The role of context in primary care

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SUMMARY. All doctor–patient interactions take place in a specific context—a particular physical, social or cultural setting. The important role of these contexts in doctor–patient communication, diagnosis and treatment is discussed, with reference to both hospital medicine and general practice.

Introduction

In recent years, especially since the work of Balint,[1] there has been increasing emphasis on the importance of doctor–patient communication in primary care and on analyses of the verbal[2] and non-verbal[3] aspects of the consultation. This emphasis has in turn led to the development by doctors of their interpersonal and interviewing skills.[4-8] In many centres these skills are taught to medical students and general practice trainees through the use of videotapes, tape-recordings and transcripts of clinical interviews. While this approach is valuable, it underplays the complementary, yet crucial role of the context in which these consultations took place. Social anthropological theories of human communication, and especially of the transmission of information by the context itself, can shed valuable light on the nature of doctor–patient interactions, on failures of diagnosis or treatment, and on intrinsic differences between hospital medicine and general practice.

Components of communication

Hall[9] pointed out that communication has other components besides speech, non-verbal behaviour or the written word. It is also dependent on certain characteristics of the individuals involved and on the situation in which communication takes place. These two components comprise the 'contexts' of communication and carry in them part of the total message transmitted. They also influence the perceptions of the receiver, and determine what he takes in, what he emphasizes and what he ignores. Any understanding of doctor–patient consultations, therefore, must take the role of context into account — particularly in the types of information exchange involved in diagnosis and treatment.

The three components of communication in medical practice are as follows.

Communication codes

This is the explicit medium used for the transmission of information — for example, speech, non-verbal cues (such as gestures, posture, or facial expressions), written or printed material, photographs or diagrams, tape-recordings or television pictures. Explicit communication codes that are commonly used between doctors include: written reports on patients, X-ray plates, electrocardiograph (ECG) strips, and the printed results of laboratory tests. However, as with the spoken word, a knowledge of their context and background, as well as of the code itself, is necessary to complete the 'message', and understand its true significance.

Internal contexts

In Hall's model[9] these refer to the 'pre-programmed responses' that both parties bring to the interaction. On the patients' side, the internal contexts include: their own experience (and that of friends or family) of similar illness in the past; experience of that particular doctor, surgery or hospital; attitudes towards doctors in general; and beliefs about the efficacy (and safety) of medical treatments, and about the origin and significance of the illness itself. Social, cultural and religious factors can all influence patients: as to whether they recognize certain symptoms as 'abnormal' in the first place;[10] how they present these symptoms to their doctors;[11] and how they answer questions such as 'What has happened?', 'Why has it happened?', and 'Why has it happened to me?'.[12] These lay 'explanatory models', which come into play when illness occurs, help to establish the aetiology, timing, pathophysiology, natural history, and appropriate treatment of the condition, and affect how patients interpret medical diagnosis and treatment.[13]

By contrast, the doctors' 'internal contexts' include: their medical training; previous experience of the patient or of the condition; special areas of interest; state of mind; and beliefs about the efficacy of certain treatments. In addition, both parties bring to the consultation their own prejudices, based on social, religious, political, ethnic or sexual criteria. For example, social class differences between doctor and patient can influence the type, and quantity, of information that each shares with the other.[14]

These pre-programmed responses may therefore determine what is said in the consultation, how it is said and how it is heard and interpreted.

External contexts

An external context is the physical or social setting in which communication takes place. Settings such as a patient's home, a general practitioner's surgery, an outpatients clinic or a hospital ward all convey messages which may aid (or retard) diagnosis and treatment. Doctors' consulting rooms usually signal information about their owner's education, scientific orientation, healing power, artistic tastes and social status relative to the patient. The 'props' that convey this information can include diplomas on the wall, shelves of medical textbooks, glass cases of scientific instruments, an examination couch and even the smell of disinfectant. Conversations that take place in such a room have a different quality from those in a sick patient's bedroom, even though the 'explicit code' used may be identical in both cases when recorded on tape or film.

Similarly, the impersonal atmosphere of a hospital ward, or outpatient clinic can remind patients of the transitory nature of their relationships with individual hospital doctors—a recollection which is reinforced by frequent changes in medical personnel. In either case, the setting of the consultation tells both participants something about their relationship, relative status and the types of information each can expect from the other.

Consultations as ritual

The social anthropological view of the medical consultation as a form of ritual—that is, as a specialized form of behaviour, separated in time and space from everyday life, and governed by implicit rules of conduct, (use of language, dress etc)—has been discussed elsewhere.[15] The internal contexts and the external contexts affect the ritual atmosphere. They create—or sustain—the patient's belief in the confidential nature of the consultation, in the healing power of the doctor and in the efficacy of his treatments. Therefore, in 'decoding' the full meaning of a medical ritual it is not enough to study only the explicit code—in the form, say, of a tape-recording of the interview—without taking context into account. As Leach[16] puts it, 'We must know a lot about the cultural context, the setting of the stage, before we can even begin to decode the message.'

High and low context communication

Hall[9] divided communication into two types: 'high context' communication—where most of the information is either in the physical context or internalized in the person, while very little is in the coded, explicit, transmitted part of the message—and 'low context' communication—in which the mass of information is vested in the explicit codes. Using this dichotomy, it is instructive to compare consultations in general practice and hospital medicine.

General practice

It can be argued that most of the communication in general practice consultations is more 'high context' than in hospital (especially outpatient) consultations. Where doctor and patient have known each other for some time, consultations are particularly rich in internal contexts. Less, therefore, needs to be actually said by each party for the same information to be transmitted, which compensates for the brief time in consultation.

General practitioners build up this internal context over the years, from many consultations with the patient and/or his family. Home visits also provide information about the social context (and perhaps the aetiology) of the patient's ill-health. Poverty, neglect, overcrowding, marital disharmony, even alcohol or drug abuse often reveal themselves in the course of a home visit. As Harris noted, 'In general practice it is easy to appreciate how a patient's illness and social circumstances are related, because the social circumstances are visible.'[17]

From the patient's perspective, the contexts of consultations include: a continuing relationship with the same general practitioner in the same surgery; experience of that general practitioner by the patient's family; and exposure to the general practitioner in a number of situations other than episodes of ill-health—for example, for antenatal care, contraceptive advice, cervical smears, immunizations, marital counselling and schooling problems. In anthropological terms, the general practitioner is not only a healer, but also a 'fictive relative', with rights of access to the patient's home and social context. General practitioners enhance their familiar image in serveral ways, by the fact that many of them live near their patients, locate their surgeries in the community, wear civilian clothes and take part in local activities. Thus communication in consultations becomes more 'high context' over time, with less reliance on the explicit code (such as lengthy explanations or written material). One shortcoming of high context communication however, is that once established it is difficult to alter, with the consequent danger of stereotyping patients—for example, 'Once an alcoholic,

always an alcoholic', or 'His family are all neurotic, so he must be too'.

Hospital medicine

By contrast, most hospital-based communication is 'low context' since each of the parties involved has little previous experience of the other. Clinical information is usually gathered mainly by history taking, physical examination and laboratory tests since the social, familial and economic contexts are invisible to the examiner. Furthermore, hospital outpatient consultations usually deal only with cases of ill-health and with a particular disease problem (in diabetics, cardiology or ear, nose and throat clinics). To the patient, hospital doctors appear very different from the general practitioner 'fictive relative': they do not usually live in the community or take part in local affairs; they have little experience of other members of the patient's family; they rarely do home visits; and they wear the standardized uniform of white coat, stethoscope, and name tag—symbols which suppress their individuality, while signalling their membership of the hospital medical community.[18]

Patients in a hospital ward, as Goffman[19] noted, are stripped of many of the props of their social, personal and religious identities. They are converted into numbered cases, in a uniform of pyjamas or bathrobe. In this setting, diagnosis rests heavily on the explicit code in which clinical information is couched—such as laboratory tests, radiographs, X-rays, ECGs and ultrasound scans. The contexts of experience, lay theories, family and socioeconomic circumstances are considered less relevant while the patient is still in the ward, though this might be assessed by social workers after his discharge.

According to Feinstein[20] there has been a shift (particularly in hospital-based medicine) in how clinical information about patients is gathered, from 'subjective' facts collected by history-taking and examination to more 'objective' facts collected by diagnostic technology. This represents, therefore, a shift from high context communication to low context communication. The shortcoming of this approach is that only a portion of the relevant information about a patient can be transmitted by the explicit code alone: for example, a set of diagnostic tests may be completely normal, but the patient still feels 'ill' as a result of stresses in the psychosocial context. This shortcoming also applies to (low context) medical check-ups which rely heavily on computerized questionnaires and laboratory tests to reach a diagnosis.

Context in treatment

Contexts—both internal and external—are essential to successful medical treatment. If both types are favourable then, as Balint noted,[1] the most powerful 'drug' that can be administered is the personality of the doctor himself. This is clearly seen in the case of the placebo effect.[21] It has also been described in psychotropic drug use, where the drug influences the patient's self-image and social relationships.[22,23] Claridge[24] pointed out that, to a variable degree, all drugs depend on a number of non-pharmacological factors for their action. These include the attributes of the drug itself (such as taste, colour and brand name), those of the recipient (such as experience, education, personality and sociocultural background), those of the prescriber (such as personality, professional status and air of authority), and the setting in which the prescribing takes place. Context, therefore, has an important role in how drugs actually work, and also whether they are ingested as prescribed. Stimson[25] found that the social context in which drugs are ingested can affect compliance: patients discuss their prescribed drugs with one another, and base their decision on whether and how to take them on their own experience and that of friends and family. This social context is especially important in view of the widespread habit of self-medication,[26] the exchange of drugs between patients[27] and the resort to non-medical sources of advice.[28]

Conclusions

Context is an important factor in diagnosis, treatment and doctor – patient communication. Hospital medicine and general practice provide different contexts for this communication, and these may influence the flow of information between doctor and patient. In understanding this phenomenon, the use of low context techniques—such as videotapes, tape-recordings and transcripts of consultations—to diagnose problems in the consultation may be insufficient. It is suggested that the role of context—internal and external—may be examined further, in order to 'decode' the full range of meaning in doctor – patient consultations.

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