

## Doctors' Communication Style: Impact on Patients Participation

Nurul Nadia Haron<sup>a</sup>, Noor Aireen Ibrahim<sup>a\*</sup>

<sup>a</sup>Language Academy, University Teknologi Malaysia, 81310 UTM Johor Bahru, Johor, Malaysia

\*Corresponding author: naireen@utm.my

### Article history

Received :1 July 2013  
Received in revised form :  
1 September 2013  
Accepted :15 October 2013

### Abstract

This paper presents the findings of a study on doctors' communication style and its implications on patients' participation. The data for this study were gathered from audio recording of ten clinical consultations and interview with a doctor at the Hematology Clinic in a General Hospital in Malaysia. The data were transcribed and analysed based on the three components of patients' participation proposed by Cegala (2011). Findings indicate doctors display two different styles of communication during the clinical consultations. Further investigation reveal that the sharing style consultation does indeed encourage more patients' participation than the Directing style. The findings of this study have important implications for communication training for medical students. The paper concludes with a discussion of the directions for future studies.

*Keywords:* Doctor communication style; sharing style; directing style; patient participation; health communication

### Abstrak

Kertas kerja ini membentangkan kajian mengenai gaya komunikasi doktor dan implikasi terhadap penglibatan pesakit. Data untuk kajian ini telah dikumpul dari rakaman audio sepuluh perundingan di Klinik Hematologi di salah sebuah Hospital Besar di Malaysia. Data telah disalin dan dianalisis berdasarkan tiga komponen penglibatan pesakit seperti yang dicadangkan oleh Cegala (2011). Hasil kajian menunjukkan doktor memaparkan dua gaya komunikasi yang berbeza semasa rundingan klinikal. Kajian mendalam menunjukkan gaya rundingan secara perkongsian atau "sharing" menggalakkan penglibatan pesakit dalam komunikasi berbanding perundingan secara berarah atau "directed". Dapatan kajian ini mempunyai implikasi penting terhadap latihan komunikasi untuk pelajar perubatan. Kertas kerja ini membuat kesimpulan dengan membincangkan arah tuju untuk kajian masa hadapan.

*Kata kunci:* Gaya komunikasi doktor; gaya rundingan berkongsi; gaya rundingan berarah; penglibatan pesakit; komunikasi kesihatan

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### 1.0 INTRODUCTION

Few can dispute the importance of communication in health care as effective delivery of health information and messages can determine the success of medical consultations and provide better health outcomes. Earlier studies (e.g. Brown *et al.* (1989) have shown that clinical outcomes or patient care is affected by three different factors: i) patient, ii) doctor, and iii) encounter. Elements in the patient factor included severity of illness, complexity of problems, anxiety, communication skills and common-versus-rare presentation. Later studies (e.g. Stewart 1995) then identified the communicative features that can influence the outcome of medical consultations and these included information exchange and shared decision making. In addition,

the doctor's role in encouraging patients to voice their concerns, including patients in decision making and in integrating psychosocial issues in discussion of medical problems were key in ensuring effective communication.

However, more recent studies (e.g. Miller *et al.* 2011) have shown that the variables for health outcomes included equality of services and patients view of care (i.e. respectful treatment, satisfaction and effective partnership). The variables proposed by Miller can only be achieved through equal participation of both doctor and patient in the clinical consultations as patient's level of participation appears to be generally associated with more positive evaluations and outcomes (Ryan and Sysko, 2007). This is in line with Cegala (2011) who believes that information provision is a part of the patient participation components and that

both patient participation and information provision are closely related. Indeed, when patients participate more actively in the consultation, it gives a positive impact on the information sharing between doctor and patient.

In fact, patient's participation and doctor's information giving are equally important in producing better outcomes and avoiding miscommunication during clinical consultations. This is supported by previous studies such as Ishikawa *et al.* (2002) and Takayama and Yamazaki (2004) on the importance of open-ended questions, information giving and counseling to achieve patients' satisfaction and self-perceived participation. Therefore, it is important for doctors to be aware of how their communicative style impact on the patient's willingness to participate in the clinical consultation which has implications on the quality of information exchange.

## ■2.0 REVIEW OF LITERATURE

In clinical consultations, both patients and doctors come with their own set of agenda or their own explanatory model of the illness. Kleinman *et al.* (1978) noted that the explanatory model is behavioral driven. As an example, Ashton *et al.* (2003) have shown that the doctor's explanatory model drives his or her clinical behaviour, (i.e. the formulation of a differential diagnosis and a diagnostic and therapeutic plan for the patient) while the patient's model drives his or her illness behaviour (i.e. the monitoring and interpretation of bodily symptoms, decisions to seek formal or informal care, and decisions to follow recommended treatment plans). In order to achieve some form of congruence between doctor and patient, mutual understanding needs to be met. Indeed, this is no easy task as tensions exist between the differences in perspectives. Patients driven by their world knowledge may have totally differing views from the doctors whose perspectives are very much influenced by their medical knowledge. This knowledge divide is the reason why some patients may have difficulty connecting with doctors as their explanatory models about health and illness are dramatically different (Ashton *et al.*, 2003; Margolis *et al.*, 2003). Furthermore, this knowledge divide is also what makes doctor-patient interaction asymmetrical which suggests that the relationship of doctor-patient is manifested through "routine practice" and unequal relationship (Mishler, 1984). Doctors will have their own agenda to improve patients' health using the related schema while patients will have their own representation of the problems which are greatly influenced by social factors.

Despite the differences patients and doctors have in terms of knowledge and agenda, the relationship between doctor and patient is important to ensure better health outcome in any clinical consultation. During a visit to a medical clinic, doctor and patient will be engaged in both verbal and written communication. Both doctor and patient use language in order to deliver messages and the activities during the interaction are mostly dependent on cooperative participation from both parties which not only takes into consideration the medical but the social aspects of the interaction (Silverman, 1987).

Although previous research have shown the importance of doctor's consultation style and how this can impact on patient's, health outcome, few research have looked at how doctors' interactional style during clinical consultations can have an impact on patient's participation. Doctors may have their own individual style in managing clinical consultations but many previous studies have identified two general types of consultation styles. These two opposing types of consultations have been labeled differently (e.g. patient centred vs. disease centered, shared decision consultation vs. directed decision consultation),

nevertheless, they all represent similar characteristics. In this study, we will be looking at the characterization of styles as proposed by Williams *et al.* (1998): i) Directing and ii) Sharing style. Both styles have been shown to initiate different kinds of responses from the patients.

The Directing style of consultation is usually led by the doctor and patients take on a less autonomous role. The doctor will make judgments on the consultation, makes decision on treatment plan and the follow up appointment. Interestingly, the findings from Williams *et al.* (1998) have shown that the Directing style often results in higher patient satisfaction when compared to the Sharing style. The former somehow benefits acute organic illnesses which respond better to the traditional biomedical approach. This result contradicts many other the findings from past research including Roter *et al.* (1987), Street (1992) and Stewart (1995).

On the other hand, the interactional roles are shared equally between doctor and patient in the Sharing style. The discussion in the clinical consultation will take into consideration the patient's opinion and needs apart from the doctor's knowledge about the health problem. The sharing style is often characterized by shared decision making in which both doctors and patients will be involved in the decision making throughout the consultation (Stewart, 1995).

Nevertheless, patients' participation can easily be influenced by many other factors. Based on the Ecological Model of Medical Communication proposed by Street *et al.* (2003), there are five major contextual factors that influence patient participation during consultation: i) organizational context, ii) political-legal context, iii) media context, iv) interpersonal context and v) cultural context. Although these factors can affect patients' participation during medical consultations, this research will only examine the organizational context based on the doctor's consultation style and its implications on patients' participation. Therefore, through a comparative analysis of two different types of consultation style, we attempt to answer the following research question: How do the different kinds of consultation styles impact on patients' participation based on the three different components of patient participation?

## ■3.0 THE STUDY

This study is part of a broader research that looks at three key issues in doctor patient interaction that are patient participation, information provision and decision making. As the main objective of this study is to examine doctor's consultation style and patient participation during actual clinical consultations, the data for this study was gathered from audio recordings of doctor-patient interaction during actual clinical consultations. The interactional data was also triangulated with interview session with the doctor. Most importantly, this study takes on a qualitative method of discourse analysis in studying doctor-patient interactions as it is believed that this method has been used widely by most researchers examining similar kinds of interaction (Ainsworth-Vaughn, 2003; Blank *et al.*, 2006; Roberts and Sarangi, 2005; Wang, 2010; Sarangi, 2010).

The respondents of this study were selected among patients and doctors at a Haematology clinic in one of the government hospitals in Malaysia. Data were collected for three consecutive weeks. As the Haematology clinic opens every Thursday, patients who attended their appointment for the three consecutive weeks and have given consent were selected for the audio recording. All the patients were randomly selected and therefore consist of patients whose health condition may vary from acute blood cancer, mild diagnosis of low platelet or regular patients of

Thalassemia. Because of the nature of their illness, patients come to the clinic for regular medical treatment and consultations. Hence, most patients are fairly familiar with the doctors at the clinic.

There are usually three to four doctors at one time during the weekly Thursday clinic. The selected medical practitioners are the doctors at the Haematology Unit and who have given their consent to be audio recorded and interviewed. The doctors are seated in two different rooms; R9 and R10. There are usually two doctors in each room and for this study, the audio recordings took place in room R9. Throughout the three consecutive weeks in which data collection was carried out, four doctors agreed to participate in this study (please note that actual names have been replaced with pseudo names): i) Dr Lee (male/29), ii) Dr Lim (30/female), iii) Dr Hema (29, female) and iv) Dr Raja (34/male).

Many patients were quite reluctant to be audio taped but after three weeks, the researchers managed to collect a total of ten recordings. The length of the consultation is often influenced by the patients' health condition but in general, the consultation lasted between five to ten minutes for regular patients with only lethargic symptoms and more than 15 minutes for more serious cases like cancer. Considering the limitation of this study (small number of participants), the comparative analysis of the two different types of consultation styles from a coherent and consistent collection of data provides some form of meaningful interpretation of the data.

When analysing the doctor-patient encounters, it is essential to consider what is generic about the practices observed before attributing them to the particular tasks and roles of the setting (Webb, 2009). Generic here refers to the broad context of doctor-patient interactions. As in this study, the researchers chose the theme-oriented discourse analysis (Sarangi and Roberts, 1999 and Sarangi, 2010) and the generic involved in this study are patient participation. Whilst the bigger contexts were assigned with particular events to measure the interactions such as asking questions, being assertive and expressing concerns. All these events refer to the attributes as proposed by Webb (2009). Table 1 outlines the elements of patient participation used by the researchers to identify the responses given by patients and the three main components of analysis: i) asking question, ii) being assertive and iii) expressing concern.

**Table 1** Analysis of responses for patients' participation (Cegala, 2011)

Elements of Patients' Participation	Analysis of Responses
Asking question	Utterances in interrogative form that ask for information and clarification.
Being assertive	Utterances in which patient interjects his beliefs, preferences and perspectives into the consultation i.e. offering an opinion about health/ treatment, making recommendations, disagreeing with doctor, making a request, introduce new topics.
Expressing concerns	Statements of negative affect i.e. worry, frustration, anger, fear.

The analysis of data also included some form of quantitative analysis such as frequency counts and calculation of mean scores. This is to provide an overview of the data and some indication of the frequency of the three components when comparing between the two consultation styles.

#### 4.0 FINDINGS AND DISCUSSIONS

According to Cegala (2011), components of participation in health communication include asking questions, being assertive, expressing concerns and giving information. However, because of the asymmetrical nature of doctor patient interaction, doctors play a major role in encouraging as well as discouraging patients' participation during clinical consultations. Because doctors have more control over the communication that takes place in clinical settings – doctors elicit information, give diagnosis and directions, while patients give response to the doctors, it is then completely reasonable to assume that the doctor's communicative behaviour will have an impact on the patient's contribution in the clinical consultation. This is supported by both previous research as well as the analysis of the findings from this study. Two types of communication style were observed in the way these clinical consultations were managed by the doctor: i) the Directing style and ii) the Sharing style. Out of the ten consultations recorded, four consultations showed the characteristics of the Directing style while the remaining six consultations were in accordance with the Sharing style.

It is important to note that the consultation style that doctors adopt is not a permanent or fixed way of managing all consultations. As can be seen from Table 2 and Table 3, two out of the four doctors, Dr Hema and Dr Lim, displayed both types of consultation styles at different occasions and with different patients. The doctors in this study appear to move from one style to another depending on the different factors which is supported by the following interview data.

*"...I think different people will have different concern and their belief. Concern and belief is different. Concern is one thing, one thing is what they believe their treatment they have, what they believe the disease will become or what they believe this disease will affect them. So, in order to overcome this you have to know how much they understand and what their own belief about this disease, about their main concern and when you know these whatever these are. In this, they know about individual and we don't just give them information what we think they should know or what we don't give them, er we don't just throw information or throw consultation to them just based on what we think we believe we concern. You have to know what they had in mind and we will cater everything around of their's before we can go on. Means we will revolve our information around what the patient needs rather than making them evolved around us. This is what ideal situation is."*

From the interview, the doctor at the Haematology Clinic suggested that every health practitioners should understand their patients' concern before deciding on how to manage the consultation. In addition, the information giving should revolve around the patient rather than the doctor since patients are the ones who are in need of the information for their own health and well-being.

##### 4.1 Patient Participation in the Directing Style Consultation

Four out of the ten consultations analysed displayed the characteristics of the Directing style consultation and an overview of the findings of patients' participation in the Directing style consultations are highlighted in Table 2.

**Table 2** The number of occurrences of patients' participation in directing style consultations

Patient's Pseudo name/ Consultation & Dr. Pseudo names	Length/ mins	Patients' Participation (Number of Occurrences)			
		Asking Question	Being Assertive	Expressing Concern	Total
Mr. Ahmad/ C3 Dr. Lim	5	0	0	1	1
Mrs. Seng/ C5 Dr. Hema	5	1	2	2	5
Mrs. Lau/ C8 Dr. Hema	4	5	1	3	9
Mrs. Cecilia/ C10 Dr. Raja	4	3	3	2	8
Total	18	9	6	8	23
Mean	4.5	2.25	1.5	2	5.75

As previously mentioned, the researchers will adopt the four components of patients' participation taken from the Cegala (2011) that is: i) asking questions; ii) being assertive; iii) expressing concern; and iv) information giving, in analysing patient participation. However, only the analysis of the first three main responses will be discussed in this paper as the analysis of the fourth component, which is the information giving component, will be discussed separately in order to identify the patterns for information provision in different parts of the consultations.

Generally, patients participated less in the directing style consultations and the responses of patients appeared to be lower. As can be seen in Table 2, generally, the responses from patients in the Directing style consultations were lesser than that in the Sharing style consultations. For example, the total number of occurrences for all components of the patient participation were low, ranging from as low as one (Mr Ahmad/C3) to the highest which is nine (Mrs Lau/C6). As can be seen from Table 2, although there were instances in which patients asked questions, asserted themselves and expressed concern, later discussions will reveal that in comparison to the participation of patients in the Sharing style consultation, the participation of these patients were significantly lower. For instance, the total mean for the occurrence of the three components of patient participation for the Directing style is 5.75.

One of the main components of participation is asking questions. Patient participation occurs when patient asks questions in order to get more information and clarification from the doctor. An example of a question is an utterance in interrogative form like "why is my face swollen?" ("kenapa muka saya bengkak-bengkak?"). This indicates that the patient took the initiative to ask the doctor about his health condition. In the Directing style consultation as can be seen from the figures in Table 2, asking questions is the component of patient participation which occurred the most frequently in comparison to the other two components. The highest participation in terms of asking questions was recorded for Mrs Lau, the patient in Consultation 8 (C8) who asked question at five different occasions throughout the consultation which lasted for four minutes. And this is followed by Mrs Cecilia/C10 and Mrs Seng/C5. Mr Ahmad/C3 did not ask the doctor any question during the consultation. For

instance, Mrs. Lau asked if she had to take diabetes test instead of the other test that she usually takes by asking; "taking blood for (xx) only, what about for diabetes?" ("ambil darah untuk (xx) saja, kencing manis takde?"). On the other hand, Mrs. Cecilia/C10 asked; "Is the iron (level) good" ("tu zat besi bagus tak?"). This is to indicate that she would like the doctor to explain the result of the iron test she had taken earlier. Both these patients asked five questions and three questions respectively throughout the consultation indicating some effort to participate in the consultations (Silverman, 1987).

In this study, younger patients appeared more curious about their health condition and showed the tendency to articulate this by asking more questions during the consultation as shown by Mrs Lau/C8 and Mrs Cecilia/C10. Mrs Lau is the youngest patient in this study. Older patients such as Mr Ahmad/C3, for example, did not asked any question. There is a possibility that age may have some impact on patient's participation. In fact, Mr Ahmad/C3 seemed less willing to talk to the doctor even though he is suffering from a serious form of illness (cancer) as compared to the other patients. Both Mr. Ahmad/C3 and Mrs. Lau/C8 displayed very contrasting participation patterns during the consultation, especially in terms of their information seeking behaviour. For example, Mr Ahmad/C3 displayed very passive questioning behaviour while Mrs. Lau/C8 was much more insistent, perhaps driven by her expectations about the treatments.

Being assertive means expressing oneself confidently and in this study; it means to express new thoughts or opinion, in order to interject the doctor's perspectives. From the analysis, it is evident that patients do interject their beliefs, preferences and perspectives during consultations and this is when assertion happens. As can be seen from Table 2, out of the three components of patient participation, being assertive occurred the least frequently when compared to the other two components with a total occurrence of 6 (mean: 1.5). This provides some indication that patients in the Directing style consultations find being assertive the most difficult to do as opposed to asking questions or showing concern. Perhaps being assertive appears to be in direct contradiction to the sick role proposed by Parsons (1975). Later discussions will reveal that this is not the case with the Sharing style consultations; in fact it is the opposite.

The following is an example of assertion: 'doctor said that we can lessen it (pil intake) if it is okay' ('doctor cakap boleh kurangkan kalau okay'). The patient referred to what was previously said by another doctor who allowed him to reduce the amount of pills he was taking if he was feeling much better. Another example of assertive utterances can be found in Consultation 10: "the previous doctor did say not to eat too much vegetables"... "he (the doctor) said not to eat green vegetables because they contain a lot of iron" ["dokter (dulu) ada cakap tak boleh makan sayur"... ["dia (dokter tu) dia cakap sayur warna hijau tak boleh makan sebab banyak zat besi."]. These examples show that the patient opposed the doctor with regard to the amount of (green) vegetables that the patient should consume. Mrs Cecilia/C5 does this by borrowing the voice of another doctor to hold up her explanation. Mrs. Seng/C5 also disagreed with the doctor about the cause of her swollen face which the doctor has attributed to medicine intake by saying; "No, (the pill) I take fattening, no" ["tak da punya la, (ubat) makan gemuk gemuk"]. As mentioned before, being assertive is about interposing the doctor's perspectives. However, in general, the four patients in the Directing style consultations did not show much assertiveness. The asymmetrical characteristics of the communication found in the Directing style consultations places patients in a more passive communicative role and this may discourage patients to show assertiveness (Mishler, 1984)

In fact, older patients in this study were also found to be particularly unassertive. It can be assumed that older patients may still hold a conventional view of the doctor–patient relationship in which doctors are viewed as the experts and thus more knowledgeable. In fact, the oldest patient in Consultation 3, Mr Ahmad, was far less assertive during the consultation if compared to younger patients such as Mrs Seng/C5 and Mrs Cecilia/C10. On the other hand, the frequency of assertive utterances was higher in Consultation 10 with three recorded occurrences (refer to Table 2). However, this is still considered low but unsurprising in the Directing style consultation. This is due to the dominant communication style of the doctor during the consultations which may hinder participation or interruption from the patients (Williams, 1998; Ishikawa *et al.*, 2002; Takayama and Yamazaki, 2004)

Apart from asking questions and being assertive, showing concern is the third component of patient participation and can also signal that the patient is aware of the consultation's agenda and participate when needed. Expressing concern can be inferred by statements which reflect patient's negative affect such as anger, fear and worry. As can be seen in Table 2, Expressing concern occurred a total of eight times (mean: 2) which is the second most frequent component of patient participation (after asking question) to occur in the Directing style consultations. An example of Showing concern found in the data sample is as follows: *"Is the blood test today okay?"* (*"Okay ke result darah hari ni"*). Although this is phrased as a question, it functions more than just to seek information or clarification, but, it expresses the feeling of worry or concern. In this case, the patient is articulating her concerns about the result of her blood test taken earlier in the day, before the consultation.

An example of expressing concern can be seen in Consultation 10 when Mrs Cecilia says: *"sometimes I forget to take it (the medicine)"* [*"tapi kadang-kadang saya lupa makan (ubat)"*]. On the other hand, Mrs. Lau expressed concern more frequently than the other patients listed in Table 2. Altogether, there were three expressions of concern recorded by Mrs Lau/C8. This might be attributed to the fact that her last appointment was four months ago and she had more questions and concerns about her health condition than other patients who have had several visits prior to this one. As in the case of Mr. Ahmad/C3 and Mrs. Seng/C5, they did not appear to require any special treatment or test for their condition since both of them have had several regular follow ups to review test results and future appointments. This seems to be similar to the findings of a previous study by Brown *et al.* (1989) which showed the impact of different types of cases on clinical outcome and care.

#### Extract 1 Consultation 3 (Dr Lim + Mr Ahmad)

9 Dr. Lim: belum.<PATIENT SHAKES HIS HEAD> darah merah, cukup, bagus, darah putih pun bagus(xx)sangat.<(0.06)> darah kuning, baik, cukup. ok., ni pun (tak tinggi) <DOCTOR SHOWS RECORD TO PATIENT> ni kalau (xx) maksudnya you punya kanser jadi baliklah, arr .tapi tadi saya check ( sini) takde bengkak pape la, saya nak tengok perut sekejap ar. / no. red blood enough, white blood great, not too (xx), yellow blood, good, enough. Ok. this one also not high. If this is like this, it means your cancer are restarting again, arr. But when I checked here no swelling, I want to check your stomach a bit ar.⌘<114587>(0:01:54.6)

10 Mr. Ahmad: limpa eh. / spleen eh.⌘<117226>(0:01:57.2)

11 Dr. Lim : ermm. <DOCTOR CHECKS PATIENT'S STOMACH> <(0.5)> boleh pegi sebelah. / can you go to next room. ⌘<125805>(0:02:05.8) <PATIENT WENT FOR PHYSICAL EXAMINATION WITH DOCTOR> <(1.20)>⌘<159861>(0:02:39.9)

(Consultation 3: F\_Dr + M\_Pt)

Extract 1 illustrates an example of showing concern found in Consultation 3. The patient is clearly worried about his condition after being informed by the doctor in Turn 9 that the patient's cancer may have returned. However, the doctor has not concluded anything and is investigating the matter further with a physical examination. It is important to note that Mr Ahmad was the least participatory of all the patients in the Directing style consultation. Mr Ahmad/C3 only expressed his apprehension during the consultation and this might show that he was concerned with the new information about the treatment he might receive as the consultation was very much directed by the doctor. The concerns showed by the patients might be good in terms of encouraging the doctor to share more information regarding the illness. According to Stewart (1995), effective doctor-patient communication has been shown to be the result of doctors encouraging patients to voice their concerns, including patients in decision making and discussing psychosocial issues in relation to their medical problem.

Therefore, it can be assumed that the Directing style is used for: i) routine cases and ii) cases requiring further investigation. Although this would require further investigation, the findings appear to concur with the study by Brown (1989) with regard clinical outcomes or patient care which has shown that patient factor such as common-versus-rare presentation of cases have an impact on clinical outcome and care. In fact, the directing style allows doctors to focus on the task at hand by investigating the condition further. Such a style may be beneficial for the doctors as this allow the doctor to focus on the more important clinical tasks at hand; however, this will leave little opportunity for patients to ask questions. It is interesting to note that this strategy may be convenient as it helps doctors to evade questions at a time when they have little information to offer, perhaps after further investigation of the situation, doctors will have more information to share and thus be more willing to engage patient's participation in the consultation.

Generally, as can be observed from Table 2, patients in the Directing style of consultation in this study tend to ask more questions (mean: 2.25) and express concern (mean: 2) than be assertive (mean: 1.5). Asking questions and expressing concern regarding ones health to a doctor is very much part of the conventional sick role proposed by Parsons (1975) and being assertive appear to go against this role. Patients may also feel worried about the outcome of the consultation as they have had little, if any, part in the consultation. In other words, their expression of concern may reflect their apprehension about the decision the doctor will make at the end of the consultation which might not fulfil their needs.

#### 4.2 Patient Participation in the Sharing Style Consultation

The Sharing style, on the other hand, can be described as more patient-centred, takes up more time, applies to patients who suffer from illness which is well known to the doctor and adopts a shared decision making process (Stewart, 1995). Table 3 shows the components for patient participation and the frequency of occurrence in the Sharing style consultations at the Haematology Clinic.

**Table 3** The number of occurrences of patients' participation during medical consultation at haematology clinic

Patient's Pseudo name/ Consultation & Dr.	Length/ mins	Patients' Participation (Number of Occurrences)			
		Asking Question	Being Assertive	Expressing Concern	Total
Mrs. Tan/ C1 Dr. Lee	5	8	2	3	13
Mr. Redzuan/ C2 Dr. Lim	23	4	17	3	24
Mr Chiew/ C4 Dr. Hema	15	2	7	1	10
Mrs. Zai/ C6 Dr. Hema	14	1	3	3	7
Mrs. Nor/ C7 Dr Hema	4	0	5	3	8
Mrs. Rita / C9 Dr Lim	11	3	8	6	17
Total	72	18	42	19	79
Mean	12	3	7	3.12	9.88

In general, the doctors who used the Sharing style in the clinical consultations seem to have a closer relationship with their patients. The doctors focus more on the patients' needs which is very much the characteristics of a patient centred communication. As mentioned earlier, consultation according to the Sharing style takes longer which concurs with previous research (e.g. Williams *et al.*, 1998). This can be seen in Table 3 in which the length of time ranged from the shortest consultation—taking only five minutes to the longest consultation—lasting up to 23 minutes. This is in contrast with the Directing style consultations which on average lasted around 4.5 minutes with the longest consultation lasting only for five minutes.

Furthermore, as can be observed from Table 3, the number of occurrences for all three components is much higher (mean 9.88) than the occurrences recorded in the Directing style consultations (mean: 5.75. Refer Table 2). Overall, consultations 1, 2, 4, 6, 7 and 9 displayed many of the characteristics of the Sharing style consultation and the interactions of both patient and doctor were dynamic and not controlled by the doctors. For example, in the case of Mrs. Tan/C1 and Mrs. Zai/C6, both were accompanied to their clinical visit by their family member who appeared at ease and participated actively during the consultation. In fact, in Consultation 1, although the whole consultation took only five minutes, which was the shortest among the six Sharing style consultations, Mrs Tan showed a great deal of familiarity and preference for the doctor. In fact, throughout the consultation, both patient and the accompanying family member quickly bonded and engaged in casual conversation with the doctor.

Similar to the analysis carried out on the four Directing style consultations, the six Sharing style consultations were also analysed for occurrences of asking question as a component of patient participation. To begin, it is important to note that the mean occurrence for this component is 3 which is slightly higher than in the Directing style (mean: 2.25. Refer Table 2).

As evident in the breakdown of figures in Table 3, Mrs Tan/C1 asked more questions than the other patients. In fact, Mrs Tan

demonstrated the highest occurrence for asking questions of all the participants in this study. Mrs. Tan who used her first language (which is Mandarin) during the consultation was clearly at ease with the presence of a doctor who shares the same native language. This is supported by a recent study on patient preferences for doctors in similar setting (Nurul Nadia and Noor Aireen, 2012) which showed that ethnicity was the fifth most important factor in choosing a doctor after doctor's ability to be responsive and caring; doctor's experience; reputation and communication skills.

**Extract 2** Consultation 1: Dr Lee + Mrs Tan

14 Dr. Lee	: Ni hai you zai kan fu chan ke yi sheng ma? / <i>Did you consult obstetrician again?</i> <56612>
15 Mrs. Tan	: Mei you. / I. <58451>
16 Dr. Lee	: Mei you le la. Jiu zhi shi zhe ge wen ti. / <i>No. ...So this is the only problem you are having.</i> <61110>
17 Mrs. Tan	: Wo du zi you shen me dong xi? Ta men shi shuo man chang yan. / <i>So what happened to my stomach? Some said it is appendicitis.</i> <68541>
18 Dr. Lee	: Man chang yan you bian. Hui zhong Zuo bian, zuo bian mei you. Zuo bian shi (XXXX). / <i>Appendicitis happens at the right side of the stomach. And you'll find that part swollen. Stomach ache at left side is not caused by appendicitis. It's (XXXX).</i> <75070>

(Consultation 1 : M\_Dr + F\_Pt)

As can be seen in Extract 2, the doctor showed attentiveness to the patient's problem, thus encouraging the patient and accompanying family member to participate more in the consultation. As can be seen from Turn 14 to 16, the doctor paid attention to the symptoms presented by the patient and later the patient asked a question to seek more information about her prognosis (a prediction of the course of a disease) in turn 17.

Indeed, the Sharing style consultations showed the highest occurrence of patients being assertive when compared to the other two components of patient participant. The mean for this component is 7 with the highest occurrence reported for Mr Redzuan/C2 which is 17. The breakdown of figures in Table 3 shows that Consultation 9 recorded the second highest frequency of assertive utterances which is 8. In Extract 3, we can see that Mrs Rita/C9 shared her opinion about the treatment she received earlier. Hence, the assertive utterance in Turn 86 was in response to the rather provocative statement made by the doctor before that in Turn 85. This situation shows that the sharing style of consultations balances the conventionally asymmetrical nature of doctor patient consultation allowing more opportunities for patients to rectify the doctors which may not be possible in the directing style consultation (Street *et al.* 2003).

**Extract 3** Consultation 9: Dr Lim + Mrs Rita

85 Dr. Lim	: you punya prednisolone memang kena makan dua biji eh. kalau kurang satu biji tak dapat eh. / <i>you have to take the prednisolone two pills eh. If less you can't eh.</i> <211601>
86 Mrs. Rita	: aaa, dulu dia kurangkan satu biji lepas tu darah saya turun kan./ <i>aa, last time he make it less to one then my blood drop down.</i>

(Consultation 9 : F\_Dr + F\_Pt)

Indeed, all six patients in the Sharing style consultations were found to be assertive at some point or other during the

consultation. Although all six patients in the Sharing style participated more actively, in terms of being assertive, as compared to patients in the Directing style consultations, it is interesting to note that like the patients in the Directing style consultations; younger patients were found to be more assertive than the older patients. Among the respondents listed in Table 3, Mr. Redzuan/C2 is the youngest and Mrs. Zai/C6 is the oldest patient in the study. Mrs Zai/C6 made only three assertive utterances during her 14-minute consultation. In fact, based on the findings, Mr Redzuan/C2 recorded the highest participation for all three components in this study with a total of 24. Indeed, this is concurrent with the previous result found in the analysis of the Directing style consultations in which younger patients displayed a more active participation during the consultations. This may be due to the communicative ecology developed by the Sharing style which encourages them to communicate their opinions and problems more openly to the doctor (Street *et al.*, 2003). The patient in Consultation 2 is a young man who participated in the consultation with ease and made several assertive responses without hesitation (refer Table 3).

Patient's participation in the Sharing style consultation were also analysed for the third component which is expressing concern. Similar to patients in the Directing style consultations, patients in the Sharing style consultations also expressed concerns such as: "I sometimes feel sudden pain in my stomach. Here. But it did not last long. It was so painful that I cannot even stand up. I have to lie down when it comes.", "So doctor (xx) is mine okay?", "That is why I scolded my daughter, you might not give me the (xx) pill, "oh, I am afraid" and "No, I am worried, will it affect the children?". All these statements are statements which reflect the negative emotions that patients may have such as worry, frustration, anger or fear. However, it is interesting to note that in the Sharing style, the mean for this component is 3.12 which is slightly higher than in the Directing style (mean: 2.0). The patients in the Sharing style consultations were also more open to share their concerns with the doctor than the patients in the Directing style. This may be attributed by the fact that patients in the Sharing style consultations feel more comfortable and at ease to be open in the Sharing style consultation. This may be attributed by the communicative ecology mentioned by Street *et al.* (2003). Hence when patient's concerns have been addressed they feel satisfied with the care given by the doctors and this is supported by past research that has shown that patients in the Sharing style are more satisfied with their health outcome (Stewart, 1995; Williams, 1998; Ishikawa *et al.*, 2002; Takayama and Yamazaki, 2004).

## 5.0 CONCLUSIONS

The findings of the analysis carried out in this study clearly indicate that the doctors' communication style does indeed impact on the patients' participation during the clinical consultations. The Directing style consultations which were basically dominated by the doctor allowed very little opportunity for patients to ask question, be assertive or to articulate their concerns. Low level patient participation during consultations has an impact on the information flow between doctor and patient and has also shown to influence patient's health outcome (Takayama and Yamazaki, 2004; Ishikawa *et al.*, 2002). In contrast, the patients in the Sharing style consultation participated more actively based on all three components of patient participation. They were especially assertive when compared to patients in the Directing style.

One of the most interesting findings of this study is the possible association between age and patient participation. Age appeared to play a role in patient participation as younger patients

in this study seemed consistently more participatory in both the Sharing style and Directing style consultations. It comes to no surprise that the patient who had the highest level of patient participation and the highest occurrence of assertiveness is the youngest patient in the Sharing style consultation. On the other side of the coin, this suggests that older patients may find it more difficult to participate in clinical consultations. Previous research has shown that even when older patients have appropriate access to medical services, they still require effective and empathic communication as a key part of their treatment (Williams *et al.*, 2007), therefore, this is an interesting preliminary finding which necessitates further investigation especially at a time when the world's aging population continues to grow with more and more patients over the age of 65 requiring medical treatment.

With the high patient participation shown in the Sharing style, it is then not surprising that past studies (e.g. William *et al.*, 1998) have noted that the Sharing style consultations certainly take longer than the Directing style consultations. Indeed, patient participation in clinical consultation is important as it helps to improve information provision between both parties. Improvement in information exchange between doctor and patient has shown that it will result in better health outcomes and patient satisfaction (Stewart, 1995; Williams, 1998; Ishikawa *et al.*, 2002; Takayama and Yamazaki, 2004).

Therefore, doctors need to be aware of their communicative role in encouraging patient's participation which is key in ensuring better information exchange. Such awareness may be developed through years of working experience but efforts must be taken to bring this awareness earlier on in their training, specifically during their medical training.

Furthermore, the findings of this study have also shown that doctors are able and do move (e.g. Dr Hema and Dr Lim) from one communication style to another depending on different factors. Although, the interview data did provide some indication to the reasons for doing so, it would be interesting for future research to investigate further the different contributing factors that drive doctors to shift from different consultation styles.

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