

Relation between Nurse and Patient-A Comparison in Malaysia, China and the UK

Nant Sohoda

Abstract

It is important to determine the similarities and differences in medical interviews in different cultures. This research has been conducted in Malaysia to find similarities and differences between doctor-patient communication patterns in different cultures. Based on a research conducted before in China and the UK, 20 patients' and 5 physicians' conversation were tape-recorded and analyzed to find the time spent in each phase, number of categorized speech acts and questions, interruptions and back-channel responses. The mean time of visits was less in Malaysia than China and the UK. Malaysian physicians spent more time on verbal examination (33%), while Chinese physicians spent more time on physical examination (29%) and American physicians spent more time on treatment (31%). Chinese used more interruptions and back-channels than the other two countries. However, the ratio of doctor-patient total speech acts was almost similar (Malaysia 57% vs.43%, China 59% vs. 41%, UK 55% vs. 45%). The differences may be due to different cultures and the similarities may stem from professional circumstances.

Keywords: Cross-cultural comparison, doctor-patient communication, linguistics, speech act, communication pattern

© 2015 BBT Pub. All rights reserved.

Introduction

Communication between doctors and patients has been in great interest of socio-linguists due to important linguistic factors that affect this communication. Doctor-patient communication is sometimes regarded as the art or heart of medicine (1). A lot of researches have been conducted with a wide variety of approaches to study this communication. However, much of work has centered on doctor-patient different patterns of verbal communication to show the "asymmetry talk" between them, or to show the association between verbal behavior in doctor-patient interactions and outcome of care (2, 3, 4, 5). Some researchers have focused on the problems of patients who do not speak the doctor's first language (2, 6) or have centered on different models of doctor-patient communications (7). These studies contribute to a better understanding of doctor-patient interaction and what is vital to reach to the best patient outcome.

As the aim of any health care organization is to provide the best quality care of the patients, considering factors that affect this goal is necessary.

One of these factors is determining the problems due to differences in medical subculture of the physicians and illness subculture of the patients (8). However, there are little researches to compare the doctor-patient interaction in different cultures. This research has been conducted in Malaysia to find similarities and differences between doctor-patient communication pattern in different cultures based on a research conducted before in China and the UK.

Methods

In order to compare the pattern of doctor-patient consultation in Malaysia with those in China and the UK, a quantitative discourse analysis from linguistics was conducted. Based on the research done in China and the UK (8), there was an attempt to have the same setting of data collection. Data collecting occurred from September to October 2011. The participants included 5 male doctors and 20 patients. All of them were provided with written informed consent. Physicians completed their residency training about 8-10 years prior to this study. They include two general internists, one ophthalmologist, one infectious disease specialist and one urologist working in the outpatient clinic of Mazandaran Medical Science university hospital. All patient participants were older than 20 years age. Most men were farmers or had small business and women were housewives. Physicians selected one day and patients recruited until five patients per each physician (20 patients) were enrolled. The doctor-patient verbal interaction was tape recorded and then were transcribed verbatim and analyzed. Patients filled a form of their demographic information after the encounter. At first the total time of the encounter and then the time spent for each phase of the encounter were examined. Each phase was modified according to the Byrne and Long model (9). Byrne and Long identified six phases from analysis of 2500 audiotaped consultations. These phases include: 1. The doctor establishes a relationship with the patient. 2. The doctor discovers or attempts to discover the reason for the attendance. 3. The doctor conducts a verbal and/or physical examination. 4. The doctor, the doctor and patient, or the patient (in that order of probability) considers the condition. 5. The doctor

and occasionally the patient detail further treatment or investigation. 6. The consultation is terminated, usually by the doctor. The non-problem talks were categorized as social talks. The ratio of physicians' speech act to patients' was examined by counting the total number of physicians' speech act and those of patients. Then, there was a comparison between Malaysia and China and The UK. A speech act is an utterance that serves a function in communication. A speech act might contain just one word or several words or sentences. In linguistics, an utterance defined in terms of a speaker's intention and the effect it has on a listener (10). Physicians' and patients' speech act were categorized and counted according to the modified category model which are explanatory statements, questions, directive and other speech act including greeting, news receipts and acknowledgment (10, 11).

Different kinds of questions were determined and then their frequencies were compared. The interruptions uttered by doctors and patients and the frequency of back-channel response were counted. According to Tannen, interruption refers to "when a second speaker interrupts another speaker's right to continue speaking by taking the conversational floor in the absence of any evidence that the other speaker intended to relinquish the turn." That means the violation of a speaker's turn (12). According to Ohtaki (8) there are different sorts of interruptions:

1. Voicing an opposite opinion.
2. Asking a question about spoken information
3. To make humor
4. To monitor or confirm spoken information.

Backchannel is that of the listener which functions to provide continuers or assessments, defining a listener's comprehension and/or interest (13) and includes sentence completions, requests for clarification, brief statements, and non-verbal responses(14).

Results

The socio-demographic characteristics of 20 patient and 5 physician participants in Malaysia and those of China and the UK are shown in table 1. The information of China and the UK was extracted from the research done by Ohtaki et al. (8). All participants were white. The patients were 11 men and 9 women and all of them were married. The mean age of physicians was 45 years. The total encounter time and the time spent in each phase were less in Malaysia than the total encounter time and the time spent in each phase in China and the UK. The average length of doctor-patient encounter time in Malaysia was 311.5 s (range 150-550s), while it was 505s (range 150-738 s) in China and 668 s in the UK (range 310-1418 s). The mean time of encounter was much less in Malaysia (311.5 s) than China (505 s) and the UK (668.7s). In Malaysia, the longest phases of doctor-patient encounter was verbal examination (33%) and the second one was treatment (30%) whereas in China, the first and second phases were physical examination (29%) and verbal examination (26%) and in the UK were treatment (31 %) and verbal examination (26 %). Physicians and patients spent 6% of total encounter time on social talk in Malaysia while in China it was 5% and in the UK it was 12%. There was no greeting in China and in the UK the greeting rate was only 1%, but the greeting rate was 4% in Malaysia. In Malaysia 3% of time was spent to discover the reason for the visit but this rate was 5% in the UK and nearly 0 in China (Fig.1).

Table 1: characteristics of patients and physicians in Malaysia, China and the UK

characteristics	Malaysia	the UK	China
patient	n=20	n=20	n=20
Age (mean)	48.6	55	56.7
range	22-66	39-52	40-59
male	11	11	11
female	9	9	9
married	20	14	18
single/widow	0	6	2
Years of schooling (mean)	11.2	14	14.2
range	(9-14)	(10-21)	(12-16)
Employment state			
working	18	13	14
retired	2	5	6
disabled	0	2	0
physician	n=5	n=5	N=4
Age (mean)	45.2	45	49.8
Department			
General Medicine	2111000	0000500	1000021
ophthalmology			
Infectious disease			
Urology			
Family Medicine			
Cardiology			
Gastroenterology			

Phases distribution of time in doctor-patient encounter in Malaysia, China and the UK

There was a comparison between the total numbers of physician speech acts versus patient speech acts, questions, explanatory statements, directive and other speech acts. Although the average numbers of speech acts in Malaysia differed from the speech act numbers in China and the UK, the ratio of total speech acts and different sorts of speech acts were almost similar (table 2).The proportion of physician total speech act versus patient's was 57% and 43%, but in China this ratio was 59% and 41% and in the UK was 55% and 45%. There were more questions from doctor side in Malaysia than in China and the UK. Like the UK, patients had a greater proportion in explanatory statements than doctors in Malaysia, but this ratio was less in patients in China. The use of directives was more in the UK and China than Malaysia. Patients were dominant for other speech acts and produced 53% of such utterances in Malaysia. Backchannel responses were used more from the doctors' side (8.7 vs. 3.4). Facilitative interruption that persuades a partner to speak was the most common type of interruptions and was 23(62.2% of total interruptions by doctors) and 10(47.7% of total interruptions by patients). This ratio in China for doctors was 157 (53%) and for patients was 52 (43%). In the UK, facilitative interruption by doctors was only 25 (66% of total interruptions) and for patients was 14(63% of total interruptions). The most frequent question was closed questions followed by open-ended ones.

Table 2: Distribution of speech acts in doctor-patient encounters in Malaysia, the UK and China

	Statement (percent)		Question (percent)		Directive (percent)		Others (percent)		Total (percent)	
	Doctor	Patient	Doctor	Patient	Doctor	Patient	Doctor	Patient	Doctor	Patient
Malaysia	21.1 (43%)	27.5 (57%)	13.1 (80%)	3.2 (20%)	13.8 (94%)	0.9 (6%)	9.4 (47%)	10.7 (53%)	57.4 (57%)	42.3 (43%)
The UK	26.85 (49%)	27.9 (51%)	17.7 (75%)	5.85 (25%)	3.5 (95%)	0.2 (5%)	3.7 (32%)	7.85 (68%)	51.75 (55%)	41.8 (45%)
China	13.65 (52%)	12.3 (48%)	13.7 (78%)	3.85 (22%)	4.4 (95%)	0.25 (5%)	5.5 (34%)	9.7 (66%)	37.25 (59%)	26.1 (41%)

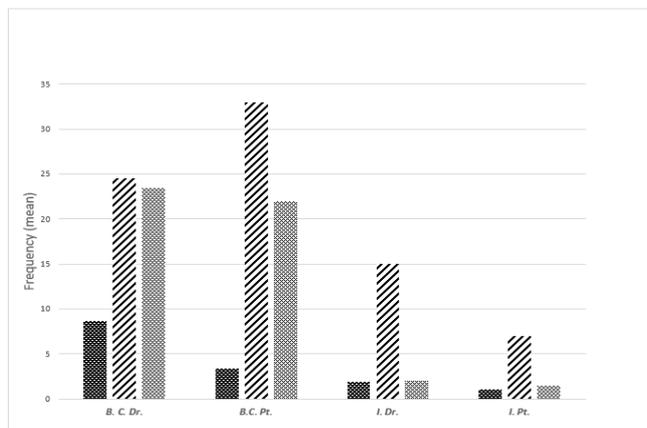


FIGURE 1: Frequencies of back-channel responses and interruption in doctor-patient encounter in Malaysia, China and the UK

Discussion:

The results generally showed the differences and similarities in doctor-patient interaction in different cultures. There was a difference in total time of interaction and the proportion of time spent in each phase in these three countries. In comparison to China and the UK, the average of total time spent in Malaysia was less than half of the UK and nearly 2/3 of China. The reason of this difference may be in the numbers of patients should be visited by doctors in university hospitals in Malaysia. The system of family medicine was not diffused in the time of this study. Patients visit the physicians at the first sign of acute illness. Because of good quality of treatment and low cost in university hospitals, there are always a big crowd of patients, and doctors have to shorten the visit by cutting down unnecessary talk and deal with only the illness and treatment. However, in the UK, due to the system of family

medicine, patients especially those perceived to have a self-limited illness are encouraged to self-treat and to schedule with a doctor if not improved. Therefore, individual visits in the US would probably require more time. In China, patients are expected to visit their physicians at the first sign of illness because of their health insurance system (8). As it was said before, the proportion of verbal examination was higher than the other parts in Malaysia, while in the UK the higher proportion was treatment and in China it was physical examination. The reason of this difference in the phases of encounter in the UK and China, according to Ohtaki, is that in American low-context communication most of the information is in explicit language with detailed information. So, the rate of 31% for treatment and follow up in US encounter suggests a style of persuasion characterized by detailed talk. But in China, this shows a specialty-related phenomenon, and it can be said that the Chinese internists probably devote more time on the physical examination than family physicians (8). In Malaysia, there was no regular visiting and physicians in this study had to spend more time on verbal examination to find out the reason for the problem. In the other words, by a long history taking, physicians tried to find out the problem. Then, in the treatment, physicians tried to explain and direct the patients. The ratio of social talk in the UK is almost twice the Malaysia's and China's. As the family medicine has not widely diffused in Malaysia and China yet, physicians usually do not know patients. So, there is little social talk in their interaction. In the UK, physicians know their patients and can talk to them more about the subjects which are not related to medical problems. The results showed that the rate of greeting in Malaysia was much higher than the UK and China (4%, 1% and 0%). In Malaysia, greeting plays an important role in beginning a conversation and if a person visits another one without greeting, he/she is strongly considered as a rude person. So, it is a kind of social behavior that reflects the Malaysian culture (15). The time of discovering the reason of visit is near 0% in China. Because of the regular visits, doctors usually know the reason of the visits. While in Malaysia and the UK there are no regular visits and doctors have to spend time to discover the reason of the visits (8). Despite the differences in distribution of time in different phases of medical encounter, the proportions of different speech acts were almost similar. Doctors usually dominate the interaction, but it should be noted that they have to control medical interviews because discourse in institutional setting are almost goal-oriented and highly-ritualized (16). So, the greater proportion of doctor in question is not surprising. Other studies implied that in medical encounters, it is the doctor who asks questions (17, 18, 19), and patients ask less questions even if they have the opportunity (20). In the UK and Malaysia, unlike China, patients have a greater proportion in statement speech acts than doctors. This may be of the lack of regular visits in both countries that made the doctors let patients explain more in order to discover the reason of visit. According to Clancy, Chinese speakers had the highest frequency of backchannel responses due to their culture (21). Long procedural tasks had more responses than short tasks. (22); therefore; in Malaysia, the low mean frequency of backchannel responses was due to short period of visits. This comparative study showed that there was a relation between the frequencies of backchannel responses and the rate of statements. The more the speaker used the statements, the more the listener had backchannel responses. So, in China patients had more backchannel responses because physicians spoke more. However, in the UK and Malaysia as patients had a greater proportion in statements, physicians had more backchannel responses. Todd & Fisher (11) showed that interruptions are a means for patients to resist control. In other words, the person who managed the speech was the dominant speaker. Studies on interruption have shown that its occurrence in interaction constrains the patient's turn at talk and can show an asymmetric relationship (23). In Malaysia, China and the UK, physicians were dominant speakers and they had more interruptions than patients. In Malaysia and the UK, the mean frequency of interruptions was almost similar. In China; however, this rate was considerably high in both physicians and patients. Ohtaki believed that interruption in Chinese community indicates positive involvement and facilitative attitude and it is not considered as a conflict or dominance (8). In Malaysia's culture, on the contrary, interruption is not a common phenomenon and is only used whenever it is necessary. If it occurs several times, it will be considered as a kind of impoliteness. The results showed that the highest frequency in different types of interruptions was facilitative interruption which was similar to those in China and the UK. In this study, we tried to have homogeneity in demographic variables such as gender, race, age and setting in patients and the length of practice and non surgical training in physicians. However, there were some differences. In rural settings in Malaysia, the years of schooling is not usually high. So, in comparison to China and the UK it is lower. These three studies were limited to one group in a university hospital in each country and only dealt with a limited number of participants. Of course, it is usual in time-consuming and detailed linguistic studies. It is a comparison between the results based on Ohtaki (8) article and there was not detailed information about his article in order to have a minute study. Consequently, we cannot say that these results can be extended to all the societies in these countries. A more detailed study is necessary to be

done to reach to an overall conclusion. However, it can be said that there are similarities and differences in doctor-patient interaction in these countries. The differences may be due to different culture and the similarities may be due to professional circumstances. In summary, cultures in different societies and training systems of physicians affect the way physicians and patients interact with each other. While there are differences in these countries, there is no specific comparative research that can show which community has a better clinical outcome. Awareness of cultural background, the similarities and the differences; however, is beneficial for physicians to communicate better with patients.

References:

1. Roter D L, Hall J A. Studies of Doctor-Patient Interaction. *Annul. Rev. Public Health* 1989; 10:163-80.
2. Van De Poel K, Brunfaut T. Medical Communication in L1 and L2 Contexts: Comparative modification analysis. *International Pragmatics*. Volume 7 2010; Issue 1, Pages 103-129.
3. Takemura Y, Lui J, Atsumi R, Tsuda T. Development of a questionnaire to evaluate patient satisfaction with medical encounter. *Tohoko j. Exp. Med.* 2006; 210, 373-381.
4. Stiles, W B, Shapiro, D A, Firth-Cozens, Jenny A. Therapist differences in the use of verbal response mode forms and intents. *Psychotherapy: Theory, Research, Practice, Training*, Vol 26(3) 1989; Fal, 314-322.
5. Han Z Li, Naghmeh G Desroches, Young-Ok Yum, Corinne Koehn, George Deagle. Asymmetrical Talk between Physicians and Patients: A Quantitative Discourse Analysis. *Canadian Journal of Communication*, Vol. 32 2007; 419-30.
6. Colson T. Linguistics and cultural Medication in Health Care, Ma Thesis ion linguistics. Tutor: Kris Van de Poel. 2008.
7. Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. *JAMA* 1992; 276(16):2221-6.
8. Ohtaki S, Ohtaki T and Fetters MD. Doctor-patient communication: a comparison of the UK and China. *Family Practice* 2003; Vol. 20, No. 3
9. Byrne and Long, *Doctors Talking to Patients*. RCGP, 1976.
10. Searle J. *Speech Acts: an Essay in the philosophy of Language*. London: Cambridge University Press, 1969.
11. Todd A D, Fisher S. *The Social Organization of Doctor-Patient Communication*. Praeger publishing; 2nd edition January 1, 1993.
12. Tannen D. *Gender and Discourse*. Oxford University Press. 1994.
13. Li Han. Patterns of Backchannel Responses in Canadian-Chinese Conversations. Paper presented at the annual meeting of the International Communication Association, TBA, San Francisco, CA, 2007.
14. Young, Richard F, Jina Lee. Identifying units in interaction: Reactive tokens in Korean and English conversations. *Journal of Sociolinguistics* 2004; 380-407.
15. Koutlaki S. The Persian system of politeness and the Persian folk concept of face, with some reference to EFL teaching to Malaysian native speakers. Unpublished PhD thesis, University of Wales College of Cardiff 1997.
16. Ainsworth-Vaughn N. Claiming Power in Doctor-Patient Talk. Oxford University Press. 1998.
17. **West C. *Symbolic Interaction* Vol. 7, Issue 1 1984; pages 87-106.**
18. Hein N, Wodak R. Medical interviews in internal medicine: some empirical investigation. 1987; 7: 37-65.
19. Weijts W, Widdershoven G, Kok G & Tomlow P. Patients' information-seeking actions and physicians' responses in gynecological consultations. *Qualitative Health Research* 31993; 398-429.
20. Heath C. The Delivery and Reception of Diagnosis in the General Practice Consultation in Drew, P, Heritage, J (eds) *Talk at Work: Interaction in Institutional Settings* Cambridge: Cambridge University Press. 1992.
21. Clancy P, Suzuki R, Tao H, Thompson S A. The Conversational Use of Reactive Tokens in English, Chinese, and Mandarin. *Journal of Pragmatics* 26.1 1996; 355-387.
22. De Kok, IA, Heylen, DKJ. Differences in Listener Responses between Procedural and Narrative Tasks. In: *Proceedings of the 2nd International Workshop on Social Signal Processing, SSPW '10* 2010; pp. 5-10.
23. Cortazzi M, Jin L. Evaluating evaluation in narrative. In: HUNSTON, SUK & THOMPSON, Geoff (eds.). *Evaluation in text: authorial stance and the construction of discourse*. Oxford: Oxford University Press, 2003.

N.Sohoda, Department of Nursing Science Faculty of Medicine, University of Malaya
50603 Kuala Lumpur, Malaysia