Short Communication

Problems in Physician-Patient Communication: What do our Students See and Hear? A Qualitative Study with a Pragmatic Approach

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Abstract:

Background: Efficient communication with patients is an indispensable necessity for physicians of the 21" century. Over the past decades, much work has been done nationally and internationally to instill this essential skill in undergraduate students and medical graduates are now formally trained to become better communicators. However, deficiencies persist and medical students of today still observe various issues when they observe physician- patient communication interactions in their training.

Objective: To understand perceptions of undergraduate medical students about the difficulties in Physician-Patient communication (PPC) & take suggestions on how to overcome them.

Methods: A qualitative study design was employed, with data collection through three focus group discussions with medical students studying in Wah medical college, Pakistan in October 2019. Thematic data analysis was done using Atlas-ti 8 software. A pragmatic approach was used to understand student perceptions about difficulties in PPC.

Results: After open and selective coding of data, six major themes were identified. Five of these were in relation to students' perceptions about major difficulties with PPC. These included gap between teaching & practice; doctor patient ratio; lack of counselling; lack of empathy and no informational care. The last theme, Effective teaching of behavioral sciences was related to student suggestions for overcoming problems in PPC.

Conclusion: The various issues regarding the problems in physician patient communication portray a realistic picture of our current communication practices. Various factors have been identified in this study and, the most practical solution to these problems lies in the effective teaching of behavioral sciences.

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Introduction:

The term "physician-patient communication" (PPC) includes all verbal and nonverbal interactions that take place between a doctor and his patient during treatment. These interactions form the basis for the doctor-patient relationship[1]. As with all relationships, this relationship can also be productive and expedient only if both the doctor and the patient are able to communicate effectively. Research has proven that the knowledge of a physician cannot benefit the patient if he/she is not able to effectively communicate with the patient[3]. Much work has been done on this topic, especially in recent times, providing evidence that communication skills can be learnt and taught like other aspects of medicine. Good communication between physicians and their patients also leads to higher treatment compliance helping the achievement of optimal health outcomes[4]. Ineffective communication can lead to dire consequences for not only the physician, but also the patient, and effective communication is part

and parcel for all milestones for graduating physicians[5].

At the undergraduate level, formal teaching sessions coupled with early clinical contact allows students to become more effective communicators and consequently better physicians. However, it is during this time in their training that student become privy to difficulties in effective communication encountered by both patients and physicians. Evidence suggests that ineffective communication training in undergraduate medical education can affect the vicarious empathy of students[6]. This waning of empathy influences physician patient communication and may threaten health care quality[7]. These findings underline that it is important to understand students' perceptions regarding difficulties in effective physician-patient communication (PPC).

Keeping these points in view, we conducted this study with the objectives of trying to understand perceptions of undergraduate medical students about the difficulties in Physician-Patient communication (PPC) & take suggestions on how to overcome them. Qualitatively reviewing the perceptions of our students regarding PPC will provide valuable insight into how these problems can be addressed before they arise through proper education of our physicians in training.

Methods:

Our study was qualitative in nature with a pragmatic approach. A pragmatic methodology provides the opportunity to utilise a range of qualitative strategies, rather than a specific defined qualitative research method[8]. Using a pragmatic approach which was simultaneously constructed and grounded in experience, enabled a focus on the multiple experiences of participants which were not accessible through a single methodological approach[9]. It also allowed for contextualised reasoning and flexibility in data analysis, affording an improvement in the quality and depth the research[10]. The study was conducted in a private sector medical college of Pakistan in October 2019. Ethical permission was obtained from the concerned college authorities. The COREQ checklist was utilized during this study to ensure quality[11]. AY was the principal investigator responsible for conducting the research. She was working as a senior lecturer in the department of Medical Education at an undergraduate College and declared her independent position to ensure honesty & objectivity

of the research as she, (being a recent employee of the college) had had no previous personal interaction with students who agreed to participate in the study. Data collection was done by focus group discussions (FGDs) held in the department of Medical Education. Two authors, AY and AA searched the literature to develop the Focus Group Discussion (FGD) guide. The purpose of the FGD guide was to provide a framework for the moderator to ask and probe questions, thus increasing the comprehensiveness of data collection. Literature search allowed for flexibility in pursuing unanticipated yet relevant issues that could be generated during the discussion[8]. Combining the results of literature searches of both authors, the FGD guide was developed with mutual consent to allow for credibility and transferability of the guide. Questions included in the guide with consensus of both authors included an opening question "Have you witnessed Physician-Patient communication in your clinical clerkships?". This question was then followed by a core question "Do you think there are any difficulties or problems in physician patient communication in hospitals? The first core question was followed by probe questions "If yes, what are they? What have you observed? How is the doctor's attitude with patients? Are the patients counselled? How is the patient's attitude?"

The second core question focused on addressing solutions to the problems identified by students. It stated "How can we improve patient physician communication skills in our graduates?" This was followed by probe questions "Is the current teaching & learning methodology of Behavioral Sciences helpful? Is role modelling effective? Should students practice more on standardized patients? What suggestions can you give to improve PPC? And is there anything else you would like to add?

Keeping in view the qualitative nature of the study, purposive sampling technique[12] was employed. Verbal consent was taken at the beginning of each FGD and anonymity of information given by participants was ensured at the onset and only those students who volunteered were included. Students from both fourth year and final year MBBS were invited to participate in these focus groups. All participants were informed that the primary purpose of research was to identify the probl-

ems occurring during physician – patient communication from the perspective of undergraduate medical students. To increase validity, 3 focus groups were conducted till the point of data saturation was reached. All FGDs included 6 to 7 participants and were moderated by the principal investigator. A total of 19 fourth year and final year students participated in the study. Each FGD lasted from 30 to 45 minutes and was audiotaped for transcription and analysis. Field notes were also taken. Probe questions were asked to elicit data regarding difficulties in physician- patient communication and the student's own experiences regarding problems in communicating with patients and suggestions on how to overcome these difficulties or problems that they had witnessed in their ward rotations.

Data obtained from the FGDs were analyzed using the Atlas-ti 8 software[13], Codes were developed after thoroughly reviewing the data. Coding is essential to the development of a grounded theory. Immediate analysis was done to allow for continuous comparison and inform further data collection. Initially open coding was done by AY to help generate as many ideas as possible inductively from early data. This was followed by selective or focused coding, by AA to pursue a selected set of central codes throughout the entire dataset. This process helped to improve confirmability of the codes that were developed. Analytic memos were also entered into the software as the coding process continued. The thematic analysis was done using an inductive approach. Following this approach, Codes were categorized into themes and refined until an explanatory framework or theory was formed. Atlas-ti software was used to iteratively categorize codes that emerged from the data into mutually exhaustive themes. The development of themes and codes helped to categorize the data and understand the recurring patterns of the students thought processes regarding their perceptions about PPC and the dilemmas that they had witnessed in these very preliminary stages of their medical careers. Data analysis yielded a total of six themes with varying codes included in each theme.

All FGD participant students were re-invited and asked to review the contents of the themes and codes of their respective focus group. FGDs a total of 69 codes emerged from the data. These following themes and codes were developed. (Table 1)

Results:

Out of the 19 students participating in the study 5 were males and rest were females. 11 students were from final year MBBS and were contacted for participation in FDGs after their send up exams (theory paper), remaining 8 were fourth year students who were regularly attending their clinical rotations. After transcription and analysis of the data obtained during)

The first theme that emerged from the coding process was "gap between teaching & practice" Students felt that their teachers or seniors did not follow the various protocols for PPC that they themselves had taught to them. "We do not see what is taught to us in class implemented during actual physician -patient interaction in our wards" said one final year student. Students also felt that their seniors did not follow preventive measures for infection control and did not use any form of personal protection while interacting with patients, but laid great emphasis on practicing the latter during SGDs.

In all three focus groups, the second theme that emerged was the students self- perceived explanations for the gap between teaching and practice. This was "Doctor- patient Ratio". "There are just too many patients for them to handle" was the reason given by a student of the same class, he went on further to elaborate "The OPDs are really crowded, with the doctor, the P-G trainee, the patient, his attendants and also us students…. All of this creates a rush and consultants just try to decrease the patient load". These comments are proof that medical students begin to accept the inequitable health dynamics of a developing country at a very early stage. Students also felt that there was no proper counselling of the patients. The doctors did not counsel the patients at all and did not give patients or their families a chance to seek clarification of terms, issues & misgivings. This led to "lack of counselling" developing as the third theme. Students also associated lack of counselling with poor listening "He (doctor) will not even listen to patient's entire complaints, if he feels he has arrived at a diagnosis" exclaimed one final year student.

The next theme emerging from the data was "No informational Care". Students felt that patients were not

informed about the care that would be provided to them in the hospital or any preventive measures that they should take. Effective informational care could not be provided to the patients due to linguistic barriers also. "doctors are unable to understand the language spoken by many patients… for example we have many elderly patients who speak Saraiki" commented one final year student.

Table 1: *Themes and codes arising from the data*

Theme	Description	Codes	Frequency	Representative Quote
Gap between Teaching & Practice	Students feel that there is a distinct gap in how communication skills are taught in class environment and how they are practiced with patients in the clinical environment	what is taught is not implemented; students need role models; no regulations against poor behavior; no counselling of patient; consent not taken; patient not examined well; preventive measures not taken/ no infection control; need real life practice; we don't know how to explain to patients; what is taught is not implemented	13	"we do not see what is taught to us in class implemented during actual physician - patient interaction in our wards"
Doctor patient Ratio	The number of patients reporting to out patient departments are too much for the doctors to handle.	Too few doctors; too many attendants; too much patient load	4	"There are just too many patients for them to handle"
Inadequate Counselling	Patients are not counselled properly regarding their illness	consent is blanketed; coping mechanisms; counselling not done; hierarchical structure for breaking bad news; junior doctors are supposed to counsel; no counselling of patient; no discussion on consent form; not explaining; patients not satisfied properly; Do not listen to patient; language barrier; not examined properly; not explaining	11	"They do not explain things well, they just examine and do not counsel them"
Lack of Empathy	Physicians do not demonstrate the ability to understand or feel what the patient is experiencing.	all patients should be treated equal; consultants do not talk much to patients in OPDs; doctors are overburdened; empathy is reduced; entitled patient not treated well; fear of losing empathy; maintaining privacy is an issue; doctors not explaining; doctor not in mood; patient load is too much; patient privacy not maintained; scold patients; temper problem	17	"The doctor should not invalidate the patient but listen to him/ her patiently and relate to his concerns"

No informational care	Provision of information to the patients using the principles of communication regarding the disease drugs and doctor[15].	Consultants interact in morning round; doctors do not follow protocols for breaking bad news; Linguistic barriers; Medical terminologies; no regulations against poor behavior; patient not informed; patient privacy not maintained; patients do not know why they are admitted in hospital; patients don't know about their illness; patients not educated; patients not guided about medicines; patients not informed about diagnosis; preventive measures not taken, no infection control; relatives not briefed properly; treatment plan not explained.	21	"Consultants only meet patients during ward rounds and then only discuss the case with PGs" "patients do not know why they have been admitted, only that they are sick"
Teaching of Behavioral sciences	Students gave suggestions on how behavioral sciences should be taught to them	Conflicts addressed by trained consultants; only 15% of taught course implemented; teach behavioral science to teachers also;	4	"The things that were taught to us in role plays were more useful for us than the lectures"

Another theme that was identified from the codes was "lack of Empathy". Students felt that doctors were unable to acknowledge the patient's emotions and relate to them empathetically. "The doctor should not invalidate the patient but listen to him/ her patiently and relate to his concerns" said one fourth year student. Consequently, this led the students to perceive that the doctors did not understand the human side of the medical problem and were unable to provide adequate an emotional response to them.

The last theme that emerged was related to the teaching of "Teaching of Behavioral sciences". When asked how physician-patient communication could be improved, the students responded by saying that they should be taught behavioral science as a subject more effectively and that their teachers should be better role models for them, so that they could work on improving their PPC skills as soon as they had clinical exposure. Another interesting suggestion by a final year student was that teachers should also undergo training workshops in improving their own communication skills, since teachers had not been taught Behavioral science as a subject.

Discussion:

Our results provide evidence that, although the diagnostic skills of the physicians were perceived to be effective by the students, they were unable to provide the patients with necessary emotional support which can be developed as a result of effective communication[14]. The results are similar to studies by Roter[15] and Paasche[16] showing that physicians tend to focus more on biomedical questions rather than psychosocial aspects. Problems in PPC have been well documented in literature and include Nondisclosure of Information, Doctors' Avoidance Behavior& Discouragement of Collaboration[17,18]; patient requirements for more information, their preference for a larger part in decision making, their awareness of medical ambiguities and their denunciation of physician paternalism[19]; language barriers, mental health issues or disability challenges[20] insufficient time, ever increasing patient-loads, communication problems and over treatment due to some ineffective medical payment systems[21]. However, the authors were unable to find even a single study that documented these problems from the viewpoint of the undergraduate medical student. It is these students that are in fact the health care providers of tomorrow and thus the

issues highlighted by them are a matter of grave concern.

Another point emphasized by the students was the fear that they would lose their empathy. Decline of empathy during undergraduate medical training has also been documented[7] and its reasons include a genuine shortage of time to interact with patients as students are usually dealing with a colossal workload hindering their cognitive abilities. Some aspects of the medical education system itself also interfere with empathy[22]. However, student distress at expecting their empathy to be lost is a significant finding.

Student recommendations regarding improvement of PPC were fixated not only on effective teaching of behavioral sciences, but also better role modelling by their teachers. One student narrated an incident during her gynecology rotation when she was very impressed by the conflict resolution abilities of one of the consultants after a maternal mortality in the ward. Other students were full of praise for a female surgeon who was known for her empathetic attitude towards her patients. Concern for proper training of the teachers was also shown by the students, as many senior doctors had not studied behavioral sciences as a subject. Evidence also suggests that pedagogical approaches based on a combination of cognitive knowledge delivery and role modelling of suitable communication skills are strongly recommendable methods for improving PPC[23].

This study provides a vivid picture of the realistic problems related to physician -patient communication. However, a limitation of our research is that it has been conducted in a single institute and not in other medical colleges of Pakistan and abroad. Thus, the generalizability of our results can be examined further by conducting similar studies in other institutes. The results of these further studies can used to enhance transferability of our findings.

Conclusion:

The qualitative approach used in this study has raised many questions regarding the effectiveness of current communication skills training program in our institutes. **To our knowledge,** is the first study of its kind which explores problems in PPC from the viewpoint of the medical students. Student's perceptions provide an insightful view on an accepted issue of concern for the medical community.

The results obtained from analysis of the data lead to the conclusion that in the student's observations the difficulties in PPC are mainly due to poor communication skills of the physicians. Several factors which may be the cause behind these poor skills have also been identified, along with students' suggestions for how improvements can be made in the existing situation regarding PPC.

Recommendations:

Further research on this topic should be done in other institutes in Pakistan and world over on the same lines to obtain a broader picture of the problems in physician patient communication. This will enable stakeholders to assess the needs of students and develop curricula focused on addressing these short comings in the teaching and learning of communication skills. Student views should be taken into consideration and their suggestions for improving PPC skills given serious appraisal.

Purpose of Research: Requirement of MHPE degree

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