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Loredmy Herrera-Kiengelher[I]

Mirna Villamil-Álvarez[I]

Blanca Pelcastre-Villafuerte[II]

Fernando Cano-Valle[I]

Malaquias López-Cervantes[III]

Relationship between health providers and patients in Mexico City

ABSTRACT

OBJECTIVE: To assess quality of the relationship between inpatients and health providers.

METHODS: A qualitative study was carried out in a tertiary care hospital in the Mexico City, Mexico, between February and July 2005. In-depth interviews were conducted with 40 inpatients. The following categories of analysis were used to explore the respondent's perception of care: attitudes and actions of medical and nursing providers, effective communication, level of knowledge of patients and their family on the diagnosis, clinical treatment, and evolution.

RESULTS: Overall the level of satisfaction with health care was high. Inpatients perceived everyday (non-clinical) interactions with medical and nursing providers as inadequate due to lack of confidence to request information on their condition. In addition, this perception was reinforced by excessive use by providers of technical terminology.

CONCLUSIONS: The routine relationship between health providers and their patients is perceived as inadequate showing that clinical effectiveness does not mean high quality of care. There is a need to bring together technical-scientific efficiency and patients' needs and expectations of non-clinical interactions.

DESCRIPTORS: Quality of Health Care. Professional-Patient Relations. Health Personnel. Health Services. Interview. Physician-Patient Relations. Qualitative Research.

INTRODUCTION

Quality of health services was first assessed in the early 1900s and then it has become a key tool for health system management. Since 1990s the assessment of care quality has included the measurement of patient satisfaction, which proved to be a valuable component for the assessment of health services.[5,17]

The conceptual and methodological mainstays of health care quality that are globally accepted are based on Donabedian's model. This author proposed to assess quality based on three dimensions: structure, process, and result. The model assumes that results are an expected consequence of care provided, although it is recognized that not all results can be exclusively attributed to processes and, therefore, not all processes will be directly and clearly determined by the structure. [5,6]

Conventional assessment studies of users' satisfaction with health services have focused on the measurement and characterization of utilization patterns and have enabled to identify the magnitude of the problem and major factors associated to these practices. However, the survey approach does not allow to exploring other aspects that could provide further input to better understand

[I] Departamento de Calidad de la Atención. Instituto Nacional de Enfermedades Respiratorias. Secretaría de Salud. México, DF

[II] Centro de Investigaciones en Sistemas de Salud. Instituto Nacional de Salud Pública. Secretaría de Salud. México, DF

[III] Facultad de Medicina. Universidad Nacional Autónoma de México. México, DF

Correspondence:
Malaquías López-Cervantes
Facultad de Medicina
Universidad Nacional Autónoma de México
Cd. Universitaria
CP 04510 Mexico, DF, Mexico
E-mail: mlopez14@unam.mx

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how these factors operate and why and how to intervene. The modern literature has been acknowledging the importance of qualitative approaches with the purpose of giving voice and knowing the experience of the different actors to understand a variety of social processes.[16,18] In a study conducted in Colombia on patients' perception of health providers (doctors and nurses), it was found that the providers are the ones with skills and knowledge to treat diseases, but they distance themselves from interaction with patients by not thinking science as a social process.[12]

The objective of the present study was to assess the quality of the relationship between health providers and patients in a tertiary care hospital.

METHODS

A qualitative study was carried out including 40 in-depth interviews of patients regularly admitted to a tertiary care hospital for at least 15 days, in Mexico City, from February to July 2005. Hospital stay was long enough to allow greater interaction between patients and the hospital's providers.

Patients' experiences regarding non-clinical interaction provided at the hospital were collected during these interviews, as described by Valles.[20] The categories of analysis to explore the perception of care among respondents were defined based on an interview guide as follows: a) attitudes and actions of medical providers and nurses, identifying actions lacking cordiality and respect to different social and cultural backgrounds, and personal and moral beliefs of patients and their family; b) effective communication, referring to adequate exchange of information between patient and/or their family and medical providers and nurses; c) diagnosis, referring to the level of knowledge of patients and/or their family about the diagnosis, clinical treatment, progress, or other information that medical providers and nurses on their capacities are required to provide in a clear, timely and reliable manner.

In addition, sociodemographic information such as age, sex and socioeconomic condition was collected and a field journal was kept. An interview guide was developed and any adjustments were made during the study as needed. Sampling was based on theoretical saturation[4] to determine the final number of interviews. Each interview lasted on average two hours.

The following strategies were used for data collection and analysis: all interviews were recorded and immediately transcribed and reviewed. The analysis was performed using Ethnograph 4 software program based on the steps described in the respective theory.

An informed oral consent was obtained from all respondents and the study was approved by the Institutional Review Board.

RESULTS

In a 20-day hospital stay, 16 interviews were carried out with male patients and 24 with female patients between February and July 2005. Mean age of respondents was 35 years (range 20–70). Adult respondents were admitted to different clinical departments due to pulmonary conditions with no comorbidities. Except for male respondents, all were married and had children, four of them had college education, ten had vocational and high school education and 26 had elementary education.

The diagnoses of patients interviewed were distributed as follows: severe asthma/pneumonia (8), lung cancer (7), chronic obstructive pulmonary disease (COPD)/ respiratory failure/plus superinfection (6), pulmonary fibrosis/plus infection (6), diffuse interstitial pulmonary disease (1), aspergillosis due to sequelae of pulmonary tuberculosis/lobectomy (1), pulmonary tuberculosis/ hydropneumothorax (1), pleural effusion (1), systemic lupus erythematous (1), obstructive sleep apnea syndrome(OSAS)/metabolic syndrome/suspected pulmonary thromboembolism (1).

In those cases where inadequate interaction with the patient was identified, it was noted that patients felt necessary to reiterate above all their improved health condition (efficacy of the medical care provided), attributed to the expert knowledge of the attending providers. At the same time, they expressed that the providers' actions, especially of physicians, were accompanied by attitudes impregnated with authoritarianism, lack of feeling or open indifference while delivering medical care.

"*…the truth is I'm still alive thanks to the hospital. When I got to the emergency room the doctors were very professional, I was in such a bad shape that I was moved to the intensive care. But if they are 10 from the professional side, from the humanist side, the truth is that I wouldn't rate them high, it is a pity, they have so much to give but they behave in such an authoritarian manner…*" (female, 20 years old, asthma)

"…The other day a doctor came in yelling at us, and when the family member of the patient he came to check asked him kindly to also check the other patient opposite her because she had the same symptoms, he asked her if she was also his wife to tell him what to do…" (female, 45 years old, pneumonia)

"….I've been told that this hospital was the only place where they have the best medical specialists. I wasn't well since November last year but in fact they decided to move me to this hospital because they didn't know what I had, (…) then I came here and began to recover (…) well, we cannot have it all, they either cure you or treat you well. But, yes, regarding the professional side, I have to acknowledge that they are the best specialists…" (male, 49 years old, tuberculosis)

Another aspect repeatedly stressed by the patients was the perception of an attitude of rejection concerning their values, fears or beliefs about their disease and/or health condition, expressed during the care process:

"…I told the doctor that the first time I felt sick was one day when they washed the bakery with ammoniac and I felt weird as something was happening to me here, see, on my chest. Then when I went out I saw a dead dog and a bad smell got inside me and soon after I became ill (…) the bad smell had infected my lungs. What do you think? (…) when I told him the doctor moved his head and I felt he got bothered…" (male, 36 years old, asthma)

The major reasons for the perception of inadequate interaction with the patients were lack of acceptance or rejection of different ways of thinking due to social and cultural diversity of the population served, in addition to lack of cordiality and attitudes of authoritarianism or indifference. Moreover, it was found a close association with lack of communication and information during care of these patients.

When the patients were asked about lack of effective communication and information during the care process, some reported having an inadequate relationship with health providers:

"…Yes, I was told why I was ill, but I didn't understand (…) why should I waste their time by asking them? Maybe they will even get angry, I haven't heard any bad words, I cannot lie to you, but the thing is that I feel embarrassed, you can see they are always in a hurry and angry…" (female, 28 years old, OSAS)

Another aspect that also confirmed the lack of effective communication and adequate information was that the patients repeatedly requested information during the interview:

"…Do you know if this thing that I cannot grasp air will kill me soon?..." (female, 28 years old, OSAS)

When they were inquired about the reasons why they did not ask their questions to the physician, the patients reported as main reason lack of confidence to ask the providers. And they justified it as follows:

"…My shortness of breath, the doctor told me that is spasm, what?, yeah, he told me I have (…) this thing bronchospasm (…) No, it is not that, I didn't understand him and I felt embarrassed to tell you the truth (…). What's the point of asking them, they don't care if I understand it or not, they don't have much time for me to bother them (…) you see their faces and feel you should not bother them." (female, 56 years old, COPD)

"…It is not that I'm not sure or I'm afraid to ask the doctors, but I like you, you make me feel good, that's why I'm asking you many questions, if my disease is this or that…") (female, 48 years old, lung cancer)

"…See, I asked you because I feel assured to do it. To tell you the truth the doctor seemed kind of annoyed when I told her I didn't quite understand it, the effusion..." (female, 52 years old, COPD)

The patients who perceived having a good relationship with medical providers and nurses described in more accurate details their illness and clinical treatment. On the other hand, those who reported adequate non-clinical interaction did not ask the interviewer questions about their condition or any other related aspects. This can be seen in the following account, where the same patient reported having asked more information directly from the medical provider and/or nurse.

"…The doctor is very good, (…) he comes in everyday, sometimes even twice a day, to check on us and talks to us, (…) they have clearly explained me about my disease, and when I don't get it very well, I ask them." (male, 38 years old, pneumonia)

Another recurrent aspect was the use of technical terminology to provide information to the patients and/or their family about their diagnosis, clinical treatment and/or progress, and since the providers used specific medical jargon, they are not quite clear or not clear at all to the patient.

"… I don't understand my diagnosis because they don't explain it clearly to me. I know I have an inflamed trachea and that's why I have a tracheostomy. But if you are asking me any suggestions, I'd suggest that the medical terms used by the doctors should be clearer so that we can understand our actual condition…" (male, 48 years old, lung cancer)

DISCUSSION

Hospitalized patients who perceived adequate interaction showed higher level of well-being and had also the required confidence to ask providers information about their illness, in addition to care actions.

On the other hand, those who perceived inadequate interaction, regardless of whether they noted a remarkable improvement on their health condition, showed fear and uncertainty about their potential recovery and a considerable lack of confidence to ask the required information. This seems to be a logical reaction to the lack of cordiality during the medical care process. Given that, there is a need to put more emphasis on the strategy to improve quality of health services.

Moreover, it was corroborated the importance of the association between adequate interaction and respect to human rights.[14,20] Health providers should incorporate

to their medical and scientific practice values and universal principles of bioethics, not as an obligation but rather as a free choice. Health providers must be fully aware that all medical actions should be at the service of human beings in the process of building up a more just and equitable society.[2] The ultimate commitment of health care services is to assure respect of human rights and personal guarantees.

The findings of the present study are consistent with what was previously stated, that "(…) different from other components of health service quality, adequate interaction is not only desirable but also achievable, whether or not other objectives are achieved. Its relevance should be considered and there should be implemented and designed activities and institutional and interinstitutional relations based on legitimate expectations of their clientele...". [15]

Another aspect expressed by the patients studied that prevents creating a trust relationship is the excessive use of technical terms. The fact that health providers use a language that is strange to their patients creates limits and symbolic fields that eliminate any possibility of developing a trust relationship during medical interactions, preventing patients and/or their family from overcoming their fears and asking questions about their illness and chances of recovery.[14,15]

Adequate interaction in health care, although essential to the interpersonal dimension, is not linked to the achievement or effectiveness of other objectives set in the care process. The respect for human dignity and integrity requires following rules of social interaction at all levels while dealing with a social individual, particularly if this individual is a hospitalized patient and thus vulnerable due to loss of health.[1,4,15] Health providers should know that pragmatic communication involves identifying and respecting the patients' social and cultural background and personal circumstances to provide them access to information, and avoid the indiscriminate use of technical terms that prevent their access to information in an adequate and timely manner.[15,20]

The relevance of the present study lies on the identification of the type of relationship between hospitalized patients and health providers as a means to attain equity in services and optimal operation of health facilities. High quality services cannot be provided when providers do not incorporate to their technical and scientific knowledge ethical and human values that support and legitimate their work, as underlined in previous studies.[14,20]

Since adequate interaction is translated into respect to the patients' human rights, one of the goals is to assure the patient's autonomy, freedom, integrity, and dignity. This can only be achieved if health providers are aware that, in addition to sharing space and time, there is a need to share ethical and humanist codes that permeate any relationship between human beings and institutions. These codes define the patients' needs and expectations of interpersonal interaction and allow health providers to find opportunities for their practice to be an effective based on equity and respect to human dignity.

Foucault highlighted that people (patients) should be converted into an object of knowledge and scientific practice rather than regarding disease as an entity.[7]

In conclusion, it is imperative that health providers should be more aware that attaching ethical and humanist values to their daily practice allows them to incorporating patients' expectations and needs and helps providing high quality services regardless of the patients' social, cultural, and economic background.[8,10]

To achieve an adequate interaction based on bioethics, quality and human cordiality, it should first be recognized that medical practice have to face today a new challenge, i.e., acknowledge human corporality not only as a vehicle to maintain life from a biological stand but also that that allows the most complex and abstract element that makes possible human life and identity.[3,9,11]

Most modern health care services have overlooked and underestimated perceptions, uses and traditional costumes about health and disease. As a consequence, individuals are unable to have access to a world of technical knowledge ruled by this solemn and impenetrable group of medical and paramedic professionals of a health facility. Therefore, patients and their family feel vulnerable, and as Bourdieu has put it, have to face a *habitus* that by excluding them, put the emphasis on one of the essential gears of quality of care: the patient's expectations as inherent to adequate interaction.[3]

There is a need to change the perception of health providers of what they consider essential for disease management and health maintenance: technical aspects rather than adequate interaction, as shown in recent studies.[13,15,19] There is also a need to change attitudes going beyond the line that divides symbolic fields that are part of the same reality, the human reality and interpersonal communication in the care process. The importance of interaction in the interpersonal dimension of the care process was described by Donabedian more than two decades ago, when he stressed it as an essential component of quality of care, derived from care provided by medical and paramedic providers.[5,6,9]

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