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Preferences for medical collaboration: patient–physician congruence and patient outcomes

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Abstract

Patient participation in medical care and in decision-making is generally viewed as a precursor to positive health outcomes. Patient participation is not always possible or desirable, however, and not all patients want to take an active part in their own medical care. This study examines the degree to which physician–patient congruence in preference for patient involvement is related to self-reported satisfaction, adherence, and health. Results indicate that when patients and their doctors share similar beliefs about patient participation, patient outcomes tend to be more positive, with highest satisfaction found in cases in which both patient and physician desire more patient involvement.

Keywords: Patient participation; Patient involvement; Collaboration; Physician–patient congruence

Physician–patient collaboration is linked to many positive health outcomes including: greater fulfillment of patient expectations [1,2], increased satisfaction with care [3–8], better adherence to treatment regimens [7,9–10], shorter recovery periods [4,5,7], and improved general health [4,11–12]. Enhanced patient–physician collaborations not only improve the quality of medical care but also may reduce medical costs by increasing the efficiency and cost-effectiveness of medical visits. Conversely, the expensive and dangerous failure of patients to correctly take prescription medications has been identified as directly resulting from a breakdown in physician–patient communication [13,14]. Failures in mutual collaboration between physicians and patients can result in increased risk of malpractice litigation and in patients changing physicians—both significant contributing factors to increased medical costs [6,15–17].

The demonstrated links between collaborative medical interactions and positive outcomes of care suggest the importance of taking steps to maximize effective communication during the medical encounter. How to do so is not always clear, however. Although most patients desire some degree of involvement in their care, they vary in the degree and type of participation they prefer. For example, while some may want only information and others prefer simply to express their ideas and preferences, others favor final decision-making authority regarding their care [18–21]. Research indicates that older, seriously ill, and emergency patients and those who have externally oriented outcome expectancies desire to be less involved in their care than patients who are ambulatory, younger, or less seriously ill [22–25]. The physical and/or emotional demands of the illness may interfere with decision-making. Socialization for subservience to physicians (such as among the cohort of elderly patients) may prompt some to accept a submissive patient role [23,25–27].

This variability in preferences has led some researchers to suggest pairing patients with physicians who have similar decision-making styles in order to enhance the effectiveness of physician–patient interactions [25,28]. Others have proposed that physicians adapt their own style to match the orientation of the patient [24]. Some researchers have suggested that when patients and physicians both prefer

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similar levels of patient involvement, patients are likely to be more satisfied, adherent, and healthy than in situations in which such preferences do not coincide. When the patient's vision of or desire for partnership is different from the physician's, however, dissatisfaction, nonadherence, and poor outcomes may ensue [28–30]. When patients prefer less autonomy but their doctors favor collaboration, anxiety and confusion may lead to less positive outcomes. Conversely, when patients and their physicians prefer little patient involvement in care, more positive outcomes may result from their agreement. The patient–physician Match Model [25] was created to describe such congruence, or lack thereof, between patients' and physicians' desires for patient participation in care. This model matches the patient's preferred level of involvement with the physician's participatory decision-making style and conceptualizes the patient–physician relationship in terms of the degree to which it is tailored to the interactants' preferences for autonomy versus medical paternalism.

The positive effects of physician–patient similarity on dimensions other than participation have been supported by past research. For example, patients who visit physicians of their own race are generally more satisfied and rate their interactions with their physicians as more participatory than in situations of racial mismatch [31,32]. Older physicians spend more time and offer more counseling to elderly than to younger patients [33]. Gender congruence also seems to be associated with better patient outcomes in some studies, although these findings are equivocal and interact with other variables within complex models [34]. In particular, the association between communication patterns and patient satisfaction varies across gender combinations [35]; female patients are generally more likely to choose female physicians [36]; but patients who choose physicians of the opposite sex tend to be more satisfied than those who choose physicians of the same sex [36]. Further, gender concordance has been associated with increased patient participation in some studies [35] but not in others [31].

The primary purpose of the present study is to investigate the relationship between similarity (congruence) in patient–physician dyads and patient satisfaction, adherence, and health outcomes. Specifically, the relationship between patient outcomes and congruence in terms of preference for patient involvement will be compared with the relationship between these outcomes and congruence on ethnicity, age, and gender. A priori study hypotheses are as follows.

Hypothesis 1. Patient–physician congruence regarding preference for involvement is expected to have a stronger association with the outcome variables than congruence regarding ethnicity, age, or gender. Although each of these demographic variables has been empirically linked to one or more of the patient outcome variables, an ecological approach to understanding medical interactions suggests that many aspects of individuals and their environments converge to influence communications and that the interpersonal elements are most important [37]. We extend this rationale to predict that these interpersonal variables interact to influence expectations and preferences and that when these are congruent, outcomes are affected (regardless of the specific demographics that led to the congruence).

Hypothesis 2. Patient satisfaction, adherence, and health are expected to be higher when preferences for patient involvement are similar, with highest levels occurring when both parties desired active physician–patient collaboration and lowest levels occurring when patients desire greater involvement than their physicians give them. Previous research has demonstrated the importance of physicians' facilitation of patient involvement in determining patient satisfaction [38], thus we expect that discrepant preferences, in the case where physicians desire less patient involvement than patients desire, will be most detrimental.

1. Methods

1.1. Participants

Participants were drawn from two populations. The first group was comprised of 74 (58% female) patients who reported no serious health problems, ranging in age from 18 to 63 years with a mean of 29.5. Of these patients, 32% were Latino, 15% African American, 40% Caucasian, and 13% Asian; they were cared for by four Caucasian physicians (two female). The second group of participants was made up of 193 (60% female) patients with type II diabetes mellitus, of whom 70% reported only fair or poor health. Patients in this sample ranged in age from 28 to 78 years, with a mean of 53.8 years. Of these patients, 47% were Latino, 31% African American, 12% Caucasian, and 10% Asian. One third of the patients interacted with their physicians in Spanish and two thirds used English. These patients were cared for by 50 physicians (40% female; 58% Caucasian, 33% Latino, 6% Asian, and 3% African American). The two groups were combined for analysis; sample sizes vary by analysis due to missing data on individual variables. All patients were assigned to their physicians (that is, they did not personally select them) and no first encounters were included in the sample.

1.2. Materials

1.2.1. Questionnaire

A questionnaire was used to assess each patient outcome variable, as well as demographics and interaction preferences. The first group of participants completed the questionnaire as a written self-report instrument, whereas the second group responded through a structured interview. The measures included the following: (1) the Patient Communication Style Scale (PCS) [39–41], a short form 7-item scale measuring a patient's preference for actively