

Assessment of Doctor-Patient Communication Among Residents in Internal Medicine Polyclinic At RSUP Dr. Mohammad Hoesin Palembang 2014 Using Simplified Checklist of Calgary Cambridge Guide

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Abstract

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Introduction : Misperceptions between doctors and patients can bring negative impact for both the doctors and patients. Misperceptions may occur due to miscommunication during doctor-patient communication. Therefore, assessment during the communication process is necessary.

Methods : This study was a descriptive study with qualitative approach. *Checklist Calgary Cambridge Guide* (CCCG) was chosen as instrument because it has been widely used in many country. The study was conducted in Polyclinic Internal Medicine of dr. Mohammad Hoesin Hospital due to its high patient load with various diseases that is suitable for doctor-patient communication observation. Subjects were six residents in the department. Observation was done during the communication process. Deep interview was then done to assess the resident's knowledge and opinions in doctor-patient communication and barriers related to it.

Results : Majority of the residents failed to do some points of the CCCG, which includes self introduction, role and nature of interview, obtain consent and explain process, obtain permission prior to physical examination.

Conclusions : In conclusion, the doctor-patient communication among residents in Internal Medicine Polyclinic At RSUP Dr. Mohammad Hoesin Palembang.

Introduction

Doctor-patient communication is one of the competence that must be mastered by doctors. This competence has a great role in aiding the physician to solve medical cases.¹ The change of paradigm from doctor-centered to patient-centered results in less attention towards the patient during information gathering.² This generate gap between doctors and patients.

The pattern of doctor-patient relationship also undergo changes from paternalistic

into individualistic, emphasizing the doctors' role as the health care provider.³ If patients are dissatisfied toward the health service given, patients have the right to express the complaints and even to sue.⁴

Good doctor-patient communication can improve health care services, increase patients' compliance, increase patients' satisfaction, increase accuracy in diagnosis, and decrease malpractice.⁵

The objective of this research was to assess communication done by residents

in Polyclinic of Internal Medicine Department of dr. Mohammad Hoesin Hospital. In addition, barriers related to communication was also identified. Polyclinic of Internal Medicine Department of dr. Mohammad Hoesin Hospital was chosen due to the heavy patient load and its variation in health cases, which can picture the doctor-patient communication more clearly. This research used Checklist Calgary-Cambridge Guide which has been utilized in many country.⁶

However, the numerous points in CCG (56 points) and difference in social and cultural aspects between Indonesia and other countries, triggers the simplification of CCG into 15 points, to make it more applicable.⁷ The simplification was guided by a panel of experts.

Methods

This research used qualitative approach. Checklist Calgary-Cambridge Guide was simplified with expert panel method. Discussion was done with experts related to the discipline, to generate key points that was more applicable in Indonesia. The simplified checklist was used to obtain data during observation and depth interview to subjects. Subjects are six residents of Internal Medicine Department that was chosen through purposive sampling. The criteria of inclusion were based on education level,⁸ gender,^{9,10} and origin^{11,12} (Table 1). This research was conducted in Polyclinic of Internal Medicine Department of dr. Mohammad Hoesin Hospital on November 2014.

Subjects was observed during patient consultation and underwent depth interview afterwards. Observation was done from 09.00 a.m to 14.00 p.m. Length of interview ranged from 15 to 30 minutes.

Analysis was done through qualitative analysis. Model Miles and Huberman, which was considered analytical and interactive, was chosen. The analysis consists of three phases: data reduction, data display, and conclusion or verification.¹³

Results

Fifteen points of simplified CCG was obtained from discussion with panel of experts (Table 2). Experts in this research were doctors that had received doctor-patient communication skills training and some clinical doctors.

Observation results is shown on Table 3. Based on results obtained from Table 3, observation, and deep interview, point 01 of the CCG was done well. Patients were addressed properly and greeted well. Identification was not done because it was already done by the administration unit before entering the polyclinic. The following are the subjects' thoughts upon point 01 of CCG.

Subject 1: "We usually only verify the patient's identity in the polyclinic by looking at the patient's medical card."

Subject 2: "Well, greet them as needed just for checking. The name of the patient has already been called by the nurse."

Subject 4: "The patient's name was already written on the status so its not necessary to ask again. The nurse has already mention their name anyway."

Point 02 was only done by Subject 6 without explaining the purpose of the anamnesis. The other subjects felt that it was not necessary to do point 02 with several reasons.

Subject 1: "If we do point 02 completely, it will create an uncomfortable situation."

Subject 3: "Point 02 is important, however its a bit awkward if we do it."

Subject 5: "Self introduction was never done because I think its not necessary because most of the patients were adults. However, if the patients are children, it is necessary to give explanation to the parents and if the patient is a pregnant woman, it is necessary to tell the husband. Nevertheless, I still think its not too important."

Subject 6: "I believe its more important to make the patient comfortable by giving greetings and praise other than explaining the purpose of anamnesis."

Point 03 was done well by all residents. The use of correct opening will enhance the easiness in obtaining the chief complains. Point 03 is usually done by the residents while doing physical examination to minimize time consumption.

Subject 1: "After asking the chief complain, the patient usually will explain it directly."

Subject 3: "We ask the patient what is the chief complain or ask whether his/her condition is better or worse."

Subject 4: "In order to use time more effectively, after greeting the patient we

usually directly ask patient to lie on the bed. While doing physical examination, we do anamnesis.”

Point 4 is necessary for resident to obtain further information of patient’s complain. The use of open and closed sentence must be used based on the question intended. The incorrect use of the sentence will lead to unsatisfactory answers.

Subject 1: “Yes, opened and closed questions are important. If we don’t use it correctly, it will be hard to find the approximate differential diagnosis.”
Subject 4: “Yes, both of the question type are important. However, the use is adjusted based on the problem faced.”

Point 05, 06, and 09 was considered difficult by some residents due to different personalities. However, majority of them did this point.

Subject 1: “We try to use the correct facial expression. Male doctors usually a bit rigid in facial expression while female doctors are more flexible.”
Subject 2: “I am a bit rigid. Well, not rigid but my facial expression is basically like this and really hard to adjust.”
Subject 4: “Doctors voice tone and expression are adjusted according to the patient. If the patient is a young mother, then a soft tone and frequent smiles are a great choice. However, with elderly male patients, a soft and a calm expression is more suitable. Appropriate voice tone and facial expression is required to prevent.”

Point 07 and 08 are needed so the information obtained are complete and less time are required. Unsystematic anamnesis leads to ineffectiveness.

Subject 1: “We must ensure that the anamnesis is still in the line. Therefore, knowledge about the correct differential diagnosis is really important.”
Subject 3: “If it occurs, we kindly pause the current conversation and lead back to the right course.”

Observation of point 11 shows that residents only address the patient to lie down on physical examination bed and then vital signs are performed by clerkship students. During physical examination, residents seldom asks for informed consent and neglects hand hygiene.

Subject 1:” I didn’t perform it because its too rigid and consume quite a lot of time.”
Subject 4: “Informed consent during examining vital signs are not necessary. However in sensitive cases such as asking patient to open their clothes, then informed consent is necessary.”

The use of simple and understandable language was done well by all residents. Parables are often used by them to explain certain information to patients with high level of education.

Subject 1: “We use sophisticated language if the patient has high level of education. Simple language are used in patients with lower level education.”
Subject 4: “We seldom use medical terms.”
Subject 6: “We adjust language based on what language the patient is using.”

Point 13 and 14 was not done in general polyclinic because definitive diagnosis was not yet ruled. In specific polyclinic, the two points are done well.

Subject 1: “In specific polyclinic we make definitive diagnosis and plan further examination needed.”

In closing anamnesis (point 15), residents scheduled for another meeting with patients and review the contents of the interview briefly while emphasizing in important points such as how to take the medication.

Subject 4: “We educate the patient during closing session of anamnesis.”

Discussion Initiating the Session

This stage aims to create an environment that is supportive and comfortable for the patient, obtain the identity of the patient and determine the main complaint that brings a patient comes to a doctor. By creating an atmosphere that is comfortable and quiet then the patient will be more open in telling his problems, it will be very influential in healing process.¹⁴

From the observation of the resident, first stage of interviews was conducted well. Residentt greets patients with a friendly expression. Patient also greets the resident and hopes the resident do similar towards other patients. This is consistent with the culture in Southeast Asia which is very concerned with the greeting as a sign

of hospitality and respect for.¹⁵ However, very few resident do self introduction. Supposedly, before a doctor asks chief complaint of the who were brought to the hospital, the doctor should introduce themselves first, find out the patient's identity and explain the benefits of anamnesis that will be submitted by the doctor.¹⁶

It is intended that the bond formed between the doctor and the patient so that the doctor can determine patient's feeling and mood that would make further anamnesis easier. In search of the main complaints of patients, residents may use open-ended questions that are said through local language (Bahasa Palembang, Java) to better familiarize themselves with the local population of patients because differences in ethnicity. Races or ethnicity may influence the patient's level of confidence to health care providers.¹² The use of open sentence when asking the patient's complaint is also advisable in order to obtain deeper information.¹⁷

Information Gathering

This stage is the most important phase of a doctor-patient communication. Without doing this stage, it is impossible doctors can find out the correct examination to be done and also the correct treatment. The residents in Internal Medicine Department do this stage while performing a physical examination in order to save time. Resident also response verbally and non-verbally to make the patients feel that they are paying attention to the patients.⁷

The question posed by the resident must be already structured and asked for their intended purpose to rule out diagnosis. Specific questions need to be used in anamnesis to prevent considerable amount of time consumption and ensure good results.¹⁶ Specific questions arise from the ideas of residents related to chief complain. In this case, insight and knowledge resident indispensable.

In accordance with the analogy of fishing that is widely used in understanding how to anamnesis,¹⁸ there are two ways to catch fish: using nets or inducement (fishing thread). When we fished with nets, then the result is not in accordance with the wishes of the angler. Garbage might caught into nets and fishing destination is not necessarily netted, so that this method more laborious and time consuming.

On how to use threads fishing, anglers can control how and what bait should be given so that the fish were obtained as expected.

In addition to relying on communication skills, resident prioritize patients to conduct investigations such as lab tests, X-ray or EKG. In fact, approximately 78% of the diagnosis can be confirmed by the ability of a good history, 12% with a physical examination and 10% with laboratorium.¹⁹ Hal examination is done so that the resident be more confident with the diagnosis he was thinking.

Physical Examination

At this stage of communication, what must be done is the time of giving informed consent and explains the procedure. However, this is rarely done because it is still an uncommon habit and checking vital signs is considered unharmed to patients that it doesn't require informed consent.

Informed consent is valid if the patient is conscious and able to make a decision and in the absence of drugs and alcohol. Supposedly, the entire health care practitioners must obtain consent (consent) of the patients that were able to take decisions.²⁰ Only patients with certain conditions doesn't have the need to give informed consent such as emergency patients, patients under influence of drugs or alcohol,¹ and patients with mental disorders.²¹

Many of the problems can arise from poor informed consent process. This process can affect the poor treatment of patients who do not need to be done so as to prevent the occurrence of a hazard. Although the actions to be taken not to cause physical damage, the decision were taken without any prior informed consent would undermine the autonomy of the patient.²⁰

In Internal Medicine Polyclinic, physical examinations are performed in wards and separated by sheets. When performing a physical examination, residents seldom wash their hands. The distance between the resident and sink is near and has been provided with hand sanitizer. Unfortunately, hand hygiene among the residents is still poor. This lacking habit might enhance nosocomial infection.²²

Explanation and Planning

Parables or modality in explaining information to patients is a technique that is performed by the resident. It is easier for residents to convey information and ensure that patients understand the procedure.¹⁶ Resident also involves patients in determining the type of medication or when taking decisions and schedule a time to take medication. It is intended that the patient is easier to remember what was said and comply towards the agreed plan. Medical term is rarely used, given the patient in the clinic are mostly elders and have low education levels. This is consistent with a review of the American College of Physicians (ACP), which states that the use of medical language is not recommended in providing information to patients.¹⁷

Resident also uses a firm tone when giving explanations about the things that need to be avoided by pasien. Humors are often presented by the resident so that the patient is more relaxed and easier to receive the information provided. Moreover, by making someone laugh, can increase their comprehension by emphasizing topic consciously, can overcome the paradox, aggression.²³ Lack of explanation will result in a low level of knowledge about the diseased patients subsequently leading to the failure of the therapy process.³

Closing the Session

At this stage, the resident enters into a contract with the patient in accordance with the treatment or follow-up inspection. It is intended that the problems experienced by patients can be solved completely complete because not all diseases can be cured in a single meeting.

Doctors must be able to remind the patient to comply towards the medication, to control every few months, and visit health centers when the drug prescribed is exhausted. Skills in closing the interview allows the patient to feel comfortable with the plan that has been agreed in advance.²⁵

In contracting with patients, residents often asked by patients to the time set in accordance with the schedule of the patient. Under certain conditions, the resident close interview with repeat prescriptions and restrictions that should

be avoided patient during the treatment process, remind schedule for examination, remind the patient to fast before further investigation, or just say hello. By doing this step, it will provide benefits to physicians in resolving more effective consultation and start the next interview without being burdened with the problems that exist in the previous interview, because the problem with the previous interview may be a new problem in the next interview.²⁶

Consultation Time

Time consultation with regard to the level of consultation services are given with a relatively longer time which will improve service quality and better outcomes for patient.²⁷ Physicians with a longer service time prescribe fewer thus lowering costs in drug spending, providing more education, giving more explanation of a better lifestyle, and other health promotion, better in the face of a patient with a psychosocial problems,²⁸ allows patients to care for themselves better, provide better clinical care, achieved a greater level of patient satisfaction, and avoid legal issues.²⁷ A large number of patients who visited the clinic Disease in RSMH resulted resident physicians must try to resolve the problem quickly and accurately. There are conditions in which the patient caused doctors try to maintain performance, while making proper diagnosis and treatment as well as giving maximum service with a short time.

Time pressure has resulted in a decline in patient care, short consultation period which will then affect the doctor-patient²⁹ communication. Consultation time span varies in each country depends on the variables related to the physician, place or country, and those associated with patient.³⁰ According to Anderson et al, found no relationship between good a consultation with a range of consulting time, but the doctor with a good proportion of the consultation showed variation in the length of time consulting.³¹

Points of simplified checklist Calgary Cambridge that were not done by residents are presented in Table 4.

Effective doctor-patient communication provides benefits in improving medical care and treatment of the patient's health problems. Most patients in the clinic Disease satisfied with the communication given by the resident. The patient

revealed that the resident in Internal Medicine is friendly enough to communicate, few are complaining that the residents might seem ignorant. This is caused by emotions, and fatigue experienced by residents. Patients are more concerned about the services provided by the hospital as a patient queue length, the guard who does not know the structure of the hospital, making it difficult patients and other problems.

In Asia, which includes Indonesia there in, the relationship between doctor and patient is different from the Western countries. Relations in countries in Asia over interpreted how doctors behave and maintain a polite and friendly attitude, is not judged by the way doctors communicate. This is the difference with state Barat¹⁵. There are high enough gaps in education levels between patients and doctors were also influential in shaping the critical patient. Data from the Board Statistics Centre of Indonesia stated that approximately half of the population of Indonesia has a level of education which does not reach the level of secondary school education (junior).¹⁵

In determining the diagnosis of patients, residents decide based on the history and reinforced by the results of the further examination. Before conducting investigations, resident only give definite therapy. This is because the hospital RSMH type A which is very comprehensive audit tool. Resident also revealed that the investigation is needed in order to be targeted treatment.

Gender differences in resident affect the way residents communicate. In resident women, more often showed a response verbally and non-verbally that is rarely found in the resident male. Doctor with female gender communication longer (2 minutes longer than the male practitioners), giving a more positive statement, more friendly, providing more

questions, giving feedback to the patient's complaints, and smile and nod more often.⁹

Differences in ethnicity/race among resident does not affect communication in Internal Medicine Department. It remains consistent in dealing with all patients despite the ethnic differences. However, the difference among the resident with patients, especially differences in language, affect the way residents communicate with the patient, but not necessarily be fatal.

Differences in level of education affects communication. Due to the more experience, chief of residents have better communication skills in comparison to their juniors.

Conclusions

In conclusion, communication skills that are included in Simplified Checklist Calgary Cambridge Guide is done poorly by residents of Internal Medicine Department of Mohammad Hoesin Hospital. Factors that contribute were the heavy patient load, time pressure, and exhaustion.

In order to improve the communication skills, residents are advised to follow seminars and training related to communication. Trainings and seminars can be held by the hospital. The executives of the hospital are advised to reevaluate the duration of work time. Further research on communication skills among residents are still needed.

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Appendix

Table 1. The criteria of inclusion Informant

Informant	Frequency (n)
chief resident (resident who already exists in the second half of the end).	1
junior resident (resident who just entered the part less than 2 years / still in the early semester).	1
Male	1
Female	1
Palembang	1
Outside Palembang	1

Table 2. Biodata Expert

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Table 3. Observation Results

Kode Checklist	Informan					
	I1 Residen A	I2 Residen B	I3 Residen C	I4 Residen D	I5 Resdient E	I6 Residen F
01	✓*	✗	✓	✓	✓	✓
02	✗	✗	✗	✗	✗	✓
03	✓	✓	✓	✓	✓	✓
04	✓	✓	✓	✓	✓	✓
05	✓	✗	✗	✓	✓	✓
06	✓	✗	✗	✓	✓	✓
07	✓	✓	✓	✓	✓	✓
08	✓	✓	✓	✓	✓	✓
09	✓	✓	✓	✓	✓	✓
10	✓	✓	✓	✓	✓	✓
11	✓*	✗	✓*	✓	✓*	✓
12	✓	✓	✓	✓	✓	✓
13	✓	✓	✓	✓	✓	✓
14	✗	✗	✗	✓	✓	✓
15	✗	✗	✓	✓	✓	✓
Waktu rerata	10 menit/ pasien	9 menit/ pasien	13 menit/ pasien	15 menit/ pasien	12 menit/ pasien	11 menit/ pasien

Table 4. CALGARY CAMBRIDGE GUIDE

INITIATING THE SESSION	
Establishing Initial Rapport	
1.	Menyapa pasien dan menanyakan nama pasien.
2.	Memperkenalkan diri dan menjelaskan tujuan dari anamnesis, mendapatkan persetujuan jika diperlukan.
3.	Mengidentifikasi masalah pasien dengan diawali kalimat pembuka yang tepat.
GATHERING INFORMATION	
4.	Mengkombinasikan pertanyaan terbuka dan pertanyaan tertutup.
5.	Menanggapi masalah pasien dengan memberikan respon secara verbal dan non-verbal (penggunaan kalimat yang men-support, keheningan sejenak,paraphrase, menginterpretasi)
6.	Menunjukkan bahasa isyarat secara verbal dan non-verbal (Bahasa tubuh, ucapan, ekspresi wajah)
PROVIDING STRUCTURE TO THE CONSULTATION	
7.	Mewawancarai pasien secara sistematis
8.	Memastikan pembicaraan tetap sesuai jalur
BUILDING RELATIONSHIP	
9.	Menunjukkan perilaku non-verbal yang tepat <ul style="list-style-type: none"> - Kontak mata,ekspresi wajah - Postur,posisi dan gerakan - Intonasi,volume dan kecepatan nada bicara
Developing Rapport	
10.	Menerima legitimasi berdasarkan pandangan dan perasaan pasien ; tidak menghakimi pasien
11.	Selama proses pemeriksaan fisik, meminta izin dan menjelaskan apa yang akan dilakukan

EXPLANATION AND PLANNING

12. Menggunakan Bahasa yang ringkas,gampang dimengerti,hindari pemakaian istilah medis.

13. Melakukan negosiasi dengan rencana yang akan dibuat

- memberikan alasan terhadap pilihan yang dipilih diantara pilihan lainnya
 - Memberikan pilihan lain kepada pasien
-

14. Menanyakan kembali dengan pasien

- apakah rencana disetujui
 - apakah keluhan pasien telah ditangani
-

CLOSING THE SESSION

15. Menjelaskan kemungkinan hasil yang tidak diinginkan ,apa yang akan dilakukan jika tidak sesuai harapan, kapan dan bagaimana harus mencari bantuan.
