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THE CONSULTATION STYLE OF DOCTORS AT AN OUTPATIENT CLINIC IN IBADAN, OYO STATE, NIGERIA: ARE PATIENTS PARTICIPATING?

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ABSTRACT

Objectives: Family Medicine (FM) training started two decades ago in Nigeria. The influence of FM training on the consultation style of practitioners in Nigeria is not known. This study examined the consultation style of family physicians in an outpatient clinic, the amount of information provided by the physicians to their patients and the level of their patients' participation in the consultation process.

Methods: A systematic sample of 212 adult patients was interviewed using semi-structured questionnaire. Chi square test was used to test significance of differences in proportions.

Results: The consultation style of the physicians was predominantly doctor-centred. Doctors provided information on nature, plan of management, prognosis and prevention of illness to 38.7%, 16.5%, 5.7% and 49.5% of the patients respectively. 34.3%, 21.4% and 16.7% of the patients sought information on nature, plan of management and prognosis of illness respectively. The commonest reason for patients not seeking such information from their doctors is that "they did not know they could ask such questions". Patients who asked their doctors about plan of management significantly reported they had their expectations met. The level of education of the patients determined to a great extent the information sought for and that provided by the doctors ($p<0.05$).

Conclusion: Patients' participation during consultation is inadequate and there is a suggestion that patients would welcome more involvement in the care of their illness. Practitioners need to be taught the patient-centred clinical method, a key distinguishing characteristic of Family Medicine, which emphasizes patients' expression of their illness experience(s) and participation in clinical decision-making.

KEYWORDS: ***Patients; participation; consultation; style; outpatient; clinic***

INTRODUCTION

Physicians exhibit different styles of interaction with their patients from doctor-centred (or disease-oriented) at one extreme to patient-centred at the other[1,2,3]. The former embodies the classic paternalistic doctor-patient relationship in which the physician is relatively dominant, the medical problem is the central concern and the patient is expected to defer to the physician's judgement[1]. The latter, patient-centred medicine, although not a new phenomenon, has recently attracted renewed attention. It has basically a humanistic, bio-psychosocial perspective, combining ethical values on "ideal physician" with psychotherapeutic theories on facilitating patients' disclosure of real worries and negotiation theories on decision-making[4]. It puts a strong focus on patient participation in clinical decision making by taking into account the patient's perspective and tuning medical care to the patient's needs and preferences.

The patient-centred model was developed by a group of researchers in General Practice in the academic department of Family Medicine at the University of Western Ontario, London Canada subsequent to a call in paradigm shift by one of the world's leading theorist, Professor Ian McWhinney[5]. The central issue of the shift was the involvement of the patient in the process of care, including the consultation and the integration of doctor and patient perspectives towards a common goal[6]. This paradigm shift has been recently re-emphasised as what should be the medical paradigm of the 21st century[7].

Patient-centredness and holism have been identified as the key distinguishing characteristics of General Practice/Family Medicine and of the orientation of those who practise in it[8,9,10]. The effectiveness of patient-centred consultation and the resulting patient satisfaction with care has been demonstrated in research studies and practising centres[11,12,13,14]. Many physicians seriously feel that patient-centredness is pre-requisite for good quality of care[4] while effective communication between patient and doctor has been described as the royal pathway to patient-centred medicine[4]. Physicians depend on patient's expertise in the experience of their symptoms which if not provided limits

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physician's ability to provide quality care and meet the needs and expectations of their patients[15,16,17]. Important patient outcome of care have been improved by good communication between doctors and patients that is characterised by full expression of the patient's problems, leading to mutual understanding[18].

In Nigeria, the common style of consultation is mainly doctor-centred. An average Nigerian patient looks up to the doctor as the one who knows all and must make decisions regarding their care (paternalistic doctor-patient relationship). They do not think it proper either to ask the doctor questions concerning their illness or make suggestions as to the way they would like to be treated. An attempt at this is believed to bring about alienation. Also, they sometimes feel that there is not much time to talk about all their problems[17,19]. This attitude of patients cuts across board from the literate to the illiterate.

Nigeria has 3 levels of health care delivery system namely, primary, secondary and tertiary levels. Primary care is usually carried out at the primary and secondary levels. However, the General Outpatients' Clinic (GOP), University College Hospital (UCH) and outpatients' clinic in some other tertiary hospitals carry out this function too. Annually, the GOPD, UCH attends to over 15,000 patients who come from far and near the hospital. These patients are mostly in the low socio-economic class. Family physicians and residents undergoing training in Family Medicine man the clinic. In a day, a doctor attends to an average of 40 patients[19]. Generally, the patients are self-referred but few are referred from private clinics and primary health centres. The clinic attends to all patients without any bias for disease type, gender, age or social class on outpatient basis. Patients requiring in-patient treatment or specialist attention are referred appropriately. The same doctor attends to registered patients at every follow-up clinic visit as much as possible. The clinic also serves as training centre for undergraduate medical students.

In Nigeria, the GP/FM residency programme started two decades ago and the General Outpatient Clinic (GOPD) of the University College Hospital, Ibadan is one of the pioneer institutions. No formal or structured teaching in patient-centred model has been provided to residents. Also, the influence of Family Medicine training programme on the consultation style of General Practice/ Family Medicine physicians is not known. However, from past studies in Canada, positive changes in residents' consultation performance were reported after a 2-month tuition on patient-centred clinical method[20]. It is in the light of the aforementioned that a pilot study was conducted to determine:

- The style of consultation at the General Outpatients' Clinic, UCH
- The extent of patients' participation in the management of their illnesses
- Factors influencing the doctors' consultation style
- Patients' expectations of visit and whether these are being met or not.

Patients' expectations in this study follows that defined by Levenstein and colleagues, 1989[21] thus: "the individuals stated reasons for the visit... that often relate to a symptom or a concern, for which is anticipated an acknowledgement or a response from the physician".

MATERIALS AND METHODS

A systematic sample of every 4th adult patient presenting at the General Outpatients' Clinic every morning for a period of four months (April- July, 1999) were interviewed using a semi-structured questionnaire.

The questionnaire was designed using responses from Focus Group Discussion sessions. Information sought includes demographic characteristics and the number of visits in the preceding year. Also included were questions to determine if (i) doctors told patients or if patients sought information on nature of illness, plan of management, prognosis and prevention of illness (ii) patient's expectations of visit were met and (iii) the level of satisfaction with care received at the clinic. The questionnaire was pre-tested and informed verbal consent was obtained from each subject prior to administration. A trained research assistant conducted interviews at the end of consultation in the last consultation cubicle on the way out of the clinic. In order to minimise bias during consultation, the physicians were blinded to the details of the study and it was ensured that they did not get to see the questionnaire.

Analysis was done using EPI-INFO version 6. Descriptive statistics and analytic statistics such as Chi-squared test for proportion were used as appropriate.

RESULTS.

Two hundred and twelve patients were interviewed. The demographic characteristics of the respondents are as shown in Table 1. The mean±SD number of visits of the respondents in the year preceding the study was 4±3 times.

Table 1.: **Demographic Characteristics of Respondents.**

	Number	Percent
Age group (years)		
15-25	54	25.5
26-35	53	25.0
36-45	53	25.0
46-55	23	10.8
>55	29	13.7
Mean age = 37.6 ± 14.4 years		
Marital Status		
Never married	71	33.5
Married	128	60.4
Ever married	13	6.1
Level of education		
None	19	9.0
Primary	56	26.4
Secondary	80	37.7
Post-secondary	57	26.9
Occupation		
Housewife / unemployed	15	7.1
Self employed	49	23.1
Employee	22	10.3
Trading	89	42.0
Schooling	37	17.5
Sex		
Male	107	50.5
Female	105	49.5

Table 2: **Patients' response to questions on whether doctor provided information on their illness. (N=212)**

Did the doctor provide information on ...	Strongly agree n (%)	Agree n (%)	50/50 n (%)	Disagree n (%)	Strongly disagree n (%)
Nature of illness	32(15.1)	50(23.6)	16(7.5)	60(28.3)	54(25.5)
Plan of management	17(8.0)	18(8.5)	18(8.5)	109(51.4)	50(23.6)
Prevention of illness	62(29.2)	43(20.3)	13(6.1)	60(28.3)	34(16.1)
Prognosis of illness	5(2.4)	7(3.3)	18(8.5)	73(34.4)	109(51.4)

The response of subjects to whether the doctor provided information on nature of illness, plan of management, prognosis and prevention of illness are shown in Table 2. Out of this information, doctor provided information on prevention of illness most and only 10(5.7%) respondents agreed that the doctor provided information on prognosis of their illness. Significantly, those who had post secondary education were more likely to have been told the plan of management of their illness (p=0.02). No significant association was found with other information and demographic variables.

Table 3 shows the respondents' responses to whether they sought this information from their doctors. Information on nature of illness was sought mostly and this was significantly related to the level of education, p=0.004 (Table 4). Those who had secondary and post secondary education were more likely to ask. Also the percentage of those who ask their doctors to explain plan of management increased as the level of education increased, p=0.04 (Table 4). Significantly, respondents that have not been informed about the nature of their illness by the doctor were more likely to seek this information, p=0.04. No significant association was demonstrated between doctor providing information on plan of management, prognosis of illness and the patients seeking these information, p=0.56 and 0.73 respectively. Asking for information or the doctor providing information was not significantly related to (a) the number of visits, (b) years of visiting the clinic and (c) the consultation time. The mean±SD consultation time in this study was 10±5 minutes.

Table 3: **Patients' response to questions on seeking information on their illness. (N=210)**

Did you ask your doctor to explain ...	Yes n (%)	No n (%)
Nature of illness	72(34.3)	138(65.7)
Plan of management	45(21.4)	165(78.6)
Prognosis of illness	35(16.7)	175(83.3)

The reasons given by respondents for not seeking information on nature of illness, plan of management and prognosis of illness from their doctors are shown in Table 5. Many of the patients mentioned that they did not know they should ask and some mentioned that the information has already been provided during consultation. Few patients felt it was due to lack of time.

Only 23(10.8%) of the respondents had other things they would have liked to discuss with their doctors at the end of consultation. These things included other physical complaints such as pains, headache, abdominal discomfort mentioned by 8(34.8%) of the respondents; explanation on illness, the current treatment and prognosis mentioned by 8(34.8%); counselling on issues such as balanced diet, reproductive health and insomnia by 5(21.7%) and request for specific investigations by 2(8.7%) of the respondents.

Table 4: **Relationship between information sought by patients and level of education of patients (N=210).**

Level of education	Nature of illness		Plan of management		Prognosis of illness	
	Yes n (%)	No n (%)	Yes n (%)	No n (%)	Yes n (%)	No n (%)
Nil	1 (5.3)	18 (94.7)	0 (0.0)	19 (100)	0 (0.0)	19 (100)
Primary	11 (20.0)	44 (80.0)	9 (16.4)	46 (83.6)	8 (14.5)	47 (85.5)
Secondary	35 (77.8)	45 (22.2)	20 (25.0)	60 (75.0)	14 (17.3)	67 (82.7)
Post-secondary	25 (44.6)	31 (55.4)	16 (28.6)	40 (71.4)	13 (23.6)	42 (76.4)
Level of significance	$X^2 = 17.93$ p = 0.0004		$X^2 = 8.32$ p = 0.04		$X^2 = 5.92$ p = 0.12	

Table 5: **Patients' reasons for not seeking information on their illness.**

	Nature of illness (N=138)	Plan of management (N=165)	Prognosis of illness (N=174)
Reasons	**n (%)**	**n(%)**	**n(%)**
Doctor had already explained	54(39.1)	13(7.9)	13(7.5)
I did not know I should ask	34(24.6)	34(20.6)	70(40.2)
There was no time	11(8.0)	6(3.6)	5(2.9)
Patient should not ask such questions	-	9(5.5)	13(7.5)
I have no illness or illness is mild	11(8.0)	8(4.9)	35(20.1)
Drugs already prescribed	-	32(19.4)	-
Believe all is well	-	-	13(7.5)
Awaiting result of test or yet to do test	10(7.2)	5(3.0)	-
I know the diagnosis / drugs	2 (1.5)	2(1.2)	-
I have not been treated	-	14(8.5)	-
Doctor knows better	2 (1.5)	5(3.0)	-
Drug given is effective	-	35(21.2)	-
Doctor would have told me if I ought to know	-	-	10(5.7)
Others	14(10.1)	2(1.2)	15(8.6)

Table 6: **The distribution of patients' expectations according to whether they were met or not.**

Expectations Doctor ...	Met (N=194 n (%)	Not Met (N=18) n (%)
Gave drugs	124(63.9)	4(22.2)
Wrote test or review result of test	56(28.9)	4(22.2)
Examined me	44(22.7)	4(22.2)
Explained or counsel	31(16.0)	3(16.7)
Asked me questions	14(7.2)	-
Was polite and patient	12(6.2)	-
Listened to me	9(4.6)	-
Referred me to a specialist	4(2.1)	3(16.7)
Others	-	3(16.7)

Note: Multiple responses were given.

Table 7: Relationship between satisfaction, age and level of education (N=211).

Characteristics	Satisfaction Yes n (%)	No n %	Level of significance
Level of education			
Nil	14 (73.7)	5 (26.3)	
Primary	43 (76.8)	13 (23.2)	$X^2 = 18.19$
Secondary	49 (61.3)	31 (38.7)	p=0.0004
Post-secondary	22 (39.4)	34 (60.6)	
Age group (years)			
15-25	27 (50.9)	26 (49.1)	
26-35	27 (50.9)	26 (49.1)	$X^2 = 13.12$
36-45	32 (60.4)	21 (39.6)	p=0.01
46-55	18 (78.3)	5 (21.7)	
>55	24 (82.0)	5 (18.0)	

One hundred and ninety four (91.5%) mentioned that the expectations of their visit to the doctor were met. Table 6 shows the expectations met. Doctors prescribing drugs was mentioned mostly, (63.9%). The expectations that were not met included doctor - prescribing drugs, examining patient, and requesting for tests. Significantly, patients who asked their doctor about the plan of management of their illness and those satisfied with care provided in the clinic were more likely to have had their expectations met, p=0.02; p=0.05 respectively.

One hundred and twenty-eight (60.4%) of the patients were satisfied with care received at the clinic since visiting, 26 (12.3%) were neutral regarding this assessment while only 9(4.2%) were not satisfied. Forty-eight (22.7%) of the patients had not received any treatment and/or were visiting for the first time hence could not make any judgement in this regard. Significantly, the older patients (p=0.01) and those with little or no education (p=0.004) were more satisfied (Table 7). Being satisfied was not significantly associated with whether patient sought for or doctor provided information on nature of illness, plan of management and prognosis of illness, p>0.05.

DISCUSSION

Patients' responses to questions on the information provided by the doctors and that sought by the patients as well as the reasons for patients not seeking information from their doctor suggest that the consultation style of doctors in this practice is predominantly doctor-centred. Also, these factors in addition to the fact that patient did not consider emotion/general support as an expectation of their visit and that some still had other things they would have liked to discussed suggest that the doctor-patient interaction is inadequate despite the high level of satisfaction expressed.

The high level of patient satisfaction expressed in this study is of course not necessarily synonymous with a high standard of clinical care[22]. The patients may possibly have such attitude because they do not know of any better service. Hence, they are satisfied with what they know and appear to meet their perceived needs.

Patient-centred method focuses on four principal dimensions of patients experience, namely "their ideas about what is wrong with them; their feelings about their illness, especially their fears; the impact of their problems on functioning; and their expectations about what should be done[5]. From this study, limited information on and explanation of patients' illness was provided, whereas, this constituted an aspect of care sought mostly by the patients. Thus, suggesting that patients attending the GOP clinic actually desire explanation on their illness. However, since it is not the usual practice of the doctors to provide much information on patients' illness and the patients do not know they could seek such information, they do not regard this as an expectation of their visit. Prior knowledge and information from previous visits have been demonstrated to influence the expectation of patients[23].

As regards meeting expectations, a large proportion of the patients indicated that their expectations were met. Three components of expectations described by William et al., 1995[16] are (i) "explanation of the problem" which refers to request for explanation of the cause, course and prognosis of the problem (ii) "support" which comprises of request for general emotional support and (iii) "test and diagnosis" referring to request for medical test and diagnostic related information. In this study the most frequently mentioned expectation was, doctor prescribing drugs followed by doctor requesting for test and physically examining patients. This is contrary to findings from studies carried out in U.K[16,24] where the most frequently stated request was for "explanation of the problem" followed by "support" items. The least requested item being test and diagnostic related information. This shows that while in U.K medical treatment is generally of lower priority for general practice (GP) patients than the desire for information or support.

The contrary is the case in Nigeria. The difference in the expectations of GP patients in different settings may be a reflection of the consultation style and the extent to which information is provided to patients[25]. Also, cultural differences could account for this[17]. In the culture of the area of this study, emotional and experiences of illness are seldom discussed with doctors. These are dealt with more at home or spiritually.

From this study, it appears that the doctor-centred style of consultation is adequate from the patients' perspective. However, this may not be the most appropriate as evidenced by the gaps on interaction identified. The positive association between doctors' interaction with patients on plan of management, satisfaction with care and meeting patients' expectations found in this study and findings in past studies[16] corroborates this. Also, it suggests that consultation style that encourages patients' participation in the management of their illnesses and decision-making will be acceptable to the patients.

In the promotion of patient-centred model of consultation in this environment, many factors need to be considered. These include doctor-related and patient-related factors. The patient-related factors include: (i) the level of education of the patients and socio-economic status, which were demonstrated in this study to be a major factor determining the extent of interaction between doctor and patient. (ii) Ignorance. Patients need to be informed on their right to ask for specific information on their problems from their physicians and be encouraged to express their fears and worries. (iii) Culture. Cultural gaps have been demonstrated to exist between doctor and patients especially in deprived areas[17]. Culture has a lot of influence on attitude of patients. People with different cultural backgrounds may have their own ideas and beliefs about health care, both on the patient's and the doctor's side. This might affect the patient-doctor communication, for example in defining health problems and explaining causes and treatment[26]. Also, diagnostic confusion can occur particularly in the presence of other psychological and physical morbidity resulting in inadequate care[17]. In addition, it has been demonstrated that patients also differ in their preferences and interaction styles[1]. Patients who are younger, better educated and female are likely to value information and want to be actively involved in the management process. While, many older patients prefer a relationship that is doctor-centred, desiring little information and leaving decision making to their physicians[27]. Doctor-related factors include: (i) Personal characteristics[28] (ii) Training background (iii) Self- efficacy and confidence. Self-

efficacy is defined as "people's judgement of their capabilities to organise and execute courses of action required to attaining designated types of performance"[29]. This perceived belief about ability is important in initiating and executing a course of action such as changing consultation style. Adequate training and self-efficacy provide the confidence required to initiate such changes. (iv) Practice type and volume. Some practice types to some extent determine the style of consultation. In an emergency practice setting, doctor-centred style often predominates. Also, this occurs more in very busy practices. This is a factor to consider in this environment as many of the outpatients' clinics are very busy. (v) Professional autonomy[30].

This study was based on patients' perception. The doctors' perspective needs to be explored. Their attitude to the patient-centred model, knowledge, competence and efficacy in the practice of the style and their opinion on patients' readiness to accept the model need to be sought in future research.

Implications to Family Medicine

Ø Family Medicine training program in this setting has not been shown to impart knowledge on, or ensured practice of, the patient-centred method. Practitioners need to be sensitised and the teaching emphasized in the undergraduate and postgraduate curricula in Family Medicine.

Ø Factors militating against patient-centred model of care need to be determined.

Ø Interviewing of doctors to determine their level of awareness and willingness to practice the model would be beneficial.

CONCLUSION

The findings of this study confirm that the doctor-centred style of consultation is common in this environment. Although patient-centred style has been demonstrated to provide better outcome of care compared to doctor-centred style, the latter appears to have provided satisfaction and met the perceived needs of the patients in the studied practice. However, the limited interaction in terms of discussing plan of management and prognosis of illness and the inadequate general emotional support and explanation of patients' problem, suggest the need for the physicians to incorporate patient-centred style in their practice. There is a suggestion that the patients would welcome full explanations of their problems but their level of education and ignorance on the rights of the patient militates against this. The effect of these factors on good doctor-patient interaction can be reduced by informing patients about their rights and the importance of expressing their experience of illness to aid the physician in meeting their needs and providing quality care. Patients can be coached to ask questions and negotiate medical decisions with their physicians[31].

The results presented here represent the patients' perception, it is therefore important to know details of the actual discourse between the doctor and patient during consultation. This will provide more information on the extent to which patients are expressing their needs, participating in disease/illness management and decision-making as well as the physicians' response to these. Also the particular communication style that may lead to greater fulfilment of needs and higher satisfaction rates can be detected.

There is the need for a large and detailed study to involve many general practice settings in order to address fully the various components of patient-centred consultation model and be able to generalize findings. For evaluation of the consultation process, video and audio tape recording of the consultations would be advised.

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