

# PARTICULARITIES OF COMMUNICATION BETWEEN DOCTOR AND PATIENT. COMPARISON OF RESULTS OF AN EVALUATION FROM ROMANIA WITH SIMILAR DATA FROM JAPAN AND THE UNITED STATES OF AMERICA

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**Keywords:**

communication, doctor-patient relationship, patient authority, dominance

**Abstract:** Despite sophisticated technologies for medical diagnosis and treatment, direct communication between doctor and patient remains a basic element of healthcare. The present study compares the particularities and the parameters of communication-structure in the Romanian outpatient clinics with similar data obtained in two remote cultures, the Japanese and USA practices.

**Cuvinte cheie:**

comunicare, relație medic-pacient, autoritatea pacientului, dominantă

**Rezumat:** În ciuda dezvoltării spectaculoase a mijloacelor utilizate în diagnostic și tratament, comunicarea directă dintre medic și pacient rămâne un factor determinant în terapie. Studiul de față își propune confruntarea parametrilor măsurabili, a particularităților consultațiilor desfășurate în cabinetele din România cu valorile corespunzătoare ale întâlnirii medic-pacient în două culturi îndepărtate, japoneză și americană.

## INTRODUCTION

Doctor and patient behaviour has changed a lot in the last decades. The dominance of traditional medical style, the paternalistic one has decreased, patient's autonomy has risen, partnership and active participation have strengthened. Today's model consists of mutual participation, where the doctor offers the patient the possibility to help himself and he changes their relationship to partnership. It is associated to this the appearance of self-conscious, well-informed patient, putting consumer's point of view forward when discussing a question, and the importance of points of view considering the efficiency of suppliers' expenditure. „Suppliers of medical services, pharmaceutical companies as well as insurance agents have changed the once intimate relationship between doctor and patient into a simple meeting”.(1)

Despite complicated technologies used in diagnosis and treatment, communication still remains the basic tool of exchanging medical information, and doctors have to anticipate a superiority of materials over the goals of the medical action, without ignoring the technological progress.(2,3)

The efficiency of the way used by the doctor to gain information needed for diagnosis, the way he identifies the patient's worries, discussing and explaining the diagnosis will all have an effect on the patient's attitude regarding the entire process of treatment. The correlation between the quality of communication and the patient's sense of comfort and satisfaction, the patient's willingness to co-operate and recover are demonstrated in the studies.(4,5,6)

A better doctor patient communication was also shown to be associated with a more efficient control of chronic diseases, including blood pressure, blood glucose and pain control.(7,8)

On the other hand, patients' discontent towards medical services is not connected with staff's professional qualification, with the way of examination and treatment, but as it is proved

by a great number of studies, it is connected with communication. The deficiencies of the latter are the most important hindrance of a successful medical act.(9,10)

In a recent survey (11) we studied the particularities, the structure of patient-doctor relationship in eight doctor's offices from Romania. We would have liked to compare the results of this survey with data of other cultures.

## PURPOSE

Our aim was to compare the particularities and the parameters of the communication-structure in the Romanian outpatient clinics with similar data obtained in two remote cultures, the Japanese and the USA practices.

## METHODS

In our survey we have analyzed the consultation of 93 patients by 10 doctors in state and private ambulatories from four different towns. Patients' average age was 56 and doctors' average age was 46. The doctors were specialists: internal medicine, physiotherapy, neurosurgery, rheumatology, ophthalmology, gynaecology and cardiology.

The majority of patients were from the rural area, 80%, 27% with higher education and the majority were suffering from chronic diseases.

We have taken into consideration only those parameters which are present in the evaluations of the other two countries, and these are the following: total time spent in the doctor's office with a patient, fragment of time during which the doctor and the patient were having a dialogue, the number of questions asked by both, percentage that represents certain activities: patient's reception/introductory dialogue, duration of the medical examination (manual and instrumental), administration, discussion in line with the diagnosis – explanations, advice about the treatment and possible change of life style, „social talking”.

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Article received on 27.05.2012 and accepted for publication on 25.07.2012  
ACTA MEDICA TRANSILVANICA September 2012;2(3):163-164

## PUBLIC HEALTH AND MANAGEMENT

The source of comparative information is a survey executed by S. and T. Ohtaki in Japan, Michael D. Fetters in the United States of America, published in the third issue of the 20th volume of learned journal entitled „Family Practice”. They analyzed 5 examinations done by 5+4 doctors in rural communities of 6000 inhabitants in Japan, and 20000

inhabitants in the USA. The doctors worked in ambulatories affiliated to a university department of family medicine (USA) and included a general internist, a gastroenterologist and two cardiologists working in the out-patient clinic of a university hospital in case of Japan.

**Table no. 1. Duration of consultation expressed in percentage in the three countries**

	Anamnesis	Examination	Administrative works	Explaining diagnosis	Discussing treatment	Free discussions
Romania	15%	39%	27%	8%	11%	
USA	29% (3+26)	12%		12%	31%	17% (5+12)
Japan	26%	29%		15%	16	14% (9+5)
Average USA/Japan	27,5%	20,5%		13,5%	23,5%	15,5%

### RESULTS AND DISCUSSIONS

During examinations in Romania, the administrative work is in average of 27% (registration, filling in recipes and letters). In the other two countries this is not present at all. *Free conversation* with the patient reveals a discussion that is not related to the disease, it is cordial and it is rather chatting, but these are very rare and with uncertain duration in the Romanian offices.

The proportion of questions between doctor and patient was 75/25% in the USA, that means that doctors had three times more questions to ask than the patients. This percentage is similar in Japan: 78/22%. In Romania, the patients put even fewer questions, only 7% of the total number of questions are asked by the patients, that is less than one question per patient.

From the total content of conversations 55% and 59% represent the doctor's part, contrary to 85% in Romania. Consequently, in Romania, the patients contributed to conversations only in a percentage of 15% (compared with 45% in the USA and 41% in Japan).

It is known that the time for consulting a patient in Romania is officially between 15-30 minutes; the insurance company thus has regulated the number of daily consultations which can be paid. However, the majority of doctors examines and treats all patients who come to the office. And thus, the optimal time meant for a patient is reduced to 5-12 minutes, *quick examinations*, during which administrative tasks seem to be inevitable, the examination is done, but there is less time for discussions (3-4 times reduced). The doctors from Romania manage their time by dominant, concise and one-way communication which the patient does not want to ruin with long, elaborate descriptions of his sufferings and questions or worries.

In Romania, a large scale of cultural diversities can be observed, from patients with higher studies from towns to people from rural areas with uncertain studies. The time spent with well-informed and qualified patients was longer, but their average is smaller compared to the rural areas from abroad.

### CONCLUSIONS

Although there are accentuated similarities in the structure of consultations from the three different countries of different continents, it turned out from the comparison, that reduced time assigned to consultations in Romania mainly affects the discussions with the patients, namely listening to them and informing them. The time dedicated to instrumental

examination is not shortened, it is even longer in absolute value compared to the values assessed in the other two countries. When seeing the doctor, the patients in Romania are less active, they put fewer questions. At the same time, the administrative obligations are present and more important. We lack social dialogues which in the other two countries represent 14 and 17 % of the time assigned to consultation.

The assessed differences tell us a pronounced doctor's dominance and a limited patient authority in the Romanian offices.

There is a need for other studies to establish whether these discrepancies are related to cultural differences, to patients' education or to other factors.

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