CHARACTERISTICS OF COMMUNICATION OF DOCTORS DURING CONSULTATION

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ABSTRACT

Communication skills are important tools for improving the quality of care. The present piece of work is designed to examine whether different types of communication style have an effect on the patient's adherence to treatment, satisfaction with recovery and satisfaction with present health status. The sample comprised of 60 Allopathic Doctors of both government and private hospitals and three patients of each doctor, i.e. a total of 180 patients. The patient centered communication is collaborative communication which involve the two way exchange process. The present findings showed attentive listening skills, empathy, and use of open-ended questions are some examples of skillful communication, had been observed by researcher.

Keywords: Doctor-centered communication, Patient-centered communication, adherence, recovery, satisfaction.

INTRODUCTION

Effective doctor-patient communication is a central clinical function in building a therapeutic doctor-patient relationship, which is the heart of medicine. People always regret about the dissatisfaction with communication with their doctors. Poor doctor-patient communication is a major problem in the management and care of diseases and this incoherent communication is stem from both sides. The list of the sources of miscommunication is long. Patients' most frequent complaints are- that physicians do not listen to their concerns, cares about their problems, or provides enough information about their treatment (Hickson, et. al, 1994). The standard medical model of the consultation follows history taking, examination, diagnosis and treatment and is lacking in what is happening in the process of communication between physician and patient. The primary objective of any doctor-patient communication is to facilitate patient's health and medical care. A doctor's communication and interpersonal skills encompasses the ability to collect information in order to facilitate accurate diagnosis, counsel appropriately, give therapeutic instructions, and establish caring relationships with patients (Hall, et. al., 2002; Bredart, Bouleuc & Dolbeault, 2005). Appropriate communication integrates both patient and doctor-centered approaches (Bredart, Bouleuc, & Dolbeault, 2005).

The three main goals of doctor-patient communication are creating a good interpersonal relationship, facilitating exchange of information, and including patients in decision making (Platt & Keating, 2007; Bredart, Bouleuc, & Dolbeault, 2005; Arora, 2003; Lee et. al., 2002). Research evidences indicated that good communication with patients leads to greater patient satisfaction (Johansson, Oleni & Fridlund, 2002), improved adherence to medical regimens (Sanson-Fisher, et. al., 1989) and good response to treatment of chronic illness. Furthermore, studies have also documented that lack of communication with patients increases healthcare costs and gives patients additional fear, unnecessary pain and anxiety about therapy and their

diseases. Seven pathways through which communication can lead to better health include increased access to care, greater patient knowledge and shared understanding, higher quality medical decisions, enhanced therapeutic alliances, increased social support, patient agency and empowerment, and better management of emotions (Street, Makoul, Arora & Epstein, 2009). The present piece of work is intended to examine whether different types of communication styles have an impact on doctor-patient relationship and patients' satisfaction, adherence and recovery.

A *doctor-centered consultation* is based on the assumption that the doctor is the expert and the patient merely required to cooperate. This follows the biomedical model of health and illness. Doctors adopting this approach focus on the physical aspects of the patients' disease and employ tightly controlled interviewing methods to elicit the necessary medical information. Doctors often pursue a 'doctor-centered', closed approach to information gathering that discourages patients from telling their story (Stewart, et. al, 2003). A patient-centered model of communication has been advocated in preference to a doctor-centered model. These doctors adopt a much less controlling style and encourage and facilitate their patients to participate in the consultation. Thus foster a relationship of 'mutuality'. Patient-centered communication is more than simply being courteous and honest with one's patients. It is multidimensional. This type of communication seeks to increase health care providers' understanding of patients' individual needs, perspectives, and values; to give patients the information they need to participate in their care; and to build trust and understanding between physicians and patients. Stewart's (2001) definition of patient-centeredness has five components: exploring patient's concerns and need for information; having an integrated understanding of the patient's world; finding common ground on diagnosis and management; enhancing prevention and health promotion; and enhancing the continuing relationship between patient and doctor. A substantial amount of evidence demonstrates that patient-centered communication has a positive impact on important outcomes, including patient satisfaction, adherence to recommended treatment, and self-management of chronic disease (Epstein & Street, 2007; Epstein et. al., 2005). In addition, recent researches provide compelling evidence that such communication improves clinical outcomes in the management of diabetes, hypertension, and cancer (Epstein & Street, 2007; Mead & Bower, 2002; Bredart, Bouleuc, & Dolbeault, 2005).

In general, patients appeared to be more satisfied after an encounter with a more-facilitating and a less-inhibiting physician, but these associations diminished when controlling for background characteristics. Patient-centered communication includes four communication domains: the patient's perspective, the psychosocial context, shared understanding, and sharing power and responsibility. The ultimate objective of any doctor-patient communication is to provide best medical care and improve the health of the patient. Therefore, the basic communication skills in isolation are insufficient to create and sustain a successful therapeutic doctor-patient relationship, which consists of shared perceptions and feelings regarding the nature of the problem, goals of treatment, and psychosocial support (Duffy, et. al., 2004; Arora, 2003). Rotter and Hall (1992) argue for a patient-centered relationship that accepts the patient's unique knowledge as just as important to outcome as the doctor's scientific knowledge. They conclude, "*The medical visit is truly a meeting between experts*".

Objective of the Study

Some studies have documented that faulty communication in doctor-patient relationship increase the health care cost and give patients' additional fear, unnecessary pain, and anxiety. Therefore, the objective of the present endeavor is twofold. First is to identify the

characteristics of doctor and patients communication in doctor-patient interaction. Second is to identify the causes of faulty communication in doctor-patient interaction.

Since every behavior, every communication takes place in certain socio cultural context. The hospital setting in which communication takes place also exerts impact in many ways. Therefore, the exploratory question of the investigation is to identify the setting related indicators which enhances or hinders the effectiveness of communication.

METHOD

Research Design

In the first step the private and government hospitals of Gorakhpur district head quarter were selected. Two government run hospitals namely, District hospital and B.R.D. Medical College were selected and five major private hospitals were identified. The research is designed in three parts. The first part deals with taking consent of the doctors to participate in the study, and also ascertaining their permission to allow the researcher to sit into their consultation chamber for a week and filling up the questionnaire related to their communication. The second part is related to talking to OPD patients of these doctors, outside of their chamber after the consultation would be over. The third part is actually the observation of consultation of doctors for a week. Initially, more than 75 doctors had given their consent to participate in the study. Some of them had participated in the first part but not continued for the further phases.

Sample: The final sample comprised of 60 Doctors and their 180 patients. The detailed description of both doctors and patients had been given below:

Doctors: All the 60 doctors were trained in Allopathic medicinal system. Amongst them 21 doctors were serving in government setup and 39 doctors were practicing in private hospitals. The average age of the doctors was 42 years. The average years in the medical profession was 10 years.

Patients: The patients were randomly contacted in the outpatient department (OPDS) of the hospitals and clinics. Three patients of each doctor were contacted. The age range of the patients was 18-75 years. The average waiting time for patients was 15 minutes. The patients were afflicted with one or other chronic health condition but not hospitalized. They need to visit their doctor for more than once. On an average, each patient who had participated in the study had at their least second or third visit to the present doctor.

Measures: The consultation of each doctor was observed for an hour daily for a week by researcher herself and was audio taped.

Methods for measuring physicians' communication skills include direct observation of communication behavior, interviews with patients or surveys about their health care experiences, and actual outcome measures. Keeping in mind that each method provides insights into a different aspect of patient-centered care, the researcher had taken care of both verbal and nonverbal aspects of communication. Doctor-centeredness' was defined in terms of a high number of closed questions, particularly in the earlier stages of the consultations, and a low number of explicit inquiries by the doctor into whether the patient had understood the information given. In contrast patient-centeredness was defined in terms of a high number of open-ended questions and a high number of explicit inquiries into the patient's understanding. The observation schedule incorporates some pertinent points like facial expressions of both

doctor and patients, sitting posture; privacy maintained etc. besides the recording of verbatim communication held on, during the observation period.

Procedure: First of all the investigator had contacted many doctors and explained the purpose of the research and had taken their consent to observe their consultation and requested to fill up questionnaires. Rapport had been established to both patients and doctors. The patients were contacted at the OPDS.

RESULTS

Interpretation of Observation Data & Personal Reflections of Researcher

The researcher had deciphered the doctor-patient communication and characteristics shown in table 1 based on the observation made by the researcher. These were related to both verbal and non verbal behavior of the doctors. The nonverbal behavior of the doctors using doctor-centered communications was like always in hurry, awkward, use harsh words, avoid eye contacts etc. However, the doctors using patient-centered communication style were soft spoken, sit comfortably, maintained eye contacts, not seemed in hurry, had given enough time to patients, etc. Similarly, the verbal behavior of the two was also different as the doctor-centered communication styles incorporates the behaviors like, interrupting the patients, shouting on patients, didn't explain the treatment properly, used more technical words, not tried to understand patients concerns etc., whereas the patient-centered communication style preferred to hear patients' conversation with tolerance, steady minded, specially attentive to illiterate patients, explained treatment, tests, medicines etc. to patients or caregiver and consol the patients and didn't frighten them.

Table 1: Characteristics of doctors of two Communication Styles as observed by the Researcher

Sl. No.	Doctor-centered Communication Style	Patient-centered Communication Style
1.	Talking with others while investigation	Special attention on illiterate patients
2.	Interrupting patients' conversation	Listen Patient's complaints with patience
3.	Talking on mobile	Don't interrupt the patients
4.	Shaking, unstable sitting	Stable sitting
5.	Recommend too many medicines	Devote sufficient time to patients
6.	Recommend too many tests	Use the local language to explain treatment regimen
7.	Always seems to be in hurry	Easy and cool minded
8.	If patients ask something or repeat something, then irritates and shout	Soft Spoken
9.	Not easily comprehendible	Use respective words like chichi, dadi, didi, baba etc. to address patients
10.	Intimidate patients	Maintain eye contacts
11.	Seems awkward and lazy	Smile frequently
12.	Exaggerate about the illness and frighten patients	Remove or discard many of the misconceptions and myths of the patients
13.	Not maintain the privacy	Explain the need for tests

14.	Use more technical words	Clearly explain the patients' about does and don'ts
15.	Failing to give feedback	Leaning towards patients

Table 2: Responses of the Patient regarding Doctor's Communication after consultation

Sl. No.	Doctor-centered Communication Style	Patient-centered Communication Style
1.	Don't hear all my concerns	Hear all my concerns and complaints patiently
2.	Too long waiting goes in vain	Doctor is cheerful
3.	Patients have fear to say something	Recommend for diagnostic tests only when essential
4.	Both time and fees are wasted	Refers to patholdogy labs which take reasonable fees
5.	Shout and irritate	Don't recommend too many medicines
6.	Harsh towards staff also	Summarize and repeat the treatment process to know whether the patient has understood
7.	I'll not come next time	Spoke softly
8.	Not concerned about their needs and concerns	Asked about social barriers in following treatment

After consultation the researcher had talked to every patient about their experiences and satisfaction level. Table 2 showed the patients of doctor-centered communication were not very satisfied with consultation in general; some of them were thinking to change the doctor even though some patients' had said that the medicines were suited to them. They said the *doctor is not ready to listen to my concerns; therefore, I will not come next time.*

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Table 3: Characteristics of the Setting (Consultation Room) of two different Communication Styles

Sl. No.	Doctor-centered Communication Style	Patient-centered Communication Style
1.	Other patients in the chamber and the doctor talks to them simultaneously	Privacy maintained and the private questions asked in soft tone
2.	BUMS doctors for help	Staff is also soft spoken
3.	Friends of doctor in the chamber	Staff also take care of patients' problems
4.	Staff not cooperative	Crowd management was proper
5.	Not so clean	Neat and clean

Table 3 presented the characteristics of hospital setting as perceived by patients of twp different communication style doctors. It was found that patients of doctor centered communication styles stated that hospital setting in general was not very conducive and positive; however, the same was not true for patient centered communication style.

DISCUSSION

Communication is a complex process involving a multitude of variables that affects physician-patient interactions. The dialogue between an individual and his or her physician can significantly affect health care outcomes (Institute of Medicine, 2004). In fact, an essential component of quality medical care is the physician-patient relationship (Gallagher & Levinson, 2004). Although most of the research on doctor-patient communication was held on the hospitalized patients, little research has been done in patients attending out-patient departments regarding communication. The present investigation has been carried out on the patients attending the outpatient departments (OPDs).

Aspects of Effective Consultation

Patients recognize the centrality of communication to the doctor-patient relationship, although they have little control over the communication skills of their physicians. In the present investigation the patients' had not stated much about the use of jargon filled language as such but in doctor centered communication style it had been reflected from the patients responses as well as from the observation from the researcher. However, the other studies have suggested that doctors use jargon filled language to stop the patients asking too many questions. The use of over complex language can create a barrier to effective doctor-patient communication. Language difference can pose a major barrier to communication. In the patient-centered communication the physicians had been using the local dialect to understand the patients' concern, beliefs and values etc. (Table 1 & 2). Without effective use of language, the physician-patient relationship is seriously impaired (Woloshin, et al., 1995).

Doctors frequently interrupt patients, often preventing patients from disclosing all of their health problems. Studies have found physician interruption times vary from 18 seconds (Beckman & Frankel, 1984) to 23.1 seconds (Marvel, et. al, 1999; Rhoades et. al., 2001). In the present investigation it was observed that the physicians with doctor-centered communication style were interrupting the patients' conversation with more than one way. They start talking to someone else present in the consultation room or start responding to mobile calls or even directly intervene when the patient is showing his/her concerns, fears and anxieties (Table 1). To the investigators' surprise many a times patients did not focus on the communication but instead commented on enduring characteristics such as trust, expertise, liking, and respect provided by the doctors (Table 1 & 2).

When communication is ineffective, patients are not only in danger of being unnecessarily distressed, but they may also doubt doctor's competence (Brock, & Allen, 2000) and it is known that most complaints against doctors focus on communication rather than clinical shortcomings (Meryn, 1997). Patients construe meaning from what their doctors actually say, but they also derive meaning from the way in which the message is conveyed that is, the meta-messages communicated through voice tone, facial expression, and body cues. As in patient centered communication style it was emerged that the doctor had maintained eye contact, smiled frequently, showed respect and used soft, mild tone and voice (Table 1). Simple gestures, such as leaning forward, have been found to help the patients relax, as well as, improve satisfaction and recall.

Patient load is one of the several factors which is likely to reduce the effective tie in doctor-patient relationship, at least on the physician's side. A doctor-patient relationship will probably be less satisfying to both physician and patient if it is one of a thousand that the physician must

maintain, rather than one of a hundred. Research also showed that length of wait for an appointment, and at appointments, are themselves major sources of patient dissatisfaction and barriers to utilization. However, the present investigation had found that the patient load has not been a constraint in effective doctor-patient communication. All the doctors who had taken part in the present investigation were very busy and overburdened with patient load. Nevertheless, many of them managed to understand patients' concerns, worries and communicate within the parameters of effective and patient-centered communication style. Perhaps, it signifies that patient overload is not an excuse of misbehaving and miscommunication to the patient. One of the major causes of faculty communication as ascertained by physicians in the present study was that the patients generally exaggerate their symptoms or may be their idea of which symptoms are important ay not correspond to the practitioners' knowledge. Therefore, they have to extract the relevant information from the patient, which office is very time consuming and frustrating as the other patients are waiting outside and time stropped schedule often is not to spend too much on a single patient.

In general, physicians give sparse information to their patients, with most patients wanting their doctors to provide more information (Beisecker & Beisecker, 1990). Between ¼ and 1/3 of patients reported receiving less information than desired, particularly in relation to the risks and benefits of medical treatments (Ford, Schofield & Hope, 2003). Nine out of 10 patients do not receive good explanations on proposed treatments or tests (Braddock, et. al, 2000). Physicians' behaviors in closure of the interview included clarifying the plan (75%); orientating the patient to next steps of the visit (56%); providing information and counseling to the patient about the therapeutic regime (41%) and checking for patient understanding (34%) (White et. al., 1994).

Communication also influences patient decision making. Patients, who have in inaccurate understanding of their illness, may make decisions based on unrealistic assumptions (Week, et.al., 1998). Communication skills which include responding appropriately to patient cues, eliciting information, responding empathetically and creating a doctor-patient alliance can be effectively taught. In the patient-centered consultation group the patients were found satisfied with the explanation given by physician about the recommendation of tests and even the patients had shown their satisfaction with the concerns expressed by the physicians regarding going to the pathology lab which are less expensive, as well as, provide quality testing (Table 1.2). Additionally, it was observed by researcher that patient-centered interviewing had allowed the physician to elicit important psychosocial information, including beliefs about etiology and treatment, important spiritual, family, work and financial information, all of which can affect the choice of treatment, patient education, and treatment adherence. Instrumental communicative behavior by patient centered physicians has been seen in the present investigation which includes speech that provides information to the patient, discussing tests and procedures, and explaining reasons for treatment options. Apart from instrumental communicative behavior, these physicians also showed affective behavior which include introducing self to patient, providing verbal encouragement and support, non-verbal communication such as touching the patient, and engaging in small talk (Hall, Roter & Katz, 1987). Communication skills involve both style and content. Attentive listening skills, empathy, and use of open-ended questions are some examples of skillful communication, had been observed by researcher. In the case of patient-physician verbal communication during a clinical encounter, which is the focus of this report, effective communication means that both physician and patient understand the content of each other's spoken communication, feel that they are understood by the other, articulate all thoughts related to the encounter, leaving no

questions and thoughts unexpressed, feel that sufficient time is available for speaking and listening and feel overall satisfaction with the communication.

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