Particularities of Doctor-Patient Communication, Assessed in 6 Romanian Ambulatory Practices

Gáspárik Andrea Ildikó[1], Ábrám Z[2], Albert-Lőrincz Enikő[3], Török Kinga[1]

[1] University of Medicine and Pharmacy, Tîrgu Mureș, Romania
[2] Department of Hygiene, University of Medicine and Pharmacy, Tîrgu Mureș, Romania
[3] Social Work Department, Babeș-Bolyai University, Cluj Napoca, Romania

Introduction: The way doctors collect data, explore patient concerns, discuss and explain the diagnosis will influence the patients' comfort, satisfaction, attitude and adherence to medical treatment and even their health outcomes. Our **aim** is to assess structure and patterns of doctor-patient communication in Romanian ambulatory practices.
Materials and methods: We included in our analysis 69 doctor-patient meetings in 6 outpatient clinics (five different specialities, state and private practice), taking place in 3 Romanian cities. Data collection was carried out by non-participatory observation of the time-structure of visits (anamnesis, examination, explanation of diagnosis, treatment-, and lifestyle recommendation, administrative works), proportion of talks and reports belonging to the parts, number of questions asked by each part, and non-verbal behaviour, helping the patient feel comfortable during the visit.
Results: The average length of the meetings was 7.41 minutes. Discussions are less representative in Romanian medical practice. Patients were let to speak about their problems 7 seconds, without interruptions. Administrative duties (registering, writing) took 27% of the time, 42% was represented by examination (physical and instrumental). Explaining diagnosis and treatment accounted for 5% and 9% respectively. There were two doctors (of six) showing different gestures to help the patient feel comfortable during the consultation. Doctors talked 3 times more than patients and had in average 6 questions compared to less than one question, formulated by the patients. Lifestyle recommendations were observed in 2 cases (of the 69).
Conclusions: Although the international literature describes a shift in the doctor's and patient's attitude from the traditional paternalistic model towards a partnership, where patients assume a more active role in their healing process, our data suggest a doctor-patient relationship strongly dominated by doctors, a passive behaviour of patients, actually a free-will subordination to the doctor's high-status (no or few questions, no willingness to participate in decision making).

Keywords: doctor-patient communication, satisfaction, compliance, outpatient clinic, status

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Introduction

The basic element of healthcare is communication between doctors and patients. The way doctors collect data, explore patient concerns, discuss and explain the diagnosis will influence the patient's attitude during the whole process of care. It will also influence the patient's comfort and satisfaction in this relation, their adherence to medical treatment and even their health outcomes.

The 3 main goals of current doctor-patient communication are creating a good interpersonal relationship, facilitating exchange of information, and including patients in decision making [1].

Better doctor patient communication was shown to be associated with better emotional and physical health, higher symptom resolution, and more efficient control of chronic diseases, that included better blood pressure, blood glucose and pain control [2,3].

It has been shown that the doctor's attitude toward their patients, their ability to elicit and respect the patients' concerns, the provision of appropriate information, the demonstration of empathy and the development of patient trust are the key determinants of good compliance with medical treatment in patients [3,4].

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 [1].

Finally, interviews with patients who have filed malpractice suits against their physicians often cite poor communication and lack of empathy as a factor in pursuing legal action [5].

Numerous scientific studies help us better understand doctor-patient relationships, reasons of increasing public dissatisfaction with the medical profession [6], its participation in the medical encounter. Studies also demonstrate communication differences in various cultures [7,8].

There are few data showing characteristics of this relationship in Romanian practice [9].

We tried to evaluate in this study the particularities of doctor-patient interaction in Romanian ambulatory practices, using qualitative and quantitative methods.

Material and Method

Data collection / Participants

The transversal analysis included 69 consultations (12, 16, 8, 8, 15, 10) in 6 practices from Tîrgu Mures, Sighișoara and Băile Felix (Mureș County Clinical Hospital, County Emergency Clinical Hospital of Tîrgu Mureș and Clinical Hospital of Recuperation from Băile Felix), in the fields of general internal medicine, cardiology, physiotherapy (2), ophtalmology and neurosurgery, four of them belonging

Correspondence to Ildikó Gáspárik
Email: gasparik@gasparik.ro

to public hospitals and two private practices. The average age of the patients was 60 (59, 65, 54, 58, 56, 71). Doctors were 45 years old on average. Data collection occured between September 2011 and February 2012.

Analysis

We examined time-fractions spent in each phase of the meeting between doctor and patient. Events and objects of discussions were categorised and were observed to be similar in the 5 encounters (patient-report/anamnesis, physical examination, investigations — EKG, echo, biometry, refractometry etc. —, administration works (registering data, writing of medical letter, prescriptions, referral etc.), detailing diagnosis and treatment recommendations.

We also recorded speech-, and behaviour related parameters, like the number of questions formulated by each part, the way doctor assures patient's comfort, whether the doctor introduced himself on the first visit, whether the patient had the opportunity to take a seat or to take his coat down, to ask questions or clear up problems. The observer's impression about the satisfaction degree of the patient was also registered. We initially tried to get a feedback directly from the patient (satisfaction questionnaire), immediately after leaving the doctor's office. Unfortunately the results were not relevant, as the patients had serious blocks in giving sincere opinions.

Results

The average time of the encounters was 7.41 minutes. Patients were let — at the beginning — to speak about their complaints 7 seconds on average before being interrupted, when doctors took control over the discussion, addressing targeted questions. Report and anamnesis lasted 1.26 minutes – 17 % (see the distribution of each phase in each practice in Table I), being partially overlapped by the physical examination and exploration phase. Examination (including echo, EKG refractometry, biometry and other special investigations) represented 42%. Paper work and administration took 1–5 minutes (27%), reaching 40% if we exlude the two cases (registered with 0 sec) where nurses did it. Detailing and explaining the diagnosis accounted for 5% (32 seconds), while treatment/lifestyle recommendations were 40 seconds long (9%), as shown in Figure 1.

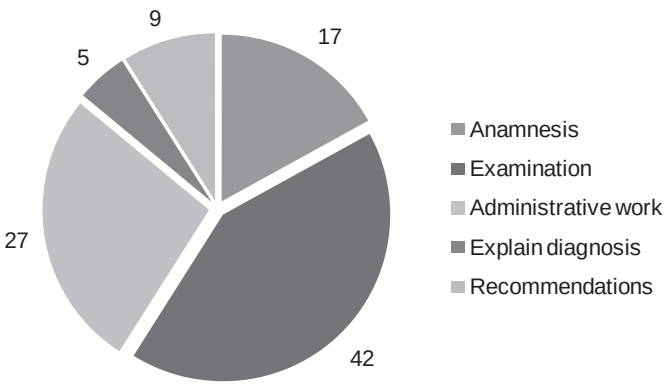

Fig. 1. Distribution of sequences, summarised, expressed in percentage

Recommendations regarding lifestyle (nutrition, exercise) were observed in 2 of the 69 encounters, social talk was insignificant.

Patients talked less than 1 minute, doctors talked 3 times more (including questions, detailing diagnosis and treatment, measured also during the examination period). Doctors formulated on average 6 questions, patients having in the same time less than one question to the doctor.

One doctor out of six introduced himself to the patients (in two out of six occasions the doctor stood up, when a new patient entered the office). In 4 offices patients had the chance to sit down during discussions. In one of them, patients had to report on foot, without having an eye contact with the doctor, being on his side or behind him.

Observers' evaluations

About half of the patients received adequate information to understand their illness in a manner and language adapted to their understanding.

Time spent listening to the patient and explaining the diagnosis was similar for the 2 doctors who had a soothing effect on patients and succeded to have a personalised contact with them, and for those who failed.

At the beginning of the day doctors were focused and concentrated on patients. After 7–9 encounters, time spent with a patient, as well as the length of explanations decreased, listening skills worsened and the number of questions asked by the doctors were fewer. After 2 hours of work, the doctors got impatient, irritated and the patients' satisfaction was observed to decrease.

Discussions

The physician-patient relationship is central in translating efficacy into effectiveness [10,11].

However, dialogues between doctors and their patients often focus on the control of the illness (e.g., discussions of blood glucose levels) and long-term complications, excluding other relevant topics [12,14–16]. Compared to the international literature [4,7], discussions are less representative in Romanian medical practice. Patients talk less about their problems and do not initiate deeper conversations.

Taking control at the beginning of the patient's report, doctors coach discussions based on the information they

Table I. Proportion of time (in percentage) in each phase of the encounters in the 6 practices

Doctor	Report/ anamnesis	Examination	Paperwork	Explaining diagnosis	Explain treatment
1	10	54	26	4	6
2	20	32	30	4	14
3	9	31	50	2	8
4	5	76	0	9	10
5	46	35	0	10	9
6	13	25	55	1	6

found out in the first seconds. As aproximately 60–80% of medical diagnosis and treatment decisions can be made on the basis of what the medical interview reveals, without the need for laboratory tests [13], a lot of information can be lost if discussions are too brief or based on a small proportion of the patient's real complaints.

Patient satisfaction and deepness of interaction does not seem to have a direct correlation with the length of the visit.

Medium-length encounters (longer than 5 minutes) seem to assure necessary space for communication, but this takes place only, when all conditions are provided for the patient to feel comfortable. Frequent interventions of the nurses, the lack of an eye-contact, lack of the interest showed by the doctor to understand the patients' problems block patients to be open, to feel comfortable and to create a partnership.

The percentage of time spent with paper-work is high, and seems — in some cases — to be the most important part of the encounter.

There were significant differences in the case of the two doctors who were working in a private practice, this aspect is to be studied in future evaluations.

Conclusions

Despite of the limited time, doctors succeed a more or less effective information-exchange focused toward a therapeutical decison. Whether this data-exchange has also the power to improve physical and emotional health, to contribute to a better control of diseases, has to be further studied.

While in western culture, data from the literature describe a change in the doctor-patient behaviour towards a partnership, and an increasing authority of the patients, with increasingly active role in therapeutic decisions, our evaluations demonstrate a hierarchical relation, strongly dominated by the doctor. Whether this is generated by the doctors' authority, or the passive behaviour of the patients, leading to a lower status and less responsibility, as well as the reasons behind this, need further investigations.

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