HHS Public Access

Author manuscript

J Natl Med Assoc. Author manuscript; available in PMC 2018 May 17.

Published in final edited form as:

J Natl Med Assoc. 2010 December ; 102(12): 1237–1242.

Perceptions of Health Care Communication: Examining the Role of Patients' Psychological Distress

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Abstract

Objective—We sought to gain a better understanding of the relationship between patients' serious psychological distress (SPD) and their perception of interactions with health care providers and their ratings of the health care quality.

Methods—We analyzed data from 6286 adult respondents to the 2007 Health Information National Trends Survey. We conducted cross-tabulations to compare sociodemographic characteristics between those with SPD and those without SPD. Using odds ratios and 95% confidence intervals from logistic regression models, we assessed the association between psychological status and indicators of perceived health care communication and the overall health care quality after controlling for sociodemographic variables.

Results—Patients with SPD were less likely to report that their provider "always" paid attention to their feelings and emotions, "always" ensured their understanding of the needed care, and "always" assisted them dealing with uncertain feelings. These distressed patients were also less satisfied with the overall health care quality.

Conclusions—Patients' psychological distress is negatively associated with their perceived quality of communication with health providers. Further knowledge on the health care need of patients with SPD would be important in improving health service delivery and optimizing the psychological care of medical patients.

Keywords

health care; psychology; patient-physician relationship

Communication between patients and health care providers is a central element of a medical visit. Effective communication with health care providers on diagnosis, treatment, and prognosis may enhance patients' health outcomes.[1–4] A systematic review of studies on patient-doctor communication revealed significant relationships between positive aspects of communication and patient improvement of psychological and functional status and

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recovery from emotional problems.[5] In addition, optimal patient-physician communication may lead to high rates of patient satisfaction with care.[6,7]

Unfortunately, problems in doctor-patient communication are very common.[5,8] Both outpatients and hospitalized patients report problems of diagnosis, a lack of patient involvement in decision making, inadequate time talking with their care providers, or the insufficient provision of medical information to the patient.[9–11] A survey among more than 2000 insured patients in the ambulatory setting showed that most patients (78%) reported at least 1 type of problems with interpersonal aspects of medical care. These negative experiences were strongly related to lower trust, and several were associated with lower ratings of overall experiences with their physician.[8]

Mental illnesses are a major source of morbidity within primary care settings and have been increasingly targeted for improving the quality of health services.[12,13] According to the 2005 National Survey on Drug Use and Health, an estimated 24.6 million American adults reported experiencing serious psychological distress (SPD) during the past year.[14] SPD is a nonspecific indicator of mental health problems that can be "severe enough to cause moderate to serious impairment in social, occupational, or school functioning."[15] Evidence has consistently indicated negative associations between patients' psychological distress and their health care experience and satisfaction of care.[16–18] Greenley and associates found psychologically distressed people who did not recognize emotional or personal problems were especially likely to be dissatisfied with health care and related services.[16]

There is a need to better understand the role of patients' psychological distress in communication in health care settings. According to findings from a qualitative study, people with anxiety and depression wished for the general practice's encouragement of disclosure of emotional or psychological problems and expected providers being more active in referrals.[19] In the current study, we used data from the Health Information National Trends Survey (HINTS), a nationally representative sample of the US noninstitutionalized civilian population, to examine how patients' SPD is related to their perception of the interaction with their health care providers and their ratings of the health care quality.

METHODS

Data Source

We used data from HINTS, a national, biennial survey designed to collect nationally representative information on the American public's need for, access to, and use of cancer information. The 2007 HINTS used 2 separate sample frames to draw the sample: one from a random-digit-dial telephone survey, using a computer- assisted telephone interview format; the other from a list of addresses from the US Postal Service administrative records.[20] Each household received 3 questionnaires. Each adult was asked fill out a questionnaire. The house-hold response rate was computed based on those cases where at least 1 completed survey was returned from a household, after adjustment of the undeliverable addresses. The within-household response rate was calculated by comparing the number of household returns to the number of adults in the household (as recorded in the survey). The overall

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response, computed by taking the product of the household and the within-household response rates, was 30.99%.

A total of 7674 participants completed the 2007 HINTS. Only those who had visited a health professional during the past 12 months answered questions concerning perceived health care communication. Therefore, we excluded those who answered no or did not provide an answer to the question of the previous year's medical visit (n = 926). We also excluded respondents who did not have a score for psychological distress and those who did answer any of the health care communication questions (n = 462). Thus, the final sample included in the study was 6286 adults. This study met the eligibility criteria of institutional review board exemption because it involved secondary data analysis on data that were publicly available.

Measures

We assessed SPD by responses to Kessler's 6-Question Scale (K6), which measures symptoms of SPD in the general population over a 30-day recall period.[15,21,22] This scale asked participants about 6 manifestations of psychological distress: "During the past 30 days, how often did you feel…: (1) so sad that nothing could cheer you up, (2) nervous, (3) restless or fidgety, (4) hopeless, (5) that everything was an effort, and (6) worthless." Frequency responses ranged from: (1) all of the time; (2) most of the time; (3) some of the time; (4) a little of the time; and (5) none of the time. The total score range is 0 to 24. According to scoring criteria established by Kessler, individuals with a score of 13 or greater are likely to be experiencing severe mental illness,[22] so we classified people with a score of 13 or greater as seriously psychologically distressed.

We used 5 indicators of communications to assess perceived health care communication. Among those who reported that they went to a health professional during the past 12 months, they were asked "How often did doctors, nurses, or other health professionals? (a) give you the chance to ask all the health-related questions you had; (b) give the attention you needed to your feelings and emotions; (c) involve you in decisions about your health care as much as you wanted; (d) make sure you understood the things you needed to do to take care of your health; (e) help you deal with feelings of uncertainty about your health or health care. An additional question evaluated the perceived reliability of patients' health care providers. Participants responded to the question, "In the past 12 months, how often did you feel you could rely on your doctors, nurses, or other health care professionals to take care of your health care needs?"

Participants rated communication and reliability measures on a 4-point scale, including always, usually, sometimes, and never. For the analysis purpose, we dichotomized the responses as "always" and "not always" (including "usually," "sometimes," and "never"), which allowed us to have approximately equal sample sizes in each group. In addition, since it is optimal for the provider to always communicate well with patients, isolating "always" would be a desirable approach to examine the health care communication.[1] Similar ways of dichotomy of responses related to communication in health care settings have been used in previous published studies.[1,23]

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We assessed patients' perception of the overall health care quality based on participants' rating of the quality of health care received in the last 12 months on a 5-point scale, including "excellent," "very good," "good," "fair," and "poor." We then dichotomized the responses as "very good-excellent" and "poor-good."

Sociodemographic variables included gender; age (18–34 years, 35–49 years, 50–64 years, 65 years); education (lower than high school, high school, higher than high school); race (Hispanic, non-Hispanic white, non- Hispanic black, Asian, and other races); household income (<$20 000, $20 000 to <$50 000, $50 000 to <$75 000, $75 000); insurance (insured, uninsured); and usual source of care (not including psychiatrists and other mental health professionals, whether or not having a particular doctor, nurse, or other health professional that they see most often).

Statistical Analyses

We conducted cross-tabulations to compare those with SPD and those without SPD in sociodeomographic characteristics and perception of health care experiences. We used odds ratios (ORs) and 95% confidence intervals from logistic regression models to assess associations between psychological status and indicators of perceived health care communication and the overall health care quality after controlling for sociodemographic variables. We conducted all analyses with SUDAAN 10.0, which allows for weighting of the estimates of the US adult population by taking into account the complex sampling design. All *p* values are 2-tailed, with values less than .05 considered statistically significant.

RESULTS

Table 1 presents the distribution of demographic variables for the sample in HINTS 2007 by psychological status. Compared with people who did not have psychological distress, people with SPD had lower levels of education and income. In addition, people who reported SPD were more likely to be women and to be at younger age (18–34 and 35–49 years) but were less likely to be Asian American, have health insurance, or have a usual source of care.

All bivariate analyses results comparing perceived medical communication and health care qualities among people with and without SPD were statistically significant. People with SPD were less likely to respond positively to all 5 aspects of health care communication than their counterparts who did not have SPD (Table 2). In addition, the former group gave less favorable response to whether they could rely on their providers to take care of their health care needs and how they would rate the overall health care quality.

Table 2 also shows the adjusted ORs from logistic regressions for medical communication and other health care indicators while controlling for patients' age, gender, marital status, race, education, household income, health insurance, and usual source of care. SPD was negatively associated with patients' rating of overall health care quality. Patients with SPD were less likely to report that providers "always" gave the attention needed to patients' feelings and emotions, "always" made sure they understood the things they needed for their health care, and "always" helped them deal with feelings of uncertainty about their health or health care.

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DISCUSSION

Findings from HINTS data show important demographic differences across individuals with and without SPD. Consistent with a previous report,[24] we found that the rate of SPD decreased with age, and was lower among men and Asian Americans. Moreover, lower education level, lower income level, being uninsured, and having no usual source of care were all associated with higher risk of SPD. Our findings indicated that patients' psychological distress was associated with their perception of the communication with their health care providers. In particular, individuals with SPD responded less favorably to 3 major aspects of health care communication: providers paying attention to their feelings and emotions, ensuring their understanding of the needed care, and assisting them dealing with uncertain feelings. These distressed patients were also less likely to be satisfied with the overall health care quality.

The less-positive perception of health care communication and the lower level of satisfaction in health care quality may be simply due to the general negative outlook held by patients with SPD;[25] however, there could be other reasons for these results. The mental status of patients can directly influence their understanding and recall of the health information and instruction given by the provider.[26] Patients with mental distress may also be more sensitive to the negative cues given unconsciously by the health provider.[25] All these barriers could result in difficulties in interacting with their providers. Moreover, individuals with SPD may have higher expectations for their health care than individuals without SPD.[19] In addition to needs of physical care, individuals with SPD may require increased attention and help from their providers to address their mental health issues.

It should also be noted that the comparison of perception of health care communication between SPD and non-SPD groups was confounded by all the demographic variables included in the analysis, even though most OR estimates did not change by more than 5% after controlling for covariates. Unmeasured personal and contextual factors such as patient's medical history and the continuity of care relationship may be potential confounders and need further exploration.

Health providers, especially primary care providers, play an important role in the management of patients with nonspecific psychological distress.[27] However, in clinical practice, there are multiple challenges to providing optimal health care to people with severe psychological distress. Evidence[28] has shown that the success of health providers in detecting psychological distress among their patients is lower than 50%. Many barriers exist in the detection and management of psychological distress among primary care providers, including lack of appropriate knowledge for recognizing psychological symptoms[12] and limited examination time.[28,29] Because of cultural barriers and stigma, some patients are simply reluctant to express psychological distress to their health care providers.[30,31]

Studies on health services have suggested that both verbal and nonverbal communication skills of providers are directly related to patients' perception of their medical visit experience.[25,32,33] Feelings of providers toward patients are not only reflected by what they actually talk to patients but also by how they talk to patients, such as their tone of voice and

eye contact.[34] More sensitive and expressive providers interact with patients in a way that can effectively communicate empathy and address needs of patients. These skills are very important when interacting with patients with SPD considering their higher emotional needs.[25] Systematic training in communication for providers' can lead to great improvement of interaction skills in defining problems and handling emotional issues in health care settings.[35]

Several limitations of this study need to be noted. First, our data did not provide information on the type of health professionals for whom the respondents were evaluating on their health care experience. In addition, the cross-sectional nature of the HINTS data cannot illuminate whether patients with SPD simply receive less satisfactory care or whether patients' psychological distress adversely affects their perception of their health care experience even though they receive comparable care service. The low response rates may limit the application of the results to the whole population. Furthermore, unmeasured patient characteristics may confound the perception of health care communication and offer an alternative explanation for our findings.

Findings from this study underscore the importance to examine the health care need of patient with SPD. Future studies need to determine whether the lower rating of health care communication of patients with SPD is just a result of their personal perception or is due to the fact that providers actually communicate poorly with them. It is also important to investigate what communication styles/methods are most effective with patients with SPD, and what educational efforts and interventions can improve providers' detection of psychological distress of patients.

The importance of psychological dimension of medical practice has been increasingly recognized. Many patients' medical illnesses are accompanied by psychological distress that requires particular attention. Our study demonstrates that patients' psychological distress is negatively associated with their perception of the quality of communication experiences with health providers. At the practice level, providers need to be especially aware of patients with SPD and their needs and adjust communication style accordingly.

References

1. DeVoe JE, Wallace LS, Fryer GE Jr. Patient age influences perceptions about health care communication. Fam Med. 2009; 41:126–133. [PubMed: 19184691]
2. Dutta-Bergman MJ. The relation between health-orientation, provider-patient communication, and satisfaction: an individual-difference approach. Health Commun. 2005; 18:291–303. [PubMed: 16187933]
3. Kerse N, Buetow S, Mainous AG, Young G, Coster G, Arroll B. Physician- patient relationship and medication compliance: A primary care investigation. Ann Fam Med. 2004; 2:455–461. [PubMed: 15506581]
4. Trummer UF, Mueller UO, Nowak P, et al. Does physician-patient communication that aims at empowering patients improve clinical outcome? A case study. Patient Educ Couns. 2005; 61:299–306. [PubMed: 15970422]
5. Stewart MA. Effective physician-patient communication and health outcomes: a review. CMAJ. 1995; 152:1423–1433. [PubMed: 7728691]
6. Hall JA, Roter DL, Katz NR. Meta-analysis of correlates of provider behavior in medical encounters. Med Care. 1988; 26:657–675. [PubMed: 3292851]

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7. Zachariae R, Pedersen CG, Jensen AB, Ehrnrooth E, Rossen PB, von der Maase H. Association of perceived physician communication style with patient satisfaction, distress, cancer-related self-efficacy, and perceived control over the disease. Br J Cancer. 2003; 88:658–665. [PubMed: 12618870]
8. Keating NL, Green DC, Kao AC, Gazmararian JA, Wu VY, Cleary PD. How are patients' specific ambulatory care experiences related to trust, satisfaction, and considering changing physicians. J General Internal Med. 2002; 17:29–39.
9. Krupat E, Fancey M, Cleary PD. Information and its impact on satisfaction among surgical patients. Soc Sci Med. 2000; 51:1817–1825. [PubMed: 11128269]
10. Roter, DL., Hall, JA. Doctors talking with patients/patients talking with doctors: Improving communication in medical visits. Westport, CT: Praeger Publishers; 2006.
11. Simpson M, Buckman R, Stewart M, Maguire P, Lipkin M, Novack D, Till J. Doctor-patient communication: the Toronto Consensus Statement. BMJ. 1991; 303:1385–1387. [PubMed: 1760608]
12. Howe A. "I know what to do, but it's not possible to do it"—general practitioners' perceptions of their ability to detect psychological distress. Fam Pract. 1996; 13:127–132. [PubMed: 8732322]
13. Sartorius N, Ustün TB, Costa e Silva JA, et al. An international study of psychological problems in primary care. Arch Gen Psychiatry. 1993; 50:819–824. [PubMed: 8215805]
14. Bender E. Serious psychological distress affects millions of Americans. Psychiatr News. 2006; 41:13.
15. Kessler RC, Andrews G, Colpe LJ, et al. Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychol Med. 2002; 32:959–976. [PubMed: 12214795]
16. Greenley JR, Young TB, Schoenherr RA. Psychological distress and patient satisfaction. Med Care. 1982; 20:373–385. [PubMed: 7078294]
17. Linn LS, Greenfield S. Patient suffering and patient satisfaction among the chronically ill. Med Care. 1982; 20:425–431. [PubMed: 7078298]
18. Hermann RC, Ettner SL, Dorwart RA. The influence of psychiatric disorders on patients' ratings of satisfaction with health care. Med Care. 1998; 36:720–727. [PubMed: 9596062]
19. Kadam UT, Croft P, McLeod J, Hutchinson M. A qualitative study of patients' views on anxiety and depression. Br J Gen Pract. 2001; 51:375–380. [PubMed: 11360702]
20. Cantor, D., Coa, K., Crytal-Mansour, S., Davis, T., Dipko, S., Sigman, R. Health Information National Trends Survey (HINTS). Final report. 2007. http://hints.cancer.gov/docs/HINTS2007FinalReport.pdf. Accessed March 4, 2010
21. Kessler RC, Baker PR, Colpe LJ, et al. Screening for serious mental illness in the general population. Arch Gen Psychiatry. 2003; 60:184–189. [PubMed: 12578436]
22. Kessler, RC., Berglund, PA., Glantz, MD., et al. Estimating the prevalence and correlates of serious mental illness in community epidemiological surveys. In: Manderscheid, RW., Henderson, MJ., editors. Center for Mental Health Services. Mental Health, United States, 2002. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2002. p. 155-164.DHHS Pub No (SMA) 3938
23. Wallace LS, DeVoe JE, Heintzman JD, Fryer GE. Language preference and perception of healthcare providers' communication and autonomy making behaviors among Hispanics. J Immigr Minor Health. 2009; 11:453– 459. [PubMed: 18814028]
24. Substance Abuse and Mental Health Services Administration. Serious Psychological Distress and Receipt of Mental Health Services. The NSDUH Report. 2008. http://oas.samhsa.gov/2k9/SPDtx/SPDtx.pdf. Accessed May 5, 2010
25. Roter, DL., Hall, JA. Doctors Talking with patients/patients talking with doctors: Improving communication in medical visits. Westport, CT: Praeger Publishers; 2006.
26. Ley, P. Communication with patients. London: Croom-Helm; 1988.
27. Brown RL, Mengel MB. Physicians' role in managing emotionally distressed patients already in psychotherapy. J Fam Pract. 1990; 31:381–386. [PubMed: 2212969]

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28. Feldman D, Rabinowitz J, Yehuda YB. Detecting psychological distress among patients attending secondary health care clinics: Self-report and physician rating. Gen Hosp Psychiatry. 1995; 17:425–432. [PubMed: 8714802]
29. Wright AF. Unrecognised psychiatric illness in general practice. Br J Gen Pract. 1996; 46:327–328. [PubMed: 8983248]
30. Good MJ, Good BJ, Cleary PD. Do patient attitudes influence physician recognition of psychosocial problems in primary care. J Fam Pract. 1987; 25:53–59. [PubMed: 3598479]
31. Cape J, McCulloch Y. Patients' reasons for not presenting emotional problems in general practice consultations. Br J Gen Pract. 1999; 49:875– 879. [PubMed: 10818651]
32. Kenny DA, Veldhuijzen W, van der Weijden T, et al. Interpersonal perception in the context of doctor-patient relationship: A dyadic analysis of doctor-patient communication. Soc Sci Med. 2010; 70:763–768. [PubMed: 20005618]
33. Marcinowicz L, Konstantynowcz J, Godlewski C. Patients' perceptions of GP non-verbal communication: a qualitative study. Br J Gen Pract. 2010; 60:83–87. [PubMed: 20132701]
34. Ong LM, de Haes JC, Hoos AM, Lammes FB. Doctor-patient communication: a review of the literature. Soc Sci Med. 1995; 40:903–918. [PubMed: 7792630]
35. Roter DL, Hall JA, Kern DE, Barker LR, Cole KA, Roca RP. Improving physicians' interviewing skills and reproducing patients' emotional distress. Arch Intern Med. 1995; 155:1877–1884. [PubMed: 7677554]

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Table 1

Sociodemographic Characteristics by Psychological Status

	People With Serious Psychological Distress	People Without Serious Psychological Distress	
	N = 368	N = 5918	
Characteristics	**% (SE)**	**% (SE)**	***P* Values**
Gender			.03
Men	36.5 (4.2)	45.7 (0.5)	
Women	63.5 (4.2)	54.3 (0.5)	
Age			.03
18–34	32.1 (4.2)	28.5 (0.6)	
35–49	33.4 (4.1)	28.0 (0.6)	
50–64	24.8 (3.0)	25.1 (0.4)	
65	9.6 (1.5)	18.4 (0.3)	
Marital status			.006
Married/living as married	46.2 (4.3)	59.4 (0.6)	
Divorced/widowed/separated	23.6 (2.5)	17.2 (0.4)	
Single, never married	30.3 (4.4)	23.4 (0.6)	
Race			.02
Hispanic	12.2 (2.8)	10.6 (0.6)	
Non-Hispanic white	72.2 (3.7)	73.0 (0.6)	
Non-Hispanic black	9.5 (1.9)	10.5 (0.4)	
Non-Hispanic Asian	1.6 (1.1)	4.2 (0.3)	
Other	4.5 (1.0)	1.8 (0.5)	
Education			<.001
Lower than high school	23.0 (3.4)	11.0 (0.6)	
High school	34.8 (3.6)	24.8 (0.6)	
Higher than high school	42.2 (3.6)	64.2 (0.7)	
Household Income, $			<.001
<20 000	38.0 (4.8)	15.2 (0.8)	
20 000–49 999	37.8 (5.2)	29.9 (1.0)	
50 000–74 999	6.9 (1.5)	21.0 (0.8)	
75 000	17.4 (3.3)	33.9 (1.0)	
Health insurance			.049
No	18.4 (3.7)	10.4 (0.6)	
Yes	81.6 (3.7)	89.6 (0.6)	
Usual source of care			.02
No	31.4 (4.3)	20.9 (1.0)	
Yes	68.6 (4.3)	79.1 (1.0)	

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Table 2

Crude and Adjusted Odds Ratios (ORs) and 95% Confidence Intervals (CIs) for Variables of Perceived Health Care Comparing People With and Without Serious Psychological Distress

	People with Serious Psychological Distress					
Health Care Variables	**Crude OR**	**95% CI of Crude OR**	***P* Value**	**Adjusted OR[a]**	**95% CI of Adjusted OR**	***P* Value**
Giving you the chance to ask all the health-related questions you had (always)	0.72	0.53–0.96	.03	0.78	0.56–1.09	.08
Giving the attention you needed to your feelings and emotions (always)	0.71	0.52–0.97	.04	0.66	0.46–0.93	.02
Involving you in decisions about your health care as much as you wanted (always)	0.70	0.50–0.99	.03	0.74	0.52–1.07	.08
Making sure you understood the things you needed to do to take care of your health (always)	0.60	0.42–0.86	.01	0.56	0.38–0.82	.002
Helping you deal with feelings of uncertainty about your health or health care (always)	0.64	0.45–0.96	.01	0.59	0.41–0.80	.04
Feeling you could rely on doctors, nurses, or other health professionals to take care of your health care needs (always)	0.62	0.45–0.86	.008	0.65	0.45–0.94	.01
Overall health care quality (very good-excellent)	0.38	0.25–0.58	<.001	0.42	0.27–0.65	<.001

[a]ORs adjusted for age, gender, race, education, marital status, income, insurance, and usual source of care.