Perceptions of health professionals about the quality of communication and deliberation with the patient and its impact on the health decision-making process

Eduardo Osuna,1 Antonio Pérez-Carrión,2 María D. Pérez-Cárceles,1 Francisco Machado2
1Department of Forensic Medicine, School of Medicine, University of Murcia; 2University Hospital Reina Sofia, School of Medicine, University of Murcia, Spain

Abstract

The information process is considered a core element in decision-making and an obligatory matter of concern for the health professional. Rather than information *per se*, we should perhaps mention the need for communication between the health professional and the patient, which should be appropriate to each specific case and situation. Interaction and communication during the relationship generates a degree of trust that contributes to improving care quality and better medical outcomes. Ideally, communication is a balanced exchange of information, ideas and preferences, and, as such, helps promote patient autonomy. Knowing the perceptions of professionals about the quality of communication may be useful for identifying deficiencies and the repercussion of the same in the decision-making process and health care in general. Promoting strategies of communication in the health system is of great value for preventing errors and failures in health care. Increasingly, effective communication is considered as one of the basic competences to be imparted in university training, and should remain a continuous subject of study for all health professionals.

Introduction

The doctor-patient relationship, which is as old as medicine itself, begins when a person feels the need for health care because of a real or a possible illness. In ancient times it was governed by the criterion of welfare, “*primum non nocere*” (first, to do no harm), which was guided exclusively by the pursuit for the patient’s well-being, so that decision-making was the professional’s responsibility, with no or little intervention on the patient’s part. However, with the recognition of rights relating to the person in the health care field and the “principle of autonomy”, which began to develop during the 1970s, patients became the protagonists, resulting in a participative model of the *health relationship*, which culminated in the right to provide informed consent.

The informed consent process holds many ethical and legal challenges that physicians can assist in resolving by using clear communication and eliminating potential obstacles. The idea of individual autonomy entitles a patient to accept or refuse any medical procedure, and is the basis of a correct informed consent procedure. Patients have a right to actively participate in making healthcare decisions, taking into account their values, ideals, beliefs and life project.1,2

Information exchange is the dominant communication model.3 In shared decision making, both parties share information: the clinician offers options and describes their risks and benefits, and the patient expresses his or her preferences and values. Each participant is thus armed with a better understanding of the relevant factors and shares responsibility in the decision about how to proceed.4 In this context, communication, which should be appropriate to each specific case and situation, becomes a core element in the interaction between patients and doctors in the decision-making process. Moreover, communication has a therapeutic quality by helping patients to incorporate their illness into their life models.

Cultivating effective communication skills, coupled to awareness and application of ethical principles, is integral to this process. One of the foremost challenges in effective patient-doctor interaction is negotiating situations that arise in the framework of the disease, as seen from different angles that may come into conflict with the idea of patient autonomy.

We propose as a working hypothesis that the process of obtaining consent has deficiencies that stem from inadequate information and communication; hence, the aim of the present study was to know the perception of professionals concerning the quality of communication and its impact on the ability of the patient to make decisions, and the degree of involvement of health professionals in the process of communication.
Design and Methods

A descriptive and observational study involving healthcare professionals who work in public healthcare centres in the Region of Murcia (SE Spain), in compliance with ethical research standards and essential legal requirements, is presented. At all times, the regulations guaranteeing the confidentiality of personal data and their automated processing were respected, in accordance with the provisions of Regulation (EU) 2016/679, 27 of April, on the protection of natural persons with regard to the processing of personal data and the free movement of such data, with regard to both confidentiality and the custody of the information. No person outside the research team had access to/was permitted to use the information.

The sample consisted of 2186 health professionals (32.4% male and 67.6% female). To carry out the study we visited 56 medical centres of the Region of Murcia (10 hospitals and 46 primary care health centres). The average age was 38.77 years (range 19 to 67 years). It is important to note that 49.6% of subjects were between 31 and 50 years old (35.5% were less than or equal to 30 years and 14.9% were older than 50). According to professional qualifications, 72.2% were nurses, physicians accounted for 26.8%, and 1% were pharmacists. According to the years of professional practice, the majority (59.62%) had worked for between 11 and 30 years (22.47% 10 years or less than; 17.91% more than 30). 95% of respondents had direct contact with patients during their professional activity. 21.8% of the professionals in the study worked in primary care and 78.2% were specialists.

Once the sample was selected, a questionnaire composed of 20 items was used to collect the data, with open and closed questions and following a period of validation. The first 6 items concerned socio-demographic aspects and aspects related to the workplace (sex, age, professional category, years of professional practice, service or clinical unit and management centre). The remaining items analysed issues related to the process of communication with the patient and obtaining informed consent. The replies are organised on a scale of 1 to 4, where 1 is 'I very much disagree' and 4 is 'I very much agree'; also possible as a reply was 'don’t know/no answer'.

The data were processed with the statistical package IBM SPSS 22.0 for Windows. A descriptive analysis of the quantitative variables (average, median and deviation standard) was made and an analysis of the distribution of frequencies for qualitative variables. Comparisons between quantitative variables were carried out using Student’s t test or combined with the Behrens-Fisher test, depending on whether or not there was homogeneity of variances between both samples. For the qualitative variables, a non-parametric Mann-Whitney test was performed.

To analyse the relation between variables, a contingency table analysis was carried out with Pearson’s Chi-square test and differences between groups were considered statistically significant at $P \leq 0.05$.

Results

Table 1 shows the frequencies and percentages of the replies to the different questions. In our study 75.8% of the subjects thought that communication skills in their workplace were sufficient to provide a good service to the patient (Table 1). There were no differences in the answers as regards the gender of those surveyed. Regarding age, those younger than 30 years old were very satisfied with the communication skills of their colleagues (P<0.01), while those in the age group 30-50 were not very satisfied (P<0.001) (Table 2). In terms of profession, doctors were very satisfied (P<0.01), nurses not very satisfied (P<0.01) and pharmacists very unsatisfied (P<0.001). We found no significantly statistical differences as regards the workplace (primary attention or specialised attention).

We found statistically significant differences in the replies to the question “Are the communicative skills of your colleagues (in the same service, unit, centre) sufficient to provide the best attention to their patients?” (P<0.05) in the scores given to the communication process (P<0.001) between the professionals working in different specialties. Those working in Intensive Care, primary attention, obstetrics and oncology considered that the communicative skills of their colleagues were adequate for the health care of their patients. Of these, the professionals working in oncology and Intensive Care units had the best opinion of their colleagues 29.6% of oncologists and 20.9% of Intensive Care professionals thinking the level excellent. This percentage fell to 9.0% in surgery, 7.9% in traumatology and 6.8% in anaesthesiology.

Participants were asked what health professional they thought had the better communication skills, whether in primary or specialised care. The most common opinion was that nurses were most skilled at communicating with patients (75.6% for specialised care and 69.5% for primary care).

78.7% of health professionals think that they possess sufficient communication skills to provide good patient care (Table 1). This answer was mostly chosen by males (P<0.001) (Table 3). Also, those younger than 30 and those older than 50 thought they had adequate communication skills, while those of the 30-50 age group had less trust in their communication skills (P<0.05) (Table 4). Amongst professional groups, it is interesting that while doctors mostly thought they had good communication skills with patients, nurses considered that their skills were insufficient (P<0.01) (Table 5). Also, primary attention professionals mostly answered that they have adequate communication skills in comparison with specialists (P<0.01).

The vast majority of those surveyed (93.8%) agreed or very

---

Table 1. Frequencies and percentages (%) of the responses of health professionals to the different questions.

| Question                                                                 | I very much disagree | I disagree | I agree | I very much agree | I don’t know/no answer |
|-------------------------------------------------------------------------|----------------------|------------|---------|------------------|-----------------------|
| Communication skills in the workplace are adequate to provide the best patient care. | 58 (2.7)             | 397 (18.2) | 1085 (49.6) | 572 (26.2)      | 74 (3.4)              |
| I have sufficient communication skills to provide good patient care.     | 67 (3.1)             | 381 (17.4) | 1145 (52.4) | 518 (23.7)      | 75 (3.4)              |
| I adapt the communicative process to the age and cultural level of the patient. | 21 (1.0)             | 111 (5.1)  | 945 (43.1)  | 1066 (48.8)     | 45 (2.1)              |
| I plan the information to give my patients when confronted with delicate or sensitive matters. | 143 (6.5)            | 357 (16.3) | 914 (41.8)  | 602 (27.5)      | 179 (7.8)             |
| The patient was aware of the details of the pathological process, treatment and alternatives. | 239 (10.9)            | 779 (35.6) | 794 (36.3)  | 296 (13.5)      | 78 (3.6)              |
| During the communication process the patients received convincing explanations about their pathology. | 174 (8.0)             | 626 (28.6) | 925 (42.3)  | 280 (12.8)      | 181 (8.3)             |
much agreed that they adapt their communicative process to the age and cultural level of the patient (Table 1). There were no significant differences for sex, age, professional category, service or management centre. The results show that nearly a quarter of those surveyed (24.8%) do not previously plan the information they are going to give their patients when confronted with delicate or sensitive matters (Table 1). Between sexes, males planned these situations less (P<0.01).

We asked questions related to any prior communication with the patient during the process of obtaining informed consent, and asked whether patient was made aware of the details of the patho- logical process, treatment and alternatives. The answers were practically the same, 51.7% considering that they knew, and 48.3% that they did not (Table 1). Significant differences were observed in this respect regarding workplace, primary attention professionals being more likely to answer that patients know, while specialists were more likely to answer that they do not (P<0.001) (Table 6).

Finally, we asked the professionals in our sample whether during the communication process the patients received convincing explanations about their pathology. In this respect, 60.1% of professionals answered affirmatively (Table 1). Amongst doctors and primary care professionals the general opinion was that explanations were adequate. On the other hand, nurses and specialised attention professionals thought otherwise (P<0.001).

| Table 2. Answers to 'Communication skills in the workplace are adequate to provide the best patient care', according to the age of the health professionals (less than or equal to 30 years of age; 31-50 years old; over 50 years old) (P<0.001). |
|---|---|---|---|---|
| Age | I very much disagree | I disagree | I agree | I very much agree |
|---|---|---|---|---|
| Less than or equal | 30 years old |  |  |  |
| Frequency | 18 | 112 | 398 | 230 |
| % | 31.0 | 28.2 | 36.7 | 40.2 |
| Residuals | -0.8 | -3.5 | 0.8 | 2.5 |
| 31-50 years old |  |  |  |  |
| Frequency | 31 | 226 | 527 | 259 |
| % | 53.4 | 50.9 | 48.6 | 45.3 |
| Residuals | 0.6 | 3.3 | -0.8 | -2.3 |
| Over 50 years old |  |  |  |  |
| Frequency | 9 | 59 | 160 | 83 |
| % | 15.5 | 14.9 | 14.7 | 14.5 |
| Residuals | 0.2 | 0.1 | 0.0 | 0.2 |

| Table 3. Answers to the 'I have sufficient communication skills to provide good patient care' according to the sex of the health professionals (P<0.001). |
|---|---|---|---|---|
| Sex | I very much disagree | I disagree | I agree | I very much agree |
|---|---|---|---|---|
| Male |  |  |  |  |
| Frequency | 16 | 104 | 361 | 204 |
| % | 24.2 | 27.4 | 31.8 | 39.9 |
| Female |  |  |  |  |
| Frequency | 50 | 276 | 776 | 307 |
| % | 75.8 | 72.6 | 68.2 | 60.1 |
| Residuals | 1.5 | 2.5 | 1.0 | -4.0 |

**Discussion**

Health assistance is becoming more complex. We are all witnesses to the intense technological evolution that now enables the use of powerful diagnosis and treatment instruments. However, patient care cannot be conceived exclusively from a technical point of view although it may take place in a highly scientific-technical
environment, and it is also necessary to develop a communicative relationship that permits carers to help patients during their ordeal and to share in the process of decision making.

Despite the huge advances in medical science, health-related professions are still founded on intensely interpersonal relations. A person with an illness asks a professional for help, which makes this relationship between the professional and the patient the cornerstone of medical care. Therefore, interaction and communication during the relationship generates a degree of trust that impacts positively on the levels of patient and professional satisfaction and on treatment adherence, which contributes to improving care quality and health-related results.

Good communication skills improve medical care (and reduce liability exposure) and help to physicians to understand patient expectations, and to help regulate patients’ feelings.

Identifying professionals with negative attitudes towards communications skills will enable health providers to set up intervention programmes to promote favourable attitudes and help ensure the delivery of quality patient care. Our results reveal the high consideration that professionals hold for their communication skills with patients since almost 80% of those surveyed, think they are sufficiently skilled.

Studies on doctor-patient communication have demonstrated patient discontent even when many doctors considered the communication adequate or even excellent. Doctors tend to overestimate their abilities in communication. Tongue et al. reported that 75% of the orthopaedic 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. Our study identified differences in the perception that professionals have concerning the communication skills of their colleagues. In general, they have a good impression of these skills, particularly in some specialities. Specialists in oncology, Intensive Care, primary attention and obstetrics thought the communications kills of those in their field adequate for helping patients, this being particularly true in the case of Oncology and Intensive Care.

When asked what health professional they thought had the best communication skills, the most common opinion was that nurses were most skilled at communicating with patients. Nursing studies focus on the effectiveness of nurses’ communication with patients and the nurses’ attitudes towards communication with patients. Giménez-Esperta and Prado Gascó explored the association and predictive value of attitude components (behavioural, cognitive and affective) with communication behaviour and found the highest scores in cognitive and behavioural dimensions, while the scores were worse in the affective component. Also, most of the professionals in our study (93.8%) answered that they adapt the communicative process to the patient’s needs, that is in which there is a balanced exchange of information, ideas and preferences, and in which each plays a complementary role during the interaction. This forms part of the model of the patient-centred relationship and helps promotes patient autonomy of contributes to making decisions in a balanced way. However, for certain authors communication adopts an asymmetric form, deformed by a confabulation process that only seems like shared comprehension. Every conversation is organised in terms in order to avoid silence or both participants talk at the same time, or redirect the conversation when something has been misunderstood. During the conversation several signals are used to organise the dialogue. Some are implicit, such as body language, looks, tone of voice, while other are explicit, such as affirmations, suggestions, petitions or questions. In any communication with the patient the non-verbal aspects of communication are of considerable importance. Classically, it is estimated that 80% of communication amongst individuals is non-verbal, which is an aspect that has received little attention in the health field and there are few tools to evaluate it. Non-verbal communication is especially relevant for social-emotional exchanges. Visual contact with the patient and gesticulation is also of great transcendence for improving the affective component of the interaction and assuring trust in the relationship. Through non-verbal communication attitudes are transmitted and supported, interest and relationships are communicated. It is of great importance to maintain an adequate level of communication with the patient in any medical discipline, but perhaps most importantly in primary care, since it is at this assistance level that most health problems are resolved and is also the first contact with the rest of the health system. In our study sample, although most of those surveyed considered their formation in communication skills adequate, we show that middle aged professionals of and those with long professional experience (31-50 years) as well as the nurses, refer to and claim a lack of formation in this matter. It is the professionals of primary attention who answer mostly that they have adequate communication skills compared with specialised professionals.

Ahnasser et al. found that confidence in communication skills amongst physicians is dependent on their years of experience. With the lack of communication skills courses in medical school curricula, trainees and younger physicians find themselves unprepared to communicate with their patients properly.

Conclusions

Communication between physicians and patients is the core of quality health care. Professionals with better communication and interpersonal skills provide better support to their patients. According our results, the perception that health professionals have on communication skills is that they are overvalued since a high percentage of those questioned considered that they possess sufficient communication skills to provide good patient care and
that they adapt their communicative process to the patients. However a quarter do not previously plan the information they are going to give their patients when confronted with delicate or sensitive matters and almost half consider that during the communication process the patients do not receive convincing explanations about their pathology. For this reason the results cannot be considered totally satisfactory. Those working oncology and Intensive Care tend to have a good perception of their colleagues’ communication skills, while the most common opinion was that nurses were most skilled at communicating with patients. Professionals with better communication and interpersonal skills provide better support to their patients. In modern medicine, there is a greater expectation of collaborative decision making, with professionals and patients participating as partners to achieve the agreed upon goals in accordance with the personal beliefs, values and attitudes.

Correspondence: Eduardo Osuna, Department of Forensic Medicine, University of Murcia, Murcia, E-30100. Spain. Tel.: +34.686883652 - Fax: +34.686883956. E-mail: eosuna@um.es

Key words: Physician-patient relations; Patient-centred care; Communication; Decision making.

Contributions: EO contributed to the conception and design of the study, statistical analyses, interpretation of the data, drafting of the manuscript, and gave final approval for submission of the manuscript. APC contributed to the data acquisition, interpretation of the data, drafting of the manuscript, and gave final approval for submission of the manuscript. MDPC contributed to interpretation of the data, drafting of the manuscript, and gave final approval for submission of the manuscript. FM contributed to the interpretation of the data, drafting of the manuscript, and gave final approval for submission of the manuscript.

Conflict of interest: the authors declare no potential conflict of interest.

Funding: none.

Received for publication: 27 July 2018.
Revision received: 29 October 2018.
Accepted for publication: 22 November 2018.

©Copyright E. Osuna et al., 2018
Licensee PAGEPress, Italy
Journal of Public Health Research 2018;7:1445
doi:10.4081/jphr.2018.1445
This work is licensed under a Creative Commons Attribution NonCommercial 4.0 License (CC BY-NC 4.0).

References
1. Gallagher T, Levinson W. A prescription for protecting the doctor-patient relationship. Am J Manag Care 2004;10:61-8.
2. Giampieri M. Communication and informed consent in elderly people. Minerva Anestesiologiale 2012;78:236-42.
3. Ha JF, Longnecker N. Doctor-patient communication: A review. Ochsner J 2010;10:38-43.
4. Barry MJ, Edgman-Levitan PA. Shared Decision Making - The Pinnacle of Patient-Centered Care. N Engl J Med 2012; 366:780-1.
5. Raposo L, Osoña E. European Convention of Human Rights and Biomedicine. In: Beran RG, editor. Legal and Forensic Medicine. Berlin Heidelberg: Springer; 2013. p. 1405-23.
6. Pawlikowska T, Zhang W, Griffiths F, van Dalen J, van der Vleuten C. Verbal and non-verbal behavior of doctors and patients in primary care consultations. How this relates to patient enablement. Patient Educ Couns 2012; 86:70-6.
7. Riess H, Kraft-Todd G. E.M.P.A.T.H.Y.: a tool to enhance non-verbal communication between clinicians and their patients. Acad Med 2014; 89:1108-12.
8. Barth RJ. New findings highlight the misdirected utilization of patient satisfaction surveys and the importance of patient psychology in general medical care. J Bone Joint Surg Am 2015; 97:c48.
9. Haynes RB, McDonald HP, Garg AX. Helping patients follow prescribed treatment: clinical applications. JAMA 2002; 288:2880-3.
10. McDonald HP, Garg AX, Haynes RB. Interventions to enhance patient adherence to medication prescriptions: scientific review. JAMA 2002;288:2868-79.
11. Anhang Price R, Elliott MN, Zaslavsky AM. Valuing patient experience as a unique and intrinsically important aspect of health care quality. JAMA 2013;148:985-6.
12. Apker J, Baker M, Shank S, Hatten K, VanSweden S. Optimizing hospitalist-patient communication: an observation study of medical encounter quality. Jt Comm J Qual Patient Saf 2018; 44:196-203.
13. Tongue JR, Epps HR, Forese LL. Communication skills for patient-centered care. J Bone Joint Surg Am 2005;87:652-8.
14. Epstein RM, Franks P, Fiscella K., et al. Measuring patient-centered communication in patient-physician consultations: theoretical and practical issues. Soc Sci Med 2005;61:1516-28.
15. Shapiro SM, Lancer WJ, Richards-Bentley CM. Evaluation of a communication skills program for first-year medical students at the University of Toronto. BMC Med Educ 2009;9:11.
16. Ahmed F, Burt J, Roland M. Measuring patient experience: concepts and methods. Patient 2014;7:235-41.
17. Rea D, Griffiths S. Patient safety in primary care: incident reporting and significant event reviews in British general practice. Health Soc Care Community 2016;24:411-9.
18. McCabe C. Nurse-patient communication: an exploration of patients’ experiences. J Clin Nurs 2004;13:41-9.
19. Finke EH, Light J, Kitko L. A systematic review of the effectiveness of nurse communication with patients with complex communication needs with a focus on the use of augmentative and alternative communication. J Clin Nurs 2008;17:2102-15.
20. Tay LH, Ang E, Hegney D. Nurses’ perceptions of the barriers in effective communication with inpatient cancer adults in Singapore. J Clin Nurs 2012;21:2647-58.
21. Chan EA, Jones A, Fung S, Wu SC. Nurses’ perception of time availability in patient communication in Hong Kong. J Clin Nurs 2012;21:1168-77.
22. Mullan BA, Kothe EJ. Evaluating a nursing communication skills training course: the relationships between self-rated ability, satisfaction, and actual performance. Nurs Educ Pract 2010;10:374-8.
23. Gustafsson M, Borglin G. Can a theory-based educational intervention change nurses’ knowledge and attitudes concerning cancer pain management? A quasi-experimental design. BMC Health Serv Res 2013;13:328.
24. Giménez-Esperta MDC, Prado-Gascó VJ. The development and psychometric validation of an instrument to evaluate nurses’ attitudes towards communication with the patient (ACO). Nurse Educ Today 2018;64:27-32.
25. Bertakis KD. The influence of gender on the doctor-patient interaction. Patient Educ Couns 2009;76:356-60.
26. Roter DL, Hall JA. Physician gender and patient-centered communication: a critical review of empirical research. Annu Rev Public Health 2004;25:497-519.
27. Betancourt H, Flynn P M. The psychology of health: Physical health and the role of culture and behavior. In Villarruel FA, Carlo G, Grau, JM, et al. (Eds.) Handbook of U.S. Latino psychology: Developmental and community-based perspectives. Thousand Oaks, CA, US: Sage Publications, Inc. 2009. pp. 347-361

28. Napier AD, Ancarno C, Butler B, et al. Culture and health. Lancet 2014;384:1607-39.

29. Collins DE. Multidisciplinary teamwork approach in labor and delivery and electronic fetal monitoring education: a medical legal perspective. J Perinat Neonatal Nurs 2008;22:125-32.

30. Walseth L, Abildsnes E. Lifestyle, health and the ethics of good living. Health behaviour counselling in general practice. Patient Educ Couns 2011;83:180-4.

31. Rao JK, Anderson LA, Inui TS, Frankel RM. Communication interventions make a difference in conversations between physicians and patients: a systematic review of the evidence. Med Care 2007;45:340-9.

32. Berwick DM. What ‘patient-centered’ should mean: confessions of an extremist. Health Aff (Millwood) 2009; 28:w555-65.

33. Robins L, Witteborn S, Miner L, Mauksch L, Edwards K, Brock D. Identifying transparency in physician communication. Patient Educ Couns 2011; 83:73-9.

34. Gorawara-Bhat R, Cook N, Sachs G. Nonverbal communication in doctor–elderly patient transactions (NDEPT): Development of a tool. Patient Educ Couns 2007;66:223-34.

35. Roter DL, Frankel RM, Hall JA, Shuyter D. The expression of emotion through nonverbal behavior in medical visits. J Gen Intern Med 2006;21:S28-34

36. Mast MS. On the importance of nonverbal communication in the physician–patient interaction. Patient Educ Couns 2007;67:315-8.

37. Butalid L, Bensing JM, Verhaak PF. Talking about psychosocial problems: An observational study on changes in doctor–patient communication in general practice between 1977 and 2008. Patient Educ Couns 2014;94:314-21.

38. Stepanikova I, Zhang Q, Wieland D, et al. Non-verbal communication between primary care physicians and older patients: how does race matter?. J Gen Intern Med 2012;27:576-81.

39. Alnasser YS, Bin Nafisah HM, Almubarak ZA, et al. Communication skills between physicians’ insights and parents’ perceptions in a teaching hospital in KSA. J Taibah Univ Med Se 2017;12:34-40.