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American Medical Association Journal of Ethics
July 2012, Volume 14, Number 7: 557-559.

JOURNAL DISCUSSION

Exploring Physicians' Attitudes about and Behavior in Communicating with Patients

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Iezzoni LI, Rao SR, DesRoches CM, Vogeli C, Campbell EG. Survey shows that at least some physicians are not always open or honest with patients. *Health Aff (Millwood)*. 2012;31(2):383-391.

There is widespread agreement amongst physicians that openness and honesty are essential characteristics of communication with patients. However, even as these principles are foundational concepts of medical ethics and endorsed by various professional associations, adherence to them in clinical settings may vary. Few studies have explored how widely these ideas are accepted or practiced by physicians and how variations in beliefs and behaviors might be explained.

Iezzoni et al. explore these questions in their 2012 *Health Affairs* article [1]. The authors present data from a 2009 national survey assessing U.S. physicians' reported practices and beliefs regarding principles of the Charter on Medical Professionalism, which is endorsed by more than 100 professional groups and the U.S. Accreditation Council for Graduate Medical Education. The article reports results of a nine-question module intended to gauge attitudes and behaviors related to patient-physician communication.

Iezzoni et al. found strong evidence of broadly shared consensus about most of the attitudes measured: in general, respondents "completely agree" that physicians should fully inform patients of risks and benefits of treatment, never tell a patient something that is not true, and never disclose confidential patient information to unauthorized persons. However, the authors express concern about the greater variation in responses on disclosing medical errors and financial relationships with drug companies. More than a third of respondents reported that they either somewhat agree or disagree that physicians must disclose these things.

The national survey showed greater variation in how physicians *acted* than in their attitudes—in other words, a gap between beliefs and practices. More than half the respondents reported having described a patient's prognosis as more positive than evidence indicated [2], about 30 percent reported having (either accidentally or intentionally) revealed confidential information to an unauthorized person [2], and approximately 20 percent reported having not fully disclosed a mistake to a patient for fear of litigation [2]. In sum, the authors conclude that there is reason to be

concerned about the accuracy of information patients are receiving from physicians and, hence, in their ability to make informed health care decisions.

Iezzoni et al.'s article raises a number of questions about variation in the nature of interactions between physicians and patients and in the ethical concerns that exist about such interactions. These questions arise, in part, because of the scope of their physician-patient communication module—the module surveys a broad range of professionalism concerns and is intended to identify variations in adherence to professional norms, rather than explain why these variations exist.

The authors acknowledge the complexity that might underlie their findings—the physicians surveyed practice in a variety of interpersonal, cultural, and situation-specific contexts. However, it is also important to acknowledge that, even as these questions may, in aggregate, comprise meaningful facets of professionalism, they rely on a more individual and less coherent set of ethical concerns and responsibilities. There are qualitative differences in the ethical concerns that underlie these questions, such as the difference between willful disregard of professional norms and inadvertent mistakes (for example, between revealing confidential patient information intentionally or accidentally); the extent to which different types of communication are perceived to directly impact individual patient care (for example, fully informing patients of the risks and benefits of treatment versus consistently disclosing financial relationships with drug companies); and the difference between concealing treatment-related information for self-interested reasons (for example, financial incentives or fear of litigation) and concealing the same information out of concern for the patient (for example, in an attempt to protect the patient from emotional distress).

Iezzoni et al. measure responses to their questions about patient-physician communication attitudes and behaviors against a number of predictor variables that previous research has suggested explain differences in medical professionalism: respondents' sex, racial minority status (race or ethnicity other than white or Asian), years in practice, graduation from a medical school outside the U.S. or Canada, medical specialty, and practice setting. They also hypothesize a possible relationship between patient-physician communication and malpractice claims..

They found differences in communication attitudes and behaviors between sexes, racial groups, and medical specialties. The meaning of these differences is difficult to interpret—although members of underrepresented groups (women and racial minorities) were more likely to respond in compliance with professional standards, more than half of the differences were not significantly associated. Likewise, even when there were differences in communication attitudes and behaviors by specialty, the authors found no consistent patterns. With regard to the differences between responses by sex and race, Iezzoni et al. suggest that members of underrepresented groups may feel more pressure to comply with professional standards because of their more tenuous position within the field. Alternatively, it is possible that

members of underrepresented groups are more likely to report adherence to professional standards than members of historically dominant groups [3].

With regard to the differences in communication attitudes and behaviors by specialty, it is possible that future research about the qualitative variations in different types of communication experiences would help to make sense of these findings. By asking respondents to provide details about their experiences with patients, researchers might be able to categorize the various types of communication experiences by specialty and region into a parsimonious model.

Iezzoni et al.'s article provides substantial evidence that future empirical research about physician approaches to and experiences of patient communication is needed. Descriptive data about the nature of physician communication experiences would increase understanding of the relationship of physicians to professional standards and the role that professional standards play in determining behavior. Why do physicians engage in behaviors that appear to violate stated professional principles? A study designed to answer this question would help determine if noncompliance with professional standards is motivated by personal or ethical concerns, as well as determine whether there are alternative ethical commitments that may conflict with professional principles.

References

1. Iezzoni LI, Rao SR, DesRoches CM, Vogeli C, Campbell EG. Survey shows that at least some physicians are not always open or honest with patients. *Health Aff (Millwood)*. 2012;31(2):383-391.
2. Iezzoni LI, et al., 388.
3. The authors acknowledge the possibility of social desirability bias, however, they seem to assume that all groups are affected equally.

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