

Problems in Communications with Patients in General Surgery Outpatient Practice

Genel Cerrahi Polikliniğinde Hastalarla İletişimde Problemler

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Abstract

Objective: Communication between the patient and physician is central to medical care. However communication skills in Turkey haven't been gained so much concern. This situation effect the national quality of health care. Here, we tried to perform some basic communication skills and to find the problems with the possible solution suggestions.

Materials and Methods: The study was conducted for a month in general surgery outpatient department located in the slum part of Ankara with low socio-economic population. Basic communication skills were performed. The age, sex, education levels of the patients were obtained. Total symptom expression and interview time were recorded. Previous medical histories were asked. Interruptions including telephone, door knocking were noted. The questions of the patients at the end of the interview classified as hospital setting, nutrition and treatment.

Results: Total 410 interviews were analysed. Mean symptom expression and interview times were 22.9 sec and 7.05 min, respectively. Educated patients, males and young patients expressed symptoms longer than the others ($p<0.05$). There were 174 interruptions in which total interview time significantly increased than the non interrupted ones ($p<0.05$). Final questions about hospital setting were significantly higher in illiterate patients than the educated ones ($p<0.05$). Awareness of medical history is higher in educated and young patients.

Conclusion: Basic communications skills can be performed whether in rural regions. Much more concern should be given to the education of communication skills. The obstacles in communication in medicine are low education levels, and unorganised health system.

Keywords: Communication skills, surgery, education

Özet

Amaç: İletişim, tıbbi bakımda hasta doktor arasında temel teşkil eder. Fakat Türkiye'de iletişim becerilerine fazla ilgi gösterilmemiştir. Bu konu ülkede sağlık kalitesini de etkilemektedir. Bu çalışmada bazı temel iletişim becerilerini uyguladık ve karşılaştığımız problemleri olası çözüm önerileri ile birlikte sunmak istedik.

Geniş ve Yöntem: Çalışma Ankara'nın varoş semtinde bulunan Genel Cerrahi polikliniğinde 1 aylık süre içinde gerçekleştirildi. Hasta muayenesinde temel iletişim becerileri kullanıldı. Hastaların yaşı, cinsiyet ve eğitim düzeyleri belirlendi. Toplam semptomları anlatma ve muayene süreleri belirlendi. Geçmiş tıbbi hikayeleri alındı. Telefon çalması, kapı açılması gibi muayeneyi engelleyen faktörler belirlendi. Muayene sonunda hastaların soruları hastane işleyişi, tedavi ve beslenme ile ilgili olarak gruplandırıldı.

Bulgular: Toplam 410 görüşme yapıldı. Ortalama semptom belirtme 22,9 saniye, ortalama muayene 7,05 dakika sürdü. Eğitimli, erkek ve genç olma semptom anlatım süresini uzatmıştır ($p<0,05$). Toplam 174 kez muayene kesilmiştir ki bunlar muayene süresini anlamlı artırmıştır ($p<0,05$). Hastane işleyişi ile ilgili sorular en çok okuma yazma bilmeyen hastalar tarafından sorulmuştur ($p<0,05$). Tıbbi öykü farkındalığı, eğitimli ve genç hastalarda daha fazla bulundu.

Sonuç: Temel iletişim becerileri varoş semtte uygulanabilir. Tıbbi eğitim konusuna daha çok ilgi gösterilmelidir. Tıbbi iletişimdeki engeller düşük eğitim seviyesi ve sağlık sistemidir.

Anahtar Kelimeler: İletişim becerileri, cerrahi, eğitim

Introduction

Communication between the patient and physician is central to medical care. Effective communication enhances the patient's recall of information, compliance, satisfaction,

psychological well-being, biomedical outcomes and protects physicians against malpractice litigations [1, 2]. The style of patient-physician communication may also affect the health outcomes [3]. While physician-centred encounters using biomedical models can interfere with the disclosure of prob-

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lems and concerns, patient-centred encounters can facilitate disclosure of information, relationship building, and patient compliance, resulting in better outcomes [4]. Patient-centred encounters are very popular in western countries and are applied successfully [5]. However, this style of patient-physician communication has been started in recent years in Turkey and the education systems in medical faculties have just adopted to. For this reason there are still some difficulties in clinical practice.

Communication in medical practice depend on patient-related factors, doctor-related factors and the setting of the interview. Socio-economic status, trust to physicians, education levels, religions, moral attitudes, stress of the illness, ethnic and cultural backgrounds, previous experiences, expectations and perceptions of the roles of physician are the patient related factors and can have consequences on national health system characteristic and national habits [6]. Physician related factors depend on personal characteristics, acquisition of knowledge, skill and appropriate attitudes. Appropriate setting of the interview is very important to facilitate the communication [7, 8]. Privacy, comfortable surroundings, seating places, undisturbed room, enough time, and trustable with understandable interview are the requirements for the communication.

The shift toward patient-centred care has propelled the need for the physicians to exhibit adequate interpersonal and communication skills, but also this shift depends on the national health care attitudes and social structures [5]. Although this kind of studies are very popular in international area, there has been no study in Turkey. We tried to practice some basic medical communications skills in a general surgery outpatient clinic located in a slum part of a city in Turkey. In this study, we want to present the problems that we encounter and possible suggestions.

Materials and Methods

This descriptive study was conducted in the slum part of Ankara, the capital city of Turkey, after approval by the local Ethical Committee. This region consists of a population of low socio-economic status. The polyclinics found in this district give outpatient service by different departments including the general surgery. The general surgery outpatient clinic has a low patient volume and everyday nearly 30 patients refer to the general surgery outpatient clinic. The patients come to the general surgery outpatient clinic by themselves or by the consultation of other departments after registry at the administration desk. Interview rooms of departments are located around the waiting area. The physicians in the interview rooms call the patients one by one with computer screen located over the door. The computer table is located between the patient and physicians chairs.

This study was performed by a General Surgeon (TUY) and a Family Medicine resident (ES) who had come to general surgery outpatient clinic by rotation for one month. The residents collected the demographic data (sex, age, and education level), obtained the informed consent forms after the interview, and followed the stopwatch during the interview. The ages of the patients were classified into three groups (younger than 30 years old, age between 30 and 60 years old older than 60 years old). In order to achieve more informal and good communication, physician chairs were put next side of the table. The interview between the physician and patient composed of opening, history taking, physical examination, education/counselling and closure. Opening included greeting, welcoming without handshake and observing whether the patient sit down without our invite like "here you are". The patients were called by their names and special national suffix which differ according to sex. History taking started by asking: "How can I help you" or "what's problem that brought you to the doctor". The time of expressing the main symptom of the patients was measured by Dr. ES. The history was detailed by open questions. During interview; clarifications, reflections and facilitations were used when possible and judged by the physician whether implemented. Other symptoms that were realized by the help of open questions were noted. Previous diseases and current medications were asked. The knowledge of the patients about previous diseases and medications were noted. All of the patients were examined according to the symptoms. The patients were informed about the signs and concerns about physical examination. Required diagnostic tests, possible diagnosis, causes, treatment plan, advice about lifestyle and expectations were explained in education/counselling section. At last, I asked whether the patient had a question as an end question. The questions of the patients were classified into hospital settings, and treatment and nutrition. Localization of the laboratories and radiology department, appointments and official works were included into hospital settings. At the end of the interview, total visit times were measured. Dr. ET noted whether the interview was interrupted by the ringing of telephone, knocking or opening the door, noise outside the room, and intervention of the attendants.

Data are presented as means±standard deviation (SD) A computer programme (SPSS version 13.00; SPSS Inc. Chicago, IL) was used for statistical analysis. Evaluation of nonparametric data such as knowledge of previous diseases and existing medications were done according to the age groups by Kruskal Wallis test. Comparison analysis of parametric tests between groups such as the difference between the mean symptom telling and total visit times according to education level, and causes of interruption were done by one-way analysis of variance followed by a post hoc Tukey's test. The

difference between the mean symptom telling and total visit times according to sex were evaluated by chi-square test. Type of end questions were compared according to the education levels by Kruskal-wallis test. A p value less than 0.05 was considered to indicate the significance.

Results

In one month period, totally 410 interviews were performed. There were 332 (80.9%) interviews with women and 78 (19.1%) interviews with men. The demographic information is given in Table 1.

Most of the women (300 (90.3%)) were housewives. The mean age for women and men were 40.54 ± 15.2 years (19-77 years) and 42.4 ± 18.1 years (20-72 years), respectively. 32.7% of the patients were younger than 30 years old, 54.6% were between 30 and 60 years old, and 12.7% were older than 60 years old. There were 262 (63.9%) patients with education level of primary school and 76 (18.5%) patients who were illiterate. Women constitute the 96% of the illiterate patients. The number of patients who keep standing without our invitation was 282 (68.8%). Only 128 patients sit down without our request directly to the empty chair. None of the patients wanted to shake their hands or warned us to call themselves other than their names with national suffix. The mean total time spent in expressing the main symptom took 22.9 ± 10.1 seconds (8-55 sec). Patients younger than 30 years old (21.5 ± 9.9 sec) and patients between 30 and 60 years old (22.9 ± 9.3 sec) told their symptoms faster than the patients older than 60 years (26.7 ± 10.1 sec) ($p=0.03$). The mean time for symptom expression in men (33.8 ± 10.7 sec) were significantly higher than the women (20.3 ± 8.1 sec) ($p=0.01$). There were no significant differences between the mean symptom expression time according to the diseases of the patients and interruption reasons of interview. The mean time for expression of symptoms was significantly higher in patients graduated from universities (32.6 ± 15.1 sec) than the patients graduated from high school (25.4 ± 9.2 sec) ($p<0.05$), primary school (21.9 ± 7.9 sec) ($p<0.01$) and patients who were illiterate (22.3 ± 9.7 sec) ($p<0.01$).

The mean interview time was 7.05 ± 1.8 (3.2-13.2) minutes (min). There was no difference between the mean interview time according to the ages ($p=0.271$), diseases ($p=0.98$) and sexes ($p=0.85$) of the patients. The mean interview time for women and men were 7.2 ± 1.8 min and 6.2 ± 1.9 min respectively. There were no difference between the mean interview times among patients according to the education levels ($p=0.78$). It was seen that the length of interview with interruptions (8.5 ± 1.6 min) were significantly longer than the interview without interruptions (6.2 ± 1.2 min) ($p<0.01$). The lengths of the interview according to the interruptions are given in Table 2.

Table 1. Demographic information of the patients

	Women (n=332) (81%)	Men (n=78) (19%)
Mean Age (years)	40.5 ± 15.2	42.4 ± 18.1
Age Distribution (n)		
<30 years (n=134)	100	34
30-60 years (n=224)	194	30
60< years (n=52)	38	14
Education Levels (n)		
Illiterate (n=76)	73	3
Primary School (n=262)	205	57
High School (n=66)	50	16
University (n=6)	4	2

Table 2. The distrution of interruptions and interview times. Length of interview without interruptions were significantly shorter than interviews with interruptions

Interruptions (n, %)	The interview time (min)
None (236, 57.6%)	$6.2 \pm 1.2^*$
Attendants (60, 19.5%)	9.3 ± 1.1
Telephone ringing (34, 8.3%)	9.2 ± 1.9
Door opening or knocking (76, 18.5%)	8.9 ± 1.2
Noise from the outside (4, 1%)	7.2 ± 1.7

* $p<0.01$; ANOVA post-hoc Tukey.

It was found that 64.4% of the patients had previous diseases or existing medications. Among them (n=264), 178 patients (67.4%) did not know the names of the drugs, and 54 patients (20.5%) did not know the names of previous diseases. The number of patients younger than 30 years old knew the name of drugs which were used for existing diseases better than the older ages ($p=0.013$). Unawareness of previous disease is significantly higher in patients older than 60 years old than the patients younger than 60 years ($p=0.013$). Also unawareness of previous disease is significantly higher in illiterate patients than the literate ones ($p<0.01$).

Totally 190 (46.3%) patients asked questions at the end of the interview. The distribution of questions asked at the end of the interview were as follows; hospital setting 138 (72.7%), treatment 20 (10.5%) and nutrition 32 (16.8%). It was seen that university graduated patients asked questions mainly about nutrition at the end of the interview. However, hospital setting type questions were mostly seen in low education levels. The distribution of the results according to the education levels are given in Table 3.

Table 3. The distribution of the patients according to their education levels

Education status (n, %)	Mean age (years)	Unaware of previous disease (n, %)	Unaware of existing medication (n)	End questions about hospital setting (n)	End questions about treatment (n)	End questions about nutrition (n)	Mean interview time (min)	Mean symptom expression time (sec)
Illiterate (76, 18.5%)	57	32 (59.2%)	66 (37.5%)	54 (39.1%)	6 (30%)	0	7.4	22.3
Primary school (262, 63.9%)	41	16 (29.6%)	100 (56.8%)	70 (50.7%)	6 (30%)	8 (25%)	6.9	21.9
High School (66, 16.1%)	34	6 (11.1%)	10 (5.6%)	14 (10.1%)	8 (40%)	22 (68.7%)	6.8	25.4
University (6, 1.5%)	28	0	0	0	0	2 (6.3%)	7.1	32.6
Total (410, 100%)	40.9	54 (100%)	176 (100%)	138 (100%)	20 (100%)	32 (100%)	7.0	22.9

Discussion

This is the first study that investigated the communication between the patient and the physician in Turkey. In this study, we thought that socio-economic status, national health system, hospital settings are possible related factors in communication between the patient and the physician.

The study was performed in a slum part of a city. The population consists of the people who had migrated from different parts of the country with low income. Although they are from the same nation, several cultural differences such as clothing, dialect, marriage and sect exist. In low socio-economic populations, it is very difficult for patients to express their symptoms in an understandable manner. The description of pain as sharp, dull, ache or report of the duration of symptoms was difficult for the patients. The words used by the patients to explain the symptoms were sometimes irrelevant and although rare, some words cannot be understood by the physicians. The reason was the cultural difference rather than the language. Some parts of the bodies were described with different words. These factors made the verbal communication difficult. Moreover, especially in populations of low socio-economic status with physician centred health systems, doctors are seemed like the hands of the God (manus dei) on the Earth by patients [9]. In this kind of health systems in low socio-economic- populations, in the patient point of view, it is thought that physicians know everything whether the patient told the symptoms shortly. Furthermore, standing on foot after entrance and not sitting till the invitation is a sign of respect of the people. All these factors form an obstacle between the communication of the patients and the physicians. In order to obtain sincere communication, we removed the table between the patient and the physician and did not call the patients with Mr/Mrs. In Turkey, suffix usage forms more suitable for the right communication. However, the attitudes did not change. The mentioned factors contributed to the low socio-economic are important obstacles for good communication.

Low education levels are another factor in communication. Patients with low education levels were unaware of previous diseases and existing medications. During the interview with these patients, we wanted to bring their medications and previous files that led to readmissions. Moreover, patients who were illiterate were mostly asked questions about the hospital settings like the locations of the laboratories, radiology clinics etc. Illiterate patients had difficulties in finding places in the hospital. Patients with low education levels told their symptoms shorter than the patients with higher education levels who told in more detail. Men express their symptoms longer than women. We thought that the reason was probably due to the lower education levels of women rather than sex. Since, 97.2% of the illiterate patients were women. This is an important education problem that effects the health system. Previous studies have cases with higher education levels [10-12]. Total interview time did not show significant difference between the education levels. The mean interview time in our study is 7 min and shorter than several previous studies [13, 14]. Since, this time depends on the physician and the severity of the diseases. As the outpatient clinic in which the study had performed was not a tertiary centre, there were not complicated or severe cases. On the other hand, university graduated patients asked questions about the nutrition. This is probably related to the healthy nutrition that gained importance with organic agriculture and hazards of Genetically Modified Organisms. Although hard to communicate, basic communication methods were successful that very little number of patients asked questions about their present disease and medications. However, it is not the aim of this study to analyse the result of communication methods.

The mean age of the patients with higher education levels were less than the mean age of the patients with low education levels. This is due to the increased education levels as the result of the education system. Eight years of compulsory education, started in 1997, is important for increased education levels in Turkey. As seen in our study improvement of

communication and quality of life is related with the education levels. Education among women must be increased.

The number of the patients come to the outpatient clinic depends on the admissions rather than appointment. For this reason, the number may increase up to 100 patients per day in some clinics. This led to mandatory decrease in the total interview time. Short visits are associated with less problem identification, fewer preventive actions undertaken less lifestyle or psychological discussion, and more antibiotic prescribing. Patients who participate more actively in their visits may have fewer complications as a result of their communication style. They may obtain more information, express their concerns in more detail, become more engaged in problem solving with their physicians. Moreover, active participation of the patients makes their preferences better known and ensures more adherence to the treatment [15, 16]. By this way, patients assume more responsibility for their health, and develop greater confidence in their ability to influence their health [15, 17]. They all receive more psychosocial support from their physicians, more satisfaction with their care and have better continuity of care [15]. Short interview is an important problem in Turkey. Health system should be arranged for better quality interviews [18].

Previous studies had been performed among populations with higher education levels and it was seen that participants had undertaken active role in communication [6, 8, 11, 12]. However, in our study, although tried to, patients did not take active role in communication. This may be due to the low education levels, learned behaviour models of patients in medical communications for years, or submissive attitudes for the suggestions of the physicians. Populations with different backgrounds and different life styles show differences in communication [11, 19]. The patient- and national health system-related obstacles can be overcome by the increased education levels and organised health systems [15, 20].

Greeting is the first impression of physician on patient. Polite, warm and kind greeting is the onset of a good communication. Greetings vary from country to country. In our study population, we hesitated to shake hands of the patients especially the women because of religious or social reasons. Furthermore, appealing to patients as Mr or Mrs might have created formal relation between patient and the physician which might also increase the timidity of the patients. Usage of national suffix led more close and informal relation between the patient and the physician. For this reason, we used national appeal instead of Mr and Mrs.

Patients and physician should feel themselves secure and comfortable without any disruption in the interview rooms [14]. Knocking of the door, or noise from the outside are obstacles for patient privacy. Additionally, these factors not only increase the duration of the interview but also decrease

the quality of communication. However, the interview rooms is located around the waiting hall in our polyclinic like most of the polyclinics in Turkey. Lack of places is the reason for this kind of setting. On the other hand, telephone ringing is another reason for the disruption. Although we wanted to close the phone during the interview, we could not do it, because of the probability of calls that might come from the emergency room. For this reason physician working in the outpatient department should not be responsible for the emergency calls. Only 19.5% of the disruptions were related with the attendants accompanying the patients. These interruptions of the attendants were related with the questions and comments of the attendants.

As a result, education, health system, hospital setting and physician's point of view about communication are the effective factors in the quality of interview. Effectively continuing the medical education programmes can improve primary care physicians' skills in communication tasks. More studies should be done in Turkey in order to determine the attitudes of people towards communication skills, to increase the awareness of communication skills and to improve the quality of interviews.

Ethics Committee Approval: Ethics committee approval was obtained.

Informed Consent: Written informed consent was obtained from the patients who participated in this study.

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