

Examining the Perceptions of Doctor-Patient Communication

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Abstract

This study explored physician-patient interaction by examining patients' perceptions of physician's communication skills in an effort to identify characteristics associated with a positive medical encounter. Patient satisfaction was examined in terms of its association with the patient's educational level, perception of the physician's intentions, and the patient's willingness to question the physician's credibility. The participants were four-hundred adults who responded to a random survey in north-central Alabama. Data were collected by telephone interviews using a Likert scale-type questionnaire. Results showed that 65% of the respondents believed most doctors make a good effort at communicating with their patients, but not all succeed. Additionally, results indicate that communication between patient and physician is less effective when the patient is of lower socioeconomic status ($p > 0.05$), as determined by education, income, or occupation.

Examining the Perceptions of Doctor-Patient Communication

Studying the communication transaction between doctors and patients is of great importance due to the numerous effects that effective communication may have on the healthcare of patients. Developing a relationship with one's physician is indispensable in the communication building process. Unfortunately, the doctor-patient relationship is very complex and as indicated, affected by numerous factors. The interaction often involves individuals of disparate educational and social positions, is usually non-voluntary and concerns issues of high importance that typically involve a strong emotional component (Chaitchik, Kreitler et al.,1992).

Although the use of sophisticated technology may be employed for medical diagnosis and treatment, inter-personal communication is the primary tool by which the physician and the patient exchange information, and the adequate and efficient exchange of information may even improve a patient's health "as quantifiably as many drugs" (Street, 1991; Travaline, Ruchinskis et al.,2005). In other words, effective communication between a patient and his or her doctor may improve that patient's condition just as much as the use of pharmacotherapy. Thus effective communication between a doctor and his or her patient is indispensable for positive medical encounters or outcomes and can be regarded an essential prerequisite for optimal medical care. For example, communication failures among physicians are a leading cause of medical errors (Frank, Lawless et al.,2005), while communication also plays a major role in a patients' efforts to cope with illness-related uncertainties (Hines 2001). The efficiency of the doctor-patient communication may also directly affect the medical encounter in numerous ways. How well a patient and his or her doctor correspond has an influence on the patients' behavior, well-being, adherence to treatment, recall and understanding of medical information, quality of life, level of anxiety, and outcome (Beckman & Frankel, 1984; Ciechanowski, Katon et al., 2001; DuPre, 2005; Kindler, Szirt et al., 2005).

Unfortunately, communication between the doctor and patient is not always optimal. Even when appropriate medical recommendations are made, therapy may fail unless the doctor-patient relationship allows open communication (Sheftell, 2002). Further, several studies indicate the physician-patient interaction has many deficiencies. For instance, some reports suggest that patients' expectations of medical encounters are not always fulfilled and that patients desire increased participation and information sharing (Suarez-Almazor. 2004). Further, results by others demonstrate significant gaps between the intended message and the message received in physician-patient communications (Gurmankin, Baron et al.,2004).

Identifying the factors that distinguishes positive communication interactions from negative ones may improve the doctor patient relationship and the medical outcome. However, to thoroughly reveal deficiencies in the process, all the mediators in the communication process need to be examined. Examining these major components (both the doctor and patient) as well as other external variables produced or affecting the communication (such as the clinical setting or the consultation environment, or even non-verbal communication), would be ideal in elucidating what constitutes positive health communication (i.e. a positive medical consultation). Nevertheless, most research focuses on the patient perspective, rather than both patient and physician perspective. The reason

for this tendency may be partly attributed to the fact that health care systems and physicians have been encouraged to focus on and consider the patient's perspective when delivering health care (Rao, Weinberger, et al.,2000).

As noted, patient satisfaction is a commonly studied variable influencing the quality of the medical encounter (Zandbelt, 2004). Street et al. (2005) concluded that most active participation behaviors are patient-initiated rather than prompted by the physician, and that the more active participants tend to be more educated, and more likely to be white. This suggests that the satisfaction of the encounter is mainly dependent on the patient, which is in disagreement with studies demonstrating that physician traits also influence patient satisfaction. For example, the gender of the doctor may affect satisfaction in that female physicians have more satisfied patients; or a physician's race may also affect the level of satisfaction if race concordance is involved (Linn, Cope, et al.,1984; Delgado, Lopez-Fernandez, et al.,1993; Cooper, Roter et al.,2003). Further, patients perceiving a lower degree of involvement in disease management have lower levels of satisfaction; that was also related to lower levels of school education and lack of familiarity with the physician (Franciosi, Pellegrini et al.,2004).

A patient's willingness to disclose and the likelihood of following advice may be determined by how the patient views his or her doctor or how that doctor communicates. For example, Epstein et al. (2005) suggested that physicians who exhibit more patient centeredness communication also generate higher levels of trust. Frank et al. (2000) reported that physicians' abilities to motivate patients to adopt healthy habits can be enhanced by physicians conveying their own personal healthy habits, and that doing so, improved physician credibility. Thus if a patient perceives the physician as "leading by example" it becomes easier to "do as said". In other words, physicians following their own advice have greater credibility in the public eye.

On the other hand, if physician perception is negative, the medical encounter may be in jeopardy. A recent study suggested that although doctors had been among the top most-respected group of professionals in previous years, this perception has decreased over the years (Romano, 2005). If this is the case, one can hypothesize that due to a decline in physician credibility, patients would be more willing to distrust and question doctor authority or credibility. Evaluation of this idea would be of significant interest.

Communicative style may also influence a person's credibility or effectiveness. If a particular message is poorly delivered, credibility will likely be negatively affected. As implied above, doctors' communicative style or approach, however, does not depend entirely on the doctor, as it is influenced by the way patients communicate and vice versa. Mainly two styles or approaches used by doctors have been described in health communication, the biomedical and the patient-centered approach. In medical schools, physicians have traditionally been taught the biomedical approach whereby physicians dominate the interaction, gather "data" from the patient (symptoms or diagnostic test results) to "fix" the problem or establish diagnosis. Using this approach, physicians typically control conversations and provide little opportunity for patients to ask questions or express concerns (Hines, 2001). Interestingly, Swenson et al. (2004) revealed that the majority of patients (69%) prefer patient centered physicians. The patient centered approach mainly functions in a collaborative fashion, where physicians act as consultants

and involve their patients and even family members in the decision-making process (Azoulay & Sprung, 2004). Briefly, physicians work closely with their patients to attempt solving a problem by “putting two heads together.” In the patient centered approach, the patient is also “empowered” or aided in becoming self-efficacious, which influences his or her outcome (Werner & Malterud, 2005).

However, the physician’s approach and how he or she delivers “the message” is not entirely dependent on his or her preferred style. In a recent study, Aita et al. examined patient-centered communication and determined that it is dependent on multiple factors including physician, patient, practice, and community characteristics, further, values and expectations also impact the effectiveness of patient centered care and communication (Aita, McIlvain et al., 2005). Patients from higher social classes communicate more actively and show more affective expressiveness, therefore eliciting more information from their doctor, who in turn, provides more of that information. Patients from lower social classes are often disadvantaged because of the doctor’s misperception of their desire and need for information and their lack of ability to take part in the care process. Therefore, perceptions that a physician may have, such as biases regarding inherent patient characteristics, can also affect how communication takes place and what approach a physician takes.

The purpose of the current study was to inquire on patients’ perceptions of communication skills of both patients and physicians. In addition, the patient’s perspective on the doctor’s intentions and his or her willingness to question the physician’s credibility were also examined. Such a study should be useful in the identification of variables and expectations that may not be overt in a doctor-patient relationship. The resulting information can lead to conscious efforts to improve the interaction, facilitating the potential to improve the medical encounter.

Method

Patient Characteristics. The participants were 400 residents of north-central Alabama who participated in a stratified random sample. Participants were surveyed via telephone interviews. The majority of the participants studied were between the ages of 45 and 65. The total number of subjects was 400. Approximately 62% of the subjects were female and 38% were male. Caucasian participants were represented more frequently than participants of racial or ethnic minorities.

Measurement. Patient perspective was measured using eight; 5-point Likert-like rating scales ranging from strongly agree to strongly disagree. The physician’s background characteristics such as age, gender, race, level of seniority, and experience were also identified.

Statistical Analyses. Statistical analyses were performed using descriptive statistics; ANOVA was performed to detect statistically significant differences among age groups. Linear regression analysis was conducted to determine the relationship between socioeconomic status or educational level and patient satisfaction.

Results

Unaddressed Issues. A large proportion of the participants felt they had unaddressed issues once they had left the doctor's office. When asked to determine the following statement, "When I leave my doctor's office, I typically feel like I have issues and concerns that have not been addressed," twenty-one percent (21%) of the participants agreed and thirteen percent (13%) strongly agreed. This results in 34% of the patients either strongly acknowledging or agreeing that their issues have not been addressed upon leaving the doctor's office. Sixty-five percent (65%) felt their issues had been addressed. Only 1% of those evaluated were unsure.

Doctor's communication skills. Participants were asked to determine how skillful their doctors were at communicating. Sixty-five percent (65%) of participants felt that most doctors were good communicators, with 39% agreeing and 26% strongly agreeing with this notion. The remaining participants either disagreed (21%) or strongly disagreed (14%) with this idea. No patients (0%) were uncertain.

When patients were stratified by age, those in the 35-49 year old age group were the most critical and were approximately equally divided between those patients who agreed and those who disagreed with the idea that doctors were good communicators. Forty-nine percent (49%) of patients agreed, where 37% agreed and 12% strongly agreed. Conversely, 51% disagreed; where 36% disagreed and 15% strongly disagreed.

Physician's intentions. As an indication of the trust variable, participants' perception of doctor's "good intentions" was examined in this study. Overall, the respondents gave doctors high marks for good intentions. Ninety-three percent (93%) of them agreed by marking either "agree" (23%) or "strongly agree" (70%) after reading the statement: "My doctor has my best interests at heart." Conversely, six percent (6%) of patients either disagreed (5%) or strongly disagreed (1%). One percent (1%) of those surveyed was unsure about their doctor's intentions.

Tendency to question doctor's credibility. To determine whether participants were willing to question their doctor, participants were asked to consider the following statement: "I am unlikely to express disagreement with my doctor." More than forty percent (40%) of participants were not willing to disagree, responding with either "agree" (21%) or "strongly agree" (20%). This comprised the majority of the participants. Conversely, two percent (2%) disagreed, whereas 27% strongly disagreed, totaling 29% of the participants who disagreed with the above remark. Approximately one-third of the participants were unsure whether they would question their doctor or express disagreement (30.3% indicated they were unsure about the likelihood of expressing disagreement with their doctor).

Both doctors and patients could do better. To determine whether participants felt that both patients and doctors could improve their communication skills through training, the researchers inquired on the benefits of training on both patients and doctors. Most people felt that both doctors and patients could benefit from more communication training. Ninety-six percent (96%) agreed that doctors could benefit from learning how to communicate more effectively with their patients. Specifically, 15% of participants agreed and 81% strongly agreed that doctors could benefit from communication training.

Only 3% disagreed with this statement, where 1% disagreed and 2% strongly disagreed, while 1% was unsure.

When participants were asked the same question about patients, most people felt that patients could also benefit from learning how to communicate more effectively with doctors. Ninety-six percent (96%) also agreed that patients could benefit from the same type of training, where 21% agreed and 75% strongly agreed. Those people disagreeing totaled 4%, with 2% disagreeing and 2% strongly disagreeing.

Summary of Results. Overall, most people had positive feelings about their trust in doctors, their confidence in their doctors' judgments (they questioned them little), and their communication with them; and although residents of the Birmingham Metro area believe most doctors make a good effort at communicating with their patients, the majority of the participants (81%) questioned their doctor's communication skills, agreeing that doctors could benefit from learning to communicate more effectively. Altogether, both doctors and patients felt that they could benefit from learning more about doctor-patient communication.

DISCUSSION

Increasing recognition of the complexity and difficulty of communication in patient care has led to a plethora of literature that, unfortunately, tends to be incomplete on any one topic. A coordinated, planned approach is required to facilitate the rapid development and implementation of evidence-based interventions in this area (Schofield & Butow, 2004). Both patient and physician perspective and characteristics need to be examined to properly identify good communication or positive encounters.

In the current study, the researchers investigated the communication skills of both patients and physicians. Additionally, the patient's perspective on the doctor's intentions and his or her willingness to question the physician's credibility were also examined. In an interaction involving multiple components, it is necessary to dissect these individual components and examine them individually, as has been accomplished here.

Patient Characteristics and Satisfaction. Patient satisfaction is a widely used indicator of the quality of inpatient and outpatient care that is usually taken into account, while physician's opinions are less often taken into account (Ong, de Haes et al., 1995; Zandbelt, Smets et al., 2004). Traditionally, health care systems and physicians have been encouraged to consider the patient's perspective when delivering health care (Rao, Weinberger et al., 2000). This is a result of the fact that patient characteristics can have a profound impact on the doctor-patient relationship (Roter & Hall, 1992). Specific patient characteristics often reported which may influence the doctor-patient interaction include the emotional state of the patient, educational level, ethnicity, and gender, with educational level being particularly relevant to the current study. Interestingly, those with the lowest educational level were the least satisfied in this particular study. We show that patient dissatisfaction was related to education level, with those without a high school education expressing the most frequent instances of dissatisfaction (57%). This is in agreement with reports showing that communication between the patient and physician is less effective when the patient is of lower socioeconomic status, as determined by occupation or insurance coverage (Ong, de Haes et al. 1995). Even topic specific communications can be altered by factors such as financial status (a measure of

socioeconomic status) as well as race; as evidence, Goldstein et al (2005) demonstrated this finding in 214 participants.

Perhaps, it can be suggested that those with the lowest educational level may not be expressing themselves as well, or making their expectations known like those with greater education, consequently, making it difficult to satisfy their expectations. It may also be the case that these uneducated persons are easily intimidated into silence due to their conscious awareness of a disproportionate level in education, implying connotations of subordinate relationships (Ely, Levinson, et al. 1995). Previous research has shown that those patients perceiving themselves as highly efficacious in obtaining medical information were most satisfied with the visit. It would appear logical that in these instances, educational level plays a role, where those more educated are able to obtain and understand medical information with greater facility than those lacking in educational resources. This is one explanation of the direct link between patient self-efficacy (which may be just another way of measuring educational level) and satisfaction. Taken collectively, these findings suggest that there is the risk of less effective communication between patients of lower socioeconomic status and their physicians. Further, physicians may not be conscious of this occurrence, warranting attention to the problem, which may be mitigated by a physician's awareness that less effective communication is taking place and consequently, modification of the communication to tailor the needs of less educated individuals.

Health Literacy. Even more problematic is the consideration that basic literacy or a high school education does not guarantee that a patient can understand and process health and medical information adequately. Yes, there is an association between low reading skills and poor health; unfortunately, when it comes to healthcare, basic reading skills may not suffice. Even though most adults read at an eight grade level, most health care materials are written at a 10th grade level or higher (Safeer & Keenan, 2005). Health literacy may require medical knowledge, medical terminology, and initiative. Consequently, patients with adequate literacy skills may not be health literate. Further, older patients are especially susceptible not only because up to 40% of the 60 to 80 years of age don't have a high school education (US Census Bureau, 2000), but because reading and comprehension abilities are influenced by cognition, vision and hearing status. Thus, inadequate health literacy can affect patients beyond those with poor reading skills (Dewalt & Pignone, 2005). Adding to this problem is the misconception that physicians often have believing their patients' literacy level is higher than it actually is (Safeer & Keenan, 2005). Physicians who are perceptive of their patient's true literacy skills can engage in behaviors to aid those that are lacking by using the spoken word to convey information as opposed to simply handing out pamphlets or literature on a health-related subject. This would be advantageous because verbal literacy is usually greater than written literacy (Dewalt & Pignone, 2005). The astute physician will recognize behaviors suggestive of inadequate health literacy skills (i.e. asking staff for help, forgetting their glasses, noncompliance, mimicking behavior, etc) and will tailor health information.

Nevertheless, educational level is just one variable to examine in the medical encounter, considering that patient satisfaction with communication skills is also strongly

related to personal characteristics, attitudes, expectations, and interestingly, perceived health of the patient -where healthier patients are more satisfied than those who are less healthy (Franciosi, Pellegrini et al.,2004; Hall, Feldstein et al.,1990).

Patients' trust in their health care providers is yet another variable that may also affect patient satisfaction and health outcome. Despite the potential importance of trust, there are few studies of its correlates which use objective measures of physician behavior (Fiscella, Meldrum et al.,2004). Our study revealed that 93% of the patients surveyed felt that their doctor had the best intentions at heart, while only a small percentage (7) either disagreed (6%) or were uncertain (1%). What, specifically, were some of the causes for this distrust could not be ascertained in this study. Trust development cannot be attributed to one sole cause and there are many strategies for enhancing trust within the healthcare setting. Nurses, for instance, have been shown to use humor to promote trusting relationships with their patients (Johnson, 2002). How humor would affect the trust that a patient has on a physician was not thoroughly evaluated in this or any other studies. Epstein et al. suggest that physicians who exhibit more patient centered communication also generate higher levels of trust (Epstein, Franks, et al., 2005). Future studies will examine the role of humor or patient centeredness in fostering trusting relationships between doctors and patients. It is also possible that there is a small percentage of patients who have difficulty forming a trusting relationship of any kind, and establishing a lasting bond of trust can be particularly difficult in these types of people. In addition, the public opinion of doctors in general has been shown to be on the decline (Romano, 2005); this finding may be due to occasional exposure by the media of unethical and fraudulent doctors and may result in a small number of patients having some reservations or distrust of their physician upon entering the relationship. Finally, it has been implied that with the inevitable advent of managed care, which turns medicine into a business comprised of consumers (patients) and businessmen (physicians), the trust factor of the relationship is affected (Bruhn, 2005). These notions could be explored at a latter time to fully understand the contribution that trust has in the physician-patient relationship.

Patient expectations. A positive association between overall satisfaction and meeting patients' expectations has been reported by Rao et al. (2000). However, patients and physicians often have different expectations and notions of the consultation process. Street suggests that it is difficult to know what a patient wants or expects of his or her physician because expectations vary with age, anxiety level, education, and how well the caregiver is known (Street 1990). For example, it is difficult for a physician to gage whether a patient wants to participate in the decision process, or would like large amounts of information, etc. Nevertheless, previous research has revealed certain generalizations. Rao et al. reviewed 23 studies, revealing that patients frequently expected information rather than specific physician actions (Rao, Weinberger, et al.). However, doctors often underestimate patients' desire for information, which leads to dissatisfaction due to unmet expectations. In support, one particular study found that 92% of cancer patients desire all information about their disease and much of their dissatisfaction stemmed from a lack of concordance between perceptions of patients and doctors (Blanchard, Labrecque, et al. 1988).

An expectation for extensive receipt of information is contrary to a finding suggesting that a significant proportion of patients prefer the traditional, biomedical communication style (Swenson, Buell, et al. 2004), a focused and “efficient” type of health communication model that only requires short questions and answers. Others have also shown that most patients prefer patient centeredness (Epstein, Franks, et al. 2005). While it may not be fully clear what approach the majority of patients prefer, it is clear that there are mixed preferences. Consequently, the physician should be intuitive in catering to the patient’s preferred style of care in order to optimize the satisfaction of the encounter.

Naturally, these general findings may conflict even when performed by the same researchers, at a later point in time. And in addition to satisfaction, age, familiarity with a clinician, and educational level, the amount of information physicians give to their patients may be influenced by multiple reasons such as the patient’s communicative styles, as suggested by Street et al. (where those who ask more questions and express more concerns, receive more information than those not doing so). Therefore, as a result of these variations, it is safe to propose that practicing physicians should strive for flexible approaches to physician-patient communication as well as attempting accurate determination of the patient’s communicative needs, in order to meet expectations and produce more frequent satisfaction. While future trends may gravitate towards patient-centeredness due to a variety of reasons, including a more self-efficacious population or that the patient centered approach has been associated with fewer diagnostic testing expenditures (Epstein, Franks et al.,2005), accommodating and tailoring the communication style may optimize the efficacy of medical encounters.

In this particular study, 34 % of the patients stated they left the office with certain issues that were unaddressed in their visit. It is possible that this 34% of individuals received unexpected or undesirable healthcare approaches (e.g. biomedical when they really desired patient-centeredness or vice versa). Perhaps the 34% of individuals having unmet expectations did not express their concerns clearly. A relevant study previously reported that 26% of the patients did not tell the doctor what concerned them the most (Korsch & Negrete, 1972), clearly pointing out to the mutual involvement issue. Alternatively, the physician may not have sensed the patient’s needs or may not have been open to responding, despite a patient’s request for information. In support, West demonstrated that physicians were less apt to answer questions than patients were (West, 1993). In any case, it becomes evident that communication is “a two-way street” requiring evaluation of not only patient characteristics but also that of the physician and his or her approach to healthcare.

Physician Authority. Forty one percent (41%) of those surveyed in this study indicated that they were unlikely to disagree with their doctors. It would be of interest to determine whether this response was associated with age. Traditionally, it is expected that physician’s authority is unquestionable and subordinates (such as patients) should comply with that authority (du Pre, 1999). It is well-known that doctors may deem people around them as subordinates (Laserman, 1981). As a result, doctors may be especially sensitive to questions and comments that seem to challenge their authority. Further, doctors may resent patients who question their judgment as they may feel inadequate. Our results

demonstrate that a large number of patients (41%) show consistency with these notions. Another possibility for why such a large number of patients may not conceive disagreeing with their doctors may be that these people could be subjected to the idea that the doctor patient relationship has been traditionally a paternalistic one, where the doctor directs and makes decisions about the treatment (Ong, de Haes et al.,1995). Within the last decade, however, there has been a shift from this type of treatment paradigm to a more collaborative one where patients are highly engaged (patient centeredness). Physicians who see their relationship with patients as a partnership or a collaboration, have more satisfied patients compared to those who have a more authoritarian relationship (Anderson & Zimmerman 1993). Despite a shift towards patient centeredness, our data suggest that patients are still reluctant to question the physician authority. It should be noted that inquiries on the physician's treatment approach (whether patient centered or physician centered) would aid in determining if those patients unwilling to question their physician were being seen by one who does not engage his or her patients.

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