Dissertations and Theses   Dissertations and Theses

1984

Satisfaction and quality : patient perspectives in medical care

Marguerite L. Foeller
Portland State University

Follow this and additional works at: https://pdxscholar.library.pdx.edu/open_access_etds

Part of the Health Communication Commons, and the Interpersonal and Small Group Communication Commons

Let us know how access to this document benefits you.

Recommended Citation

AN ABSTRACT OF THE THESIS OF Marguerite L. Foeller for the Master of

Science in Speech Communication presented February 9, 1984.

Title: Satisfaction and Quality: Patient Perspectives in Medical

Care.

APPROVED BY MEMBERS OF THE THESIS COMMITTEE:

Milton Bennett, Chairman

Jean P. Edwards
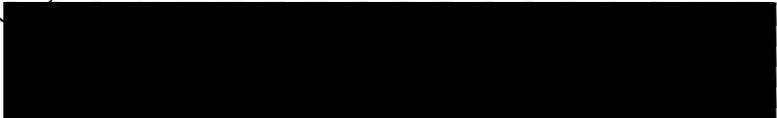
Theodore G. Grove
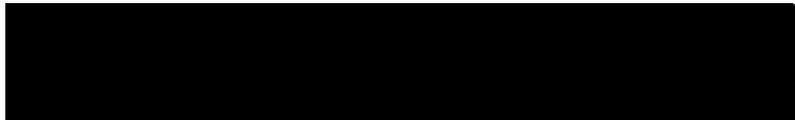
Larry Steward

Patient dissatisfaction with the physician/patient
relationship and medical care is well documented in both the lay
press and the medical literature. This problem appears to stem from
communication between physician and patient and is drawing increased
attention from the communication discipline. Research conducted in
interpersonal communication satisfaction theory provides a basis for
this study of patient satisfaction with physician/patient

communication and its relationship to the perceived quality of medical care.

This paper reports two sets of interviews with a total of 108 respondents on the topic of physician/patient communication which resulted in the identification of nine salient issues which appeared to contribute strongly to patient communication satisfaction. These issues are explained in terms of three areas of communication theory: control, empathy and confirmation.

Examination of the interview results and theoretical framework discussed in this paper served to generate the stated hypothesis: The more satisfied a patient is with his/her communication with the physician, the more satisfied he/she will be with the quality of medical care.

To test this hypothesis, three instruments were administered to a total of 151 subjects. These instruments included:

A. The Physician/Patient Communication Satisfaction Inventory (PPCSI) constructed to measure patient communication satisfaction with eighteen items reflecting the nine issues identified in the examination of the interview results.

B. An interpersonal communication satisfaction inventory (ICSI) adapted for use in this study to establish construct validity of the new instrument and to provide a second measure of communication satisfaction.

C. A nine point verbally anchored graphic rating scale developed to measure perceived quality of medical care.

The data obtained through this method was subjected to statistical analysis procedures which demonstrated reliability and validity of the two communication satisfaction instruments and a significant correlation between communication satisfaction and the perceived quality of medical care. The three themes identified in the analysis of the interview data were found to be highly relevant to patient satisfaction with physician/patient communication and to the perceived quality of medical care.

SATISFACTION AND QUALITY:

PATIENT PERSPECTIVES

IN MEDICAL CARE

by

MARGUERITE L. FOELLER

A thesis submitted in partial fulfillment of the
requirements for the degree of

MASTER OF SCIENCE
in
SPEECH COMMUNICATION

Portland State University

1984

TO THE OFFICE OF GRADUATE STUDIES AND RESEARCH:

The members of the committee approve the thesis of

Marguerite L. Foeller presented February 9, 1984.
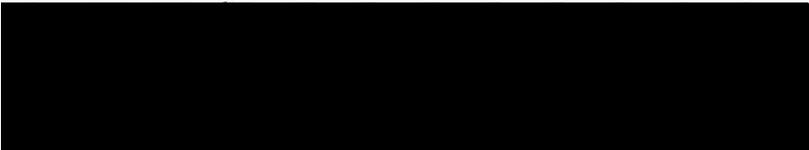
Milton Bennett, Chairman

Jean P. Edwards
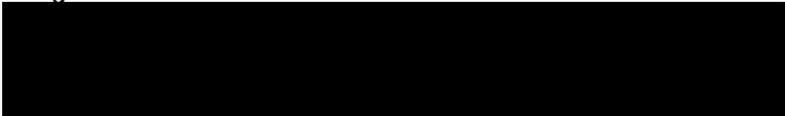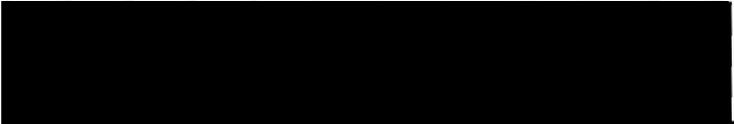
Theodore G. Grove

Larry Steward

APPROVED:
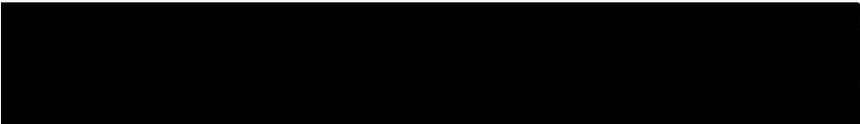
Theodore G. Grove, Chairman, Department of
Speech Communication

Stanley E. Rauch, Dean of Graduate Studies and Research

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

As a professional in a medical setting and a consumer of medical services I have observed that communication between physicians and patients is frequently unsatisfactory. I have also noticed that patient communication satisfaction seems to influence the patient's perception of the quality of medical care.

This observation prompted me to turn to the medical literature to explore the extent of communication problems in medical practice. Numerous computer searches of the medical literature and examination of medical journals revealed that, while this problem is recognized by a number of physicians and allied health professionals, very little research has been addressed to the topic of physician/patient communication and few attempts have been made to remedy what seems to be a lack of emphasis on communication competence by physicians. Dissatisfaction with the physician/patient relationship is documented in the lay press as well and is receiving increased attention from the communication discipline.

This review of the literature substantiated my observation that communication seems to influence patient satisfaction with the physician patient relationship and the perceived quality of medical care. It also supports the significance of the problem addressed in this paper: To what extent is patient satisfaction with physician/patient communication associated with the patient's

perception of medical care?

A study reported in the medical literature directed specifically to patient communication satisfaction provided a rationale for using satisfaction as a framework for examining physician/patient communication and the perceived quality of medical care. An examination of communication theory relating to satisfaction as an outcome of the communication process revealed a study in interpersonal communication satisfaction which provided a theoretical basis for the method described in this paper.

In order to develop an instrument to measure patient communication satisfaction, I first needed to identify salient issues which seem to contribute to patient satisfaction and dissatisfaction. During the initial stage of this process, I listened to people who initiated conversation about their medical experiences and recorded statements which seemed pertinent to physician/patient communication. In all, I kept notes on ninety-six conversations. In examining the information I compiled from these notes, I looked for issues which were cited by a majority of the people with whom I talked and eliminated those which seemed to be uncommon experiences. This process gave me a general awareness of physician communication behaviors which seemed to contribute to patient satisfaction.

At this point, I elected to conduct twelve formal interviews with people who had indicated a prolonged experience with medical care. I chose these subjects, who had all participated in the first stage, according to a specific set of criteria that I designed. The first twelve approached agreed to be interviewed. The interviews

were tape recorded and loosely structured around an interview
checklist which included the issues that emerged from the previously
described conversations. The checklist was completed by the
respondent at the beginning of the interview but did not limit the
respondent to the issues listed. The data from these interviews were
subjected to a process of elimination until nine issues were found
which all twelve subjects agreed were important to their satisfaction
with their physicians.

I divided these issues, according to their content, into three
categories which could be explained in terms of communication theory:
control, empathy, and confirmation. These three themes and the
issues ascribed to each generated item development for a measure of
patient communication satisfaction. The resulting instrument, titled
the Physician/Patient Communication Inventory, was included with an
interpersonal communication satisfaction instrument developed by
Michael Hecht and a rating scale designed for this study to measure
the perceived quality of medical care. The resulting questionnaire
was administered to 151 respondents. The data obtained through this
method were subjected to statistical analysis procedures.

CHAPTER II

PROBLEM AND PURPOSE

The rapid growth of medical technology in recent years has made it possible for physicians to diagnose and treat more human ailments than ever before with a corresponding increase in medical consumerism. The increase in medical knowledge and the development of specialties and subspecialties in medical practice have subtly changed the role of physician as "teacher" to physician as "technologist" or "engineer". This shift may be associated with an increase in patient complaints that today's physician concentrates on the technical aspects of treating disease while neglecting the personal concerns and needs of the patient. The angry cry of one of my students states the problem well: "My doctor may know a lot about fixing broken legs, but he sure doesn't know anything about fixing ME!"

As a professional in a health care setting, I hear frequent and numerous complaints from patients about their physicians; the doctor does not listen, does not care, is not available or in a hurry, uses incomprehensible jargon, and withholds information. Whether or not these complaints are justified, many patients seem to be dissatisfied with their physicians and the quality of medical care they receive.

Patient complaints are seldom directed at the technical skills of the physician. A dissatisfied patient can, in fact, be recovering

well from a successful surgery. Conversely, a patient who is not responding to treatment may insist that his/her doctor is "the best".

Patient dissatisfaction appears to stem largely from the affective skills of the physician. Affective skills are reflected through communication; therefore, communication between physician and patient may contribute to patient satisfaction with the physician/patient relationship and have some influence on patient perception of the quality of medical care.

STATEMENT OF THE PROBLEM

To what extent is patient satisfaction with physician/patient communication associated with the patient's perception of the quality of medical care?

SIGNIFICANCE OF THE PROBLEM

To explore the significance of this problem, I looked to the literature to support my observation that all is not well with physician/patient (P/P) communication. Dissatisfaction with the P/P relationship is reflected in newspaper columns, the popular press and the majority of medical journals and associated health care literature. Poor communication is cited as the cause of dissatisfaction by many of the authors writing on this topic; however very little research has been generated to address this problem.

The Medical Literature

Lack of affective communication on the part of the physician is

not a new concern. Eisenberg and Kleinman (1981), in their essay on clinical social science quote Francis W. Peabody, Professor of Medicine at Harvard, writing in 1930 that:

> The layman of the older generation, who has been disappointed in his medical experience and who feels that something has been lacking in the way of warmth, sympathy and understanding of his case as a whole, is very apt to hark back to earlier days. 'What we need,' he says, 'is a general practitioner!' (p.5)

More recently, Ann Hill-Beuf (1979), in her treatise on children's hospitals, points to what she calls "a dangerous trend in modern American medicine - the separation of medical and technological skill from the affective or caring attitude of the physician" (p.43).

G.L. Engel (1980), in advocating a change in the P/P relationship, describes the importance of communication when he proposes that:

> In the everyday work of the physician the prime object of study is a person, and many of the data necessary for hypothesis development and testing are gathered within the framework of an ongoing human relationship and appear in behavioral and psychological forms, namely, how the patient behaves and what he reports about himself and his life (p. 136).

Korsch, Gozzi, and Francis (1968), reporting in Pediatrics, found that:

> ....a number of communication barriers between pediatrician and patient's mother were found to contribute significantly to patient dissatisfation: notably lack of warmth and friendliness on the part of the doctor, failure to take into account the patient's concerns and expectations from the medical visit, lack of clearcut explanation concerning diagnosis and causation of illness, and use of medical jargon (p. 855).

Wolraich, Albanese, Reiter-Theyer, and Barrat (1981) and Foster (1981) suggest that patient dissatisfaction with communication is a significant factor in the instigation of malpractice suits against physicians. Fletcher (1980), writing in the British Medical Journal, states that patient satisfaction with communication is a significant factor in compliance or non-compliance with medical advice (p. 846).

The Lay Press

A recent column by Ann Landers quoted John A.D. Cooper, M.D., President of the Association of American Medical Colleges, as stating:

> Medical school deans and faculties are deeply concerned about the growing public perception that physicians are insensitive to patients' human needs. The pressure placed on students to learn a rapidly expanding body of knowledge has tended to deemphasize their parallel development of sensitivity to human needs.

Author and newspaper columnist Jory Graham (1982) defends the patient's right to information and decision making, writing that:

> With his expectations, with his pain, with his life, and with his money, the patient is the one who will pay. To him who pays belongs the right to call the tune. Most of my column readers believe that the assumption of risk and the right to choose and decide are matters of their autonomy, their responsibility (p. 60).

The Communication Literature

Most of the research in health communication has been conducted by medical and allied professionals. From the communication discipline, Dean Barnlund (1976) writes in his article in the Journal of Medical Education:

Nearly everyone inside and outside the medical profession

affirms that communication with patients deserves study, but few institutions have offered to support such research. To know little about something as complex as interactions between physicians and patients is nothing to apologize for. But to know little and to choose to remain ignorant about it is tragic for the patient and demeaning for the profession (p. 724).

Cassata (1978), in Communication Yearbook 2, advocates for further involvement of communication specialists in the health field, stating:

The state of the art of health communication is embryonic, to say the least....By applying communication theory and research, as well as interpersonal and group skills, communication specialists can enhance interactions in medicine, the health care delivery system, and health care in general (p. 503).

The authors cited in this section lend support to my observation that patient dissatisfaction with physician/patient communication merits study. An examination of communication theory reveals that the topic of communication satisfaction has been specifically addressed by research from this discipline.

Satisfaction in Communication Theory

"Communication satisfaction has been a neglected empirical variable", reports Michael M. Hecht (1978a) in reviewing measures of communication satisfaction in Human Communication Research. While approaches to measuring interpersonal communication satisfaction have included examination of traits ascribed to communication competence and rhetorical sensitivity, Hecht argues that these approaches neglect the transactional and environmental aspects of communication. With this in mind, he developed a nineteen item instrument for measuring interpersonal communication satisfaction in social settings

based on "discriminative stimuli most commonly present when satisfaction is experienced" (1978b). This instrument will be discussed in more detail in a following section of this chapter.

Hecht's suggestion that elaboration of his contextual based construct is needed in contexts other than informal social settings forms a theoretical basis for the identification of issues which are described in the next two chapters.

Communication Satisfaction and Medical Care

Research specific to the topic of patient communication satisfaction in medical care has been conducted by Korsch, Gozzi, and Francis (1968). They found that the affective skills of the physician correlated highly with satisfaction on the part of the parent in their study of physician/parent communication in pediatric medicine. Citing the correlation between reassurance and satisfaction, Korsch et al. supported the wisdom of using satisfaction as a measure of effective communication. They established a relationship between long term health behavior and previous satisfaction with medical care as well as a relationship between communication satisfaction and compliance with medical advice. Thus, patient communication satisfaction can be seen to influence the patient's perception of the quality of medical advice. Patients who are not satisfied with their communication with the physician apparently do not feel that the quality of care received merits compliance or further treatment.

From the review of the literature presented in this chapter,

the following conclusions are drawn:

A. The problem of patient dissatisfaction with physician/patient communication is documented in the lay press, the medical literature and communication literature.

B. A specific area of communication theory is addressed to the topic of interpersonal communication satisfaction

which will prove useful to any study of the physician/patient relationship.

C. Calls for study from both the medical and communication disciplines justify the purposes of this study as stated in the following section.

PURPOSES OF THE STUDY

The purposes of this study include:

A. Identification of issues which contribute to patient satisfaction with physician/patient communication.

B. Development of an instrument for the measurement of patient communication satisfaction.

C. Correlation of the relationship between patient communication satisfaction and perceived quality of medical care.

The review of the literature presented in this chapter points to some specific areas of concern in physician/patient (P/P) communication; however, in order to develop items to measure patient

communication satisfaction it was necessary to further explore issues which contribute to patient satisfaction. As patients themselves seemed to be logical sources of this information, I employed two stages of interview procedures with people who receive medical care. These procedures are discussed in Chapter III, salient issues contributing to patient satisfaction are identified, and their significance to communication theory is explored.

CHAPTER III

IDENTIFICATION OF ISSUES WHICH CONTRIBUTE TO PATIENT
SATISFACTION WITH PHYSICIAN/PATIENT COMMUNICATION

In a search to identify issues which contribute to patient
satisfaction with P/P communication, I conducted interviews in two
stages. Stage I consisted of informal conversations with ninety-six
people about their communication with their physicians. Twelve
formal interviews were scheduled during Stage II for the purpose of
obtaining more specific information. In all, 108 respondents were
interviewed over a period of twelve months.

STAGE I INTERVIEWS

The informal interviews were spontaneous, the topic initiated
by the respondents, and took place in a variety of settings from city
buses to cocktail parties. The respondents included friends,
acquaintances, and strangers. My experience indicates that the topic
of medical care is a favored discussion item by many people. Upon
learning that I work in a medical setting, people frequently begin to
describe their adventures with medical care- often with the
assumption that my position makes me an "expert". Disclaimers on my
part seldom discourage conversation.

Once the person had introduced the topic of medical care, I
informed he/she that I was conducting research on the topic of
doctor/patient relationships and would be interested in his/her

observations. This statement usually served to generate a great deal of information, interest in my research, and offers to help me in the future. During these conversations I employed the position of "reflective listener" (Dinkmeyer, McKay 1978) encouraging conversation without offering opinions of my own. I made written records of statements which appeared to reflect patient satisfaction or dissatisfaction with P/P communication.

The respondents chose to discuss their P/P relationships in extremes, describing their physicians as "wonderful" and "fantastic", or as "horrible" and "terrible", with little in between. While a list of the "best" and "worst" P/P relationships does not adequately represent the entire scope of patient experiences, it did make information collection easier as it identified the most salient factors in patient satisfaction with P/P communication and medical care.

In examining the information I compiled from these conversations, I looked for concerns which were cited by a majority of the people with whom I talked and eliminated those which seemed to be uncommon experiences. Some of these concerns merit discussion. I found that the adjectives "caring" and "understanding" were used at some point by nearly every subject in describing a physician. The physician who really cared or understood was "wonderful"; the one who did not was "awful", "no matter how good he is supposed to be". People who had been hospitalized expressed concern about their ability to control what was happening to them, particularly their access to the physician. Descriptions of waiting up to three days

before receiving any kind of information was not uncommon.
Physicians who consulted their patients in the treatment process or
offered choices were described more positively than those who did not
People who felt that the physician did not listen or did not
"believe" them expressed the most anger, often stating that they
wanted to "sue him/her."

Issues representative of the above concerns were incorporated
into a checklist of patient and physician behaviors which formed the
basis for the formal stage II interviews.

STAGE II INTERVIEWS

Based on the tentative list of issues derived from the stage I
interviews, I conducted formal interviews with twelve subjects in
order to examine these issues and to explore other issues which might
contribute to patient satisfaction with P/P communication.

I chose respondents for these interviews according to the
following criteria:

  A. Each respondent must have had repeated contact with at
      least two physicians within the past year.

  B. Each respondent or the respondent's child must have spent
      at least two weeks in the hospital during the past year.

  C. Respondents were chosen from those who had participated
      in the informal interviewing process.

Seven of the people interviewed met the criteria through
personal illness or injury. Five were accepted for study through the
illness or injury of a child. I included both in the study in order

to assess possible differences in P/P communication when the respondent was describing self or child. In the five cases where respondents described interaction with a physician due to injury or illness of the child, the child was unable by virtue of age or injury to communicate effectively with the physician.

Interview Format

At the beginning of each interview, the respondent was asked to complete a checklist describing the issues derived from the stage I interviews (refer to Appendix A). This checklist subsequently served to provide a loose structure for the interview although, in keeping with phenomenological assumptions, I did not structure the interviews according to a previously determined set of questions (Bogdan and Taylor 1975).

The loosely structured interview format was possible in stage II because all subjects were familiar with my research project through previous contact and were interested in contributing to the collection of data. I was able to follow the advice of Bogdan and Taylor to "let the subject take over from there" (p. 111). Although I occasionally asked for clarification, all respondents kept to the topic and detailed coherent chronicles of their experiences with medical care within the past year.

All interviews were tape recorded with the permission of the respondent. Four respondents expressed some apprehension about having their comments recorded, but did not appear to be inhibited during conversation. The interviews lasted from twenty-five to forty

minutes. Forty-five minute tapes were used so that the conversation was not interrupted by the activity of changing tapes.

Results of Stage II Interviews

All respondents included in the stage II interviews had interacted with at least five physicians during the treatment for the illness or injury described. One subject had been treated to some extent by ten different physicians. This does not include residents or medical students who may have been involved. With one possible exception, the number of physicians involved in the treatment process can be seen as the outcome of the division of specialties in medicine rather than the attempt of the patient to obtain satisfaction by seeking out a number of physicians.

No notable differences seemed to exist between respondent as patient and respondent as parent. All respondents reported different degrees of satisfaction with each physician and expressed both satisfaction and dissatisfaction with interaction with a single physician. The results of these interviews yielded more information about the spectrum of dissatisfaction and satisfaction with P/P communication and medical care than was found in the previous informal interviews.

All respondents reported the highest degree of satisfaction with the physician who emerged as the primary physician, i.e. the one who maintained control of the case. Extreme dissatisfaction with a physician resulted in his or her removal from the case. Otherwise, respondents reported increased satisfaction over time with a

corresponding increase in communication satisfaction.

There seemed to be a strong relationship between the degree of satisfaction with P/P communication and the perceived quality of medical care when patients were at least minimally satisfied; e.g. a patient who expressed moderate satisfaction with communication reported moderate satisfaction with medical care. The converse was not as apparent; some respondents who reported great dissatisfaction with P/P communication felt that they had received adequate care. Respondents who stated that they were very dissatisfied with P/P communication arranged for the physician to be removed or to take a lesser part in the treatment process whether or not they felt he or she was providing adequate medical care.

All of the respondents interviewed relied on at least one outside person, e.g. a friend or relative who had some experience in a medical setting, to supplement information and advise plans of action, or to act as go-between with the patient and medical staff. This was particularly important during hospitalization. One allied professional, e.g. nurse or social worker, was often also singled out to play this role.

IDENTIFICATION OF ISSUES

In reviewing the tape recordings of each interview, I listed expressions of satisfaction or dissatisfaction in the respondent's words. A second list was drawn up to include the most frequently mentioned issues and the context in which they were expressed. From this list, an attempt was made to determine the most salient issues

which might be considered indicators of patient satisfaction with P/P communication on which there was an agreement among the respondents interviewed. For example, a single report that the physician had cried with the patient when the diagnosis was made was not considered a consensual issue, whereas the statement by all subjects that the physician who understood their concerns was important to their satisfaction was considered a significant issue.

I categorized responses and subjected them to a process of elimination until I found issues which all twelve subjects agreed were contributing to their satisfaction or dissatisfaction with P/P communication. These issues are:

A. Access to information.

B. Ability to understand information.

C. Participation in decisions concerning medical treatment.

D. Access to the physician with sufficient time allotted to discuss patient need and concerns.

E. Patient perception that the physician understands his/her experience with illness or injuries.

F. Patient perception that the physician genuinely cares about him/her.

G. Freedom to disagree with treatment plans without fear of rejection or diminished quality of medical care.

H. Perception that patient symptoms and concerns are taken seriously by the physician.

I. Perception that the physician believes what the patient says.

These nine issues were introduced and discussed by all twelve respondents and elicited strong expressions of dissatisfaction or satisfaction with P/P communication. Each of these issues was rated highly in the results of the stage I interviews. Five were listed specifically in the review of the literature. It was decided to include these issues in the study as indicators of patient satisfaction with P/P communication.

RESEARCH THEMES

Examination of relevant communication theory provided three themes which could be used to organize the above issues into categories for questionnaire item development. These themes and the corresponding issues are listed below.

A. Issues describing control are:

1. Access to information.

2. Ability to understand information.

3. Participation in decisions concerning medical treatment.

4. Access to the physician with sufficient time allotted to discuss patient need and concerns.

B. Issues which describe empathy are listed as:

1. Patient perception that the physician understands his/her experience with illness or injuries.

2. Patient perception that the physician genuinely cares about him/her.

C. Issues describing <u>confirmation</u> include:

1. Freedom to disagree with treatment plans without fear of rejection or diminished quality of medical care.

2. Perception that patient symptoms and concerns are taken seriously by the physician.

3. Perception that the physician believes what the patient says.

Any discussion of communication strategies or theories in P/P relationships must take into account the extreme vulnerability of the patient. Effective communication is not only desirable; the patient's life may literally depend on it. Ironically, during times of illness or injury when communication strategies are most important, they are often diminished. Anxiety reduces the patient's ability to comprehend information; pain and many medications used during treatment distort perception of time and sequence; emotional lability which frequently accompanies physical distress reduces coherence.

The respondents I interviewed expressed extreme responses to physician communication behaviors, the extremity of which would have most likely have been modified in describing other interpersonal relationships. The perception of vulnerability may heighten the importance of the three themes discussed below.

The Significance of Control in Communication Theory.

Perceived physical malfunction threatens the ability of the patient to control his or her environment. Dependence on the

physician may serve to further threaten patient control, and the institutional demands of the hospital can render the patient almost powerless.

Relational communication theory, which traces its origins to the research of psychiatrist Gregory Bateson (1958), addresses the issue of control in communication from the concepts of symmetry and complementarity, and accounts for most of the research of this topic (Rogers 1981). Control is examined through the pattern of messages exchanged in a transactional context.

Relational theorists describe two elements of control which can be seen to be important in P/P communication (Millar and Rogers 1976). The first is the "rigid-flexible" continuum which describes how control passes back and forth between participants. In all of the P/P communication described by the subjects, the physician maintained control most of the time. The more rigid the physician, the less satisfied the patient was. When the physician allowed more flexibility, e.g. offered the patient choices or made more information available, the patient described a higher degree of satisfaction.

The second element of control which affected patient communication satisfaction is described as "stability-instability". This determines the pattern of control shifts between the participants. The most stable relationships, in which the physician always held the control, were described by the respondents as the most unsatisfactory. The opposite end of the continuum was also described as unsatisfactory. Respondents reported that they wanted

to know what to expect in their relationships with their physicians; unpredictable shifts of control in communication were found unsettling.

Respondents reported the highest degrees of satisfaction with physicians who were flexible but moderately stable in their maintenance of control.

In a highly rigid, highly stable relationship, the issues ascribed to control in the previous section were described in the following manner:

1. The physician controlled information; the patient did not demand more.

2. The physician imparted information in highly technical terms; the patient did not ask for a translation.

3. The physician made all decisions; the patient agreed.

4. The physician structured time spent with the patient; the patient did not protest.

As the control patterns were moderated, the respondents described higher degrees of satisfaction with P/P communication.

The Significance of Empathy in Communication Theory

The most frequent statement made by all respondents expressing dissatisfaction with P/P communication was that "the doctor doesn't understand", followed closely by "the doctor doesn't care". Understanding and caring were cited first in describing "a really good doctor".

The respondents used the terms "understanding" and "caring" to

mean that the physician understood what was happening to them as a result of the injury or illness being treated and the meaning it had for them. As Barnlund (1976) put it:

> One is forced to conclude that there is no patient who does not present the medical profession with, at least in part, a symbolic problem. No illness lacks its semantic dimension. The professional who feels involved exclusively in the maintenance of a physical mechanism and who dismisses the communicative aspect of this work operates on a simplistic and even dangerous premise. Human beings are not merely symbol users; every moment of life is permeated with symbolism (p. 718).

The symbolic experience of each patient is unique; patients who present identical symptoms experience them very differently. In order to understand symbolic experience of their patients, physicians must be able to empathize. Empathy, according to Bennett (1979), is "the imaginative intellectual and emotional participation in another person's experience" and is based on the theory of "multiple realities" and "assumption of difference" (p. 418). Contrasting empathy with sympathy, Bennett suggests that the "Golden Rule" which is sympathetic in context be replaced by the "'Platinum Rule': 'Do unto others as they themselves would have done unto them'" (p. 422). His suggestion would be applauded by the people I interviewed who deeply resented being expected to feel what the physician would feel in the same circumstances or who suffered by comparison to other patients.

In a report of a highly satisfactory relationship in which the patient felt that the physician demonstrated empathy, the issues ascribed to this theme were described this way:

1. The physician understood financial concerns experienced by the patient because of inability to work, arranged for a social service consult, and contacted the patient's employer to arrange for disability compensation.

2. The physician made an effort to discuss treatment and concerns with family members, reassured the patient that he/she would be feeling better, and promised to explore all treatment options. The physician demonstrated caring through non-verbal communication, e.g. a gentle touch.

The Significance of Confirmation in Communication Theory

The study of confirmation discussed here stems from the area of Relational Communication theory. Cissna and Sieburg (1981) state that "the behavior of one person toward another is confirming to the extent that it...expresses an awareness of the significance or worth of the other" (p. 259). This element was best described by respondents in relation to their perceived freedom to disagree with or to challenge the physician. Respondents who expressed extreme dissatisfaction with their physicians felt that they were insignificant to the physician as anything more than a medical curiosity and could be dismissed completely or subjected to inadequate treatment if they caused the physician any displeasure.

The second element of confirmation as described by Cissna and Sieburg which pertains to issues in this category is the acceptance or endorsement by one person of the other person's experience. The expression of concerns being "taken seriously" by the physician or

being subjected to outright disbelief centered around the issue of
"real" versus "imagined" symptoms. As Barnlund explains:

> ...For the patient there is no distinction between perceived
> pain and real pain, between perceived health and real health.
> This is a dichotomy implied by language but one without
> counterpart in human experience (p.718).

Subjects reported that they often perceived the physician as
dismissing their concerns as unimportant or believing them to be
imagined, i.e. nonexistent. The difference between "being taken
seriously" and "believed" can be considered to be a matter of degree.
However, as the difference significantly affected the degree of
satisfaction related by the subjects, the two are separated for the
purposes of item generation.

Statements which reflected the patient's perception of the
issues ascribed to confirmation included:

1. "I couldn't disagree with him. After all, who am I to
    argue with a doctor? He would have ignored anything I
    said and walked away."

2. "After my hip surgery, when I told the doctor that I had
    a headache, he said 'the hip is what we're worried about
    now' and wouldn't even talk about my headache."

3. "The doctor told me that there was absolutely no medical
    reason for my stomach cramps. He thinks I made that
    up!"

The themes and issues identified in this chapter provide a
foundation for developing a measure of patient satisfaction with P/P
communication. The theoretical basis for studying the relationship

between patient communication satisfaction and the perceived quality of medical care has been described in the examination of the research themes and in the two studies reported in Chapter II. Chapter IV will include a statement of the hypothesis and a description of the method used to test it.

CHAPTER IV

HYPOTHESIS AND METHOD

STATEMENT OF THE HYPOTHESIS

The more safisfied a patient is with his/her communication with
the physician, the more satisfied he/she will be with the quality of
medical care.

METHOD

To test the above stated hypothesis, an instrument to measure
patient satisfaction with P/P communication was constructed and
titled the Physician/Patient Communication Satisfaction Inventory
(PPCSI). The instrument designed by Hecht to measure general
interpersonal communication satisfaction (ICSI) was included to
assess construct validity of the PPCSI as well as to provide a second
measure of communication satisfaction. Finally, a rating scale was
designed to measure the perceived quality of medical care. These
three instruments were administered to 151 subjects.

Construction of the PPCSI

A physician/patient communication satisfaction inventory
(PPCSI) was constructed to test the discriminative power of each
issue identified in Chapter III in measuring patient satisfaction
with P/P communication. Items were developed for use with a seven
point Likert scale (Disagree: 1: 2: 3: 4: 5: 6: 7: Agree) and their

order determined by reference to a table of random numbers.

The summated ratings method of the Likert was chosen for use in this inventory as an extension of the "response method" used to generate item candidates from the interview data (Edwards 1957). Items were optimally worded for this purpose, and reflect the language of the respondents insofar as possible.

Two statements, one positive and one negative according to my interpretation of the interview data described in Chapter III, were designed to reflect each issue and are listed below with the organizational themes identified in the previous chapter.

    A. The following items were developed to reflect the <u>control</u> theme:

       1. The doctor was open and willing to share information with me.

       2. The doctor did <u>NOT</u> tell me everything I needed to know about my health or treatment.

       3. I could easily understand what the doctor was saying.

       4. I did <u>NOT</u> understand what the doctor was saying.

       5. The doctor offered me choices.

       6. The doctor did <u>NOT</u> let me decide how I wished to be medically treated.

       7. The doctor was relaxed and interested.

       8. The doctor appeared busy and in a hurry to end this conversation.

B. Items developed to address the significance of <u>empathy</u> are as follows:

1. The doctor showed me that he understood my concern about my health.

2. The doctor did <u>NOT</u> understand how my health was affecting my life.

3. I felt the doctor genuinely cared about what was happening to me.

4. The doctor did <u>NOT</u> seem to care about <u>me</u>.

C. The following items were developed to reflect the <u>confirmation</u> theme:

1. I felt free to disagree with the doctor.

2. I did <u>NOT</u> feel that I could disagree with the doctor.

3. The doctor listened carefully to everything I said.

4. The doctor did <u>NOT</u> think my concerns were important.

5. The doctor showed me that he took my symptoms seriously.

6. The doctor did <u>NOT</u> believe me.

Refer to Appendix B.

The ICSI

Hecht, as mentioned in Chapter II, developed the nineteen item "Interpersonal Communication Satisfaction Inventory" (ICSI) for use with a seven point Likert scale and tested its reliability and validity in social intercourse with Midwestern undergraduate

university students. His items were selected on their ability to
discriminate between satisfaction and dissatisfaction with
interpersonal communication. The results of this study will be
discussed in Chapters V and VI.

Because items on the ICSI deal with general communication
satisfaction while the items on the PPCSI are specific to P/P
communication, it was decided to include the ICSI in this study as a
means of establishing construct validity of the PPCSI and to test the
reliability and validity of the ICSI in a specific communication
setting.

The direction of scoring on the Likert scale utilized by Hecht
was reversed here to agree with the PPCSI in order to simplify the
task on the questionnaire booklet.

Construction of the Rating Scale

In order to determine the relationship of patient communication
satisfaction reflected by the PPCSI with patient perception of the
quality of medical care, a rating scale (MEDC) was employed.
Respondents were directed to complete the statement:

> Overall, I would describe the medical care I received from this
> doctor as:
> Rotten, Totally Unsatisfactory, Very Poor, Poor, Adequate,
> Good, Very Good, Excellent, Fantastic.

The nine point verbally anchored graphic rating scale was chosen to
permit a large number of response options. (See Appendix B.)

The Questionnaire Booklet

The resulting survey titled the Physician/Patient Communication

Questionnaire Booklet (PPCQ) was assembled in the order described below for presentation to subject.

Introduction. A cover sheet explained the two inventories, directing respondents to "recall, to the best of your ability, your most recent face-to-face conversation with a doctor during which you were seeking medical care".

The length and frequency of contact with physicians was expected to vary among potential respondents. As these variables would not be considered in this part of the study, it was decided to use a single conversation with a physician, i.e. the most recent, in measuring patient communication satisfaction.

Spaces were provided for the respondent to record the number of months since the last conversation with a physician and his/her age.

The Rating Scale. Titled "Medical Care Rating Scale", the rating scale was placed after the cover sheet in one half of the questionnaire booklets and at the end of the PPCQ in the other half as a check on order effects between the ICSI and PPCSI and the medical care rating task.

ICSI. The ICSI followed either the cover sheet or the Medical Care Rating Scale and included directions for using the seven point Likert response format on both the ICSI and PPCSI.

PPCSI. The PPCSI followed the ICSI. The complete questionnaire booklet is shown in Appendix B.

Data Collection

Communication experience with physicians was the primary

criterion in choosing a sample population for the purposes of this study. Stewart, Pantell, Dias, Wells, and Ross (1981) found that communication in pediatric medicine took place primarily between parent and physician, so the decision was made to seek subjects who were old enough to have had significant interaction with a physician as adults.

A sample population of 150 subjects was deemed adequate to explore the new instrument and test the hypothesis. After a brief introduction, the questionnaire booklets were distributed to eighty-eight students in three upper division Speech Communication classes and one graduate Special Education class. Three of these classes were held at a metropolitan university and one at a private college that attracts older students. All students accepted and completed the booklets within a fifteen minute time period.

Nineteen booklets were accepted and completed by members of a cancer support group meeting at a local hospital. Twenty-one booklets were completed by adults during an elementary school parent meeting. Personnel at a metropolitan hospital completed eleven questionnaire booklets, and twelve adults in this researcher's neighborhood agreed to participate in the study. No subject approached refused to participate.

Subjects ranged in age from eighteen to sixty-eight years, with a mean age of thirty-six. The number of months since the last conversation with a physician varied from "today" (computed at 0) to five years, registering a mean score of six months.

The ratio of males to females was determined to be roughly

equal through informal observation. The majority of subjects were
Caucasian and probably most representive of the middle class
socioeconomic group. It can be assumed that the majority of subjects
had the ability to pay for medical care, a factor that will be
considered in discussing the limitations of the study.

Subjects appeared to take the PPCQ seriously; many remarked on
it after completing it, and several stated that they had had
difficulty interpreting item six on the ICSS: "I had something else
to do". One subject used two colors of ink to describe conversations
with both a physician and a chiropractor about the "same painful
problem". While only the responses for the physician were recorded
in the data, this researcher notes that the chiropractor received a
much more positive score.

All subjects who chose to comment expressed their belief that
good communication between physician and patient is important
although often difficult to find. A few were distressed that the
directions to refer to their "last" visit had not allowed them to
refer to the doctor they would have chosen.

The data obtained through the method described in this chapter
included:

> A. The eighteen items on the PPCSI.
>
> B. The nineteen items on the ICSI.
>
> C. The MEDC response.
>
> D. The demographics (age and number of months).

Total scores were obtained for each of the above parts of the
questionnaire booklet and were subjected to statistical analysis

procedures which will be described with the results in Chapter V. A scoring key for positively and negatively worded items can be found in Appendix C.

CHAPTER V

DATA ANALYSIS AND RESULTS

All statistical computations were performed according to the various subprograms in Statistical Package for the Social Sciences, (Nie, Hull, Jenkins, Steinbrenner, and Brent 1975) and SPSS Update 7-9 (Hull and Nie 1981) by a Honeywell 6640 computing system at Portland State University. Subprograms utilized in the present study included "Pearson Correlation" and "Reliability".

RELIABILITY STUDY

Test/Retest

A subset of twenty-five of the main sample was retested with the PPSCI after an interval of two weeks for the purpose of assessing test/retest reliability through computation of Pearson product moment correlation coefficients. The results of the first sample yielded a mean score of 84.201 and a standard deviation of 26.164, with the retest sample yielding 85.923 and 25.734 respectively, and samples correlating with a coeffieient of r=+.970. The high correlation between the two samples establishes test/retest reliability at a very high level. The degrees of satisfaction expressed by the subjects appear to remain stable over time.

Internal Consistency and Item Analysis: The PPCSI

Chronbach's Alpha was computed at +.956 and standardized item

Alpha at +.955, indicating a high internal consistency reliability. Corrected item-total correlations ranged from +.429 to +.886 with a scale mean of 92.039, a standard deviation of 26.590, total scale scores ranging from 18 to 126, and a mean inter-item correlation of +.540 (refer to Table I). Based on the data from this sample, all scale items are considered relatively cohesive and the scale itself is highly reliable. All items are strongly associated with the scale total and are very possibly related to the construct which this scale attempts to measure.

TABLE I

CORRECTED ITEM-TOTAL CORRELATION OF
THE PPCSI

ITEM	r	ITEM	r
1	+.870	10	+.429
2	+.826	11	+.815
3	+.820	12	+.718
4	+.687	13	+.804
5	+.779	14	+.476
6	+.765	15	+.564
7	+.886	16	+.702
8	+.829	17	+.685
9	+.800	18	+.544

Internal Consistency And Item Analysis: The ICSI

Although not the primary intent of the present study, reliability of the Hecht instrument (ICSI) was also assessed on data from this sample. Chronbach's Alpha was computed at +.949 and standardized item Alpha at +.949, also indicating high internal consistency reliability. Corrected item-total correlations ranged from +.485 to +.868 with the exception of item six which registered

at +.129 (refer to Table II). Not incidentally, a large number of
subjects remarked about the difficulty of responding to this item
during and after test administration, as discussed in an earlier
section.

TABLE II

CORRECTED ITEM-TOTAL CORRELATION OF
THE ICSI

ITEM	r	ITEM	r
1	+.777	11	+.791
2	+.680	12	+.586
3	+.652	13	+.697
4	+.724	14	+.760
5	+.780	15	+.785
6	+.129	16	+.850
7	+.682	17	+.485
8	+.807	18	+.514
9	+.860	19	+.589
10	+.868		

Scale mean was computed at 93.337; the standard deviation was
25.848. Mean inter-item correlation registed +.493. High internal
consistency characterizes the ICSI with the exception of item six.
These findings are consistent with the split half reliabilities of
+.97 and +.90 for the actual and recalled treatments respectively, as
reported by Hecht. All items, excepting item six, are strongly
associated with the scale total.

VALIDITY

The procedures used to identity potentially valid items to form
the PPCSI have been described in Chaper III and encompassed stage I

and stage II interviews with a total of 108 respondents on the topic

of P/P communication and examination of issues derived through this

process. Construct validity was assessed by examining the

relationship of the PPCSI to a general communication satisfaction

inventory, the ICSI. A correlation of +.890 (n=151) was obtained,

indicating that the two measure exhibited a 79% common variance on

this sample. Hecht's general communication satisfaction instrument

and the instrument developed here specifically for assessing patient

satisfaction with P/P communication were mutually confirmatory. The

degree of satisfaction reflected by the PPCSI is also reflected on

the ICSI, indicating that patient satisfaction with P/P communication

is directly related to overall interpersonal communication

satisfaction.

The three correlations among the two measures of communication

satisfaction (PPCSI and ICSI) and perceived quality of medical care

(MEDC) were all quite high. In the development of a new instrument,

it is hoped that the instrument correlates more highly with other

measures of the same thing than with a measure of a different

construct. In pursuit of this hope, tests of statistical

significance were performed on all pairs of coefficients shown on

Table IV in the "Hypothesis" section of this chapter.

The difference between correlations of $r_{PPCSI/ICSI}$ and

$r_{PPCSI/MEDC}$ was statistically significant at t=3.785 and (df.=148;

p<.005). The PPCSI did indeed correlate significantly higher with

its companion measure of communication satisfaction than it did with

the MEDC instrument, which is not, in itself, a measure of

communication satisfaction. In symmetrical fashion, the ICSI
correlation with the PPCSI was stronger than the ICSI with MEDC,
although this difference was (t=1.06; df.=148;NS); these results
supported the convergent validity of the PPCSI developed in the
present study.

ANCILLARY VARIABLES

As described in Chapter IV, data was obtained from 151 subjects
on two demographics; the first referred to the number of months since
the last conversation with a physician, while the second indicated
the age of the subject. The relationships of these two variables
with each of the three measures measures of the present study (ICSI,
PPCSI and MEDC) were assessed through computation of Pearson product
moment correlation coefficents. The results are presented in Table
III.

TABLE III

PEARSON CORRELATION COEFFICIENTS WITH
ANCILLARY VARIABLES

	Months	Age
MEDC	+.005	+.153
ICSI	+.101	+.139
PPCSI	+.086	+.111

None of the resulting six coefficients were noteworthy, and
only $r_{age/ICSI}$ and $r_{age/PPCSI}$ were statistically significant, and
those at an unimpressive level, accounting for only 1.93% and 2.34%

shared variance with the age data. Based on these results, both variables were set aside for all subsequent analyses. Neither age nor time lapsed since the last visit to a physician seem to influence the degree of patient satisfaction with P/P communication as measured by either the PPCSI or the ICSI.

<div style="text-align: center;">HYPOTHESIS</div>

Statement of the Hypothesis

The more satisfied a patient is with his/her communication with the physician, the more satisfied he/she will be with the quality of medical care.

Data were collected on two different measures of patient communication satisfaction with a physician; a physician/patient communication satisfaction inventory developed for this study and an adaptation of a general interpersonal communication satisfaction inventory were administered to 151 respondents, accompanied by a verbally anchored graphic rating scale developed to measure perceived quality of medical care.

Pearson product moment coefficients were computed to determine the relationships among all three measures. Results can be seen in Table IV.

Both measures of patient communication satisfaction were very strongly and directly associated with perceived quality of medical care. Both tests of the hypothesis using these two scales with very different item content were statistically significant beyond the p= .001 level. Using these measures on this sample, the data failed

to disconfirm the hypothesis.

TABLE IV

PEARSON CORRELATION COEFFICENTS AMONG TWO MEASUREMENTS
OF PATIENT COMMUNICATION SATISFACTION AND
PERCEIVED QUALITY OF
MEDICAL CARE

	MEDC	ICSI
ICSI	+.778	-----
PPCSI	+.802	+.890

From this we can conclude that there is a strong relationship between patient communication satisfaction and the patient's perception of the quality of medical care.

ANALYSIS OF ORGANIZING THEMES

In Chapters III and IV, organizing themes were discussed as part of the theoretical basis and as part of the scale development procedures for the present study. These themes consisted of control (CONT), empathy (EMP) and confirmation (CONF).

TABLE V

PEARSON CORRELATION COEFFICIENTS AMONG CONTROL,
EMPATHY, AND DISCONFIRMATION

	CONT	EMP
EMP	+.887	-----
CONF	+.885	+.899

A sub-scale analysis was performed by totalling items of the

PPCSI scale associated with each of the three themes. Subtotals for each of the themes were subjected to a correlational study resulting in the high and extremely equivalent correlations presented in Table V.

It was originally intended that subtotals would be entered as predictor variables to a multiple regression analysis with MEDC as the criterion variable. However, it was clear from the correlational data in Table V that the multicolinearity problem of these subscale variables would render results of such an analysis misleading and of little value (Nie et at., p. 340). Therefore, this intended analysis was not performed. However, it was of interest to inspect the degree of association that each of the variables registered with MEDC. Table VI presents those results.

TABLE VI

PEARSON CORRELATION COEFFICIENTS BETWEEN
THEMATIC VARIABLES AND PERCEIVED
QUALITY OF MEDICAL CARE

	MEDC
CONT	+.759
EMP	+.795
CONF	+.773

Although the size of the correlations of the three thematically grouped items with MEDC varied to some extent, none of the correlations were significantly different than any of the others. The largest difference was obtained between the correlations of EMP

with MEDC, and CONT with MEDC. That difference failed statistical significance with t=1.378 (df.=148). All three thematic variables are seen to be important to the patient's perception of the quality of medical care.

These results bode well for both the PPCSI and the ICSI as measures of patient satisfaction with P/P communication because of their very high correlation with each other and their mutual correlation with patient perception of the quality of medical care.

The limitations and possible applications of the results of this study will be discussed in Chapter VI along with recommendations for further study.

CHAPTER VI

LIMITATIONS, APPLICATIONS, AND RECOMMENDATIONS

Through the research methods described in the previous chapters of this paper, I am able to draw the following conclusions with a fair degree of credibility:

A. Patient dissatisfaction with physician/patient communication is a problem that needs to be addressed by both the medical and communication disciplines.

B. The "Physician/Patient Communication Satisfaction Inventory" developed to measure patient communication satisfaction appears to be a reliable instrument for this purpose.

C. Patient satisfaction with P/P communication appears to be directly related to how the patient perceives the quality of medical care.

D. The three themes identified in Chapter II, control, empathy, and confirmation, are well defined in communication theory and appear to be useful in describing issues which relate to patient communication satisfaction.

The interpretation and possible applications of these conclusions will be discussed in this chapter, beginning with an examination of the limitations of this study.

LIMITATIONS OF THE STUDY

The results of this study are based on the relatively small number of 151 subjects. A larger sample would allow a more comprehensive generalization from these data.

While subjects included in this study were relatively heterogeneous with regard to age, sex, and medical history, they were largely middle class Caucasians. Future testing of the PPCSI should include a variety of ethnic and socio-economic groups. It can be assumed from the settings in which these subjects were found that the majority had completed high school and many were college graduates. Different educational backgrounds need to be considered.

It should be pointed out that Korsch et al., in the study discussed in Chapter II, stated that "no significant differences in satisfaction were found when different social classes or different educational levels were compared" (p.860). However, the majority of physicians in this country can be described as well educated, upper-middle class Caucasian males (Mendelsohn 1979). As this description is quite disparate from any profile of the "average American medical consumer" that one might venture, I think these variables merit further consideration.

Based on my observation, I think two variables might be addressed: ability to pay and age of the patient. Medical science and technology in very recent history have made possible some elaborate and incredibly expensive "life saving" procedures such as heart transplants, emergency intervention and some types of

chemotherapy. These have presented the medical profession with legal, ethical and moral dilemmas that concern many physicians with whom I talk. The questions of "who should be saved" and "at what cost" are frequently discussed at medical conferences I attend. As these questions often center around the age of the patient and his/her ability to pay for costly treatments, I think these factors will influence patient communication satisfaction form the standpoint of fulfillment of expectations and from the patient's perception of control, empathy and confirmation on the part of the physician.

This study has been directed solely to the patient's perception of what takes place when physician and patient meet to discuss medical care. Inquiry into this study might also consider the physician's point of view.

The Physician's Perspective

To put it very simply, I meet a number of physicians in my every day work, but I have yet to meet a physician who does not care about his or her patient. I read many medical journals, but I have yet to come across an article that is not aimed at the well being of the patient. While this may seem contradictory to what has been discussed in this paper thus far, it can largely be explained by the differences between patient expectations of the physician and the physician's training and communication style.

Glymour and Salker (1983) write in the New England Journal of Medicine that:

The practice of medicine in the United States and in other industrialized nations is a form of consultant engineering.

The subjects are people rather than bridges, but in many respects the professions of medicine and engineering are alike (p. 960).

To illustrate his point, I offer the following anecdote. I was sitting one morning at the bedside of one of my young students. The boy had sustained a severe head injury and multiple fractures in a fall from a pick-up truck. A physician walked in and, mistaking me for the boy's mother, introduced himself. "I'm Dr. X", he said. Gesturing toward the boy's leg in traction, he added: "I'm taking care of this piece". Without another word, he left the room.

This child was walking the last time I saw him, attesting to the physician's skill. Although pleased with his eventual recovery, the boy's parents were not comfortable with the idea that he had been "treated in pieces" and felt that the quality of care was diminished by this attitude.

Most patients do not think of themselves as bridges, and consequently tend to take offense at the idea of consultant engineering; however, the days of the general practitioner are gone. Medical training is long, costly, arduous, and devoted to developing a specialty. Competition is fierce. Mendelsohn (1979), in his biting criticism of American medical practices, states:

> If I had to characterize doctors, I would say their major psychological attribute is fear. They have a drive to achieve security-plus that's never satisfied because of all the fear that's drummed into them in medical school; fear of failure, fear of missing a diagnosis, fear of malpractice, fear of remarks by their peers, fear that they'll have to find honest work....Since everybody can't win, everybody suffers from a loss of self-esteem. Everybody comes out of medical school feeling bad (p. 213).

If the statements by Glymour and Mendelsohn were combined with

the quote from Cooper in Chapter II, p. 7, a physician could be described as a "consultant engineer, suffering from a loss of self-esteem, who is under such pressure to learn a rapidly expanding body of knowledge that his/her development of sensitivity to human needs is deemphasized". This may be an exaggeration of the problem, but it contains enough truth to point out that physicians probably do not receive the communication training necessary or operate in an environment which allows them to present themselves as the warm, compassionate human beings that patients seem to expect.

APPLICATIONS OF THE STUDY

At the beginning of this chapter, I stated four conclusions that I have drawn from the results of this study. These conclusions can be applied to medical school training programs. Based on the discussion in the previous section, it would seem that the most logical place to address the problem of patient dissatisfaction with physician/patient communication is at the medical school level. Support from both the medical and communication disciplines has been presented for this type of intervention in earlier sections of this paper. A cooperative effort could be made by both disciplines to add communication skills development to medical school curriculum.

Like most long standing institutions, medical schools are somewhat resistant to change. Perhaps the most convincing argument for adding communication study to medical school curriculum can be made from the relationship found in this study between patient communication satisfaction and the patient's perception of the

quality of medical care. The physician's goal is to provide high quality medical care. Assuming that it is important to the physician that the patient appreciate the quality of medical care rendered, it can be argued that the development of communication skills to meet patient expectations would serve to further this goal. Most physicians are also in business; good business practices suggest that satisfied patients are not only more likely to return, they are more likely to recommend the physician to other patients.

Let us assume, for the moment, that a convincing argument has been made, and the Dean of the Medical School has agreed that the addition of communication studies is important to the future of aspiring physicians. The question then becomes, "what courses should be offered?"

"For a start", says the Communication Specialist, "basic courses in public speaking, interpersonal communication, non-verbal communication, and an overview of communication theory."

"No!" screams the Dean of the Medical School. "My students are already over-extended. There is no way I could add that many courses."

"In that case," ventures the Communication Specialist slyly, "a recent study in physician/patient communication shows that there are three areas of communication theory which seem to be important to patient communication satisfaction; control, empathy, and confirmation. We could cover them in three terms...two terms...a crash course in one term?"

"Sold!" sighs the Dean of Medical School gratefully.

Fantasy aside, it would be possible to design a course of study around the themes of control, empathy, and confirmation as outlined in Chapter II, specific to the area of physician/patient relationship. As research continues in the area of physician/patient communication, other areas of concern will emerge. For purposes of physician education, it will be helpful to deliniate them as closely as possible to the physician/patient relationship. Given the time constraints of medical school training and the amount of knowledge that students are expected to obtain, it is not reasonable to expect that the curriculum will expand to include very many communication courses.

Physicians are not devoid of communication skills by any means. I observe medical students and residents, who spend long hours in the hospital, demonstrating care, concern, and a willingness to know their patients. Although physicians-in-training were not included in this study, the subjects I interviewed often praised their participation in medical care. Unfortunately, this type of interaction seems to diminish in importance when the training programs end.

The value of classroom instruction is limited; communication skills are also learned from observing others. If medical students are to be expected to take communication courses seriously, they should be able to see the attending physicians demonstrating good communication skills. One resident I interviewed while investigating this problem described her training this way: "Any compassion that I ever had has been bred out of me. The best I can hope to do now is

to adopt an attitude of compassion." From her description, and from others I have heard, it would appear that the importance of control, empathy, and confirmation needs to be accepted by the attending physicians and preceptors as well as by students.

Practicing physicians are required to participate in continuing education programs. In-services stressing the importance of communication with patients with emphasis on the areas of control, empathy, and confirmation could well be included in these programs. Professional organizations might be persuaded to add these courses to their lists of in-service topics. Hospital administators, who are concerned with attracting patients to their institutions, might find it to their advantage to encourage and reward physicians on staff who take part.

Applications of the PPCSI

The PPCSI, based on the sample in this study, appears to be a reliable instrument for measuring patient satisfaction with physician/patient communication. A subject can complete it in less than ten minutes. As none of the subjects included in this study expressed any difficulty in completing it, I am assuming that the language is fairly clear and understandable. It should be useful to anyone wishing to obtain a quick check on patient communication satisfaction and perceived quality of medical care. As such, it could be used to give feedback to medical students in practicum courses or in resident training programs.

As mentioned in the previous section, communication between

attending physicians (those who train students and residents) and patients could well be addressed. The PPCSI could be adapted for use by students in rating these physicians, e.g. "the doctor listened carefully to everything his/her patient said". This would serve the dual purpose of increasing student awareness of communication behaviors and of stressing the importance of communication to the attending physician who is modelling for the student. One way to gauge the pressure under which students seem to operate (Mendelsohn 1975) would be to adapt the PPCSI to measure the student's perception of how he/she is treated during training.

Although I do not anticipate a demand for such an instrument from physicians in private practice, I think it could have some use by the health maintainance organizations. Allied health professionals such as nurses, social workers, and therapists generally receive more training in communication with patients than physicians; an adaptation of the PPCSI could be used in conjunction with these programs.

RECOMMENDATIONS FOR FURTHER STUDY

Further study of patient satisfaction with physician/patient communication can be directed to more specific medical settings. The identification of empathy as a major theme contributing to patient satisfaction in this study suggests that intercultural communication in medical settings would be a valuable area of study. Bennett's explanation of "assumption of difference" and "multiple realities" mentioned in Chapter III indicates that studies of the differences in

male and female or heterosexual and homosexual experiences in medical treatment could well be explored from the standpoint of empathy as well as from control and confirmation. The use of the PPCSI in these and other areas of study may require additional item development.

Applications and recommendations of this study have been directed to physicians and medical training. Control, empathy, and confirmation are important to other interpersonal relationships. Further study of these three themes and adaptations of the PPCSI could well be directed to teacher/student, lawyer/client, or social worker/client relationships.

The interpersonal communication satisfaction instrument developed by Hecht, which has been described in this study as the ICSI and was included in order to establish construct validity of the PPCSI, deserves some discussion. Subjects in this study expressed some difficulty in interpreting items on this instrument, particularly, as already mentioned, item six. If I were going to use this instrument again, I would change the wording of "the other person" to "the doctor", which I believe would make it less confusing to respondents in this setting. I would also delete item six. Otherwise, the results of the ICSI as reported in this study are compatible with Hecht's study, supporting the reliability and validity of his instrument.

For purposes of measuring patient communication satisfaction, the PPCSI is a better instrument. Its higher reliability and more positive association with the perceived quality of medical care have been reported in Chapter V. This instrument also makes it possible

to identify specific physician communication behaviors which should prove useful in medical education and communication skills training.

Finally, there is the question that should be addressed in any study: "so what?" I spend by professional life working with people who are dissatisfied, disillusioned, and disgusted with the medical practices they find upon entering the institution they had thought would solve their problems— the American hospital. I am also a medical consumer and, as such, I have not always been pleased with my physicians or the medical care I have received.

I hope that the results of this study will contribute in some way to improving this troublesome situation. Some improvements may include increased awareness of the problem on the part of physicians, inclusion of communication courses in medical education, and directions for future research in both communication and medicine.

SELECTED BIBLIOGRAPHY

Arnston, P., Droge, D., and Fassl, H. "Pediatrician-Patient
    Communication: A Final Report." In Communication Yearbook 2.
    Ed. Ruben, D. New Brunswick: Transaction, International
    Communication Association, 1978, pp. 505-522.

Barnlund, D.C. "The Mystification of Meaning: Doctor-Patient
    Encounters." Journal of Medical Education, 56 (1976),
    716-725.

Bateson, G. Naven. Cambridge: Cambridge University Press, 1958.

Bennett, M.J. "Overcoming the Golden Rule: Sympathy and Empathy."
    In Communication Yearbook 3. Ed. Nimmo, D. New Brunswick:
    Transaction, International Communication Association, 1979,
    pp. 407-422.

Beuf, A. Biting Off the Bracelet. University of Pennsylvania Press,
    1979.

Blumberg, R. Headstrong. New York: Crown, 1982.

Bogdan, R. and Taylor, S. Introduction to Qualitative Research
    Methods. New York: John Wiley, 1975.

Cassata, D. M. "Health Communication Theory and Research: An
    Overview of the Communication Specialist Interface." In
    Communication Yearbook 2. Ed. Ruben, D. New Brunswick:
    Transaction, International Communication Association, 1978,
    pp. 497-505.

Cissna, K. and Sieburg, E. "Patterns of Interactional Confirmation
    and Disconfirmation." In Rigor and Imagination: Essays from
    the Legacy of Gregory Bateson. Eds. Wilder-Mott, C. and
    Weaklund, J. New York: Praeger, 1981. pp. 254-281.

Cochrane, C. "Effects of Diagnosic Information on Empathic
    Understanding by a Therapist in a Psychotherapy Analogue."
    Journal of Consulting and Clinical Psychology, 38 (1972),
    pp. 359-365.

Costello, D. "Health Communication Theory and Research: An
    Overview." In Communication Yearbook 1. Ed. Ruben, D. New
    Brunswick: Transaction, International Communication
    Association, 1977, pp. 557-567.

Crable, R. E.   One to Another: A Guidebook for Interpersonal
       Communication.   New York: Harper and Row, 1981.

Dinkmeyer, D., McKay, G.   Parent's Handbook.   Circle Pines: American
       Guidance Service, 1978.

Edwards, A.   Techniques of Attitude Scale Construction.   Englewood
       Cliffs: Prentice-Hall, 1957.

Eisenberg, L. and Kleinman, A., eds.   The Relevance of Social Science
       for Medicine.   Boston: D. Reidel, 1981.

Engel, G. L.   "The Clinical Application of the Biopsychosocial
       Model."   American Journal of Psychiatry, 1980, 137 (1980),
       535-544.

Erickson, P. and Rogers, L.   "New Procedures for Analyzing Relational
       Communication."   Family Process, 12 (1973), 245-267.

Fine, V. and Therrien, M.   "Empathy in the Doctor-Patient
       Relationship: Skill Training for Medical Students."   Journal
       of Medical Education, 52 (1977), 752-757.

Fletcher, C.   "Listening and Talking to Patients."   The British
       Medical Journal, 281 (1980), 845-847, 1116-1117.

Foster, C.   "The Use of Transactional Analysis in Patient Teaching."
       Supervisor Nurse, 12 (1981), 18-23.

Glymour, C. and Salker, D.   "Engineers, Cranks, Physicians,
       Magicians."   The New England Journal of Medicine, 308 (1983),
       960-964.

Gorlin, M. and Zucker, H.   "Physicians' Reactions to Patients."   New
       England Journal of Medicine, 308 (1983), 1059-1063.

Graham, J.   In the Company of Others.   New York: Harcourt, 1982.

Hecht, M.   "The Conceptualization and Measurement of Interpersonal
       Communication Satisfaction."   Human Communication Research,
       4 (1978a), 253-263.

----------.   "Measures of Communication Satisfaction."   Human
       Communication Research, 4 (1978b), 350-361.

Hull, C. and Nie, N.   SPSS Update 7-9.   New York: McGraw-Hill, 1981.

Joyce, C., Caple, G., Mason M., Reynolds, E. and Mathews, J.
       "Quantitative Study of Doctor-Patient Communication."
       Quarterly Journal of Medicine, 150 (1969), 183-194.

Kassirer, J. "Adding Insult to Injury; Usurping Patients'
    Perogatives." New England Journal of Medicine, 308 (1983),
    898-901.

Korsch, B., Gozzi, E., and Francis, V. "Gaps in Doctor-Patient
    Communication: Doctor-Patient Interaction and Patient
    Satisfaction." Pediatrics, 42 (1968), 855-871.

Kushner, T. "Conversation with Norman Cousins." British Medical
    Journal, 281 (1980), 527-528.

Landers, A. "Schools' Criteria Blamed for 'Insensitive' Doctors."
    The Oregonian, Sunrise Ed., 27 December 1982, Sec. C, p. 4,
    Cols. 1, 2.

Littlejohn, S. Theories of Human Communication, 2nd Ed. Belmont:
    Wadworth, 1983.

Mendelsohn, R. S. Confessions of a Medical Heretic. Chicago:
    Warner, 1979.

Millar, F. and Rogers, L. "A Relational Approach to Interpersonal
    Communication." In Explorations in Interpersonal
    Communication. Ed. Miller, G. Beverly Hills: Sage, 1976,
    pp. 87-103.

Miller, G., ed. Explorations in Interpersonal Communication.
    Beverly Hills: Sage, 1976.

Nie, N., Hull, C., Jenkins, J., Steinbrenner, K. and Brent, D.
    Statistical Package for the Social Sciences. New York:
    McGraw-Hill, 1975.

Parks, M. "Relational Communication: Theory and Research." Human
    Communication Research, 3 (1977), 372-381.

Peabody, F.W. Doctor and Patient. New York: Macmillan, 1930.

Preston, T. The Clay Pedestal. Seattle: Madrona, 1981.

Rogers, C. On Becoming a Person. La Jolla: Houghton Mifflin, 1961.

---------- and Stevens, B. Person to Person: The Problem of Being
    Human. Lafayatte: Real People Press, 1967.

Rogers, L. "Symmetry and Complementarity: Evolution and Evaluation
    of an Idea." In Rigor and Imagination: Essays from the Legacy
    of Gregory Bateson. Eds. Wilder-Mott, C. and Weaklund, J.
    New York: Praeger, 1981, pp. 232-251.

---------- and Farace, R. "Analysis of Relational Communication in Dyads." Human Communication Research, 1 (1975), 222-239.

Stewart, T., Pantell, R., Dias, J., Wells, P. and Ross, A. "Children as Patients: A Communications Process Study in Family Practice." Journal of Family Practice, 13 (1981), 827-835.

Tager, M. and Jennings, C. Whole Person Health Care. Portland: Victoria House, 1978.

Tucker, R., Weaver, R. and Berryman-Fink, C. Research in Speech Communication. Englewood Cliffs: Prentice-Hall, 1981.

Watzlawick, P., Beavin, J. and Jackson, D. Pragmatics of Human Communication: A Study of Interactional Patterns, Pathologies and Paradoxes. New York: Norton, 1967.

---------- and Weaklund, J. The International New: Studies at the Mental Health Institute, Palo Alto, 1965-1874. New York: Norton, 1977.

Wilder-Mott, C. and Weaklund, J., eds. Rigor and Imagination: Essays from the Legacy of Gregory Bateson. New York: Praeger, 1981.

Wolraich, M., Albanese, M., Reiter-Thayer, S., and Barratt, W. "Teaching Pediatric Residents to Provide Emotion-Laden Information." Journal of Medical Education, 56 (1981), 438-440.

APPENDIX A

INTERVIEW CHECKLIST

Check the appropriate answer.

___YES ___NO I usually understand most of the information I have
been given by my doctors.

___YES ___NO I usually ask my doctor to give more information or
to recommend reading materials or other people with
whom I can talk.

___YES ___NO I ask to read my medical records.

___YES ___NO I ask my doctors to explain what choices I have in
treatment.

___YES ___NO I ask my doctors about the possible side effects
that medicines, diagnostic procedures, or surgeries
could have on my health.

___YES ___NO My doctors usually understand what I am saying.

___YES ___NO My doctors understand how my health is affecting
my life, my family, my job.

___YES ___NO My doctors understand me as a total person.

___YES ___NO My doctors are willing to talk to my family/import-
ant others about my health and their concerns.

___YES ___NO My doctors return telephone calls promptly, or at
least on the same day.

___YES ___NO I tell my doctors what I think is affecting my
health.

APPENDIX A

INTERVIEW CHECKLIST

___YES ___NO I tell my doctors everything that I want them to
know.

___YES ___NO I ask my doctor any questions that I have.

___YES ___NO I ask my doctor to schedule time to answer my
questions and listen to my concerns.

___YES ___NO I tell my doctors when I am feeling upset, nervous,
or depressed that I am feeling that way.

PHYSICIAN/PATIENT COMMUNICATION QUESTIONNAIRE

This questionnaire booklet contains a single overall question on medical care followed by two sets of questions pertaining to doctor/patient communication. The first set of questions is a general communication inventory in which the doctor is referred to as "the other person". The second set of questions deals specifically with doctor/patient communication.

In completing this questionnaire booklet, recall, to the best of your ability, your most recent face-to-face conversation with a doctor during which you were seeking medical care. Please complete all items included in this booklet.

Please note that this is an anonymous questionnaire and do <u>not</u> include an identifier.

Please indicate the number of months it has been since your last visit to a doctor. _____

Your age _____

MEDICAL CARE RATING SCALE

Please circle the number that best describes your response:

OVERALL, I WOULD DESCRIBE THE MEDICAL CARE I

RECEIVED FROM THIS DOCTOR AS:

1	:	2	:	3	:	4	:	5	:	6	:	7	:	8	:	9	:
ROTTEN		TOTALLY UNSATISFACTORY		VERY POOR		POOR		ADEQUATE		GOOD		VERY GOOD		EXCELLENT		FANTASTIC	

INSTRUCTIONS:

The purpose of these two questionnaires is to investigate your re-
actions to the most recent conversation you had with a doctor
regarding you medical care. On the next few pages you will be
asked to react to a number of statements. Please indicate the
degree to which you agree or disagree that each statement describes
this conversation. The 4 or middle position on the scale repre-
sents "undecided" or "neutral", then moving out from the center,
"slight" agreement or disagreement, then "moderate", then "strong"
agreement or disagreement.

For example, if you strongly agree with the following statement
you would circle 7:

> The other person moved around a lot.

> Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

INTERPERSONAL COMMUNICATION SATISFACTION INVENTORY

1. The other person let me know that I was communicating effect-
   ively.

   > Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

2. Nothing was accomplished.

   > Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

3. I would like to have another conversation like this one.

   > Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

4. The other person genuinely wanted to get to know me.

   > Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

5. I was very dissatisfied with the conversation.

> Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

6. I had something else to do.

> Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

7. I felt that during the conversation I was able to present myself as I wanted the other person to view me.

> Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

8. The other person showed me that he/she understood what I said.

> Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

9. I was very satisfied with the conversation.

> Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

10. The other person expressed a lot of interest in what I had to say.

> Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

11. I did NOT enjoy the conversation.

> Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

12. The other person did NOT provide support for what he/she was saying.

> Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

13. I felt I could talk about anything with the other person.

> Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

14. We each got to say what we wanted.

> Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

15. I felt that we could laugh easily together.

> Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

16. The conversation flowed smoothly.

    Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

17. The other person changed the topic when his/her feelings were brought into the conversation.

    Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

18. The other person frequently said things which added little to the conversation.

    Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

19. We talked about something I was NOT interested in.

    Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

PHYSICIAN/PATIENT COMMUNICATION SATISFACTION INVENTORY

1. I did <u>NOT</u> feel that I could disagree with the doctor.

    Disagree: <u>1</u>: <u>2</u>: <u>3</u>: <u>4</u>: <u>5</u>: <u>6</u>: <u>7</u>: Agree

2. The doctor listened carefully to everything I said.

    Disagree: <u>1</u>: <u>2</u>: <u>3</u>: <u>4</u>: <u>5</u>: <u>6</u>: <u>7</u>: Agree

3. The doctor did <u>NOT</u> tell me everything I needed to know about my health or treatment.

    Disagree: <u>1</u>: <u>2</u>: <u>3</u>: <u>4</u>: <u>5</u>: <u>6</u>: <u>7</u>: Agree

4. I felt the doctor genuinely cared about what was happening to me.

    Disagree: <u>1</u>: <u>2</u>: <u>3</u>: <u>4</u>: <u>5</u>: <u>6</u>: <u>7</u>: Agree

5. I did <u>NOT</u> understand what the doctor was saying.

    Disagree: <u>1</u>: <u>2</u>: <u>3</u>: <u>4</u>: <u>5</u>: <u>6</u>: <u>7</u>: Agree

6. I felt free to disagree with my doctor.

    Disagree: <u>1</u>: <u>2</u>: <u>3</u>: <u>4</u>: <u>5</u>: <u>6</u>: <u>7</u>: Agree

7. The doctor offered me choices.

    Disagree: <u>1</u>: <u>2</u>: <u>3</u>: <u>4</u>: <u>5</u>: <u>6</u>: <u>7</u>: Agree

8. The doctor did <u>NOT</u> understand how my health was affecting my life.

    Disagree: <u>1</u>: <u>2</u>: <u>3</u>: <u>4</u>: <u>5</u>: <u>6</u>: <u>7</u>: Agree

9. I could easily understand what the doctor was saying.

    Disagree: <u>1</u>: <u>2</u>: <u>3</u>: <u>4</u>: <u>5</u>: <u>6</u>: <u>7</u>: Agree

10. The doctor showed me that he understood my concern about my health.

    Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

11. The doctor did <u>NOT</u> seem to care about <u>me</u>.

    Disagree: <u>1</u>: <u>2</u>: <u>3</u>: <u>4</u>: <u>5</u>: <u>6</u>: <u>7</u>: Agree

12. The doctor was open and willing to share information with me.

Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

13. The doctor did NOT let me decide how I wished to be medically treated.

Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

14. The doctor did NOT believe me.

Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

15. The doctor was busy and in a hurry to end this conversation.

Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

16. The doctor did NOT think my concerns were important.

Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

17. The doctor was relaxed and interested.

Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

18. The doctor showed me that he took my symptoms seriously.

Disagree: 1: 2: 3: 4: 5: 6: 7: Agree

APPENDIX C

SCORING KEY

THE PPCSI:

For Items 2, 4, 6, 7, 9, 10, 12, 17, 18:

Strongly Agree = 7, Moderately Agree = 6, Slightly Agree = 5,

Neutral = 4, Slightly Disagree = 3, Moderately Disagree = 2,

Strongly Disagree = 1

For Items 1, 3, 5, 8, 11, 13, 14, 15, 16:

Strongly Agree = 1, Moderately Agree = 2, Slightly Agree = 3,

Neutral = 4, Slightly Disagree = 5, Moderately Disagree = 6,

Strongly Disagree = 7.

THE ICSI:

For Items 1, 3, 4, 7, 8, 9, 10, 13, 14, 15, 16:

Strongly Agree = 7, Moderately Agree = 6, Slightly Agree = 5,

Neutral = 4, Slightly Disagree = 3, Moderately Disagree = 2,

Strongly Disagree = 1.

For Items 2, 5, 6, 11, 12, 17, 18, 19:

Strongly Agree = 1, Moderately Agree = 2, Slightly Agree = 3,

Neutral = 4, Slightly Disagree = 5, Moderately Disagree = 6,

Strongly Disagree = 7.