

Introducing a Partnership Doctor-Patient Communication Guide for Teachers in the Culturally Hierarchical Context of Indonesia

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ABSTRACT

Introduction: A guide for a partnership style of doctor-patient communication tailored to a Southeast Asian culture was previously developed and validated. We introduced the guide to clinical teachers in Indonesia through a participatory approach. Evaluation was based on teachers' demonstrated comprehension and ability to teach the guide. **Methods:** Three junior researchers invited twelve senior clinical teachers to learn about the guide by writing a chapter on doctor-patient communication using their clinical expertise, reflections on the guide, and the international literature. A participatory study comprised of two cycles (producing first and second drafts of the chapters) was conducted over 18 months with guidance from researchers and written feedback from an expert in communication skills. Qualitative content-analysis was used to assess the content of the submitted chapters. **Results:** The clinical teachers understood the concept of partnership style doctor-patient communication but demonstrated limited reflection on the Southeast Asian culture. Teachers had difficulty translating the guide into a written learning guide. However, teachers proposed an adapted guide with a simpler structure, tailored to their clinical environment characterized by high patient load and limited time for doctor-patient communications. **Discussion:** The adapted guide was proof of the teachers' willingness to learn about a partnership style of doctor-patient communications. However, the process of introducing the guide was hindered by the wide power distance between participants throughout all aspects of the study, including communication between senior teachers and more junior researchers.

Keywords: Doctor-patient communication, intercultural communication, participatory study

Introduction

Current guides for doctor-patient communication generally advocate a partnership style, with two-way information sharing. This is seen as preferable to the one-way, paternalistic interaction style in which the doctor dominates the encounter.

Most partnership guides are developed in Western Europe and North America^[1,2] and inevitably reflect Western cultural values. Therefore, they require modification before they can be implemented successfully in other cultures.^[3]

Southeast Asian culture is characterized by a hierarchical social structure. A large power distance between people of higher and lower social status is combined with a collective rather than an individual orientation. This results in less autonomy for individuals in making decisions, and for patients, strong involvement of their family in medical decisions. High value is placed on nonverbal expressions of etiquettes of politeness.^[4-7]

Recent studies in a Southeast Asian showed that doctors, patients, and medical students prefer a partnership style

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in doctor–patient communications. However, doctors in this region use mostly the one-way communication style in practice. Consequently, the current situation satisfies neither doctors nor patients.^[8-11]

As a step toward reducing the discrepancy between the desired and practiced communication styles, we developed and validated a doctor–patient communication guide specifically tailored to the Southeast Asian context.^[12] Guide A stresses the importance of a partnership communication style while accommodating key cultural characteristics: Hierarchical culture, collective decision making, nonverbal etiquette of politeness, and common use of traditional medicine [Table 1].^[12]

Three junior researchers (MC, APS, and MK) with approximately five years of teaching and clinical experience facilitated the introduction of Guide A to clinical teachers. They faced two cultural challenges related to the fact that the clinical teachers are more senior in their teaching and clinical experience. First, given the prevailing one-way communication style, the participatory approach recommended by the guide may be hard for the clinical teachers to understand.^[8,12] Second, the hierarchical power distance affects not only doctor–patient communication but also permeates all aspects of social life including relationships between teachers and students, seniors and juniors, parents and children.^[12-15] Communicating on an even footing is highly unusual within this study’s context. When someone of lower social status speaks to someone who is perceived to be higher in the social hierarchy, communication is expected to remain confined to rather superficial topics and not to include decision making.

In the Western world, effective introduction of a guide would require educational strategies entailing training, feedback, and reflection. It was evident that a formal course, whether in large or small groups, was unlikely to be effective in Southeast Asia due to the cultural and healthcare-related factors such as high patient load.^[8,16] As for an intervention in a large group, junior researchers do not carry enough status to be able to successfully introduce a new concept to a large audience higher in the academic hierarchy, and as for an intervention with small groups junior researchers can expect difficulty dealing with the seniors’ dominance in the discussion. Furthermore, inviting teachers to participate in simulations with role-play, feedback, and reflection would demand that they remain in class for longer than they would be willing. In Indonesia, clinical teachers are permitted to come and go during meetings due to the priority placed on patient care.^[8,12] It was therefore imperative to design an implementation strategy for the new guide taking account of the idiosyncrasies of this complex setting.

Participative activities are assumed to empower participants to gradually change their behavior toward better outcomes. Based on Prochaska’s “stage of change” model, Van Eekelen had

invited participants to take part in different activities based on their “willingness to learn”.^[17,18] In line with the participatory communication advocated in Guide A, we adopted a participative strategy to introduce Guide A.^[19-22] Knowing that a request to author a book chapter would make teachers feel respected, we invited the targeted teachers to write a chapter for a regional handbook on doctor–patient communications in Southeast Asia. We assumed that writing a chapter, combined with support from researchers explaining the details of the communication model, would stimulate participants to carefully study the doctor–patient communication guide yielding a more thorough comprehension and, subsequently, the ability to teach the new concept. We expected that writing would have a more extensive and pervasive impact than a workshop.

This study is an evaluation of the particular way of introducing partnership style of doctor–patient communication by inviting teachers’ participation in writing chapters. The principal objective was to learn how well clinical teachers can demonstrate their understanding of the partnership communication style and convey it in writing as it was introduced to them through a participative “chapter-writing” approach. We assessed the chapters that were written by participating clinical teachers for the following: (1) Do the chapters present the principles of a partnership rather than a paternalistic doctor–patient relationship? Partnership principles assessed were derived from our earlier studies and reflected mutual understanding characterized by “trust”, “equity”, and “two-way exchange of information”.^[8,12] (2) Do the chapters describe characteristics of doctor–patient communication that reflect the Southeast Asian culture like nonverbal politeness, the use of traditional medicine, and strong family involvement?^[12] (3) Do the chapters present learning guides for applying the principles in a particular clinical setting?

Methods

A participatory study was conducted over an 18-month period in a state medical school in Java, Indonesia [Figure 1]. This medical school was a leading institution in the development of communication skills training within PBL curricula.^[23] This study was part of series of studies titled: Developing a doctor–patient communication guideline tailored to Southeast Asian context, approved by the Commission of Ethics Faculty of Medicine Gadjah Mada University, November 2007.

We invited teachers to write a chapter on the partnership doctor–patient communication style tailored to the Southeast Asian context, asking them to refer to their clinical experiences, the literature and Guide A.^[12] During the writing process, we guided teachers through one-on-one discussions. Analysis of their written texts and their contributions to the discussions yielded information to answer the research questions.

Table 1: A guide of doctor-patient communication more appropriate for doctors working in Southeast Asian context

What are expected by Southeast Asian patients in communicating with their doctors?	Educational consequences for doctors to help Southeast Asian patients with a more informed and shared decision making during consultation			
	How to be helpful during consultation to Southeast Asian patients?	How to be aware of Southeast Asian context	Skills to be strengthened in Southeast Asian context	Contextual examples
Mutual understanding relationship Characterized by trust, equal level, and two-way exchange information	To be curious of patients' problem and showing willingness to help	The high patients load Allow only 5 minutes for communication with patients. Use effectively the first 30 seconds to establish rapport The familial relationship Try to place the doctors in a familial relationship with patients will make doctors closer to the patients - despite the wide hierarchical gaps between doctors and patients in the society Wide gaps of educational background Leads to specific life-style and daily routine for each individual patients	Nonverbal behavior of doctors to express equality, invites two-way conversation and promotes trust The doctor showing interest by her nonverbal behavior: The tone of voice posture and hand gestures is important in developing rapport with the patient (regarding the fact that Southeast Asian doctors may also be subtle in their expression of politeness) The greeting toward family member: "Mother, Father, Sister, and Brother". Doctors should support the patients as if the doctor is part their family Exploration skills Active listening, open questions, facilitation, paraphrasing, responding emotion, empathy	Expression of equality is a challenging skill in such paternalistic circumstances in Southeast Asian context: Examples Doctors in Southeast Asia usually greet their patients while they stand behind their desk. It would be helpful if the doctors greet the patients by moving toward the direction of where the patients come Especially with a child patient, doctors should kneel down so that they are at the child's height. This is rarely practiced in Southeast Asian context For female doctors who wear the veil, expression of nonverbal assistance using eye contact, the tone of voice and the move of the hands and body is essential Doctors may suggest insulin, but patients may not like it or is afraid of injection. Doctors may say: "Mother, you can use 'the tick-tick', no hurt!" (A doctor who explains about the latest technology of an insulin-syringe to the patient with maximum persuasive manner by putting himself as a family member of the patient) "Would you like to tell me about your history of allergy, because I think it will help the present symptoms become clearer? And please also tell me about yourself and your daily routines; it will help me to understand your illness
Cultural background appreciation on the closeness relationship between doctor and patient: The strong family support system	To be balanced when assessing the family's participation and still be aware of patients' preferences	Awareness of patients' hopes and expectations of informed and shared decision making: Individual decision making, Participation of family member, relatives, and community where patients' live, to the clinical decision making	Triadic conversations and Negotiation skills Uses gaps and silence to obtain patients' agreement (verbal/nonverbal)	A direct instruction face-to-face patient education process between a doctor and a patient might not be effective in Southeast Asia "Please reduce your salt-intake" A more effective example "How many spoonfuls of salt does your wife use during cooking, Father? May I ask your wife who usually cooks for you? (Uses gaps and silence to obtain agreement) Two, Mother? Okay, how about only half of spoon for your husband? To help his hypertension controllable"
The strong nonverbal behavior	To be aware of Southeast Asian patients' subtleness or nonverbal sense of politeness	Variation of nonverbal politeness Hesitations in asking for more information from the doctor or in telling more information to the doctor	Strengthening the very basics of observation skills and facilitation skills Maximize the use all appropriate senses including vision, hearing, touch, and smell. Check understanding and inviting discussion is important	A poor example "Please take this antibiotics three times a day until five days. Okay?" The Southeast Asian patients will likely to say answer: "Yes" only Doctors should be careful of nonverbal cues following the answer More effective example "What is the best time you think you can take the medicine three times a day?"
The use of traditional medicine	Invites the use of traditional medicine in harmony with modern medicine	Variation of the traditional medicine consumed From herbal medicine to anything logical to their context	Negotiation skills to invite discussion Acknowledge patients' effort to use any of traditional medicine, and then discuss the alternatives. Kindly communicate with the traditional healers or doctors whose formal education in traditional medicine (if any, in your situation)	A poor example "Please only use insulin; do not even try other medicines". More effective example "I will check the advantage in taking the herb you told me in the list of WHO or I will consult my colleague who studies traditional medicine. For the mean time, you can try, but just a small amount to not force your liver and to maintain the optimum use of insulin. How do you think of that?"

Source: Claramita M, Prabandari Y, Van Dalen J, Van der Vleuten CPM. A guideline for doctor-patient communication more appropriate in South East Asia. Southeast Asia Medical Education Journal. 2010; vol 4 no 2: 23-30

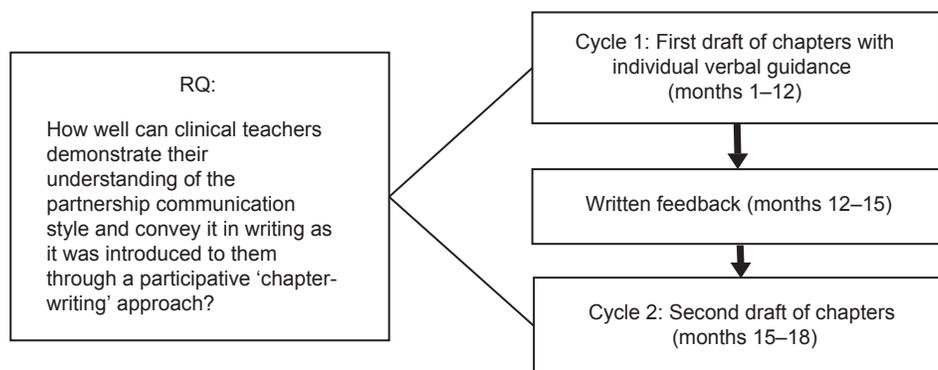


Figure 1: Two cycles of this participative study

Sampling

In the recruitment process, we invited 30 clinical teachers who are responsible for the competence-based medical curriculum, which includes the competency of “effective communication”,^[24] to a meeting to introduce Guide A.^[12] One of the authors (MC) introduced Guide A and its rationale during the meeting and requested feedback from the teachers. Two researchers (APS and MK) and an anthropologist rated the teachers’ feedback. Those who supported the idea of the partnership style and provided constructive feedback on Guide A were invited to write book chapters. Participants were thus selected in accordance with Van Eekelen’s approach,^[18] that is, “participants who show willingness to learn”. The selected teachers were from six clinical departments and were generally more senior (averaging more than 15 years of clinical teaching experience) than the 18 excluded teachers (who averaged less than 10 years of clinical teaching experience). All participants gave written consent prior to the study.

Study Design

In a participatory study, the “intervention” is designed together by the researchers and the participants in a sense to explore the “lessons learned” of an improvement action in an organization.^[20-22] Thus, we met with each of the selected teachers to discuss optimal ways to introduce the guide in the medical school. The teachers agreed that writing a book chapter on doctor–patient communication would promulgate the idea of a partnership communication style appropriate for the Southeast Asian culture. They were also proud that besides understanding the theories of doctor–patient communication, readers would also learn from their clinical expertise and teaching experience.

Data Collection

We collected two types of data. The first type was the drafts of the submitted chapters. The second type was notes from the discussions between the researchers and teachers during the writing process, which were guided three questions [Table 2]. Both chapters and discussions were in Indonesian, then chapters were translated and analyzed in English.

Data collection was conducted in two cycles. In the first cycle (months 1-12), each participant was requested to write one chapter on partnership doctor–patient communication style tailored to the Southeast Asian context referring to their clinical experiences, existing literature, and Guide A.^[12] For example, a pediatrician was asked to write a chapter about doctor–patient communication based on his particular clinical setting. This process was assisted by the researchers through discussions with each teacher. Researchers gathered information from these discussions relevant to the three research questions [Table 2]. We analyzed teachers’ initial drafts and provided feedback (months 12-15). Written feedback, also guided by these three questions, was given to each teacher in a formal meeting between researchers and teachers (month 15). The second cycle was the second draft submission and analysis (months 15-18).

Content Analysis

We used content-analysis^[25,26] using Guide A as a theoretical framework to explore teachers’ comprehension of the partnership style of communication and ability to teach it. MC, APS, and MK independently coded the chapters and interview notes using Guide A as a framework. Differences in coding process were discussed until consensus was reached, after six weeks of iterative process. JVD validated the constructs underlying the analysis. Recommendations in the English text and justification within the literature were judged by JVD

Table 2: The three questions for researcher-teachers discussion sessions to guide the chapter writing

Aim of the questions	The questions
To stimulate general comprehension of doctor-patient communication as indicated by research question 1	How would you like a doctor who works in your field of expertise to communicate with their patients?
To stimulate description of specific cultural characteristics of Southeast Asia as indicated by research question 2	Could you refer to guide A and other literature on partnership doctor-patient communication?
To stimulate teaching skills as indicated by research question 3	What would you advise your junior doctors, in order to help them use the desired communication style?

by comparing them to the most recent literature on doctor–patient communication. MC, APS, MK, and JVD discussed this content validity of the information in the draft and subsequent chapters in three “live” sessions and subsequent electronic discussion. If no or outdated references to justifying literature were provided in the draft chapters, this information was fed back to the authors and suggestions for more recent literature were given.

Results

Despite general comprehension of the principles of partnership doctor–patient communication, teachers still had difficulty reflecting it to the Southeast Asian culture and teaching the concept in their chapters.

Discussion sessions between researchers and teachers during the first draft writing.

Ten of twelve teachers were able to answer our questions about partnership doctor–patient communication:

Q: “How would you expect a doctor, working in your area of clinical expertise, to communicate with their patients?”

A: “I like doctors who have patience and understanding of people with disabilities.” (Teacher 4: Associate Professor, 20-year experience).

No teachers, however, were able to answer questions about how to transmit that knowledge to learners:

Q: “How would you advise doctors, working in your area of expertise, to show patience and understanding during their communication with patients?”

A: “Well...they should be patient and show understanding to the patients. Like, be patient...you know.” (Teacher 4)

Two teachers were able to describe teaching strategies to introduce two of four cultural characteristics listed in Guide A: the importance of acknowledging the common use of traditional medicine and an awareness of nonverbal signs typical of Southeast Asian patients.

“I would say to my patient, ‘If you would like to use any traditional medicine, please let me know, because I would like to learn and together we may observe the effectiveness of those herbs’. Usually patients become more open with me and it will be easier for me to collaborate with them”. (Teacher 2: Associate Professor, 20-year experience).

“We should be aware of the ill-child’s condition, from the mother’s nonverbal signs as well as her verbal information. As a pediatrician I would like to also know who helps the mother to take care of their sick children, because the doctor might have to invite discussion with the helper about administering a certain drug to the child.” (Teacher 3: Professor, 30-year experience).

While other cultural characteristics, Guide the importance of acknowledging the potential influence of the family in decision making and how to reduce the wide social distance between doctors and patients, were not mentioned.

Three teachers (Teacher 1, 2, and 3) proposed to adapt Guide A into a new guide that can be used for doctor–patient consultations that occur with limited time. In this paper, we call it Guide B – The Gajah Mada Guide of Doctor-Patient Communication in Southeast Asia: Greet-Invite-Discuss [Table 3]. The presentation of both guides are similar; however, Guide B fit its important components into a simpler structure based on various studies.^[1,2,12,27]

“Why don’t we adapt your Guide A into our guide named after our institution which offers the simplest structure so that it is easy to remember by everyone? Like one of those international guides, The Greet, Summarize and... especially considering the limited time for consultations due to high patient load.” (Teacher 1: Professor, 30-year experience)

The “Greet” component emphasizes different verbal and nonverbal skills to create closer relationship that can reduce strong socio-hierarchical gap between doctors and patients. According to Guide B, doctors should be aware of patients’ unspoken messages by actively paying attention to subtle nonverbal cues. The “Invite” component refers to gathering both psychosocial and biomedical information. Besides conducting a comprehensive history taking, doctors should carefully listen to patients’ preferences and invite family’s contribution as it is important in a strong communal culture. The “Discuss” component underlined the partnership style decision making of doctors and patients in which the decision is shared between them. Doctors should ensure that the wishes of doctors and family are not overriding patients’ autonomy.

Teachers’ first and second drafts of chapters

All first drafts were submitted within 12 months (range 3-12 months). The length of the chapters ranged between 5 and 26 pages. They presented adequate concepts of generic partnership doctor–patient communication, indicated by the use of phrases like “willingness to listen”, “encourage the patient to explore”, and “trust”.

“Good communication with the patient is the key for success in clinical problem, for establishing better relationship between doctor and patient and for output of health treatment. The success in communication requires an effective approach to the patient, willingness of the doctor to listen and encourage the patient to explore, in order to obtain information and patients’ trust.” (Chapter of Teacher 5: Associate Professor, 15-year experience).

Table 3: The Gajah Mada (UGM) guide of doctor-patient communication in Southeast Asia: Greet-invite-discuss

Structure ^(1,2,12,27)	General explanation of the structure ^(1,2)	Specific explanation of the structure ^(1,2)	Specific explanation of the structure specific to Southeast Asian setting ^(1,2)	Skills should be strengthened for Southeast Asian doctors ^(1,2)
Greet (initiating and maintaining a 'familial' relationship with patients)	Builds mutual relationship	Greets patient and shows interest in patient as an individual Uses words that show care and concern throughout the interview Observes patients' nonverbal cues Reflects emotion	All patients in Indonesia from high and low educational backgrounds are willing to use the principle of mutual understanding Equity Trust Two-way exchange of information	Greeting and maintaining the familial relationship with patients during consultations Avoid power distance inherent in hierarchical social system and superficial relationship Maximize nonverbal expression of willingness to help Facilitate patients' prominent nonverbal expression of politeness
Invite (exploratory skills)	Initiating conversation with patient	Encourages the patient to tell his/her story and does not interrupt Uses open question first then clarifies with closed question Uses additional questions effectively Responds to patients' feelings, hopes and expectations Exploring the main reason for visit and other reasons for visit Obtains agreement for today's agenda	Less educated patient needs more encouragement from the doctor	Examples of exploratory skills Listening and facilitation Responding to emotion The doctor should not make assumptions or be prejudiced in the beginning. Using more open questions in the beginning and closed questions for clarification later Using patient's answer about personal details as the start of further exploration of the patient's daily circumstances Awareness of the patient's culture and background (use of traditional medicine and nonverbal cues and atmosphere of politeness) Ability to invite family and community to take part in the consultation process Shared thinking
	Gathering information on patient's illness perception	Elicits what the meaning of the problem is for the patient and checks whether this is accurate. Responds to patient's hopes, feelings and expectations	The nonverbal atmosphere of politeness does not mean that patients do not think they may have serious problems. The use of traditional/alternative medicine cannot be eliminated and should be acknowledged The family or the communities where patients live contribute significantly to clinical decision making. This should not be ignored.	
Discuss (negotiation skills)	Shared information	Checks patient's understanding Checks patient's expectations	Awareness of hierarchical distance between doctor and patient, which may be a barrier to information sharing Maintaining a two-way exchange of information	Awareness of patient's background and culture Context-sensitive individual discussion Exploring patient's background and culture, daily life, and habits to initiate the discussion
	Shared decision making	Involves patient's family and community (if the patient agrees) in clinical decision making Checks all possibilities for care plan Checks all possibilities for compliance.	Explanation will be effective when the doctor discusses with patients and family, acknowledges the use of traditional medicine and checks whether patients are satisfied with the care plan	Awareness that in Southeast Asia, autonomy relies on patient's group rather than individual patients Ability to include family and community in the clinical decision making process without ignoring patient's consent Ability to include other health professions and local healthcare in the careplan (e.g. nutritionist, traditional healers, nurse, birth attendance, and community leaders) Negotiation with patients and the family/community: Awareness of patient's hopes and expectations verbal and nonverbal willingness to learn local wisdom of medicine (e.g. herbs or traditional medicine) Assisting in clinical decision making, e.g. using tools
	Closing the session	Checks other problems to be discussed Elicits the result of today's meeting and the next meeting-plan Says thank you	Continued awareness that patients who still hesitate (nonverbal cues) may have something they want to tell the doctor A written validated manual of information for certain diseases may be helpful in encouraging patients to ask questions	Observation skills for nonverbal cues: Responsiveness to patient's hesitation to ask questions or propose a different plan (mostly expressed in a very polite nonverbal manner)

Only two teachers mentioned “Two-way exchange of information during communication” or “inviting patients’ contribution to the communication and clinical decision making” in their chapters. These following quotations mentioned “patient-participation” and “clinical decision-making.”

“Making an adjustment in the style of communication between doctor and patient is a necessity that cannot be avoided due to the demand for a change in relationship between doctor–patient from that of being paternalistic in nature to becoming a relationship that is based on partnership. This requires doctors to involve the patients’ participation in deciding what kind of medical action is to be taken...” (Chapter of Teacher 6: Associate Professor, 15 years clinical teaching experience).

“To improve active participation from both husband and wife in the decision making, the doctor should give adequate attention to each of them”. (Chapter of Teacher 7: Associate Professor, 20-year experience).

Most chapters paraphrased the universal principles of partnership doctor–patient communication without making any specific reference to Southeast Asian cultural characteristics as presented in Guide A:

“Communication is the most important element in the doctor-patient relationship in which all stages that aimed at reaching mutual agreement are interrelated. An inaccurate information exploration process will lead to an inaccurate diagnosis”. (Chapter of T3).

No drafts mentioned specific behaviors to apply the suggested partnership principles of doctor–patient communication within the context of Southeast Asian culture. The specific behavior that had been described by Teachers 2 and 3 during the earlier discussions with researchers was not addressed in their chapters. Despite their enthusiasm, teachers did not use Guide A as a reference in their chapters. As a consequence, the written feedback given to teachers focused on the absence of specific references to the Southeast Asian context and the limited specificity with respect to the actual use of partnership style communication in this context. Only three drafts were resubmitted after three months and there was no discernible improvement in the rewritten chapters.

Discussion

Despite the enthusiasm for the partnership communication style, teachers did not provide practical guidance within their chapters to help learners implement this style. Some teachers could explain the techniques of communicating in the partnership style with Southeast Asian patients during discussions with the project’s researchers, but their chapters did not reflect this awareness.

The missing concepts within the first draft chapters and the lack of improvement in subsequent drafts may be explained as follows. First, busy clinical teachers have a huge variety of tasks to perform in our unstructured healthcare system. Thus, they need someone to help them translate their initiative into a teaching guide, such as a lecturer assistant or an educational support center. Second, teachers need systematic and constructive teaching guidance. This need could be met by a continuous and sustainable faculty development program.^[28] Clinical teachers in the context of this study are busy professionals who sit in the highest social hierarchical level and are unlikely to interact with “lower” partners. Therefore, such a program would need strong support from the highest administrative levels of the faculty.

The deficiencies of the chapters may also be attributable to insufficient depth of reflection on the guide and its implications for practice and teaching. The problem with “reflection” reminded us of the general phenomenon in the Southeast Asian culture in which people are accustomed to being ordered to do things and rarely encounter someone who listens to their ideas and concerns. In education, this is characterized by a one-way style of communicating in teaching and learning, although it should be noted that recently there has been a gradual trend toward more interaction. Starting from primary education, the transfer of information has been mostly one-way, with information being transmitted from the higher hierarchy (teachers) to the lower hierarchy (students) without any appeal to the receivers’ reflective skills or in-depth comprehension.^[12-14] The one-way style prevails in interpersonal communication in all areas of life with minimal exploration of the responses of others.^[4,6,12,14]

We acknowledge the predicament of the participating teachers, who were asked not only to embrace a partnership style of communication (asking for trust, equity, and two-way communication), which went against their common communication style, but also to explain this counterintuitive principle to others in a teaching guide.^[12] Moreover, communicating in writing is another cultural hurdle in Southeast Asia, where attention is focused on symbolic layers of meaning (e.g. shadow puppets show, god and goddess, myths, the character of the great king in poems, traditional drama, and traditional ceremonies) rather than on a clear and straightforward message conveyed in a tightly structured and grammatically correct text.^[4,13]

Central to a partnership communication style, informed and shared decision-making (the “Discuss” component in Guide B) seems to be a hard concept to grasp in this part of the world.^[11,12] Socio-cultural theories contend that children’s learning occurs in the interaction with their caregivers. Vigotsky, a Russian researcher who established a theory that learning occurs within individuals in the interaction between the individual and their

environment, coined the phrase “Guided participation” for this concept of learning.^[29] However, when the caregivers and the environment are hierarchical and, consequently, not conducive to two-way interaction, as in the context of this study, it seems unrealistic to expect people higher in the social hierarchy, like teachers and doctors, to fully comprehend let alone embrace a participatory style in communicating with people at lower hierarchical levels, as students and patients. We agree with Rogoff that “Guided participation” in a nonwestern context relies more on nonverbal (and one-way) than verbal (and two-way) communication.^[30] Therefore, inviting participation in learning in this context poses a complex problem.

Creating an atmosphere of equity in communication (“Greet” and “Invite” component in Guide B) is not only central to partnership doctor–patient communication but also to student-centered learning. It requires conviction and persistence to overcome barriers that are deeply ingrained in the culture. It will remain a challenge to stimulate teachers who are higher in the academic hierarchy to use a partnership style in communicating with colleagues, such as paying attention to the concerns of others and using questions to encourage them to tell their stories.

Limitations of the Study

The Greet–Invite–Discuss (Guide B) proposed by the teachers was established in a process dominated by the researchers. In a participative study, participants would ideally be involved in all aspects of the study.^[26] This researcher-dependence is a limitation that is frequently found in teacher training studies.^[31]

Another limitation is that we included only teachers who showed willingness to learn. It may be more interesting to see how teachers in the excluded group learn about partnership-style communication. The teachers in the excluded group received further training on the use of Guide B, but the results are not presented in this study.^[32]

It cannot be ignored that a “power” issue played a role in this study, as is the case in any participative study.^[33] It is promising that the teachers who showed willingness to learn were the more senior teachers than the ones in the excluded group. Their expertise had probably enhanced their awareness of the importance of proper doctor–patient interaction. We assumed that they would help to spread the concept of partnership communication style by enlisting the support of the highest academic hierarchy within the faculty. Nevertheless, the results of the book chapters were somewhat disappointing at this point.

At the end of the second participatory cycle the project did not stop. The revision of the chapters of the book is in progress. We hope that the drafts will mature in the future.

Recommendations

We wonder if collaborative learning like the participative approach proposed by Van Eekelen is feasible in the Southeast Asian context, because chances are slim that it will promote real collaboration and mutual support.^[18] On the contrary, lack of familiarity with autonomy and responsibility, seniority prevailing over other concerns, and nonverbal politeness all militate against open expression of real concerns.^[4,6] Before proceeding to implement a more student-centered educational approach in Southeast Asia, we recommend that individual self-directed learning, individual reflective thinking, and development of individual autonomy to express interest in learning should be reinforced. Furthermore, learning processes should accommodate individual needs and concerns.

This study also revealed a need for regular and proper communication skills training in medicine in postgraduate setting in Southeast Asia. We point to the lack of training in socio-behavioral sciences, including doctor–patient interaction, communication, and professionalism, in current undergraduate and postgraduate education programs.^[34]

Conclusion

The participation of senior teachers in this study is an encouraging sign of Southeast Asian doctors’ willingness to learn how to communicate better with patients despite the current prevalence of a one-way style of communication.

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