



Original Article

Doctor-Patient Communication skills: Knowledge and Practice among Physicians of private medical colleges of Chattogram, Bangladesh

Happy Rani Barua¹, Maliha Ata², Sabrina Karim³, Tanuka Barua⁴, Himon Barua⁵, Aysha Osman⁶, Tanya Barua⁷, Rozina Hoque², Anupam Barua⁶

¹Department of Forensic Medicine, Chattogram Maa O Shishu Hospital Medical College, Chattogram, Bangladesh. ²Department of Pharmacology, Chattogram Maa O Shishu Hospital Medical College, Chattogram, Bangladesh. ³Department of Forensic Medicine, Southern Medical College, Chattogram, Bangladesh. ⁴Department of Paediatrics, Chattogram Maa O Shishu Hospital Medical College, Chattogram, Bangladesh. ⁵Department of ENT, BGC Trust Medical College and Hospital, Chandanaish, Chattogram, Bangladesh. ⁶Department of Medicine, Chattogram Maa O Shishu Hospital Medical College, Chattogram, Bangladesh. ⁷Department of Biochemistry and Biotechnology, University of Science and Technology, Chattogram, Bangladesh

Abstract

Background: Quality patient care and fostering doctor-patient relationships with compassion and mutual respect rely on effective communication. This study sought to evaluate the physicians' knowledge and proficiency in doctor-patient communication skills across three private medical colleges and hospitals in Chattogram, Bangladesh.

Materials and Methods: From April to May 2024, Chattogram, Bangladesh's Southern Medical College (SMC), BGC Trust Medical College (BGC TMC), and Chattogram Maa O Shishu Hospital Medical College (CMOSHMC) conducted a descriptive cross-sectional research. A total of 384 physicians voluntarily participated in this study. A structured questionnaire including Knowledge and Practice towards Doctor-Patient Communication skills based on Calgary- Cambridge framework was distributed among the physicians. Data were analyzed by Statistical Package of Social Sciences version 24.

Results: In this study, out of 384 physicians, 168(43.8%) were male and 216 (56.3%) were female. The mean age of the physicians was 33.0859 ± 9.241 . 142(37%) were from Chattogram Maa O Shishu Hospital Medical College (CMOSHMC), 132(34.4) from BGC Trust Medical college (BGCTMC) and 110(28.6) from Southern Medical College (SMC). The mean of total knowledge score was 41.914 (SD: ± 3.893) and total practice score was 38.554 (SD: ± 4.317). According to Bloom's scale, the doctors in this research had a moderate degree of practice (76%) but an excellent level of knowledge (>80%) about doctor-patient communication.

Conclusion: Though physicians in this study had a good level of knowledge but illustrated a Moderate level of Practice on Doctor Patient Communication skill. The barriers to practice good communication skills must be overcome for a better Doctor Patient Relationship.

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Address for Correspondence:

Happy Rani Barua, Assistant Professor, Department of Forensic Medicine, Chattogram Maa O Shishu Hospital Medical College, Agrabad, Chattogram, Bangladesh. Email: drhappybarua@gmail.com

Introduction

Doctor Patient Relationship (DPR) is regarded as the key component of communication skill which is created when a doctor provides a patient with comfortable examination, diagnosis, and treatment. The doctor has an obligation to either successfully end the relationship or go forward with the patient's illness, in order to provide patients with top-notch care and create an acceptable DPR¹. Three functions of DPR are to gather information, develop and maintain a therapeutic relationship, and communication which interact with each other. The quality and completeness of information directly determines the DPR that influences the practitioner, satisfies the patient and as a result prevents negligence by the practitioner, majorly determining compliance^{2,3}.

Most developing countries comprise of different social and cultural entities, with diverse languages, customs, religion, which provide sufficient chance to research how these elements affect the DPR⁴.

The patient's complete medical history can be obtained from the doctor if he/she is approachable, understanding, and reliable, dedicate optimal time, offer mental support, acting indiscriminately, clearly explaining the type of disease, and fully outlining the prescription and treatment procedures.

Medical results are thus predicted to be influenced by the doctor-patient interaction. It is imperative for a physician to engage in emotional and cultural communication in order to deliver effective treatment. Patient's compliance and collaboration during the course of therapy are also essential for high-quality medical care^{5,6}.

"Knowing the patient is at least as important as knowing the disease" in primary care, and doctors who have a warm, approachable manner are more productive than those who

are formal. The DPR has been demonstrated to be specifically correlated with patient satisfaction, treatment adherence, and treatment outcome⁷⁻¹¹. It is thought to be in charge of the placebo effect, the efficacy of complementary and alternative medicine, and the puzzling differences in how patients react to traditional treatments¹²

The patient's wellbeing will be restored if his disease is identified and treated successfully. The quality of the process of the patient-physician contact is the focus of the "relational model." Rather than offering the patient technical information that they obediently accept, the relationship now becomes shared decision making^{13, 14}. Better health outcomes, lower litigation rates, patient adherence and satisfaction, and high information disclosure are linked to trustworthy doctor-patient interactions¹⁵⁻¹⁹. A number of factors, including those related to the patient (e.g., low health literacy, lack of understanding of medicine), the health care professional (e.g., awareness of occupational risk, high workload), the health care setting (e.g., hospital environment), the interpersonal interaction (e.g., poor communication, lack of empathy), and negative media reports, have combined to cause the degeneration of the DPR.²⁰⁻²³.

Materials and Methods

Study design and participants

This descriptive cross-sectional study was carried out in CMOSHMC, BGCTMC, SMC from April 2024 to May 2024. A total of 384 physicians answered the questionnaire. Data were collected from physicians after taking consent from them. Those who gave consent were included and those who refused to give consent were excluded from the

study.

Ethical consideration

The ethical clearance for the study was taken from the Institutional Review Board (IRB) from the above-mentioned institutions.

Data collection

Data was collected from physicians by using a structured pretested questionnaire containing all the variables of interest after taking consent from the physicians. The questionnaire was divided into three sections. The first included the socio-demographic details such as age, gender, years of work experience of the physicians. The questions on knowledge and practice were based on Calgary-Cambridge framework on doctor – patient communication²⁴. The second section on Knowledge included ten (10) questions where the participants were instructed to mark their responses based on a five-point Likert scale (strongly agree, agree, neutral, disagree and strongly disagree) and scores from 1 to 5 were applied. The third section included Practice towards Doctor-Patient communication skills that consisted ten (10) questions which were marked by a five-point Likert scale (Never, Seldom, Occasionally, Often, always) where 1 to 5 were applied. Total score ranged from 10-50 in each section.

Descriptive statistics using Percentages, frequencies, means, standard deviation, chi square were used to assess the demographic data. t-test was used to evaluate relation between the knowledge and practice score with gender, institution and years of work experience. Statistical significance was considered if p- value was < 0.05

Interpretation

Based on Bloom’s Theory²⁵, Knowledge was classified on the basis of percentage of total score: if score was <=60% it illustrated poor knowledge, > 60- 80% moderate knowledge

and > 80% good level of knowledge. Similarly, practice scores were classified as poor if <=60%, moderate if >60-80% and good level of practice if > 80%. Data were analyzed using computer based statistical package for social science (SPSS) 24 version.

Results

Among 384 physicians 168(43.8%) were male and 216(56.3%) were female. 142(37%) were from CMOSHC, 132(34.4%) from BGC Trust Medical College and 110(28.6%) from SMC.

224(58.3%) had work experience of 1-5years. The mean age of respondents was 33.085±9.241. The demographic data of the physicians are showed in Table1.

Table-1: Demographic characteristics of the physician

Variables	Mean ± SD
1. Age (yrs)	33.085 ± 9.241
2. Gender	n (%)
o Men	168 (43.8)
o Women	216 (56.3)
3. Institution	
o CMOSHC	142 (37)
o BGC TMC	132 (34.4)
o SMC	110 (28.6)
4. Work experience (yrs)	
o 1-5	224 (58.3)
o 6-10	76 (19.8)
o 11-15	35 (9.1)
o 16-20	18 (4.7)
o 21-25	9 (2.3)
o >25	22 (5.7)
Total	
• 384	100%

The mean ± standard deviation (SD) score of knowledge and practice among physicians were 41.914±3.893 and 38.554±4.317 respectively. On the basis of Bloom’s scale >80% of Physicians had a good level of knowledge on Doctor Patient Communication Skill.

79.9%, 61.7% and 65.6% strongly agreed that physician must greet his patient while initiating a visit, physician must introduce himself to patient at baseline visit, physician should ask open ended non directive questions and encourage patient to tell the story of their problems at the start of the interview respectively. The knowledge of the physicians based on the 10 questions are capitulated in the Table 2.

Only 76% of the physicians executed a moderate level of practice on Doctor Patient Communication Skill.79.9% ,55.7%, 68% strongly agreed that they greeted their patient at first, introduced themselves to their patient at first meeting, asked open ended questions to their patients at the start of interview respectively. The Practice of the physicians based on the 10 questions are illustrated in the Table 3.

The mean score±SD of Knowledge towards Doctor- Patient communication skills of female physicians(42.12±4.18) was greater compared to the male (41.64±3.47) with a significant p-value (0.005) .

The mean score±SD of Practice towards Doctor- Patient communication skills of female physicians(38.72±4.319) was greater compared to the male (38.33±4.317) with a significant p-value (0.000).

Physicians with work experience of 6-10yrs and >25yrs expressed good level of knowledge with a mean score ± SD of 44.05 ± 3.76 and 43.27 ± 1.35 respectively and a significant p-value (0.000).

Physicians with work experience of 6-10yrs and 11-15yrs

expressed good level of Practice with mean score ± SD of 40.40 ± 4.27 and 38.68 ± 3.19 respectively and a significant p-value (0.000).

Table-2: The physician’s Knowledge towards doctor- patient communication

Knowledge questions	Strongly agree	Agree n (%)	Neutral n (%)	Disagree n (%)	Strongly disagree n (%)
When initiating a visit, physician must greet patient	307 (79.9)	72 (18.8)	4 (1)	0	1 (0.3)
Physician must introduce himself to patient during baseline visit	237 (61.7)	129 (33.6)	13 (3.4)	4 (1)	1 (0.3)
At the start of the interview, physician should ask open ended, non-directive questions and encourage patient to tell the story of their problems	252 (65.6)	113 (29.4)	17 (4.4)	2 (0.5)	0
Physician should actively listen and not interrupt patient before they could express their concern	242 (63)	119 (31)	22 (5.7)	1 (0.3)	0
Physician must maintain consistent eye contact with the patient	163 (42.4)	153 (39.8)	59 (15.4)	8 (2.1)	1 (0.3)
Physician must agree to patient’s request for unnecessary tests when patient do not convince by a rational argumentation	67 (17.4)	93 (24.2)	92 (24)	106 (27.6)	26 (6.8)
Physician can’t resolve patients emotional, familial and social problems so they should avoid such issues.	62 (16.1)	152 (39.6)	71 (18.5)	64 (16.7)	34 (9.1)
Physician should encourage patient to express their expectations, so that they could address their information needs.	126 (32.8)	129 (51.8)	49 (12.8)	6 (1.6)	4 (1)
Physician should empathize patient’s stress, sadness and problems	164 (40.7)	172 (44.8)	38 (9.9)	7 (1.8)	3 (0.8)
Physician should enable patient to participate in shared decision making	133 (34.6)	182 (47.4)	45 (11.7)	20 (5.2)	4 (1)

Table-3: Physicians Practice toward Doctor-patient relationship

Sl.	Practice questions	Always n(%)	Often n(%)	Occasionally n(%)	Seldom n(%)	Never n(%)
1.	When I meet a patient, I greet him first	307 (79.9)	62 (16.1)	12 (3.1)	1 (0.3)	2 (0.5)
2.	I introduce myself to patient at first meeting	214 (55.7)	123 (32)	34 (8.9)	5 (1.3)	5 (1.3)
3.	At the start of the interview, I prefer to ask open ended questions	261 (68)	97 (25.3)	15 (3.9)	5 (1.3)	6 (1.6)
4.	I interrupt a talkative patient who is wasting my time	99 (25.8)	128 (33.8)	84 (21.9)	23 (6)	46 (12)
5.	I maintain consistent eye contact with the patient	213 (55.5)	115 (29.9)	47 (12.2)	6 (1.6)	3 (0.8)
6.	When patient request for unnecessary tests, I discourage them.	157 (40.9)	144 (37.5)	63 (16.4)	12 (3.1)	8 (2.1)
7.	I don't deal with patient's emotional, familial and social problems.	78 (20.3)	76 (19.8)	110 (28.6)	28 (7.3)	92 (24)
8.	I am too busy and don't have time to offer a detailed explanation to patient about potential problems	29 (7.6)	35 (9.1)	61 (15.9)	13 (3.4)	299 (76.6)
9.	I react to patients intense feelings such as sadness and express my emotions	116 (30.6)	117 (31.3)	59 (15.4)	45 (11.7)	47 (12.2)
10.	I ask my patient to actively participate in shared decision making	192 (50)	120 (31.3)	46 (12)	13 (3.4)	13 (3.4)

The age of physicians ranging between 21-30 years were 213 (55.47%), 31-40 yrs were 106 (27.60%), 41-50 yrs were 37 (9.64%), 51-60 yrs were 20 (5.21%) and 61 yrs and above were 8 (2.08%). The age range of the physicians are shown in Figure 1 below.

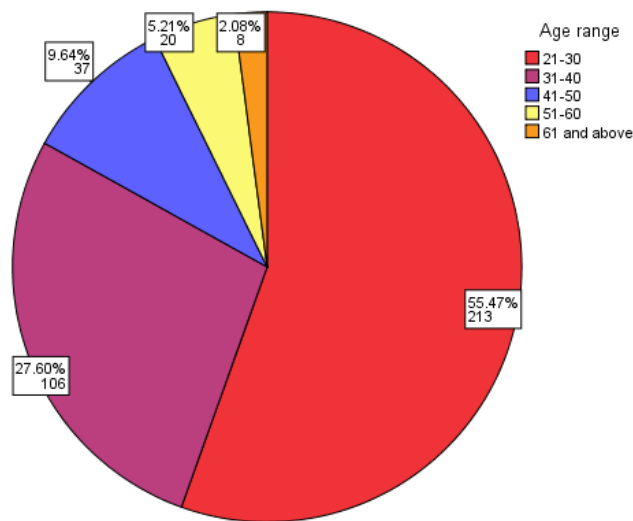


Figure 1: Age range of the physicians

Physicians with age ranging from 51 yrs and above had better knowledge mean score and with age ranging from 31-40 yrs accomplished better practice score towards Doctor Patient communication skills with a significance of (p=0.000) which are displayed in Table 4 .

Discussion

The number of female physicians were more and showed better knowledge and practice towards doctor patient communication skills compared to males in this research. In an Iranian study by Shiraly R et al, females showed better knowledge but males showed better practice²⁶.The knowledge and practice mean score±SD was more in physicians of BGC Trust Medical College compared to other Medical Colleges. Physicians with work experience of 6-10 yrs revealed higher knowledge and practice towards Doctor Patient communication skills.Physicians with age ≥51 yrs experienced better knowledge compared to ≤50 yrs.Physicians with age 31-40 yrs practiced good level of Communication skills compared to others. In a research in Riyadh, Saudi Arabia by Zahrani Al et al, age,years of experience and practicing skills had a close relation with

age of the physician²⁷.

Table-4: Mean of knowledge and practice of physician respective to gender, institution, years of work experience and age range

Variables	Knowledge			Practice		
	mean±SD	Chi square(χ^2)	P-value	mean±SD	Chi square(χ^2)	P-value
Gender						
❖ Male	41.64 ±3.47			38.33 ±4.31		
❖ Female	42.12 ±4.18	40.119	0.005	38.72 ±4.31	74.30	0.000
Institution						
❖ CMOSHMC	41.73 ±4.14			38.76 ±4.62		
❖ BGC TMC	42.08 ±3.81	87.36	0.000	39.06 ±4.26	115.27	0.000
❖ SMC	41.93 ±3.67			37.66 ±3.84		
Work experience (yrs)						
❖ 1-5	40.97 ±3.93			38.27 ±4.50		
❖ 6-10	44.05 ±3.76			40.40 ±4.27		
❖ 11-15	42.51 ±3.50			38.68 ±3.19		
❖ 16-20	41.77 ±2.34	246.98	0.000	37.05 ±3.52	225.98	0.000
❖ 21-25	41.88 ±4.28			38.44 ±4.50		
❖ >25	43.27 ±1.35			36.09 ±1.77		
Age range (years)						
❖ 21-30	41.42 ±3.70			38.61 ±4.58		
❖ 31-40	42.53 ±4.72			39.04 ±4.27		
❖ 41-50	41.78 ±3.03			38.05 ±3.33		
❖ 51-60	43.40 ±1.18	190.87	0.000	36.50 ±3.22	232.39	0.000
❖ 61 and above	43.62 ±2.38			37.87 ±2.53		

Question on knowledge regarding, greeting patient at initial visit, introducing to patient at baseline visit, asking open ended question to patient, actively listening to patient, maintaining consistent eye contact with patient, encouraging patient to express their expectation, empathizing their patient and shared decision making >80% agreed and strongly agreed which showed a good level of knowledge. In researches by Rahman A et al, Haidet P et al, Bordreau JD et al, Aomatsu M et al, physician must introduce himself to reduce patient’s anxiety, maintain persistent eye contact, actively listen to his patient, simplify his questions, empathize his patient and follow patients emotions²⁸⁻³¹.

In two questions regarding agreeing to patients request for unnecessary test and physician unable to resolve patients familial, social, emotional problems <60% agreed to strongly agreed which showed a poor level of knowledge. Kaul S et al, revealed in her study that family physicians and Internists prescribed brand name drugs more compared to paediatricians on request of patients. Lowe B et al, stated that psychotherapy could improve patients emotional well being³²⁻³³.

Question on practice regarding, greeting patient, introducing to patient, asking open ended question, maintaining consistent eye contact, shared decision making >80% of physicians showed a good level of practice. Makoul G et al found in his research that only 82.9% of physician and patient shook hands at the start of a visit. Khan FH et al of Pakistan mentioned that 86.1% of patient’s believed that establishing eye contact showed that the doctor was attentive. Mueller J et al stated, shared decision making helps in effective DPR³⁴⁻³⁶

Question on interrupting a talkative patient, discouraging

patient for unnecessary tests on patient's request, not dealing with patient's emotional social and familial problems, not offering detailed explanation to patient, expressing emotion to patient's feelings <60% strongly agreed to agreed showing poor level of practice. Girolid E et al, implied that managing a talkative patient by clarifying patient's expectation and attentively listening effects DPR. Caress AL et al, Ambuel B et al, emphasized on giving detailed explanation to patient , giving importance to patients feelings that promoted DPR³⁷⁻³⁹.

Conclusion

This study will help in developing better Knowledge and Practice towards Doctor Patient relationship which will prevent litigations against doctors in near future if adequate trainings are conducted in medical institutes on Communication Skills.

Limitation: This research was carried out in non-government medical colleges and hospitals of Chattogram but not in government medical College Hospitals and outside Chattogram District.

Conflict of Interest: The authors declare that there is no conflict of interest.

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Contributors:

HRB- Conception, study design, manuscript writing, final approval and drafting.

MA- Conception, study design, manuscript writing and final approval.

SK- Data acquisition.

TK- Data acquisition.

HB- Data acquisition.

AS- Data acquisition.

TB- Data Interpretation, Data Analysis, Manuscript writing

RH- Critical Revision, Final approval.

AB- Conception, Critical Revision, Final approval.

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