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Identification of Patient-perceived Barriers to Communication between Patients and Physicians

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Abstract

Purpose: Barriers to full disclosure and communication of complete and accurate health history from patients to their physicians can compromise patient care. Identification of barriers to communication between patients and their physicians, and assessing communication techniques to overcome putative barriers may improve medical training, quality patient care, and patient experience.

Methods: The authors performed a cross-sectional study using a novel questionnaire at an urban, inner-city hospital in Toronto, Ontario between January 1, 2011 and January 1, 2012, in order to evaluate potential barriers to communication. Variables included physician age, gender, education, ethnicity, position, perceived sexual orientation, marital status, physical attractiveness and reason for appointment. All patients attending a gynaecology appointment received the paper-based, anonymous questionnaire. Analyses applied the statistical package, SAS Software, Version 9.2.

Results: Responses for 286 completed questionnaires were analysed. The most common barriers to communication included having a male physician (40.9%) and having a history taken by a medical student (24.5%). Sensitivity to having a male provider was more frequently reported in women under the age of thirty (63.6%) and nulliparous women (49.6%), $p<0.05$. Communication was perceived to be improved when physicians acknowledged patient concerns (95.1%), sought to understand patient concerns (91.9%), and included the patient in decision-making (74.1%).

Conclusions: Physician gender and education level are barriers to full disclosure and communication from patients. Physicians should strive to understand patient concerns and include patients in decision-making in order to encourage full disclosure. Awareness of these obstacles is vital to promoting patient-centered care and to effective physician training.

Keywords: Communication barriers; Disclosure; Patient care; Medical education

Introduction

Full disclosure is defined as open communication wherein a patient provides complete health information to health care workers particularly during patient intake and collection of patient health history [1]. Barriers to full disclosure are numerous and include patient-oriented barriers such as ethnic and religious identity, which may influence whether individuals seek medical attention; as well as patient-perceived stigma and misinformation regarding diagnosis or treatment, which has been shown to limit patient disclosure of medical history [1,2].

Barriers also relate to patient perceptions of their health care team, including physician gender preferences, and physical appearance or attire of a physician, the latter of which is suggested to play a role in perceived patient comfort and assessment of competence [3,4]. Gender has been well documented in the literature, with female physicians reportedly demonstrating greater empathy and rarely interrupting their patients compared to their male counterparts [4]. As such, female physicians are perceived to be approachable and tend to ease feelings of discomfort for their patients [5].

Patient histories typically include demographic information such as age, gender, ethnicity, marital status, occupation, as well as family structure [6]. Studies examining barriers to full disclosure have not considered the influence of patient demographics, or whether certain patient characteristics augment varied sensitivities to particular communication barriers. While some non-modifiable characteristics such as gender and ethnicity may manifest as putative barriers to communication, these may be overcome through training and customer service approaches to improve physician awareness and sensitivity to these potential obstacles. Previous studies investigating approaches to improving patient communication have demonstrated improved physician-patient interactions through standardized communication rubrics and discussion techniques [6,7].

Identification of factors that encourage full disclosure may facilitate patient communication and enable physicians to anticipate challenges in a clinical encounter in order to optimize communication. The intimate nature of obtaining gynaecologic and sexual histories that typically occurs alongside a physical examination in the gynaecological

practice makes this clinical setting especially vulnerable to the effects of communication barriers. Therefore, the primary objective of this study was to examine barriers to full disclosure of information during gynaecology appointments, including the perceived barriers related to specific characteristics of the health care worker. We also assessed patient-perceived value of various communication techniques to assess their potential utility to promote open communication and full disclosure from patients.

Materials and Methods

Prior to study initiation, approval was obtained from the St. Michael's Hospital Research Ethics Board, REB 10-339.

There was no pre-existing validated questionnaire identified to investigate the specific study question assessing barriers to communication, therefore we developed a novel questionnaire to assess barriers to full-disclosure in a gynaecologic appointment. Prior to distribution, we piloted the questionnaire among a sample of physicians, nurses, medical students and residents, and a sample of patients, for face validity and clarity. Ambiguous questions were revised or removed during this pilot process. Barriers included in the questionnaire were derived from a literature review, combining search terms communication, barriers, and healthcare and were limited to literature written in English. Communication techniques were developed to overcome Beitel's communication pitfalls [7] and through informal interviews with health care practitioners. Demographic information collected in routine medical histories was included in the questionnaire to analyse the influence of respondent characteristics on potential barriers and included age, country of birth, primary language, parity, household income, ethnicity, education and relationship status.

A paper-based, anonymous questionnaire surveyed English-speaking women presenting for an outpatient gynaecology or colposcopy appointment to an urban, inner-city hospital in Toronto, Ontario between January 1, 2011 and January 1, 2012. Questionnaires were disseminated to all patients checking into their appointment and were completed in the waiting room or examination rooms while waiting for the physician. Completed questionnaires were placed in a locked box in the waiting room and collected daily.

The final section of the questionnaire examined good customer service approaches and techniques to improve full disclosure and to overcome barriers to communication. These techniques included 'Doctor acknowledges your concerns', 'Doctor seeks to understand reasoning behind your concerns', 'Doctor asks for your opinion regarding diagnosis and treatment options', 'Doctor is smiling as he/she enters the room', 'Doctor shakes your hand upon introducing him/herself', 'Personality of the doctor is similar to your own', 'Doctor avoids using medical terminology', 'Doctor asks you to refer to him/her by his/her first name'.

Questionnaires missing more than one demographic variable were determined to be incomplete a priori and were therefore not included in the analyses. Data were grouped according to demographic information for analysis. Statistical comparisons were determined using the Chi-Square Test where appropriate and significance level was set to $p<0.05$. A sample of convenience was used; however, this was determined to be suitable as patients recruited for the study were representative of women attending this outpatient gynaecological clinic over the course of the year. The questionnaire was limited to English-speaking women who could read the questionnaire and respond to questions. Collected questionnaires were coded and analysed using SAS Software, Version 9.2.

Results

A total of 300 questionnaires were disseminated of which 14 were removed for incomplete demographic information. There were 286 questionnaires included in the final analysis. Demographic characteristics of the study population are shown in Table 1. The majority of respondents were 30 years of age or older (83.6%), were born in Canada (68.2%) and had high school or college/university level education (71.3%) (Table 1).

Demographics	Number (%)
Age (years)	
≤ 19	0 (0)
20-29	44 (15.4)
30-39	74 (25.9)
40-49	60 (21.0)
50-59	60 (21.0)
≥ 60	45 (15.7)
Unanswered	3 (1.0)
Country of Birth	
Canada	195 (68.2)
Other	84 (29.4)
Unanswered	7 (2.4)

Primary Language	
English	238 (83.2)
Other	42 (14.7)
Unanswered	6 (2.1)
Prior Pregnancy	
Yes	155 (54.2)
No	123 (43.0)
Unanswered	8 (2.8)
Has Biological Children	
Yes	137 (47.9)
No	145 (50.7)
Unanswered	4 (1.4)
Annual Household Income	
≤ $50,000	85 (29.7)
$50,001-$99,999	93 (32.5)
≥ $100,000	102 (35.7)
Unanswered	6 (2.1)
Ethnicity	
Caucasian	207 (72.4)
Other	77 (26.9)
Unanswered	2 (0.7)
Level of Education	
High-School	27 (9.4)
College/University	177 (61.9)
Post-Graduate	81 (28.3)
Unanswered	1 (0.4)
Relationship Status	
Married/Long term Relationship	160 (55.9)
Single	77 (26.9)
Divorced/Widowed	43 (15.0)
Other	4 (1.4)
Unanswered	2 (0.7)

Table 1: Demographic information of the study cohort.

Barriers to full disclosure are presented in Table 2. Across all respondents, the most common barriers to full disclosure included having a male physician (117/286, 40.9%) and having a history taken by a medical student (70/286, 24.5%).

Table 3 shows the impact of physician male gender as a barrier to full disclosure according to patient age and parity. Physician male gender was identified as a statistically significant and important barrier for women under the age of 30 (28/44, 63.6%) compared to women aged 30 and above (89/242, 36.8%), $p<0.05$. This barrier was also more

common among nulliparous women (62/126, 49.2%) compared to those with previous pregnancies (55/160, 34.4%), p<0.05

Barrier	Number Identified (%)
Male gynecologist	117 (40.9)
History taken by medical student	70 (24.5)
Gynecologist appears younger than patient	40 (14.0)
History taken by nurse	31 (10.8)
Appointment for purpose of discussing new problem	26 (9.1)

Table 2: Most frequently identified barriers to communication.

	Male Gender is a Barrier	Male Gender is not a Barrier	Total	RR
Nulliparous	62	64	126	1.43
Pregnancy history	55	105	160	
Age<30	28	16	44	1.73
Age>30	89	153	242	

Table 3: Examining the relationship between previous obstetrical history and age of respondent as it pertains to physician male gender as a barrier to communication.

Women sensitive to male gender specified perceived physician heterosexual orientation as a barrier to full disclosure more than homosexual orientation. Among those who identified male gender as a barrier (n=117), 43 (36.8%) identified both orientations as a barrier, whereas 51 (43.6%) specified heterosexual alone, and 22 (18.8%) specified homosexual alone.

Among the different communication techniques, acknowledging patient concerns (272/286, 95.1%), understanding patient concerns (263/286, 91.9%) and including the patient in decision-making (212/286, 74.1%) were each identified by women as approaches to overcome communication difficulties. Smiling during an introduction was reported by 189/286 (66.0%) of women as promoting a marked improvement in communication (Table 4). Common themes emerged from the results of open-ended questions about communication, including the requirement for a health care worker to be non-judgmental and professional in his/her demeanor.

Technique	No effect	Small effect	Large effect
Doctor acknowledges your concerns	2	2	95
Doctor seeks to understand the reasoning	3	4	92
behind your concerns			
Doctor asks for your opinion regarding	10	15	74
diagnosis and treatment options			
Doctor is smiling as he/she enters the room	8	25	66
Doctor shakes your hand upon introducing	30	26	43
himself/herself			
Personality of the doctor is similar to your own	28	33	38
Doctor avoids using medical terminology	23	43	32
Doctor asks you to refer to him/her by his/her first name	49	28	21

Table 4: Percentage of respondents in whom the identified technique would encourage full disclosure.

Discussion

We examined barriers to full disclosure and open communication between patients and their health care providers during gynaecology appointments. Physician male gender emerged as the barrier with the greatest impact on full disclosure. Previous studies have demonstrated that female physicians are commonly viewed as approachable, demonstrating an ability to reduce distress during a clinical encounter [5]. As such, a female physician may achieve full communication of biomedical and psychosocial information from their patients [8]. Indeed, the inherent intimate nature of gynaecology appointments may enhance this female physician gender bias. Moreover, in gynaecological settings, desexualized professional behavior has been reported to be associated with improved satisfaction after vaginal physical exams by male practitioners [9]. Our findings are consistent with this research as women in the present study reported increased comfort with disclosing health history information to male physicians whom they perceived to be homosexual. These results may be attributed to patient perception and reassurance of the strict professional nature of the encounter. Furthermore, analysis of open-ended questionnaire responses revealed an increased ability to relate to physicians who appear to identify as lesbian, gay, bisexual, or transgendered (LGBT), and an interpretation that these physicians are less judgmental. Indeed, studies demonstrate that LGBT physicians are more likely to have LGBT patients disclose their orientation, and are able to establish higher quality communication during HIV-specific health discussions [4,10].

Despite purported apprehensions toward male physicians, some studies have shown that actual responses to clinical questions relating to personal sexual history do not appear to differ between patients with physicians of the opposite sex, suggesting instead that when choosing a physician, gender is considered to be secondary to physician experience, knowledge, and ability [5,11]. Taken together, these studies demonstrate that while physician gender and sexual orientation are non-modifiable constructs, future research should focus on these specific barriers with particular emphasis on early career education for trainees and established physician training that raises awareness of impediments to patient full disclosure during clinical encounters, along with fundamental strategies to overcome these barriers.

Patient age emerged as a stronger predictor of sensitivity to male physician gender than parity. Given that many nulliparous respondents in our study population, who reported male gender sensitivity as a barrier to communication, were also under 30 years of age, we explored the relation between age and pregnancy history with male gender sensitivity. McCallum et al. investigated the barriers to women accessing sexuality resources following gynecologic cancer treatment and found differences in resource uptake with increasing patient age [12]. The influence of patient age is likely multifactorial but may hinge on prior personal experiences. With advanced age, patients may have more health care encounters and experiences which expose them to opportunities for interactions with male physicians possibly contributing to their increased comfort with male physicians [12]. Consistent with this literature is our finding that, women who were least sensitive to physician male gender had a previous obstetrical history which characteristically involves multiple previous visits, and examinations with potentially various physicians.

The next most frequently identified barrier to full disclosure in our study was physician education wherein a medical student conducted the interview to collect patient history. Medical students are less experienced, potentially less skilled at interviewing, and may appear to lack empathy, knowledge or competence, and may portray discomfort themselves with the content of the medical encounter. Patients may also withhold personal health information when interacting with an individual that they perceive as non-essential in their care team. Many respondents in the present study cited a previous negative experience with a medical student that influenced their readiness for future interactions with trainees. These observations emphasize the importance of adequate medical training such as the use of Standardized Patients, i.e. actors trained to depict the personal and medical history and symptoms of a patient for training purposes. Medical curricula with focused, hands on, patient communication training have been shown to improve patient-physician interactions [13,14]. Indeed, standardized education tools such as rubrics have been created and utilized with some success for communication in specific clinical contexts, including palliative care [15]. Implementation of similar models for communication in other clinical areas, such as gynecology and family practice, may contribute to improved patient care.

Physician professionalism was identified as the most important characteristic to promote full disclosure. This result highlights the significance of standardized professionalism training in medical curricula as well as continued education for experienced physicians, and emphasizes the importance of a professionalism component in Competency Based Medical Education. Eight communication strategies were evaluated for effect on communication, of which three were found to predict strong increases in communication from patients: 'acknowledging patient concerns', 'seeking to understand those concerns', and 'including the patient in decision-making'. Notably, 66% of respondents identified that a smiling physician would have a large effect on promoting their full disclosure. Research studies examining perspectives of junior medical staff; identify time constraints or lack of time as the primary barrier to hindering thorough investigation of complex issues during an appointment [16]. Collectively, the literature and the study findings reported herein, elucidate a training gap in medical education that could potentially be addressed through training using customer service techniques that are readily implemented and valued by patients and may include simple modifiable behavioural approaches such as smiling during patient encounters as a simple way to encourage open communication. There is an extensive literature evaluating survey tools about teaching strategies to improve communication between physicians and patients, but what remains unclear is the patient perspective of perceived barriers to their communication with their physicians, which was the focus of the present research.

This study has several limitations which should be acknowledged. The questionnaire was modelled from other surveys in the literature, though no existing validated survey could be applied, therefore an internal validation approach that included piloting the survey tool, was used to design the questionnaire which was furthermore, only available in English and therefore excluded non-English speaking participants which may have offered an enriched demographic perspective and may have captured nuances related to immigrant experiences and varied socioeconomic experiences [17,18]. The study design included a convenience sample, in which the reason for refusal of study participation was not collected which may have revealed any potential selection bias. Barriers were identified, but were not prospectively addressed and evaluated. However, this type of prospective research approach was outside of the scope of this study which was designed to address the objective of merely identifying the barriers to full disclosure and communication from patients to physicians.

Notwithstanding these limitations, this study is the first to our knowledge to identify barriers to full disclosure specifically among women seeking gynaecologic care. The findings reported herein contribute important information to the field of medical education that can be used to assist with efforts to improve physician training toward enhanced patient communication. Moreover, the barriers identified here represent an emergent component of medical training that can be applied to other clinical settings including family practice. In their review of the methodological quality of psychometric studies evaluating physician-patient communication, Zill et al. describe research showing that core functions of patient-centered communication including supporting patients' self-management, the management of uncertainty and emotions, and enhancing the physician-patient relationship, as well as improved patient adherence [19-21].

In conclusion, we found that physician gender and education level are barriers to full disclosure and communication from patients. The present study highlights a clear need for physician training and a medical curriculum that addresses barriers to full disclosure and communication from patients. The quality of patient care and patient satisfaction is compromised in the absence of patient full disclosure and complete communication of health information. Physicians and medical trainees should be aware of the obstacles to full disclosure in order to avoid the collection of inaccurate and incomplete health information that could conceivably affect patient care [17,18,22]. Recognition of these barriers may help improve patient satisfaction, enhance the patient-physician relationship and enhance patient-centered care. Future research should apply the findings of this study as a prospective intervention to assess medical education and training methods, including implementation of the techniques identified herein, for improved patient communication as a quality improvement initiative. This potential future work should employ qualitative research methods in addition to the well-known SEGUE framework that is widely applied in most US and Canadian Medical schools to improve learning of effective communication for medical students [23], in order to more fully explore different barriers and strategies to overcome them.

Ethical Approval

Ethical approval was obtained from the St. Michael's Research Ethics Board, REB 10-339.

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