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Communication behaviors and patient autonomy in hospital care: A qualitative study

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ABSTRACT

Background: Little is known about how hospitalized patients share decisions with physicians.
Methods: We conducted an observational study of patient-doctor communication on an inpatient medicine service among 18 hospitalized patients and 9 physicians. A research assistant (RA) approached newly hospitalized patients and their physicians before morning rounds and obtained consent. The RA audio recorded morning rounds, and then separately interviewed both patient and physician. Coding was done using integrated analysis.
Results: Most patients were white (61%) and half were female. Most physicians were male (66%) and of Southeast Asian descent (66%). All physicians explained the plan of care to the patients; most believed that their patient understood. However, many patients did not. Physicians rarely asked the patient for their opinion. In all those cases, the decision had been made previously by the doctors. No decisions were made with the patient. Patients sometimes disagreed.
Conclusions: Shared decision-making may not be the norm in hospital care. Although physicians do explain treatment plans, many hospitalized patients do not understand enough to share in decisions. When patients do assert their opinion, it can result in conflict.
Practice implications: Some hospitalized patients are interested in discussing treatment. Improving hospital communication can foster patient autonomy.

Respect for autonomy is universally recognized as a foundational principle in bioethics [1]. Respecting patient autonomy is classically discussed in terms of honesty from clinicians (e.g. about prognosis in the face of serious illness) and informed consent, which is legally required for invasive medical procedures. Respect for autonomy also provides the theoretical and psychological foundation for shared decision-making and many forms of behavior change counseling, such as motivational interviewing. In the ambulatory setting, patient understanding and involvement in treatment plans (shared decision making) is seen as essential because these plans tend to be carried out *by* the patient, whereas in the inpatient setting, they tend to be carried out *on* the patient [2,3].

Hospitalized patients are sicker, and clinicians may assume (perhaps correctly) that patients will give universal agreement to their treatment recommendations. One observational study found that "to a large extent" medical decisions in the inpatient setting were made by doctors before being discussed with the patients [4]. If many hospitalized patients prefer physicians to make decisions, then the minimum standard we might expect for physicians to respect patient autonomy would be for patients to fully understand their diagnosis and treatment plan. Yet studies have consistently shown that patients do not understand the majority of what has happened to them in the hospital, and that physicians overestimate patient understanding [5–8].

There are very few studies directly observing encounters between physicians and hospitalized patients, especially when compared to the large body of research directly observing ambulatory encounters. Farnan et al. provided a review of communicative domains relevant to quality care in the inpatient domain provided by hospitalists, including communicating and promoting partnership with patients; ensuring safe and effective transitions and handoffs of care; and using systems to encourage continuity of care [9]. The extant empirical literature falls into several broad categories. In terms of emotional rapport, one study found that patients perceive physicians to have spent more time with them if the doctor sits rather than stands in their hospital

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room [10], and another study found that physicians tend to avoid responding to patients' expression of negative emotion during dialogue in the hospital, especially if that communication involved an explicit concern [11]. In terms of communication content, one study found that most communication by physicians to patients on hospital ward rounds was focused on the transfer of medical information; patients, on the other hand, communicated about medical information less often than question-asking and checking information already received [12]. Finally, a limited literature addresses decision making in the hospital. One study by Oftstad et al. based on transcripts of ambulatory, emergency room, and hospital dialogues found that decisions in the healthcare context were made over a span of time exceeding the clinician-patient dialogue itself [13].

In terms of hospitalized patients' understanding of their diagnosis and treatment plans, several studies employed survey methodology to demonstrate that patients do not understand as much as physicians think they do. Calkins et al. surveyed physicians and patients post-discharge and found that physicians overestimated their patients' understanding of postdischarge treatment plan [14]. Similar findings obtain for understanding of reason for admission [5]; in particular, there are several studies examining communication of the risk and diagnosis of acute coronary syndrome, showing lack of concordance in understanding between clinician and patient [15]. With a relative dearth of studies observing communication between hospitalized patients and physicians, it is not entirely known how these misunderstandings occur.

Thus, the literature lacks analysis of communication in the inpatient hospital setting, and in particular the ways in which decision making and communicative practices interact. Our goal in this study was to evaluate communication between physicians and inpatients, examine the extent to which hospitalized patients exercise their autonomy during communication with physicians, demonstrate ways in which physicians facilitate patient autonomy, and identify opportunities for engaging patients in their own hospital care.

1. Methods

1.1. Study design, subjects and setting

We conducted an observational study of patient-doctor communication on an inpatient medicine service. Study subjects were hospitalized patients and hospitalist physicians on a geographically-defined hospitalist service at a single, urban academic medical center. Members of the treatment team included hospitalist (attending) physicians and nurses as well as support staff. All hospitalist physicians who were on the inpatient service during data collection were eligible for the study. Patients were eligible for the study if they were physically located on the hospitalist service during data collection (i.e., not in another part of the hospital for treatment), English-speaking, and able to understand the study and give informed consent. All study procedures were approved by the Johns Hopkins Institutional Review Board (IRB).

1.2. Data collection methods

Patients were recruited from December 2011 to May 2012. At the beginning of the day, a research assistant had access to a list of newly admitted patients to the service. Before the patients were seen by the hospitalist physician, the research assistant assessed the patients' eligibility, entered patient rooms and informed them about the study using an IRB-approved script, and assessed their understanding of and interest in the study. If patients expressed interest, they provided consent to participate.

Thereafter, the research assistant approached the hospitalist physician taking care of the patient who had consented to participate in the study. If a hospitalist declined to participate in the study, neither the patient nor the physician were recorded or interviewed. If a hospitalist agreed to participate, the research assistant recorded the rounds on that patient with a digital audio recorder. Any third parties present in the room at the time of rounds gave their oral informed consent. On each subsequent day of the patient's hospitalization, the RA recorded subsequent conversations. The RA only recorded one 'main' patient-physician encounter daily for each patient.

After rounds, the RA conducted brief semi-structured interviews once daily separately with physicians and patients who had agreed to participate in the study. The content of the interviews were based on a priori hypotheses about physician and patient knowledge of reasons for admission and criteria for discharge; communication between physician and patient; and engagement of the patient in their own care. Interview questionnaires are found in the Appendix.

1.3. Coding methodology

Two reviewers (ZB and MCB) each read all transcripts (patient-physician dialogues, patient interviews, and physician interviews) in their entirety, focusing on behaviors which would reflect or affect patients' exercise of autonomy in the hospital. Our approach owes much to the integrative qualitative communication analysis presented by Salmon et al. [16], In particular, letting methodological purity be subordinate to data; adopting a multidisciplinary approach with features of conversational analysis, discourse analysis, and interactional analysis; and their model of two interlinked strands. In our case, one strand comprised the within-case analysis and one the between-case, integrative analysis of the entire set of transcripts.

1.3.1. Within-case strand

The units of analysis were the inpatient rounds and associated interviews for each case. We began by using the doctor-patient dialogue as the basis for understanding their interaction, with interviews of physician and patient as checks and reflections on that interaction. Analysis was iterative between the dialogue and interviews, using each as a point of comparison for interpreting the other. The reviewers used the entirety of each case to understand the behaviors displayed by patient and physician in the context of the particular relationship, hospitalization, and case disposition. We paid particular attention to how physicians facilitated (or not) and patients exercised their autonomy (or not), in their understanding of their situation and decision-making.

1.3.2. Between-case, integrative analysis

Thereafter, the reviewers compared the behaviors noted in each within-case strand between individual cases, noting patterns in patient behavior, physician behavior, and their interaction, and organizing such interactions into representative types.

2. Results

2.1. Patient and physician characteristics

We audio-recorded 22 patient-doctor dialogues, representing 18 separate patient hospitalizations. Most hospitalizations (n = 18) lasted no more than one day but 4 patients stayed two days and were thus recorded twice. As well, we recorded 22 corresponding interviews with 9 hospitalists and 22 interviews with the 18

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