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How do lay people assess the quality of physicians' communicative responses to patients' emotional cues and concerns? An international multicentre study based on videotaped medical consultations

Maria Angela Mazzi [a,*], Jozien Bensing [b], Michela Rimondini [a], Ian Fletcher [c], Liesbeth van Vliet [b], Christa Zimmermann [a], Myriam Deveugele [d]

[a] Department of Public Health and Community Medicine, University of Verona, Italy
[b] NIVEL, Netherlands Institute for Health Services Research/Utrecht University, The Netherlands
[c] Division of Clinical Psychology, Whelan Building, University of Liverpool, Liverpool, UK
[d] Department of General Practice and Primary Health Care, University of Ghent, Ghent, Belgium

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ABSTRACT

Objective: to establish which kind of physician communicative responses to patient cues and concerns are appreciated by lay people.
Methods: A balanced sample (259 people) was recruited in public places to participate in a full day observation of four videotaped standardized medical consultations. In a two-step procedure participants gave their individual quality ratings of the whole consultations and then of a set of four fragments from each consultation. They contained a patient negative emotional expression and the subsequent physician response, according to the VR-CoDES.
Results: Higher quality ratings were given to physician responses which provided space to the patient to talk and to the explicit expressions of empathy. The explicit responses were favored above non-explicit responses. Participants' global evaluation of the whole consultation affected their quality assessments of the fragments (halo-effect). In a multivariate model, lay people's background characteristics appeared to be relevant: to be female, of lower educational level and living in Belgium or Italy predicted higher ratings.
Conclusions: Providing space to patients is appreciated by all participants, combined with the need for tailor made communication.
Practice implications: To teach physicians listening skills and how to show empathy with distressed patients should be a core element in medical education.

1. Introduction

There is growing plea for incorporating the public's experiences in the quality assessment of health care [1]. Doctor-patient communication is a domain 'par excellence' to include the public's perspective in quality assessments, as (a) health care users often have different priorities from health care providers [2], (b) tend to stress the importance of good communication [3,4], (c) often report quality problems in this area [5], and (d) these communication problems contribute to many adverse patient outcomes, such as non-adherence [6], formal and informal complaints [7], medical lawsuits [8] and patient dissatisfaction [5]. In short: doctor–patient communication is an area which is under scrutiny of the general population and could benefit from patients' input when trying to make improvements.

A key concept in research on doctor–patient communication, which reflects this orientation, is 'patient-centered care' (PCC). In a Cochrane review, patient-centeredness was defined as 'a philosophy of care that encourages shared control of the consultation, decisions about management of the health problems with the patient, and/or a focus in the consultation on the patient as a whole person who has individual preferences situated within social contexts (in contrast to a focus in the consultation on a body part or disease)'. This review also concluded that 'patient-centeredness' is hard to define, and that more research is needed [9]. The concept 'patient-centeredness' claims to cover divergent areas: exploring the experience and expectations of disease and illness, understanding the whole person, finding common ground (partnership), health promotion, enhancing the doctor–patient relationship, and

* Corresponding author at: Dipartimento di Sanità Pubblica e Medicina di Comunità, Sezione di Psichiatria e Psicologia Clinica, Università degli Studi di Verona, Policlinico G.B. Rossi, Piazzale L.A. Scuro 10, 37134 Verona, Italy.
Tel.: +39 045 8124441; fax: +39 045 8027498.
E-mail address: mariangela.mazzi@univr.it (M.A. Mazzi).

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the realistic use of time [3,10]. However, there is little empirical evidence from the patients' perspective to support the precise structure of the model or to identify the components most important to patients [3].

De Haes et al. suggested to deconstruct communication in a number of meaningful elements, by – theoretically – deriving specific communication behaviors from the different aims and functions of the medical encounter, and – empirically – link these behaviors to predefined endpoints [11]. The following core functions of the medical encounter were distinguished: fostering the doctor–patient relationship, gathering information, providing information, (shared) decision making, enabling the patient and stimulating self-management, and responding to emotions.

Inspired by this approach, we decided to undertake a study in which ONE core function of the medical consultation was selected, which is vital for patient centered care, i.e. '*responding to negative emotions*', and ONE relevant endpoint is defined, i.e. *lay people's' views on the quality of physicians' responses*. We decided to focus on a particularly sensitive area: physician's response to patients' cues or concerns, because, from the literature, we know that patients are often reluctant to reveal their real problems directly, providing subtle cues or concerns, instead [12]. This means that dedicated effort is required to get patients' emotions in the open. However, the literature also shows that health care providers often ignore patient cues and concerns [12–14], thus leaving potential important topics unspoken [15]. For doctors, this seems to be a delicate area to maneuver, where a 'faux pas' is easily made. The quality assessment of lay people, who do not have specialized or professional knowledge of the subjects, could be helpful to develop empirically based guidelines and targeted skills training.

Lay people's perspective on the quality of physicians' response to emotions is a relevant topic, because up to date little is known about which physicians' responses to patients' cues or concerns are appreciated or disliked by those on the receiving end: potential patients. When patients or the public are approached for the evaluation of health care, usually only general assessments are tapped from the respondents, such as whether there was sufficient time or attention, but without a clear benchmark, which would make it possible to compare people's opinions on the quality of care, based on the same concrete examples of communication. Yet, knowledge about which kind of communication is approved or disapproved by the public in situations where a physician has to deal with sensitive issues, could be helpful for physicians in choosing a communication strategy for those situations. It is also important to know when physician's communication evokes different reactions, because that would mean that physicians need to tailor their communication to patient preferences and expectations in those situations.

For this study we presented to lay people an identical set of various examples of a specific doctor–patient interaction in which the physician replies to patient's expression of a negative emotion, cue or concern.

The aims were to explore how lay people with different backgrounds assess the quality of the physician responses and how universal their quality assessments are. Are some types of communication always favored over others, or do they evoke differential responses in different respondents? We are also interested to learn whether people assess *the doctor* or his/her *behavior*: in other words to what extent is people's assessment of concrete communicative behaviors directly related to the type of communication at the micro-level, or determined by their general image of the doctor (halo-effect). The added value of studying these aspects in an international study with a wide variety of participants is, that we get to know how universal lay people's assessments of physician responses to patient cues and concerns are, putting to test the assumption that 'patient-centered communication' has the same meaning for all people, regardless who they are, and where they live.

2. Methods

2.1. Design

The study is an international observational study which draws its name (GULiVer) from the four centers involved: Ghent University (Belgium), Utrecht University/NIVEL (the Netherlands), Liverpool University (United Kingdom) and the University of Verona (Italy). The benchmark material consists of an identical set of $2 \times 4 = 8$ videotaped OSCE's (Objective, Structured, Clinical Examinations), used to examine the quality of communication of medical students as part of their final exams. The videotapes cover two different scenarios (period pain and vaginal discharge) and were selected to represent a maximum variation in the quality of communication according to the examiners. For the present study these videos were subtitled (the Netherlands and Belgium) or dubbed (Italy), reflecting the common way international television programs are handled in the respective countries. In each country, the same videotaped OSCE consultations were shown to 8 or 9 lay panels, each consisting of 6–8 citizens. Each lay panel observed (in random order) four different examples of the same scenario. In all four countries the same procedures were followed according to a detailed protocol [16], approved by the local ethics committee.

2.2. Sample

Participants were recruited in public areas, via calls in free local newspapers and word of mouth. Inclusion criteria were: age over 18 years; at least one GP-visit over the last 12 months; speaking the country's language. In order to ensure a heterogeneous distribution of the sample, the selection of participants was stratified by gender (separate male and female panels) and age (18–30; 31–49; $\geq$50). The overall sample consisted of 259 participants, equally distributed across the centers and the stratification variables, as established by the study design and confirmed by the Generalized Linear Model (GLM) analysis [17] (deviance = 21.2 (df = 40); $p = 0.99$).

2.3. Physicians' responses to patient cues and concerns

For the selection of consultation fragments all videotaped consultations had been coded to identify patient cues and concerns as well as doctor responses, applying the Verona Coding Definitions of Emotional Sequences (VR-CoDES) [18–20]. This system consists of two parts for respectively patients' cues and concerns (VR-CoDES-CC) and provider responses (VR-CoDES-P). Cues are defined as ''verbal or nonverbal hints which suggest an underlying unpleasant emotion and that lack clarity''. Concerns are defined as ''clear and unambiguous expressions of an unpleasant current or recent emotion that are explicitly verbalized with or without a stated issue of importance''. The VR-CoDES-CC has a satisfactory interrater-reliability: Cohen's kappa of 0.70 ($\pm$0.03), percentage agreement 81.46 [18]. The validity of the coding system was confirmed by Eide et al., who replayed videotaped medical consultations to the patients involved and invited them to comment their contributions [21]. The VR-CoDES-P has two main axes for classifying provider responses, corresponding to the explicitness of the response (yes/no) and the amount of space for the patient (yes/no). As in the original study