Doctor-patient communication in surgery[1]

Jessica Richards BM
Peter McDonald MS FRCS
University Surgical Unit, Southampton

Summary: The efficiency of communication between junior hospital doctors and 77 general surgical patients was assessed by using standardized questionnaires before and after the doctor/patient interview on both the patient and the house doctor. Patients were better informed about their illness than their surgery, and doctors wrongly estimated patients' knowledge in 41% of cases. Self-reported preoperative anxiety of patients was low and was estimated wrongly by house doctors in 58% of cases. In 52% of cases house doctors were considered by patients to be the most important source of information, but patients had little comprehension of the seniority of other doctors. Although 60% of patients were satisfied with the communication, the majority complained of lack of information concerning convalescence, postoperative pain and routine ward procedures.

Introduction

Despite major advancements in medical knowledge and technology, difficulties of communication remain a serious problem. Research into communication in medicine suggests that the failure to resolve these difficulties can be partly attributed to doctors (Pellegrino 1976, Francis *et al.* 1969, Reinhard 1974). The medical profession appears to be content with its ability to communicate with patients and seems unaware of existing problems.

Numerous studies have highlighted the benefits for doctors and patients which can be attained by improving communication (Reading 1979, Schmitt & Wooldridge 1973, Langer *et al.* 1975). In surgery, it has been suggested that effective communication can reduce postoperative complications and analgesic requirements, thus effecting earlier discharge. This study was undertaken to evaluate communication in a surgical setting and to assess the satisfaction of doctors and patients with the present level of communication.

Method

A questionnaire/interview format was used to obtain information from patients and doctors on the surgical wards at the Royal South Hants Hospital, Southampton. Questionnaires were administered to patients preoperatively after the house surgeon had clerked them, and postoperatively prior to discharge from hospital. Patients were asked to describe various aspects of their illness and surgery. Satisfaction with communication was assessed by considering, for each patient, the ease of obtaining information; the adequacy of information received; the desire for further information; and a self-reported satisfaction status.

The house surgeons who clerked each patient were given a questionnaire to complete on the day of admission. They were asked what information had been given to each patient and to make an assessment of each patient's knowledge of their illness and surgery. They were also asked to describe their own and their patient's satisfaction with this communication.

Results

In total, 77 general surgical patients were interviewed pre- and postoperatively. Sixty-six of these were matched with a questionnaire completed by their house surgeon. A total of 17 different doctors were interviewed. Patients were aged between 18 and 84 years and comprised 42

[1]Accepted 27 June 1985

0141–0768/85/011922–03/$02.00/0

males and 35 females. They were undergoing one of five operations: herniorrhaphy, varicose vein surgery, femoropopliteal bypass, cholecystectomy or mastectomy.

Patients' knowledge: The patients emerged as a well-informed group, tending to know more about their illness than their surgery. However, their ability to describe different aspects of illness and surgery varied considerably. For example, 72 patients (94%) knew the name of their illness, but only 15 (20%) could name their operation. Also, while 73 patients (95%) knew how their illness had been diagnosed, only 31 (40%) could name any risk of surgery.

Performance on eleven multiple-choice questions concerning medical terms and surgical procedures showed similar variation. For example, although 67 patients (87%) knew the correct use of a 'premed' (preoperative premedication injection), only 24 (31%) understood the function of a nasogastric tube. Also, while 63 patients (82%) knew the reason for preoperative electrocardiograms, only 42 (55%) knew why they had preoperative chest X-rays.

When patients were asked to place the doctors on the surgical ward in order of seniority, only 21 (27%) were correct in their selection. One patient asked 'How am I supposed to know who they are? They are all around the bed in their white coats and they all seem the same...'

House surgeons' assessments: House surgeons were found to predict wrongly their patients' knowledge of their illness and surgery in 30 cases (40%). They tended to underestimate patients' knowledge of their illness and overestimate knowledge of surgery.

House surgeon as source of information: The house surgeon was selected by both doctors and patients as the most important source of information for patients. Patients claimed that most of their questions during their hospital stay were directed at the house surgeon. Patients' rating of house surgeons as a source of information were: 'quite important' 42 (55%); 'very important' 27 (36%); and 'not at all important' 7 (9%).

The information given by the house surgeon to each patient varied greatly. There were, however, four subjects which house surgeons claimed to discuss with only a small minority of patients – postoperative pain and discomfort 30 (39%), outcome without surgery 25 (33%), risks of surgery 12 (15%), and alternatives to surgery 2 (3%).

Satisfaction with communication: Forty-six (60%) patients scored full marks on the satisfaction score and no patient scored less than half marks. However, when patients were encouraged to talk freely, unprompted by questions, three areas of discontent were revealed:

(1) Patients wanted better preparation for the experience of postoperative pain and discomfort. One patient (varicose veins) commented: 'I did not realize how painful walking would be, nor how much bandage would be used – it'll stop me wearing most of my clothes and it's going to affect my sex life'.
(2) There was lack of preoperative information concerning convalescence for patients. One elderly patient asked: 'What's going to happen to me when I leave hospital? I am all on my own...'
(3) Patients were concerned by the lack of information about some routine procedures (e.g. drips, drains, etc.). One hernia patient said: 'I wish I'd been told that everyone had an ECG... I thought there was something wrong with my heart'.

Although no house surgeons felt themselves or their patients to be dissatisfied with their communication, 11 (17%) questionnaires revealed uncertainty in these assessments. Of the more senior surgeons interviewed, only 9/17 (53%) were satisfied with their communication skills, although 14/17 (82%) felt that their patients were satisfied with them.

Discussion

The analysis of such subjective data is open to criticism. Although both patients and doctors were asked to express themselves objectively, it is acknowledged that dissatisfaction may have been under-reported and free discussion inhibited.

Patients were found to be well-informed about many aspects of their illness and surgery, although certain aspects such as the risks of surgery had been poorly explained and were found to be a source of concern for many patients. Preoperative information concerning convalescence, routine surgical procedures and postoperative pain and discomfort was inadequate for patients. From a legal viewpoint, certain aspects of surgery should be discussed with patients in order for informed consent to be achieved (Rockwell & Pepitone-Rockwell 1979). House surgeons in this study claimed to have discussed some of these aspects with only a limited number of patients. For example, the risks of surgery were discussed with only 12 (15%) patients.

Clearly, there are numerous information sources available to patients in addition to the house surgeon. However, in this study the house surgeon was viewed as the most important source of information by both doctors and patients. Also, consent for surgery was obtained from the majority of patients by the house surgeon.

In 31 cases (40%) house surgeons wrongly estimated patients' knowledge of their illness and surgery. It has been argued that before doctors embark on any explanation to patients, they should understand their patients' own model of the illness and how surgery will benefit them (Rockwell & Pepitone-Rockwell 1979). Some studies have shown that when doctors underestimate patients' knowledge, information is withheld from patients in the belief that it will not be understood (Pratt *et al.* 1957, McKinlay 1975).

Most patients and doctors interviewed were satisfied with the present level of communication in surgery. Their views emphasized that good communication has an essential role to play in the management of patients.

Unlike other studies (Pellegrino 1976, Francis *et al.* 1969, Reinhard 1974), doctors in Southampton appear to be aware of the existence of problems in communication and suggested ways to overcome them. Suggestions for improving communication included information pamphlets (Johnson *et al.* 1970), audiovisual aids and group therapy (Schmitt *et al.* 1973), specific coping techniques (Langer *et al.* 1975) and teaching communication skills to medical students (Maddison 1978, Maguire 1978). However, none of these techniques is being used routinely on surgical wards in Southampton.

References

Francis V, Korsch B M & Morris M J (1969) *New England Journal of Medicine* **280,** 535–540
Johnson J E, Dabbs J M jr & Leventhal H (1970) *Nursing Research* **19,** 18–21
Langer E J, Janis I L & Wolfer J A (1975) *Journal of Experimental Psychology* **11,** 155–165
McKinlay J B (1975) *Journal of Health and Social Behaviour* **16,** 3–11
Maddison D C (1978) *Medical Education* **21,** 97–102
Maguire P (1978) *Psychological Medicine* **8,** 695–704
Pellegrino E D (1976) *Journal of the American Medical Association* **235,** 1043–1044
Pratt L, Seligmann A & Reader G (1957) *American Journal of Public Health* **47,** 1277–1283
Reading A E (1979) *Social Science and Medicine* **13A,** 641–654
Reinhard E H (1974) *Pharos* **37,** 117–129
Rockwell D A & Pepitone-Rockwell F (1979) *Medical Clinics of North America* **63,** 1341–1351
Schmitt F E & Wooldridge P J (1973) *Nursing Research* **22,** 108–115