

THE IMPORTANCE OF EFFECTIVE DOCTOR-PATIENT COMMUNICATION IN ENHANCING QUALITY HEALTHCARE OUTCOMES: A STUDY ON CANCER PATIENTS IN INDIA

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Abstract

Background: Effective doctor-patient communication is crucial for quality healthcare, especially in cancer care. Patient-reported outcomes, expressive writing, and the EORTC quality of life scoring system improve patient well-being. However, QoL studies in Indian cancer patients are lacking, and this study aims to assess QoL scores in various parameters at a hospital in South India. **Materials and Methods:** Cancer patients attending the quaternary multispecialty hospital were recruited for the study, aged 18-80. Data collection and measurement tools- EORTC QLQ- C30 validated Tamil translated questionnaire was used as a patient self-reported tool. One hundred eighty-six patients were offered to fill out the questionnaire, and 150 consented and filled out the tool. **Results:** On the Global QoL front, the mean score of our study patients was 55; with increasing age, there was a fall in almost all the parameters of quality of life, except for Emotional function. Females comprised 56.6% of the study population. Females had better scores than males in almost all dimensions of QoL. Analysis of quality of life scores among cancer patients in India showed that although the functional scores were poorer than the EORTC study subjects, our study participants scored better in symptom scores with comparably better sleep patterns, fatigue scores, etc. **Conclusion:** The study found that Indian cancer patients had lower QoL scores but showed resilience, while women had higher functional scores but faced more pain, sleep disturbances, and fatigue.

INTRODUCTION

Effective doctor-patient communication is crucial for providing quality healthcare and achieving positive patient outcomes.^[1-4] It involves more than just basic communication skills; it requires developing strong interpersonal skills to establish a therapeutic relationship with patients. This relationship is built on shared understanding, empathy, and mutual respect, and it plays a significant role in patient satisfaction and treatment compliance.^[5,6] While basic communication skills are important, they are insufficient to establish a successful doctor-patient relationship. Interpersonal communication skills go beyond basic communication and address the psychosocial aspects of a patient's condition. These communicational skills or via media enable doctors to connect with patients on a deeper level, understand their concerns, and work collaboratively towards shared treatment goals. This helps to effectively

integrate a doctor-centric approach with a patient-centric approach.^[4]

Research has shown that doctors often overestimate their communication abilities, and patients may express dissatisfaction even when doctors perceive their communication as adequate.^[7] This highlights the importance of patient-centred communication, where doctors convey information effectively and actively involve patients in decision-making, address their emotional needs, and provide psychosocial support. By adopting a patient-centred approach, doctors can enhance patient satisfaction, improve treatment adherence, and ultimately contribute to better health outcomes. Effective doctor-patient communication is a fundamental aspect of healthcare. It involves exchanging information, understanding patient perspectives, and building trust. This communication forms the essence of medicine and plays a central role in delivering quality healthcare.^[8,9]

Effective doctor-patient communication aims at Good interpersonal relationships, better exchange of information, and Inclusion of patients in decision-making.^[4,8,10] Patient self-reported outcomes can bridge the gap in facilitating the exchange of patients' symptoms and emotional states and serve as a tool to communicate in a language the medical field interprets. Patient Reported Outcomes (PRO) have evolved tremendously in recent years and hold a key position in cancer clinical trials reporting treatment outcomes and safety. Also, it is worth noting that numerous studies in the past two decades have consistently shown the positive impact of expressive writing on both physical and emotional well-being. Expressing one's feelings and traumatic experience in a written format can have therapeutic effects, helping individuals process and cope more effectively.^[11] Cancer is one disease where the patient faces myriads of pain, trauma, anxiety and fears regarding treatment and its outcome. They are overwhelmed by the sudden change of events in their daily routine. These mixed feelings are hard to express, so to seed confidence in the patient, the patient must be given ample opportunity to lay down the functional, cognitive, and psychological change this disease has brought on him and also facilitate him to express the physical and emotional downturn he has suffered as an outcome of the disease. At the same time, we need scales to measure these outcomes in a meaningful and reproducible way so that they can be used to understand all the possible dimensions of disease effects at the baseline level and further gauge the effect of the treatment on these dimensions to offer holistic treatment to the cancer patient. Further, it is noteworthy that quality of life is not a single entity. It is multifaceted and dependent on various factors, which may be patient-related or sometimes treatment-mediated. Physical, emotional, and cognitive functions contribute to the comprehensive functional score. Similarly, symptom-wise classification must be considered to fully assess the magnitude of these sub-parameter's effect on the overall QoL. The EORTC quality of life scoring helps in fulfilling all the above needs like the patient-reported outcome, quantification of all dimensions that cancer can affect a patient as well as serves as a way to evaluate the mitigation or aggravation of these dimensions by the anti-cancer therapy modalities like Surgery, Radiotherapy and Chemotherapy. Assessing QoL has reached greater heights recently, with most clinical trials reporting the superiority in the QoL outcomes of their interventional modality rather than restricting only the survival outcomes. Nevertheless, in India, QoL studies in cancer patients are still lacking, with

no clear threshold levels on the various dimensions of the QoL parameters. Hence, this study intends to study the cross-sectional QoL scores of various sub-parameters in cancer patients attending a quaternary care hospital in south India.

MATERIALS AND METHODS

Cancer patients attending the quaternary multispeciality hospital were recruited for the study.

Inclusion Criteria

Aged between 18-80 years, those who could give valid consent and read and understand Tamil were included.

Exclusion Criteria

Those not consenting, not in an able general condition to fill the form, and those with brain tumours or metastasis were excluded.

Data collection and measurement tools- EORTC QLQ-C30 validated Tamil translated questionnaire was used as a self-reported tool; 186 patients were offered to fill the questionnaire, and 150 consented and filled the tool.

We would need 293 patients (147 in each treatment arm). Since we had only one arm, we recruited 186 patients, and 150 participated. In the control arm, we used the EORTC study population for comparison.

Statistical analysis- Linear regression was used to study the interrelation of sub-parameters of dimensions of QOL as laid down in the questionnaire. Pearson correlation coefficient was calculated between sub-parameters, and p-value <0.05 was taken as significant.

RESULTS

The overall symptom score revealed that the 70-80 years group fared poorly, with higher detrimental scores for fatigue, sleep pattern, appetite and pain. The 2nd most affected group with disturbed sleep was 30-39 years. Pain and appetite problems were seen to increase with advancing age. On the Global QoL front, the mean score of our study patients was only 55. Even the 30-39 years group, which had the top quality of life, scored only 62.5. Cognitive and physical function were better among 30-39-year-olds, with a mean score of 91.67 and 76.67, respectively. Emotional function score revealed a peculiar pattern wherein 40-49 years had the lowest mean score. The expected norm of increasing age having a lower functional scale saw another deviation in the physical function scale for the 40-49 age group, whose score was even lesser than that of 50-59 age group patients (Table 1 and 2).

Table 1: Comparison of age group and Functional score between QoL

Age group	Fatigue	Sleep	Appetite	Pain
10-19	11.11	33.33	0	50
30-39	38.89	66.67	0	16.665
40-49	38.09	47.62	23.8	38.09
50-59	43.331	33.333	33.333	31.667

60-69	65.28	54.16	33.33	54.1675
70-80	66.66	88.89	88.89	66.66
Mean Scores	48.74	49.46	33.33	41.93
Functional score	Avg of QOL	Avg of CF	Avg of EF	Avg of PF
18-29	58.33	33.33	100	66.67
30-39	62.5	91.67	70.84	76.67
40-49	58.33	73.81	49.99	58.09
50-59	52.501	73.334	62.5	70
60-69	53.13	72.92	57.29	57.49
70-80	55.55	55.55	61.11	46.66
Mean Scores	55	71.51	59.95	62.15

Table 2: Comparison between Indian and EORTC QoL scores

	QOL	CF	EF	PF	Fatigue	Sleep	Appetite	Pain
This study	55	71.51	59.95	62.15	48.74	49.46	33.33	41.93
European study	67.2	85.2	73.33	83.54	54.52	56.93	61.22	61.22

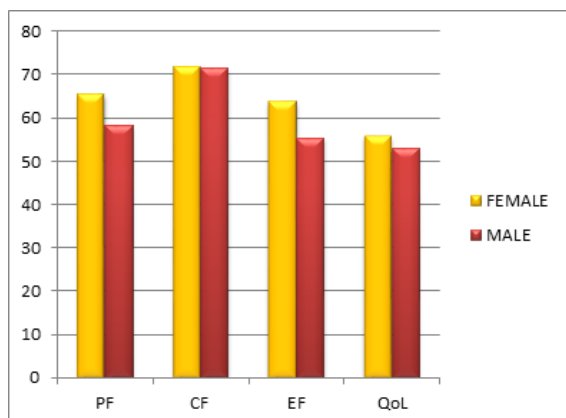


Figure 1: Distribution of gender between functional scores

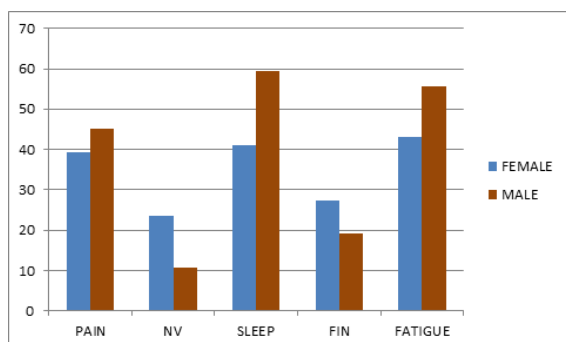


Figure 2: Distribution of gender between symptom score

DISCUSSION

The percentage of patients consenting and responding to this questionnaire was encouragingly 80.64 %, which implies high acceptability and ease of completion of this questionnaire. It was clear from these results of the study that Indian cancer patient's QoL scores were lower than their Western counterparts. Women showed higher functional scores, meaning they could cope with the disease better than the males. Figure 1, Concerning the symptoms scores, they had lesser sleep disturbances and fatigue, but the parameter affecting the females was nausea/ vomiting. Similarly, they were worried more about the financial outcomes of the disease, hence exhibited poor financial scoring Figure 2.

These indicate that Indian women were more resilient than their male counterparts in facing cancer, but the financial impact of expenses was the only issue that dragged down their QoL to an extent. This tendency for women to manifest higher ratings of QoL was a surprise compared to earlier studies, and other reasons behind these findings kindle interest in further in-depth studies in future.^[12,13,14] However, this concurs with Western data, as tabulated in Table 1. Age was a significantly important factor, which was inversely related to QoL. Increasing age had lower quality of life scores.

In contrast, increasing was directly proportional to the symptoms scores wherein fatigability, sleep disturbances, loss of appetite and pain were higher with an increase in age. Thus, increasing age was consistently following a pattern of decreasing QOL. The older age group (60-69 & 70-79 years) exhibited low levels of PF and CF and higher pain, appetite, sleep and fatigue scores. These results correlate with previously published findings.^[14,15] by endorsing the questionnaire's construct validity.

Sleep & Pain scores

Sleep disturbances and Pain scores were tested for their co-relation using the Pearson Co-relation coefficient. The resultant R-value for the entire study population was 0.6835, implying a positive correlation between sleep disturbances and pain scores, albeit the association was a bit weak. The 30-39-year-old group had the worst score for sleep patterns, but at the same time, pain scores in the age group were minimal. Hence, the group-wise Pearson co-relation co-efficient R was calculated for the 60-80 years group, which resulted in a higher co-relation co-efficient in the form of $R=0.8165$, meaning in most of the cases, the presence of pain adversely affects the normal sleep pattern in the older age group, at the same time there can be instances, particularly in the younger age group sleep can be disturbed irrespective of cancer-related pain.

Indian QoL vs European QoL in cancer patients

As seen in Table 2, the scores of this study population were lower in terms of QoL, PF, EF & CF scores compared to the EORTC study population. Still, at the same time, the symptom scores, like sleep disturbances, fatigue, pain, etc., in the present study on Indian cancer patients were way lower than the

EORTC study population. This suggests that Indian patients are more resilient and can adapt themselves to the challenges posed by the disease, though function-wise, physically, emotionally and cognitively, these populations seem to be scoring badly. Their perceived sleep disturbances, fatigability and pain scores were way lower than the EORTC study counterparts. Nevertheless, the Global average QoL for the cancer patients included in this study was only 55, which is problematic. This underlines the necessity for carrying out routine and periodic assessments of QoL in cancer patients and taking steps to improve the Quality of Life and medical management of the disease. Only then can meaningful control over the disease can be achieved.

CONCLUSION

Effective doctor-patient communication plays a crucial role in enhancing the delivery of quality healthcare and improving patient outcomes, particularly in the context of cancer care. The study revealed that the EORTC questionnaire had good acceptability. Indian cancer patients had lower QoL scores than their Western counterparts but coped better with symptoms like sleep disturbances, fatigue, and pain. Women had higher functional scores compared to male cancer patients. Increasing age was inversely related to QoL, with older age groups experiencing more pain, sleep disturbances, and fatigue. The study emphasizes the need for routine assessment of quality of life and comprehensive approaches to cancer care.

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