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How do patients define satisfaction? The role of patient perceptions of their participation and health provider emotional expression

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Abstract

Patient satisfaction is important to patient outcomes. Previous attempts to conceptualize satisfaction have often taken an atheoretical approach and focused on doctors' communication skills. Patients are becoming more active health consumers involved in their health care and current definitions of patient satisfaction may not accurately reflect patient expectations about their health consultations. Earlier research found that meeting patients' emotional needs - through empathy and patient-centred communication - is important to patient satisfaction. New research is needed to explore how those needs can be met given the changing trend in patient behaviors and the focus on patient-centredness. This study employed two communication theories - the Willingness to Communicate Model and Communication Accommodation Theory - to consider both patients' communicative decisions, and the intergroup features of the health context that can influence communicative behaviors. Two hundred and fifty-three patients from health clinics in Canada and Australia described what satisfaction meant to them, and identified what aspects of their health consultation were satisfying (or not), and we investigated their perceptions of doctor's emotional expression. Results suggest that patient perceptions of their participation in the consultation predicts their perceptions of doctor emotional expression, and their satisfaction with the consultation. Patients want both emotional and medical needs met in an environment that balances interpersonal and intergroup communication. Our findings suggest the need to expand current definitions of patient satisfaction, patient-centredness and emotional expression. We discuss the implications of these findings for health practitioners and consider future research that addresses the need for more individualized health care.

How do patients define satisfaction? The role of patient perceptions of their participation and health provider emotional expression

The importance of effective communication between patients and health professionals to quality health care has been well established (Dutta-Bergman, 2005; Epstein & Street, 2011a). Research that explores doctor-patient communication has paid particular attention to the effects of the provider-patient relationship on patient satisfaction. Patient satisfaction has significant implications for health outcomes such as adherence to treatment and overall well-being (Joosten et al., 2008) so it has warranted the attention. Satisfaction is often operationalized by researchers without any consultation with patients. In this paper, we investigate how patients in a health consultation define satisfaction, and what they found satisfying (or not) about a recent health consultation. Our intention is not to question previous measures of patient satisfaction but rather to confirm and possibly extend previous definitions.

Researchers have shown that, although it is important to meet patients' medical needs, it is equally important to attend to their emotional needs to assure healthcare satisfaction (Levinson et al., 2000; Yagil & Shnapper-Cohen, 2016). As medical science progresses, and new technologies for diagnosing and treating patients emerge, there is a risk that the emotional needs of patients will be neglected. Therefore, it is important to continue research in this area to reinforce the benefits of attending to patients' emotional needs and how this relates to their satisfaction. When it comes to meeting the patient's emotional needs, the emphasis is placed on the communication abilities of the health provider. For this reason, research that explores how health providers address the emotional needs of their patients

tends to take an interpersonal approach and focus on the communication skills of the health provider and how they effectively manage the consultation. This approach is understandable, but communication is not one-sided and, when it is possible, successful communication in the health context requires a cooperative effort from both the doctor and the patient. Indeed, health providers cannot meet the emotional needs of their patients unless those needs are expressed. Therefore, there is a requirement for patient-centered research to investigate patient communicative behavior, and how it affects patients' evaluations of their health care. The application of robust theories allows researchers to explore patients' communication behaviors and predict patterns of responses to different styles of health consultations. We adopt two theories in our study - Communication Accommodation Theory (CAT; Giles, 1973) and the Willingness to Communicate (WTC) model (MacIntyre et al., 1998; McCroskey & Richmond, 1991). We propose that invoking these two strong communication theories will increase understanding of the role that patient participation and their perceptions of health provider emotional expression play in how patients define satisfaction with their health care. The two theories are complementary and acknowledge the role of group relations in interactions.

CAT and Emotional Expression in the Health Context

The focus on interpersonal communication ignores the group dynamics of a medical consultation. Communication in the health context is often driven by social identities (salient identities of the 'health provider' and the 'patient') due to the power, role, and social differences among interactants (e.g., Street, 1991; Watson et al., 2016). Further, Street noted that patients and providers interact because the patient is seeking medical advice, making the interaction more business-oriented than social. Thus, we argue that both interpersonal and intergroup dynamics must be investigated. CAT has been shown to be ideally suited to

examine the interpersonal and intergroup facets of the provider-patient relationship (see Watson & Soliz, 2019).

CAT aims to explain communication patterns that often emerge in intergroup encounters. It is beyond the scope of this paper to describe the theory in detail (see Giles, 2016 for a complete description), but essentially CAT was developed to describe how interactants use language to signify and negotiate their personal (individual idiosyncrasies) and group identities (social and professional memberships) through the use of communication strategies. These strategies can either accentuate (nonaccommodative) or reduce (accommodative) group differences between interlocutors. What determines which strategy will be used often depends on the ultimate goals of the speaker. For instance, the more strongly the speaker identifies with their ingroup and wishes to emphasize that membership (and so differentiate themselves from their speech partner's outgroup), the more nonaccommodative they may be.

We focus on the communication strategy of Emotional Expression and the fact that effective interactions need to meet emotional and relational goals. Although CAT is a general theory of communication, it addresses specific contexts, including doctor-patient interactions. In the health setting, CAT posits that emotional expression strategies involve patients expressing their health anxieties and concerns, and the health provider responding, when appropriate, with understanding and reassurance. The reassurance needs, health concerns, and mood and anxiety levels will vary from patient to patient, but CAT posits that a successful emotional expression occurs when a patient's individual needs are met (Cegala et al., 1996; Kreps, 1988). This means that patients' perceptions of the interaction will likely override doctors' intentions. Specifically, if the patient does not feel that their needs are met, they will not be satisfied with the consultation. Importantly, our emphasis on emotional expression is not being considered at the expense of acknowledging the importance of a doctor's medical

competence. Indeed, if a doctor has excellent levels of emotional expression but is not competent and task-focused, then patient satisfaction is likely to be reduced. We explore the presence of appropriate emotional expression but also take account of competency. We do this by investigating what aspects of care patients report provide satisfaction or dissatisfaction in their actual health consultation.

The theoretical addition of emotional expression to CAT was originally explored in the health context by Watson and Gallois in the late 1990s (Watson & Gallois, 1998, 1999). In their research, participants were asked to watch and rate doctor-patient interactions. Their findings showed that participants identified satisfactory interactions as meeting more of the patient's relational and emotional needs. Specifically, the health providers showed interest and concern for the patient and were more reassuring. As a result, those health providers were rated as higher in emotional expression. The present research aims to expand on that research in two ways. First, we are examining patient reactions to their own personal health consultations (as opposed to rating others'). Second, in the twenty years since Watson and Gallois' work, there has been a notable shift in patient communication that warrants attention. Patients were once described as passive recipients of health care (Parsons, 1951; Thompson, 1994), but more recent research suggests this trend is changing, and that patients are more active participants in their health (Delaney & Martin, 2017; Epstein & Street, 2011b). For instance, it has been suggested that the extensive amount of health information available on the Internet is being widely used by patients, so they no longer have to rely solely on their health provider for information. Further, a recent study by Baker and Watson (2020) showed that some patients searched for health information online specifically for the purpose of communicating with their doctor. Therefore, we should now consider patients' growing motivation to communicate their anxieties, preferences, and concerns, and to be active participants in the health consultation, and how this influences their perceptions that the

health provider is meeting their emotional needs. Using the WTC model provides an important measure of how patients feel about talking in a medical interaction, and complements CAT's emphasis on needing to know a patient's attitude (WTC) towards a medical encounter.

Patient Willingness to Communicate

McCroskey and Baer (1985) designed the WTC construct to describe the probability of communication in one's first language (L1) when given the choice. WTC was considered to be a trait that reflected a stable predisposition to talk. This finding was supported by research that showed consistent reliability in people's choice to communicate across a variety of situations (McCroskey & Richmond, 1991). The WTC construct was later employed to examine communication in the second language (L2) context. Findings from that research revealed that, compared to communication in the L1 context, communication in the L2 context produced much more variability in communicative behaviors (Baker & MacIntyre, 2000; MacIntyre et al., 2001).

L2 contexts tend to highlight the intergroup aspects of communication because they often entail differences in language status and identity that subsequently influence communicative choices (see Clément et al., 2003). As such, it has been argued that L2 communication evokes more variation in two of the best predictors of WTC - communication anxiety, and subjective perceptions of communicative competence. Specifically, when a speaker's anxiety is high, and their perceptions of competence are low, they will probably choose not to communicate. The WTC construct has been recently employed to explore doctor-patient communication. The construct is a valuable tool in exploring communication in the health context because it can account for why some patients actively avoid communicating with their health providers. Recent research has shown that WTC can be an asset to patients. For instance, Baker and Watson (2015) found that patient WTC significantly

predicted both adherence to treatment recommendations, and patient satisfaction with health care.

In the context of the present study, patient WTC may be related to their perceptions of their health provider's emotional expression in the health consultation. Health providers can only address patients' anxieties and concerns if they are communicated. Indeed, research has found that active patient participation results in doctors using more patient-centered communication (Cegala & Post, 2009). Thus, compared to patients with low WTC scores, patients with high WTC scores may be more likely to express their needs to their provider, and subsequently have those needs met. As a result, their perceptions of provider emotional expression would be higher. It is important to remember that the WTC construct is conceptualized and measured based on an assumption that individuals can choose to communicate (or not). This premise means that under certain conditions, people may have the intention to communicate, but feel that they are not free to do so. As suggested by CAT, the health context represents a communication setting in which one interlocutor (i.e. the health provider) limits the communication of their speech partner (i.e. the patient). In addition to patient WTC, therefore, we must consider how patient perceptions of their participation in the health consultation influences their perceptions of provider emotional expression. Specifically, health providers must be willing to give up some of the control in the health consultation. Compared to patients who feel they did not have the opportunity to participate, patients who perceive that they had the opportunity will likely perceive the health provider is showing interest and/or concern, which may signal higher health provider emotional expression. The relationship among patient WTC, their perceptions of participation in the health consultation, and their perceptions of provider emotional expression may be an important component in how patients define satisfaction with their health care.

The Present Study

At the time of data collection, the two researchers were each based in Canada or Australia and thus obtained data from these two countries. The justification for this is that Canada and Australia both represent Westernized culture, with comparable healthcare systems. Using a mixed-methods approach, this study aims to define health care satisfaction from the patient's perspective, and to determine the role of emotional expression. By applying WTC and CAT theory, we can explore how patient communication, and perceived participation in the health consultation influence patient perceptions of provider emotional expression. We propose the following hypotheses:

H1: Patient perceptions of provider emotional expression will positively correlate with both patient WTC and perceptions of their participation in the health consultation.

H2: Patient WTC and perceptions of their participation in the health consultation will significantly predict patient perceptions of provider emotional expression.

Since the qualitative aspect of this study is exploratory, we do not have specific hypotheses concerning how patients define health care satisfaction. Rather, we anticipate that the following research questions will assist in obtaining a better understanding of how levels of satisfaction, as defined by patients, relate to measures of patient WTC, perceptions of participation in the health consultation, and perceptions of emotional expression.

RQ1: How do patients define health care satisfaction, and do they focus on their communication and provider emotional expression?

RQ2: What do patients identify as satisfying and dissatisfying about their health consultation?

Method

Participants

There were 253 participants (151 Canadians comprising of 97 females, 53 males, median age=29, age range=15-74; 102 Australians comprising of 67 females, 31 males, median age=62, age range=21-86 years) from Sydney, Canada and Brisbane, Australia in this study.

Materials

The study consisted of a questionnaire, which included the following:

Patient Willingness to Communicate with Health Provider (patient WTC). This scale was adapted from McCroskey and Baer's (1985) WTC scale for this study (see also Baker & Watson, 2015). This 5-item WTC in health contexts scale (alpha=.92) was administered with instructions asking participants to indicate the chances, expressed on a scale from 1 to 5 (1=almost never willing, 5=almost always willing), of their being willing to communicate in each of the 5 situations. The scale was administered with reference to speaking only in healthcare contexts. A sample item is "discussing medical treatment with the doctor." High scores indicated high patient WTC.

Emotional Expression Perceptions (EEP). The consultation and relation empathy (CARE) scale (Mercer et al., 2004) is a 10-item scale (alpha=.97) used to assess patient perceptions of their doctor's emotions during a given healthcare consultation. This scale was chosen because it taps into emotional expression as defined by CAT and is designed for more general medical practice. Participants responded using a five-point Likert scale, ranging from 1 (poor), to 5 (excellent). Sample items are "showed care and compassion", and "really listened." Higher scores indicated that patients perceived more caring and attention from their doctors during the consultation.

Patient Perceptions of Participation in the Health Consultation (PPP). In order to assess patients' perceptions of their participation during consultation, the perceived patient

centeredness of the consultation (PPCC, Hou & Shim, 2010) scale was adapted and administered. This scale is comprised of five items (alpha=.90) measured on a four-point Likert scale, ranging from 1 (never), to 4 (excellent). A sample item is "Gave me a chance to ask all the health-related questions I had." Higher scores were indicative of higher patient perceptions of participation in the health consultation.

In addition to the quantitative measures described above, participants also responded to the following three open-ended questions:

- What does it mean to you to be satisfied with your visit to the doctor?
- Can you tell us what you were satisfied with in your consultation today?
- Is there anything you were dissatisfied with in your consultation today?

Procedure

Research assistants (RAs) from the team approached patients at local health clinics while they were waiting for their appointment with the doctor. The RAs asked patients if they would be able and interested in taking part in the study which involved completing a questionnaire upon exiting their consultation. In both countries the clinics were not for emergency treatment but were for general health issues. Permission to approach patients was granted by the managers of the clinics, but neither they nor the doctors and patients knew in advance what questions patients would be asked. Patients (or parents of patients under ages 16-18) who agreed to participate were given a consent form/information sheet and the questionnaire once they exited their consultation. Participation took approximately 15 minutes. Recruitment of participants was conducted on different days and at different times over a period of approximately two months.

Results

Preliminary analysis

A multivariate analysis of variance was conducted to determine if there were any significant differences between Canadian and Australian patients on the variables of interest in this study. The fixed factor was country (Canada vs. Australia), and the dependent variables were patient WTC, patient perceptions of participation in the health consultation (PPP), and emotional expression perceptions (EEP). At the multivariate level, there was a significant effect of country, $F(3, 224)=3.630$, $p=.014$. At the univariate level, there was a significant effect of country on PPP in the health consultation, $F(1, 226)=10.713$, $p=.001$, and on EEP, $F(1, 226)=6.375$, $p=.012$. The means were significantly higher among Australian patients (PPP M=16.99; EEP M=41.28) compared to Canadian patients (PPP M=15.44; EEP M=38.04). There was no effect of country on patient WTC, $F(1, 226)=1.963$, $p=.163$.

The results were in the same direction for both samples, but Australian patients rated their perceived participation and the doctors' emotional expression significantly higher than did the Canadian patients. The median age of Australian patients (62) is higher than the Canadians' (29). We address the possibility that this may be the reason for the differences in our discussion. Given, though, that Australian and Canadian patients significantly differed on two of the three key variables of interest, the remaining quantitative analyses were conducted separately for each country.

Relationship among patient WTC, PPP, and EEP

Correlational analyses were conducted to determine the relationship of patient WTC, and PPP with EEP.

Canadian patients. EEP significantly correlated with patient WTC ($r=.190$) at the 0.05 level, and with PPP ($r=.716$) at the 0.01 level. There was a significant correlation between patient WTC and PPP ($r=.198$) at the 0.05 level. This finding indicates that increases in

patient WTC and PPP are associated with increases in EEP. This supports the hypothesis (H1) that patient WTC and PPP are both positively correlated with EEP.

Australian patients. There was a significant correlation between patient WTC and EEP (r=.413), and PPP and EEP (r=.784) at the 0.01 level. Patient WTC and PPP also significantly correlated with each other (r=.410). Again, H1 is supported.

Predicting EEP

Multiple regression analyses were conducted to examine the predictive nature of patient WTC, and PPP for EEP.

Canadian patients. The adjusted R^2 was 0.494, indicating that approximately 49% of the variability in EEP is accounted for by the predictors. The regression equation was significant, F(2, 129)=64.910, p=.000. Results indicated that PPP (B=1.926, t(129)=11.011, p=.000) was a significant predictor of EEP. Specifically, PPP is associated with higher EEP. Patient WTC did not significantly contribute to the model (B=0.100, t(129)=0.588, p=.558).

Australian patients. The results of the regression for Australian patients showed that the adjusted R^2 was 0.618, indicating that the predictors account for approximately 62% of the variability in EEP. The regression equation was significant, F(2, 93)=78.002, p=.000. Results indicated that PPP (B=1.952, t(93)=10.657, p=.000) was a significant predictor of EEP. Thus, patients' perceptions of their participation in the health consultation is associated with higher perceptions of health provider emotional expression among Australian patients as well. As with the Canadian patients, patient WTC was not a significant predictor of EEP (B=0.346, t(93)=1.578, p=.118).

Taken together, the correlation and regression results for the two groups suggest the possible presence of mediation. Patient WTC correlated significantly with EEP but was not a significant contributor in the regression model. For both cohorts, PPP significantly predicted EEP, indicating that it potentially acts as a mediator between patient WTC and EEP. Testing

mediation was not an initial goal of this study, so we did not manipulate PPP. Therefore, we can only suggest it as a mediator. This finding is considered further in the discussion.

Patient satisfaction

To address the research questions in this study, patients' definitions of satisfaction, and their descriptions of satisfying and dissatisfying aspects of their health consultation were analyzed using Leximancer 4.5 (Smith & Humphreys, 2006). Leximancer is a text-mining software program that identifies key themes (general topics) and concepts (specific topics that make up the general topics) in a text. Information about the program, the manual and tutorials are available at http://www.leximancer.com.

For the qualitative analysis, Canadian and Australian patients were analyzed together. If there were any significant differences between the groups, they would become evident once we identified the central themes and concepts on the maps and examined the excerpts.

Defining patient satisfaction

Figure 1 presents the most prominent concepts and clusters for this analysis. The map shows three distinct themes that emerged - Time, Patient-centered communication, and Listening. We have provided exemplar extracts for each theme with participant number, country of origin, sex, and age in parentheses.

<Insert Figure 1 here>

Theme 1: Time. We called this theme 'time' because patients indicated that doctors could show concern for them by not rushing them through their consultation. The predominant concepts here were 'time', and 'concern'. Patients highlighted the importance of removing time-constraints from consultations. An examination of the concepts associated with this theme also suggest that time combined with caring are key features of a satisfying consultation. Although there were many extracts to choose from, they all expressed the same idea, so we provided two that best illustrate this theme.

- I want someone who will take their time with me; someone who will listen and be concerned about what I have to say. Hate being rushed out because there are others behind me; if I waited so should those behind me. (#111, Canada, female, 61)

- Feeling confident that [the doctor] relates concern and genuine interest in what is important to me. Whilst I know the public can be demanding of their time with each patient, better communication and time is a satisfying outcome for expectation of good results for myself. (#182, Australia, female, 70)

Theme 2: Patient-centered communication. We labelled this theme "patient-centered communication" because the concepts in it (e.g. talk, comfortable, care, problem) describe patients' desire to feel comfortable talking and disclosing information to their doctor. Thus, patients want to communicate with their doctor, but feel that it is important to be in an environment that encourages them to do so freely. For example:

- I am a new patient as I have moved to Banora and need a new doctor. I am 80 years and appear to be in fair health, but I like a doctor I can talk to and understands the problems of ageing. (#166, Australia, female, 80)

- To be made to feel comfortable and easy to talk to. Knowing what I say is kept in confidence. (#35, Canada, female, 35)

In the following excerpts, we can see that patients were also task-focused and emphasized the importance of seeing a doctor who can treat the patient and communicate information in a clear and comprehensive way. Some patients added that they want to feel that the doctor also cares about them.

- Leaving and understanding all the Dr. said and that you've been taken care of. (#110, Canada, male, 45)

- *Getting appropriate treatment, feeling comfortable about visit and feeling respected, and sure in understanding the problem and the treatment. (#185, Australia, female, 72)*

Overall, this theme describes the importance of creating a patient-friendly environment that invites patients to participate. The doctor's medical and emotional competency are both highlighted. Patients felt that the doctor should put them at ease, assure they understand the problem, and provide the health information the patients require to achieve optimal health outcomes. We feel that the following extract brings the main concepts in this theme together:

- *For most patients it can be difficult to work up the nerve to go to the doctor's. Apprehensive thoughts can hold someone back from seeking the help they need. It is important that the doctor be courteous and kind as well as thorough with their examination. Having the patient feel cared for should be a priority. (#113, Canada, male, 25)*

Theme 3: Listening. We called this theme 'listening' because patients described the desire to be respected and heard. Thus, in addition to wanting to be able to talk during the consultation (Theme 2), patients want their doctor to really listen to what they say. The prominent concepts in this theme were 'respect', 'concerns', 'listened', 'advice', and 'treatment'. Patients indicated that they expect to be part of their health care, and to be able to make informed decisions about their health care options and treatment. Patients said that they rely on their doctor's advice, but they feel that it is important to first be heard, so they are certain that the advice they get is appropriate for them (i.e. they want individualized care).

- *You have to have confidence in the doctor. If it sounds out in left field then I have no problem questioning the treatment. I need to feel the doctor actually listens. (#71, Canada, female, 50)*

- I need to feel like I am heard. I need to feel like I am informed. I need a level of control over my treatment. I need my opinion to count. (#222, Australia, female, 37)

- I expected to be listened to and have the health care professional base their recommendations on their training and experience rather than biases or perceptions. (#65, Canada, male, 45)

The following excerpt brings all three themes together, and provides a unifying description of a satisfying health consultation:

- Being satisfied by a doctor's visit involves him/her listening to my health concerns, identifying the issue and providing me with advice and if necessary medication to assist in getting back to optimal health. Feeling comfortable in front of the doctor is also extremely important and it took me 2 years to find a doctor that I am happy with for that reason. I am extra satisfied now as the doctor I have has a sound knowledge of my medical history for the last few years and I think that is also important – he has an understanding of my life. And also a willingness to release prescriptions. I was suffering from depression due to my sister passing away and my previous doctor - who I now no longer see - refused to listen to my needs and told me to simply "go and have a walk in the afternoons after work, that will make you feel better" and that would be sufficient in helping me deal with my loss. (#158, Australia, female, 23)

The Health Consultation Experience

For these data, we performed a Leximancer analysis designed to compare and contrast the concepts that emerged for satisfying and dissatisfying aspects of the patients' health consultation. The map depicted in Figure 2 shows that there were differences in the concepts associated with patient satisfaction and dissatisfaction.

<Insert Figure 2 here>

Dissatisfaction with the health consultation. It is important to note that the majority of patients (59%) said that they did not find anything particularly dissatisfying about their consultation. The remaining patients, though, did express some discontent. The concepts 'talk', 'rushed', 'time', 'discussion', 'feel', 'explain', 'things', 'consultation', and 'everything' were nearest on the map to dissatisfaction in the health consultation. This means that those concepts are more closely associated with patient dissatisfaction. A close examination of the concepts indicated that patients were primarily dissatisfied because they felt rushed through the consultation and/or that they felt that they did not have enough time to explain their health issues and concerns. Some patients indicated that they felt ignored by the health provider. The exemplars below suggest that in some cases, the patients felt that the doctor did not listen to them.

- The Dr. was not fully present or very communicative. It felt as though the Dr. wanted to get me out of there as fast as possible. (#80, Canada, male, 54)

- Dr. was on the phone to someone else whilst I was in the consult room. Dr. didn't take my blood pressure when prescribing the contraceptive pill (I thought this was required). (#230, Australia, female, 26)

In other cases, patients, although they wanted to, did not feel they could easily communicate with the doctor.

- Was very fast, not really patient. Didn't really listen to what I had to say; cutting me off, not letting me finish what I have to say. (#39, Canada, female, 19)

- There was a moment or two when the doctor was reading and writing on their mobile phone, which made me think that our (my) time was over - but I had more to say. (#180, Australia, female, 66)

Satisfaction with health consultation. We will not list all of the concepts here, but the prominent ones associated with satisfaction were 'friendly', 'asked', 'problem', 'treatment',

'issue', 'listen', and 'concerns'. In exploring these concepts, we found that several patients mentioned that the doctor was friendly, but did not mention communication.

- The Dr. was warm and friendly and understanding. (#84, Canada, female, 52)

- He was very friendly and talked about my interests. (#97, Canada, female, 18)

Other patients said that they were primarily satisfied because they felt that they were able to be part of their treatment plan. For instance:

- We talked about having a procedure to give me peace of mind if the results are negative - if not I know I will receive the best treatment possible. (#209, Australia, female, 86)

- She showed careful consideration of my issues and guided me to a understanding of what my most important worries were. Thus identified, we came to a consensus as to treatment. (#238, Australia, female, 64)

Many patients indicated that they prepare in advance of their consultation and liked that the doctor was knowledgeable and competent.

- Before going to the doctor, I do extensive research on what could be wrong with me. As I've learned from the past, my assumptions are not always right. However, the few times that I do come close, I'm glad to know that my doctor is up to date with new research and treatments and can intelligently and effectively communicate along with me. (#113, Canada, male, 25)

- I was able to express my health issues freely. I was very prepared with my notes or what meds I take. And a general run through on my history was noted. The GP gave me advice and help with my issues and advised me how to proceed when I felt ready to do so. (#211, Australia, female, 62)

Patients interpreted the doctor's listening as a sign of caring and concern. They felt they were heard and, as a result, were confident they were receiving the appropriate advice.

Patients said they did not feel rushed, and that they were given the time necessary to address their health issue.

> *- That my Dr. listened to what I had to say and gave the proper medication and advice that was needed. (#118, Canada, female, 18)*
>
> *- My doctor supported our concerns (i.e. I didn't feel I was wasting her time). She addressed all of my concerns and said I was doing all the right things. Further, she said if I was concerned at all she'd be happy to see us later in the week. (#197, Australia, female, 30)*
>
> *- This time I was most satisfied because before I even told her of my new concerns, the doctor gave me some new information regarding a problem I had seen about several weeks ago. Without any prompting, she remembered and addressed my needs. Today's visit was satisfying because the doctor heard my concerns, agreed to a plan of action and wrote a referral and asked for feedback. (#183, Australia, female, 68)*

Overall, there were no notable differences between the Australian and Canadian patients in the qualitative analyses. Given that the quantitative results showed higher PPP and EEP among Australian patients, we wanted to examine the demographics of those who reported dissatisfaction with their health consultation. There were an equal number of Australian and Canadian patients who reported being unhappy with their consultation. When we looked at only the age of the participants, we noticed that 45% were aged 18-29, 37% were 30-50, and 18% were 51-79. This suggests that older patients are more satisfied with their health care than younger to middle-aged patients. We contemplate the implications of such findings in the discussion.

Discussion

Using a mixed-methods approach, this paper explored patient satisfaction, and how it relates to the emotional needs of patients, and how patient WTC and their perceptions of

participation in the health consultation influence perceptions of doctor emotional expression. We asked patients to define for us what satisfaction means to them in general. As well we asked them to identify which aspects of their own actual health consultation were satisfying and/or dissatisfying, and to provide their perceptions of both their WTC with the health provider, and their participation in the health consultation.

The first analyses focused on identifying the relationship among patient WTC, perceptions of participation in the health context, and perceptions of doctor emotional expression. We explored possible differences between Australian and Canadian patients and found that Australian patients indicated significantly higher PPP and EEP. We noted that Canadian participants were younger than their Australian counterparts and suggest that this may be one reason for the differences. Patient age has been associated with satisfaction (Jaipaul & Rosenthal, 2003), and perceptions of doctor-patient communication (DeVoe et al., 2009). Specifically, older patients (typically age 65+) tend to view the communication more positively than younger patients. It has been suggested that older patients have greater familiarity with the health care system, so their expectations tend to match the health care they receive (Bower et al., 2003). Another possible explanation for the differences we found is that the sample from Australia was drawn from an affluent part of the country while the Canadians were middle class. In addition, unlike the Canadian sample, Australians could choose and change their doctors as they wish. Thus, the Australian patients may have been able to move to a new health care situation that resulted in more positive perceptions. Finally, another possibility - and this relates to age as well - is that the Australian patients (because they were older) may have had more chronic conditions. Research has shown that the structure and topics of consultations differ between chronic and acute patients. The former tends to discuss a broader range of issues with the provider than do acute patients (Watson & Cretchley, 2010). As well, those with chronic illnesses tend to have more interactions with

health providers and become experts in communicating what they want. Smith et al., (2017) recognised that that chronic patients have their own needs and frustrations, and that health providers would do well to recognise this fact in order to facilitate effective communication. Future research should explore the effects of patient age and condition (chronic vs. acute) on perceptions of patient communication, and doctor's emotional expression. Findings from such research could underscore the value of offering health care that meets individual patient needs.

Despite the mean differences, the pattern of relationships among patient WTC, PPP and EEP were the same for Australian and Canadian patients. As anticipated, there was a positive relationship among the variables, indicating that higher patient WTC, and perceptions of participation are associated with higher emotional expression perceptions. Only patient's perceptions that they participate in the health consultation, though, significantly predicted their perceptions of doctor's emotional expression. Although patient WTC was significantly correlated with EEP, it was not a significant predictor when PPP was taken into account. This indicates that PPP potentially mediates the relationship between a patient's choice to communicate and their perceptions of doctor's emotions. The WTC construct describes the choice to communicate when given the opportunity to do so. In the health context, the freedom to communicate is often greatly reduced. As suggested by CAT, the intergroup features of the health context are such that the doctor has more control over the communication. Patients, although they want to, may not be given the chance to participate in the consultation. As such, patient WTC may only indirectly influence EEP through perceptions that they get to participate in the consultation. Examining PPP as a possible mediator was not the goal of this study, so we did not manipulate the extent to which patients could participate in the consultation. Importantly, this finding, though, opens avenues for further investigations. Future research that includes larger sample sizes (N>500), longitudinal

data, and manipulation of the mediator would be ideal to test the mediating role of PPP in patient WTC and EEP.

Our first research question aimed to determine how patients define satisfaction with their health care, and if they focus on provider emotional expression and their perceptions of participation. The results revealed three main themes that highlight (1) the importance of giving patients time to tell their story, (2) a comfortable context in which to communicate, and (3) the respect to listen to what they say. The participants in this study seemed to be aware that doctors' time is limited, but they also felt that time is necessary to achieve better health outcomes. They also placed the onus squarely on the doctor to create a context in which the patient felt at ease to discuss their issues. Patients revealed that doctors can show they care by really hearing what the patient says, rather than making assumptions or offering overly generalized advice. This speaks to the importance of two-way communication. The patients want to work with their doctor for the best solution to their health issues. Being actively engaged may validate the interaction and allows the patient to be an individual who has something to contribute, rather than being constrained in the role of ‘patient’. Finally, in addition to meeting their emotional needs, patients said that they want a doctor who is competent and can address their health problem.

We propose two important takeaways from our findings. The first is that patients (at least in this study) have high WTC, but that this, alone, is not enough. Patients want to be given the opportunity to communicate, and they look favorably on doctors who allow them to do so. This finding appears to coincide with the quantitative results that suggest that patient perceptions of participation mediates the relationship between patient WTC and perceptions of doctor's emotions. Specifically, the choice to communicate in the health context does not directly affect perceptions of emotional expression. A necessary component is the perception that patients could talk in their consultations. The second is that patients appear to want a

combination of interpersonal and intergroup communication in their consultations. Although they expect that the doctor will show caring, respect their concerns, and view them as an individual, they also want sound medical advice from a confident, knowledgeable professional. Watson and Gallois (1998, 1999) noted this important mix of intergroup and interpersonal salience in the consultation. They found that the health provider needs to be seen by the patient as an expert (intergroup emphasis - competence) but also demonstrates that they see the patient as a person with individual needs (interpersonal emphasis – caring). The ability for a health provider to move between interpersonal and intergroup dynamics matters in a consultation makes a difference to the patient's evaluation. CAT provides the theoretical framework to make that balance explicit because it can identify communication behaviors beyond emotional expression that demonstrate the patient's perceptions of empowerment. Invoking WTC complements that finding. The results expand our understanding of what is satisfying for the patient. Both theories recognise that power and status influence communication and the active recognition of this by a health provider can influence patient perceptions. This is important because it allows robust theory to further unpack what is a complex context – the balance of health professional competence and emotional expression with patient expectations.

In our second research question, we were interested in what patients identify as satisfying and dissatisfying about their personal health consultation. In describing their dissatisfaction, none of our participants questioned the medical competency of their doctor. Rather, they focused on issues like feeling rushed and being ignored. As a result, patients said that they could not easily communicate with the doctor. Thus, the extent to which patients felt that they could not engage in the consultation negatively influenced their perceptions of the doctor's emotional expression. Specifically, the patients felt that the doctor was not concerned about them. This finding suggests low rapport between doctor and patient, and further

highlights the importance of patient participation to their perceptions of provider emotional expression, as revealed by the quantitative results.

In contrast, when describing satisfaction in their consultations, patients said they liked that the doctor was friendly, allowed them to be part of the healthcare decisions, listened, showed concern, and exhibited knowledge and competence. Patients did not explicitly talk about communication, but it can be inferred by the fact that patients spoke about being able to talk and be part of the treatment plan. These findings suggest that rapport building is important to patients - they were satisfied because they felt they were receiving competent care from a task-focused doctor who could also express positive emotions.

The fact that patients who expressed dissatisfaction with their consultation focused on non-medical issues (e.g. doctor inattentiveness) perhaps highlights the importance of emotional expression - particularly when it is missing. In describing satisfaction, patients discussed emotional expression (listening, showing concern), but competence also mattered. This implies that patient satisfaction is best achieved when doctors can strike a balance between meeting patients medical and emotional needs. Thus, taking a patient-centred approach means more than just effectively communicating health information. It entails the ability to dispense good medical advice, and possessing good communication skills that signal listening, and considering patients' views, as well as showing concern when required. When doctors are attuned to patients' medical and emotional needs, they demonstrate patient-centredness. It is important to note that if a patient does not feel empowered and cared for, it does not mean that they have had a poor consultation. It could, however, result in lower satisfaction, which means they may be less likely to adhere to their doctor’s advice or return to see the same doctor (or any other doctor) again.

Implications and Limitations

The findings in this study have implications for how doctors negotiate patient care. The use of WTC and CAT has extended, in the medical context, what EE means. Previously CAT focused on the health professional responding to the patient's anxiety and providing appropriate levels of concern and reassurance. However, when patients in this study spoke about EE, they included active listening and the doctor's response to their opinions in ways that showed concern for what was being said by the patients. It is important from a diagnostic standpoint for a patient to be given the opportunity to talk, but it also gives patients a sense of control in the consultation, which tends to result in higher satisfaction. The findings from this study also underscore the value of asking patients to describe what they expect from their consultation, and the utility of unifying models like WTC and CAT to account for both patient perceptions of communication and the intergroup characteristics (which strongly influence communication) of the health context. The WTC model explains why many patients actively avoid communication with their health provider. At least some of those patients, though, will have to go to the doctor. CAT offers insights into how health providers can put patients at ease, and potentially alter (in a positive way) their future perceptions of health communication.

Our results also indicate that the definition of an effective and satisfying health consultation may differ across interactants and may be associated with variables such as patient age, health and socioeconomic status. Quirk et al. (2008) noted individual differences in how patients defined caring, but what seemed to most important to patients was that their doctor took their viewpoints into account. Therefore, doctors cannot employ a 'cookie cutter' approach to treating their patients. They need to listen to (and hear) what their patients want to not only provide sound medical advice, but to establish good communication that they take into their future consultations.

There are some limitations to this study. In studies based in the actual populations, it is difficult to achieve representation of samples that mean all ages, social demographics, gender and health problems are equally represented. However, we believe our sample provides a representation of patients who visit doctors in non-emergency clinics. We believe the next steps are to more explicitly examine chronic and acute patients as well as selected age groups. Further there is a need to audio-record health consultations so that PPP can be directly mapped onto actual communication behavior. In the same way, we can look at the specific behaviors of the doctor and examine how emotional expression emerges and influences communication. This is an exciting path for bringing together CAT and WTC and expanding our understanding of satisfying and effective patient interactions.

Conclusions

In this study we have explicitly shown that CAT predictions of appropriate EE by the doctor are influenced by PPP. We have also demonstrated that doctors who can provide both EE and competence are positively evaluated by patients. Based on these results, we propose that the definition of a satisfying medical consultation has three elements. First, the doctor is task-focused and competent. Second, the doctor demonstrates interest in the relationship with the patient through respectful listening (i.e. really hearing the patient) while giving the patient time to talk. Third, the doctor expresses concern and caring for the patient. Patient satisfaction will depend largely on how much the consultation has met their expectations, so it is important to customize the consultation as much as possible. This is not a simple task, but one that can be achieved by allowing the patient to disclose what they want. Active patients receive more patient-centered care, so we should create health contexts that encourage communication across all patients.

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Figure 1 - Defining Satisfaction

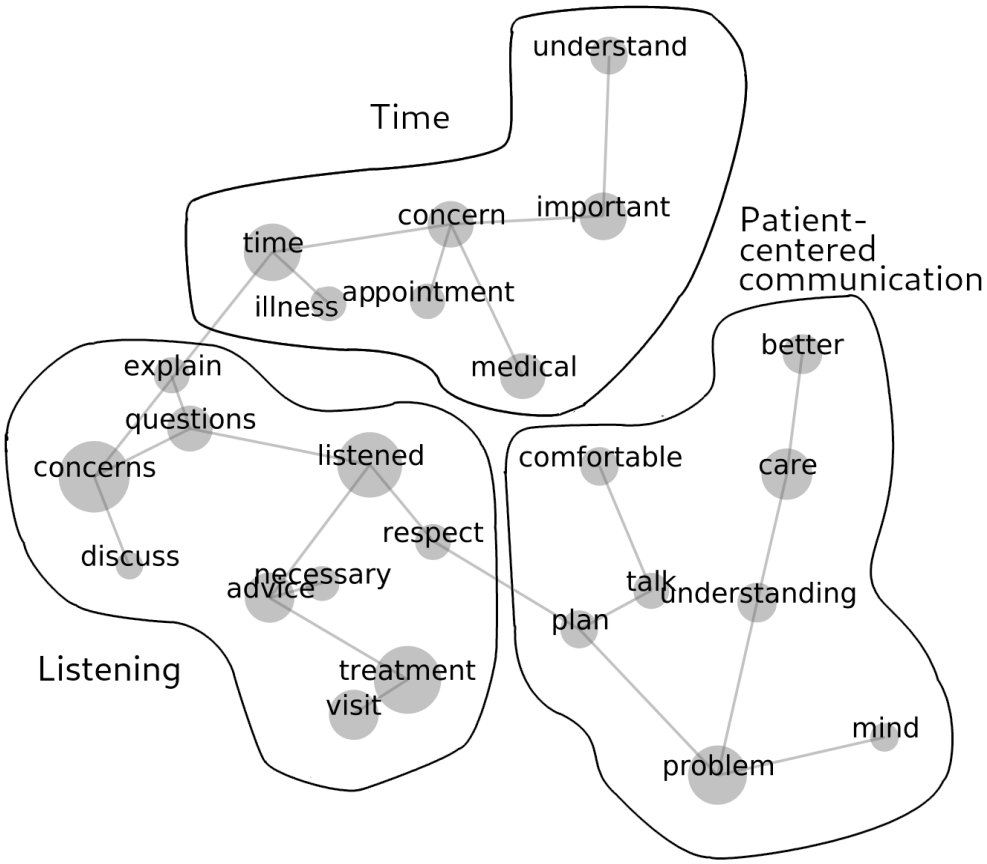

Figure 2 - Health Consultation Experience