# Doctor-Patient Interaction: Standardized Patients' Reflections from Inside the Rheumatological Office

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***ABSTRACT.*** ***Objective.*** To assess appreciation and quality of doctor-patient interaction by exploring standardized patients' (SP) opinions on aspects of the interaction between doctors and standardized patients.

***Methods.*** A focus group interview was organized with SP who had completed 254 incognito visits to 26 Dutch rheumatologists in a study assessing rheumatologists' daily practice performance; 13 of 16 SP attended the interview. Patients discussed aspects of interaction with the physicians. The interview was audiotaped and transcribed literally. Recurring themes were identified.

***Results.*** Participants were on the whole very satisfied with the rheumatological care received. Factors contributing to satisfaction included "being approached as a person," "being treated respectfully," and "being given enough room to mention all complaints." On the other hand, SP were struck by the variation in performance among the rheumatologists.

***Conclusion.*** Physicians may not be aware of the influence of their behavior on patients. Most critical comments from patients regarding communication and behavior were on small things, which should not be too difficult to change in daily practice. (J Rheumatol 2002;29:1496–500)

*Key Indexing Terms:*

STANDARDIZED PATIENTS | RHEUMATOLOGY | HUMAN INTERACTION
FOCUS GROUP INTERVIEW | QUALITY OF CARE | APPRECIATION

Quality in doctor-patient interaction is important and has great influence on patient satisfaction[1]. Among primary care physicians it has been shown that those without malpractice claims have better communication skills than physicians with claims. Those without claims laughed and used more humor, thereby encouraging patients to talk more and to express feelings and opinions[2]. Effective communication between physicians and patients, both verbal and nonverbal, enhances patient satisfaction[3,4]. Other factors such as hospital accessibility and waiting-room situations contribute to this as well[5]. It is important to know which specific skills and attitudes contribute to patient satisfaction, because it has been shown that patient satisfaction can improve patient outcomes[6-9].

It has been shown that patients are more satisfied if doctors pay attention to psychosocial issues and are not dominant in the conversation[10]. Focus group interviews with real patients revealed that patients want to be respected and treated as individuals[11].

Studies focussing on patient satisfaction usually deal with patients and their own primary care physicians. However, it is known that it is difficult for patients to evaluate their physicians since patients are emotionally involved in the consultation. Moreover, they are to a certain extent dependent on their doctors' actions. The use of patient reports is considered inadequate for assessing the quality of physicians[12].

To overcome these problems, standardized patients (SP) can be used. SP are real patients or healthy persons trained to accurately play a role in a consistent way[13]. They objectively evaluate physicians' skills, are not emotionally involved, and since they see different physicians in a standardized role, are able to compare physicians' communication skills and behavior.

Recently, in a large study we assessed rheumatologists' daily practice performance by sending 16 incognito SP presenting 8 different rheumatological conditions to 26 rheumatologists' outpatient wards[14]. SP stayed incognito for the duration of the study. In total, 254 incognito visits took

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place, 201 first visits and 53 followup visits. The study focused on the medical content of the visits, with SP completing case-specific checklists[15]. As before[16], we noticed that the SP also wanted to share with us nonmedical aspects of the interaction with the rheumatologists. Thus we decided to address a number of questions more systematically by organizing a focus group interview. These questions are: (1) What makes SP like or dislike a rheumatologist; (2) Is there any influence of situations in the waiting room or the doctor's office on an SP evaluation of the physician; and (3) does the experience of being a SP influence their opinion of physicians?

## MATERIALS AND METHODS

*Participants*. Near completion of the project, all 16 SP were invited by letter to participate in the focus group interview. Three were unable to attend the interview. The remaining 13 had a mean age of 55 years (range 45–73), 6 were male, 9 had previous experience as SP in undergraduate medical curricula, and 3 SP were real patients (with no prior experience as SP). Two SP had participated as incognito SP in a previous study assessing general practitioners' performance[17].

The SP each presented one of the following 8 rheumatological conditions: ankylosing spondylitis (AS), fibromyalgia (FM), hemochromatosis, arthropathy, lateral epicondylitis, osteoporotic vertebral fracture, polymyalgia rheumatica (PMR), psoriatic arthritis (PsA), and rheumatoid arthritis (RA).

*Focus group interview*. A focus group interview is a popular method for assessing and exploring opinions and perceptions[18]. It is a group interview with a moderator encouraging people to talk with each other. The moderator does not ask each person to answer questions, but stimulates the group to comment on each other's experiences and points of view and to exchange anecdotes. In this way, experiences and perceptions that are difficult to capture in one-to-one interviews or quantitative research methods can be explored. The strength of the focus group interview lies in its ability to observe the interaction (verbal and nonverbal) between participants. On the other hand, the researcher has less control over the issues and the discussion can surprisingly deal with other subjects than expected[18].

*Procedure*. Thirteen SP participated in the 3 hour session, which was moderated by one of the researchers (AS). Three other researchers (SG, JJR, JB) took notes and interrupted whenever the discussion became irrelevant. The discussion started with the 3 initial questions. During the course of the interview, the group spontaneously raised additional issues concerning their experiences as SP.

*Data analysis*. The interview was recorded on audiotape and transcribed literally. The transcript was first compressed by 2 researchers individually (SG and JB) by deleting all superfluous and noncontributing remarks. Each of them identified recurring themes. A summary was sent to a third reviewer (AS) and all 13 participating SP. They all agreed with the content and accuracy of the summary report.

## RESULTS

In addition to the 3 research questions, SP spontaneously raised the following topics: the variation in performance between rheumatologists, the difference in physician behavior between first visit and next followup visit, and the perceived effect on the consultation of the general practitioner's referral letter. The different themes will be reported consecutively and illustrated by quotations of the participants. We present those quotations that we valued as common and striking. Since opinions and experiences were not always shared by most SP, individual but striking quotations will also be presented.

### What makes SP like or dislike a rheumatologist?

In general, SP liked the rheumatologists. Sometimes they were even surprised by their friendly way of approaching them, their patience and capability to listen to their stories. The reasons why SP liked a rheumatologist are often for seemingly small things, such as going in person to the patient in the waiting room instead of calling them in from the office, or asking about the situation at home. Typical remarks included: "It is how they treat you, how much time they have for you, how they explain things to you or show that they really understand your complaints... For the first time in my life I thought, this man has probably been working hard since 7:30 this morning and I am his umpteenth patient today and even so he is joking or being very kind. I was really very impressed" (female SP simulating FM).

"It was little things that made me feel they really had time for me. I remember a doctor who seemed to be just going through the routine, but when she noticed something that I had written on my hand, she said: 'Do you also write things on your hand, I used to do that.' This kind of remark shows that she really did see me, not just another case. And suddenly I liked her very much" (female SP simulating AS).

On the other hand, some events may make a physician suddenly appear unsympathetic. One of the SP recalled the following experience: "During the interview I thought he was very nice and then he was going to examine me and everything changed, I had to undress in a tiny cubicle with a curtain that did not close properly and then he received a phone call and he was asking endless questions of a colleague about conferences and research grants and all sorts of things...then he started to examine me and I was standing there barefoot on the cold floor, and he had another phone call, another colleague, and again about money. It wasn't a short conversation either...and there I was, turned towards him. I felt dreadfully uncomfortable, and I thought what shall I do, go and sit in the cubicle, remain standing here...I have rarely felt so uncomfortable" (female patient simulating AS).

Showing respect is considered very important. The SP interpret a serious approach by the rheumatologist as a sign of respect. This encourages the SP to tell their story. However, it was sometimes difficult to judge the interaction, for example when the SP noticed that the physician missed a lot of important information during the encounter (because he or she did not perform a full physical examination), but appreciated that the rheumatologist was very friendly. One remark regarding respectfulness: "A person may explain things very clearly, but when they show no respect I find it very difficult to listen. Yes, as a patient my ears are closed.

So to me respect is far more important than clarity" (female SP simulating AS).

The influence of situations in the waiting room or the physician's office

Sometimes situations in a waiting room or physician's office influenced SP's opinion on a rheumatologist. Other SP experienced unpleasant situations, but these did not affect their evaluation of the rheumatologist. Some experiences: "I sat in the same waiting room twice where nearby girls were typing and faxing and these girls were having fun! They walked in and out of the room and laughed themselves silly. That is all very nice, of course, but when you are sitting in this waiting room as a real patient and in a lot of pain you don't want to be there" (male SP simulating hemochromatosis).

"I was in one waiting room which was totally cheerless. It was far too crowded and people had to wait for an hour and a half and the doctor was upset because there were so many patients...I don't like that at all" (male SP simulating hemochromatosis).

"What the doctor will be like or what the hospital will be like, I already know as soon as I have talked to the receptionist on the telephone. It may change because of the doctor, but often it is already fixed what I will think of him or her" (female SP simulating AS).

"In one hospital the outpatient rheumatology ward was a long way away, it takes forever to walk there and I just think it is stupid" (female patient with RA).

"I was on the examination table when the secretary came in to put something on the table. And she gave me this look like, oh, yes, there's someone on the examination table. It is very embarrassing when you are lying there in front of someone who has nothing to do with it" (female SP simulating AS).

Does the experience of being a SP influence SP's opinion of physicians?

SP each had sometimes special reasons for participating in the project. One of the SP who wanted to overcome her fear of going to a specialist commented, "It really did help me!"

One of the real patients found that her own rheumatologist, who was aware of the project, now treats her differently and she appreciates this very much: "He says, you're an expert now...He makes special efforts for me, for instance, he ordered a new drug for me..." (female patient with RA).

One patient expressed the opinion of most of the SP as follows: "I have a lot of respect now for their efforts and their attitude towards their patients" (female SP simulating FM).

Additional topics

*Variation in performance between rheumatologists*. The SP in our project had the unique opportunity to compare rheumatologists' performance, since the SP each played their standardized role about 13 times for as many different rheumatologists. The SP spontaneously mentioned the variations between rheumatologists and were surprised by it. A real patient would not notice this, since most of the time patients consult only one physician for a particular problem. Three striking remarks regarding this theme:

"What really fascinates me is that you see one doctor on Wednesday afternoon, for instance, and then the next one on Thursday morning and they come up with totally different things...What these people discover on the physical examination, it is unbelievable. If they use this when they decide on the treatment..." (female SP simulating FM).

"I was given totally different results ranging from, 'Well, this is a textbook story [of AS], but it doesn't fit the x-ray,' to 'Yes, well the x-ray is clear [sacroiliitis], but the story doesn't fit,' while I had told them exactly the same story" (female patient simulating AS).

The variation in performance among rheumatologists affected opinions on the medical profession. This is expressed by one of the SP: "There were lots of different treatments and one rheumatologist even said — and to be honest I agree with him — 'there are 24 different treatments for you'...so medical science as such, I have lost some of my respect for it" (male SP simulating lateral epicondylitis).

Differences in physicians' behavior during first visit and followup visit

The SP were instructed to present specific complaints at the first visit and to present other complaints only when the physician asked about them or encouraged them to tell more. The SP noticed that many rheumatologists approached them differently at the first visit compared to the followup visit. During the first vist, much more time was spent on the patient's history, whereas in the followup visit SP were given fewer possibilities to present complaints. There was hardly any room for the patient to talk about complaints that he or she had forgotten to tell or did not have the opportunity to tell during the first visit. This problem was shared by many of the SP participating in the focus group interview. "If you didn't tell the doctor all your complaints on the first visit, it's too late, the verdict has been reached...I really think that patients should be told how important it is that you present all your complaints during the first visit, even though they may feel that it is all too much and that they had better tell things in small doses" (female SP simulating FM).

Sometimes SP got the impression that at the followup visit the rheumatologist had forgotten who they were. SP really appreciated if rheumatologists recognized them or showed that they were well prepared for the visit. "It makes me trust a doctor when he makes you feel that he has really looked at your x-rays and your record, that he has given it some serious attention" (female patient with RA).

One SP had the following positive experience at followup: "In my eyes he was the perfect doctor, on the followup visit he told me what he had written down about me the first visit and he checked everything and I could tell some more right away. This is very polite and it doesn't even take that much longer..." (female SP simulating FM).

Perceived effects of the general practitioner's referral letter on the consultation

All SP knew the content of the referral letter they brought with them to the rheumatologist. Many of them noticed that the referral letter often guided the consultation. The rheumatologist focused on the complaints mentioned in the letter and did not give the SP room to spontaneously come up with other complaints. SP were concerned that a rheumatologist may miss the correct diagnosis when a patient is unable to relate complaints with each other and the general practitioner failed to mention one of these complaints in the referral letter. "About the referral letter: It is just what the GP indicates and not a guideline..." (female SP simulating FM).

"I think it is partly negative, the letter causes prejudice and then the specialist focuses on the one item stated in the letter. He or she could have found out much more if only they had looked more carefully and asked more questions" (male patient with PsA).

Another patient, presenting a typical case of polymyalgia rheumatica, did not experience this in a negative way. He said: "Almost all specialists took note of the letter and then asked me to tell my story".

## DISCUSSION

This study expresses opinions of 13 SP on some aspects of the human interaction between physicians and SP by means of a focus group interview in a large project assessing performance of rheumatologists[19]. The SP were very enthusiastic about the rheumatologists. They found them very friendly and in their opinion most rheumatologists took enough time to listen to their stories. Approaching them as a person was very much appreciated by the SP. It was not what they said, but the way in which they said something that made the SP like or dislike the rheumatologist. Treating the patients respectfully and giving them enough room to mention all complaints were some factors that contributed to satisfied patients. Many SP had noticed that during the next followup visit it was often very difficult to express feelings or present other complaints. They were disappointed when this happened to them. For some patients contextual factors such as hospital convenience and accessibility or waiting room situations really made them have a different approach to the rheumatologist. The SP were struck by the variation in performance among the rheumatologists. Several of these issues will now be discussed in more detail.

Our SPs' concerns regarding the possibility to express all their complaints confirm an earlier study, which showed that physicians frequently miss important information that often influenced the development of diagnostic hypotheses[20].

Almost all SP had some negative experiences regarding accessibility or crowded waiting rooms, etc. This is in agreement with the study of Stern and MacRea, who organized focus groups with real patients visiting emergency rooms or ambulatory clinics[5]. Patients who visited the ambulatory clinics also mentioned related factors as important, such as nearby parking areas and enough privacy in physician's office and examination room.

It might be important for physicians to know how they are being evaluated by patients. They should realize the influence of their behavior on their patients. Small things can have a great influence on a patient's opinion about his or her physician. Paying attention to patients' opinions will enhance mutual understanding. Patients can give valuable information ranging from hospital accessibility to very detailed information on the physician's behavior. Patients' experiences can be used to improve the delivery of care.

We used incognito SP to evaluate aspects of interaction with the rheumatologists. SP are unique in their opportunity to compare different physicians. They are not emotionally involved with the physicians and not dependent on physicians' actions. On the other hand, it is possible that appreciation of a physician by someone with a real health problem might be different from appreciation by an incognito SP simulating a disease. In the only study that compared patient satisfaction rates with satisfaction rates by incognito SP, a moderate correlation (0.51) was found[21]. We think that SP do give valid information on these aspects of human interaction and that this information is comparable and additional to real patients'opinions.

Until recently, little attention has been paid to communication skills training during undergraduate and postgraduate training. Continuing medical education (CME) activities should not only address technical aspects of medicine, but should address aspects of human interaction between patient and physician as well. This can make physicians aware of the importance of good communication and interaction with their patients[22]. In addition, daily practice should preferably involve patients' opinions on different aspects of care, since this is the way in which doctors are evaluated by their patients. Doctors can learn from patients' feedback. Especially since it has been shown that satisfaction influences patient outcomes in a positive way, it is worthwile to invest in this kind of feedback[6-9].

While examining real patients' opinions about their own physician, patients' privacy should be guaranteed. Therefore, surveys are preferred and feedback should take place tailored to the individual rheumatologist. SP visits could take place at the same time. After each consultation, SP should unmask themselves and give feedback or the researcher should do this, also immediately after a consulta-

tion. This would add value to feedback by surveys and physicians would have the opportunity to respond immediately.

In our study many comments of patients on communication and behavior are related to small things, which should not be so difficult to change.


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