DOCTOR-PATIENT COMMUNICATION IN HEALTH CARE: ISSUES AND CHALLENGES

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ABSTRACT

Effective doctor-patient communication acts as a fulcrum in accommodating a smooth transition from doctor centered communication to the patient centered communication in the health care system. This review presents the significance of the doctor-patient communication health care scenario. The benefits and barriers of doctor-patient communication and the methods to enhance the doctor-patient communication are reviewed. The present qualitative and quantitative measurements of doctor patient communication are critically analyzed. Endorsing that communication is a two way process, this review suggests the need for quantifying the communication based on the bidirectional approach of communication.

Keywords: Doctor-patient communication, relevance, measurement, benefits, barriers.

INTRODUCTION

For a remarkable transformation of health care system, communication plays a decisive role as a cost effective strategy. Veritably, doctor–patient communication is one of the most essential dynamics in health care, affecting the course of patient care and clinical adherence (Matusitz & Spear, 2014). According to Schofield (2004), ‘effective communication was a drug that could

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be prescribed!’ as the patient gains therapeutic benefit just from venting concerns in a safe environment with a caring clinician. The clinical adherence is high among the patients who have knowledge about the illness and good communication with the doctor (Conthe et al., 2014). This lays an emphasis for a patient centred approach in health communication process.

WHY PATIENT CENTRED COMMUNICATION?

Historically in medicine, there was a paternalistic approach to decide what should be done for a patient—the doctor knew the best and the patient accepted the recommendation without question. This era has come to an end, being replaced with consumerism and the movement toward shared decision-making. Patients are advised to educate and ask questions. Patient satisfaction with their care rests heavily on how successfully this transition is accomplished. Ready access to quality information and thoughtful patient-doctor discussions is at the fulcrum of this revolution.

Good doctor-patient communication has the potential to help regulate patients’ emotions, facilitate comprehension of medical information, and allow for better identification of patients’ needs, perceptions and expectations (van Zanten, Boulet, McKinley, DeChamplain, & Jobe, 2007; Bredart, Bouleuc, & Dolbeault, 2005; Arora, 2003; Platt & Keating, 2007). Thus the shift from doctor centered communication to the patient centered communication has begun. As a result, majority of patients are preferring family doctor over super specialist. Unfortunately Indian system has moved away from the age old practice of having family doctors.

Research evidence in the past three decades has proved that doctor-patient communication plays a pivotal role in delivery of high quality patient-centered health care (Golin, Thorpe, & DiMatteo, 2007). With the paradigm shift from biomedical to biopsychosocial approach in health care, the professional assessment of health providers also demands the skills of patient centred communication in addition to professional knowledge and technical skills (Mead & Bower, 2000). This is because the patient who suffers from a disease and seeks treatment does so in a psychosocial context.

It is essential to know if the patient is high on anxiety and depression (which impacts the cognition and thus the memory to be regular with medication), has a social support network of family and friends to aid in therapeutic adherence (that includes diet, exercise and other lifestyle factors) and the economic status to afford the medication and other treatment regimen prescribed. Such considerations can play a role in treatment line only when the doctor-patient communication in the initial consultation is effective to provide an insight to the doctor on the patient’s psychosocial background. Once this is achieved, further process of health care ropes in the patient and family in major decision making which successfully enforces sharing of responsibility on both the patient and the
doctor. Such patient-centered care through biopsychosocial approach helps in
developing a therapeutic alliance between the doctor and the patient, where
inputs on patients’ preferences and doctors’ professional advice receive
considerable assessment in the best of optimal outcome. In this process the
doctor and the patient develop a bond where the patients’ trust in the doctor
goes beyond the perceived components like clinical competence and describes
the doctor as ‘supportive’ and ‘humane’.

Thus, while endorsing the doctor as a professional, the patient also perceives
the important human face in the doctor which is very essential in developing a
relationship. Thus effective communication skills are required for a patient-
centered approach, emphasizing on building rapport through the use of empathy,
listening skills and non-verbal communication skills (Platt & Gordon, 2004).
Therefore, the health communication that takes a biopsychosocial approach
forms a reciprocal relationship between the doctor and the patient.

SIGNIFICANCE OF DOCTOR-PATIENT COMMUNICATION
The ultimate aim of doctor-patient communication is to improve patient’s
health and optimize medical care (Duffy et al., 2004). With optimal adherence,
the prognosis is expected to be the best (Swain, 2013). The basic elements of
doctor-patient communication are to build the relationship, create a path for the
discussion between the doctor and the patient, gather information about the
patient’s problems and issues, and to mutually decide the plan of action to
handle them (Makoul, 2001).

A substantial body of evidence shows that effective communication between
the doctors and the patients can lead to positive outcomes for patients, for
doctors and others. A healthy doctor-patient communication leads to creating a
good interpersonal relationship, exchange of information between the doctor and
patient, and facilitates the decision-making process (Ha, Anat, & Longnecker,
2010). Studies give evidence that links effective doctor-patient communication
to desirable health outcomes such as improved adherence to treatment and
improved prognosis (Swain, 2013), lower patient stress levels and higher physician
satisfaction (Guadagnino & Branch, 2006).

INDIAN SCENARIO: A CHALLENGE
A recent Indian statistics reveal that, because of its dramatic doctor-patient
ratio of 1:1800, (Deo, 2013) India is listed under countries with critical shortage
of health service providers. The average time a physician interacts with a patient
is progressively becoming shorter across the globe and more so in India (Thomas,
Hariharan, Rana, Swain, & Andrew, 2014). While the reason in Indian scenario
can be attributed to the disproportionately large number of patients the doctor
has to see in a day compared to his/her counterpart in the West, one cannot
ignore the fact that technology dependence in health care is compelling the
doctors to distribute the time between the patients and computers and other electronic gadgets. This has reduced the average doctor-patient interaction time to something between two to ten minutes (Deveugele, Derese, van den Brink-Muinen, Bensing, & Maeseneer, 2002). Groopman’s (2007) study found that a patient on an average is given just 18 seconds to describe the symptoms before the doctor interrupts which greatly increases the scope of making errors in diagnosis and treatment plans. With a desirable ratio between doctors and patients, if this is the state of affairs in developed countries, with the given doctor patient ratio, the Indian scenario with respect to consultation time is anybody’s guess. While this reality cannot be transformed overnight, the challenge lies in accepting this reality and optimising time management and communication within the limited time.

Demand for effective doctor-patient communication assumes added significance in the light of chronic illness replacing acute problems, which can be attributed to life style changes. The non-communicable diseases (NCDs) demand effective lifelong management. The NCDs are viewed as epidemic posing the greatest global challenge to the 21st Century (Murray & Lopez, 1996; Reddy, 2003). Collectively, NCDs account for 63% of all deaths worldwide with 80% of those taking place in developing countries (Narayan, Ali, & Koplan, 2010; WHO, 2013). According to a report by WHO (2002), it is expected that chronic diseases will account for 73% of deaths and 60% of the global disease burden by 2020, and also for major percentage of diseases and deaths in India. Treatment of NCDs, like diabetes, hypertension, asthma, cancer or HIV/AIDS demand a dire need of life style changes along with medication. This calls for skills of counseling involving the competence to motivate the patient to enhance health promoting behaviours and minimise health risk practices.

These diseases being asymptomatic are termed as silent killers. The asymptomatic characteristic of the disease is likely to prompt the patient undermine the potential dangers of non-adherence. Unless the doctor impresses upon the patient the asymptomatic nature of the disease and the devastating impact on the prognosis, it would lead to lethal consequences. It is essential that communication of the doctor includes the significance of adherence to medication, diet, exercise and self-monitoring and also highlight the alarm signals that warrant immediate medical consultation. Such communication needs to be powerful with emphasis added at right places and also must be reinforced in subsequent consultation.

QUALITY OF DOCTOR-PATIENT COMMUNICATION: IT’S CONTRIBUTIONS

Impact on Patient Adherence

Among all the consequences of doctor-patient communication, the most outstanding effect is seen in the form of increased clinical adherence in the
patients and subsequently improved prognosis. Adherence is defined as the regularity and punctuality with which the patients takes the prescribed medication, follows the diet and exercise regimen (Hall, Willgoss, Humphrey, & Kongso, 2014). Effective communication from doctors in terms of explanation, feedback, sharing of medical data was found to have enhanced adherence in patients (Tongue, Epps, & Forese, 2005; Platt & Keating, 2007; Chen et al., 2007). Friedman et al. (2008) reported that patients who received less information from their doctors showed poor adherence. Gaps in the doctor-patient communication like uni-dimensional decision making, and physicians’ lack of knowledge of patients, indicating sub-optimal communication, lead to non-adherence that adversely affects the health status of patients (Wilson et al., 2007).

**Impact on Patient Mental State and Doctor-patient Relationship**

The holistic approach to health care views the patient not just as a bearer of a disease, but as an individual and as a physical, psychological and social and spiritual entity. Hence apart from the treatment of the disease, the concomitant implication on affect, cognition, behaviour and other social aspects such as financial pressures and social relationships receive their due importance. In this context the impact of high quality doctor-patient communication can be perceived in all the dimensions mentioned above. Higher quality of doctor-patient communication leads to mutual understanding, patient satisfaction, trust, bilateral involvement in decision making, agreement about treatment, and patient motivation (Street et al., 2009).

Better intermediate outcomes include better adherence and self-care by patients, both of which lead to improved health outcomes (Moore et al., 2004). Effective communication is also found to reduce psychological distress in patients along with higher rate of symptom reduction and better prognosis (Golin et al., 2007). Studies have proved that direct communication and support have a significant role in reducing visits to emergency department (Bolton, Tilley, Kuder, Reeves, & Schutz, 1991) and control of chronic illness (Tildesey, Mair, Sharpe, & Piaseczny, 1996). Literature has shown that effective communication in medical treatment leads to improved health, functional and emotional status, adherence to treatment regimen, doctors’ satisfaction, and reduced medical malpractice risk (Wong & Lee, 2006). Effective communication has also been shown to manage post-operative pain in surgical patients (Sugai, Deptula, Parsa, & Don Parsa, 2013).

Patients seem to have a clear preference for doctors based on the quality of communication. In a study by Schattner, Rudin, and Jellin (2004), it is reported that 38% of patients selected physicians on the basis of their professional expertise while 30% selected on the basis of physicians’ patience and attentiveness, informing the patient, representing the patient’s interests, being truthful and
respecting patient’s preferences. Except the professional expertise, rest of the factors can be translated as outcomes of effective communication between the doctor and the patient.

Consulting the doctors high on quality of communication is found to be the key for patient satisfaction. In a qualitative study by Anden, Andersson, and Rudebeck (2005), it is reported that the patients’ perception of the outcome of clinical consultation is greatly determined by the patients’ understanding of communication leading to improved satisfaction. In a review study of interventions on cancer patients, the results revealed the importance of effective doctor-patient communication in promoting patient satisfaction with the health care (Bredart, Bloulec, & Dolbeault, 2005). The results of the review emphasized on the use of various strategies that improved patient satisfaction and resulted in positive health outcomes, effective doctor-patient communication being one of the major strategy.

**Impact on Doctors**

The positive impact is not just limited to patient benefit. The doctor is an equal beneficiary of high quality doctor-patient communication. For the doctor, the process of diagnosis involves three sequential and overlapping steps viz. data gathering, data integration and verification of diagnosis (Kuhn, 2002). Effective doctor-patient communication plays a pivotal role in collecting relevant data from the patient. It may be an exaggeration to state that this preliminary process determines the line of investigation through laboratory tests and further invasive diagnostic tests to arrive at a final diagnosis. In addition to this the studies pointed out the positive impact that good doctor-patient communication has on the doctor job satisfaction and productivity (Haas et al., 2000).

Physician satisfaction more often than not is linked to patient satisfaction with the health care service that they receive. Satisfied patients are advantageous for doctors in terms of greater job satisfaction, less work-related stress, and reduced burnout (Bredart et al., 2005). Satisfied patients are less likely to lodge formal complaints or initiate malpractice complaints on doctors (Brinkman et al., 2007).

**Overall Outcome**

The overall outcome of healthcare involves, democratic decision making, improved mutual trust and better doctor-patient relationship. Shared-decision making ensures shared responsibility which binds the patient to clinical adherence. Active doctor-patient communication facilitates communication of doctor’s empathy to the patient. This lays the foundation for the trust in the relationship that breaks the ice facilitating the patient to unleash the fears, anxiety, and apprehension. Such interaction provides a scope for the doctor to effectively address the patients’ emotions. This process helps in easing the emotional state.
of the patient. Further, the effective communication of the doctor, through information exchange enhances the knowledge base of the patient about the disease, adherence requirements, which in turn help in giving desirable direction to the health behaviour of the patient. While the doctor’s communication skills contributes in the ways described above, it is also true that equal participation of the patients creates a sense of partnership and involvement in decision making. This in turn contributes to the internal locus of control. Once the internal locus of control is stimulated and reinforced, the adherence behaviour is likely to be high and sustained. One may wonder, when quality communication has such inherent advantages casting its multifaceted impact, what prevents the practice of quality communication between the doctors and patients?

**BARRIERS TO DOCTOR-PATIENT COMMUNICATION**

Emerging data suggest a high prevalence of communication breakdowns among physicians, patients, and important members of the health care services who assist with the diagnostic process (Gandhi, 2005; Singh et al., 2007; Sutcliffe, Lewton, & Rosenthal, 2004). In a study on patients with abnormal mammograms, one third of the women in the sample reported not to have received appropriate follow-up (Poon et al., 2004). This indicates the barriers in communication can be possibly be caused by either the doctor or the patient or both.

In the context of doctor-patient communication, various socio-economic factors like age, gender, and educational qualification are seen to affect the communication. Studies identified that patients’ age is a major determinant of the doctor’s quality of listening (Govender & Penn-Kekana, 2007). In a study on elderly patients, it is found that doctors tend to communicate more in a patient-centered style with patients over the age of 65 years (Peck, 2011).

With regard to the gender, studies indicated an interaction between gender and income level posing a barrier in communicative style. A study conducted by Thorson and Johansson (2004) shows that woman patients of low income and status are described shy, hesitant and limited in their knowledge. They were found to verify with their husbands, family members and neighbours rather than adhering to the doctor’s perception.

While the above study reported on differential behaviour by patients of two genders, there seems to exist a reciprocal relationship between the communication of doctors and patients. Bertakis, Franks, & Epstein, (2009) revealed that the doctors were more likely to have patient-centered style of interaction with female patients in comparison to male patients, suggesting that, women are more likely than men to express their feelings and talk about psychosocial issues.

The third barrier is educational level of the patient. Patients with a higher educational level have more skills and confidence in talking to their doctors and
tend to provide more information, ask more questions and speak longer than other patients. It was also found that highly educated patients are more expressive and opinionated. They also receive more diagnostic and health information than less educated people (Willems, De Maesschalck, Deveugele, Derese, & De Maeseneer, 2005). To sum up, it is likely that more educated, higher income and older patients receive more information because they have communicative styles that elicit information from the doctors.

It is found that hospitalized patients with limited health literacy reported poor communication in the domains of general clarity, responsiveness to patient concerns, and explanations of care compared with patients with higher health literacy (Kripalani, Jacobson, MugullaCawthon, Niesner, & Vaccarino, 2010; Katz, Jacobson, Veladar, & Kripalani, 2007).

Doctors are found to use medical jargons in their interaction with patients that is beyond the comprehension of patients. Doctor’s use of complex medical language (Castro, Wilson, Wang, & Schillinger, 2007) may contribute to poor physician-patient communication. Extra care is to be taken while communicating with the patients in younger age group since younger participants have reported significantly lower level of knowledge of jargons than their older counterparts (Thomas, Harirharan, Rana, Swain & Andrew 2014). Cardiologists’ communication involving jargons is, thus, not adequately reaching patients, specifically young adults. The use of such language leaves the patient confused and mystified, leading to poor comprehension of the doctor’s instructions and consequently, inappropriate health behaviour that may bring about adverse health effects. A recent study on 96 preoperative patients reveals that usage of medical jargons leads to patient’s dissatisfaction (Fields, Freiberg, Fickenscher, & Shelley, 2008). The usage of jargons distances the doctors from their patients and therefore it was suggested that the emphasis should be on interaction with the patients rather than telling the patients (Fields et al., 2008).

The personality factors sometimes may play a very dominant role in the quality of communication which may sometimes even camouflage the other factors such as age, gender, education, or socio-economic factors. The quality of doctor-patient communication is not singularly impacted by the patient. The doctor as the health provider has a significantly high contribution in the quality of communication.

In order to deliver patient-centered care, the physician must be equipped and educated to serve as trusted advisor, educator, and counselor, as well as medical expert, and must know how to encourage the patient’s participation in the design and delivery of care. The caring component in doctor-patient communication manifests in the doctors expression of empathy, reassurance, support, positive reinforcements, psychosocial talk, sense of humour, and extension of courtesy (Beck et al., 2002). Communication is a two way process. When
the doctor is not proactive in sharing and initiating, the patient lacks encouragement for questions. Disregard for the patient’s views, incomplete sharing of medical data with the patient, guarded discussion of the treatment effects, low response to the patient’s remarks, lot of interruption in patients’ speech are indicators of poor sharing in doctors’ communication (Beck et al., 2002). A study conducted on 167 patients who have interacted on computer with virtual physicians who are simulated to show high and low caring, the high caring was found to lead to higher patient satisfaction (Cousin, Mast, Roter, & Hall, 2012).

Patient feedback is a valid reflection of doctor’s quality of communication. Often the patients are found to complain about the duration of consultation that remains inadequate and hurried (Swaminathan, 2007). The pressure is felt more in times when there is a shortage of medical personnel. Given these circumstances, the doctors tend to fasten or even cut down on the consultation time. The lack of time is a constant factor associated with the doctors about which the patients are aware (Pollock & Grime, 2002).

Research has shown that apart from the patient and doctor factors, many other phenomena like patient’s personality factors, doctor’s personality factors influence the communication between the doctor and the patient, e.g. the social status of the patient. It is beyond the scope of the present review to enlist all the possible variables involved in this complex process.

METHODS FOR ENHANCING DOCTOR PATIENT COMMUNICATION

Primarily, training sessions on communication skills for the doctors is suggested (Finset, 2012). Several studies have reported that training the doctors in communication skills to meet the biopsychosocial needs of the patients is imperative (Chatterjee & Choudhury, 2011). In its report ‘vision 2015’, the Medical Council of India (2007) stressed on the importance on communication skills training of the doctors. Doctors need to individualize their communication to patients based on patients’ needs and desires (Lazarus, 2013).

The need of the hour is acknowledging and training the health care professionals in effective communication skills leading to improved health care system, sensitizing clinicians to respond to patients’ emotional cues, encouraging doctors to communicate without/with minimal use of medical terminologies (Terpstra, 2012), facilitating feedback from the patients after consultation, accelerating the empowerment of the patients (Chana, 2012), teaching doctor-patient communication skills during undergraduate medical curriculum (Egnew & Wilson, 2010; Sommer, Rieder, & Haller, 2011), promoting listening by the doctors (Snyder, 2008; Jagosh, Boudreau, Steinert, Macdonald, & Ingram, 2011) and involving family members (Kuzari, Biderman, & Cwikel, 2013; Guenter, Gillett, Cain, Pawluch, & Travers, 2010). All these are found to contribute
towards a correct diagnosis, enhance healing, apart from boosting the doctor-patient relationship. While doctor-patient communication is given heavy emphasis and innovative interventions are suggested to enhance the quality, the crucial question around which the entire issue revolves relates to the method of measuring the quality.

**MEASUREMENT OF DOCTOR-PATIENT COMMUNICATION**

Measuring communication is a challenging task. Health communication researchers have devised numerous ways to identify measure, quantify and categorize doctor-patient communication. Doctor-patient communication can be studied using qualitative and quantitative approaches. Quantitative approaches have focused on measuring aspects such as information exchange, shared decision making, patient enablement, verbal dominance, and communication control (Collins, Britten, Ruusuvori, & Thomson, 2007). In qualitative approaches, the focus of measurement is on professional responsibility and behaviour, and on details of observed and recorded communication in consultations, as well as on the structure of consultation and its phases (Collins et al., 2007). Quantitative approaches have used Interaction Analysis System (IAS), such as the Roter Interaction Analysis System (RIAS), Brown University Interpersonal Skill Evaluation (BUISE), Communication Assessment Tool (CAT), and Doctor-Patient Communication Inventory (DPCI).

The qualitative approach uses the method of coding the videotaped content of clinical consultations. The measurement comprises of both the verbal and non-verbal behaviour. The coding systems provide useful information like the extent to which patients talk in the consultation, factors influencing the interpersonal effectiveness of the health professional, such as length of consultation or continuity of care and communication competence of the doctors.

The problem with the coding systems relates to arbitrariness of relationship between coded actions. For example, it fails to connect doctor’s communication style to the patient’s level of information about their diagnosis, prognosis and treatment options. Further it speaks nothing about how the length of the consultation might have influenced the discussion of issues between the doctor and the patient. Further, these methods fail to capture the functional aspects related to the exchange of information about the present health status of the patient, dosage of medication, adverse effects, alarm signals, etc which contribute to a strong logical base for adherence.

Campbell, Lockyear, Laidlaw, and Macleod (2007) developed a Matched-Pair Instrument (MPI) to measure the communication skills of the doctor in terms of process and content. In a study on physician-patient communication behaviour on HIV patients in Kenya, Wachira, Middlestadt, Recce, Peng, and Braitstein (2013), reported that the MPI failed to capture the patient’s role in the communication behaviours as usually the case with patient-centered communication measures.

*Vol. 9, No. 1, September, 2014*
The major qualitative approach for analyzing doctor-patient communication is through the use of content analysis. Conversation Analysis (CA) is one such method of content analysis that measured the communication using themes such as the themes that discussed the interrelationship between the patient’s concerns and the biomedical agenda. In CA research, the consultation is regarded as consisting of phases of activities based on video or audio recordings of actual consultations. The phases observed in doctor–patient consultations are the opening of the consultation, the problem presentation, verbal examination (including history-taking), physical examination, discussions of treatment and closing. Various studies have used CA to study doctor-patient communication quality (Gafaranga & Britten, 2003; Heritage & Robinson, 2006).

Heritage and Maynard’s (2006) review of the CA literature on patients’ participation in the consultations revealed that patients had less opportunity to participate in diagnosis than in the treatment phase. CA studies concentrate on analyzing the process of interaction and cannot adequately deal with other equally relevant dimensions of the process of patient participation, such as what the patient could not reveal in the consultation, like what the patient said ‘between the lines’.

**NEED FOR QUANTIFICATION OF DOCTOR-PATIENT COMMUNICATION**

Communication is a two-way process and the degree of the quality of communication is dependent on whether the receiver comprehended the message the way the sender intended it to be. In clinical context, it transforms into whether the patient comprehended what the doctors communicated. In a way, the patient has to validate his/her understanding about the doctor’s instructions. Only a method that matches these two aspects can be considered as the one that is complete and objective.

The discussion based on the review clearly suggests the cost effectiveness of doctor-patient communication in the present context of health care and management. Given the high doctor-patient ratio resulting in low consultation time, optimising the quality of doctor patient communication remains a challenge. The only way this challenge can be met is by integrating innovative techniques and approaches of validating doctor-patient communication in the medical curriculum, reinforced by in service training programmes and involvement of Health Psychologists in developing disease specific check lists and communication packages for use in consultation. However the major lacunae in evaluating the effectiveness of this would be appropriate tool and method of measuring doctor-patient communication involving the communicator and receiver on the one hand and covering the content, affect and behaviour on the other. Concerted efforts are called for in health care research to fill this void. Therefore a reliable and valid method for measuring bi-directional communication is the need of the hour to replace the unidirectional approach.
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