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ORIGINAL ARTICLE

EVALUATION OF COMMUNICATION AND ACCEPTANCE OF THE PATIENTS BY MEDICAL PERSONNEL

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ABSTRACT

Background. The low level of patient satisfaction recorded in many studies and, at the same time, the level of frustration and burnout, disclosed by medics in the perception of the patient as a 'problem', incline to look for the causes of inadequate relationship between physician and patient.

Objective. The aim of this study was to evaluate the level of acceptance of the patient by the medical personnel. The research problem was the acceptance level which was within the range of the communication skills of the nurses and doctors. Another aim was to discover the factors determining this level of acceptance.

Material and Methods. Two methods were used in the research process: 1) a diagnostic survey regarding the medical, professional communication skills; 2) testing of professional self-esteem from the medical aspect. The study population consisted of a total of 1,244 respondents divided into the following groups: registered nurses and doctors (729), students of nursing and medical faculties (515).

Results. The results of the research showed that in most cases the acceptance of the patient by the medical staff was 'conditional', which translated into the level of frustration or lack of satisfaction with their profession, and ultimately into the level of burnout. The level of patient acceptance by medical staff (unconditional acceptance), depended primarily on age, followed by their profession. However, the relationship between this acceptance and gender and work experience was statistically insignificant.

Conclusions. As the method to improve this situation, the expansion of education in the field of interpersonal communication is proposed, adding issues related with both the conditional and unconditional acceptance of the patient, as well as issues regarding how to deal with the patient from the aspect of disease and the psycho-socio-spiritual area.

Key words: *patient satisfaction, communication, personal satisfaction, frustration, medical staff*

STRESZCZENIE

Wprowadzenie. Niski poziom satysfakcji pacjenta odnotowany w wielu badaniach naukowych, jak również frustracja oraz wypalenie zawodowe wśród personelu medycznego skłania do poszukiwania przyczyn tych problemów w nieprawidłowej relacji pomiędzy pacjentem a lekarzem.

Cel. Celem badań była ocena poziomu akceptacji pacjenta przez personel medyczny. Badaniem objęto poziom akceptacji, który mieścił się w zakresie umiejętności komunikacyjnych pielęgniarek i lekarzy. Celem wtórnym było odkrycie czynników determinujących ten poziom akceptacji.

Materiał i metoda. W procesie badań naukowych zostały wykorzystane dwie metody: 1) badanie diagnostyczne dotyczące medycznych, zawodowych umiejętności komunikacyjnych; 2) badanie samooceny zawodowej z punktu widzenia medycznego. Badana populacja składała się z 1244 respondentów podzielonych na grupy: pielęgniarki i lekarze (729), studenci pielęgniarstwa oraz nauk o zdrowiu (515).

Wyniki. Wyniki badań wykazały, że w większości przypadków akceptacja pacjenta przez personel medyczny jest „warunkowa", co przełożyło się na poziom frustracji i brak satysfakcji z wykonywanego zawodu, a ostatecznie na poziom wypalenia zawodowego. Natomiast bezwarunkowa akceptacja pacjenta przez personel medyczny zależała przede wszystkim od wieku, a następnie zawodu pacjenta. Związek między akceptacją a płcią i doświadczeniem zawodowym był statystycznie nieistotny.

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Wnioski. W celu poprawy relacji interpersonalnych na linii pacjent – personel medyczny w zakresie edukacji z komunikacji interpersonalnej proponuje się dodanie do edukacji zawodowej zagadnień związanych zarówno z warunkową jak i bezwarunkowa akceptacją chorego, jak również zmianę dotyczącą sposobu postępowania z pacjentem począwszy od aspektu chorobowego aż do obszaru psycho-społeczno-duchowego.

Słowa kluczowe*: satysfakcja pacjenta, komunikacja, satysfakcja osobista, frustracja, personel medyczny*

INTRODUCTION

Categorization of patients into good and bad, popular and unpopular, or desirable and undesirable used by medical professionals has been present in research in the field of ethics, sociology, and medical psychology since the 50s of the last century [11, 21, 22]. The starting point for research in this area was the phenomenon of the disease (its seriousness), individual behaviours of patients, or their social origin [2, 5, 19].

According to this scheme, a 'good' patient is one who has fairly simple health problems and behaves very peaceful in the physician-patient relationship. A 'bad' or 'problem' patient, firstly shows emotions (complains, grumbles), secondly presents dependence on medical staff (asks for painkillers, does not agree to all treatments), and thirdly, and often most importantly, the health condition of the patient is relatively serious. However, no matter how seriously ill the patient is, in the case of the patient described as being a 'problem', the medical staff regard the patient's behaviour as unjustified ('you should not feel such pain', 'it does not hurt that much', 'do not be afraid', 'please do not get upset', etc.) [18, 23, 31]

The phenomenon of dividing patients by the medical personnel into good or bad, was also considered from the aspect of the personality traits of individual medical professionals, as well as the social interaction between patients and medical professionals (doctors/nurses / physiotherapists, etc.) [14].

Based on interviews conducted with medical staff and patients, physicians emphasized that the 'problem' patients divest them of the sense of the effectiveness of treatment and care, and in physicians' opinions the need for information and involvement of the patient in the treatment process undermines their competences. 'Good' patients thought that when in contact with the medical staff, they should show a passive attitude and acceptance. 'Problem' patients demanded full knowledge concerning their health status, medical interventions undertaken, and demanded cooperation with the medical staff in the treatment process [25, 26].

Considering previous research experiences, in the presented article individual attitudes of medical personnel have been assessed, as well as the social interaction between patients and the staff based on interpersonal communication [34, 35, 36].

Such a categorization of patients by medical personnel is associated with the psychological mechanism of conditional or unconditional acceptance. This conditional acceptance is related with the assessment of others. In such a relationship with another person we feel either accepted, or we realize that the given person - without any words, and very often unconsciously, poses conditions or requirements, which means limiting or denying unconditional acceptance. In each one of us, there is a subjective need for making assessments as character landmarks in our social life. The assessment is mostly comparison with an ideal standard, which is not universally achievable. Unfortunately, an acceptance is often considered as the lack of assessment or false assessment of the state of affairs (e.g. the patient, as such).

Conditional acceptance in the physician-patient relationship, leads to the situation when medical personnel imposes conditions on the patient ('accept the patient if ...' is clean, pleasant, complies with orders, etc.), and in contact with the patient, initially checks whether these conditions are met, and secondly: heals, nurtures, rescues and rehabilitates. Emotional help on both sides of the physician-patient relationship would be the unconditional acceptance of the patient (which does not mean a non-assertive attitude of the medical staff).

In practice, to accept others, means to let them be as they are, with everything that composes their physical and mental traits, this applies to not only to mood - serenity, but also, for example, to sombre discouragement or mistrust. Such unconditional acceptance may be developed only based on good communication with the patient. There are many ways of showing acceptance, primarily by devoting some time to the patient, during which respect can be shown by gesture and word. The simplest sign of respect is to listen carefully to what the patient is saying. An important element of acceptance is emphasizing personal freedom, respect for this freedom (patient's right to decide about health and even life), focusing attention on the patient and on things that he/she experiences (taking into account the fears before surgeries, procedures, or effects of the disease), as well as refraining from expressing assessments of the patient's emotions - each experienced and manifested emotion is appropriate for the patient [24].

The authors of the presented study examined the extent to which medical staff (nurses, doctors and students) accept a patient conditionally and unconditionally.

The rationale for selecting the research problem were the results of studies investigating patient satisfaction with medical services, which show that the cause for negative assessment are, among others, inadequate communication skills of medical personnel.

The aim of this study was to evaluate the level of acceptance of the patient by the medical personnel (a test of the state). The research problem was the acceptance level which was within the range of the communication skills of the nurses and doctors. The aim of the study was also to discover the factors determining this level of acceptance, such as gender, age, occupation, education.

MATERIAL AND METHODS

Research problems:

1) What is the level of patient's acceptance by medical personnel? - lack of acceptance, conditional acceptance, unconditional acceptance.
2) Does the level of acceptance depend on the age, gender, work seniority (professional experience) and medical professions (nurses vs. physicians)?

Research hypotheses:

1) Acceptance of the patient by medical personnel is often located at the level of conditional acceptance.
2) The level of acceptance of the patient by medical staff (unconditional acceptance), depends primarily on age and seniority, and less on gender or type of employment within the health professions.

The diagnostic survey regarding medical, professional communication skills was applied in the research process, and the questionnaire designed by the authors was used as a research instrument. As part of the standardization of the research instruments, the condition of objectivity was fulfilled by ensuring the independence of the studied respondents. All respondents expressed their written consent to participate in the study. The conditions for conducting the study were standardized for all groups examined, and the questionnaire contained precise and clear instructions. The reliability and validity of the instruments were verified by pilot studies, evaluated by competent judges test, *Kendall's* coefficient of concordance for assessing agreement among rates, 'test – retest' examining stability and reliability of the instrument, as well as *Student's* t-test for dependent variables, which explores the significance of the difference of each pairs of questions, having at the same time statistically significant positive correlation, in the test and retest.

Plans for the research and the research instruments were assessed by Local Bioethical Commission of Medical University in Lublin (acceptance number: KE-0254/221/2008), and received a positive assessment.

The research was conducted from October 2009 to January 2014 at: the Medical University (students of nursing and medical faculties), University of Economics and Innovation in Lublin (students of nursing and professional nurses), the 'Novum' Association for Education and Training of Nurses and Midwives (professional nurses), Institute of Rural Health in Lublin (vocational training for family doctors), Clinical Hospitals of the Medical University in Lublin, and the Cardinal Stefan Wyszynski Provincial Specialist Hospital in Lublin (professional nurses and doctors).

The study covered a total of 1,244 respondents in the following groups: 1) professional nurses and doctors (729); 2) students of nursing and medical faculties (515), including: 982 females and 229 males (imbalance due to the feminization of the nurse profession in Poland) in the following age groups: up to 25 (315 respondents), 26-30 (169 respondents), 31-35 (223 respondents), 36-40 180 respondents), 40 and over (345 respondents).

The obtained data were statistically analysed (IBM SPSS) using: descriptive statistics, contingency tables and testing of hypotheses. The existence of relationships between variables was investigated using the *Pearson Chi*-square and *Fisher's* exact test. The level $p \leq 0.05$ was considered significant, whereas the level $p \leq 0.01$ was considered 'very significant', and $p \leq 0.001$ – 'highly significant'.

RESULTS

The great majority of respondents showed a lack of acceptance of patients, with a similar percentage of females (91.3%) and males (89.4%). The relationship between gender and acceptance of patients was investigated using the *Chi*-square test. Analysis showed no statically significant relationship between variables (Table 1).

Table 1. Acceptance of the patient according to gender

			Acceptance of the patient		Total
			Lack	Present	
Gender	Female	n	878	104	982
		% within gender	89.4%	10.6	100.0
	Male	n	209	20	229
		% within gender	91.3%	8.7	100.0
Total		n	1087	124	1211
		% within gender	89,8%	10.2	100.0

Test: *Pearson Chi*-square=0.697; df=1; p=0.404 (*Fisher's* exact=0.468)

Source: Own research.

The biggest number of respondents in the study group were females (81.09%) due to the significant

feminisation of the nurses' profession. In the group, the nursing profession represented 59.91% of the total. The results indicate no significant differences in the area of patient acceptance between females and males.

In the analysed age groups, the highest prevalence of unconditional acceptance of the patient was observed among respondents aged 31-35 (13.9%) and 41 and over (13.3%). The following tendency was clearly observed: the older the group, the higher the percentage of respondents declaring acceptance of the patient. It can be assumed that this is directly related with the professional and life experience of the respondents (Table 2).

Table 2. Acceptance of the patient according to age of medical staff.

			Acceptance of the patient		Total
			Lack	Present	
Age	≤ 25	n	299	16	315
		% within age	94.9	5.1	100.0
	26-30	n	157	12	169
		% within age	92.9	7.1	100.0
	31-35	n	192	31	223
		% within age	86.1	13.9	100.0
	36-40	n	159	21	180
		% within age	88.3	11.7	100.0
	≥41	n	299	46	345
		% within age	86.7	13.3	100.0
Total		n	1106	126	1232
		% within age	89.8	10.2%	100.0%

Test: *Pearson* Chi-square=18,202; df=4; p=0.001
Source: own research.

In the analyzed age groups, the lowest level of patient acceptance was demonstrated by the respondents from the youngest group, aged up to 25 years. The great majority in this group were students, who may have a lower tendency to empathize because of the insufficient experience. It noteworthy that the intensity of the examined trait was relatively lower among respondents in group aged 36-40. *Chi*-square test confirmed a significant correlation between respondents' age and acceptance of the patient (Table 2).

In the analysed material, the work experience variable was observed in two categories: students of medical fields of studies, and working medical personnel. It should be noted that a distinct difference in the presence of unconditional acceptance of the patient was found between both groups. In the category of students, only 8.3% declared such approval. In the category of workers, such a declaration was made by 11.7% of respondents. This indicates that the work experience gained by the professionally active respondents can influence the level of unconditional acceptance of the patient (Table 3). Statistical analysis did not confirm a significant relationship between 'acceptance of the patient' and 'experience of medical personnel', at the required level of significance, although it was at a level very close to significance (Table 3).

Table 3. Acceptance of the patient according to work seniority (professional experience) of medical staff.

			Acceptance of the patient		Total
			Lack	Present	
Professional experience	Student	n	472	43	515
		% within professional experience	91.7	8.3	100.0
	Employee	n	644	85	729
		% within professional experience	88.3	11.7	100.0
Total		n	1116	128	1244
		% within professional experience	89.7	10.3	100.0

Test: *Pearson Chi*-square=3.583; df=1; p=0.058 (*Fisher's* exact=0.059)
Source: own research.

In the study group, nearly half of the respondents were representatives of the nursing profession, both male and female. Representatives of the nursing profession were an occupational group who significantly more often indicated unconditional acceptance of the patient (12.4%). Doctors declared such acceptance only at the level of 8.1% (Table 4). Statistical analysis showed a statistically significant relationship between patient acceptance and profession performed at the level of significance p = 0.013.

Table 4. Acceptance of patient according to professional groups of medical personnel

			Acceptance of the patient		Total
			Lack	Present	
Profession group	Nurse	n	551	78	629
		% within profession	87.6	12.4	100.0
	Physician	n	565	50	615
		% within profession	91.9	8.1	100.0
Total		n	1116	128	1244
		% within profession	89.7	10.3	100.0

Test: *Pearson Chi*-square=6.144, df=1, p=0.013 (*Fisher's* exact=0.015)
Source: own research.

Analysis of the collected material confirmed significant differences in the declared level of acceptance of the patient in studied groups. Tests showed the statically significant effect of the variables of profession and age of the respondents. On the other hand, the differential impact of gender and level of education in terms of professional activity of the respondents was not confirmed. It should be pointed out that the level of declared patient acceptance among medical personnel was generally quite low.

DISCUSSION

Among the members of medical staff, there are increasing numbers who claim (e.g. on online forums) that the cause of abnormal physician-patient relationship are inappropriate attitudes of patients. According to the doctors, a 'demanding attitude' of patients discourages physicians from good communication. At the same time, in the study on patient satisfaction, the patients claim that interpersonal relations and communicating with medical personnel are the weakest aspects. The study showed that acceptance of the patient, required in the process of proper communication, leaves much to be desired.

Gender

Theories about social attitudes relate, *inter alia*, to psycho-social predispositions of gender. The communication dichotomy connected with gender, which divides channels for communication, for 'male' and 'female' was pointed out by *Shem* and *Surrey*. In their opinion, males embody the concreteness of communication, language is less emotional and devoid of personal connotation, while females in communication use primarily emotionality, and thus, a male is more likely to accept conditionally and females unconditionally [10, 27, 29].

Man learns very early about gender stereotypes, knows how a 'real woman' and 'real man' should behave [17]. In the created 'perfect image', women have much more efficient verbal abilities (an expanded speech centre and improved communication between the right and left hemisphere) and also identify themselves with the caller, which implies kindness for the interlocutor [28]. The presented study showed no significant differences in the way of acceptance of the patient, between males and females. Both genders presented a low level of patient's acceptance.

Age

The literature on interpersonal attitudes indicates a relationship between communication competences and age. Knowledge of the human social system is the factor which, among others, enables human communication skills and the appropriate attitudes towards others (the patient), increasing with age. The wider experience of social objects (knowledge of self, parents, spouses, children, institutions, relationships, social events, etc.), the greater the motivation, skill, and consequently, knowledge about the relationship with others. Mature communicate with people is neither innate nor spontaneous. It requires improvement and knack that can only be developed over time – and increases with age [4, 15].

At the same time, researchers recognize a barrier in human communication in the form of stiffness of beliefs, which are intensified with age. Physiological changes due to aging can cause personality changes, depressed mood, irritability, anxiety, aggression, and belief in infallibility. All these qualities together can reduce openness in relation to another human being. Simultaneously, psychological theories proclaim that human personality traits do not change with age. According to this criterion, there are human traits which are consistent, these are human self-confidence (an important element of interpersonal communication), internal heat (understood in communication as kindness, openness, empathy) and cognitive interests (essential in dealing with human curiosity in others, and openness to otherness). At the core of any changes there are specific life experiences so important to the entity that causes metamorphosis [1, 3, 16, 20, 37].

Our own research confirms the tendencies in worldwide studies concerning the lowest acceptance for the patient in the youngest age group. Starting from the middle age of respondents, the level of patient's acceptance significantly increases, although, at the same time, the 36-40 age group had the lowest level of acceptance of the patient, among the middle and oldest age groups (31-35 years old; 41 years and over). This may indicate burnout symptoms which are characteristic of occupations requiring high responsibility, among which the medical professions are definitely included. The result was highly statistically significant.

Professional experience

Experience, or lack of it, arising from the profession, could also be a communication barrier. This appears when people present a different level and range of experiences, which makes them differ in the way of thinking or receiving the surrounding reality, and hence mutual understanding. Communication theories assume that broader horizons (through experience) mean a greater openness to the diversity of attitudes. The meta-communication approach, a reference going beyond the message itself (contextuality), assumes the reference to information about the views and experiences of the sender and recipient [3, 12, 13, 30, 33].

In this study, a big difference was observed in the unconditional acceptance of the patient, between medical students with little experience and medical staff with more work experience. However, it was not statistically significant.

Profession

As with the previous independent variables, affiliation with a particular occupational group influenced the social attitudes within the range of communication skills. According to the literature, the issue that we deal with is feedback. People are predisposed to a particular occupation by their personality, and influence its development through the professional environment.

The choice of profession is a derivative of personal interests connected with the possibilities offered by the world of work, and the professional environment consists of people with a certain type of personality, specific problems, as well as demands specific for the given profession. People in certain occupational groups have similar patterns of personality and react in a similar way to many situations. If the search for the professional environment ends in the wrong choice, we have to deal with internal conflict and frustration. Such a person has low achievement and low motivation to work, as well as a wrong interpersonal attitude [6, 8, 9, 32]. In the presented study, two occupational groups differed from each other in the approach to the patient. Nurses more often accepted the patient unconditionally, but doctors often presented requirements to the patient as a person, limiting the acceptance as conditional. The result was statistically significant.

The number of complaints and low level of satisfaction of patients, recorded in world studies and, at the same time, the level of professional frustration of medical staff, which is manifested in the perception of most patients as 'demanding', as well as the level of burnout of medical staff, show the importance of the issues undertaken. The independent variable - age, which in the studies is identified as the most statistically significant when it comes to the way of acceptance of a patient by medical staff (conditionally / unconditionally), and at the same time, the lack of statistical significance of variables related to work seniority and way of acceptance of the patient, shows that in order to maintain a proper (benefiting both parties relation) attitude towards the patient, work experience is not enough, life experience is also necessary; however, this cannot be obtained by young people / students, in ways other than simply by proper education in the area of communication. Appropriate knowledge, proper motivation and skills training are essential.

The correct way of education is also the basis of the differences in relation to the patient between the nurses and doctors. Separately trained, medical staff acquire other educational experiences, and their understanding of the role of a patient is very different. Proper education should teach the procedure of communication with the patient, not only in the area of physical illness, but also show patients as human beings in all dimensions of their lives (physical, mental, social and spiritual). It should also show benefits for medical staff (individual and group) which are the results of a proper relationship with the patient.

CONCLUSIONS

In the presented study an acceptance of the patient by medical personnel in most cases is conditional. Only a few respondents understood the relationship between imposing conditions on the patient, and their own, interpersonal attitude towards the patient (checking whether the patient met the conditions). At the same time, this translates to the level of frustration or satisfaction with their profession, and ultimately to the level of burnout. In the conducted research, the level of acceptance of the patient by medical staff (unconditional acceptance) depended primarily on age and secondly on profession. Gender and work seniority were not statistically significant when dealing with the way of accepting the patient by medical personnel.

Conflict of interest

The authors declare no conflict of interest.

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