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A Study on Doctor Patient Relationship – A Cross Sectional Study on Satisfaction and Communication Aspects in Urban Chidambaram

Authors
Prabu.T[1], Venmathi.E[2], Govindarajan.P.K[3]
[1]Lecturer, Department of Community Medicine, Rajah Muthiah Medical College and Hospital, Chidambaram, Tamilnadu, India
[2]Postgraduate, Department of Community Medicine, Rajah Muthiah Medical College and Hospital, Chidambaram, Tamilnadu, India
[3]Head of the Department, Department of Community Medicine, Rajah Muthiah Medical College and Hospital, Chidambaram, Tamilnadu, India

ABSTRACT

Background: *Doctor-patient relationship is a multifactor dependant entity and has evolved substantially to a more interactive relationship in past few generations. The changing scenario and its influence on the relationship particularly in developing countries require to be studied.*

Objective: *(1)To study the level of satisfaction in Doctor Patient Relationship from patient's perspective.(2)To identify the factors leading to communication gap in Doctor Patient Relationship in a primary health care of RMMCH.*

Methods: *A cross sectional study done among the out patients of peripheral health care facility of Urban Chidambaram including 442 participants over a period of one week. Assessment of socio demographical, time involved in consultation and waiting, satisfaction and communication skills of physicians in patients' perspective done with preformed questionnaire.*

Results: *The study included 442 patients attending the outpatient unit of the primary health care with majority between the age group 51 to 60 yrs ie 22.6%. The socio cultural factors did not show any significant association with the doctor–patient relationship. 95% of the consultations were reported to be highly satisfactory. Also 67% of the consultations resulted without communication gap (67%).*

Conclusion: *The practice of medicine firmly relies on the relationship between the doctor and his/her patient irrespective of their sociodemographical backgrounds.*

Introduction

Good doctor-patient relationship has benefits for both patients and practitioners[(1)]. Doctors and patients, even if they come from the same social and cultural background, view ill health in very different ways [(2)] having different expectations of their relationship with each other [(3)]. In the past few generations, substantial changes have evolved in the nature of the physician patient encounter [(4)] from a largely paternalistic model to a more interactive relationship [(5)].

Doctor-patient relationship is a multifactor dependant entity [(1)]. Most developing countries comprise of many social and cultural entities, with diverse languages, customs, religion, and so on, which provide ample opportunity to study how these socio cultural factors affect the doctor–patient relationship [(2)].

The art of medicine depends on the ability to acknowledge and respect these differences and treat every patient as an individual [2]. The first and major part of the consultation is talking with the patient [1]. Building a fruitful doctor patient relationship is a vital part of successful medical care, and one of the most complicated professional responsibilities of physicians [5].

Patient satisfaction is a very important component of quality of care, but difficult to measure [1]. Globally, patients expect a certain kind of treatment from their doctors such as to be kind, humble, compassionate, honest, trustworthy, and respecting confidentiality [5]. Communication problems in health care may arise as a result of healthcare providers focusing on diseases and their management, rather than people, their lives health problems [6] Effective communication skills improve the identification of patients' problems more accurately [5], which in turn improve doctors satisfaction enhancing the relationship between them [1]. Complaints of doctors' communication skills are recorded at the top of the analyzed complaint lists. Patients should be informed of the condition in a simple language without medical jargons [5].

Time factor also can affect patient satisfaction, doctor patient relationships and communication, and care [7]. Longer consultations may be required to achieve clinical effectiveness and patient safety: aspects also important for achieving high quality of care and increased patient satisfaction [8].

Apart from these the other factors influencing the relationship are frequency of visits , initiation of consultation, obtaining consent, confidentiality, knowledge of the consultant etc. [5][9]. Patients' perception of treatment efficacy strongly influences the relationship to the treating physician. Adherence to treatment regimens and persistence to therapy play central roles for therapeutic success which in turn stresses the education of patients with respect to reasonable expectations and knowledge of associated risks and benefits to prevent discontinuation and increase satisfaction of patients [10].

Hence the practice of medicine firmly relies on the relationship [5] which is influenced by the rapid social changes on one hand and advances in medical technology on the other hand. Good doctor–patient concordance (agreement) leads to better trust in the physician, which in turn leads to better patient enablement, irrespective of the socio cultural determinants [2]. In this scenario studies on the changing doctor–patient relationship, particularly in developing countries, are indicated [2].

Thus the following study was done with the objectives to study the level of satisfaction in Doctor Patient Relationship from patient's perspective and to identify the factors leading to communication gap in Doctor Patient Relationship in a primary health care of RMMCH.

Methodology

Study Population and Area

The study was done at the Urban primary health care centre of our Institute as it was considered to be the ideal place to assess direct patient doctor interaction. With proper ethical approval the study population included all the outpatients attending the health care irrespective of their age , gender or complaints , from morning 9am to 1 pm over a period of 1 week from 9th October 2015 to 15th October 2015. Thus at the end of one week 442 patients were included and studied. All participants were informed prior to the interview and informed consent was obtained. Minor patients ie younger than 14 yrs of age were interviewed with the help of their respective guardians as standby. Patients who were unwilling, unresponsive and requiring emergency care were excluded from the study.

Study tool

The participants included in the study were met, comfortably seated and interviewed after their consultation period by the interviewer. They were questioned with a preformed questionnaire by a face to face interview for about 20 to 30 mins allowing adequate time for them to respond without any external pressures.

The questionnaire include four parts covering details on socio demographic, present medical status, questions on satisfaction and communication in patients' perspective respectively. The socio demographic details included age, gender, socioeconomic status, education, income and occupation. The present medical details included questions on purpose or visit, waiting and consultation times and frequency of visits.

Statistical analysis and interpretation:

The questionnaire on satisfaction and communication was designed as closed type questions of 12 in each category to interpret the satisfaction level and communication gap between the physician and patient. The satisfaction level was graded as not satisfied, satisfied and highly satisfied based on the scores. Also the presence or absences of communication gap along with the factors leading were assessed. The data collected was entered into Microsoft excel sheet later analyzed using SPSS version 20. The results were expressed in forms of descriptive and tabulations.

Results

Table : 1 Distribution of the study population based on sociodemographic factors:

Sociodemographic indicators	Frequency (%)
Age	
<10	46(10.4)
11-30	51(11.6)
31-50	159(35.9)
51-60	170(38.5)
>60	16(3.6)
Gender	
Male	161(36.4)
female	281(63.6)
Education	
Illiterate	100(22.6)
Primary	276(62.4)
Secondary	51(11.3)
Higher secondary	10(2.3)
Graduate	5(1.4)
Occupation	
Unskilled	158(35.7)
Semiskilled	138(31.2)
Skilled	87(19.7)
Dependant	59(13.3)
Income	
<25000	404(91.4)
25000- 50000	30(6.8)
50000 – 75000	6(1.4)
>75000	2(0.5)

Table 2 : Distribution of study subjects based on waiting and consultation time:

Time	Waiting time(%)	Consultation time(%)
<5min	351(79.4)	156(35.3)
5-10 min	59(13.3)	228(51.6
>10min	32(7.2)	58(13.1)

Figure 1 : Distribution of study subjects based on frequency of previous visits:

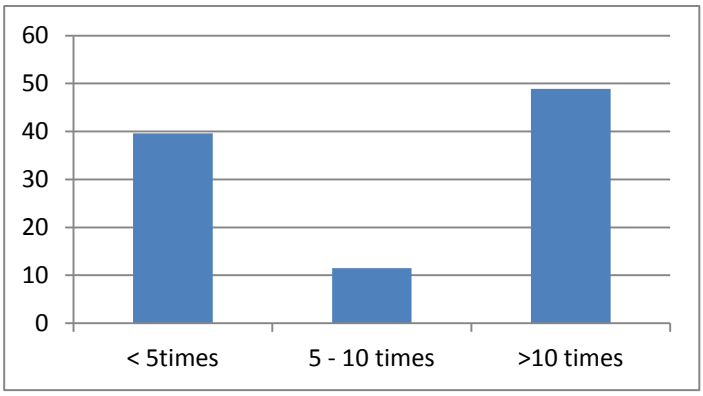
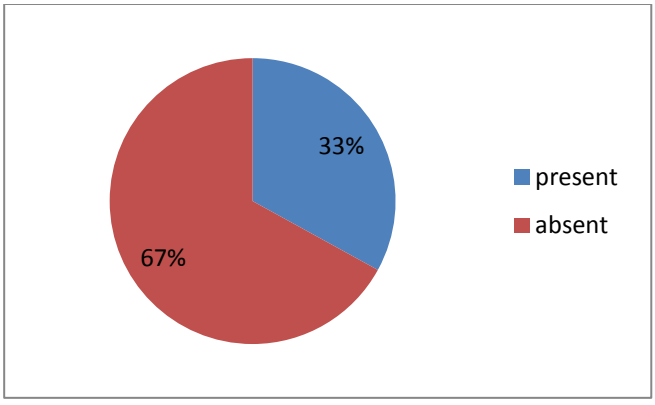


Table 3: Distribution of study subjects based on satisfaction level:

Satisfaction level	No of patients	Percentage
Unsatisfied	7	1.6
Satisfied	15	3.4
Highly satisfied	420	95

Figure 2: Distribution of study subjects based on communication gap:



The study included 442 patients attending the outpatient unit of the primary health care. Among the patients majority were of the age group 51 to 60 yrs of old ie 22.6% followed by 40 to 50 yrs old ie 21%. The study subjects had 10.4% of paediatric patients. The female patients constituted more with 63.6% of the total participants. On comparison of distribution of participants based

on education, occupation and income majority of the study subjects had primary level of education (62.4%) with either unskilled (35.7%) or semiskilled (31.2%) employment ,also majority earning within Rs.25000 per annum.

Majority of the patients were frequent visitors to the health care 216 out 442 patients have availed treatment more than 10 times in last 3 months. Among the patients though most of them had waiting time less than 5 mins ie 79.4% around 7.3% complained of longer waiting time of more 10 mins. Also the consultation time was about 5 to 10 mins for most of the patients (51.6%) still 35.3% had lesser than 5 mins of consultation time.

The satisfaction level among the patients assessed based on the scoring of responses given by patients for questions on greeting, listening, eye contact, interaction, answering queries, touching, examination, prescribing of medicines etc were graded resulting in majority of the participants (95%) highly satisfied. Also the communication assessment regarding language usage, explaining of symptoms, audibility, precautions and preventive measures to be taken etc resulted in majority of the consultations without communication gap (67%).

Discussion

Effective doctor patient communication is essential for high quality medicine [(11)]. Both patients and doctors differ in their beliefs, attitudes, and hopes [(2)]. Parsons , sociologist, viewed the role of the doctor as complementary to the role of patient doctors where they are expected to apply their specialist knowledge and skills for the benefit of the patient, and to act for the welfare of the patient and community rather than in their own self-interest [(12)]. The satisfaction with the service provider i.e., the prescriber is a vital component of the whole process of consultation and largely determines the compliance of the patient to the treatment prescribed [(13)].

As the doctor–patient interaction does not take place in a vacuum, but in different social and cultural environment, it may be influenced by socio cultural factors[(2)]. The present study inferred no significant association between the socio demographic features and satisfaction or communication of patients. It reflects the results of the study by Banerjee et al, a cross sectional study, the quantitative analysis of the socio cultural factors did not show any significant association with the doctor–patient relationship except gender [(2)].

The present study among 442 outpatients in a primary health care set up had a female predominance of 63.6% which could be due to the data collection done at working hours yet no gender had significant association with satisfaction of patients. This is contrary to the study done by Amitav Banerjee which stated that gender was significantly and strongly associated with trust in the physician. Female patients showed a much lower trust in the physician (50%) as compared to male patients (75%) [(2)]. Also the communication aspect of the consultation was reported to be insignificant with regards to gender. This contradicts the study by Banerjee et al in which among the participants in the study male patients were more communicative with their doctors [(2)]

The study participated with majority having primary education qualification showed an increased satisfaction yet it was not statistically significant. This is same as the result stated by banerjee et al that 198 surveyed hundred and seven (54%) did not have an education beyond school level, 71 (35.9%) had completed graduation, and 20 (10.1%) were postgraduates. People with higher education also showed better agreement with their doctors [(2)]. Among the Participants those with lower income status stated higher satisfaction levels and lesser barriers in communication though not statistically significant. It is contrary to the results of Banerjee et al where higher socioeconomic status was related to better concordance [(2)]

Physicians and patients differ in subjective experiences of time. Some critics have felt that the amount of time physicians have with each patient has decreased [(7)]. The impact of consultation

length on doctor–patient relationships, workload, and workforce requirements in general practice has long been debated. Longer consultations have been associated with increased patient satisfaction, are associated with better health outcomes [8]. In recent decades, the rise of managed care and of technological interventions approaches have each exacerbated the other in shortening the amount of time doctors have with patients [7]. In the present study majority of the consultations were within 10mins as reported by the patients owing to the workload and pressure of attending more cases in short period of time. Though the patients irrespective of consultation time reported good satisfaction there was no significant association between the consultation time and satisfaction levels. This result agrees with the study by Elmore n et al which reports The shortest consultation was 2 minutes 15 seconds and the longest >30 minutes The mean consultation length (10 minutes 22 seconds) no association between consultation length and patient experience of communication, trust and confidence in the doctor, or overall satisfaction [8].

Long wait times may be associated with decreased overall satisfaction with treatment though other research has found that patient perceptions of time are often inaccurate, with over more than underestimations of wait times to see physicians [7]. Time delays have been documented in receiving treatment. [7]. In this study majority of the participants reported waiting time less than 5 mins which were not statistically significant. This is same as the study Care H et al which states patients with higher waiting time were less satisfied. Waiting time did not moderate the relationship between satisfaction with dominant communication style, and overall satisfaction at the outpatient clinic [14].

In this study the participants reported better satisfactory levels overall (95%) for the physicians regarding listening patiently, explaining the conditions answering queries and respecting their opinions. This is similar to the study Care H et al which states that satisfaction of a patient depends also on the doctor's ability to provide information on the symptom, effects and consequences [14]. It is also supported by the study by Elmore N et al where out of 440 participants 304 (70%) patients endorsed the highest rating indicating that they had definite trust and confidence in their doctor, and that they were very satisfied with their overall care [8].

The present study reported presence of communication gap in the doctor patient relationship in 33% of the participants. These included various factors like poor information delivery regarding disease symptoms treatment (26.5%) dosage and drug details (48.2%) precautions and preventive methods to be followed (58.8%). This correlates with the study by Raj Kishore et al which reports that though 73.58% doctors agreed explaining the disease and related remedy to patient assist to establish a good doctor-patient relationship but nearly half of the participating doctors(49.06%) were not able to practice it [1]. About 74.2% of participants stated that they had many doubts even after the consultations with 60.9 % reporting inadequate advice regarding alternatives and complications of diseases. Though many physicians are aware of the importance of proper communication the adherence is not significant. This correlates with the study by Raj Kishore et al which states that doctor adherence is less as compared to doctors positive opinion regarding factors like addressing the patient by name, receiving the patient with smile, listening the patients‟ problem carefully indicating heavy clinical work load as the reason [1]. doctors with good communication skills experience fewer difficult consultations [15] which help them to identify patients' problems more accurately, and the patients are more satisfied [5].

Limitations and Recommendations

The present study population had a predominance of female participants due to the time of study conducted being in morning of working days. Though the study assessed the satisfaction and communication level from patience perspective

the doctors' perspective has not been assessed which would add to strengths of the study. Recall bias and interviewer's bias are common in the study as there is no blinding. Apart from these the also study has strengths of assessing both satisfaction and communication gaps with specific questions regarding the lacking points in patients perspective.

Realizing the importance of Doctor patient relationship in the final outcome and quality of life of the patient, multiple measures such as training sessions on communication skills for the doctors, sensitizing clinicians to respond to patients emotional cues, encouraging doctors to communicate without/with minimal use of medical terminologies , facilitating feedback from the patients after consultation, accelerating the empowerment of the patients, teaching Doctor patient relationship skills during undergraduate medical curriculum [(16)] can be put forth in practice.

Conclusion

Globally, the Doctor patient relationship has changed drastically over the years owing to the commercialization and privatization of the health sector [(16)] a poor Doctor patient relationship has been proved to be a major obstacle for both doctors and patients, and has eventually affected the quality of healthcare and ability of the patients to cope with their illness [(16)].

Medicine is more than the sum of our knowledge about disease [(17)]. The practice of medicine firmly relies on the relationship between the doctor and his/her patient. [(5)] Despite worldwide emphasis on the distinguished responsibility of physicians, teaching the art of physician patient relationship has not yet been incorporated, into the curriculum of many medical schools [(5)] the doctor–patient relationship continues to be more in the realm of art rather than science with No measurement tool to capture every nuance of this complex relationship [(2)].

Modern technology makes the physician's skills focused on the treatment of the disease with less emphasis on the patient himself [(5)]. The responsibility for individual health care has shifted from a physician oriented, paternalistic approach to a patient centered one. It is the ability of the system to meet patients' expectations in respect of the emotional and human features of the consultation, and the clinical outcomes, that matter most to people. [(18)]. Patients now assume two identities: health consumers and active participants in the medical decision making process. [(6)] Good Doctor patient relationship is the crucial determinant for a better clinical outcome and satisfaction with the patients, irrespective of the sociocultural determinants [(16)].

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