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Communication study

Talking about psychosocial problems: An observational study on changes in doctor–patient communication in general practice between 1977 and 2008

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ABSTRACT

Objective: To examine whether GPs' communication styles have changed since the introduction and implementation of clinical guidelines for psychosocial problems in Dutch general practice in the 1990s.
Methods: From a database of 5184 consultations videotaped between 1977 and 2008, 512 consultations assessed by GPs as 'completely psychosocial' were coded with RIAS (Roter Interaction Analysis System). The 121 consultations prior to and 391 consultations after implementation of guidelines were analyzed whether communication styles have changed over time.
Results: We found that GPs were more likely to consider consultations to be mainly (17%) or completely (12%) psychosocial after the implementation of guidelines. They gave more biomedical and psychosocial information and advice in the second period compared to the first period. We also found that empathy decreased over time (frequency of empathic statements by GPs changed from 2.9–3.2 to 1.4–1.6 between periods).
Conclusion: Communication in psychosocial consultations has changed; GPs have become more focused on task-oriented communication (asking questions, giving information and advice) and less on showing empathy.
Practice implications: GPs face the challenge of integrating an evidence-based approach of applying guidelines that promote active symptom exploration with understanding patients' personal contexts and giving room to their emotions.

Contents

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1. Introduction

Developments in medical and psychological care influence the way general practitioners (GPs) deal with psychosocial aspects of patients' presented problems. In 1959, GPs of the Dutch College of General Practitioners stated that GP care had to be continuous, integrative and personal [1]. With this agreement, GP care was explicitly placed in a broader societal and emotional context and not limited to a biomedical framework. GPs started to emphasize the importance of understanding the meaning of illness for patients rather than merely diagnosing medical diseases [2]. Problem behavior of patients (behavior related to psychosocial aspects of patients' life) was considered as starting point for GPs to deal with patients' health complaints [3]. During a doctor's visit, GPs should get a clear and complete idea of patients' reasons to seek GP care. A system to classify patients' reasons for encounter was developed (RFEC: Reason for Encounter Classification) to motivate GPs to use these reasons as starting point for further action, such as providing treatment or advice [4]. In a Dutch study on morbidity in general practice in the period 1978–1982, all minor psychological problems were coded by an overall label 'emotional disorders', while only classic psychiatric diseases – such as dementia, schizophrenia, and manic depressive disorder – were categorized separately [5]. In this study, over 80% of the registered mental disorders were classified into the overall label 'emotional disorders'. This indicates an emphasis on acknowledging general emotional problems, rather than diagnosing psychiatric diseases. During this period, also attention was paid to the prevention of somatic fixation; a process in which patients or GPs focus exclusively on the physical aspects of complex health problems that may also include psychosocial aspects, such as anxiety or depression [6–8]. In 1987, the Dutch National Association of General Practitioners described the tasks and responsibilities of GPs, which was used as the main framework for the profession of GPs [9]. In line with previous ideas on continuous, integrative and personal care, it was again emphasized that family care and taking into account emotional aspects of health problems were part of GPs tasks and responsibilities. In the 1970s and 1980s, GP care was characterized by an approach in which GPs were motivated to understand the patient as a 'whole' and to understand the personal contexts surrounding patients' presentation of psychological, social, or physical health problems.

From the 1990s, more emphasis was placed on evidence-based medicine with the introduction of clinical guidelines in Dutch general practice. GPs' need to categorize social and psychological problems grew and they were more often encouraged to diagnose psychological disorders with psychiatric classification schemes such as the Diagnostic Statistical Manual (DSM) of the American Psychiatric Association [10]. For example, somatic symptoms associated with psychosocial problems, could now be diagnosed as somatization disorders as described in the DSM. The DSM approach of categorizing mental distress by counting symptoms was also applied in the development of clinical guidelines for psychological problems in general practice. In 1994, the Dutch College of General Practitioners published the national clinical guideline for depression [11]. In the years that followed, clinical guidelines for other psychological problems, such as anxiety disorders were introduced [12]. Today, there are eight clinical guidelines specifically for psychological problems and the use of guidelines is widely implemented in general practice in the Netherlands [13]. In the past decades, the integrative approach of understanding patients within their personal contexts (*What is the meaning of the illness for the patient*?) has been replaced by a more evidence-based approach in which symptoms are listed and categorized (*How can the illness of the patient be defined*?).

These changes in the approach of psychosocial problems in general practice may also have implications for the communication between doctors and patients in the consultation room. In line with Rogers' client-centered approach, in which empathy and unconditional positive regard were keywords, GPs were encouraged to let patients talk freely during consultations in the 1970s and 1980s [14]. Studies on doctor–patient communication show the importance of listening, personal attention and empathy during consultations [15,16]. However, there are indications that GPs' communication styles have changed and GPs engage more in giving information in recent years [17]. Possibly, the introduction of clinical guidelines for psychosocial problems in general practice have motivated general practitioners to focus more on providing a structured consultation by specific question asking and giving information or advice, rather than inviting patients to talk freely. While shifts in communication styles by GPs were found during consultations discussing hypertension [17], it is unknown whether these shifts are also visible during consultations that are psychosocial in nature. GPs tend to communicate differently when psychosocial issues are perceived, compared to consultations in which only biomedical problems are perceived [18,19]; we therefore cannot automatically assume that previously found shifts in communication styles toward giving more information during hypertension consultations also account for consultations psychosocial in nature.

1.1. Hypotheses

The aim of this study is to investigate whether changes in general practice regarding psychosocial problems also influenced doctor–patient communication in the consultation room. We consider the introduction of clinical guidelines (1990s) as a major turning point in the history of general practice in the Netherlands and we therefore compare consultations prior to and after the implementation of these guidelines.

First, we investigate how often GPs attribute psychosocial aspects to health problems prior to and after the implementation of clinical guidelines. Attention to psychosocial aspects of health complaints has been promoted starting from the inception of the Dutch College of General Practitioners in 1956, but may also be affected by the emphasis put on evidence-based medicine in the 1990s. We therefore expect that GPs less often attribute psychosocial aspects of health problems in recent years.

Second, we hypothesize a change in symptoms discussed during consultations considered psychosocial by GPs. Consultations considered psychosocial by GPs can contain talk about either psychological, social, or physical symptoms. With the increased focus on diagnosing psychological disorders according to guidelines, we expect an increase of explicit psychological symptoms