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Barriers to effective communication between family physicians and patients in Georgia

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A – Study Design, **B** – Data Collection, **C** – Statistical Analysis, **D** – Data Interpretation, **E** – Manuscript Preparation, **F** – Literature Search, **G** – Funds Collection

Summary **Background.** Effective doctor–patient communication is one of the most significant parts of medicine since it has a huge influence on the outcome of treatment, patient satisfaction and quality of health care.
Objectives. The purpose of the research was to identify the main barriers to effective communication between patients and family physicians.
Material and methods. Quantitative, cross-sectional studies were conducted. 230 patients and 36 family physicians participated in the study.
Results. The study showed that the main barriers to doctor–patient communication were limited time during consultation (35.2%), the extensive amount of information being delivered by the family physicians (31%), patients mispresenting their health problems (77.8%), insufficient meeting time (72.2%), inconsistent information being delivered by the patients (47.2%), patients complying with the treatment strategy (38.9%) and patients having difficulty in understanding the outcomes of the diagnosis (33.3%).
Conclusions. Active communication between family physicians and patients stimulates patients' motivation and self-confidence, which has a positive impact on their treatment. Patients would like to have doctors who can conduct effective communication, diagnose the disease correctly and treat it successfully. Family physicians must pay attention to patients' social and personal problems. Particular attention should be paid to effective communication with patients whose involvement in treatment is low. In this regard, it is necessary to undertake various measures to enhance communication between the family physician and the patient.
Key words: communication, family physicians, patient satisfaction.

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Background

Effective communication between doctors and patients is the main concept of patient-cantered medicine and an integral part of medical services [1–4]. Its goal is to set up a good interpersonal relationship between doctors and patients, facilitate the exchange of information comprehensively and involve patients in the decision-making process [5].

Good doctor–patient communication certainly indicates a trusting and caring relationship between doctors and patients, as it helps doctors to gather more information about patient's disease and understand their needs, problematic issues, perceptions and expectations [6, 7]. In accordance with the above-mentioned, doctors can make an accurate diagnosis, provide proper advice and treatment instructions [8], manage the disease effectively, strengthen patient's adherence to the recommended treatment [9] and therefore achieve the best treatment results [10–14]. Patient-cantered health care increases the quality of medical care [15–18] and a doctor's satisfaction [19–21].

Both the doctor and the nurse, as well as the medical organisation, are responsible for effective doctor–patient communication [22, 23]. Doctors should try to establish a good relationship with the patient, listen carefully to his/her health problems and do his/her best to address them [24]. Patients should participate in discussing the issues related to their health. They should be given adequate time and opportunity to fully convey information about their disease. The medical organisation is required to create an environment where patients feel that their personal information is protected. Only such mutual understanding between doctors and patients can result in the desired treatment [25].

The main barriers to effective communication between doctors and patients are difficulties in establishing relationships, language, culture, patients' anxiety, fears and unrealistic expectations, the workload of doctors and the physical setup of the medical organisation [26, 27]. Doctors often overestimate their communication skills with patients. Although many doctors consider their communication with patients to be adequate, patients still express dissatisfaction [28, 29].

Studies show that doctors sometimes avoid discussing the social and psychological factors of a patient's disease because it requires the appropriate time. As a result, patients have no desire to talk openly about their problems and to mention more information about the disease. Low awareness about the disease and less understanding between doctors and patients negatively affect treatment [30].

Many studies have been carried out on doctor–patient communication [31–33]. However, this issue is poorly studied in Georgia, and no significant studies have been conducted in this area. This suggests that additional research is needed to study communication problems between doctors and patients.

Objectives

The goal of the study was to recognise the key barriers to effective communication between family physicians and patients.

Material and methods

Quantitative, descriptive and cross-sectional studies were conducted. Patients and family physicians were selected as the

target population based on the aim of the study. 230 patients and 36 family physicians participated in the study. The study was conducted in outpatient medical institutions in Tbilisi from January 2021 to July 2021.

A non-probabilistic random sampling technique was used for the study. After consulting with the family physician, patients were asked to complete a questionnaire. Two types of questionnaires were used for the study, one for family physicians and one for patients.

The socio-demographic data of patients included age (in years), gender, level of education, number of visits by the patient to the doctor during the last year, the purpose of the last visit to the doctor, general health condition and satisfaction with the family physician.

The socio-demographic data of family physicians included age (in years), gender, work experience (years), training of communication skills with patients at a medical university, as well as during residency, job satisfaction and contentment with communication skills.

The frequency of patients coming across the barriers of communication was shown in categories (organisational factors, information transfer, personal characteristics and attitudes, linguistic and cultural factors) and subcategories. Patients had to rate each category on a scale from 1 to 5 points (from "rare" to "very common") according to the frequency. A similar rating scale was used in the family physicians' questionnaires from 1 to 5 points (1 point was the lowest, and 5 points were the highest).

The questionnaire was accompanied by instructions and a description that the survey was anonymous, where patients and doctors did not indicate personal data that would allow for determination of their identity (name, surname, personal number or other data).

The data collected during the study was analysed using version 23 of the IBM SPSS program.

The study was approved by the Ethics Committee of the Health Policy Institute (N 2020-32). The protocol was in accordance with the Declaration of Helsinki.

Results

There was a total of 230 patients participating in the research. Patients' socio-demographic and satisfaction data about the family physician is shown in Table 1. Most of the participants were female (*n* = 164; 71.3%). In terms of age, the majority were aged between 51–65 years (*n* = 93; 40.4%). The majority of respondents had higher education (*n* = 185; 80.4%).

According to 31.7% of the patients surveyed (*n* = 73), they had about 1 visit to a family physician within the last year, while 48.7% (*n* = 112) had at least 2–5 visits. The majority of patients surveyed stated ongoing follow up (*n* = 123; 53.4%) and the need for repeat prescriptions (*n* = 56; 24.3%) as frequent reasons for visiting the doctor.

Most patients evaluated their general health condition as normal (*n* = 141; 61.3%), and 20% of patients as unsatisfactory (*n* = 46). Most of the patients surveyed were satisfied with the services provided by the family physician (*n* = 217; 94.3%).

Table 1. Socio-demographic characteristics of patients and general satisfaction (*n* = 230)

Category	Subcategory	*n*	%
Age (in years)	18–30 31–50 51–65 > 65	39 71 93 27	16.9 30.9 40.4 11.7
Gender	female male	164 66	71.3 28.7
Education	higher secondary partial	185 45 0	80.4 19.6 0
Number of consultations within last year	0 1 2–5 > 5	20 73 112 25	8.7 31.7 48.7 10.9
Purpose of the last visit	new symptoms follow up repeat prescriptions other	32 123 56 19	13.9 53.4 24.3 8.3
Perceived general health status	very good normal poor	43 141 46	18.7 61.3 20
Satisfaction with the family physician	very satisfied average satisfaction not satisfied	85 132 13	36.9 57.4 5.6

Patients' perceived frequency of encounters with communication barriers is given in Table 2. As can be seen from the table, the range of frequency of encounters with barriers to communication is from 35.2% to 3.04%. Patients consider the biggest barrier to communication with the doctor is limited time during consultation (35.2%; *n* = 81). The next barrier is the large volume of information provided by the family doctor (31%; *n* = 72). Along with this, doctors do not check how well the patient understood the provided information (30.4%; *n* = 70). Further barriers were the lack of aid tools, such as educational brochures written in a popular language (29.6%; *n* = 68), the doctor's indifference to the patient's problems (26.1%; *n* = 60), the doctors do not consider all the issues raised by the patient (22.2%; *n* = 51), the doctor's inability to recognise the patient's problem (22.2%; *n* = 51), the doctor is not empathic (20%; *n* = 46), the doctors do not give a chance for the patient to talk and ask questions (17.4%; *n* = 40).

Though, at the same time, while evaluating patients' perceived frequency of encounters with communication barriers, the following create fewer problems: not having a physician of the same gender (11.3%; *n* = 26); the physician's preoccupation with computer/mobile (5.2%; *n* = 12), unsatisfactory manners of the physician (3.5%; *n* = 8), and less problematic were linguistic and cultural factors, physicians using medical jargon (4.3%; *n* = 10), frequent use of medical terminology by the physician when talking to the patient (2.2%; *n* = 5) and the issue of the physician's understanding of the patient's culture and beliefs (2.2%; *n* = 5) (15.8%).

The results of the study show that patients' education level and age are correlated with the number of visits to the family physician during the last year (Table 3).

Socio-demographic data of family physicians

A total of 36 family physicians were interviewed (100% response rate). Table 4 shows the socio-demographic data of the surveyed family physicians. The majority of family physicians participating in the study were between the ages of 41 and 50 years (55.6%; *n* = 20). The majority of family physicians were female (80.6%; *n* = 29). Only 7 male family physicians (19.5%) participated in the study. The work experience of the majority of family physicians surveyed was 6–10 years (58.3%; *n* = 21).

Most family physicians have undergone communication skills training at a medical university (94.4%; *n* = 34), as well as during residency (77.8%, *n* = 28), and only 16.7% (*n* = 6%) in the last 1 year. The majority of family physicians were averagely satisfied with the job (61.1%; *n* = 22), while there were a number of physicians who are more or less satisfied with communication skills (50%; *n* = 18).

Table 2. Patients' perceived frequency of encounters with barriers to communication (*n* = 230)

Domain	Subdomain	Barriers to communication	Frequency of encounter			
			Frequently/ always		Once in a while/ never	
			n	%	*n*	%
Administrative aspects	time restriction	having restricted time during the consultation	81	35.2	149	64.8
	physician's gender	does not have a doctor of the same gender	26	11.3	204	88.7
	health record use	the doctor is busy with computer/mobile	12	5.2	218	94.8
Communication of information	lack of communication attributes	the doctor provides a large amount of information	72	31.3	158	68.7
		the doctor is not checking the patient's understanding	70	30.4	160	69.5
		the physician is talking too fast	28	12.2	202	87.8
		the physician is not giving the patient a chance to talk/ ask questions	40	17.4	190	82.6
	lack of shared management	lack of information brochures	68	29.6	162	70.4
		the physician is pressurising the patient into making quick decisions	7	3.04	221	96.08
	lack of shared understanding of medical history	not all problems raised by the patient are discussed by the doctor	51	22.2	179	77.8
		the inability of the physician to understand the patient's problem	42	18.3	188	81.7
Personal characteristics and attitudes	failure of rapport building	the doctor is less interested in the patient's issues	60	26.1	170	73.9
		the doctor has less empathy	46	20	184	80
		the doctor has bad manners	8	3.5	222	96.5
Linguistic and cultural factors	medical jargon use	the doctor is using medical jargon	10	4.3	220	95.7
	difficulty with language use	difficulty understanding the doctor's language	5	2.2	225	97.8
	lack of cultural competency	the doctor does not understand the culture of the patient	5	2.2	225	97.8

Table 3. Relationship between patients' education level, age and the number of visits to the family physician within the last year

Number of visits within the last year			Education level		Total
			higher	secondary	
1	Age	18–30	9	0	9
		31–50	20	1	21
		51–65	24	5	29
		≥ 66	13	1	14
	Total		66	7	73
2–5	Age	18–30	21	2	23
		31–50	33	5	38
		51–65	31	16	47
		≥ 66	1	3	4
	Total		86	26	112
> 5	Age	18–30	3	1	4
		31–50	7	1	8
		51–65	8	3	11
		≥ 66	1	1	2
	Total		19	6	25
0	Age	18–30	2	1	3
		31–50	2	2	4
		51–65	4	2	6
		≥ 66	6	1	7
	Total		14	45	59
Total	Age	18–30	35	4	39
		31–50	62	9	71
		51–65	71	22	93
		≥ 66	21	6	27
	Total		185	45	230

Table 4. Family physicians' socio-demographic characteristics and satisfaction data (*n* = 36)

Category	Subcategory	Count	%
Age (in years)	30–40 41–50 ≥ 51	12 20 4	33.3 55.6 11.1
Gender	female male	29 7	80.5 19.5
Work experience (in years)	3–5 6–10 ≥ 11	10 21 5	27.8 58.3 13.9
Communication skills training	medical university yes no	 34 2	 94.4 5.6
	during residency yes no	7 28 8	7 7.8 22.2
	within last year yes no	1 6 30	1 6.7 83.3
Job satisfaction	very satisfied average satisfaction not satisfied	10 22 4	27.8 61.1 11.1
Communication skills satisfaction	very satisfied more or less satisfied not satisfied	24 12 0	67 33 0

The Table 5 shows that the range of frequency of encaunters with bariers to communication is from 33.1% to 9.5%. It shows that the range of frequency of encounters with barriers to communication is from 33.1% to 9.5%. Family physicians consider that the largest barrier to communication is multiple problems represented by the patients during consultation (77.8%). Further barriers were limited time during consultation (72.2%), inconsistent information delivered by the patients (47.2%), patient's failure to follow the treatment plan (38.9%) and patient's difficulty in understanding the diagnosis (33.3%).

Table 5. Physicians' perceived frequency of encounters with barriers to communication (*n* = 36)

Category	Barriers to communication	Level of risk			
		High		Low	
		n	%	*n*	%
Time restriction	having restricted time during consultation	26	72.2	10	27.8
Medical record use	preoccupation with medical records	11	30.5	25	69.5
Physical setup	the unsuitability of the physical setup	9	25	27	75
Lack of shared understanding of history	presentation with multiple problems	28	77.8	8	22.2
	disorganised history by patient	17	47.2	19	52.7
Lack of shared management	patient not following through with treatment plan	14	38.9	22	61.1
	patient's lack of interest in self-care	5	13.9	31	86.1
	inconsistent information provided by the patient	13	36.1	23	63.9
	patient not buying into the treatment plan	5	13.9	31	86.1
Lack of shared understanding of diagnosis	patient's difficulty understanding the implications of diagnosis	12	33.3	24	66.7
	difficulty reconciling patient self-diagnosis with physician's diagnosis	6	16.7	30	83.3
	difficulty getting patients to understand the diagnosis	11	30.6	25	69.4
Failure of rapport building	patient's lack of interest in building a relationship with the physician	4	11.1	32	88.9
	patient's lack of trust in the physician	3	8.3	33	91.7
	difficulty establishing rapport	7	19.4	29	80.6

The results of the study show that the age of family physicians is correlated with the work experience of family physicians (Table 6).

Table 6. The age of the family physician * Work experience

			Work experience			Total
			3–5	6–10	≥ 11	
The age of family physicians	30–40		4	7	1	12
		the age of family physicians	33.3%	58.3%	8.3%	100.0%
	41–50		4	12	4	20
		the age of family physicians	20.0%	60.0%	20.0%	100.0%
	≥ 51		2	2	0	4
		the age of family physicians	50.0%	50.0%	0.0%	100.0%
Total			10	21	5	36
		the age of family physicians	27.8%	58.3%	13.9%	100.0%

Discussion

The study aimed to identify some risk factors which can affect appropriate doctor–patient communication. First of all, the most important factor turned out to be the limited consultation time, both from the perspective of physicians and the patients. The above-mentioned correlates to many studies around the world and emphasises the importance of time management and the impact of time limitations on medical consultation [34, 35].

Physicians noted the problem of patients misrepresenting their health history and anamnesis, as well as the less involvement of patients in the treatment process. Patients are often less likely to follow a doctor's prescription and treatment plan. On the other hand, in terms of patients, family physicians provide them with a large amount of information and do not try to check how well it is understood by them (30.4%), or doctors often use medical terminology that is not understood by all patients (2.2%). Sometimes the doctor does not respond (22.2%) and does not show interest (26.1%) in all the problems raised by the patient. Patients are more likely to trust those physicians who try to express emotional support to them, listen carefully, spend more time discussing their disease and explain the diagnosis and treatment of the disease in detail. Similar results have been obtained in other studies [36, 37].

Effective communication between physicians and patients involves productive dialogue and mutual understanding of the views of both sides. To ensure the best results of medical care, exchanging information and mutual understanding are required. Sometimes doctors try to make treatment-diagnostic decisions based on quick assessments, which may turn out to be incorrect. In this regard, physicians should spend more time on discussing possible treatment options with patients and sharing the responsibilities with them. Joint communication between physicians and patients, as well as the successful exchange of information, will ensure better identification and evaluation of a specific disease. Discussing treatment options will help patients to understand them better, to make the desired choice and to jointly implement the decision-making process. Similar results have been obtained in other studies [38–41].

In such an approach, physicians facilitate a discussion with patients, and treatment options are tailored to the patient's conditions and needs rather than to standardised protocols. The treatment agreed upon between the physician and patient is mostly about patient expectations, possible risks and possible costs. According to doctors, an important barrier to communication is the obligation to fill out medical records, which reduces the already limited time required for consultation and hinders communication with patients. Similar results have been obtained in other studies [42–44].

Research has shown that communication barriers in Georgia are least related to language and culture. The majority of patients surveyed were female (68.3%), which is explained by the fact that women are more attentive to their health. Although women should have a doctor of the same gender, no significant difference was found in terms of satisfaction with a doctor based on gender. Female patients were also more dissatisfied with the time-limited consultation factor, which is explained by the fact that women are likely to pose more questions to the physician and participate in discussions with doctors better.

It should be noted that no family physician was dissatisfied with their communication skills; moreover, the number of family physicians who are completely satisfied with their communication skills was much higher (67%; n = 24) than the number of family physicians who were averagely satisfied (33%; n = 12) with their communication skills, which confirms the high rate of doctors overestimating their abilities.

Through training, doctors can understand the theory of good communication with the patient, learn and apply these skills in practice and change their communication style. The study of communication skills improves the relationship between physicians and patients; however, their continuous development is essential [45, 46].

Conclusions

Patient encouragement, motivation, persuasion and support can only be achieved through effective doctor-patient communication. A trustworthy connection between the physician and patient extends job satisfaction, enhances patients' self-confidence and motivation and positively changes patients' attitudes towards their health status, which also has a great impact on their treatment.

Both physicians and patients do not consider linguistic or cultural factors to be particularly important barriers to communication. Most of the complaints made by patients were about physicians' communication issues and not about their medical competencies. Patients would like to have doctors who can conduct effective communication, diagnose the disease correctly and treat it successfully.

Physicians who have good communication and interactive skills can early detection of the diseases, avoid expensive interventions as a result of complications and provide better support for patients.

Limited time for consultation with the family physician was named as the main problem of communication. Both the patients and the physicians thought that having an accurate description of a patient's illness is especially important. Family physicians must pay attention to patients' social and personal problems. Particular attention should be paid to effective communication with patients whose involvement in treatment is low.

Additional research is needed to address the problem of limited time for consultation with a family physician, and further development of electronic medical records is needed. In this regard, it is necessary to undertake various measures to enhance communication between the family physician and the patient.

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