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Patients' perspectives and characteristics

Patient perception and the barriers to practicing patient-centered communication: A survey and in-depth interview of Chinese patients and physicians

Xu Ting[a,b], Bao Yong[c,*], Liang Yin[d], Tian Mi[a]

[a] Antai College of Economics & Management, Shanghai Jiao Tong University, Shanghai, China
[b] Management School, Guizhou University of Finance and Economy, Guizhou, China
[c] Public Health Department, Shanghai Jiaotong University School of Medicine, Shanghai, China
[d] Public Health Department, Human Resource Department, Zhongshan Hospital Fudan University, Shanghai, China

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ABSTRACT

Objective: To investigate patient perceptions of patient-centered communication (PCC) in doctor–patient consultations and explore barriers to PCC implementation in China.
Methods: This study was conducted in public teaching hospital in Guiyang, Guizhou, China. In Phase 1, patient attitudes to PCC were quantitatively assessed in 317 outpatients using modified Patient-Practitioner Orientation Scale (PPOS). In Phase 2, we conducted in-depth interviews with 20 outpatients to explore their views on PCC and expose potential barriers to PCC implementation.
Results: Participants communicated "patient-centered" preferences, particularly with regard to their doctors' empathy, communication skills, time and information sharing. Patients were more concerned about doctors exhibiting caring perspective than power sharing. Younger and highly educated patients were more likely to prefer PCC and highly educated patients paid more attention to power sharing. Several factors including inadequate time for PCC resulting from doctors' high patient-load, doctor-patient communication difficulties and excessive treatment due to inappropriate medical payment system affected PCC implementation in China.
Conclusions: Patients expressed moderate enthusiasm for PCC in China. They expressed strong preferences concerning physician respect for patient perspective, but less concern for power sharing.
Practice implications: Government should improve health care system by implementing PCC in daily healthcare practice to improve patient awareness and preferences.

1. Introduction

Good doctor–patient communication is essential for achieving positive healthcare outcomes [1]. Patient-centered communication (PCC) is widely endorsed in Western countries and is gaining popularity in some developing countries [1]. PCC ensures balanced contribution and mutual understanding in doctor–patient communication [2] and is regarded as an ideal doctor–patient communication style [3]. In the PCC model, patients share the decision-making process and responsibility with their doctors.

PCC studies have been carried out in developed and developing countries [4–13]. Epstein et al. reported that female, younger, more educated and healthier patients are more patient-centered [14]. A South African study suggested that PCC was associated with heightened doctor empathy towards their patients, greater patient trust and increased symptom and concern resolution [15]. In an Indonesian study, the factors ranked by patients as contributing to satisfaction included receiving information, having questions answered and privacy [4]. A Bangladeshi study suggested that patients expect doctors to communicate openly with them; and reported that if their communication expectations were not met, they would seek other health care providers [16]. An Egyptian study demonstrated that client-centered communication produced better outcomes in a family planning clinic [5]. A Guinean study revealed that factors determining patient healthcare quality perception were the technical competence of the medical practitioners, resource and service availability, interpersonal relationships, healthcare accessibility and effectiveness of care [6]. Other studies assessing medical student, doctor and patient

* Corresponding author at: Public health department, Shanghai Jiaotong University School of Medicine, 407, East building 1, 227 South Chongqing Road, Shanghai, China.
E-mail address: baoyong@sjtu.edu.cn (B. Yong).

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attitudes towards PCC using the Patient-Practitioner Orientation Scale (PPOS) have been conducted in Sierra Leone [7], Nepal [8,9], Brazil [10] and Korea [11]. These studies suggest that PCC should become an integral part of medical training.

Little to no information has been reported concerning the attitude of Chinese patients and healthcare professionals towards PCC. The majority of the country remains underdeveloped. This is particularly true of the western regions. Even in the developed regions of the country, numerous factors hinder the implementation of PCC. Therefore, the present study had two main objectives: (1) investigate patient perception of PCC in doctor-patient consultations in a less developed area of China; and (2) explore the barriers to PCC implementation in China through in-depth patient interviews.

2. Methods

2.1. Quantitative methods

2.1.1. Study design

The study was carried out in Guiyang city, the provincial capital of Guizhou Province in southwestern China. Guiyang has historically been regarded as a less developed area, with a lower level of acculturation, income and education when compared with more developed regions in China [17]. Our study was conducted in an 800-bed university hospital in Guiyang that provides training for most medical specialties in Guizhou province. We selected the Department of Internal Medicine as the study setting because it could provide an optimal number of observational cases and a large number of random patient samples for both quantitative and qualitative research.

2.1.2. Participants and sampling procedure

Participants were randomly selected from the adult patients presenting for treatment at the hospital's outpatient department (OPD). Inclusion criteria were as follows: patients had the ability to communicate with the doctor directly and had no serious condition or terminal illness that affected their normal communication [18]. The simple size was calculated as follows: for Type I and II errors of 5% and 20%, the number of subjects (N) was $N = 32/ES^2$, where ES was the smallest effect size worth detecting. For ES = 0.3, the total N was determined to be 355. Due to limitations imposed by the inclusion criteria and the number of patients available at the collection site, the final sample size was 350. OPD and other patients were enrolled from December 12, 2013 to January 17, 2014. Twenty-six patients declined study participation for various reasons. Thirty-three patients were excluded after survey completion due to missing values in the PCC questionnaire or demographics survey. The remaining 317 patients were included as study respondents and their data was considered sufficient for subsequent quantitative analysis. The response rate was 90.6%.

2.1.3. Study instruments: Patient-Practitioner Orientation Scale (PPOS)

The quantitative section of the study was a cross-sectional survey of outpatients using a version of the PPOS [7–11,19]. The 18-item survey covered the main domains of PCC [9,19], was designed to be administered to either doctors or patients and had previously been validated by many relevant studies [7–10,20–24]. The survey includes two 9-item dimensions, termed "sharing" and "caring", that measure an individual's attitude towards doctor–patient communication. The PPOS is a 6-point Likert scale, and scores range from 1 (strongly agree, doctor-centered) to 6 (strongly disagree, patient-centered). Items 9, 13 and 17 are reverse-scored because they are worded in patient-centered terms. The original PPOS was a self-administered English language questionnaire formulated in third-person terms by Krupat et al. [25]. Taking the literacy level and local language style of Guiyang into consideration, the scale was translated to Chinese and back to English by two translators highly skilled in both the Chinese and English languages. For this study, the following modifications were made to the scale: (1) all original third-person terms were translated into simplified first-person terms [9]; and (2) some words and items (items 2, 16 and 17) were modified to be more easily understood and more suitable for the Chinese context (Table 2). The modifications to items 2, 16 and 17 follow: Item 2 "Although health care is less personal these days, this is a small price to pay for medical advances." [9] was modified to "It is more important for a doctor to use the latest tests and medicines than to know more information about me." Item 16 "The doctors do not need to know my culture and background in order to treat me" was expanded with some specific words to help participants understand the concept of culture (including religion, beliefs and values) and background (including education, race and nationality). Item 17 "Humor is major ingredient in the doctor's treatment of the patient" was adjusted to "Humor and ease to talk with are major ingredients in the doctor's treatment of the patient", because a sense of humor is not typically considered a positive feature in traditional Chinese culture. The adapted version of the survey was tested with 15 patients in a pilot study to make certain that the general public could understand the questionnaire.

Demographic characteristics of patient participants, such as age, gender and education, were obtained through a self-reported questionnaire. The study design was chosen to match the demographic data collected by previous studies [5,7,9,11,22].

2.1.4. Ethical consideration

The study design and protocol were reviewed and approved by the Research Ethics Committee of our hospital.

2.1.5. Statistical analysis

PPOS data were analyzed by calculating means and standard deviations (SDs) for individual items, the total survey scores and the caring and sharing sub-scores for the entire cohort. The effects of age (six age groups), gender and education level on the overall PPOS score were analyzed using Student's t-tests (gender and education levels) and one-way analysis of variance (ANOVA; age) as appropriate. The caring and sharing subscales were compared using paired t-tests. All analyses were conducted with SPSS 16.0 (SPSS Inc., Chicago, IL, USA). The scores of the reverse-scored items (9, 13 and 17) were adjusted to match the order of the other items using the SPSS recode function.

2.2. Qualitative methods

Qualitative analysis was conducted using in-depth interviews of patients to explore patients' views of PCC and to discover any potential barriers to PCC implementation. A grounded theory approach was used to analyze the transcripts in the qualitative study [13,18,26].

2.2.1. Participants

We selected 20 patients not included in the previous survey for the in-depth interview study according to the maximum variation sampling technique [12]. Among these patients, 10 had low education levels (high school or below) and 10 had high education levels (above high school).

2.2.2. Interview procedure

Standardized in-depth interviews were guided by the following question list covering the key points of this study: (1) What did you think of your doctors' communication style during the medical