Original Research

Patient-centred interviewing in Outpatient Departments: A doctor-client perspective

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Abstract

Background: The medical interview is the most common undertaking by a physician. On average, a doctor performs over 200,000 interviews during his career. The traditional medical interview was centred on the clinician. In the late 1970s, the bio-psychosocial model was first introduced by Engel and followed by McWhinneys' as patient-centred approaches which were swiftly adopted into practice by clinicians. However, in Sri Lanka, no clear evidence could be found to suggest that patient-centredness in the medical interview was given much emphasis in the past. Research evidence available from the local setting on this field is limited. Against this backdrop, it is imperative to assess the perceptions of patient-centred interviewing among the doctors as well as patients.

Objective: To assess the doctor and patient perceptions on patient-centred interviewing in Outpatient Departments (OPD) consultations.

Methods: A descriptive cross-sectional study was conducted in OPDs of government hospitals in the Colombo Regional Director of Health Services division. All doctors and a sample of patients over the age of 18 years were included. Data collection was done through a self-administered questionnaire and focus group discussions. Data analysis was done by using MS Excel and framework thematic analysis.

Results: Both doctors and patients perceived the short consultation time as a leading challenge to have patient-centred interviews in OPDs. In addition, interviewers being disrespectful to patients, providing inadequate information, not getting the involvement of the patient in decision making, and having poor listening skills were negatively perceived by the patients. Overcrowding, heavy workload, stressful work conditions, lack of privacy, and low priority given by the hospital management to OPD functions were perceived by the doctors as barriers to improve the patient-centred interviews. Even though the majority of the doctors have already undergone communication skills training, their willingness to learn and improve these skills was noted.

Conclusions and Recommendations: As perceived by the partakers, the patient-centred interviewing in the OPDs has multiple challenges. Placing more emphasis on organizing communication skills training, ensuring longer consultations, providing a more responsive working environment for the doctors, ensuring privacy and confidentiality of transpired information, reformulating OPD functions are recommended.

Keywords: Patient-centred interviewing, Outpatient Department, doctor-patient relationship

Background

The medical interview is the most common undertaking by a physician. On average, a doctor performs over 200,000 interviews during his career. Despite many advances in modern medicine, medical consultation remains the most valuable diagnostic tool, surpassing the combined worth of both medical examination and laboratory investigations [1].

The traditional medical interview was centred on the clinician. It consisted of structured, predominantly closed-ended questions with the primary objective of arriving at a diagnosis. This often resulted in incomplete and flawed information and led to a less than satisfactory relationship between the doctor and the patient [2]. This form of the interview was based on a biomedical model and left no room for exploring social, psychological, and behavioural dimensions of an illness [3].

In the late 1970s, the bio-psychosocial model was first introduced by Engel [3]. This was followed by McWhinneys' patient-centred approaches which were swiftly adopted into practice by clinicians [4]. This model allowed doctors to recognise patients' values, needs, and preferences and permitted patients to participate actively in the decision-making process. Today, patient-centred interviewing (PCI) is recognised widely as the central element of high-quality health care [5].

The PCI has four domains: patient's perspective, psychosocial context, shared understanding and sharing power and responsibility [5]. Effective PCI entails mastering a set of skills by the doctor to practice during consultations: eliciting the patient's agenda with open-ended questions; encouraging the patient to express his/her opinions uninterrupted; engaging in active listening; understanding the patient's perspective of the illness; exploring the patient's feelings, ideas and concerns; expressing empathy by demonstrating respect, support; exploring the patient's illness experience and emotions; shared decision making and providing information. These are the key components that construct a patient-centred consultation [6]. Advantages of PCI over earlier models include enhanced patient satisfaction, increased compliance with treatment, higher client satisfaction, lesser chance of legal actions against caregivers and in general improved patient outcomes [7].

In Sri Lanka, no clear evidence could be found to suggest that patient-centredness in the medical interview was given much emphasis in the past. Research evidence available from local settings in this field is also limited [8]. However, it may be safe to assume that the cultural and social norms and lack of awareness may have led to the misconception that the status quo was acceptable and no intervention was required. Against this backdrop, it is imperative to assess the perceptions of PCI among the doctors as well as among the patients.

Objectives

This study was undertaken with the objectives of assessing doctors' perceptions on the importance of learning, the importance of practising and the actual practice of patient-centred interviewing skills in Outpatient Departments, and the clients' perception of doctors' practice of patient-centred interviewing skills.

Methods

A descriptive cross-sectional study was conducted in two phases, viz; questionnaire-based survey and Focus Group Discussions (FGD). The questionnaire-based survey was conducted at the Outpatient Departments (OPDs) of all eleven government hospitals in the Colombo RDHS division (two Base Hospitals and nine Divisional Hospitals). All medical officers and registered medical officers working in the OPDs (n = 101) and patients over the age of 18 years, coming for OPD treatment during the study period were included (Exclusion criteria; critically ill or psychologically unsound patients). The study was conducted from June to September 2015.

A sample of 422 patients was allocated to the hospitals proportionate to the number of patients attending the OPDs in the previous year. At each hospital, convenience sampling was used to select the participants. Data were collected using interviewer and self-administered questionnaires for the patients and doctors respectively. Selection of specific variables and development of questionnaires were carried out following an extensive online literature review and discussions with experts in the field of study including senior medical officers, Community Physicians, Medical Administrators, and university academics. Two FGDs were conducted with doctors and patients to identify barriers and means to overcome them. The self-administered questionnaire for doctors consisted of two main components: socio-demographic data and an assessment of doctors' perception on the importance of learning and practising patient-centred interviewing skills and assessment of the doctors' perception of

their practice of PCI skills in OPD consultations. The interviewer-administered questionnaire for patients consisted of socio-demographic data and an assessment of patients' perception of doctors' practice of PCI skills in OPD consultations.

Two FGDs were conducted using an FGD guide. The first group was patients and the second was doctors. For the first group, participants were selected based on their age, gender, and occupation, and the second based on their gender and category (Medical Officer/Registered Medical Officer). Discussions were conducted by a facilitator using a semi-structured FGD guide. The principal investigator participated as an observer. All discussions were electronically recorded and transcribed. Thematic analysis was done.

Administrative clearance was obtained from the Provincial Director of Health Services, Western Province and the RDHS, Colombo District, and from the relevant heads of institutions, before undertaking the study. Ethical clearance was obtained from the Ethics Review Committee of the Postgraduate Institute of Medicine.

Results

Socio-demographic characteristics of OPD doctors and the patients

As shown in Table 1, the majority of doctors (78.7%, n = 63) were above the age of 45 years. Age ranged from 27 to 59 with a mean of 49.28 (SD = 7.46). Females (70.9%, n = 61) formed the majority.

Total work experience as a doctor ranged from 1 to 33 years with a mean of 21.28 (SD = 8.15). The majority (67.4%, n = 58) had 20 years or more of service experience. Duration of the service in the OPD ranged from six months to 33 years with a mean of 16.65 (SD = 10.78). The majority (57.0%, n = 49) had over 20-year service in the OPD. Medical Officers and Registered Medical Officers are the two categories of doctors working in OPDs and both of these groups were equally represented in the current study. The majority (54.7%, n = 47) of the doctors had prior training in communication skills. Out of them, 70.2% (n = 33) had received this training as a part of their in-service training and the others received it during their undergraduate training or postgraduate training. The majority of the doctors in the sample (68.91%, n = 51) had postgraduate training.

The majority of the patients in the sample (64.1%, n = 262) belonged to the age group of 18–40 years. Minimum and maximum ages were 18 and 69 years respectively. Males (53.1%, n = 223), Sinhalese (93.6%, n = 394), and Buddhists (90.8%, n = 383) made up the majority. Over two-thirds of the patients had faced GCE A/L (39.1%, n = 164).

Doctors' perception of their interviewing skills and the value of learning interviewing skills

The majority of the doctors in the sample (88.3%, n = 77) perceived that their communication skills as good, very good, or excellent. None of the doctors believed their communication is at a poor level. Only nine doctors (11.7%) rated it at a fair level. All the doctors agreed with the statement "in order to become a good doctor I must learn good interviewing skills". However, 14.3% (n = 12) of the respondents believed that learning interviewing skills is a 'waste of time'.

Doctors' perception of the importance of practising patient-centred interviewing skills

As illustrated in Figure 1, the overwhelming majority responded positively either agreeing or strongly agreeing with all seven statements which assessed the importance of practising patient-centred interviewing skills.

Doctors' perception of their practice of patient-centred interviewing skills and the clients' perception of the doctors' practice

As to the perception of the doctors, the majority of the doctors were practising PCI at the OPD. However, getting the involvement of the patient in decision making and educating them were very poorly practised aspects in patient-centred interviewing. As percentages, 40.5% (n = 34) of the doctors had not got the involvement of the patients adequately in decision making and 23.3% (n = 20) had not educated the patients sufficiently. The majority (52.50%, n = 220) of the patients had stated that the doctors rarely educated them. Nearly half of them (47.50%, n = 200) had claimed that they were not involved in decision making and the decision making was done by the doctor. As demonstrated in Figure 2, for all the domains tested in the study, the doctors rated their practice as at a higher level than the ratings given by the patients.

Focus Group Discussions

The FGDs were used to explore further, the perception of both the doctors and patients on PCI

in the OPDs. For the first discussion, ten patients including four males and six females had participated. There was a retired school teacher, lawyer, mechanic, two self-employed males, and four housewives. Three participants were under 30 years and three were above 60.

Analysis of the discussion yielded several themes. One repeatedly mentioned theme was, the short consultation time which limited the opportunity to explain the illness, expressing feelings, and asking questions to clarify matters. However, the majority had felt that the doctors themselves were also helpless in this regard. The patients had felt the short consultation time was due to the overcrowding and the doctors had given their priority to finish work. There were some experiences of doctors writing the prescriptions even before the patient presented his/her problem completely.

However, when questioned further, it emerged a deeper dissatisfaction in them. The question 'Are doctors ever rude to the patients?' stimulated an emotional response from a patient. According to her, very few doctors were indeed rude and unkind. Further, they did not even look at the patient's face throughout the interview, instead took notes while the patient presented the problem. Some even got angry with the patients without having any apparent reason. A few of them demonstrated unresponsiveness, chatting with other staff members and using mobile phones during the interview. In general, most of the participants expressed their dissatisfaction regarding the amount of information given by the doctors while highlighting the time factor. However, participants felt that a little more time could have been spent explaining the illness and the treatment which will benefit them. Yet, when doctors took time to explain, patients were generally able to understand what doctors said.

Physical arrangements of the OPDs were figured out in the conversation when discussed regarding the privacy and confidentiality of the patient. During the consultation, two or more doctors shared one cubicle and many patients stood outside the door waiting for their turn. The conversations could be overheard by all of these people and privacy was non-existent.

Eleven doctors participated in the second FGD, including a Consultant Family Physician, four Medical Officers, and six Registered Medical Officers. The most shared concern was the shortage of doctors. 'Clearing the OPD' had become the priority and the resultant short consultations were perceived as the foremost obstacle to a patient-centred consultation. At the same time, doctors who engaged in longer consultations were treated negatively by both the waiting crowd and also by the other doctors. The pressure to choose quantity over quality coupled with inflexible working hours, heavy workload and family commitments put severe mental stress on a doctor, and it adds a negative demeanour to how they treated their patients. Nevertheless, discontent about the existing situation was not evident in the group. Doctors were of the view that, even in a short consultation, they listened to the patient's concerns, empathized with their grievances, involved them in decision making to an appropriate level, and had given adequate information in a manner that the patient could understand.

Difficulties in ensuring privacy and confidentiality also came under the consideration of the FGD. Lack of space and disorganized OPD functions were identified as contributing factors. In addition, doctors were unsatisfied with the level of commitment of administrators towards the day-to-day functioning of the OPD. They felt that the management gives a low level of attention to the OPD, allocating inefficient minor staff and unequally distributing physical resources such as space, equipment, and even stationary.

The commitment and willingness of the doctors to improve the patient-centred consultation were emphasized in the FGD. All participants agreed that there is room for improvement and they are ready to make the effort. Communication skills training was considered an essential requirement by the doctors; however, the shortage of opportunities to get this training was resounded over and over.

Discussion

Silverman and Rosenbaum have stated that the fast-developing field of health care communication could be seen as a Western trend and that it may only be suitable to a particular cultural setting [9]. Research done in this area relevant to the local setting are limited [8].

The findings of the questionnaire-based survey revealed that the majority of the doctors had not undergone communications skills training, but doctors agreed on the value of learning and practising patient-centred communication. When asked to rate their communication skill level, the majority of them perceived it as good, very good, or excellent. This is compatible with other global studies conducted in

settings where patient-centred communication was given high priority and recognised as a learning interest [10,11].

However, when a comparison was made between the doctors' and patients' perceptions of doctors' practice, patients gave lower ratings for all dimensions. According to Silverman and Rosenbaum, communication is a clinical skill that could be taught and learned. However, they observed a gap in knowledge transfer from classroom to work setting. They also indicated that experience alone cannot make doctors good communicators [9].

The two FGDs were conducted to explore these findings deeper. The first and foremost issue highlighted by both parties was the inadequate time allocation for a consultation. Many works in the literature support this fact. A report published by the British Medical Association highlighted the time constraint as the main barrier for effective communication [12]. Wiggers and Fisher went further by stating that the time duration of the consultation is a determinant of quality of care [13].

However, the time limitation was not the sole pivotal factor. Statements such as "even when I'm telling my problems, the doctor sometimes engage in a conversation with others" or ''at times he/she engages in telephone conversations" and "Some doctors treat patients unkindly, talk to them rudely, get angry when we try to tell them our problems" were demonstrated a deeply rooted problem. Not showing adequate attention to patients' emotional needs, providing inadequate information, and not involving patients in decision-making were also emphasized in both segments of the study. Even though these accusations were half-heartedly accepted by doctors, they had their justifications, leaving with a lack of time, heavy workload, emotional stress, and lack of support from the management.

Another striking yet contrasting feature observed in the FGD was the reluctance of the patients to complain openly against the doctors. Even though people expressed their dissatisfaction many of them agreed that they would not be willing to make complaints. The reasons included; "There would be no point of doing it", "Not all doctors are bad", "Doctors also have problems", and "Patients are also to blame sometimes". This line of thinking may stem from the hierarchical nature of Asian health systems which put doctors at a higher level of power [8].

Overall the study showed evidence of a system in which the two parties to the medical consultation perceive the practice of patient-centred skills by doctors in a different light and a system that requires further examination and urgent interventions for improvement. One key solution was training. Silverman identified communication as a clinical skill, which can be taught and learned [9]. However, during the FGD, while agreeing with the importance of learning communication skills, the lack of learning opportunities was mentioned by the doctors as a limiting factor. Many health systems around the globe struggle to provide adequate communication training opportunities for doctors [14]. Hence, Sri Lanka is not alone; however, a remedy is needed.

The study may have a few limitations. Respondents may have been tempted to give socially favourable answers to the questionnaires which are not accurate in real practice. Hence, instead of assessing the perceived quality of practice using questionnaires, observation of the actual consultations using checklists would have given a more accurate insight. Coupling/pairing of doctors and patients would have given a more accurate comparison of the perception of the practice. Only two FGDs were conducted due to time constraints.

Conclusion and Recommendations

The study demonstrated that the PCI in OPDs, when perceived through the eyes of two partakers had many attributes including challenges brought on by short consultation time, the inadequate practice of skills by doctors, especially when providing information, and mutual decision making. Most of the identified reasons for a poor level of patient-centred communication are the responsibilities of the hospital management. The issues identified were overcrowding, heavy workload, privacy and confidentiality, poor level of maintenance and facilitating that can only be solved by the hospital management. To overcome these shortcomings, a careful study and an effective work plan should be identified as a collaborative effort of doctors and hospital management. Interviewers' willingness to learn and improve their skills can be taken as an opportunity to introduce some training programmes to enhance the communication skills of the doctors. The patients also need to be equipped with their rights and a well-established complaint system needs to be introduced in the OPD.

Author declaration

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Table 1: Characteristics of OPD doctors

Characteristic		Frequency	Percentage
Age (in years) (n = 80)	≤ 40	11	13.8
	41–45	6	7.5
	46–50	19	23.7
	51–55	34	42.5
	56–60	10	12.5
Sex (n=86)	Male	25	29.1
	Female	61	70.9
Work experience as a doctor (years) (n=86)	< 20 years	58	67.4
	≥ 20 years	28	32.6
Work experience as an OPD doctor (years) (n=86)	< 20 years	49	57.0
	≥ 20 years	37	43.0
Designation (n=82)	Medical Officer	41	50.0
	Registered Medical Officer	41	50.0
Postgraduate training (n=74)	With training	51	68.9
	Without training	23	31.1
Previous training on communication skills (n=86)	Had training	47	54.7
	No training	39	45.3

Table 2: Socio-demographic characteristics of the patients

Characteristic		Frequency	Percentage
Age (in years) (n = 409)	≤ 30	158	38.6
	31–40	104	25.4
	41–50	70	17.1
	51–60	43	10.5
	Over 60	34	8.3
Sex (n = 420)	Male	223	53.1
	Female	197	46.9
Ethnicity (n = 420)	Sinhala	394	93.8
	Tamil	09	2.1
	Moor	16	3.8
	Others	2	0.4
Religion (n = 422)	Buddhism	383	90.8
	Christian/Roman Catholic	13	3.1
	Hindu	12	2.8
	Islam	14	3.3
Educational level (n = 419)	No formal schooling	6	1.4
	Year 1–Year 5	36	8.6
	Year 6–Year 10	81	19.3
	GCE (O/L)	132	31.5
	GCE (A/L)	135	32.2
	Beyond GCE (A/L)	29	6.9

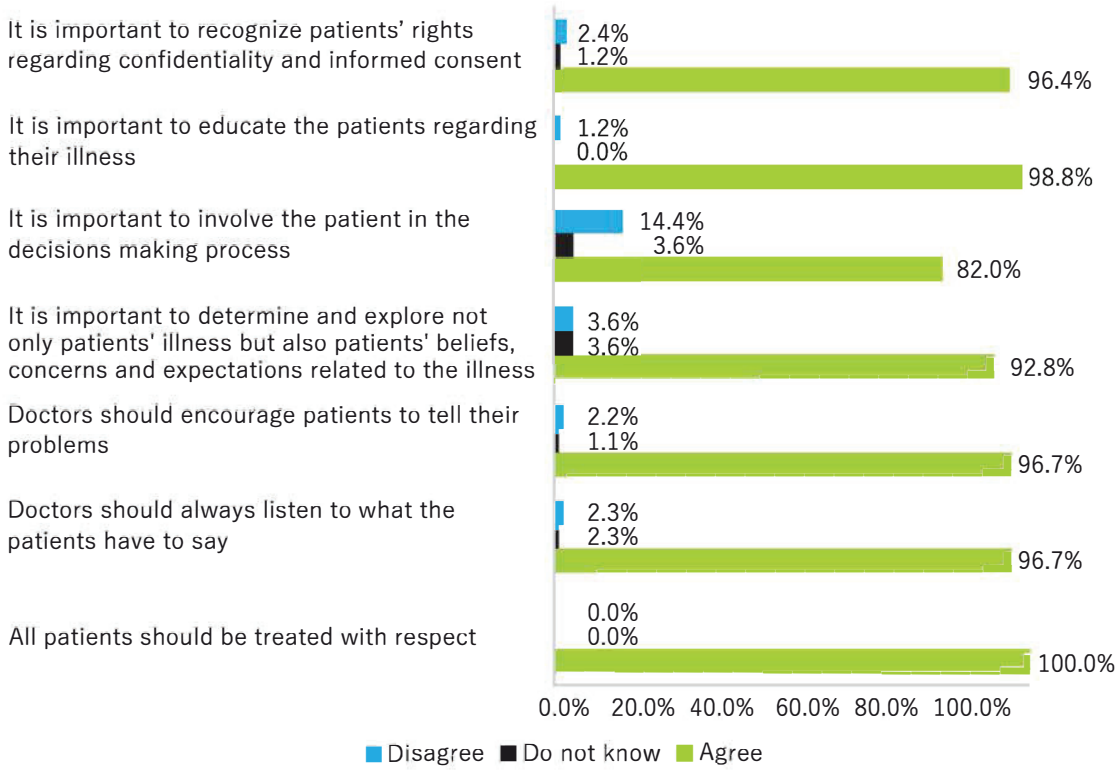

Figure 1: Doctors' perception on the importance of practising patient-centred interviewing skills

Responses strongly agree and agree were amalgamated as 'Agree' and responses disagree and strongly disagree were amalgamated as 'disagree'.

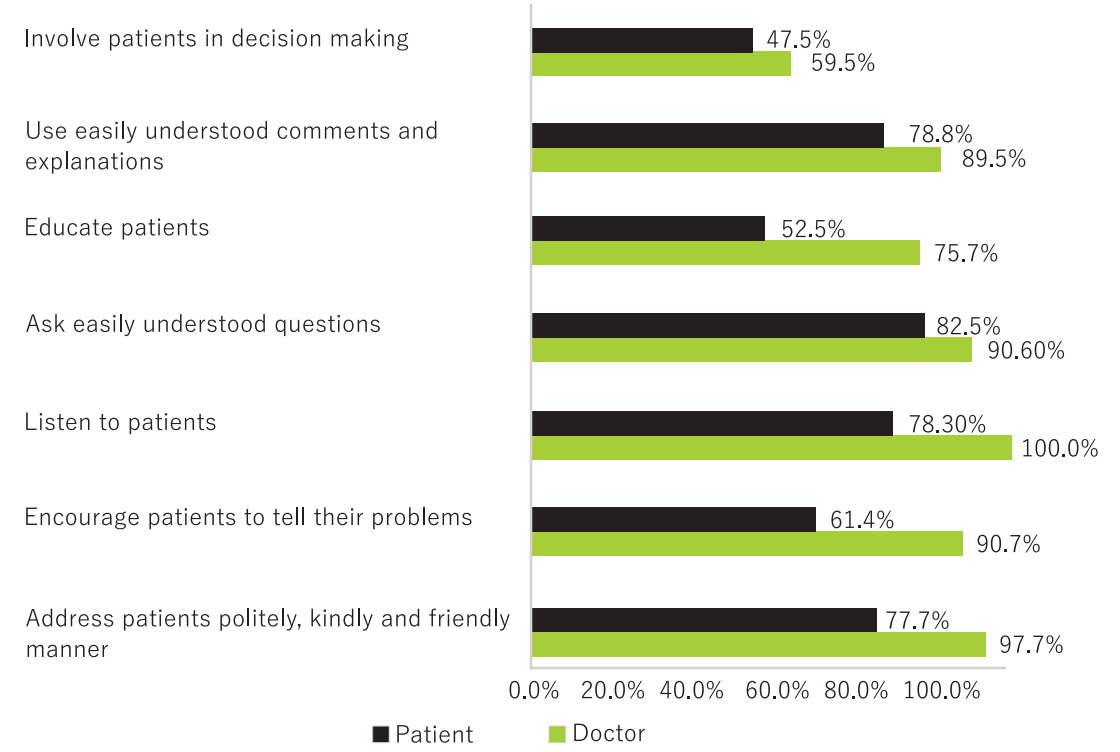

Figure 2: Doctors' perception of their practice of patient-centered interviewing skills and the clients' perception of the doctors' practice

The percentages depict the ones who have given the responses 'always' and 'often'. The other responses, 'sometimes', 'rarely', and 'never' represent the complementary percentage in each statement.