Original Research Paper

Developing and validating a guideline on doctor-patient communication for Southeast Asian context

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Abstract

Introduction: In Southeast Asia there is a big gap between the partnership style now desired by patients and the reality of actual practice, which reflects a more paternalistic style. Asian culture, with its hierarchical social system, less autonomy for members of society and less verbally explicit communication style contributes to this difference. This paper describes the development and validation of a guideline to help doctors in the context of the study to become more patient-centered.

Method: To develop a guideline, we triangulated results from previous studies on doctor-patient communication with in-depth interviews with communication skills teachers at an Indonesian School of Medicine. To validate the guideline, we interviewed international experts who had conducted research on this subject in an Asian context.

Results: Southeast Asian patients expect more partnership in their consultations. In this respect they do not differ from Western patients. Three other distinct issues emerged from the data. Firstly, the social and cultural context of their communities is very important for Southeast Asian patients compared with patients from the West who, on the whole have more autonomy. Secondly, much of the communication expressed by patients and their families with doctors is non-verbal compared with Western patients. Thirdly, traditional medicine still holds an important place.

Conclusion: There is a shifting paradigm towards partnership communication during doctor-patient consultations in Southeast Asian context. Our guideline alienates the skills needed to consult effectively also tabulates what needs to be taught to young doctors in order to enhance their responsiveness to Southeast Asian patients. It builds on Western models of the consultation enriched with contextual examples.

Keywords:, doctor-patient interaction, hierarchical culture.

Introduction

Doctor-patient communication is a fundamental aspect of healthcare delivery (Curtis, 2000). Successful doctor-patient communication improves clinical outcomes and leads to satisfaction for both doctors and patients (Silverman *et al.,* 2005).

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Patients value being listened to, taken seriously and being respected. More recently, "Shared Decision Making" has become a central concept within the Western mode (Hall *et al.*, 1988; Charles *et al*., 1999; Makoul & Clayman, 2006; Roter, 2006).

However, the Southeast Asian culture differs considerably from that in the West. It is characterized by a strong hierarchical pattern in which respect is given to the elder, and a strong family social support system which may influence individual autonomy as well as the common use of traditional medicine (Iragiliati, 2006; Galanti, 2008; Hofstede, 2003; Geertz, 1976; Geertz, 1983). Many Southeast Asians are poorly educated (Claramita *et al.*, 2011). The wide cultural differences and gaps in patients' educational background have lead to the assumption that a full partnership style cannot be implemented in a Southeast Asian

context. Even though we found that the equality of participation during consultation is also desired by non-Western patients including Southeast Asians (Claramita & Majoor 2006; Kim *et al*., 2003; Kiguli 2007), a more paternalistic style is common in practice. We have noticed a conflict between the desired ideal style and the reality of actual practice in the Southeast Asian context (Claramita *et al*., 2011). This mismatch results in unhappiness for both doctors and patients.

We thought that it was important to improve the style of consultation in Southeast Asia and to design a guideline for doctor-patient communication for Southeast Asian doctors which would be generic for different types of consultations, and could be used for patients from a wide variety of backgrounds.

Method

We used a qualitative method (Finlay & Ballinger, 2006) by interviewing Southeast Asian communication skills teachers. We triangulated their views with results from our previous studies and the relevant literature. Our guideline was validated by experts who study communication skills in the Southeast Asian context.

1. Interviewing Southeast Asian communication skills teachers

Subjects

An independent interviewer (an anthropologist) interviewed ten communication skills teachers, all of whom were members of a communication skills team in the Faculty of Medicine, Universitas Gadjah Mada in Indonesia. They had all been teaching communication skills in the medical interview for between 10 and 20 years. They were from different backgrounds: two clinical psychologists, two psychiatrists, one pediatrician, two internists, two general practitioners and a palliative medicine specialist. All gave consent prior to the interview.

Interviews

The interview began with a brief presentation of our previous studies (Claramita et al., 2011; Galanti, 2008; Geertz, 1976) summarized in Table 1.

Table 1: A summary of previous studies presented to Southeast East Asian communication skills teachers at the beginning of their interviews

A. What is known so far?

1. Conflict between desired consultation style (partnership) and reality (paternalistic) is typical in the Southeast Asian context
2. Paternalistic style of doctor-patient communication in Southeast Asia is caused by:
   a. Lack of time for effective consultation due to high-patient load caused by the poorly managed nature of the healthcare system
   b. Patients with little knowledge about their health and what is available because of poor education
   c. Lack of adequate communication skills training of Southeast Asian doctors
3. Patients from Southeast Asia are not satisfied with the paternalistic behaviour of their doctors; they dislike the inflexible hierarchical system in which doctors practice, the difficulty of developing a relationship with their doctors, the distance doctors put between themselves and their patients by being superficially polite and the uncertainty of the doctors role. Patients feel that their care plans are unclear and they find the appointment schedules confusing.
4. Southeast Asian patients would like:
   a. Closer and more meaningful relationship with their doctors
   b. Closer relationships with their family and neighbours (for communal support when they are ill)
   c. being able to use traditional medicine as well as modern medicine
   d. A doctor who responds supportively with their body language
5. Southeast Asian doctors who are used to a very formal relationship with their patients are probably unaware that patients would like a closer relationship with them and the distance which they put between them and patients is probably unintentional.
6. Conflict between the use of modern and traditional medicine is very common. It is most marked when a paternalistic doctor has a different agenda to the patient and prioritises his own agenda in front of that of the patient.
7. Communication skills training for Southeast East Asian doctors is the key for a more participatory style of consultations

B. What do you think will be suitable educational communication skills model for Southeast East Asian context?

Table 2: A guideline of doctor-patient communication more appropriate for doctors working in the Southeast Asian context

What is expected by Southeast Asian patients in communicating with their doctors?	Educational consequences for doctors to help Southeast Asian patients with a more informed and shared decision making during consultation			
	How to be helpful during consultation to Southeast Asian patients?	**How to be aware of Southeast Asian context**	**Skills to be strengthened in Southeast Asian context**	**Contextual Examples**
Mutual understanding relationship: Characterized by trust, equal level and two-way exchange information	**To be curious of patients' problem and showing willingness to help**	**The high patients load** Allow only 5 minutes for communication with patients. Use effectively the first 30 seconds to establish rapport.	**Non-verbal behaviour of doctors to express equality, invites two-way conversation and promotes trust** The doctor showing interest by her non-verbal behaviour: The tone of voice, posture and hand gestures are important in developing rapport with the patient (regarding the fact that Southeast Asian doctors may also be subtle in their expression of politeness).	Expression of equality is a challenging skill in such paternalistic circumstances in Southeast Asian context: examples - Doctors in Southeast Asia usually greet their patients while they stand behind their desk. It would be helpful if the doctors greet the patients by moving towards the direction of the patients. - Especially with a child patient, doctors should kneel down so that they are at the child's height. This is rarely practiced in Southeast Asian context. - For female doctors who wear the veil, expression of non verbal assistance using eye contact, tone of voice and the movement of the hands and body is essential.
		The familial relationship. Try to place the doctors in a familial relationship with patients will make doctors closer to the patients' - despite the wide hierarchical gaps between doctors and patients in the society.	**The greeting towards family member**: "Mother, Father, Sister and Brother". Doctors' should support the patients as if the doctor is part their family	Doctors may suggest insulin, but patients may not like it or be afraid of injection. Doctors may say: "Mother, you can use 'the tick-tick', no hurt!" (A doctor who explains about the latest technology of an insulin-syringe to the patient with maximum persuasive manner by putting himself as a family member of the patient).
		Wide gaps of educational background Leads to specific life-style and daily routine for each individual patients.	**Exploration skills**: Active listening, open questions, facilitation, paraphrasing, responding emotion, empathy.	"Would you like to tell me about your history of allergy, because I think it will help the present symptoms become clearer? And please also tell me about yourself and your daily routines; it will help me to understand the background of your illness.

Cultural background appreciation on the closeness relationship between doctor and patient:				
1. The strong family support system	**To be balanced when assessing the family's participation and still be aware of patients' preferences.**	**Awareness of patients' hopes and expectations of informed and shared decision making:** - **Individual decision making,** - **Participation of family member, relatives, and community where patients' live, to the clinical decision making**	**Triadic conversations and Negotiation skills** Uses gaps and silence to obtain patients' agreement (verbal/ non verbal).	A direct instruction face-to-face patient education process between a doctor and a patient might not be effective in Southeast Asia: "Please reduce your salt-intake." A more effective example: "How many spoonfuls of salt does your wife use during cooking, Father? May I ask your wife who usually cooks for you? (Uses gaps and silence to obtain agreement) Two, Mother? Okay, how about only half of spoon for your husband? To help his hypertension controllable."
2. The strong non-verbal behaviour	**To be aware of Southeast Asian patients' subtleness or non verbal sense of politeness.**	**Variation of non-verbal politeness** Hesitation in asking for more information from the doctor or in telling more information to the doctor.	**Strengthening the very basics of observation skills and facilitation skills** Maximize the use all appropriate senses including vision, hearing, touch, and smell. Check understanding and inviting discussion is important.	A poor example: "Please take this antibiotics three times a day until five days. Okay?" The Southeast Asian patients will likely to say answer: "Yes" only Doctors should be careful of non-verbal cues following the answer. More effective example: "What is the best time you think you can take the medicine three times a day?"
3. The use of traditional medicine	**Invites the use of traditional medicine in harmony with modern medicine**	**Variation of the traditional medicine consumed** From herbal medicine to anything logical to their context.	**Negotiation skills to invite discussion** Acknowledge patients' effort to use any of traditional medicine, and then discuss the alternatives. Kindly communicate with the traditional healers or doctors whose formal education in traditional medicine (if any, in your situation).	A poor example: "Please only use insulin; do not even try other medicines." More effective example: "I will check the advantage in taking the herb you told me in the list of WHO or I will consult my colleague who studies traditional medicine. For the mean time, you can try, but just a small amount to not force your liver and to maintain the optimum use of insulin. How do you think of that?"

The interview continued with one core question: What would be the best possible of a communication skills guideline for doctors applicable to various educational and cultural backgrounds of Southeast Asian patients. Each interview was recorded for approximately 40 minutes and transcribed within 48 hours of the interview.

Analysis
An open coding was used to code the transcripts. The first and second author coded the transcripts individually and discussed the categories that emerged during a meeting every week for six weeks. A communication skills guideline, generic for patients from a wide variety of educational backgrounds in the Southeast Asian context was then compiled from the data into a table. Table 2 presents the final validated guideline.

2. Validation of the model by international experts

Subject
There are very few researchers and teachers in medical communication skills in Southeast Asia. We therefore had to include interested academics from outside Southeast Asia and from outside medicine. Four of the six experts were general practitioners (GPs) who were from Indonesia, Vietnam, Nepal and the United Kingdom, one was a professor of applied linguistics from Indonesia and the other was a professor of anthropology from Japan. Three of the GPs had experience in publishing and teaching communication skills in the West as well as outside Europe including Asia.

Instrument
The interview scheme used the following questions: Do you or don't you support the categories and examples given in the guideline from your own practice and experience? Are there any differences between the guideline and other models you are familiar with? Do you agree or disagree with the four categories in the guideline (see Table 2). Can you help to think through the consequences for teaching from the guideline and the comments you have made? At each stage the interviewees were invited to comment further.

Procedure
One week prior to the interview the experts received a draft of the guideline (Table 2), the interview scheme and a consent-form describing the structure of the forthcoming interview. An independent interviewer, an anthropologist, skilled in in-depth interviewing helped the authors. The interviews lasted on average one hour.

The interviews were semi-structured and recorded. The results of the analysis were sent back to the participant for further verification (member-checking). All results were transcribed and analyzed. One of the experts preferred to deliver comments by e-mail. Communication between this expert and the first author by six e-mail messages (back and forth) during a period of two weeks was considered sufficient for analysis.

Analysis
The first and second authors, both of whom are native to Southeast Asia and practicing locally, but also with postgraduate experience from the West, analyzed the data. Both authors did an open coding individually and met at the end of each week during a period of six weeks to discuss the results until both of them reach agreement. Finally, the guideline was redesigned to include the experts' opinions (Table 2).

Results

The development of the guideline
Table 2 presents recommendations for doctor-patient communication in the Southeast Asian context which summarizes the data. All the teachers interviewed suggested that the guideline should start with eliciting the needs and expectations of the patient. This is the first dimension of the guideline.

"Doctors should be aware of what is expected by Southeast Asian patients and based on that how we should help the patients in the most proper way." (An Indonesian communication skills teacher)

The second dimension of the guideline addressed the communication skills needed to help the Southeast Asian patients. One of the issues that emerged from the data was how a patient-centered style can be achieved in a context of a hierarchical, less verbally explicit and less autonomous culture. Another theme to emerge was that although skills such as listening or questioning might be considered as generic or universal, the micro skills, or exact phrasing need to be context specific. For example, the generic skill of "negotiation" with patients while at the same time valuing the specific character of traditional medicine was as follows:

"If you take any traditional medicine, please let me know so I can also learn its benefits. But please do not to take too much herbs to start off. We will evaluate those additional herbs you take for the next few months. Would that be an option?" (An Indonesian communication skills teacher)

The validation of the guideline

In general, the experts we interviewed agreed with our proposed guideline based on the data elicited from the teachers. However, they suggested that several new issues should be included which we agreed to. Comments from experts accommodated in Table 2 were:

1. Achieving mutual common understanding between the patient, the family and the doctor is particularly difficult to achieve in a fundamentally hierarchical culture e.g. a caste society. Patients may find it difficult to express their desire for a more equal relationship. Patients often come with the whole family into the doctors' consultation room. The aim may be to support the patient and help with explaining the patient's problem to the doctor. Unfortunately this kind of situation may make the doctor irritable and lead to restriction of the number of relatives in the consultation room. Communication between the doctor, the patient and the family may suffer and common mutual understanding is unlikely to be achieved in a fundamental hierarchical culture.

2. The non-verbal politeness is not only shown by patients and their families, but also by doctors. Clear non-verbal skills, such as facial expression and warmth of manner to gain patients' trust, is even more important for Southeast Asian doctors, whose facial expressions may sometimes be hard to interpret. The expression of clear non-verbal messages with the eyes to show willingness to help is essential for female doctors who wear a veil. In a culture where patients are unused to talking with their doctors, or where there is a language problem, expressing adequate supportive non-verbal behaviour to provide optimum assistance to patients needs to be more marked. This issue was adjusted to the guideline in this study.

3. Asian patients' autonomy relies on their family or the community surrounding the patients. The locus of autonomy of Asian people in general is different from Western autonomy, where most patients take more responsibility for their health themselves. Southeast Asian doctors need to elicit the patients' preference when there are options for management and treatment. They will need to be skilful in negotiating preferences when there is a difference of opinion between the patient and family members. Our guideline was adjusted with this issue.

4. It is important for doctors practicing Western medicine to negotiate with patients about the use of traditional medicine and discuss with them whether they would like to visit the traditional doctor. Many Southeast Asian countries have doctors who graduated from a formal traditional medical education in addition to the doctors who graduated from formal modern medical education. Our guideline was adjusted with this information.

5. This guideline should not only focus on a geographical area like Southeast Asia. The culture and circumstances extracted from Southeast Asians, in which there is a higher power-distance, less autonomy in many members of the society, a higher degree of communalism and higher short-term orientation, may be used more broadly for countries with similar characters. This issue is discussed below.

Discussion

Southeast Asian patients are beginning to move towards a more equal partnership with their doctors, despite their strong hierarchical culture. Many Western authors recommend trust-building skills which show interest in patients' concerns and willingness to help. Current Western consultation models and guidelines also emphasize the skills required to give information to patients and share clinical decision-making (Silverman *et al.,* 2005). The guideline that we have developed and validated in this paper underlines the use of similar skills as proposed by Western authors, but applied within the context of Southeast Asia.

However, we need to be aware that strong hierarchical perceptions in Asian people are common, and where doctors tend to prioritize their own concerns before those of their patients. In any hierarchical context, including Southeast Asia, basic communication skills to accommodate patients' concerns (e.g. exploration, observation and negotiation) are usually neglected during consultations (Kleinman & Benson, 2006). Therefore encouraging doctors to use such patient-centered skills suggested in our guideline will be a real challenge.

One of the problems highlighted by our study is that the skills that we have suggested be taught to medical students and doctors would lead to longer consultations. We need to carry out further studies to determine how doctors can use patient-centered skills in the context of a high patient-load and ineffective health care system (Claramita *et al.,* 2011). However, we would like to emphasize that the way a doctor communicates in the first consultation with a patient will affect how successful any further consultations will be. If the patients are satisfied with the consultation style, there is likely to be an increase of compliance with the care-plan. Therefore, by using the skills in our guideline, the overall process of doctor-patient consultation is likely be more effective.

Our guideline could be used in a broader context such as Asian or non-Western societies which have a hierarchical structure, less verbally explicit decision making communication style and less individual autonomy, a culture characters as stated in Hosftede, 2003. Western medicine has moved towards a more equal partnership between the doctor and the patient, earlier than in Southeast Asia. One of the possibilities is that Western patients are more used to expressing their concerns verbally which is related to their higher level of autonomy than Southeast Asians. A Southeast Asian patient usually talks to his/her family/ community if he/she does not find satisfactory answers from the doctors. At that moment, a suggestion from the family/ community on the use of any of traditional medicines suits the less-autonomous patient (Claramita *et al.,* 2011; Kim *et al.,* 2003). Moreover, this Southeast Asian patient may feel hesitation to talk to his/her doctor about the unsolved health problems, because of the high power-distance between doctors and patients restrict the verbal expression between two people from different social classes (Hofstede, 2003, Lamiani *et al.,* 2008). Therefore, this illustration may explain why the move towards equal partnership relationship during doctor-patient consultation, although desired by both doctors and patients in Southeast Asia becomes difficult to realize.

In the context of this study doctors were usually at a higher level of society than their patients. Moreover, the ineffective healthcare system and the high patient load have forced the doctors to pay very little attention to the purpose of the patient's visit (Claramita *et al.,* 2011). In addition, Southeast Asian doctors may have insufficient knowledge about doctor-patient communication. Among six competences (Carracio *et al.,* 2002), communication skills, professionalism and system-based practice should be more emphasized in the Southeast Asian context. Introducing our guideline to medical teachers at this time may be difficult, for all the reasons we have outlined above. Encouraging further research may prove challenging.

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