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Assertiveness as a Measure of Satisfaction in the Physician-Patient Communication Process

Joan Delores Johnson

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ASSERTIVENESS AS A MEASURE OF SATISFACTION
IN THE PHYSICIAN-PATIENT COMMUNICATION PROCESS

A Thesis
Presented to
the Faculty of the Department of Communication
Western Kentucky University
Bowling Green, Kentucky

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

by
Joan Delores Johnson

May 1992

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ASSERTIVENESS AS A MEASURE OF SATISFACTION
IN THE PHYSICIAN-PATIENT COMMUNICATION PROCESS

Date Recommended May 4, 1992

Randall Boyd
Director of Thesis

Barry Winn

Judith Hoover

Date Approved May 29, 1992

Elmer Gray
Dean of the Graduate College

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**ASSERTIVENESS AS A MEASURE OF SATISFACTION
IN THE PHYSICIAN-PATIENT COMMUNICATION PROCESS**

Joan Delores Johnson May 1992 71 Pages
Directed by: Randall Capps, Judith Hoover, Larry Winn
Department of Communication Western Kentucky University

In recent years medical societies have begun to recognize the effects and benefits of good communication between physician and patient. Like any other relationship, the exchange of information with fluent understanding creates a stronger bond of trust. Most applied research conducted in the area of physician-patient communication concentrates on physician behaviors which the patient views as problematic. This thesis focuses on patient assertiveness and its relationship to physician-patient satisfaction in the consultation process. Specifically, the study focuses on the relationship between patient assertiveness and physician-patient satisfaction.

For the study the researcher developed a patient questionnaire and pre-and post-physician questionnaires to assess patient assertiveness. This factor relates to outcomes of satisfaction from the physician-patient consultation. Twenty doctors and two hundred patients participated in the study. The implications of these findings should provide insight into the patient-physician consultation process.

CHAPTER I

INTRODUCTION

In recent years medical societies have begun to recognize the effects and benefits of good communication between physician and patient. In 1985, the National Conference on the Role of the Doctor in New Zealand presented a summary report entitled "Implications for Medical Education." The Conference reported the following summary of communication in medicine:

The ability to communicate clearly is pivotal to the role of the doctor. The development of adequate communication skills should be accorded high priority in the undergraduate medical curriculum and be taught and practiced throughout the course. Counseling is also an important skill in virtually all practice settings and should occupy a more important place in the medical curriculum (Grant, 1988).

With such a declaration from the medical profession, an opportunity exists for communication scholars to

research the methodology needed to attain such "adequate" communication.

Most applied research conducted in the area of physician-patient communication concentrates on physician behaviors which are seen as problematic by the patient (Assante, 1990). This thesis focuses on patient assertiveness and its relationship to physician-patient satisfaction in the consultation process. Specifically, this study will determine the relationship between patient assertiveness and physician-patient satisfaction. Physicians who utilize these findings will have the opportunity to recognize such possible problems and gear the consultation toward overcoming them. Such desire for effective communication has become the key to a physician's professional success as well as personal fulfillment (Grant, 1988).

Statement of the Problem

The purpose of this thesis is to ascertain if there is a positive correlation between patient assertiveness and physician-patient satisfaction with regard to the physician-patient consultation. The absence of trust, openness, curiosity, and respect needed by a patient

hinders, the interaction with the physician. The interviewing process, the treatment plan, and the therapeutic relationship, may, therefore, be altered by (Quill, 1989). If similar feelings are experienced by the physician, the interaction will once again be impaired. The final consultation between physician and patient is an interactive process which can be an effective form of communication for both parties. If either party feels threatened or disinterested, effective communication suffers.

The role of assertiveness as a personality trait can be an influential factor. Assertiveness, the ability to state opinions with conviction and to be able to defend one's opinions and oneself, (McCroskey, 1989) is crucial to the role of a patient. The physician must know the opinions and feelings of his/her patient before designing a treatment plan. The level of such assertions will affect the physician's satisfaction. A highly assertive patient may threaten the physician while a patient low in assertiveness may appear disinterested in the consultation.

The parallel to this idea is the study of communication apprehension as a personality trait. A patient who has a broadly based anxiety related to oral

communication will not be able to offer much to the interaction process. The physician may view the high communication apprehensive patient as a submissive follower in the process. Additionally, insecurities about self-disclosure may create an interactive barrier (McCroskey, 1989). Persons low in communication apprehension engage in more interaction and self-disclosure than highly communication apprehensive persons. Both of these factors affect physician-patient interaction and the physician's level of satisfaction.

Previous research found in a review of ERIC, Infotrac, ACORN, and Medline fails to examine personality components of the patient in correlation to physician satisfaction. Most classifications of previous research deal with communication from the standpoint of health care providers to the patient. Yet, communication from patients to health care providers has perhaps equal salience. The physician-patient questionnaires will help identify whether patient assertiveness during the consultation contributes to physician-patient satisfaction.

Definition of Terms

- Physician - a healer; a doctor of medicine; an individual currently licensed to practice medicine as an occupation
- Patient - a person under medical care; an individual currently receiving medical care by a physician
- Assertiveness - the ability to make requests; actively disagree; express personal rights and feelings; initiate, maintain, or disengage from conversations; and to stand up for self (Kearney, 1984)
- Satisfaction - to gratify completely the needs of the physician and patient in relation to physician-patient interaction
- Consultation - the act of considering medical conditions by physician and patient; the spoken words between physician and patient

CHAPTER II

REVIEW OF LITERATURE

Doctors spend significant amounts of time discussing with patients the nature and implications of their illnesses. Good communication differentiates a clever doctor or an effective doctor, and The Royal New Zealand College of General Practitioners recognizes the importance of communication skills when candidates for membership of the college examine these skills using actors or actresses in clinical situations. Physicians have not yet tested these skills, but physicians are aware that training should be given in communication and that it should be tested. In "Doctor: Patient Communication," Caughey states that this assessment may be made by lay people.

Hirsh's article "The Physician-Patient Relationship: The Art and Science of Communication," examines the significance of communication in the physician-patient relationship. The article reviews various studies which have explored different aspects of

communication between physician and patient such as age, intellectual level, emotional state, and various other problems. A summary of the many studies on recall reveals the following recommendations. Communication can be improved by: summarizing and feedback, explicit categorization of information, repetition of information, and specific rather than general instructions.

According to Mazzuca and Weinberger, the literature inconsistently portrays clinical communication associated with knowledge, compliance, and satisfaction of patients. Their article, "How Clinician Communication Patterns Affect Patients' Comprehension and Satisfaction," identifies similarities and discrepancies between patterns of communication associated with patients' satisfaction with encounters in a diabetes clinic and comprehension of their therapeutic regimens. On the basis of this study and others, the researchers are confident that communication, which enhances comprehension, is different from that which engenders satisfaction.

Quill states in "Recognizing and Adjusting to Barriers in Doctor-Patient Communication" that barriers frequently develop in physician-patient encounters. If

these encounters go unrecognized, they can severely limit the therapeutic potential of the doctor-patient relationship. Types of barriers mentioned in this study are verbal-nonverbal mismatch, cognitive dissonance, unexpected resistance, and physician discomfort. Once defined and understood, physicians can overcome most barriers and find resolution to these problems by using the basic communication skills of acknowledgment, exploration, empathy, and legitimation. Utilizing these basic communication skills, the physician often turns roadblocks to effective communication into means for enhancing the therapeutic relationship.

Richmond and McCroskey state that communication apprehension is probably the single most important factor in ineffective communication. Their book, Communication: Apprehension, Avoidance, and Effectiveness, emphasizes the idea that a person who experiences communication apprehension is not the strange exception. Almost everyone experiences some form of communication apprehension during his/her life, but it affects some people to a greater degree than others. According to these researchers, using a variety of methods can reduce communication apprehension for literally thousands of individuals.

According to Bourhis, Roth and MacQueen, medical language and everyday language are operational because of distinct speech registers which doctors, nurses, and patients use in their encounters with each other. In "Communication in the Hospital Setting: A Survey of Medical and Everyday Language Use Amongst Patients, Nurses, and Doctors," researchers have evaluated certain language use strategies. From this survey all groups feel that it is more appropriate for health professionals to converge to the everyday language of patients than to maintain medical language. Furthermore, the results of the survey also reveal that health professionals' use of medical language is a source of problems for patients, while everyday language appears to promote better understanding for patients.

Cecil G. Helman's article, "Communication in Primary Care: The Role of Patient and Practitioner Explanatory Models," discusses four inter-related aspects of clinician-patient communication in the context of primary care. Additionally, three factors which may influence information exchange and the outcome of consultations are the characteristics of the physician, those of the patient, and those of the situation in which the consultation takes place.

Information in the clinical context is that which removes or reduces anxiety.

Brattstom in "Communication Problems in Health Care," reveals that the sharing of responsibility for the treatment between health care providers and the patient creates a need for knowledge about compliance, the degree to which the patient understands, accepts, and follows given instructions. Yet, the process of communication in health care is difficult because senders and receivers have fundamentally different backgrounds and educational levels. Communication is also difficult because the patient is in a stressful situation and the physician is under limited time constraints. The study concludes that formal patient education and time could change this situation. Although patient education is time consuming, it would help the patient explain his/her needs and, therefore, be worth the effort. Patient education would create an active partnership between patient and health care worker.

Wolraich's "Medical Communication Behavior System" reports the use of an interactive observation system which records the time physicians and patients spend on specific behaviors in the categories of informational,

relational, and negative situation behaviors by using hand-held electronic devices. The study includes observations of 101 genetic counseling sessions and also assesses the outcome measures of patient knowledge and satisfaction. Additionally, to examine the effects of the recording session, forty-one of the sessions are rated using the Roter Interactional Analysis System, and twenty additional control subjects complete the post-counseling information without being observed. The results indicate that the Medical Communication Behavior System is a promising method of describing the communication which occurs among physicians, counselors, and patients in a situation which focuses on information giving (genetic counseling).

In Robins, "Confrontation and Politeness Strategies in Physician-patient Interactions," the researcher has examined the therapeutic success of physician-patient interactions. According to Robins, the interaction process depends on how physicians interpret and respond to patients' implicit and explicit messages. Using a hypothetical vignette in which a patient refuses to comply with a recommended therapeutic regimen, first-year medical students, with no classroom training in medical interviewing, implicitly recognize that the

situation calls for face preserving or polite linguistic behavior. Ninety percent of the students use culturally sanctioned politeness forms to repair the conversational breakdown depicted in the vignette. The students respond to this clinical scenario, however, with linguistic behaviors borrowed from their everyday interactions, some of which were culturally appropriate, but not necessarily therapeutic. Robins' article proposes that students can learn to adapt their culturally appropriate behaviors and engage in therapeutic communication as physicians, if they are given the necessary conceptual tools.

The article also suggests that Brown and Levinson's theories of politeness and strategic language usage can (1) provide a framework for interpreting communication in general and physician-patient interaction in particular, (2) illuminate some of the problems inherent in doctor-patient encounters, and (3) be used prescriptively for teaching students and health professionals how to avoid specific communication difficulties.

Another interactive health care article by Assante and Schrader, "How to Construct an Illness in Your Spare Time," reviews recent literature regarding the

application of communication theory to health care interaction. The researchers demonstrate that such theory is woefully underutilized in the training of health professionals. Additionally, the notion that both patients and health professionals have socially constructed models about illness and health care has rarely been discussed or applied in health care communication research.

The research literature on patient perceptions of general practice consultations shows that while patients are generally satisfied with the treatment they receive from doctors, they report less satisfaction with the amount and clarity of information they receive and doctors' expression of caring and respect. The development of a communication skills program incorporates variables from both the emotional and cognitive domains of the consultation. In the article, "A Communication Skills Program for Increasing Patient's Satisfaction with General Practice Consultations," Evans, Keillerup, Stanley, Burrows, and Sweet hypothesize that patients of trained doctors report greater satisfaction and less anxiety when compared with patients of untrained general practitioners. The use of this instrument confirms their hypothesis.

Auyash's "Exploring the Impact of Technology on Communication in Medicine and Health" reveals that the greater use of modern technology in medical care and public health raises questions about impacts on practitioner-patient relations. This article summarizes some important events in the use of medical technologies in relation to the states of the spoken word. Consumers continually prefer the following qualities in their physician: listening skills, professional manner, a kind and caring personality, easy style of communication and ability to explain. All of these qualities include a communication component, yet none of these is specifically a part of the medical training in the majority of medical schools in the United States. This study states that talk remains an important technology in the treatment and cure of common maladies. The modern medical scenario includes physicians as scientists who research and program computers, as well as physicians as teachers who listen, explain, and talk to their patients about health.

By videotaping a series of consultations and carrying out pre-consultation and follow-up interviews Campion demonstrated in "Communication: Learning From Our Patients," that patients arrive at their own

diagnosis and also have opinions about their own treatment prior to visiting their general practitioner. By listening to patients and actively seeking their views, doctors can enhance their understanding of the patients' illnesses and improve the effectiveness of their interventions. Patients seek explanations from their doctors, but, unless the doctor knows the nature of the concern and the uncertainties of that particular patient, the explanation is unlikely to be relevant to that patient.

In recent years humanism is emerging as an important concept in medical education and practice. Humanism, according to Pellegrino, is based on human values in the relationships people establish with one another. Central to the concept of humanism is a common set of assumptions in establishing these relationships: the centrality of human dignity, justice, and respect for persons as individuals. In the article, "Patient Perceptions of Humanism in Physicians: Effects on Positive Health Behaviors," Hauck, et al., discover positive association between perceived physician humanism and patient satisfaction. Additionally, some medical specialties such as family practice, internal medicine, and pediatrics address the need to train

humanistic physicians.

According to Buller and Buller, research links the communication styles of physicians to patients' satisfaction with health care. The authors state in their article, "Physicians' Communication Style and Patient Satisfaction," that two general styles of communication styles are assessed: affiliation and control. The researchers define affiliation as communication behaviors designed to establish and maintain a positive relationship between the physician and patient. The behaviors which communicate interest, friendliness, empathy, warmth, genuineness, candor, honesty, compassion, a desire to help, devotion, sympathy, authenticity, a nonjudgmental attitude, humor, and social orientation help to establish this positive relationship. On the other hand, control includes behaviors which establish and maintain the physician's power, authority, status, and professional distance in the medical interaction. Buller and Buller are able to demonstrate that affiliative styles relate positively to patient satisfaction, whereas, dominant/active styles have a negative relationship with patient satisfaction.

In an article by Bertakis, Roter, and Putnam, "The

Relationship of Physician Medical Interview Style to Patient Satisfaction," a number of significant relationships distinguish between communication during the visit and the various dimensions of patient satisfaction. Physician questions concerning biomedical topics negatively relate to patient satisfaction. On the other hand, the researchers find a positive association when physician questions relate to psychosocial topics. Physician counseling for psychosocial issues is also positively related to patient satisfaction. This study also demonstrates patient dissatisfaction when physicians dominate the interview. The findings further suggest that patients' satisfaction is more apparent during interviews which encourage them to talk about psychosocial issues and in an atmosphere characterized by the absence of physician domination.

Richard Baker states that the assessment of patient satisfaction has become an important concern in the evaluation of health services. While patient satisfaction is but one objective of care, satisfaction is also a contributor to the outcome because satisfied patients are more likely to cooperate with treatment. His article, "Development of a Questionnaire to Assess

"Patients' Satisfaction with Consultations in General Practice," presents three principal components of patients' assessments of care. These three factors of satisfaction are: the professional aspects of the consultation, the depth of the patient's relationship with the doctor, and the perceived length of the consultation.

"Patients' Satisfaction with General Practitioner Services: A Survey by a Community Health Council," is a satisfaction survey which looks at the practices of five general practitioners and their relationships with mothers and children under five. Generally, these primary health care systems are given high marks except in the areas of professionals' unwillingness to take patients' concerns at face value and to recognize the validity of patients' own experiential knowledge. Moreover, patients express displeasure when they cannot ask questions or have the opportunity to adequately explain their problems or when they perceive that the physician is unwilling to listen. In some cases there are complaints of abrupt and unsympathetic manner of doctors and unwillingness to accept the legitimacy of mothers' concerns about their children. As a result, patients state that this kind of treatment causes them

to feel neurotic and inadequate. Valerie Williamson concludes that a more interactive partnership between patients and professionals can lead to a more effective service.

In "Teaching the Medical Interview: An Intervention Study," by Putnam, Stiles, Jacob and James, internal medicine residents learn the effects of teaching specific interviewing techniques on verbal behaviors and on health outcomes. The residents train in individual and group sessions which stress active listening and giving thorough information about illness and treatment. The residents are taught to use respectful silence, verbal encouragements, and occasional reflections to encourage patients to tell their stories in their own words. The training intervention results in better interaction between the physician and patient and improves the physicians active listening skills.

Judith Hall and Michael Dornan investigate "What Patients Like about Their Medical Care and How Often They Are Asked: A Meta-Analysis of the Satisfaction Literature." In reviewing the literature, satisfaction, humanness, informativeness, and technical and overall quality rank near the top with regard to consumer

satisfaction. The authors also find uneven frequencies in satisfaction instruments when measuring different aspects of medical care.

CHAPTER III

PROCEDURES

Hypotheses

The major hypotheses for this study are:

- Hypothesis 1. Patient assertiveness correlates negatively as the age of the patient increases in the physician-patient consultation.
- Hypothesis 2. Patient assertiveness correlates positively with male patients and negatively with female patients in the physician-patient consultation.
- Hypothesis 3. Patient assertiveness correlates positively as the income level of the patient increases in the physician-patient consultation.

- Hypothesis 4. Patient assertiveness correlates positively as the educational level of the patient increases in the physician-patient consultation.
- Hypothesis 5. Patient satisfaction correlates positively with patient desire to return to visit the physician in the physician-patient consultation.
- Hypothesis 6. Patient and physician perceptions of assertiveness correlate positively in the physician-patient consultation.
- Hypothesis 7. Patient assertiveness correlates positively with patient desire to return to visit the physician in the physician-patient consultation.
- Hypothesis 8. Patient assertiveness correlates positively with patient satisfaction in the physician-patient consultation.
- Hypothesis 9. Patient assertiveness correlates positively with physician satisfaction in the physician-patient consultation.
- Hypothesis 10. Patient assertiveness correlates negatively with patient apprehension in the physician-patient consultation.

- Hypothesis 11. Patient satisfaction and desire to return to visit endocrine/metabolism physicians correlates higher than other physician speciality areas in the physician-patient consultation.
- Hypothesis 12. Patient assertiveness and desire to return to visit endocrine/metabolism physicians correlates higher than other physician speciality areas in the physician-patient consultation.

Design of Survey Tools

The author chose to use survey questionnaires for this study due to the fact that physicians and some patients would be under very limited time constraints. Moreover, surveys would allow a large number of subjects to be sampled and would have limited interference with the physician-patient consultation. Due to the particular nature of this study, the researcher found it necessary to develop three surveys. These surveys included a pre-and post-interview questionnaire for the physicians and a post-interview questionnaire for the patients.

The pre-interview questionnaire for the physician provided information as to the type of interview the physician conducted and factors which he/she thought contributed to a satisfactory consultation. The post-interview questionnaire for the physician provided a direct measurement of patient assertiveness and physician satisfaction as perceived by the physician. The post-interview questionnaire for the patients provided direct and indirect levels of measuring assertiveness and satisfaction for the patient. Additionally, there was also a direct level of measurement of communication apprehension for the patient.

The author queried 10 physicians to determine the factors which they thought contributed to a satisfactory consultation with patients. From the discussions with the 10 physicians and after a review of the literature in this field, the researcher developed a five-point Likert scale survey. After the development of the survey, the researcher conducted a pilot study with 10 different physicians to evaluate the instrument for content, clarity, validity, and ease of administration. Additionally, the researcher discussed the instrument with the physicians for additional comments, thoughts,

and changes to be incorporated into the instrument. The researcher chose physicians in different specialities to prevent contamination of the study by the physicians discussing the questionnaires with each other.

Moreover, the author interviewed 20 patients to determine the factors which they thought contributed to a satisfactory consultation with physicians. From the discussions with the 20 patients and after a review of the literature in this field, the researcher developed a five-point Likert scale survey. After developing the survey, the researcher conducted a pilot study with 20 different patients to evaluate the survey for content, clarity, validity, and ease of administration. Upon completion of the survey, the author questioned the patients for additional comments, thoughts, and changes to be incorporated into the instrument.

After the pilot studies, the author finalized a pre-and post-patient visit questionnaire for the physicians and a post-visit survey for the patients. The researcher also collected demographic background information on both the physician and patient groups.

Selection of Subjects

The subjects for the study included 20 physicians and 200 patients currently under the care of these physicians. The physicians were currently practicing medicine at a nationally known medical center in the Southern United States. The researcher selected the physicians and patients on a volunteer basis for participation in this project. Twenty patients of each physician volunteered to participate in the study.

Treatment of Subjects

The method of data collection was the use of three surveys. Each patient and physician completed the surveys which included a complete set of directions, a release form, and a form collecting certain demographic information. The researcher asked each of the 20 physicians to fill out the pre-survey questionnaire and the demographic background information prior to any physician-patient interaction. After the consultation, each physician filled out the post-questionnaire on each of his/her 20 patients who participated in the study. Additionally, each of the 200 patients filled out a post-interview questionnaire after his/her physician-patient consultation. To aid in assuring

validity, the researcher did not directly observe nor interact with the physicians or patients while they completed the survey or during the consultation process. Furthermore, the researcher did not discuss the questionnaires with the physicians prior to the study.

Statistical Design for the Study

The statistical procedure utilized in analyzing the data gathered for this study was the Pearson Product-Moment Correlation procedure. After the physicians and patients completed the information on the questionnaires, the researcher took the identification code of each doctor and each patient and developed codes for each item on the questionnaires and assigned labels for the demographic information as well as for the items on the surveys. The next step was to create data files for the patient and for the physician. The researcher then created files using the SPSS system file for both the patients and physicians and ran frequencies on the 200 patients and 20 doctors to determine the mean, standard deviation, and valid percentages for each value

label on the surveys. The researcher accounted for any missing data in order to obtain the valid percent figures.

Then, the researcher ran correlations on the variables of patient's age, sex, visit, health, income, education, and the items on the patient survey as well as correlations on the demographic data of each physician and the items on the physicians' questionnaire. The next procedure included both direct and indirect correlation measures between the physician and the patient on such factors as assertiveness, apprehension, patient satisfaction, and physician satisfaction.

Questions 1, 4, and 8 on the patient survey were the only questions not written in the same direction as the other items; therefore, these items were recoded prior to running the correlations. Finally, the researcher divided the doctors into two different groupings according to the specialty of the physicians. The fourteen endocrine/metabolism physicians composed one group and the six doctors with various specialties made up the second group of physicians. Then, the researcher created an average patient file for each

doctor in these two groups. The final set of correlations revealed the average patient of each doctor in these two sub groupings. The error of acceptance used for all correlations was at the .001 level of significance for error.

CHAPTER IV

ANALYSIS OF DATA

After administering the pre-and post-questionnaires to the 20 selected physicians and the post-questionnaire to 10 patients of each physician, the researcher coded the results of all questionnaires and generated a computer program for determining frequencies and correlations of the data collected.

The demographic background information for the patient questionnaire is given in Table I, page 57. The researcher determined the mean or average age of the patients in the study to be 46 years. Forty eight percent of the patient-subjects were female and 52 percent of the patient-subjects were male. When patients were asked if this were the first visit to the physician, 56 percent replied no, 43.5 percent replied yes, and one patient did not respond to the question. Six percent of the patients considered themselves to be in poor health, 35.5 percent thought that their health

status was fair and 56.5 percent answered that their health was good. Two percent of the subjects did not respond to the question concerning their health status. The mean income for the two hundred subjects ranged between \$10,000 - \$35,000. Twenty seven percent of the subjects answered that they were high school graduates, 19 percent of the subjects stated that they had received some college education, and 18 percent of those surveyed had graduated from college.

Questions 1,4, and 8 directly measured patient communication apprehension. When patients were asked if they were afraid to discuss their problems with their physician, 13.5 percent of the patients agreed with the statement and 20 percent indicated that they neither agreed or disagreed with the statement. This response indicated an ambivalence on the part of the patients in responding to the question. When asked if they were afraid to bring up subjects with their doctor, 17.5 percent of the patients agreed with the statement, but 61 percent disagreed with the statement. Seventy seven percent of the patients were not afraid to ask their doctors questions. In trying to develop a survey which measured the stated hypothesis for the study but met the limited time constraints of the patient, the researcher

concedes the fact that three questions may not be enough to adequately measure communication apprehension.

Ninety percent of the patients stated that they wanted to be involved in decisions relative to their treatment and 88 percent of the patients stated that they would tell their doctor if something were bothering them. Additionally, 94.5 percent of the subjects stated that they would ask physicians to explain language which they did not understand and 95 percent stated that they would tell their physician when they were uncomfortable during a procedure. When patients were asked if they expressed feelings, concerns, worries and/or frustrations to their physician, 63.5 percent agreed with the statement. Of the 200 patients participating in the study, 69 percent agreed or strongly agreed that they would ask their doctor for written instructions or literature.

Questions 9, 10, and 12 were designed as measures of assertiveness. Although the response was positive, the percentages were not as high as the percentages on other assertiveness questions. The percentages of the patients agreeing with the statements ranged from 52.5 percent to 65.5 percent of all patients who responded to these statements.

Eighty five percent of the patients thought they were assertive during the consultations and 93.5 percent of the patients found the consultation satisfactory. On the physicians' post questionnaire, 87.5 percent of the physicians agreed or strongly agreed that the patients were assertive. In response to the physicians' satisfaction with the consultation, 95.5 percent of the physicians stated that they were satisfied with the consultation while 3 percent neither agreed or disagreed, and only 1.5 percent were not satisfied with the consultation. Additionally, 96 percent of the patients stated that they would return to see their physician.

In analyzing the frequency table on the doctors (Table II, page 58), the researcher found the average physician's age to be 42 with 85 percent of the physicians being male and 15 percent being female. In years of practice, the mean number of years for the physician was 13. Seventy percent of physicians in the study were in the specialty area of endocrinology and metabolism and 30 percent of the doctors were outside of this field. All physicians in the study spent an average of 4.5 hours in interview training and 1.1 hours in interpersonal communication training. Sixty five

percent of the physicians did not feel that more time should be devoted to the interviewing process while 35 percent felt that more time should be devoted to these skills.

When physicians were asked if the patient were given sufficient time during the interviewing process, 85 percent answered that they usually allowed sufficient time for the patient in this process. One hundred percent of the physicians answered that they encouraged patients to describe their problems and ask questions while 75 percent of the physicians stated that they wanted the patients to collaborate with them during the treatment process. Eighty percent of the physicians stated that they usually allowed time for social interaction during the interview process. Forty percent of the physicians stated that they gave written instructions for medications to their patients and written materials relating to the patients' condition. Physicians answered that they avoided using medical jargon 80 percent of the time and that they asked open ended questions 90 percent of the time. Thirty five percent of the doctors said that they encouraged their patients to seek a second opinion.

After investigating the frequency of responses for both the patient and the physician, the researcher looked at correlations of certain items using .001 as the conservative alpha for acceptable error (Table III, page 59). When looking at the patients' age factor and the direct assertiveness measure, it was interesting to note that the higher the age of the patient, the less assertive he/she was in the consultation. The negative correlation was $-.0948$, thus, proving Hypothesis 1. Also, males tended to demonstrate more assertiveness than females in the study, but the correlation was not significant. The researcher was unable to prove Hypothesis 2. Additionally, the results of Hypothesis 3 and Hypothesis 4 demonstrated a positive correlation between higher income and education of the patient and assertiveness. Patients with higher income levels had a positive correlation of $.2603$ and patients with higher education levels had a positive correlation of $.3516$.

There was a positive correlation of $.6849$ between patient satisfaction and patient's desire to return to the physician again for the 194 patients reporting on these items in the study. This figure indicated that the high degree of patient satisfaction directly

correlated with the statement that the patient would return to see the physician again, thus confirming Hypothesis 5.

The researcher found a significant positive correlation of .6408 between the indirect measure of patient assertiveness and the direct measurement of patient assertiveness (question 13). The researcher also discovered a relatively high correlation of .5989 between the doctors' perception of the patients' assertiveness and the patients' own perception of their assertiveness, thereby proving Hypothesis 6.

Moreover, there was a significant positive correlation of .3691 between the patients' assertiveness measures and the patients' response on the question which stated that they would return again to visit their physicians. There was also a significant positive correlation of .5778 between patient assertiveness and patient satisfaction with regard to the patient physician consultation. The significant positive correlations in these two areas confirmed Hypothesis 7 and Hypothesis 8.

Further, there was a significant positive correlation of .4865 between the doctors' perception of patient assertiveness in the consultation and the

physicians' own satisfaction with the consultation. Finally, patient assertativeness and patient apprehension correlated negatively, $-.6231$, that is, the more assertive the patient was, the less apprehensive he/she appeared to be. These results confirmed Hypothesis 9 and Hypothesis 10.

Further analysis of the data on patient assertiveness, apprehension, and satisfaction took place as the researcher grouped the 20 physicians in the study into two major categories; namely, endocrine/metabolism physicians and physicians with other specialities. The endocrine/metabolism physicians numbered 14 and doctors in other specialty areas numbered six. Then, the researcher created the average patient for each of the doctors in these two categories. The rationale for looking at the data in this manner was the supposition by the researcher that additional information might be revealed when studying the patients of endocrine/metabolism physicians and comparing that information to the patients of doctors outside this group.

A review of the literature had previously revealed that patients were more satisfied, less apprehensive,

and more assertive during consultations and more likely to return to doctors who emphasized more patient interaction during the consultation. Additionally, the patients of this group of doctors were generally under long term care of physicians and had the opportunity to develop a more humanistic relationship with their physicians. This researcher, being in the endocrine field, decided it would be informative to create an average patient for the 14 physicians in this particular specialty area in order to compare the data with the six physicians outside this field. The purpose of the subgroupings was to determine if there were any significant differences between the average patient of endocrine/metabolism physicians and the average patient of physicians in other specialty areas in this study with regard to patient assertiveness and physician-patient satisfaction in the physician-patient consultation.

For the most part, when comparing the data of the two subgroups, there were not significant differences in correlations except for two categories. In analyzing and comparing the data of the average patient visit of both groups, the researcher discovered that the average patient in the endocrine/metabolism subgroup

demonstrated an even higher positive correlation of .9127 between the patients' desire to return to the doctor and patient satisfaction. In comparing the data for all 20 doctors, there was a positive correlation of .6849. For the endocrine/metabolism group, a significant positive correlation of .6161 was demonstrated for the average patients' assertiveness measure and the patients' desire for return visit as compared to .3691 for all doctors in the study. This high positive correlation confirmed Hypothesis 11.

Although conclusions could not be drawn from this data, doctors in certain specialty groups like endocrine/metabolism, who the medical field identified as long term care physicians, should be compared with other groups of doctors such as surgeons, who the medical field identified as relatively short term physicians. This might allow for additional insights into the communication process between physician and patient.

This data should be of great benefit to the medical community in improving the interaction process between patient and physician in the consultation.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Giving patients the opportunity to talk about their illnesses is an important clinical maxim. Physicians ask open-ended questions during the interview, yet, researchers know relatively little about this communication process. While researchers agree that medical content is important, there is very little insight into the communication styles of the physician and patient.

Physicians focus on the technological health care issues to the detriment of treating patients as human beings. It appears that the physician has a double obligation to the patient. On the one hand, the physician must remain faithful to his/her own values, but he/she must also find a way to protect the values of the patient. Increasing awareness of these concerns leads to an emphasis on humanistic values in the education of health care providers.

This study demonstrates that patients generally assert themselves during the interviewing process and demonstrate satisfaction with their visit to the physician. Additionally, the doctors find the patients assertive and also express satisfaction with the consultation. The study also points out that further research will be necessary to understand other factors which determine patient satisfaction in the interview process other than assertiveness factors.

For example, information as to why these patients select physicians for treatment will also be important. Another point worth considering will be the possibility that dissatisfied patients have already left the practice of these physicians. Finally, the correlations between variables of certain items on these surveys point out the need to look at overlapping items through a factor analysis to determine other factors which influence the the consultation-communication process between physician and patient.

In the meantime, despite the large number of variables contributing to the physician-patient relationship, studies reveal that patients want as

much information as possible, much more they they would directly request and much more than they are likely to receive from their physicians (Roter, 1987).

Patient-centered exchanges not only provide information and counseling, but allow the patients to participate more actively in the decisions which affect their treatment. To gain this information, patients will have to request it from their doctors.

Scholars expressing an interest in the interaction between physicians and patients know that they must conduct a considerable amount of research before reaching an understanding of the communication processes which may contribute to a satisfactory consultation. In addition, researchers know that the personal qualities of the patient need to be taken into consideration.

While the study demonstrates that assertiveness is only one aspect of the communication process, the researcher finds that it is certainly a useful approach for the patients, especially if they are to share in the responsibility for their health care and receive satisfaction from their physician-patient consultation.

PHYSICIAN PRE-QUESTIONNAIRE

This questionnaire is designed to gain information from you regarding your perception toward the physician-patient consultation process. Your participation and cooperation in answering the questions will be greatly appreciated. Please circle the number to indicate how much you agree or disagree with each statement. Be sure to rate each statement. Please do not write your name on this form.

1. I give patients sufficient time for the consultation process.

Always	Usually	Sometimes	Rarely	Never
1	2	3	4	5

2. I encourage patients to describe their medical problems.

Always	Usually	Sometimes	Rarely	Never
1	2	3	4	5

3. I encourage patients to ask questions about their medical problems.

Always	Usually	Sometimes	Rarely	Never
1	2	3	4	5

4. I encourage patients to ask questions about their treatment.

Always	Usually	Sometimes	Rarely	Never
1	2	3	4	5

5. I devote time to social interaction during the interview.

Always	Usually	Sometimes	Rarely	Never
1	2	3	4	5

6. I want the consultation to emphasize treatment and diagnosis.

Always	Usually	Sometimes	Rarely	Never
1	2	3	4	5

7. I encourage the patient to collaborate with me in decisions concerning treatment.

Always	Usually	Sometimes	Rarely	Never
1	2	4	4	5

8. I give written instructions for prescribed medicine and/or treatment.

Always	Usually	Sometimes	Rarely	Never
1	2	3	4	5

9. I give written materials relating to patients' condition.

Always	Usually	Sometimes	Rarely	Never
1	2	3	4	5

10. I avoid the use of jargon with patients.

Always	Usually	Sometimes	Rarely	Never
1	2	3	4	5

11. I ask open ended questions during interviews.

Always	Usually	Sometimes	Rarely	Never
1	2	3	4	5

12. I encourage patients to seek a second opinion.

Always	Usually	Sometimes	Rarely	Never
1	2	3	4	5

PHYSICIAN DEMOGRAPHIC BACKGROUND

Please fill in the blank or place a check mark in the appropriate column. Be sure to answer each question. Please do not write your name on this form.

1. Age _____
2. Sex Male _____ Female _____
3. Years of Practice _____
4. Specialty _____
5. How many hours in your medical training was devoted to interviewing skills/techniques? Please check the correct answer.

0-1 _____	2-3 _____	4-5 _____
1-2 _____	3-4 _____	Greater 5 _____
6. How many hours in your medical training was devoted to interpersonal skills/techniques? Please check the correct answer.

0-1 _____	2-3 _____	4-5 _____
1-2 _____	3-4 _____	Greater 5 _____

7. Do you feel that more time should be devoted to interviewing/interpersonal skills/techniques during your medical training?

Yes _____ No _____

8. Any additional comments _____

PATIENT QUESTIONNAIRE

The physician with whom you have just had your interview is interested in learning what patients feel and think about how she/he conducts an interview. Would you please take a moment to rate this physician-patient consultation? Please fill in the blanks or place a check mark in the appropriate column. Be sure to rate each statement. Please do not write your name on this form. The physician will not see your answers.

PATIENT DEMOGRAPHIC BACKGROUND

1. Age _____
2. Sex Male _____ Female _____
3. Is this your first visit to this physician?
 Yes _____ No _____
4. What is your health status?
 Good _____ Fair _____ Poor _____

5. What is your income level?

- Less than \$10,000
- \$10-\$25,000
- \$25-\$35,000
- \$35-\$50,000
- \$50-\$75,000
- Greater \$75,000

6. What is the highest level of education you have reached?

- 8th grade or less
- Some high school
- High school graduate
- Post secondary school other than college
- Some college
- College Degree
- Some graduate school
- Graduate school

7. What is the highest degree you have earned?

- Bachelor's
- Master's
- Ph.D.
- Other degree

8. Feel free to make any comments about yourself _____

PATIENT QUESTIONNAIRE

Please circle the number to indicate how much you agree or disagree with the statement.

1. I am afraid to bring up personal problems with my doctor.

Strongly

Agree	Agree	Neither	Disagree	Strongly Disagree
1	2	3	4	5

2. I ask my doctor to involve me in decisions relative to my treatment.

Strongly

Agree	Agree	Neither	Disagree	Strongly Disagree
1	2	3	4	5

3. I tell my doctor if something is bothering me.

Strongly

Agree	Agree	Neither	Disagree	Strongly Disagree
1	2	3	4	5

4. I am afraid to bring up certain things because my doctor may think I am stupid.

Strongly

Agree	Agree	Neither	Disagree	Strongly Disagree
1	2	3	4	5

5. I tell my doctor if I am uncomfortable during a medical procedure.

Strongly					Strongly
Agree	Agree	Neither	Disagree		Disagree
1	2	3	4		5

6. I ask my doctor to explain language which I do not understand.

Strongly					Strongly
Agree	Agree	Neither	Disagree		Disagree
1	2	3	4		5

7. I express my feelings, concerns, worries and/or frustrations to my doctor.

Strongly					Strongly
Agree	Agree	Neither	Disagree		Disagree
1	2	3	4		5

8. I am afraid to ask my doctor questions.

Strongly					Strongly
Agree	Agree	Neither	Disagree		Disagree
1	2	3	4		5

9. I tell my doctor that he/she does not appear to be taking a personal interest in me.

Strongly					Strongly
Agree	Agree	Neither	Disagree		Disagree
1	2	3	4		5

10. I tell my doctor that he/she did not offer a satisfactory explanation of my problem.
- | | | | | | |
|----------|-------|---------|----------|----------|----------|
| Strongly | | | | | Strongly |
| Agree | Agree | Neither | Disagree | Disagree | |
| 1 | 2 | 3 | 4 | 5 | |
11. I ask my doctor for literature and/or written instructions concerning my condition and/or treatment.
- | | | | | | |
|----------|-------|---------|----------|----------|----------|
| Strongly | | | | | Strongly |
| Agree | Agree | Neither | Disagree | Disagree | |
| 1 | 2 | 3 | 4 | 5 | |
12. I tell my doctor that he/she did not appear to investigate my problem thoroughly.
- | | | | | | |
|----------|-------|---------|----------|----------|----------|
| Strongly | | | | | Strongly |
| Agree | Agree | Neither | Disagree | Disagree | |
| 1 | 2 | 3 | 4 | 5 | |
13. I was assertive during this consultation.
- | | | | | | |
|----------|-------|---------|----------|----------|----------|
| Strongly | | | | | Strongly |
| Agree | Agree | Neither | Disagree | Disagree | |
| 1 | 2 | 3 | 4 | 5 | |
14. I found this consultation to be satisfactory.
- | | | | | | |
|----------|-------|---------|----------|----------|----------|
| Strongly | | | | | Strongly |
| Agree | Agree | Neither | Disagree | Disagree | |
| 1 | 2 | 3 | 4 | 5 | |

15. I would return to see this physician.

Strongly

Strongly

Agree

Agree

Neither

Disagree

Disagree

1

2

3

4

5

Feel free to make any comments regarding this physician
or this visit _____

PHYSICIAN POST-QUESTIONNAIRE

Please circle the number to indicate how much you agree or disagree with the statement. Be sure to rate each statement. Please do not write your name on this form.

1. The patient was assertive during this consultation.

	Strongly		Strongly
Agree	Agree	Neither	Disagree
1	2	3	4
			5

2. I found this consultation to be satisfactory.

	Strongly		Strongly
Agree	Agree	Neither	Disagree
1	2	3	4
			5

CONSENT FORM

You are being asked to participate in a study which deals with the physician-patient consultation. The survey which follows will take only a few minutes of your time. Your name will not appear on the questionnaire; therefore, your response will be completely confidential. Thank you for your cooperation.

I give my consent for this information to be used for research purposes in the above mentioned study.

—

Signature

TABLE I
 PATIENT DEMOGRAPHIC INFORMATION

Average Age		46 Years
Average Income		\$10,000 - \$35,000
Sex	Male	52%
	Female	48%
First Visit to the Physician	No	56%
	Yes	43.5%
Health Status	Poor	6%
	Fair	35.5%
	Good	56.5%
Education	Graduated High School	27.5%
	Some College	19%
	Graduated College	18%

TABLE II

PHYSICIAN DEMOGRAPHIC INFORMATION

Average Age		42 Years
Years of Practice		13 Years
Sex	Male	85%
	Female	15%
Speciality Area	Endocrinology and Metabolism	70%
	Other Areas	30%
Communication Skills	Interviewing	4.5 Hours
	Interpersonal	1.1 Hours

TABLE III

CORRELATIONS

1. Assertive - patient age increase	-.0948
2. Assertiveness - male	.4873
female	.4865
3. Assertiveness - higher income	.2603
4. Assertiveness - higher education	.3516
5. Satisfaction - patient return to visit physician	.6849
6. Assertiveness - physician-patient perception	.5989
7. Assertiveness - patient return to visit physician	.3691
8. Assertiveness - patient satisfaction	.5778
9. Assertiveness - physician satisfaction	.4865
10. Assertiveness - patient apprehension	-.6231
11. Endocrine/metabolism - patient satisfaction	.6849
12. Endocrine/metabolism - patient assertiveness	.6161

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