



Communication study

Obese patients overestimate physicians' attitudes of respect

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ABSTRACT

Objective: To evaluate whether obese patients overestimate or underestimate the level of respect that their physicians hold toward them.

Methods: We performed a cross-sectional analysis of data from questionnaires and audio-recordings of visits between primary care physicians and their patients. Using multilevel logistic regression, we evaluated the association between patient BMI and accurate estimation of physician respect. Physician respectfulness was also rated independently by assessing the visit audiotapes.

Results: Thirty-nine primary care physicians and 199 of their patients were included in the analysis. The mean patient BMI was 32.8 kg/m² (SD 8.2). For each 5 kg/m² increase in BMI, the odds of overestimating physician respect significantly increased [OR 1.32, 95%CI 1.04–1.68, *p* = 0.02]. Few patients underestimated physician respect. There were no differences in ratings of physician respectfulness by independent evaluators of the audiotapes.

Conclusion: We consider our results preliminary. Patients were significantly more likely to overestimate physician respect as BMI increased, which was not accounted for by increased respectful treatment by the physician.

Practice implications: Among patients who overestimate physician respect, the authenticity of the patient–physician relationship should be questioned.

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1. Introduction

A core element of the patient–physician relationship is respect, which has been defined as “the recognition of the unconditional value of patients as persons” [1]. Beach et al. showed that physician respect varies across patients [2]. The same study found that physicians exhibited different communication behaviors during encounters with patients whom they respected, such as sharing more information and having a more positive emotional affect [2]. Although the philosophical ideal of respect should be independent of a patient's personal characteristics, studies have shown that increased patient body mass index (BMI) is negatively associated with physician respect [3] and multiple studies document health professionals' overall negative regard toward patients with obesity [4–9].

Despite negative provider attitudes, other studies find that obese patients are satisfied with their healthcare providers

[10–13]. These paradoxical findings may result from patients' inability to accurately perceive providers' negative regard. Societal discrimination toward obese persons is common in work, educational and social settings [14,15]. Therefore, we theorize that obesity may alter a person's ability to accurately perceive the attitudes of others during interpersonal interactions, either through desensitization or over-sensitization to disrespectful behaviors. For example, if an obese patient is desensitized to disrespectful behaviors, then he/she may interpret biased treatment from their physician as normal, and consequently overestimate physician respect. Conversely, a patient who has heightened awareness of any disrespectful attitude may underestimate physician respect. This idea of inaccurate estimation of physician attitudes among obese patients is supported by work from Brandsma [16]. In Brandsma's study, dyads of physicians and their obese patients were recruited to participate in a survey about general attitudes regarding obesity. When physicians' attitudes were compared to how their patients perceived the physicians' views, the patients perceived less positive attitudes than those reported by physician. This survey asked questions regarding attitudes toward obese individuals in general, and did not ask about physician attitudes toward the patient surveyed. To date, no

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studies have compared patient and physician perspectives to evaluate how obesity impacts the patient's ability to accurately estimate his/her physician's level of respect.

Obese patients' ability to accurately estimate their physicians' attitudes may have implications regarding the authenticity of these patient–physician relationships. Beach and Inui conceptualized authenticity as the physician not only acting respectfully toward a patient, but also actually having respect for that patient [17]. Arnason described an authentic conversation as when patient and physician participate in a dialog in which the subjectivity of both is respected [18]. While the association between authenticity and patient outcomes has yet to be evaluated, authenticity is considered an ethical principle in patient–physician relationships [17,18]. Authentic conversations may facilitate shared decision-making and reduce alienation between patients and physicians [18]. If obese patients are not able to accurately estimate their physicians' regard, then the authenticity of these patient–physician relationships may be compromised.

In this study, we aimed to justify our theory that obesity alters one's ability to accurately perceive the attitudes of others during interpersonal interactions by examining whether patients' weight influences their ability to accurately estimate levels of physician respect. We hypothesized that higher patient BMI would be associated with both overestimation and underestimation of physician respect. In addition, we assessed the level of physician respect as rated by an independent third party, in order to assess differences in physician respectfulness that may have contributed to over- or underestimation of respect.

2. Methods

2.1. Study design, subjects, and setting

We carried out a cross-sectional study by performing a secondary analysis of data from the baseline visit of the Patient–Physician Partnership Study (Triple P study). The Triple P study was a randomized controlled trial of a patient–physician communication intervention to improve patient adherence and blood pressure control [19]. The study included urban, community-based primary care physicians seeing their established patients for routine follow up. Primary care physicians were recruited from 15 practices in Baltimore, MD between January 2002 and January 2003. Adult hypertensive patients were recruited from the participating physicians' panels between September 2003 and August 2005. Additional details regarding patient and physician recruitment have been published previously [19]. The Johns Hopkins Institutional Review Board approved this study. Patients and providers provided written consent prior to inclusion in the study.

2.2. Data collection methods for the parent study

At time of physician enrollment into the Triple P study, physicians completed a survey that included demographic information and medical practice characteristics. At time of patient enrollment, patients completed a survey that included demographic information and health status. A single outpatient encounter was audio-recorded for each patient at baseline. These visits were a part of ongoing clinical care, and not specifically scheduled for the study. Immediately following the audio-recorded encounter, both the patient and physician completed post-visit questionnaires to assess their attitudes about the visit and perceptions of one another. Post-visit physician questionnaires assessed the physician's regard for that patient including respect, while post-visit patient questionnaires assessed how the patient felt regarded by his/her physician including level of

respect. While the patient and physician questionnaires for the Triple P study contained multiple questions assessing different attitudes and perceptions, for this secondary data analysis, we used only one physician question and one patient question that assessed level of physician respect.

2.3. Selection of study sample

The parent study included 42 physicians and 279 of their patients. We excluded from this analysis any encounters where the outpatient visit was not audio-recorded ($n = 35$), patients lacked documentation of BMI ($n = 9$), or the patient and/or physician did not complete the question assessing the level of physician respect for the patient ($n = 36$). Our final sample included 39 physicians and 199 of their patients.

2.4. Primary analyses

2.4.1. Outcome measure

The primary outcome was the accuracy of patient-estimated level of physician respect. To our knowledge, only one previous study has examined this concept of accuracy of patient-estimated level of physician respect [2]. In that study, Beach et al. constructed this variable by comparing the amount of respect the physician reported with the level of respect the patient perceived.

In order to create this variable, we first needed to evaluate the level of physician-reported respect. In the previous study, Beach et al. asked physicians to respond to the statement, "Compared to other patients, I have a great deal of respect for this patient," on a 5-point Likert scale (strongly agree, agree, neutral, disagree, strongly disagree) [2]. They then created three categories of physician-reported level of respect. The categories were high level of respect (strongly agree), medium level of respect (agree), and low level of respect (neutral or disagree). Beach et al. chose this categorization because so few physicians disagreed and no physician strongly disagreed that they had respect for their patient [2]. When the Triple P study was designed, the investigators planned to evaluate physician respect using the same statement and scale as in the Beach study. However, pilot testing with a group of primary care physicians found the wording of this question and scale unacceptable. The investigators changed the final phrasing of the question and scale responses in order to address these concerns. Physicians answered the question, "How much respect do you have for this patient?" on a 5-point Likert scale (much more than average, more than average, average, less than average, much less than average). When we examined the distribution of responses from the physicians in our study, we found 50 reports of 'much more than average,' 73 reports of 'more than average,' 72 reports of 'average,' and 3 reports of 'less than average.' No physicians reported 'much less than average.' We conceptualized that responses of 'much more than average' and 'more than average' indicated the physician having more than average respect for the patient. As a result, we decided to dichotomize physician-reported respect as "high" (much more than average or more than average) versus "low" (average or less than average) for the main analysis.

The second step needed to create this variable was to examine the patient-estimated level of physician respect. In the previous study, Beach et al. asked patients to respond to the statement, "My doctor has a great deal of respect for me," on a 5-point Likert scale (strongly agree, agree, neutral, disagree, strongly disagree) [2]. They then created three categories of patient-estimated level of physician respect. The categories were high (strongly agree), medium (agree), and low (neutral or disagree). In the Triple P study, the investigators used the same question and scale responses as Beach et al. [2]. When we examined the distribution

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