

Do our talks with patients meet their expectations?

Yes, for the most part they do. Results of this study, however, reveal specific areas that require greater attention

Practice recommendations

- Patients want an attentive, friendly, frank and empathic doctor who listens well.
- To enhance quality of health care, consider asking patients at the end of a visit whether their communication preferences were met.

One physician has written that good patient-doctor communication, like jazz, calls for improvisation.¹ We agree. And improvise we must when patients' expectations for how we will communicate with them vary between visits and individuals.

For example, those who are ill may prefer that their doctor communicate with them in a way that is less important to those who are healthy. Patients with biomedical problems may have different preferences than persons with psychosocial problems. And older individuals may have communication desires that differ from those who are younger.²⁻⁴

Do patients want cure or care, or both?

Depending on the reason for a visit—eg, biomedical or psychosocial—patient preferences may fit either the cure or the care dimension.

Cure dimension. On one hand, patients expect their doctor to be task-oriented and to find a cure for what ails them. They want an explanation of what is wrong and advice about possible treatments, and they want the doctor to do whatever is needed to get answers.⁵

Care dimension. On the other hand, patients may feel anxious and want reassurance. They expect the doctor to listen to their story and encourage them to disclose all health problems, concerns, and worries. They also expect friendliness and empathy. They want to be taken seriously. The extent to which the doctor shows this affect-oriented (and patient-centered) behavior will determine how fulfilled patients feel in their preference for care.^{6,7}

Why does it matter? Good communication serves a patient's need to understand and to be understood.^{6,8,9} And communication aimed at matching patient preferences enhances satisfaction with care, compliance with medical instructions, and health status.¹⁰⁻¹³

How well do we assess patients' communication preferences?

Patient-centered behavior is a necessary tool for discovering and fulfilling patients' task-oriented (cure dimension) and affect-oriented (care dimension) communication preferences.¹⁴⁻¹⁷ It's important to

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TABLE 1

**General practitioner and patient characteristics
 (N GPs=142, N patients=1787)**

	MEAN	SD	RANGE
GP characteristics			
Age (yrs)	46.9	6.2	32-62
Full-time equivalents	0.8	0.2	0.2-1
Patient characteristics			
Age (yrs)	49.5	17.4	18-95
Psychosocial problem (1=yes)	9.8%	—	—
Overall health (1=excellent, 5=poor)	3.2	1.1	1-5
Depressive feelings (1=not at all, 5=extremely)	2.2	1.2	1-5
Consultation length (min)	10.1	4.8	1.3-33.0
Patients' preferences			
Affect-oriented preference (1=not, 4=utmost important)	3.2	0.5	1-4
Task-oriented preference (1=not, 4=utmost important)	3.1	0.6	1-4

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**Communication
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know how well primary-care physicians interpret patients' preferences for clinical encounters and if they respond in a manner that satisfies those expectations.

Reassuringly, patients indicate on surveys that their physicians do a fairly good job of interpreting their communication preferences and acting accordingly.¹⁸⁻²⁰ They also report that their desires and expectations from consultations are increasingly met.

There is always the worry, though, that physicians in certain positions—eg, non-gatekeeper roles or positions involving only part-time clinical responsibilities—would be challenged to assess patient preferences as accurately as others.²¹

The aim of our study

While it's encouraging that physicians by and large understand their patients and communicate with them meaningfully, we wondered whether communication could improve further. Our purpose in this study was to gain detailed insight into patients' preferences in physician

communication and, through patients' subjective perspectives and observed real practice consultations, learn how well physicians communicate according to those preferences.

Methods

Design

We derived physician data from the Second Dutch National Survey of General Practice (2001). This study was carried out in practices representative of Dutch general practice.²² We asked patients for permission to videotape consultations with the general practitioner (GP), and asked them to sign a consent form. Collected data were kept private as per regulations.

We videotaped consultations of 142 GPs (76.1% male) and 2784 patients (41.2% male). The number of patients cared for by each GP ranged between 17 and 21 (mean=19.6). Each patient was videotaped just once. We rated roughly 15 patient-consultations per GP (13-15, mean=14.8), excluding the first 3 to correct for possible bias because of the video camera. Before and immediately after the consultation, patients 18 years of age and older answered a questionnaire. We used data from 1787 patient consultations.

Patients rate their communication preferences

The patient questionnaire covered demographic characteristics (gender, age, education); health problems (psychosocial or not [ICPC-coded]);²³ overall health during the past 2 weeks (1=excellent, 2=very good, 3=good, 4=fair, 5=poor); and depressive feelings during the past 2 weeks (1=not at all, 2=slightly, 3=moderately, 4=quite a bit, 5=extremely) (COOP-WONCA charts²⁴).

We defined communication preferences as "the extent of importance patients attach to communication aspects."²⁵ Patients' preferences and the actual performance by the GP were measured using the conceptual framework of

the QUOTE scale (quality of care through the patient's eyes).^{5,25}

Before consultation, patients recorded how important they considered different aspects of communication for the coming visit (1=not important, 2=rather important, 3=important, 4=utmost important). Following consultation, they rated the GP's performance in meeting their expectations for these aspects (1=not, 2=really not, 3=really yes, 4=yes).

Factor analysis of both the pre- and post-visit lists of questions on preference and performance revealed 2 relevant subscales: an affect-oriented scale of 7 communication aspects and a task-oriented scale of 6 communication aspects (Cronbach's alpha between 0.74 and 0.89).

We also used communication aspects from the original 4-point scale to present 4 new categories that compared and contrasted preferences and relevance. These categories included: important and performed; important and not performed; not important and performed; not important and not performed. In the multilevel analysis, we included the 2 subscales using the original 4-point scale.

Socio-demographic and practice variables were derived from the GP questionnaires in the Second Dutch National Survey of General Practice (2001).

Video observations

Nine observers measured verbal behavior during the videotaped visits using the Roter Method of Interaction Process Analysis (RIAS²⁶), a well-documented, widely used system in the US and Netherlands. This observation system distinguishes both affect-oriented (socio-emotional) and task-oriented (instrumental) verbal behavior of doctors and patients, reflecting the care and cure dimensions, respectively. The RIAS categories are mutually exclusive and exhaustive.

Affect-oriented communication consists of personal remarks, agreements, concerns, reassurances, paraphrases, and disagreements.

Task-oriented talk includes asking questions, giving information, and (only GPs) counseling about medical/therapeutic and psychosocial, social context and lifestyle issues, and process-oriented talk (instructions, asking for understanding).

After finishing the RIAS-coding, we calculated the total numbers of affect-oriented and task-oriented verbal behaviors separately for GPs and patients.

The relevance and performance items and the RIAS-categories all measured the affect-oriented and task-oriented aspects.

We used the Noldus Observer-Video-Pro computer program for the observation study,²⁷ including measurement of consultation length. The interobserver reliabilities were good to excellent: between $r=0.80$ to $r=0.95$ per category, except for personal remarks (0.72).

Patient-centeredness measured in 3 ways

The observers, using a 5-point scale, also rated the extent to which GPs communicated in a patient-centered way in 3 areas: patient's involvement in the problem-defining process; patient's involvement in the decision-making process; and doctor's overall responsiveness to the patient.

Based on ratings in these 3 areas, we determined an overall magnitude of patient-centeredness (Cronbach's alpha=0.75). Observers and the responsible researcher met weekly to validate the quality of rating. The same was done for the RIAS coding.

Controlling variables

For GPs, controlling variables were gender, age, and number of full-time equivalents (FTEs) working. For patients, GP and patient gender were included in the variable "gender-dyad"—male GPs/male patients, male GPs/female patients, female GPs/male patients, female GPs/female patients. Other patient variables were age; education (low=not/primary school, middle=secondary school, high=higher vocational training/university); health problems: somatic or

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General practitioners did well with affect-oriented communication; less so with task-oriented aspects

psychosocial (ICPC chapters); overall physical health and mental health during the past 2 weeks; and consultation length.

Data analysis

We used descriptive and multilevel analyses. The intra-class correlations of the affect-oriented and task-oriented communication and patient-centeredness were significant (between .05 and 0.23), which made it clear that consultations of the same GP did indeed exhibit a greater degree of similarity than the consultations of different GPs. Therefore, multilevel analyses were necessary to account for the clustering of patients with the same GP.²⁸ We applied a significance level of ≤ 0.05 (2-sided).

Results

Response rate

The overall patient response rate was 88%. Analysis of non-responders' gender, age, and type of insurance showed no bias resulting from patients' refusal.

GP response rate was 72.8%. Respondents were representative of all Dutch GPs with respect to gender, age, working hours, practice experience (mean=15.6 years, SD=8.3, range=1-32), and location (58% in an urban area). More GPs worked in a partnership or group practice than in a solo practice. We analyzed the influence of the practice type on doctor-patient communication and deemed it insignificant.

Study population

GP and patient characteristics appear in **TABLE 1**. Among patients, 22% had little education, 62% had an average education, and 16% had higher education. Nearly 10% had a psychosocial problem. GP-patient gender dyads were as follows: 32.1% male GP/male patient; 45.3% male GP/female patient; 6.9% female GP/male patient; 15.8% female GP/female patient.

Preference and performance of communication aspects

GPs good with affect-oriented communication aspects. Patients considered 6 of 7 affect-oriented communication aspects as very important (87%-96%, **TABLE 2**). The item "Doctor was empathic to me" was less important (61%) than items like "Doctor listened well to me" (96%) and "Doctor took enough time for me" (93%). We noted only a few discrepancies between preference and performance of the GPs' affect-oriented behavior. If patients said beforehand that a communication aspect was important, the doctors nearly always performed that aspect. For instance, 87% wanted enough attention from the doctor and received it, while 99% of all patients received GP's attention, whether it was important to them or not.

GPs less successful with task-oriented communication aspects. Many patients wanted information, explanations, advice, and help with their problems (85%-94%, **TABLE 2**). Knowing the diagnosis was less important (77%) than, say, receiving advice on what to do and having details of treatment explained.

GPs also performed most of the task-oriented aspects, if patients considered these aspects important.

Subjectively, preferences for GP task-oriented behavior and perceived performance often went together, though more discrepancies were visible than with affect-oriented behavior. One fifth of patients said their problems were not helped, though they had said this was important. Similarly, GPs did not give a diagnosis to nearly 15% of patients who considered it important.

GP communication varies by doctor gender, patient characteristics

GPs engaged less in affect-oriented than in task-oriented communication (48.6 and 70.0 utterances on average, respectively, $P \leq .001$).

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The more a patient valued affect-oriented talk, the more likely a physician actually showed affective and patient-centered behavior

TABLE 2

**Care vs cure-centered communication:
Physicians fared better on the care side (N=1787)**

AFFECT-ORIENTED ASPECTS (CARE DIMENSION)	PERFORMED		NOT PERFORMED		TOTAL*	
	N	%	N	%	N	%
Doctor gave me enough attention						
Important	1304	87.5	9	0.6	1313	88.1
Not important	174	11.7	4	0.3	178	11.9
Doctor listened well to me						
Important	1456	95.3	10	0.7	1466	95.9
Not important	61	4.0	1	0.1	62	4.1
Doctor took enough time for me						
Important	1412	92.3	11	0.7	1423	93.1
Not important	105	6.9	1	0.1	106	6.9
Doctor was friendly						
Important	1331	87.2	3	0.2	1334	87.4
Not important	193	12.6	0	0.0	193	12.6
Doctor was frank to me						
Important	1451	95.5	5	0.3	1456	95.8
Not important	63	4.15	0	0.0	63	4.2
Doctor took my problem seriously						
Important	1455	95.8	7	0.5	1462	96.3
Not important	55	3.6	1	0.1	56	3.7
Doctor was empathic to me						
Important	846	58.4	36	2.5	882	60.9
Not important	492	34.0	74	5.1	566	19.1
TASK-ORIENTED ASPECTS (CURE DIMENSION)						
Doctor diagnosed what's wrong						
Important	921	62.8	209	14.2	1130	77.0
Not important	197	13.4	140	9.5	337	23.0
Doctor explained well what's wrong						
Important	1166	78.3	101	6.8	1267	85.0
Not important	175	11.7	48	3.2	223	15.0
Doctor informed well on treatment						
Important	1304	86.6	109	7.2	1413	93.9
Not important	75	5.0	17	1.1	92	6.1
Doctor gave advice on what to do						
Important	1294	85.9	121	8.0	1415	94.0
Not important	75	5.0	16	1.1	91	6.0
Doctor helped me with my problem						
Important	1031	70.0	121	18.9	1152	88.9
Not important	94	6.4	16	4.7	110	11.1
Doctor examined me						
Important	902	59.9	132	8.8	1034	62.8
Not important	228	15.1	244	16.2	472	27.2

* Totals do not always add up to 1787 because of missing data.

The more patients regarded affect-oriented talk by GPs as important, the more the GPs actually showed affective and patient-centered behavior (**TABLE 3**). Preferences for task-oriented behavior (question-asking, information-giving, and counseling) were mirrored in their doctors' talk.

When taking into account other GP and patient characteristics, female doctors were more often affect-oriented as well as task-oriented when communicating with patients than were male doctors, especially with female patients. In consultations with older patients and those in poor health, the doctors were more affective than in consultations with younger and healthy patients.

Discussion

Our study suggests most patients receive from their GPs the kind of communication they prefer in a consultation. In general, patients consider both affect- and task-oriented communication aspects important, and believe they are often performed. Our findings agree with most of the literature.^{5,14,20} Furthermore, patients' preferences are for the greater part reflected in the GPs' observed communication during the visit, which agrees with one earlier study¹⁸ but not with others.^{5,20}

Patient preference for an affective doctor is very often met. GPs are generally considered attentive, friendly, frank, empathic, and good listeners. Patients seem satisfied in this respect. However, the task-oriented communication of the GPs is sometimes less satisfying. Contrary to patient preference, for example, GPs are not always able to make a diagnosis.

Observed physician behavior: patients usually get what they want. Looking at the relationship between preferences and actual GP communication, it appears that the more patients prefer an affective or caring doctor, the more they are likely to get an empathic, concerned, interested, and patient-

centered doctor, especially when psychosocial problems are expressed. An affective GP was patient centered, involving patients in problem definition and decision making. This relationship between affective behavior and patient-centeredness was also found in earlier studies.^{22,29} However, Swenson found that not all patients wanted the doctor to exhibit a patient-centered approach.³⁰

Likewise, the more patients prefer a task-oriented doctor, the better the chance they will have a doctor who explains things well, and who gives information and advice to their satisfaction. However, task-oriented doctors are usually less affective and less patient-centered when talking with patients. In view of the postulate that a doctor has to be curing as well as caring,⁶ doctors would be wise to give attention to both aspects.

GPs do improvise while communicating with patients. The study shows that GPs and patients working together can create the type of encounter both want. GPs are able to change their behavior in response to real-time cues they believe patients are giving in an encounter.

Physician gender often makes a difference. Our findings suggest that female doctors are more affective and task-oriented when talking with their patients than are male doctors, especially with female patients. In view of the steady increase of female doctors in general practice, this combined communication style may become more common in the future.

Psychosocial complaints prompt affective communication. Patients with a psychosocial problem are more likely to encounter an affective doctor than those with a biomedical problem. The growing number of psychosocial problems in the population may lead to a more affective communication.

Eventually the demand and the supply of affective communication may coincide. However, it is a challenge for

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Patients who prefer a caring doctor were more likely to get one who was empathic, concerned, interested, and patient-centered

TABLE 3

On observation, physician communication corresponded to patient preferences (N GPs=142, N patients=1787)

	REGRESSION COEFFICIENTS		
	AFFECT-ORIENTED TALK GPs	TASK-ORIENTED TALK GPs	PATIENT- CENTEREDNESS
GP characteristics			
Age (yrs)	-0.20	-0.37*	-0.01*
Full-time equivalents	-12.13*	2.45	0.03
Patient characteristics			
Gender-dyad:			
- Male/female	-0.89 ^c	0.17 ^d	0.01
- Female/male	9.40 ^{a,b,d}	6.24 ^{a,d}	0.10
- Female/female	5.73 ^{a,c}	6.85 ^{a,b,c}	0.02
Age (yrs)	0.09*	-0.15	-0.00*
Education (1=low, 2=middle, 3=high)	-0.70	0.15	0.05
Psychosocial problems (1=yes)	7.93*	-4.62*	0.13*
Overall health (1=excellent, 5=poor)	1.13*	0.96	-0.01
Depressive feelings (1=not at all, 5=extremely)	0.78	-0.72	0.01
Consultation length (min)	4.03*	4.30*	0.04*
Patients' preferences			
Affect-oriented preference (1=not, 4=utmost important)	2.81*	-1.94	0.16*
Task-oriented preference (1=not, 4=utmost important)	-4.23*	3.62*	-0.15*

* $P < .05$

a. Score differs significantly from score of male GP/male patient dyad (reference group).

b. Score differs significantly from score of male GP/female patient dyad.

c. Score differs significantly from score of female GP/male patient dyad.

d. Score differs significantly from score of female GP/female patient dyad.

every doctor to keep his or her mind open to both biomedical (task-oriented) and psychosocial (affective-oriented) information.³¹

Study caveats. Because we used scale scores for affect- and task-oriented preferences instead of the separate item scores for patient preferences, the reflection of preferences for GP communicative behavior might be somewhat overestimated. Likewise, we used total observation scores for affect- and task-oriented talk instead of the separate RIAS categories. More detailed measures of such communication aspects as

empathy might give better insight into patient preferences.

Final thoughts on personal application. Primary care physicians would do well to take notice of patients' preferences for communication. GPs in our study were often able to grasp what patients considered important to talk about, and there seemed to be only modest mismatches between patient expectations and physician behavior. To increase the quality of health care, consider asking patients at the end of a visit whether their preferences were met. ■

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Patients who preferred a task-oriented doctor were more likely to have one who explained things well

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Primary care physicians are able to change their behavior in response to real-time cues from patients

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