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COMMUNICATION WITH PATIENTS. THE IMPORTANCE OF DOCTOR – PATIENT COMMUNICATION

Mirela PĂDURARU
Faculty of Medicine and Pharmacy - University of Oradea

Abstract

This study is a research report, developed as an overview of the concept of doctor - patient communication. One of the most important aspects of the relationship between doctor and patient is the way that both parties have something to gain. This research is based on the necessity of performant communication between doctors and patients, the purpose of which is to ensure that patients and caregivers receive all the information that they need. The main focus of this study is to create a theoretical basis of the importance of doctor – patient communication by pragmatically analyzing the concept of communication as an integral aspect of health care.

Effective doctor - patient communication can be a source of motivation, incentive, reassurance and support. A good doctor-patient relationship can increase job satisfaction and reinforce patients' self- confidence, motivation and positively influence their view of their health status, thus positively impacting the treatment outcome. Most complaints made about doctors are related to issues of communication, not clinical competency. Patients want doctors who can not only skillfully diagnose and treat what ails them, but also communicate with them effectively.

Keywords: communication; medical communication; communication methods; medicine; doctor patient communication; health system; healthcare system; sanitation.

"Medicine is an art whose magic and creative ability have long been recognized as residing in the interpersonal aspects of patient-physician relationship." (Hall J. A., Roter D. L., Rand C. S. Communication of affect between patient and physician)

We can not talk about an effective doctor-patient communication without taking into account that communication is a central clinical function in building a therapeutic doctor-patient relationship. We can treat this subject with the importance that it deserves and consider it like *"the heart and art of medicine".* Communication between doctors an patients is the central pawn in the delivery of high-quality health care. At the opposite pole, is the faulty communication whose outcome is the patient dissatisfaction and the ground of many complaints.

Nevertheless, too many doctors tend to overstate their capability in the field of communication. Over the years, communication research tried to understand how the relationship between doctors and patients works. Moreover, they tried to conceptualize the process of doctor – patient communication.

A medical worker's communication and interpersonal skills encompass the ability to gather information in order to facilitate accurate diagnosis, counsel appropriately, give therapeutic instructions and establish caring relationships with patients. These represent *„the heart"* of clinical skills in the practice of medicine, with the ultimate goal of achieving the best outcome and patient satisfaction, which are essential for the effective delivery of health care.

Basic communication skills alone 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. Interpersonal skills, in addition to basic communication skills, are necessary for doctors to develop in order to appropriately deal with patients.

The main goal of any doctor - patient interaction is to improve the patient's health and medical care. Surveys on doctor - patient communication have revealed patient discontent, even when many doctors considered their communication adequate or even excellent, meaning that medics tend to overestimate their ability to communicate with patients. Tongue et all. reported that *75% of orthopedic surgeons surveyed believed that they*

communicated satisfactorily with their patients, but only 21% of the patients reported satisfactory communication with their doctors. Patient surveys have consistently shown that they want better communication with their doctors.

Medical communication has been a part of development communication or communication for development for the past five decades. Royal Colle explains that health communication has been one of the threads of development communication together with population information, education, and communication (IEC) since 1969. Then, it was concerned with population and family planning programs, with an emphasis on reproductive health that includes family planning, maternal and infant death and disability prevention, sexually transmitted diseases (STD) and HIV/AIDS prevention, harmful cultural practices such as female genital mutilation (FGM), violence against females, human trafficking and female health. In her book, *Effective Health Communication for Sustainable Development*, Patchanee Malikhao explains how the history of health communication, as a separate field of study, has emerged from being only a part of health education and training in medical and public health, to the integration of health-related aspects of individuals, communities, organizations or their environment, with appropriate communication and mass communication theories. These communication theories borrow models and frameworks from social science fields (such as psychology, social psychology, anthropology and sociology), humanities subjects - such as culture, linguistics and languages, ecological and environmental science and medical science fields.

Today health communication has expanded its scope from biomedical interventions at a personal level to a more context-based communication about health, which includes the social and environmental factors that may impact an individual's health. Robert Rattle affirms that these are the social determinants of health, apart from the physical determinants and above all the health policies that impact health behaviors.

Health Communication Perspectives

In the 1980s and early 1990s, health communication was known as a form of health education, health promotion and preventive medicine and focused on communication at many levels (interpersonal and organizational communication) in healthcare settings. Mainly in the USA, but also in the UK, the focus was even more down to communication among the patients and the health- care provider.

Health communication theories originated in the USA and have focused on mainstream quantitative research perspectives for many decades. Malikhao claims that these theories originated in fields like psychology and social psychology. The fields mentioned are centered on and emphasize cognitive and behavioral changes at the intrapersonal, interpersonal, and group level. Popular models for intrapersonal communication are, for instance, the health belief model, theory of reasoned action (TRA), theory of planned behavior (TPB), the integrated behavioral model (IBM), the transtheoretical model and stages of change (TTM), and the precaution adoption process model (PAPM). Models used for interpersonal communication are social cognitive theory (SCT) or social learning theory (SLT). Models used for organizational communication are stage theory of organizational change, diffusion of innovation and social marketing and education.

Malikhao claims that the signature of these kinds of models is that they rely heavily on positivism, which is based on natural science models of cause and effect. They flatten the well-rounded facts of life into a linear line for prediction, with inferential statistics. The models used for intrapersonal communication seem to assume direct relationships between knowledge, attitude and behavior, regardless of the context within which people live.

The templates employed for interpersonal communication are centered on the simplicity of the stimulus-response formula and the modifications of it, such as Laswell formula, *"Who? Says what? Through which channel? To whom? With what effect?"* and Katz and Lazarfeld two-step flow of communication, which relies on the spreading of messages from opinion leaders received via the mass communication to other people. Moreover, at the organizational level, these templates focus on the ability of humans to act in stages from being laggards to people who adopt innovation completely. Nevertheless, they pay less attention to the socio-politico-cultural context that impinges on the ability to change those individuals. The *"all in all"* models assume the *"one-fit-all"* models and technology transfer, from a more developed country to a less developed country.

These actual-based models are built under the modernization paradigm, which assumes that the Western way of living is a desirable goal for development everywhere. It is a favorable perspective that descends from an empirical observations and statistics. Health communication within the modernization paradigm involves a high-tech, top-down and unilinear approach from health professionals, either directly or through the mass media to the receivers, aiming to educate, upgrade, or train them to be informed in public health. Having a positive attitude towards biomedical interventions or health-related advice/information, is also important in order to have the self-efficacy to transform health-risk behaviors into a healthy lifestyle and health behaviors.

The evolutional paradigm has been challenged since the 1990s in the multiplicity paradigm proposed by Servaes. This paragon is more than a *„many-roads-lead-to-Rome”* approach, as one can go by foot, by plane, or by boat and one can mobilize others to join them to Rome without having to listen to the commands from Rome. Health communication within this model lists the following as human rights, such as: freedom from exploitation, the right to access adequate health care and health insurance, equity, community efficacy to come up with one's own solutions to manage resources and health issues, participatory democracy and sustainability in health, and health for all in a given socioeconomic and cultural system at all geopolitical levels. With the help of the new media, the dream of managing community health and disease prevention by the people and for the people, has become a reality.

Scholars tackle with medical communication perspectives within the framework of the multiplicity model at the individual level, interpersonal level and group or community level:

1. At the individual level, the Self Determination Theory of SDT by Ryan and Deci is preferred. This hypothesis focuses on the context where an individual lives or the extrinsic factors that lead that person to motivate oneself to engage in behavioral change. The internalization process of an individual comes from having opportunities to make a choice that is meaningful to oneself in the socialization process and receive positive feedback to encourage the change of behavior. This means an individual can not change his/her behavior by just receiving a message, one has to have an environment that enables them to foster desirable health behaviors.

2. At the interpersonal level, life skill training and education are essential to build up intrinsic factors of an individual to prevent health risk behaviors and health hazards. Intercultural competency training is important for health care professionals to empathize with patients and people in the community.

3. At a group or community level, social capitals such as support groups and peers together with positive rewards can help reinforce the change of bad habits into desirable ones. Theories of social network and social support, community organization and community building theories as well as the PRECEDE/PROCEED Model and the Ecological Models of Health Behavior have in common the characteristics of an enabling environment, including advocacy communication, participatory communication, communication for structural and sustainable social change.

Promoting effective communication regarding health is about using the mass media to empower the voiceless to be heard regarding health hazards, issues on environment and health-related issues. Participatory communication for health enables the locals, regardless of sociocultural and politico- economic status, to act and have dialogues in a democratic way to discuss and prevent diseases, hazards and pollutions, to promote healthy life style, safety and clean environment.

Participatory- based advocacy diversifies advocacy communication by adding the idea that the locals could get together and manage the content of the mass media, used to advocate solutions on health issues, pollution, hazards and clean environment. Health communication for structural and sustainable social change uses *mix and match* approaches, to advocate change and participation according to the situation, felt-needs of the locals, the budget and available resources. A health communicator can be called a social mobilizer who cultivates his/her attitude to empathize with others, in order to achieve capacity building and empowerment, to be able to mobilize the community to research, plan, and execute projects that are useful for the sustainability on health of the community.

Conclusion

"The patient will never care how much you know, until they know how much you care." (Terry Canale in his American Academy of Orthopaedic Surgeons Vice Presidential Address)

Doctor-patient communication is a major component of the process of health care. Doctors are in a unique position of respect and power. Hippocrates suggested that doctors may influence patients' health. Effective doctor - patient communication can be a source of motivation, incentive, reassurance and support. A good doctor - patient relationship can increase job satisfaction and reinforce patients' self-confidence, motivation, and positively influence their view of their health status, thus positively impacting the treatment outcome

Most complaints about doctors are related to issues of communication, not clinical competency. Patients want doctors who can not only skillfully diagnose and treat what ails them, but also communicate with them effectively.

Doctors with better communication and interpersonal skills are able to detect problems earlier, can prevent medical crises and expensive intervention and provide better support to their patients. This may lead to higher-quality treatment, more satisfaction, lower costs of care, greater patient understanding of health issues and better adherence to the treatment process, resulting in a better outcome. There is currently a greater

expectation of collaborative decision making, with physicians and patients participating as partners to achieve agreed upon goals and the improvement of quality of life.

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