PARTICIPATION, INFORMATION GIVING AND DECISION MAKING IN DIFFERENT COMMUNICATION STYLES DURING MEDICAL CONSULTATIONS

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Specially dedicated to those who have supported me all along:

My family members,

my significant other and

not to forget, all Thalassemia's survivors out there.

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ABSTRACT

Patients' participation and doctor's information giving are two important components within medical consultations. Research has shown that both components are influenced by the communication style adopted by doctors during medical consultations. This will consequently affect the decision made at the end of the consultations. Therefore, this study aims to look at how communication style affects the three important inter-related components in clinical consultation which are patients' participation, information provision and decision making. Respondents for this study consist of patients and doctors at a Haematology Clinic in a government hospital in Malaysia. The data gathered for this study involves audio-recordings from authentic clinical consultations. This study adopts a discourse analytic approach based on the components of patient's participation for the first stage of analysis while the second stage analysis involves the Roter's Interaction Analysis System (RIAS). The findings suggest that there are two types of communication style used by the doctors during the consultations which are the directing and sharing consultation styles. The data analysis in the sharing consultation style showed higher patients' participation and higher information giving by the doctor, and these resulted in a more shared decision making at the end. The type of communication style used by the doctors can affect the outcome of the consultation. The findings of this study have important implications on appropriate consultation style and provide a guideline on improving communication during consultations at the Haematology Clinic.

ABSTRAK

Penglibatan pesakit dan penyampaian maklumat oleh doktor ialah dua komponen penting dalam konsultasi perubatan. Kajian menunjukkan kedua-dua komponen itu dipengaruhi oleh cara komunikasi yang digunakan oleh doktor semasa konsultasi perubatan. Keadaan ini akhirnya akan mempengaruhi keputusan yang dibuat pada penghujung konsultasi. Oleh itu, kajian ini bertujuan untuk mengkaji bagaimana cara komunikasi dapat mempengaruhi tiga komponen yang saling berkaitan iaitu penglibatan pesakit, penyampaian maklumat oleh doktor dan keputusan yang dibuat. Kajian ini melibatkan para pesakit dan doktor di Klinik Hematologi iaitu sebuah hospital kerajaan Malaysia. Data yang dikumpulkan melibatkan rakaman audio daripada konsultasi klinik yang sebenar. Kajian ini menggunakan pendekatan analisis wacana iaitu berdasarkan komponen penglibatan pesakit bagi analisis tahap satu manakala analisis pada tahap dua pula melibatkan *Roter's Interaction Analysis System* (RIAS). Dapatan kajian menunjukkan terdapat dua jenis cara komunikasi yang digunakan oleh doktor semasa konsultasi iaitu secara bersama atau sendirian. Analisis data bagi cara komunikasi bersama ketika konsultasi menyebabkan tahap penglibatan pesakit dan penyampaian maklumat di dalam sesebuah konsultasi adalah tinggi. Keadaan ini akan menghasilkan keputusan secara bersama pada akhir konsultasi. Jenis cara komunikasi yang digunakan oleh doktor dapat menjangkakan hasil akhir sesebuah konsultasi. Hasil kajian ini memberi implikasi yang penting terhadap pendekatan konsultasi yang sesuai digunakan oleh doktor semasa konsultasi klinikal dan seterusnya mencadangkan panduan bagi menambah baik komunikasi semasa konsultasi di Klinik Hematologi.

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RIAS   -   Roter's Interaction Analysis System

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CHAPTER 1

INTRODUCTION

1.1   Introduction

Communication, according to Minardi and Riley (1997), is an essential, task-focused, and purposeful process. In daily life, we need to communicate with each other. If we do not communicate, we cannot send messages to others and we cannot understand what people want. The communication transaction is the sharing of information that uses a set of common rules (Northouse and Northouse, 1998). Therefore, it is important to understand communication in order to share information with each other and at the same time, deliver correct meaning in each message. This chapter will give brief information about the background of the study, statement of problem, objectives and research questions, significance of the study, and also the scope. There will also be the definition of terminologies and the conceptual and theoretical framework for this study at the end of this chapter.

1.2 Background of Study

In the society, people have to communicate in order to deliver their ideas and intentions. However, the way people communicate and the factors that influence their communication may differ from one individual to another. Moreover, there are many factors to determine whether communication is effective or not. If there is miscommunication, most often the messenger will be failed to deliver the message well. According to Kurtz (2002), effective communication is based on five principles: i) ensure interaction, not just transmission, ii) reduce unnecessary uncertainty, iii) require planning and think in terms of outcomes, iv) demonstrate dynamism, and also, v) follow a helical rather than linear model. In short, there are various ways to achieve effective communication.

Communication and society cannot be parted as people need to communicate with each other on a regular basis. Some people gain the skills to communicate well naturally while others may require work to become fluent in delivering messages through communication. Whatever way people gain their communication skills, they just have to be precise in using the correct words during communication with different walks of life, especially when involved in human resources and public relations activities. The skill to communicate well is especially important in a professional setting as communicating effectively with others have a profound effect (O'Daniel and Rosenstein, 2008). The interactions could become a failure (i.e. misunderstanding, unreached messages, reduced client's satisfaction) if professional workers do not acquire the relevant skills of effective communication.

It is important to acknowledge that people in the medical field are one of the communities that require their members to work on their communication skills as they meet various types of people on a daily basis. According to a review of literature for communication behaviours of health practitioners and patients (Williams et al.,1998), most researches focus on examining patients' satisfaction level and communication behaviours, always with the purpose of investigating: i)

information provision by the doctors or patients, ii) information seeking behaviours of doctors and patients, iii) relationship of the doctors and patients with negative or positive effects by either one of them, and iv) the communication styles of the doctors. Those elements are important in order to measure the effectiveness of doctor-patient interactions during medical consultations.

The lack of understanding between doctor and patient may lead to serious consequences. Patients' participation and information giving by the doctor can also lead to miscommunication. Additionally, the miscommunication here can exist during the decision making process. As patients participate lesser, the doctor would not know their problems better. Consequently, the information and explanation given by the doctor would also be lacking in order to support the patients' need and as a result, the patients lose their trust towards the doctor because of the unsuitable decision made due to incoherent interaction between them. Stiles et al. (1979) also stated that there is a positive relationship between patient satisfaction and certain verbal interactions that enhance the exchange of information.

Numerous studies have shown that the communicative features including information exchange and shared decision making can influence the outcome of medical consultations, as stated in Stewart (1995). According to Miller et al. (2011), the variables for health outcomes include equality of services and patients view of care (i.e. respectful treatment, satisfaction and effective partnership). If the interactions are incoherent from the start, the outcomes can be negative. In addition, the study by Stewart (1995) also reveals that the doctor has to encourage patients to voice their concerns and include patients in decision making and discussion of psychosocial issues in relation to their medical problems in order to be effective in communication. In fact, the patients' participation and doctor's information giving are equally important in producing better outcomes and avoiding miscommunication during clinical consultations. Most people will probably have encountered miscommunication during their conversation due to insufficient information provided or lack of understanding in certain terms which are not familiar within their culture. This is supported by studies by Ishikawa et al. (2002) and Takayama and

Yamazaki (2004) on the importance of open-ended questions, information giving and counselling to achieve patients' satisfaction and self-perceived participation.

Moreover, communication barriers prevent health care providers or doctors from providing good services and contribute to negative health outcome. For example, when the doctor could not determine the patients' needs, it may lead towards misunderstanding and therefore, the best treatment plan for the patients' diagnose cannot be achieved. There are many types of barriers in health communication such as language, ethnicity, and accessibility to care. Due to this problem, Trudgen (2000) suggests the development of special programs which are culturally sensitive in order to overcome the barriers that prevent the doctors from diagnosing patients' problem and providing sufficient information and explanations. However, those barriers cannot be avoided during any consultations and the only way to overcome them is by selecting the right consultation styles for the selected patients. Parson (1951) once said that the role of the doctors is complementary to the role of the sick patients. Therefore, it is better for the doctors to adapt to the patient's situation in order to facilitate friendly relationship and easy flow of information between the dyad. This study identifies patient participations and information provision towards decision making in different clinical consultation styles.

1.3   Statement of Problem

Effective doctor-patient interaction as both achieved mutual understanding to make decision during the consultation will help to make clinical consultation more affectionate through friendly conversations and easy-going information exchange between the doctor and patient. Once the patients feel comfortable during consultations, they will share more information and participate actively in the interaction with the doctors. The quality of the partnership between doctor-patient dyad can determine the outcomes of the clinical consultation as cited earlier from

Miller et al. (2011). Ineffective communication where both doctor and patient could not understand each other's needs can contribute to certain negative effects, including lack of attention towards patient's emotional state, deficiency of adherence between the doctor-patient dyad and failure to provide appropriate treatment due to insufficient information.

Moreover, Datuk Dr. Jacob Thomas (2011) who is The president of the Association of Private Hospitals of Malaysia pointed out in a newspaper article in The Star that good and clear communication between the doctor and patient about the treatment plan is clearly needed in order to clarify the patients' health condition and why some of the medical tests are needed. This issue stirred after some patients or their family members complained or showed displeasure when they did not understand clearly or receive explanation on whether a test or retest was necessary. Therefore, it can be proven that communication skills are important for the health practitioners or doctors in Malaysia. Doctors should acquire better communication skills and also be able to adapt the consultation styles according to situation in order to facilitate the clarification of medical information to the patients.

Medical graduates are required to communicate with different people in the society since they have been trained to do so during their practical training (Malaysian Medical Association, 2001). However, the training they receive during their intern session does not prepare them with effective communication skills Apart from that, Dr. Danial Wong from his article in The Star online on 3rd July 2011 also said that there is no rigid way in telling the bad news to patients even he had taken the communication skills training over and over again. This situation supports that there are many ways for the doctors in telling information to the patients during the consultations. Hence, it is important to determine the suitable practice styles or consultation styles for their consultation.

There are some issues that are often related to health communication such as patients' participations, the relationship between doctor-patient and also decision making in the medical setting in Malaysian healthcare. Many other studies also address the same health communication problems (Kiesler and Auerbach, 2006;

Cooper et al., 2003; Roberts et al., 2005; Stewart, 1995; Cooper-Patrick, 1999). It is believed that people change their behaviour to adapt to their environmental needs, more so in the workplace environment (Kuang et al., 2011). Such study becomes more important when effective communication in doctor-patient dyads has a significant impact on the health outcome and health care of the patients. Nevertheless, these issues have relatively been unaddressed in Malaysia for many reasons. One of the reasons is ude to the difficulty in accessing naturally occurring data. It is quite hard to receive consent from the health care department and doctors due to ethical issues within the medical field.

The health communication issues in Malaysia are somehow difficult to define. It is not a matter of absence, but more likely the matter of confidentiality and the lack of research in this area. By looking specifically into the field of health communication, the researcher will be able to discover various communication problems and the possible causes during patients-health practitioners' consultations. It is believed that there are many gaps that can be looked for in order to develop better health care plans in Malaysia. Therefore, the investigation of doctor-patient communication is very important. This research is hoped to highlight a few issues of medical consultations in Malaysia and at the same time, improve the outcomes of health care services offered by health care providers in Malaysia. The following are the main issues existing within the medical setting in Malaysia:

i) **Consultation Styles**

In The New Straits Times on 18th March 2010, there was a commentary on the inability of doctors to communicate effectively with patients. The article was written in the JohorBuzz column entitled, "Better bedside manners will help". The writer complained about the bedside manners of doctors in general while giving treatment to the patients. The writer also made a statement on the importance of communication styles during medical consultation:

"doctor's method of consultation could have been replaced with a human-based approach to promote better understanding communication between doctor and patient."

Based on the commentary, it seems important to match the consultation style of a particular doctor with the patient's preference to achieve better interaction during consultations. Nevertheless, patients often do not have the choice over which doctor they will get to see so the patients' preference of doctors are often not taken into consideration. Patients' preference of doctor may change their participation during consultation. The patients will naturally respond more to doctors with those characteristics. However, patients are not able to meet doctors who share the same language and culture with them for all their clinical consultations (Donald, 1986; Patient 3 et al., 1989; Van Wieringen et al., 2002; Ohtakis and Fetters, 2003; Roberts and Sarangi, 2005; Roberts et al., 2005; Schouten and Meewesen, 2006; Jain and Krieger, 2010). This situation may cause some problems in understanding each other's thoughts. Therefore, the match-up dyads can be effective if both doctor and patient can take their roles efficiently.

ii) Patients' Participation

The patients' participation will also determine the decision making during health consultations. For example, the doctor has to decide on blood retest if the patient is clueless about the blood test that he had taken in his previous visit. Most of the time, patient participation is crucial to provide information that the doctors lack. Effective communication between doctor and patient can overcome patients' dissatisfaction in every decision made at the end of the consultation. There are studies that have proved positive outcomes when patients and doctors agree on decision making styles and participation level (Jahng et al., 2005; Janz et al., 2004; Krupat et al., 2001).

Higher level of patient participation appears to be generally associated with more positive evaluations and outcomes (Ryan and Sysko, 2007). Every time the patients visit the clinic, there is a possibility that they would not get the same doctors as their last visit so the doctors have to check out the history of each patient in order to make the decision of what should be considered for the treatments and tests for the patients. If a patient does not have any complaints or questions, the doctor will consider the patient does not have any problem during the visit. Therefore, there is a close relation between patients' participation and decision making during medical consultation.

iii) Information Provision

In communication, it is important that both speakers interact with each other actively so that the message will be delivered correctly. However, Treichler et al. (1984) said that there is imbalanced power distribution within most interactions between doctor and patient. The doctor who has the power to control the consultations always move on to the next stage of consultations whenever there is not much new information received for a new diagnosis. Hence, it is crucial for doctors to select the suitable consultation styles to encourage patient participation in medical consultation settings so that later, both the doctors and patients can provide sufficient explanations. Information provision is a part of patients' participation components (Cegala, 2011). Thus, it is undeniable that both patients' participation and information provision are closely related. In general, the researcher found that when patients participated more actively in the consultation, it gives a positive effect on the information sharing and provision of both doctor and patient. When the doctors deliver enough information and explanation to their patients, it helps the patients to solve their problems. Less patient participation can cause less problems presented by the patients and the doctor will consider the patients as having no problem at all.

Doctors might also have unfavourable styles of consultancy that could lead to failure in discovering enough information from the patients. The participation of the patients in the consultation can also define the level of comfort that the doctors provide during the conversation. When the patients are comfortable with the conversation, the patients become more open to tell the details of their condition of health. There are other factors such as time management, patient's characteristics and behaviours and also structural context which influence the doctor-patient relationship (Morgan, 2003). Generally, the duration of time for each consultation is about 5 to 10 minutes. The consultation length can change depending on the types of consultation style used by the doctors. If the doctors use their authority to decide, the consultation length can be shorter as there are many patients waiting for their turn. On the other hand, the patients also can influence the length of the consultation based on their level of interactions with the doctors. The longer the time taken in each consultation, the more there is participation and information giving. The patients' characteristics and behaviours are different among each of them. A study of 1470 general practice consultations showed that only 27 percent of working-class patients sought clarification of what the doctor had said, compared with 45 percent of middle-class patients (Tuckett et al., 1985). Hence, the doctors need to choose the best method to encourage them to participate actively during the consultations. The usage of words is also important to determine how the interactions flow will go. The unfamiliar words can make the patients less participate during the consultations and later may lead to insufficient information provision which can also affect decision making process. Therefore, this research aims to examine the relationship between patients' participation, doctor's information giving, and also the decision making process.

iv) Decision Making Process

Other than information provision, decision making is very important in clinical consultation because it decides on how the patient will be treated in the

future. Doctors have to encourage the patients to voice their concerns and make them involve in decision making and discussion of their medical problems issues (Stewart, 1995). During every medical consultation, the patients will be given a chance to describe their problems and the doctors will choose the suitable medications or treatments needed to control the problem. The patients will be given another appointment according to their health condition. If it seems like there is no problem, then the longer the time will be taken for the patients to receive medication or treatment. At the same time, there will be negative consequences on the patients' health condition if the decision is wrongly made.

Based on the two issues discussed above, this study intends to reveal the relationship between patients' participation, information provision, and decision making process in medical consultations. However, the study will also concentrate on different types of consultation styles used by doctors. It is believed that these issues are important to be highlighted in order to overcome the problem of communication and later provide positive health outcomes (i.e. equality of services, respectful treatments, effective partnership, and higher satisfactions) for Malaysian's health care system.

1.4   Objectives of the Study

The study aims to investigate different consultation styles adopted by doctors at the Haematology Clinic. The investigation will focus on how patient participation and information giving have effects on the decision making process if different consultation styles are being adopted. There are three objectives of the study:

1.   To examine patients' participation in different consultation styles

2. To analyse doctor's pattern of information giving in different consultation styles

3. To investigate how patients' participation and doctors' information giving contribute to decision making in different consultation style

1.5   Research Questions

Based on the objectives of the study stated above, three research questions were formulated:

1. How do patients' participate in different consultation styles?

2. What are the doctor's patterns of information giving in different consultation styles?

3. How do patient participation and doctors' information giving affect decision making in different consultation styles?

1.6   Significance of the Study

The main focus of this study is to determine the interactions during clinical consultations of different consultation styles.   The patients' participation is an element analysed within the interactions.   Moreover, the study also attempts to examine the doctor's pattern of information giving in clinical consultations that affect the decision making process.   Therefore, the results will help in suggesting the social appropriateness in communication within the medical consultation settings.

From this study, there will be four social units that would benefit from the findings.   They are i) doctors, ii) patients, iii) communication researchers and iv) medical educators/ doctor training.   The benefits are as listed in Table 1.1 below:

Table 1.1: The Significance of the Study to Various Members of Society

Members of the Society	Benefits
1. **Doctors**	- Once the issue of doctor-patient interaction has been addressed, they will be aware of how to use suitable approaches and communicative styles with different patients.
2. **Communication Researchers**	- The results will help in suggesting the social appropriateness in communication within the medical settings.
3. **Medical Educator/ Doctor Training**	- The medical school will be able to use the findings of this study to provide training to medical students in order to provide better health services.

1.7   Scope of the Study

This research focuses mainly on the analysis of communication during medical encounters in different types of doctor's consultation styles. The aspects that this research highlights are patients' participation and doctor's information giving during clinical consultations. Moreover, the researcher is trying to examine on how both aspects give impact on the decision making process. This study involves only the data from doctor-patient dyads of Haematology Clinic at Hospital Sultanah Aminah, Johor Bahru.

The participants are: i) doctors and ii) patients who seek their medical consultations. The doctors involved in this study were; four doctors; two female and two male doctors. All of them have given their consents for preliminary investigation and real data collection. Meanwhile, the patients involved in this study were patients who sought medical care at Haematology Clinic from a public hospital in Johor Bahru.

The researcher focused on the doctors rather than the patients because the doctors of Haematology Clinic remained the same while the patients are changing accordingly. In addition, the clinical consultation at Haematology Clinic does not allow the patients to choose their preferred doctors for the consultations. Thus, it is best for the study to identify the doctor's style of consultation which could later affect the patients' participation, information provision and decision making process.

1.8 Limitations of the Study

All researches will encounter problems and issues during its progress. The limitations of this study are as follows:

i) **Data Collection** – The researcher was not given permission to video recordthe consultation session. In, addition not many doctors were willing to give consent to audio-recording of their interactions with patients during the medical consultations either. Hence, the researcher was only able to record consultations of doctors who have given consent. There were some background noises due to other doctor-patient interactions and medical staff going in and out of the room. The data were collected from two male and two female doctors. All doctors spoke Malay except for one Chinese doctor who attended to a Chinese patient.

ii) **Respondents** – This research selected only those patients who sought medical treatment at the Haematology Unit. The respondents were limited to those who gave their consent to participate in this study. In addition, some patients who brought their guardian also participated less within the presence of their guardian.

iii) **Researcher** – Although data from the observation of the consultations wouldhave enrich the data collection, this was not possible. The researcher was not able to carry out an ethnographic observation of the actual clinical consultation for the actual study because the setting was not feasible. Because of the size of the consultation room, the presence of the researcher was too noticeable and appeared to affect the doctor-patients interaction. The patients were easily distracted and their interactions appeared not natural and this clearly affected the authenticity of the interactions. As a result, this research was not able to include data from observation of the clinical consultation.

1.9   Definition of Terminologies

Clinical consultation.   Clinical consultation involves interaction between doctor and patient in a room where the patient attends to seek for doctor's advices and suggestions related to their health condition.   In this study, the clinical consultations took place in the consultation room at the Haematology Clinic of Hospital Sultanah Aminah, Johor Bahru.

Consultation styles.   Consultation styles refer to doctor's practice styles in organising the clinical consultations.   Peter (1994) listed four consultation styles or practice styles by the doctors: i) paternalism, ii) deferential styles, iii) participatory approach, and iv) directed styles.   However, according to William et al. (1998), there are two types of consultation styles in general, which are: i) sharing style and ii) directing style.   In this study, the consultation styles in William et al. (1998) are being used to describe the approach used by the doctors at Haematology Clinic.

Decision making.   Decision making occurs when there is one final solution that has been decided between two parties.   It is important in health care settings because it will incidentally affect patients' physical and emotion whenever positive or negative decision has been made.   In this study, the decision making is signalled with the diagnosis and prescriptions from the doctors.

Participation.   Participation is some kind of interaction (i.e. utterances, expressions) between two people to produce a set of communication which conveys meaning or information.   It is just like question-and-answer session where the questions are always followed by the answers.   Participation within this research is

any verbal response made by patients in return to the doctors' questions. If the patient is unable to give any response or feedback, the patient is not participating during the consultation with the doctor. In this study, the patients' participation is counted by three types of verbal responses which are asking questions, showing assertiveness, and expressing concerns.

1.10 Conceptual Framework

There are a few areas such as clinical consultation styles, patients' participation, doctor's information giving and also decision making in medical consultations emphasised by the researcher for this study. The study will also discuss the factors influencing the effectiveness of medical consultations and also the outcomes. Importantly, a conceptual framework helps to provide a general idea of what a research looks like. According to Fisher et al. (2007), the purpose of conceptual framework is to provide generalisations about processes and the interaction of concepts. It is believed that the concepts highlighted are interrelated.

The following Figure 1.1 illustrates the conceptual framework of the current study.
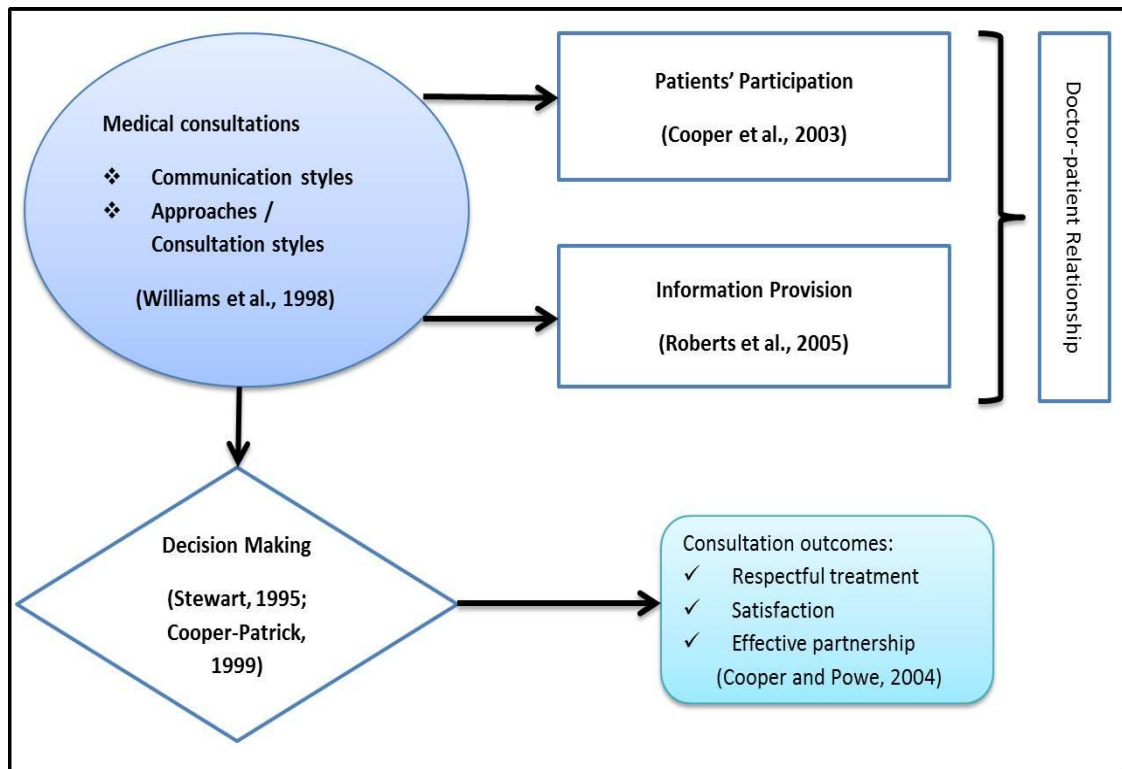
Figure 1.1: Conceptual Framework

As revealed in Figure 1.1, the study only focuses on doctor-patient relationship which include the doctor's consultation styles and investigates the patterns of medical consultation to show the level of patients' participation and doctor's information giving which later affect the decision making process.

1.11 Theoretical Framework

A theoretical framework is a structure that guides a research by relying on a formal theory (Eisenhart, 1991).   Although this research is based on discourse

analysis study and data-driven rather than theory based (Roberts et al., 2005; Shaw and Baily, 2009; Sarangi, 2010), Sinclair (2007) highlights that it is also relevant to include theoretical framework as a complementary to guide along the data found and enable the researcher to achieve the research objectives. This study has been guided by the root theory of Social Constructivism that describes the whole study since this study uses discourse analysis. Social Constructivism is a theoretical construct which considers all forms of communication, including silence, as being socially constructed and historically and culturally situated (Berger and Luckman, 1966). Therefore, the researcher came out with Figure 1.2 after choosing Williams et al. (1998) as the basis of the framework and other research as guides for this study.

From Figure 1.2, it is illustrated that the patients' participation, doctor's information giving can also be influenced by doctor's consultation styles. As the components of patients' participation (Cegala, 2011) are inlcuding information seeking, frequency of assertive utterances, information provision and also expression of concern, it can be true that there is a relationship between patients' preferences, patients' participation and also information giving and seeking during consultation styles. At some points, all those elements could also change the consultation styles of the doctors during clinical consultations. Peter (1994) refers doctor's consultation styles as "practice style". Whichever it is, the relationship of both doctor's information giving and seeking with doctor's consultation styles can be explained by Social Exchange in Roter Interaction Analysis System (Roter, 1999). Brown (1989) believed that the clinical outcomes or patient care is affected by the three different factors: i) patient, ii) doctor, and iii) encounter. Examples of elements in patient factor that can affect clinical outcome include severity of illness, complexity of problems, anxiety, communication skills and common-versus-rare presentation. Within the doctor factor, the elements that can influence clinical outcomes are knowledge, skill, professionalism, fatigue, experience and expertise. In addition, the example of elements in encounter factor which can influence clinical outcomes are appointment length, in-patient setting, support systems, and staffing. Therefore, the patterns of information giving and seeking by the doctors could be influenced by the types of consultation styles adopted by the doctors. It is matched with the findings in

Zimmerman (2000) which said that the production of a well-coordinated performance that involves a kind of dance between person and environment rather than the one-way action of one on the other.
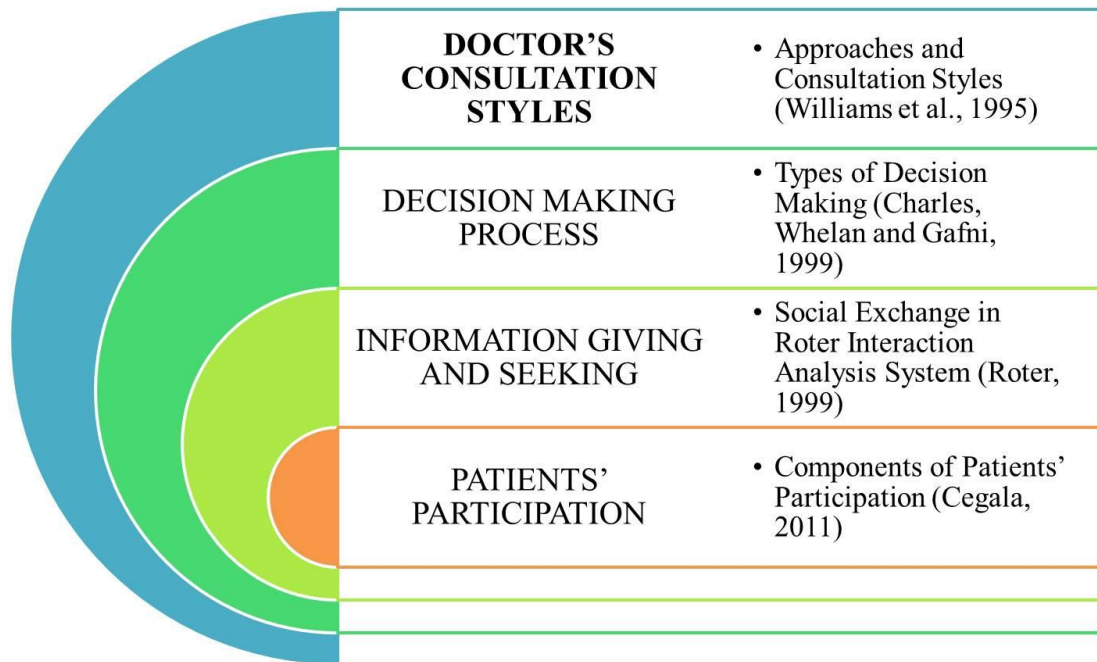
Figure 1.2: Theoretical Framework of This Study (Williams et al., 1998).

This research also highlights the decision making process in clinical consultations. To illustrate the relation between decision making and doctor's consultation styles, Figure 1.2 shows that consultation styles of a doctor can also decide the decision making process in a clinical consultation. Based on Charles, Whelan and Gafni (1999), there are three types of decision making; paternalist decision making, shared decision making and informed decision making. Each type of decision making has significant difference in terms of patients' participation, information giving and seeking and not to forget the consultations styles adopted by the doctors. Apart from that, Allen and Fred (1968) have highlighted four factors to process the decision. At the topmost, the doctors' judgment on the possible disease

based on the evidenced symptoms and preliminary tests is likely to be an important step to make a decision. The next step would be the assessment of the amount of information gained from further testing, followed by the possibility of side effects from the tests and treatments. The last step in making decision is to identify the value of the various outcomes to doctor and patient which might intensify from any particular course of action. Thus, it is believed that the decision making process involves doctor's consultation styles as a whole from the explained factors in decision making. If the doctor only thinks about his own good from the start, then the process of decision making would be different and perhaps more simple.

Basically, all the discourse data are bound to investigate the talks which always involved abstract ideas. The analysis based on talks for discourse analysis uses the Social Constructivism theory. In summary, the theoretical framework of this study basically adopted the Social Constructivism theory as the root since the study used the layered data analysis that involved quantitative analysis for the first stage analysis and the second stage analysis used discourse analysis method.

1.12 Summary

This section has reviewed the background of the study, the statement of the problem, the three objectives and research questions, the significance of the research, the scope of the study, limitations, and also the definition of terminologies that will be used in this research. Although research into health communication is important, it is an area of research that is relatively new in Malaysia. Hence, the main aim of this study is to investigate the doctor's consultation styles during medical encounters. Apart from that, this research endeavours to look into patients' participation in clinical consultations and to discover for specific emerging patterns in the way information is delivered in doctor-patients communication, and simultaneously look at how doctor's consultation styles affect on patients' participation, doctor's

information giving, and decision making process in Haematology Clinic. The following chapter will explain the literature of this study. There are few main issues highlighted in the following chapter including doctor-patient interactions and clinical consultations, doctor's consultation style, patients' participation, doctor's information giving and decision making in clinical consultations.

REFERENCES

Adegbite, W. and Odebunmi, Z. (2006).*Discourse Tact in Doctor-Patient Interactions in English: An analysis of diagnosis in medical communication in Nigeria.*Nordic Journal of African Studies. 15 (4): 449-512.

Ainsworth-Vaughn, N. (1998). *Claiming Power in Doctor-Patient Talk.* Oxford: Oxford University Press.

Alden, D.L. et al. (2010). *Patient Decision-Making Preference and Physician Decision-Making Style for Contraceptive Method Choice in an Asian Culture: Does Concordance Matter?.*Health Communication, Vol. 25, Issue 8, 2010.

Antaki, C. and Widdicombe, S.(Eds.) (2008).*Identities In Talk.* Sage Publication: London.

Baker DW, Hayes R, Fortier JP. (1998). *"Interpreter Use and Satisfaction with Interpersonal Aspects of Care for Spanish-Speaking Patients".* Medical Care 1998 Oct; 36(10): 1461–70.

Balsa, A. and McGuire, T.G. (2001).*Statistical discrimination in health care.Journal of Health Economics.* 20 (6), 881-907.

Barzini, L. (1965). *The Italians.* New York: Bantam Press.

Berger, P. L. and Luckman,T.(1966).*The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. Armondsworth: Penguin.

Blank, T. et al. (2006). *Understanding treatment decision making: Contexts, commonalities, complexities, and challenges*. Annals of Behavioural Medicine. 32 (3), 211-217.

Bradby, H. (2001). *Communication, interpretation and translation*. In Lorraine Cully and Simon Dyson (eds.) Ethnicity and Nursing Practice. New York: Palgrave.

Byrne, P.S. and Long, B.E.L. (1976).*Doctors Talking to Patients.* Exeter: RCGP.

Bultman, D.C. and Svarstad, B.L. (2000).*Effects of physicians' communication styles on client medication beliefs and adherence with antidepressant treatment.*Patient Education Counselling. 40: 173-185.

Callery, P. (1997b). Maternal knowledge and professional knowledge: Cooperation and conflict in the care of sick children.*International Journal of Nursing Studies*. 34(1), 27-3.

Cameron, K.A.(2009). *A practitioner's guide to persuasion: An overview of 15 selected persuasion theories, models and frameworks*. Patient Education & Counseling. 74, 309-317.

Carrasquillo O, Orav EJ, Brennan TA, Burstin HR. (1999). *"Impact of language barriers on patient satisfaction in an emergency department".*Journal of General Internal Medicine. 1999 Feb; 14(2): 82–87.

Cass, A. et al. (2002*). Sharing the true stories: Improving communication between Aboriginal patients and health care workers*.Medical Journal of Australia. 176: 466-470.

Cegala, D.J. (2011). An Exploration of Factors Promoting Patient Participation in Primary Care Medical Interviews. *Health Communication*, Vol. 26, Issue 5.

Charles, C., Whelan, T. & Gafni, A. (1999). What do we mean by partnership in decision makings about the treatment? *British Medical Journal.*319, 780-782.

Chimombo, M. and Reseberry, R.L. (1998).*The power of discourse: An introduction to discourse analysis.* London: Lawrence Erlbaum Associates.

Cicourel, A.V. (2007). *A Personal Retrospective View of Ecological Validity*. Text & Talk. 27 (5): 735-752.

Collins, T. C., Clark, J. A., Petersen, L. A., & Kressin, N. R. (2002). Racial differences in how patients perceive physician communication regarding cardiac testing. *Medical Care.*40(Suppl. 1), I27–I34.

Cooper, L. and Roter, D. (2003).*Patient-Provider Communication: The effect of race and ethnicity on process and outcomes of healthcare*. In Brian D. Smedley,

Adrienne Y. Stith, & Alan R. Nelson (ed.*) Unequal Treatment: confronting racial and ethnic disparities in health care.* USA: National Academies Press.

Coulthard, M. and Ashby, M. (1976).*A linguistic description of doctor-patient interviews*. In M.Wadsworth and D. Robinson (eds.) *Studies in everyday medical life.* London: Martin Robertson.

Coulter, A. (2005).*Shared decision-making: The debate continues*. (Editorial).Health Expectations. 8 (2), 95-96.

Coupland, N., Coupland, J. and Giles, H. (1989).*Telling Age in Later Life: Identity and Face Implications.* Text 9 (2): 129-151.

Coupland, J., Robinson, J.D. and Coupland, N. (1994).*Frame negotiation in doctor-elderly patient consultations*. Discourse and Society. Vol. 5(1): 89-124.

DaleE.Brashers and Daena J. Goldsmith (Eds.).(2009). *Communicating to Manage Health and Illness.* New York: Routledge.

Davis, K. Schoenbaum, S.C. & Audet, A.M. (2005).*A 2020 vision of patient-centered primary care.*Journal of General Internal Medicine. 20: 953-957.

Deber, R. B., Kraetschmer, N., Urowitz, S. and Sharpe, N. (2007).*Do people want to be autonomous patients?: Preferred roles in treatment decision-making in several patients populations.* Health Expectations, 10: 248–258.

Doescher, M.P. et al. (2000). *Racial and ethnic disparities in perceptions of physician style and trust.*Archives of Family Medicine, 9, 1156-1163.

Drew, P., Chatwin, J. and Collins, S. (2001), *Conversation analysis: a method for research into interactions between patients and health-care professionals*. Health Expectations, 4: 58–70.

Drew, P. and HePatient 9ge, J. (1992).*Analyzing Talk at Work: An Introduction*. In P. Drew and J. HePatient 9ge (eds). Talk at Work: Interaction in Institutional Settings. Pp. 3-65. Cambridge: Cambridge University Press.

Duranti, A. (1997). *Antropología Lingüística*. Trans. Pedro Tena.Cambridge: Cambridge University Press.

Edwards, A., Evans, R. & Elwyn, G. (2003).*Manufactured but not imported: New directions for research in shared decision making.*Patient Education and Counseling. 50: 33-38.

Enguidanos ER, Rosen P. (1997). Language as a Factor Affecting Follow-up Compliance From the Emergency Department.*Journal of Emergency Medicine*. 1997 Jan-Feb; 15(1): 9–12.

Fishbein, M. and Azjen, I. (1975).*Belief, Attitude, Intention and Behavior: An Introduction to Theory and Research*. Reading, MA.: Addison Wesley.

Fisher, S. and Groce, S.B. (1990).*Accounting Practices in Medical Interviews.*Language in Society. 19 (2): 225-250.

Gamble, V.N. (1997). *Under the shadow of Tuskegee: African Americans and health care*. Am J Public Health. 87: 1773-1778.

Garfinkel, H. (2002).*Ethnomethodology's Program: Working Out Durkheim's Aphorism*. Lanham, MD: Rowman & Littlefield.

Globe Study. (2004). *Culture, leadership and organizations*: The GLOBE Study of 62 Societies, Thousand Oaks, CA: Sage.

Goffman, E. (1981). *Forms of Talk.* Oxford: Blackwell.

Goffman, E. (1983).*'The Interaction Order'.*American Sociological Review, 48, 1-17.

Goffman, E. (1986). *Frame Analysis*. New York: Harper and Row.

Gordon, H.S. et al. (2005). *Physicians-patient communication following invasive procedures: an analysis of post-angiogram consultations*. Soc. Sci Med. 61: 1015-1025.

Grant, R.W. et al (2007). *How doctors choose medications to treat type 2 diabetes: A national survey of specialists and academic generalists*. Diabetes Care. 30 (6), 1448-1453.

Grol R, de Maeseneer J, Whitfield M and Mokkink H. (1990).*Disease-centred versus patient-centred attitudes: comparison of general practitioners in Belgium, BPatient 9in and the Netherlands.*Family Practice.7: 100–103.

Gumperz, J.J. (1982). (Ed.).*Conversational code-switching.*Discourse strategies, pp. 59–99. Cambridge University Press: New York.

Gumperz, J.J. (2003). *Interactional Sociolinguistics.*In Schiffrin, D., Tannen, D., and Hamilton, H.E. (eds.) *A handbook of discourse analysis*. Madlen: Blackwell Publishing. Pp. 215-228.

Hall, J.A., Roter, D.L. & Katz, N.R. (1988).*Meta-analysis of correlates of provider behaviour in medical encounters.*Med. Care. 26: 657-675.

Heine, S. J., Takata, T. and Lehman, D. R. (2000).*Beyond self-presentation: Evidence for self-criticism among Japanese*. Personality and Social Psychology Bulletin, 26(1): 71–78.

HePatient 9ge, J. and Maynard, D.W. (2006). (Eds.). *Communication in medical care: Interaction between primary care physicians and patients.* Cambridge, UK: Cambridge University Press.

Hughes, D. (1982). *Control in the medical consultation: organizing talk in a situation were co-participants have different competence.*Sociology. 16: 359-376.

Ishikawa, H., et al. (2002). *Physician-patient communication and patient satisfaction in Japanese cancer consultations*. Soc. Sci. Med. 55: 301-311.

Jahng, K. H., Martin, L. R., Golin, C. E. and Di Matteo, M. (2005).*Preferences for medical collaboration: Patient–physician congruence and patient outcomes*. Patient Education and Counseling, 57: 308–314.

Jared, R.A. and Roberts, E.D. (2006).Shared Decision-Making and Evidence-Based Practice.*Community Mental Health Journal*, Vol 42, No. 1.

Jaworski, A. (1992). *The power of silence: social and pragmatics perspectives*. California: Sage Publications.

Jefferson, G. (1980). On "Trouble-Premonitory" Response to Inquiry.*Sociological Inquiry*. 50: 153-185.

Kaplan, S.H. et al. (1995). Patient and visit characteristics related to physicians' participatory decision making style. *Results from the Medical Outcome Study. Med. Care*. 33: 1176-1187.

Kiesler, D.L. and Auerbach,S.M. (2003). *Integrating measurement of control and affiliation in studies on physician–patient interaction: The interpersonal circumplex*.Social Science & Medicine. 57, pp. 1707–1722.

Kiesler, D.J. and Auerbach, S.M. (2006). Optimal matches of patient preferences for information, decision-making and interpersonal behavior: Evidence, models and interventions. *Patient Education and Counseling*. 61 (2006) 319–341.

Kurtz S, Silverman J, Draper J. (1998). *Teaching and Learning Communication Skills in Medicine*. Oxford: Radcliffe MedicalPress.

Kurtz, S.M. (2002). *Doctor-Patient Communication: Principles and Practices*. The Canadian Journal of Neurological Sciences, Volume 29.Canadian Journal of Neurological Sciences.

Krupat, E., Bell, R. A., Kravitz, R. L., Thom, D. and Azari, R. (2001).*When physicians and patients think alike: Patient-centered beliefs and their impact on satisfaction and trust*. Journal of Family Practice, 50(12): 1057–1062.

Laver, J. (1974).Communicative Functions of Phatic Communion.

Lewis, R. (2000). *When Culture Collide.Managing Successfully Across Cultures*. London: Nicholas Breley Publishing.

Lutfey, K.E. et al. (2008). How are patient characteristics relevant for physicians' clinical decision making in diabetes? An analysis of qualitative results from a cross-national factorial experiment.*Social Science and Medicine*. 67, 1391-1399.

Malinowski, B. (1923). *The Problem of Meaning in Primitive Languages*, in C.K. Ogden and I.A. Richards (eds.) The Meaning of Meaning. Pp. 146-152. London: Routledge & Kegan Paul.

McKinlay, J. et al. (2006). *How do doctors in different countries manage the same patient?* Results of a factorial experiment. Health Services Research, 41 (6), 2182-2200.

McWhinney, I. (1998). *Listening to patients: a lifetime perspective*. CJRM, 3:168–1699.

Meeuwesen, L. (2003). *Sequential analysis of the phasing of the medical interview.*Epidem. Psych. Soc. 12:124-129

Meeuwesen, L, Harmsen, J.A.M, Bernsen, R.M.D and Bruijnzeels, M.A. (2006).*Do Dutch doctors communicate differently with immigrant patients than with Dutch patients?*Journal of Social Science and Medicine. 2407-2417.

Moore, J.B. andKordick, M.F. (2006).*Sources of Conflict Between Families and Health Care Professionals*.Journal of Pediatric Oncology Nursing. 82-91. Retrieved from http://jpo.sagepub.com/content/23/2/82.refs.html on 17 January 2012.

Mohd. Jamil Yaacob (2011). *Komunikasi Kesihatan Berkesan*. PTS Professional Publishing Sdn. Bhd.: Kuala Lumpur.

Morgan, M. (2003).*The doctor-patient relationship.In G. Scambler (Ed.).*Sociology as applied to medicine. 5th edition. 49-65. London: Billiere Tindal.

Minardi, H.A. and Riley, M.J. (1997).Communication in health care: A skills-based approach. Butterworth-Heinemann : Oxford and Boston.

Miller, A.N. et al. (2011).*Kenyan Patients' attitudes regarding doctor ethnicity and doctor-patient ethnic discordance.* Patient Education and Counselling, 82, 201-206. Elsevier Ireland Ltd.

Mishler, EG. (1984). *The discourse of medicine: dialectics of medical interviews.* Ablex: Norwood.

Nahla Abdel-Tawab and Roter, D. (2002).*The relevance of client-centered communication to family planning settings in developing countries: Lessons from the Egyptian experience*. Social Science & Medicine, Volume 54, Issue 9, Pages 1357–1368.

Northouse, L.L. and Northouse, P.G. (1998).Health communication: Strategies for health professionals. (3rd Edition) Appleton & Lange: Stamford, Conn.

O'Daniel, M and H. Rosenstein, A. (2008). Professional Communication and Team Collaboration:Chapter 33. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Retrieved from http://www.ahrq.gov/qual/nurseshdbk/docs/O%27DanielM_TWC.pdfon 11 February 2012.

Oliver, R.L. (1997). *Satisfaction: A behavioural perspective on the consumer*. Boston: Irwin McGraw-Hill.

Ong, L.M.L. (1995).*Doctor-patient communication: A review of the literature*. Social Science &Medicine, Volume 40, Issue 7, Pages 903-918. Available at http://www.sciencedirect.com/science/article/pii/027795369400155M

Peter, R.M. (1994). Matching Physician Practice Style to Patient InformationalIssues and Decision-Making Preferences.*An Approach to Patient Autonomy and Medical Paternalism Issues in Clinical Practice.*3:760–3. Arch Fam. Med.

Poteet, S. et al. (2008).*Linguistic Sources of Coalition Miscommunication*.Retrieved from http://www.cs.bath.ac.uk/~is/Poteet_Xue_Patel_Kao_Giammanco_Whiteley_NATO%20HFM142_2008.pdf on 8 January 2012.

Pruitt, D. G., Kim, S. H., & Rubin, J. Z. (2004). *Social conflict: Escalation, stalemate, and settlement* (3rd ed.). Boston:McGraw-Hill.

Richards, K. (2005). *Language and professional identity.* Basingstoke: Palgrave Macmillan.

Rimal and Lapinski.(2009).*Why health communication is important in public health. Retrieved from* www.who.int/bulletin/volumes/87/4/08-056713.pdf on 10 January 2012

Rivadeneyra, R. et al. (2000). *Patient centeredness in medical encounters requiring an interpreter.*The American Journal of Medicine. 108: 470-474.

Roberts, C. and Sarangi, S. (2005). *Theme-oriented discourse analysis of medical encounters.* Medical Education, 39: 632–640.

Roberts, C. et al. (2005). *Misunderstandings: A Qualitative Study of Primary Care Consultations in Multilingual Settings, and Educational Implications*. Medical Education. 39: 465-475.

Roter, D.L., Hall, J.A. & Katz, N.R. (1987).*Relations between physicians' behaviours and analogue patients' satisfaction, recall and impressions*. Med. Care. 25: 437-451.

Roter, D. (1993).*The Roter Method of Interaction Process Analysis: RIAS manual*. The Johns Hopkins University :Baltimore, MD.

Rubin, R.R., Peyrot, M. & Siminerio, L.M. (2006).*Health care and patient-reported outcomes: results of the cross-national diabetes attitudes, wishes and needs (DAWN) study.* Diabetes Care, 29 (6), 1249-1255.

Ryan, J. R. and Sysko, J. (2007).*The contingency of patient preferences for involvement in health decision-making.* Health Care Management Review, 32(1): 30–36.

Sacks, H., Schegloff, E.A. and Jefferson, G. (1974).A Simplest Systematics for the Organization of Turn-Taking for Conversation.*Language.Linguistic Society of*

America. Vol. 50, No. 4, Part 1, pp. 696-735. Available at
http://www.jstor.org/stable/412243.

Sahay, T. (2004).*A Review of the Literature on the Links Between Health Promotion Capacity Building and Health Outcomes*. OHPRS Evaluation and Needs Assessment Committee Ontario Health Promotion Resource System.Available at http://www.ohprs.ca/resources/tina_finalreport_27dec2004.pdf.

Sandman, L. and Munthe, C. (2009).Health Care Analysis.Retrieved from http://www.springerlink.com/content/m2r4lw5726hqq05k/?p=7d64e0f8d9ab4492813737d33465d347&pi=8 on 9 April 2013.

Santos, S. and Amaro, K.V. (2011). Health care provision in a Huichol community in Mexico: an issue of intercultural communication. *Journal of Intercultural Communication*.Vol. 26.

Sarangi, S. (2010). Reconfiguring self/identity/ status/role: The case of professional role performance in healthcare encounters. *Journal of Applied Linguistics and Professional Practice*. 7 (1): 75-95).

Sarangi, S. and Roberts, C. (1999).*Talk, work and institutional order: Discourse in medical, mediation and management settings*. Berlin: Mouton de Gruyter.

Sawyer, L. et al. (1995).Matching Versus Cultural Competence in Research: Methodological Considerations.*Research in Nursing and Health*, 18(6), 557–67.

Schegloff, E.A. and Sacks, H. (1973).Opening up closings.Semiotica. 8: 289-327.

Schiffrin, D. (1987). *Discourse Markers*. Cambridge: Cambridge University Press.

Scollon, R. (1985). The machine stops. In Tannen, D. and Saville-Troike, M. (eds.). *Perspectives on Silence*. Norwood, NJ: Ablex.

Silverman, D. (1987). Coersive interpretation in the clinic: The social constitution of the Down's Syndrome Child. *Communication and Medical Practice: Social Relations in the Clinic*. London: Sage. 136-175.

Silverster, J., Patterson, F., Koczwara, A. & Ferguson, E. (2007). "Trust me…": Psychological and behavioural predictors of perceived physician empathy. *Journal of Applied Psychology*. 92, 519-527.

Stewart, M.A. (1995). Effective Physician-Patient Communication and Health Outcomes: A Review. *Canadian Medical Association Journal*, 152(9), 1423–33.

Stiles, W.B. and Putnam, S.M. (1992). Verbal Exchanges in Medical Interviews: Concepts and measurement. *Social Science and Medicine*, 40(7), 903-918.

Stiles WB, Putnam SM, Wolf MH, James SA.(1979). *Interaction exchange structure and patient satisfaction with medical interviews*.Med Care. 1979 Jun;17(6):667-81.

Street, R.L. (1992). *Communicative styles and adaptations in physician-parent consultations.* Soc, Sci. Med. 34: 1155-1163.

Street, B. (2003). What's "new" in New Literacy Studies?*Critical approaches to literacy in theory and practice*.Current Issues in Comparative Education, Teachers College, Columbia University,Vol. 5(2). Kings College: London.Available at http://www.tc.columbia.edu/CICE/Issues/05.02/52street.pdf.

Ten Have, P. (1989).*The consultation as a genre*. Retrieved from http://www.paultenhave.nl/genre.htm on 10 January 2012.

Trudgen*, R. (*2000).*Why warriors lie down and die*. Darwin, Aboriginal Resource and Development Services Inc. *Retrieved from* http://www.docstoc.com/docs/2294480/Summary-of-relevant-literature-on-communication-in-Indigenouson 9 February 2012.

Tuckett D, Boulton M, Oban C, Williams A.(1985).*Meetings between experts: an approach to sharing ideas in medical consultations*. Tavistock Publications, London.

Van Wieringen et al. (2002). *Intercultural Communication in General Practice*.European Journal of Public Health. 12: 63-68.

Weisse et al. (2001).*Do gender and race affect decisions about pain management?*.Journal of General Internal Medicine, Vol 16. Pp. 211-217. Indiana: Springer.

West, C. (1984). *Routine complications: Trouble with talk between doctors and patients.* Bloomington: Indiana University Press.

Williams S., Weinman, J. and Dale, J. (1998). *Doctor-patient communication and patient satisfaction: review*. Oxford University Press *Vol 15, No. 5: Great BPatient 9in.*

Wooffitt, R. (2005).*Conversation Analysis and Discourse Analysis: A Comparative and Critical Introduction. Sage Publication: London.*

Webb, H. (2009) *Doctor-patient interactions during medical consultations about obesity.*PhD thesis, University of Nottingham.

Young, M. and Klinge, RS. (1996). Silent partners in medical care: a cross-cultural study of patient participation.*Health Communication*. 8: 29-53.

NEWSPAPER ARTICLE

"Better bedside manners will help". (2010, March 18th). JohorBuzz column in The News Strait Times.

Thomas, J. (2011).Nation column in The Star Online.Retrieved from http://thestar.com.my/news/story.asp?file=/2011/5/29/nation/8782482&sec=nation on 29 February 2012.