 0030 2810 394621
e-mail: lionis@galinos.med.uoc.gr

In Greece, specifically, the Medical Faculty of the University of Crete is the only academic institute in the country, which offers an undergraduate course to medical students and teaches them communication skills (http://vml.med.uoc.gr-doctor-patient). Furthermore, as a result of close collaboration with the Institute of Social Sciences, University of Leiden, the Netherlands, this Medical School experiences the important contribution of Medical Anthropology in teaching medical students the concept of illness and health behavior and implementing certain theoretical models into research in the utilization of health care services.[v-vi]

In the present paper, we draw on the above experience to discuss the doctor-patient relationship with the aim to highlight some of its most important determinants. According to Silverman et al (2005)[1], the type of relationship established between a doctor and his/her patient seems to be a complex issue which involves a number of parameters, including: the type of partnership between doctor and patient, the type of skills acquired by the doctor, the type of patient, the type of setting where the medical encounter is performed and the medical interview. Teaching

the doctor-patient relationship issues to medical students within the Mediterranean setting is a difficult task, since contemporary evidence is lacking. Thus, a clear objective of this paper is to examine each of the above parameters in more detail drawing specifically from our experience of the Southern European and Mediterranean settings.

Towards an effective communication between patient and doctor

Type or partnership

The type of partnership between doctor and patient has undergone major changes through time.[5-vii] From a type of paternalistic relationship, which was exercised by the doctor towards the patient and the decisions were solely the responsibility of the former, we have moved towards relationships of mutuality and processes of joined decision making.[viii-ix] Patient rights have come to the centre of attention of institutions and bodies involved in health care, and various models of involvement of the patients in the management of their health have been implemented across the globe, such as the Patient and Public Involvement Forum in the U.K. (http://www.cppih.org).

Furthermore, as the principle of autonomy and involvement assumes central role in health care the role of family and caregivers in the therapeutic process is enhanced. The doctor not only needs to enter into a collaborative partnership with the individual patient, but also to take into account the familial and social background of the patient. In general practice and primary care, whose object is to a large degree the management and treatment of chronic conditions, the role of the family and caregivers is prominent. The discussion on the burden of the family in cases of chronicity provides further confirmation of the family's role.[x] In addition, the role of family and caregivers is particularly enhanced in cases of patients whose ability to communicate is limited. It follows from the above that the shared decision model of partnership often involves not only the patient as an individual, but a nexus of relationships (family and caregivers). The practice of family consultation may be more complicated as it involves multiple networks of relationships, and is therefore more time consuming, but it is rewarding in that it provides a holistic perspective. GP/FM in Europe is still focused on an individualistic type of partnership, although the new European definition of GP/FM makes a strong reference to the concepts of family and community (http://www.woncaeurope.org).

In the Southern European setting the transition to an autonomous patient role has not been made and the paternalistic model still seems to hold strong.[xi] In rural Crete, despite the severe burden they experience, informal caregivers of patients with major mental disorders did not seek care from their primary care doctor.[10] More research is needed in order for the existing situation to be depicted, future tendencies to be deciphered and policies to be designed.

Type of acquired doctor's skills (the doctor's side in the communication process)

Communication with the patient is a demanding situation, which requires a range of skills from the doctor. In order for the encounter to be successful, the doctor must be empathetic towards the patient and alert to both verbal and non-verbal messages in the communication process. Communication skills, however, do not constitute a natural gift endowed the doctor, but are acquired through education[1] and, hence, communication is included in the curricula of numerous medical schools. Furthermore, the type of communication and the expectations held from their encounter, by both patient and doctor, are culture specific. As Harrison[xii] has shown, patients in the Emirates evaluate their communication with the doctor differently from patients elsewhere. In Greece, patients tend to express their gratitude to the doctor through the offer of homemade tidbits or products such as house wine.[11] It is therefore very important that the doctor is aware of the cultural characteristics of the patients. This needs an active effort on the part of the doctor to get familiar with the patients' culture. In rural Crete, the constitution of a list of disease names in local dialect facilitated both research and clinical practice.[xiii]

In all situations of communication with the patient Silverman et al., identify the skills required as follows: content skills, process skills and perceptual skills.[1] As the authors explain, the doctor must know both what to say, and how to say it to the patient. Equally important, the doctor must be alert to the feelings and thoughts generated by the situation both within himself and within the patient. Those feelings and thoughts must be taken into account and addressed by the doctor when consulting with the patient. The above form is indissoluble and equally

important aspects of the doctor-patient encounter.

Non verbal communication also seems to have an important role in the doctor-patient relationship, especially within the Mediterranean setting, as a consensus report in Reggio Emilia, Italy underlined.[3] Further research is needed to explore this important issue especially during the patient's first encounter with his/her general practitioner.

Type of patient (the patient's side in the doctor – patient relationship)
In a type of partnership where responsibility is shared between doctor and patient, the role of patient in the relationship is accentuated. The doctor should acquire and make best use of all information on the patient's background. Different cultural and social characteristics greatly determine the way in which the patient relates to the doctor, accepts treatment and complies or not with the doctor's instructions.

Suchman[xiv] introduced a model, which proposes five stages of illness and medical care: the symptom experience, the assumption of the sick role, the medical care contact, the dependent patient role and recovery/rehabilitation. By making general practitioners aware of the above five stages, medical anthropology provides a satisfactory explanatory theory of patient behavior and thus helps doctors better understand their patients' behavior. With such knowledge a course of action which might appear unreasonable to the doctor, such as non-compliance or seeking medical advise at a late stage when medical services are no longer capable of stopping the natural course of the disease, might make sense and be dealt with. Furthermore, knowledge of patient behavior can help eliminate feelings of anger or frustration in the doctor.

A last issue to be mentioned is that the patient comes to the doctor with specific beliefs and concerns on his/her condition, with feelings of hope, fear or despair and carrying particular expectations from the doctor. All the above often constitute a mute background to the doctor–patient relationship, which can prove either facilitating or hindering to the encounter. The doctor must be aware of the existence of hidden agendas in the encounter with the patient and aim towards bringing hidden worries, fear, doubts to the fore. It is only then that tensions generated by such feelings can be resolved and the relationship with the patient can be productive. This part of the doctor-patient encounter is not only important for the establishment of a good and effective relationship, but provides a major contribution in the success of health promotion programs in primary care and especially in the ones which focus on behavior modification. GP/FMs should be aware of the principles of the Theory of Planned Behavior[xv] and be well trained in translating it into research and clinical practice. There is little experience from the translation of this theory into practice. Attempts have been undertaken at the Department of Social Medicine, School of Medicine, University of Crete to explore the possibility of the implementation of this theory into intervention programs which aimed at reducing the use of over-the-counter medicines.

Type of setting
The doctor's office and its capacity in both technologies and staff critically influence the doctor–patient encounter. Both the waiting area and the doctor's office must offer a calm and reassuring environment for the patient. It is important that the patient is welcomed by the appropriate personnel and informed on issues such as, processes that must be followed, waiting time, possible delay and reasons of delay. The office itself must be provided with all the appropriate technological and medical equipment, which will enable the doctor to provide the proper treatment. The appropriate setting in terms both of human and of technological capacities, can induce a feeling of trust in the patient, and can greatly reduce anxiety and uncertainty. Despite the discussion of the setting in modern industrialized societies and among certain European and Australian colleagues,[xvi] the issue is still not sufficiently resolved in Southern Europe, where a conventional arrangement of the doctor's office, reflecting the paternalistic type of relationship is still predominant. Advances in electronic technology make possible the communication between patient and doctor without face-to-face consultation. The introduction of telemedicine has an impact on the new skills and training programs needed for the improvement of doctor-patient communication in such a setting.[xvii]

The medical interview
The medical interview is the time *par excellence* where the communication between doctor and patient is performed and worked out. Taking the patient's history and performing a medical interview are among the skills acquired through the years of medical education. However, a problem which has

been identified is the rigid adherence of many doctors on what is meant to be a rough guide for the acquisition of a patient's medical history. The enhanced Calgary-Cambridge guide[l] addresses the shortcomings of a typified medical interview and provides clues towards an interview which will be flexible and allow the patient to provide richer information on his/her condition and background. The Calgary-Cambridge guide provides detailed and useful guidelines for every phase of the medical interview: initiating the session, gathering information, physical examination, explanation and planning and closing the session. The anticipated result is one where both the patient leaves the doctor's office reassured, with a clear plan to follow, and the doctor is in hold of all the useful information needed for a successful rapport with the patient and treatment plan. The translation of this model within the Mediterranean and southern European settings and discussion of its key elements remains to be studied.

Conclusion

In conclusion, it is a fact that the patient-centered, or relationship-centered approach to the medical work, requires more time than the traditional paternalistic approach which seems to be preferred by many Southern European practitioners. However, the benefits from the former model are undoubtedly worth the time investment. The factors, which have an impact on the quality of the consultation are wide ranging. Establishing a good, working relationship with the patient is a complex issue, yet vital for the successful outcome. Further research is needed in order to determine and quantify, where possible, the different factors affecting consultation. A discussion of physician's skills with emphasis on verbal and non verbal communication, awareness of the patient's background, the symptom experience and sick role, remain to be explored within the Southern European and Mediterranean setting. Towards the above direction, a collaborative study among Southern European countries could usefully highlight particular key issues for an effective partnership between doctor and patient. Previous country-to-country collaborations should be led towards this goal.[xviii]

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