Four Physician Communication Styles in Routine Japanese Outpatient Medical Encounters

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BACKGROUND: Few studies have explored how physicians approach medical encounters in Japan.

OBJECTIVE: This study examined how Japanese physicians conduct routine medical encounters in the context of outpatient care to patients with nonmalignant disorders.

DESIGN: Qualitative study using semi-structured interviews and direct observation.

SETTING: The outpatient department of a general hospital located in an urban area of Japan.

PARTICIPANTS: Physicians and nurses providing care and patients receiving care for nonmalignant disorders.

RESULTS: A 2-dimensional model was developed, with patient communication (how physician interacted with patients) along 1 axis, and nurse communication (how physicians collaborated with nursing staff) along the other axis. Four physician communication styles (individually adaptive, individually defined, collaboratively adaptive, and collaboratively defined) were identified as typical ways in which the Japanese physicians in the sample interacted with patients and nurses during routine medical encounters.

CONCLUSIONS: Results suggest the need for a *multiprovider-patient model of medical communication* among physician, nurse, and patient. Further research is needed to establish the applicability of this model to the communication styles of physicians in other countries.

KEY WORDS: communication; Japan; medical interview; outpatient care; physician-patient relationship; qualitative study.

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Contextual factors such as culture, language, gender relations, and health care systems influence physician communication styles.¹⁻⁴ Researchers have developed models of physician communication styles,⁵⁻⁷ but how well the current models of communication style apply to the clinical milieu of non-English-speaking countries is unknown. Ohtaki et al.³ found differences between medical encounters in the United States and Japan in length of interview time, proportion of time spent on various tasks, and use of back-channel responses. Rhunke et al.⁴ suggest that open discussion between physicians and patients in Japan is limited in comparison with the United States. The extant literature thus suggests that U.S.

and Japanese physician communication styles differ but exactly how remains unclear.

This study explored how physicians communicate with patients in Japan. Communication here denotes both verbal and nonverbal forms of communication. We used the following 3 functions to define a physician's communication style: (1) gathering data, (2) rapport building, and (3) providing information to the patient.⁸⁻¹⁰ Given that a physician's communication style is influenced by the setting, the patient's disease, and the physician's area of specialization^{7,11} and that Japanese physicians and patients tend to behave differently in cases of cancer (i.e., physicians often withhold information),¹²⁻¹⁵ we limited our focus to internists providing routine outpatient care to patients with nonmalignant disorders.

METHODOLOGY

Data Collection

This study was carried out in the outpatient department of a general hospital located in Kyoto, Japan. Direct observation of interaction among physicians, nurses, and patients in the examination room for entire visits served as the basis for the initial development and subsequent revision of interview questions (videotaping was not allowed at the study site). These observations, collected in the form of field notes and jottings, indicated that numerous physicians relied on their nurse to communicate with and collect information from the patient. For this reason, we conducted semi-structured interviews with physicians, nurses and the patients.

We recruited physicians and their nurses between the ages of 25 and 65 currently working in the outpatient department and with over 5 years of experience of providing outpatient care. We used convenience sampling to identify patients between the ages of 20 and 70 who had received outpatient care concurrent to this study for a nonmalignant disorder. Those who met the above criteria were sent an informed consent form with a letter explaining the study and the interview survey. All physicians ($n=21$) and nurses ($n=23$) agreed to participate in the study; 2 of the 19 patients asked to participate declined ($n=17$). Interviews with physicians and nurses were conducted in a private room of the hospital; those with patients were conducted at a place indicated by the patient. All observation and interviews were conducted by the first author who was not affiliated with the hospital, was fluent in Japanese, and was trained in semi-structured interviewing and direct observation.

Using an interview guide, the interviewer asked participants to describe medical encounters and methods for data

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Table 1. Participant Characteristics

Physicians	
Age	41.7 y (range 31 to 57)
Years in practice	15.4 y (range 5 to 33)
Sex	14 male, 4 female
Specialty	4 generalists, 5 cardiologists, 1 hematologist, 5 gastroenterologists, and 3 pulmonologists
Hold a PhD	8 physicians
Nurses	
Age	42.0 y (range 28 to 61)
Years in practice	11.2 y (range 5 to 28)
Sex	0 male, 14 female
Patients	
Age	39.9 y (range 24 to 64)
Sex	8 male, 9 female

gathering, rapport building, and providing information to the patient. Themes were identified from observation and a literature review using MEDLINE, PUBMED, and Japana Centra Revuo Medicina. Additional themes were identified during data analysis. Participants were encouraged to speak freely, to raise issues important to them, and to support their responses with examples. Each audiotaped interview was transcribed verbatim and assigned a unique identifier. Data collection continued until theoretical saturation was achieved and no new themes appeared.

Analysis

Data collected from observation and interviews were analyzed using the constant comparison method.¹⁶ Data collected from direct observation were used to delineate and cross-check respondent responses. Themes pertaining to how physicians gather data, build rapport, and provide information to the patient were first identified using open coding.^{8–10} Second, using axial coding, we (B.T.S. and A.A.) developed additional themes and compared them with one another. Third, using selective coding, B.T.S., S.Y., and A.A. developed a model by linking themes to a master theme and to each other. The analysis was conducted simultaneously with data collection, which allowed for further investigation and “mid-course corrections” in the data analysis while there was still an opportunity to explore and participate in the setting.¹⁶ A reflexive journal was also

maintained by the interviewer to reflect on and reformulate relationships between analytic findings and data collection.

Credibility

A central concern for rigor in qualitative research is evidentiary adequacy: sufficient time in the field and extensiveness of the body of evidence used as data.¹⁷ The trustworthiness of this research was ensured by methodological triangulation (each theme was triangulated across type of respondent (e.g., physician, nurse, patient) by cross-checking responses as well as with data collected by direct observation and member-checking interviews (discussing results with participants from whom the data were originally collected).

Ethics

This study was approved by the Ethics Committees of the Graduate School and Faculty of Medicine, University of Tokyo.

RESULTS

Study Participants

Theoretical saturation was achieved after 18 physician interviews, 14 nurse interviews, and 17 patient interviews. Participant characteristics are shown in Table 1. The mean interview duration was 59.8 minutes (range 48 to 73) for physician interviews, 30.8 minutes (range 24 to 41) for nurse interviews, and 21.2 minutes (range 14 to 28) for patient interviews, measured as content that followed introduction of the study and small talk. Physician communication styles included 2 components: how physicians interacted with their patients, and how they interacted with their nurse (Table 2). These 2 communication styles informed 4 typologies of how Japanese physicians communicate with patients and nurses during routine medical encounters.

Communication Styles with Patients

We identified a continuum of communication styles with patients, consisting of a “defined” pattern at 1 end of the spectrum and an “adaptive” pattern at the other.

Defined Style. Study physicians with a defined communication style maintained that style regardless of patient or con-

Table 2. Physician Communication Styles

Communication styles with patients	
A <i>defined</i> patient communication style is one in which	
The physician maintains the same communication style across patients of varying characteristics, e.g., gender, age, medical conditions	
The diagnosis emerges primarily from “objective” indicators such as the physical examination or laboratory findings rather than the patient-physician encounter	
An <i>adaptive</i> patient communication style is one in which	
The physician adopts a communication style appropriate to individual patient characteristics	
A functional patient-physician relationship is the focus of the clinical encounter	
Communication styles with nurses	
An <i>individual</i> style of communication with nurses in which the physician does not rely on the nurse to communicate with the patient. The two types of individual styles are	
One in which there is good rapport between patient and physician (consistent with the <i>individual adaptive</i> style)	
One in which the physician sees no benefit to collaboration (consistent with the <i>individual defined</i> style)	
A <i>collaborative</i> style of communication with nurses in which the physician relies on the nurse to assist in communicating with the patient. The motives for adopting the collaborative style range from	
The desire to improve patient-provider communication (consistent with the <i>collaboratively adaptive</i> style)	
The desire to avoid communicating with patients (consistent with the <i>collaboratively defined</i> style)	

text. Reasons for adhering to such a style most often included “the belief that clinical medicine is technical (e.g., defined by test results) and not humanistic (i.e., dependent upon physician-patient communication),” and “the belief that justice in medicine means to treat each patient identically.” Physicians with this style tended to view the clinical encounter as revealing or uncovering the diagnosis within the standard nosology rather than viewing knowledge of the patient’s disease as being constructed in the course of the clinical encounter. In cases of psychological problems, these physicians often suggested that the patient should seek counseling.

A defined style also denoted a distinct mode of providing information, stressing the importance of providing information to each patient in the same style.

I say what I need to say at least once. Whether the patient fully understands and accepts that is really up to him. I also provide the patient with enough information to avoid any legal trouble.

(Physician 11)

Or,

It doesn’t matter if the patient is in her teens or comes from a bad neighborhood; I speak with every patient the same, in polite Japanese. (Physician 6)

The defined style of communication often impeded building rapport with patients. Many of these physicians intentionally left out small talk. As a result, on many occasions, patients looked to the nurse for further explanation and information.

Adaptive Style. At the other end of the spectrum was an adaptive style of communication. Reasons cited for adopting this style most often included: “the belief that clinical medicine centers on a functional physician-patient relationship” and “the belief that justice in medicine means to treat each patient according to his or her needs.” Study physicians with an adaptive communication style were more likely to be female, to have had work experience outside of medicine, and were less likely to hold a PhD.

Physicians with an adaptive communication style focused on the individual patient in order to understand the disease; they often probed for psychosomatic or psychosocial factors related to the patient’s complaints.

To take the time to convince a patient ultimately leads to a relationship of trust. To just say what you need to say without compassion is . . . Well, it’s just like any other interpersonal relationship: It’s not so much what one is saying, but how one says it. (Physician 15)

Based upon the belief that each patient interprets a physician’s behavior differently, these physicians adapted their way of speech and behavior to what felt most appropriate for the particular encounter.

Even when saying the exact same thing, some patients may respond amenably, while others might react defensively. When first communicating with a patient, you really have to watch how a patient reacts to what you are saying and, depending on what seems most appropriate, alter your way of communicating. (Physician 7)

Physicians in this group paid attention to several factors including age (younger, same generation, older), disease type (chronic, infectious), intelligence (knowledge, ability to understand), motivation to change addictive behavior (inclined, disinclined), nonverbal behavior (facial expressions, body language), personality (introverted, extroverted), psychological state (depressed, anxious, content), sex (same, opposite), severity of chronic disease, and voice (tone, speed, volume).

Others claimed that adaptation was based on “an intuition”¹⁸ and not on calculation.

It’s important to pay attention not so much to what a patient says, but to how she says it—to the tone, speed, and volume of her voice, and to changes in facial expressions. . . . Obviously if a patient says, “I am worried,” her words are important, but it is more common for patients not to say this kind of thing. It is more important to pay attention to how a patient expresses herself than what she says. Physicians have to understand their patients by sensing what they feel. (Physician 9)

At times, physicians with an adaptive communication style drastically altered their own behavior and language in an attempt to facilitate patient adherence and behavior change.

Cirrhosis of the liver secondary to hepatitis C is quite common in Japan. . . . Among my patients, there are those who have little understanding of their disease, while others have a good understanding and show a great deal of concern. How I treat them is really case-by-case. With anxious patients, I communicate in a gentle manner when I suggest that they have to take a certain test. On the other hand, for patients who always protest, “I’m fine,” and continue to drink alcohol profusely, I usually try to be a bit more harsh. I guess you can say it depends on the person. (Physician 4)

In contrast to the defined style of communication, in which information was provided in formulaic fashion, physicians with an adaptive style did not always provide thorough explanations and instead provided information based on what seemed most appropriate during each encounter.

Communication Styles with Nurses

In our study, conducted at a general hospital in Japan where the norm was for nurses to be present in the examination room, the clinical encounter could not be analyzed simply as a binary communication between physician and patient. We identified a continuum of physician communication styles with nurses, with “individual” at one end and “collaborative” at the other.

Individual Style. An individual style of communication with nurses was common among physicians who rarely relied on their nurses to communicate with the patient. Reasons for this individual style included “the desire to do everything alone,” “there is no need to collaborate,” and “there is not enough time to collaborate.” As one physician explained,

With outpatient care, there is no time to work with the nurse in communicating with patients. I am too busy. (Physician 15)

Nurse interview data suggest 2 types of individual communication styles with nurses: physicians who worked individually “because patients feel comfortable speaking directly with the physician,” and those who worked individually “because they don’t listen to anybody.” Nurses considered the prior type to be “easy to work with.”

There are physicians who know how to deal with each patient differently as soon as they enter into the room. It’s hard to explain, but as soon as the physician sees the patient’s face, the conversation has already begun, often with a smile. There is little for me to do with such physicians. (Nurse 3)

Conversely, nurses regarded physicians who worked on their own and did not listen as “difficult to work with.”

Some physicians take the stance of “I’ll take care of everything” or “Just do as you are told.” (Nurse 8)

Study physicians with an individual communication style with nurses, and a defined patient communication style left many of their patients dissatisfied with their encounters. In

many of these cases, patients preferred to communicate with nurses who the physician had chosen not to involve.

Collaborative Style. Physicians with a collaborative communication style relied on their nurses to assist in communicating with the patient. These physicians were motivated “to improve patient-provider communication,” “to provide the best treatment possible,” or “to foster patient trust.” They were also more likely to have an adaptive communication style with patients.

Patients who seem uncomfortable telling me something will often feel fine sharing their feelings with the nurse. So, at times, I will ask my nurse to talk to them, and then later she will tell me what they said. (Physician 12)

Other physicians “entrusted patient communication to the nurse” as a means of minimizing communication with patients. Many of these physicians viewed patient communication as a “pain.” These physicians often adopted a defined communication style and had patients who preferred to speak with the nurse because their physicians seemed “uninterested,” “too busy,” or “arrogant.”

It's easier to talk to the nurse. I mean, think about it. I have had physicians who have spoken on the interphone right in front of me in the middle of my examination, saying, “Oh, I'll finish up here in just a few minutes,” or one who talked on the phone at length despite being in the middle of examining me. (Patient 3)

Patients often looked to the nurse as their “ambassador” to the physician. This was particularly common with physicians with a defined style of patient communication. For example, one patient explained,

The nurse serves as a mediator between the physician and me. When I don't really understand the doctor, she asks him to explain it again for me. The nurse acts on my behalf and helps create a congenial atmosphere. (Patient 6)

Nurses expected and enjoyed playing the role of “mediator between physician and patient.” When asked, “What do you consider to be your most important role in outpatient care?” all nurses answered either “to facilitate physician-patient communication,” or “to assist the patient in communicating with the physician.” This finding suggests that a collaborative style may be particularly important in providing effective care when physicians have difficulty communicating with patients.

A Typology of Physician Communication Styles

The 2 continuums of physician communication informed 4 physician communication styles—collaboratively adaptive, collaboratively defined, individually adaptive, and individually defined—which represent typical ways in which Japanese physicians communicate with patients and nurses.

Collaboratively Adaptive. Physicians with a collaboratively adaptive style looked to understand the patient. They utilized all available means of accomplishing this—direct communication with the patient and indirect communication via their nurse.

It is better to collect as much information as possible from the nurse. Only about half of what we say to a patient is understood, about 50/50. At best we probably understand only about half of what a patient says to us. (Physician 7)

Both nurses and patients positively evaluated physicians with a collaboratively adaptive style.

Collaboratively Defined. Physicians with a collaboratively defined style approached the medical interview as a formulaic

task and focused on the disease as an entity rather than a process that emerges from the encounter. These physicians largely relied on nurses to communicate and build a rapport with the patients.

Even if I try my hardest and do my best, if a nurse is rude, then patients will no longer confide in me and this facility. Patients will lose their trust in us and our facility. To provide effective treatment, it is imperative to emphasize teamwork and a team-approach to patient interaction. (Physician 10)

Physicians who worked collaboratively to avoid patient communication were evaluated poorly by their nurses. Although patients found it difficult to speak with physicians with a defined patient communication style—as long as the physician was willing to collaborate with the nurse, patients communicated with nurses and thus were still satisfied with their clinical encounters.

Individually Adaptive. Physicians with an individually adaptive style encouraged direct physician-patient communication. Even when the nurse had volunteered information regarding a patient, the physician would ask the nurse to call the patient back to speak with him or her directly.

Patients feel fine speaking directly with me. The only time that I could imagine it being easier for a patient to talk to my nurse is when the patient is female and feels more comfortable speaking to the nurse about her gynecological history or about the possibility of pregnancy. But I usually just sit down and try to communicate with her. (Physician 5)

While both nurses and patients highly evaluated physicians with an individually adaptive style, some nurses occasionally felt ignored and “taken for granted.”

Individually Defined. Physicians with an individually defined style worked with numerous patients longitudinally. These physicians, however, often ran into trouble.

I have my own way. There are plenty of patients who go along and are happy with me. Many patients just want a physician who will take charge and take responsibility for what he says. That's the physician-patient relationship. There is no need to use any special technique! How I practice medicine is a reflection of my personal character. But I guess I sometimes get a bad rep; I guess I sometimes come off as being scary. (Physician 13)

It was common for patients seeing a physician with an individually defined communication style to direct their utterances to nurses before, during, or after the medical examination. Yet, because these physicians preferred to work independently, patient information frequently failed to reach them. Both nurses and patients evaluated physicians with individually defined styles poorly.

DISCUSSION

The 4 physician communication styles identified in this study were derived from observation of medical practice and reflect the everyday conduct of medicine in the words of a small number of physicians, nurses, and patients. In this exploratory, theory-building study, we have not attempted to enumerate the relative frequency of the different styles. In comparing our findings with extant models, several differences are apparent. The most significant is that previous models posit that a physician's approach to medical interviewing is singularly dependent on how he or she interacts with the patient.^{19–21} At this study site, where the norm was for nurses to be present in the examination room, we found that physicians often rely on nurses to gather patient data, engender fiduciary relation-

ships, and provide information to patients. This is a noteworthy difference unaccounted for by previous models of primary care practice. These results suggest the need for a multi-provider-patient model of medical communication.

A team approach to patient encounters is common in the clinical milieu in many English-speaking countries. Physicians work closely with other health workers in many settings. Nursing staff and pharmacists try to be present during physician rounds on hospitalized patients. Mental health workers and case workers find value in being present at patient-physician encounters. Physicians work with interpreters when caring for non-English-speaking patients.²² In the teaching setting, trainees try to be present when consultants see their patients, and they often interpret findings and the decisions of senior staff for patients and families. As medical trainees gather data, build rapport, and provide information to the patients, they often find themselves acting as cultural brokers between the world of medicine and the lived experience of patients. As patient care is commonly delivered by interdisciplinary teams, we need a better understanding of communication strategies in such teams.²²

While the Japanese outpatient setting for this study represents a specific social and cultural milieu, the fact that the presence of nurses is so consistent also represents an opportunity to observe the behavior of physicians in the presence of other health professionals—and perhaps glean insights generalizable to other settings. In order to do so, we must ask what aspects of Japanese (medical) culture per se influence these interactions. The medical profession in Japan is dominated by men, and conversely, the nursing profession is dominated by women.²³ This is consistent with Japanese cultural conceptions of men as being suited for technical tasks, and women as being suited for affective tasks such as caring and nurturing. Indeed, we found that female physicians were more likely to have adaptive communication styles. Differences in communication style between female and male physicians have also been reported in the United States.^{24,25} As medical trainees gather data, build rapport, and provide information to the patients, they often find themselves acting as cultural brokers between the world of medicine and the lived experience of patients. As in many Western societies, the entry of more women into the medical profession in Japan will likely change the dynamic of patient-physician communication over time.

Other research has described a collaborative approach to patient care among Japanese health workers in the treatment of stroke patients.²⁶ The literature suggests that some patients in Japan prefer to communicate and participate in treatment decision making with their families.^{14,27,28} This study found the role of the family to be limited in outpatient care; it was called in only when a patient required hospitalization or had a malignant disorder.

Finally, another reflection of Japanese culture may be found in the fact that patients felt comfortable with physicians with poor patient communications skills as long as their nurses were effective mediators. This suggests that indirect forms of communication, in which physician and patient communicate with each other through their nurse, can be just as effective as direct forms as long as the physician works collaboratively with his or her nurse. Further study of the communication tasks of Japanese nurses from an explicit nursing perspective, and of medical students or residents from their

perspectives, may uncover additional ways to enhance their respective roles in improving patient satisfaction and outcomes.

This study has several limitations. First, the presence of an observer may have had an impact on participant behavior. Second, our sample of physicians was small, nonrepresentative, and largely male. Likewise, our sample of nurses was all female. No male nurses worked in outpatient care at the study site. However, our sample approximated the ratio of male to female physicians at the study site (10:3) and nationally (17:3).²⁹ Also, all gender differences reached theoretical saturation. Third, our study site was an urban private general hospital, and findings may differ at university hospitals, private offices, or at facilities in rural areas. Fourth, nurses' communication styles were not taken into account, highlighting the need for similar research focusing on nurses. Fifth, what one says in an interview may differ from what one does. We were fortunate to be able to triangulate our interview results with direct observation of clinical encounters, and nurse and patient interviews. We found that the study physicians generally act in a manner consistent with their interview responses. Finally, this study was limited to internists providing outpatient care to patients with nonmalignant disorders.

In conclusion, this study provided a model for understanding how Japanese physicians communicate with patients and nurses during medical interviews. We found that physicians and patients often relied on the nurse to mediate data gathering, rapport building, and information sharing. From our results, we conclude that a *multi-provider-patient model of medical communication* is necessary to fully understand how Japanese physicians communicate in primary care practice.

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