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More than words: the role of communication in doctor-patient relationship in the management of a chronic lifestyle disease such as diabetes mellitus in South Africa.

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ABSTRACT

This study explores the role of the doctor-patient relationship in the management of diabetes in South Africa. The originality of this study lies in the unique manner in which the topic is approached from an explicit theoretical perspective as well as the context in which it is studied. It takes into account the biomedical aims of diabetes management as well as the socio-cultural context of the environment in which communication occurs.

Diabetes Mellitus is a chronic disease of lifestyle (CDL) and one of the most prevalent chronic diseases, both globally and within South Africa. In South Africa, although statistics vary across provinces and within different demographic and socio-economic groups, it is estimated that about 5.5% of the population over the age of 30 years, has diabetes. The disease has a significant impact on morbidity and mortality in the country, as well as on socio-economic development. The need to improve diabetes education and awareness, in addition to the need to address patient adherence to management plans and the prevention of complications, are vital in order to effectively manage this rising epidemic.

Current management of diabetes favours an individualised approach to risk reduction. This involves patient adherence to a negotiated (between doctor and patient) management plan, as well as modifications in the patient's lifestyle behaviours. International literature on adherence to the management plans of all CDLs suggests that there are many challenges. Furthermore, most studies have shown that there are shared common barriers inherent to all chronic diseases, where the complexity and chronicity of treatment are major factors in adherence. Despite the large number of studies and the identification of many influencing factors, few direct and replicable causal links to adherence have been found. Models of adherence from other chronic diseases in South Africa have highlighted the importance of patient motivation to change behaviour as being linked to their perceptions and beliefs, formed by the attitudes of those with whom they interact.

A review of the literature on health communication in various fields of medicine identifies the need for a firm perspective and justification of the methodology employed in the study. Various theoretical stances are examined but it is ultimately the interaction between doctor and patient within the socio-cultural context of the consultation that is seen to be most relevant. A social constructionist perspective is justified as the basis from which a disease such as diabetes, which requires complex therapeutic manipulation and lifestyle adaptations, can be studied.

A brief overview of medical education is also discussed as it pertains particularly to the teaching of communication skills and behaviours. This becomes relevant as it is medical training that ultimately informs clinical practice. In recent years, medical education has been called upon to be more socially relevant and incorporate a multitude of supporting competencies into training. These models are described and interrogated with relevance to the study aims.

The research was conducted in the province of KwaZulu-Natal (KZN) in South Africa within the diabetes clinics of two district level public health care institutions; one was located in the eThekwini metropolitan area (Durban) and the second at a rural site in northern KZN. These hospitals were purposively selected because of their contrasting locations, reflecting diverse socio-economic, ethnic, racial and language groups, thus providing a rich set of data. In keeping with the social constructionist perspective of the study, natural consultations at both sites were the primary source of data aimed to focus on the communication between doctor and patient. A total of 24 routine diabetes follow-up

consultations provided the data source. Consultations between patients and doctors were audio- and video-recorded and ethnographic observations were made by the researcher, who was an observer in all consultations. All consultations were transcribed, translated into English if necessary, and analysed using elements of conversational analysis transcription conventions. In order to understand the contextual environment of the study, ethnographic observations made by the researcher during the consultations and other site visits are also included in the data set. These observations are presented and contrasted with the experiences of doctors and patients as explored in interviews and focus group discussions at each site. Participants were asked to comment on their experience of their clinical care as well as the interaction with their doctor and their ability to manage their diabetes. By using multiple data sources and contrasting the findings, the study provides a robust framework from where communication in diabetes can be examined.

By analysing the data from a socio-constructionist viewpoint it became evident that the relationship between doctor and patient was a strong influential factor on disease management. Furthermore, the manner in which various communication behaviours were interpreted was seen to be able to transcend the superficial socio-cultural environment should other interpersonal factors mitigate the relationship. Not only was the process by which communication content delivered important, but also the underlying attitudes, past experiences and broader context of the consultation. If patients and doctors found themselves in the position to internalise the behaviours experienced in the consultation, their feelings, ideas and beliefs towards one another and diabetes was seen to change. Over time, it was suggested that these new attitudes would feedback either positively or negatively on future interactions.

This study also showed how cultural norms cannot be part of a checklist but that they are dynamic over time and are influenced by a multitude of factors, including past experiences and mutual respect, which need to be understood from an interactional and relational perspective. A new model that incorporates existing knowledge coupled with integration of clinical, scientific diabetes management and the art of communication is also described.

The findings from this study should be used to guide and inform clinical practice in order to improve health outcomes for those living with diabetes. By extension, they should also be used to inform medical education models where communication is being incorporated into clinical skills training. As was found by observing and analysing clinical practice behaviours for the purpose of this study, the author believes that by internalising experiences, students may be able to forms new ideas and attitudes towards communication which will enhance their clinical practice. The methods utilised in this study have also highlighted the fact that previous methods have not been sensitive enough to the human dynamics that occur in health communication in diabetes and future research should be developed with a strong theoretical perspective that guides an appropriate methodological approach.

This study depicts the pivotal role communication plays within each unique consultation and how the manner in which the interaction is perceived and interpreted will have a strong influence on behavioural decisions. However, it is not merely the words that are spoken or the language in which they are spoken but rather the internalisation and adaptation to the context that will ultimately will guide behavioural change.