



## Communication study

## Patient–physician concordance and discordance in gynecology: Do physicians identify patients' reasons for visit and do patients understand physicians' actions?

Karin Gross<sup>a,b,\*</sup>, Christian Schindler<sup>a,b</sup>, Leticia Grize<sup>a,b</sup>, Anna Späth<sup>a,b</sup>, Bettina Schwind<sup>a,b</sup>, Elisabeth Zemp<sup>a,b</sup><sup>a</sup> University of Basel, Basel, Switzerland<sup>b</sup> Swiss Tropical and Public Health Institute, Basel, Switzerland

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## ABSTRACT

**Objective:** To assess physician–patient concordance on reasons for consultation and actions taken during consultation in five different gynecological practices, and to investigate patient and physician factors influencing discordance in reporting.

**Methods:** 1667 post-encounter questionnaires completed by patients and physicians were compared in terms of reasons for consultation and actions taken during consultation. Patient–physician concordance was assessed using kappa statistics. Multivariable regression analyses served to identify determinants of discordance.

**Results:** A moderate to high level of patient–physician concordance on reasons for consultation and actions taken during the consultation was found. Discordance regarding reasons for consultation was associated with patient and practice characteristics, discordance regarding actions taken during the consultation only with practice characteristics. Counseling emerged as a particular source of patient–physician discordance.

**Conclusion:** In gynecological practices, discordance depends on the reason or action assessed, but is particularly pronounced when it comes to counseling. The influence of physician characteristics on patient–physician concordance needs more attention in research.

**Practice implications:** Gynecologists need to establish a mutual understanding with their patients about the reason of the consultation and the actions taken in the consultation, in particular with regard to counseling.

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## 1. Introduction

Concordance is an important feature of the patient–physician interaction. Not surprisingly, a considerable body of literature has investigated patient–physician concordance with regard to symptom etiology [1–3], patients' health status [4–6], physicians' understanding of their patients' expectations and treatment goals [7–10]. Studies from different medical fields provide evidence that patient satisfaction, adherence to treatment and outcomes of care are higher when physicians and patients agree with each other [7,10–13]. Moreover, better understanding between patients and physicians is also related to a reduced need for further consultations [1] and better patient self-management of care [7], thereby decreasing health care costs.

Less is known on the degree of agreement between patients and physicians on why the patient consults the doctor and on what happens during the consultation itself. Studies showed that doctors and patients do not always agree with each other regarding the reasons for a specific consultation [14–16] and actions taken therein [15,17,18]. Using post-consultation questionnaires, Boland et al. [14] observed that although physicians were generally able to identify patients' reasons for seeking a general medical examination, in 20% of the visits agreement was low or absent. Family physicians and patients frequently gave discrepant reports of what had happened during the consultation [18]. As reported by Street and Haidet [19] physicians may misperceive how their patients understand clinical actions even for relatively common medical issues, such as blood pressure control.

So far, physician–patient concordance in gynecological care has hardly been addressed apart from studies which examined the validity of patient reports regarding preventive clinical interventions such as mammography and Pap screening in comparison to medical record data which were considered as gold standard [20–22]. However, in basic gynecological care, the ability to establish a

\* Corresponding author at: Swiss Tropical and Public Health Institute, Socinstrasse 57, PO, 4002 Basel, Switzerland. Tel.: +41 61 284 86 10; fax: +41 61 284 81 05.

E-mail address: [Karin.Gross@unibas.ch](mailto:Karin.Gross@unibas.ch) (K. Gross).

mutual understanding regarding reasons and content of consultation may be of particular importance because, besides treatment, information giving, counseling and decision making involving patient preferences constitute a considerable part of a consultation, e.g. for contraception, pregnancy, or menopause.

Factors influencing patient–physician concordance are still not fully understood [5]. Several studies have examined how patients' socio-demographic characteristics such as socio-economic status, education, or ethnicity influenced patient–physician concordance. Results of these studies have been mixed. While some suggested that concordance might be negatively effected by lower socio-economic status [17] or ethnicity [18] through less effective patient–physician communication, others found no effect for patient education, income or race/ethnicity [5]. Again other studies showed that agreement rather depends on patients' health status [5,6], their active participation [7] or the continuity of the patient–doctor relationship [24]. Yet, few studies have investigated the influence of physician characteristics on patient–physician concordance [10]. According to an early study by Sawyer et al. [20], women who had been seen by nurse practitioners were more likely to report their last Pap smear more accurately than women seen by an internist or family practitioner. Rohrbaugh and Rogers [18] reported that discrepant physician and patient perceptions on what happened in routine family clinic visits could not be explained by patients' demographic characteristics but varied by visited physicians and were more pronounced if physicians minimized attention to psychosocial issues and/or felt confident about understanding the patient's problem.

In order to address the above mentioned lack of research with regard to patient–physician concordance on reasons and content of gynecological consultations, the aims of the study are, first, to compare patients' and gynecologists' reports of reasons for a particular consultation and actions taken during this consultation based on post-encounter questionnaires across five different gynecological practices, and to assess physician–patient concordance in these reports. Second, we sought for a better understanding of the factors influencing discordance in reporting. Based on the insights from other studies, we hypothesized, that discordance would not only vary by patient characteristics but also differ between the practices due to different working approaches. We also expected that physicians will have a better concordance with long-term patients than with patients with whom they have had only few or no previous visits.

## 2. Methods

### 2.1. Participant selection

For the analysis we used data from five private gynecological practices in the Basel region in Switzerland which were collected in the frame of a larger ongoing study on the impact of gynecologists' working approaches on their patients (“Women and Gynecology in Evaluation”). These practices – one group practice and four practices led by single gynecologists – were chosen to represent a broadly varying range of gynecologic working approaches. In the five practices, a total of 2154 women, 1226 long-term patients (attending their practice for at least 10 years) and 928 recent patients (attending their practice less than 2 years), had been recruited by the end of February 2012. Patients were eligible for the study if they spoke German and were above 18 years of age.

### 2.2. Data collection

Eligible women were informed about the study during the consultation by their physician and were invited to complete a self-administered questionnaire. The questionnaire included

questions on women's reasons for the current consultation (“What was the reason for today's consultation?”) and actions taken by the physician during the consultation (“What has been done today?”). Women could choose from 12 reasons for consultation and 9 actions taken during consultation, or alternatively write them as free text if not listed. Further information was collected on women's socio-demographic characteristics (i.e. age, marital status, education, income, nationality, mother tongue) and women's self-rated health (measured on a 5-level scale ranging from excellent to very poor). Additionally, the questionnaire provided data on women's medical history; use of health services (during the last 12 months); attitudes toward health; receipt of services and satisfaction with care received which will be subject of forthcoming analyses.

Out of the 2154 recruited women, 86% (1049) of long-term patients and 69% (642) of new patients had sent back their questionnaire by the end of February 2012. For all 2154 patients who had given their written consent to the study, physicians completed a short protocol immediately after the consultation. The protocol included information on the woman's socio-demographic characteristics, her reason for consultation and actions taken during the consultation (with identical items as in the patient questionnaire), the duration of consultation as well as few details of her medical history. After data cleaning, a total sample of 1667 sets of patient questionnaires and corresponding physician protocols were available for analysis.

### 2.3. Statistical analysis

Means of numbers of reasons for consultation and actions taken during the consultation reported by patients and physicians were compared using the paired *t*-test. McNemar's test served to compare frequencies of specific reports between patients and physicians. Because we compare reports of reasons for and actions taken during the consultation, we use the terms ‘concordance’/‘discordance’ and not ‘agreement’/‘disagreement’ which would require some sort of rating scales. Patient–physician concordance on the 12 reasons for the consultation and 9 actions taken during the consultation was assessed using the kappa statistic which quantifies concordance between patients and physicians in excess of what would be expected by chance alone. A kappa of 1 indicates perfect agreement, whereas a kappa of 0 indicates agreement equivalent to chance [23]. One difficulty of kappa is that, for low prevalence rates,  $\kappa$  may be low despite of high absolute agreement [23]. Kappa values are therefore provided together with overall agreement rates.

Two discordance indices were defined: (1) the number of reasons for consultation on which the physician- and patient-reports differed and (2) the number of clinical actions on which they differed. To analyze determinants of patient–physician discordance, multivariable analyses were conducted with the discordance indices as outcome measure. To account for the non-normal distribution of the indices, bootstrapped multivariable linear regressions were performed. In each model, we included patient characteristics as well as the practices.

Random effect models were run to assess the influence of specific characteristics of the practices, e.g. gynecologists' sex and mother tongue and mean unexplained consultation time (i.e. the difference between observed consultation time and time predicted based on reported reasons for consultation and actions taken). Given the small number of practices, these influences were assessed one by one. Furthermore, multivariable logistic regressions were used to analyze discordance on single reasons for consultation and actions taken during consultation. Differences in discordance rates across practices were again adjusted for potentially confounding patient characteristics. Moreover, we

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