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RELATIONAL ASPECTS AND DOCTOR'S EMOTIONS IN MEDICAL COMMUNICATION

The aim of the paper is to present a study on interpersonal relationship in doctor-patient communication. We shall present some preliminary results of a research on doctor-patient relationship as a part of a project on antibiotic resistance.

Our theoretical framework which originates from contributions of Human Ethology and Evolutionary-Cognitive theories allows us to analyse interpersonal relationship's dynamics and different relational styles in doctor-patient communication.

The aim of our research is to study which aspects of doctor-patient relationship may affect the physician's practice such as an improper antibiotic prescription through role-plays between real doctors and simulated patient. The results suggest that the features of relationship affect both doctor's communication style and consultation's outcomes such as an improper antibiotic prescription which also emerges from the analysis of doctors' emotions.

Keywords: interpersonal relationship, doctor-patient communication, antibiotic prescription, Interpersonal Motivational Systems, role-plays.

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The aim of the paper is to present a study on interpersonal relationship in doctor-patient communication. We have adopted an interdisciplinary perspective which integrates in particular the contributions of clinical psychology and health communication. This approach has been applied to present some preliminary results of our research on doctor-patient relationship as part of a project on antibiotic resistance.

The interpersonal relationship develops into interactions between two individuals and it acquires specific features on the basis of relational styles which individuals play during the exchanges of those interactions.

Our theoretical framework which originates from contributions of Human Ethology and Evolutionary-Cognitive theories (Bowlby 1969-1980; Gilbert 1995; Liotti 1991) - the latter particularly developed in the field of clinical psychology - allows us to analyse interpersonal relationship's dynamics and different relational styles in doctor-patient communication. The shared background of these theories concerns the origin of human social behaviour; in particular they claim that there is an innate basis - also defined Interpersonal Motivational System (IMS) - which predisposes people to social behaviour (Carassa 2007).

The emotions as well as thoughts and behaviour are the most relevant components for studying IMS in human beings; in fact when we usually experience emotions, we may be aware of them: positive emotions, e.g. joy or satisfaction, signal the success of ISM objective, while negative emotions, e.g. disease or suffering, express the failure of ISM objective and its lasting activation.

The assumption of our discussion refers to the relational styles developed by doctor and patient also through the communicative exchanges performed in the course of the consultation. The quality of the relationship seems to influence not only patients' outcomes, as the application of treatment (Heszen-Klemens & Lapińska 1984; Schneider et al. 2004) and patients' satisfaction (Williams et al. 1998; Flocke et al. 2002), but also doctor's behaviour, for example in the case of medicine prescriptions.

In order to exemplify this concept, we will consider some researches regarding the problem of antibiotic resistance, which will show to what extent the quality of interpersonal relationship can affect communication and the outcome of the consultation.

Antibiotic resistance is considered as a relevant public health concern. Its causes are of two kinds. On the one hand researches have proved that antibiotics are often prescribed inappropriately and excessively, in spite of the various efforts to modify such practices (Davey et al. 2003). On the

other hand it has been found that a relevant percentage of patients misuses antibiotics not following the doctor's indications (Williams and Heymann 1998).

Since antibiotics misuse is increasing within the medical domain, there is the need for effective measures aiming at promoting a more reasonable use of these medicaments (Belongia et al. 2001). In fact there is the conviction that more adequate information, from a quantitative and qualitative point of view, will help patients to use the medicament correctly and to adhere more precisely to the treatment.

Clinical practice shows that, when prescribing antibiotics, it is often not enough for the doctor to simply follow with competence and precision the standard procedures defined by research protocols. In many cases patients show bad adherence to prescriptions – irregularity or interruption of treatment – that can be attributed to various causes, as for example to a lack of understanding, will, cooperation, etc. In any case, the consequence is the spreading at a social level of bacterial resistance to antibiotics. It seems then useful to encourage studies that can increase knowledge on interactions and communication types, and on factors that influence both decision and adherence.

Some researches have shown that patients' expectations actually have an influence on the prescription of antibiotics and are considered by many doctors as a non-clinical factor influencing their clinical practice (Macfarlane et al. 1997; Cooper et al. 2001). In fact in some cases doctors admit to prescribe unnecessary antibiotics in order to comply with patients' expectations. Moreover, another percentage of doctors say that it takes them less time to prescribe a medicament rather than give the patient some explanations. An interesting aspect revealed in a research by Rao et al. (2000) is that in general the accuracy in doctors' perception of patients' expectations is very low, resulting in a negative effect on patients' satisfaction.

Some interesting observations can be made when comparing these studies with the ones that are focused on patients' expectations regarding the medical consultation (Welschen et al. 2004). It seems that patients expecting an antibiotics prescription are satisfied with the consultation not only when they receive this prescription, but also when they receive information and reassurances from their doctor. Thus the expectation doesn't seem to be the only variable conditioning patients' satisfaction.

Generally speaking, doctors perceive patients' expectations as strongly related to the prescription and this perception often affects prescription

even more than patients' actual expectations (Little et al. 2004). Some doctors explain the influence of such expectations in terms of a request from patients with certain health beliefs or particular social conditions. The latter are often associated with specific relational modalities activated by the patient in order to obtain the desired prescription. The fact that doctors often comply with patients' requests is often motivated by the desire to maintain a good interpersonal relationship (Stevenson et al. 1999).

Researches on relational aspects in the medical domain have progressively shifted the attention on emotional components and on the influence they have on outcomes. Many studies have been conducted in this field, and the characteristics of the medical interview are evaluated for example on the basis of the degree of consciousness doctors have of patients' emotions during the consultation. These studies have shown that doctors often think patients react more negatively than they actually do to the medical consultation (Hall et al. 1999). A similar study (De Coster & Egan 2001) has focussed not only on how doctors perceive their patients' emotions, but also on what kind of actions they perform as a response to these emotions: anxiety and fear tend to activate doctors much more than emotions such as sadness or rage. Within a study on the causes and emotions that can influence the way doctors and patients interact (Hall et al. 2002), doctors and patients had been asked to tell whether or not they had liked their interlocutor and how much, from their point of view, their interlocutor had liked them: in general, when they both judged each other positively there was a correlation between this judgement and the patient's satisfaction regarding the doctor, which was filed one year later during the follow-up.

Other studies stress the necessity to increase doctors' awareness regarding the emotions experienced during consultations with patients they see more often or with the most difficult cases, which are more apt to generate emotions such as anxiety. This kind of study aims at improving relational and communicative aspects between doctor and patient, and preventing excessive stress to doctors (Bellón & Fernández-Asensio 2002).

In our hypothesis emotional and relational aspects play a role in doctor-patient communication and behaviour as well as outcomes such as client's adherence to antibiotic treatment, satisfaction etc. In particular the aim of our research is to study how and to which extent doctor-patient relationship may affect the physician's practice such as an improper antibiotic prescription.

To explore the impact of interpersonal relationship on doctor prescription we developed several casevignettes that were enacted during role-playing session by real doctor and simulated patient. The former are general practitioners working for the National Health Service in Italy; the latter are students with degrees in medicine or psychology, trained in "cognitive psychotherapy" schools. These students are given specific instructions about both the expectation for antibiotic and the relational style to play as well. The doctors receive only information about the type of patient infection.

One of the assumptions of the study is that antibiotic expectations are associated to a relational style characterised by a patient's pressure for antibiotic which create difficulties for doctors. These relational aspects can affect doctors' clinical practice such as prescribing.

To analyse the doctor-patient interaction we have chosen two instruments that allow us to deeply explore the ongoing interaction focusing on relational aspects and communication style. In particular:

a) Trantor Emotions Questionnaire-TREQ (Rezzonico & Bisanti 2002);
The *TREQ* has its origins in experimental and clinical studies on emotion adjective lists (Plutchick 1989, 1994). It is different from other lists in that it refers to both theoretical approach and goals of application. In particular our emotion approach takes its reference from the constructive approach of cognitive clinical psychology (Guidano & Liotti 1983; Guidano 1987, 1991). It means that emotions are also considered subjective experience we have with others.
TREQ is composed of two tables of 102 terms which are lists of emotions and feelings. Each table contains the same list of terms that is composed of a different kind of emotions: there are basic emotions, such as happiness, fear, anger, sadness, disgust; emotional states, feelings; emotional dispositions or traits; sensations; moods, etc. It is not an exhaustive list of emotions. In fact there is the possibility to complete it by adding "Other relevant emotions".
At the end of the role-plays doctors were asked to fill in a modified version of *TREQ* (only one table) - marking emotions' intensity and frequency – regarding emotions felt during the role-plays.

b) Measure of Patient-Centred Communication-MPCC (Brown, Stewartand Ryan 2001), developed by The Centre for Studies in Family Medicine, University of Western Ontario, Canada. The *patient-centred approach* (Stewart et al. 2003; Mead & Bower 2000) considers

the analysis of the patient's "lifeworld" one of the aims of doctor-patient communication. This approach has contributed to a better definition of the characteristics of interpersonal relationship in the medical domain. The analysis system concerns different dimensions of medical consultation such as exploring both the "Disease" (i.e. the patient's symptoms) and the "Illness Experience" (i.e. the patient's feelings, ideas, expectations about symptoms); "Understanding the Whole Person" (i.e. family, life cycle, social support, etc.); "Finding Common Ground" (i.e. diagnosis, goal of treatment, treatment plan, etc.) The analysis also includes the doctor's communication style such as blocking the patient's discourse; whether statements are clearly expressed or not; whether the doctor gives an opportunity to ask questions or not; the doctor's empathetic statements about what patient is talking about (i.e. concerns). This approach enable us to highlight to which extent the doctor-patient communication has been patient-centred, responding to the patient's needs

The role-plays have been transcribed and analysed with MPCC categories.

c) *External judges*: to analyse relational styles between doctor and simulated patient, two external judges, both clinical psychologists, have been used to identify relational styles in ongoing interaction.

We intend to present a sample of preliminary results from our research aiming to highlight to which extent interpersonal aspects play a role on doctor-patient communication and outcomes as well.

In 4 role-plays with 4 different doctors, the actor plays a patient affected by an acute pharyngitis that does not need an antibiotic treatment although the patient asks doctors for an antibiotic prescription. The patient is given specific instructions to keep on asking for an antibiotic prescription if the doctor refuses to prescribe it.

The results show some relevant facts: 2 doctors out of 4 prescribe unnecessary antibiotics, although they know they are definitely not suitable for the patient's symptoms. We did not expect such prescriptions to be given during the role-plays precisely because doctors knew the diagnosis in advance which they do not normally in their clinical practice. Usually in a first consultation they have to handle the uncertainty of not knowing if the patient's symptoms are associated to a viral or bacterial infection. Something seems to have interfered with their correct treatment plan.

If we focus on emotions doctors have reported as prevalent during the role-plays, it emerges that all four doctors experienced a prevalence of negative feelings such as annoyance, competition, aggression, frustration, intolerance, etc. The quality of emotions suggests a prevalence of opposing relational styles within all ongoing interactions between doctors and patient, as confirmed by external judgment.

The analysis of doctors' communication during role-plays shows that all doctors have used a communication style that is not characterised as patient-centred. It means that they do not deeply explore the patient's "illness experience" nor do they find "common ground" about treatment. In general here, we observe doctors' difficulties to deal with patient pressure for antibiotics when it implies an opposing relational style. Some doctors seem to solve this kind of problem by prescribing unnecessary antibiotics. In other cases, when they explore the patients' "illness experience" more in depth they succeed in not prescribing antibiotics.

These preliminary results suggest that patients' expectation or pressure is associated with a prevalence of doctors' negative emotions and mainly opposing relational style in the relationship. Furthermore doctors' negative emotions are associated with a low level of patient-centredness during consultation.

When the patient's "Illness Experience" has been explored, doctors do not prescribe antibiotics although sometimes with a high control on the communication.

Analysis of doctors' emotions shows that patient's expectation/pressure is a non-clinical factor that influences the decision to prescribe antibiotics and it affects not only the communication style but also ongoing interaction and its outcome (Rao et al. 2000).

This preliminary data suggest that the features of relationship, developed in the doctor-patient interaction, affect both doctor's communication style and the outcome of the consultation such as an improper antibiotic prescription which is also apparent from the analysis of doctors' emotions.

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References

BELLÓN, J.Á. & FERNÁNDEZ-ASENSIO, M.E. (2002). Emotional profile of physicians who interview frequent attenders. *Patient Education and Counseling* 48/1: 33-41.

BELONGIA, E.A. et al. (2001). A community intervention trial to promote judicious antibiotic use and reduce penicillin-resistant Streptococcus pneumoniae carriage in children. *Pediatrics* 108/3: 575-583.

BOWLBY, J. (1969). Attachment and loss: Vol. 1. Attachment, New York: Basic Books.

BOWLBY, J. (1973). Attachment and loss: Vol. 2. Separation, New York: Basic Books.

BOWLBY, J. (1980). Attachment and loss: Vol. 3. Loss, New York: Basic Books.

BROWN, J.B. et al. (2001). Assessing Communication between patients and physician: the measure of patient-centered communication (MPCC) (2nd ed.). Working Paper Series 95/2. London, Ontario: UWO.

CARASSA, A. (2007). Communication within human activities. A research programme for the psychology of communication. *This volume*.

COOPER, R.J. et al. (2001). Principles of appropriate antibiotic use for acute pharyngitis in adults: Background. *Annals of Internal Medicine* 134/6: 509-517.

DAVEY, P. et al. (2003). Interventions to improve antibiotic prescribing practices for hospital inpatients (Protocol for a Cochrane Review). The Cochrane Library 1. Oxford: Update Software.

DE COSTER, V.A. & EGAN, M. (2001). Physicians' perceptions and responses to patient emotion: implication for social work practice in health care. *Social Work in Health Care* 32/3: 21-40.

FLOCKE, S. et al. (2002). Relationships between physician practice style, patient satisfaction, and attributes of primary care. *The Journal of Family Practice* 51/10: 835-840.

GILBERT, P. (1995). Biopsychosocial approaches and evolutionary theory as aids to integration in clinical psychology and psychotherapy. *Clinical Psychology and Psychotherapy* 2: 135-56.

GUIDANO, V.F. (1987). The complexity of the Self: A developmental approach to psychopathology and therapy, New York: Guilford.

GUIDANO, V.F. (1991). The Self in process: Toward a post-rationalist cognitive therapy, New York: Guilford.

GUIDANO, V.F. & LIOTTI, G. (1983). Cognitive processes and emotional disorders, New York: Guilford.

HALL, J.A. et al. (1999). Inaccuracies in Physicians' Perceptions of their Patients. *Medical Care* 37/11: 1164-1168.

HALL, J.A. et al. (2002). Liking in the physician-patient relationship. *Patient Education and Counseling* 48/1: 69-77.

HESZEN-KLEMENS, I. & LAPIŃSKA, E. (1984). Doctor-patient interaction, patients' health behaviour and effects of treatment. *Social Science and Medicine* 19/1: 9-18.

LIOTTI, G. (1991). Patterns of Attachment and the assessment of interpersonal schemata: Understanding and changing difficult patient-therapist relationships in cognitive psychotherapist. *Journal of Cognitive Psychotherapist* 5: 105-114.

LITTLE, P. et al. (2004). Importance of Patient Pressure and Perceived Pressure and Perceived Medical Need for Investigations, Referral, and Prescribing in Primary Care: Nested Observational Study. *British Medical Journal* 328/7437: 441.

MACFARLANE, J. et al. (1997). Influence of Patients' Expectations on Antibiotic Management of Acute Lower Respiratory Tract Illness in General Practice: Questionnaire Study. *British Medical Journal* 315: 1211-1214.

MEAD, N. & BOWER, P. (2000). Patient-centredness: a conceptual framework and review of the empirical literature. *Social Science and Medicine* 51/7: 1087-1110.

PLUTCHICK, R. (1989). Measuring emotions and their derivates. In: PLUTCHICK, R. & KELLERMAN, H. (eds.). Emotion, theory, research and experience. The measurement of emotions 5. New York: Academic Press.

PLUTCHICK, R. (1994). The Psychology and Biology of Emotion, New York: Harper Collins College Publishers.

RAO, J. et al. (2000). Visit-Specific Expectations Patient-Centered Outcomes. *Archives of Family Medicine* 9/10: 1148-1155.

REZZONICO, G. & BISANTI, R. (2002). Il Trantor Emotions Questionnaire (TREQ) in psicoterapia cognitiva. *Quaderni di Psicoterapia Cognitiva* 11: 36-53.

SCHNEIDER, J. et al. (2004). Better physician-patient relationships are associated with higher adherence to antiretroviral therapy in patients with HIV infection. *Journal of General Internal Medicine* 19/11: 1906-103.

STEVENSON, F.A. et al. (1999). GPs' perceptions of patient influence on prescribing. *Family Practice* 16/3: 255-261.

STEWART, M. et al. (2003). Patient-Centered medicine: Transforming the clinical method (2nd ed.), Oxon: Radcliff Medical Press.

WELSCHEN, I. et al. (2004). Antibiotics for acute respiratory tract symptoms: patients' expectations, GPs' management and patient satisfaction. *Family Practice* 21/3: 234-237.

WILLIAMS, R.J. & HEYMANN, D.L. (1998). Biomedicine: Containment of Antibiotic Resistance. *Science* 279/5354: 1153-1154.

WILLIAMS, S. et al. (1998). Doctor-patient communication and patient satisfaction: a review. *Family Practice* 15/5: 480-492.