Communication and the Quality of Healthcare: Understanding the Role of Communication in Caregiver-Patient Encounters

INTRODUCTION

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Discontent regarding the health care, health care personnel, and our health care systems, in general, is widespread, and detractors are visible and vocal.

It is clear that a number of factors have contributed to the present circumstance. Among these:

- Managed Care
- Cost Pressures
- More Demanding Consumers
- Capital and Labor Shortages
- Increasing Competition
- Rapid Technological Change
- Threat of Litigation
- New Diseases

In analyzing the challenges facing health care providers, primary attention is focused on clinical/technical quality of care, and we are seeing increasing efforts to gather, quantify, and analyze information on clinical outcomes. For a decade, major projects of this kind have been underway, with leadership initially provided by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and involving about 400 hospitals (McCormick, 1990, p. 34).

Emphasis has also being directed toward questions of administrative quality—matters related to management procedure and policy. Interest in administrative quality led to the emergence and implementation of programs such as Phillip Crosby Associates, Inc.'s Quality Improvement Process (QIP) and 3M's Total Quality Management (TQM), both of which sought to apply quality assurance methodologies from other industries to the health care field.

As central as clinical/medical and administrative practices are to the quality of health care, it appears that much of the discontent with the quality of health care has to do with a third dimension of quality, which might be termed relationship quality. My own research, and the recent writings of others, confirmed that much of the widespread dissatisfaction is the result of a lack of quality in caregiver-patient relationships (e.g., Ben-Sira, 1990; Oma-Chonu, 1990; Ruben, 1990a, 1990b, Ruben 1992a, 1992b).

What is relationship quality? Why is it important? What are its components? In the article, these issues are explored from different perspectives.
Insights from Patients

Much can be learned about the nature of caregiver-patient relationships from patients themselves. And a number of researchers have emphasized the patient perspective in their work (e.g., Bertakis, 1977; Ellmer & Olbrisch, 1983; Greenfield, Kaplan & Ware, 1985, 1986; Kaplan, Greenfield & Ware, 1989; Lebov, 1988; Pascoe, 1983; Ruben, 1985; Ruben, 1992a, 1992b; Waitzkin, 1984, 1986; Ware & Davies, 1983). One focus of my own patient-centered research has been to determine what patients most remember from hospital stays and visits to health centers. The research involved nearly 4,000 patients at six different hospitals and health services.¹ As a part of the project, patients were asked to:

"Think back to your stay at the hospital (or visit to the health center) and describe, in a sentence or two, your most memorable positive or negative experience. (This can be any experience related to the hospital (or center), its staff or services)."

The open-ended responses were then content analyzed and categorized, and frequencies were calculated. The six categories that emerged are:

"Most memorable experiences related to . . ."

1. Clinical/technical facets of the treatment (abbreviated as: clinical);
2. The institution's policies and procedures (abbreviated as: policies);
3. The institution's facilities/accommodations (abbreviated as: facilities);
4. Aspects of their treatment relating to personal treatment and/or interpersonal communication (abbreviated as: interpersonal);
5. The quality and/or quantity of information provided (abbreviated as: information);
6. Other (abbreviated as: other).

As is apparent from Table 22.1, in each case, patients' most memorable experiences more frequently involved the quality of their relationships with caregivers—and the way they were treated interpersonally—than circumstances related to either a clinical or administrative quality (Ruben, 1990a, 1990b, 1992a, 1992b, 1995; Ruben & Bowman, 1986; Ruben, Christensen & Gutman, 1990; B. Ruben & J. Ruben, 1987, 1988).
Contrary to what one might expect, patients did not most remember the clinical or technical care they receive, as might be expected. In five of the six populations studied, the “Clinical/Technical” category ranked second; in the case of the ambulatory health care center, the rank was third. Overall, “clinical” aspects of care accounted for only 27.0% (304/1125) of remembered experiences. Health care facilities—which included food in the case of the hospitals—was even less significant to the more lasting memories of health care. “Facilities” ranked fourth overall, accounting for only 7.3% (82/1125) of the experiences reported.

First, by a substantial margin for all health care institutions, was “Personal Treatment/Interpersonal Communication.” Across the six populations, “Interpersonal” accounted for 46.7% (525/1125) of all responses. “Policies and Procedures” accounted for 9.4% of the responses overall. “Quality/Quantity of Information Provided” ranked fifth at 5.8%, and “Other”—which included factors like cost and convenience—ranked sixth at 3.9%.

“Quality/Quantity of Information Provided” and “Personal Treatment/Interpersonal Communication” are facets of communication. If these two categories are combined the primary role of relationship quality is emphasized even more dramatically. Tables 22.2–22.7 provide examples of the patient responses in each category.
Table 22.1

<table>
<thead>
<tr>
<th>Rank Order</th>
<th>Acute Care Hospital&lt;sup&gt;a&lt;/sup&gt; 582-Bed—Community (N = 204)</th>
<th>Acute Care Hospital&lt;sup&gt;b&lt;/sup&gt; 206-Bed—Urban (N = 96)</th>
<th>Acute Care Hospital&lt;sup&gt;c&lt;/sup&gt; 284-Bed—Suburban (N = 286)</th>
<th>Acute Care Hospital&lt;sup&gt;d&lt;/sup&gt; 354-Bed—Community (N = 217)</th>
<th>Rehab Hospital&lt;sup&gt;e&lt;/sup&gt; 88-Bed—Regional (N = 94)</th>
<th>Ambulatory Care Center—University&lt;sup&gt;f&lt;/sup&gt; 84,867 Visits (N = 1125)</th>
<th>Combined Data—Six Institutions (N = 228)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>Interpersonal 39.2%</td>
<td>Interpersonal 47.9%</td>
<td>Interpersonal 46.5%</td>
<td>Interpersonal 58.5%</td>
<td>Interpersonal 56.4%</td>
<td>Interpersonal 37.7%</td>
<td>Interpersonal 46.7%</td>
</tr>
<tr>
<td>Second</td>
<td>Clinical 34.8%</td>
<td>Clinical 25.0%</td>
<td>Clinical 33.2%</td>
<td>Clinical 24.9%</td>
<td>Clinical 19.2%</td>
<td>Policies 22.4%</td>
<td>Clinical 27.0%</td>
</tr>
<tr>
<td>Third</td>
<td>Information 6.9%</td>
<td>Facilities 12.5%</td>
<td>Information 10.1%</td>
<td>Facilities 6.5%</td>
<td>Facilities 18.1%</td>
<td>Clinical 18.4%</td>
<td>Policies 9.4%</td>
</tr>
<tr>
<td>Fourth</td>
<td>Other 6.9%</td>
<td>Policies 9.4%</td>
<td>Policies 5.2%</td>
<td>Policies 6.0%</td>
<td>Policies 5.3%</td>
<td>Information 11.8%</td>
<td>Facilities 7.3%</td>
</tr>
<tr>
<td>Fifth</td>
<td>Policies 6.4%</td>
<td>Other 4.2%</td>
<td>Facilities 3.2%</td>
<td>Information 3.7%</td>
<td>Other 1.1%</td>
<td>Other 7.9%</td>
<td>Information 5.8%</td>
</tr>
<tr>
<td>Sixth</td>
<td>Facilities 5.9%</td>
<td>Information 1.0%</td>
<td>Other 1.8%</td>
<td>Other 0.5%</td>
<td>Information 1.8%</td>
<td>Facilities 1.8%</td>
<td>Other 3.9%</td>
</tr>
</tbody>
</table>

<sup>a</sup>B. Ruben, Zaboli & Kreps, (1985).
<sup>c</sup>Reported in Ruben (1990); Ruben & Bowman (1987); Ruben (1986).
<sup>d</sup>Reported in B. Ruben, 1987.
### Table 22.2. Patient's most memorable experiences:
representative responses

**Personal Treatment/Interpersonal Communication**

**Positive Statements:**

"The staff gave me the impression that they were interested in me as a person rather than just in doing a job of taking care of me."

"All physicians are nice... They seem to care."

"Without exception, every nurse on the floor took care of my father as if he were their father."

"The most pleasant experience was that most of the people treated me very well."

**Negative Statements:**

"Need more attentive and listening doctors and nurses."

"Many technicians, in my opinion, lacked compassion and concern. They also had no respect for my dignity or modesty. A friendly smile would have helped. They just did what they were trained to do and that's all."

"Being a new mother, I needed instruction, not criticism."

"Elderly patients are treated like garbage."

"The guards and the receptionists were very impolite with my friends and myself."

### Table 22.3. Patients' most memorable experiences:
representative responses

**Clinical/Technical**

**Positive Statements:**

"Got better fast. Identified problem and gave medicine quickly."

"I was very happy with the services rendered in the Emergency Room. I was admitted and treated quickly."

"Blood test didn't hurt at all."

**Negative Statements:**

"They don't know what they're doing... couldn't find vein."

"The RN almost gave my infection medicine to my roommate who was very allergic to it."

"They never x-rayed anything. Just said it was a sprain."
Table 22.4. Patients’ most memorable experiences: representative responses

<table>
<thead>
<tr>
<th>Policies/Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive Statements:</strong></td>
</tr>
<tr>
<td>“They let you walk in. You don’t need an appointment.”</td>
</tr>
<tr>
<td>“Attention given to siblings of newborn is a nice touch.”</td>
</tr>
<tr>
<td><strong>Negative Statements:</strong></td>
</tr>
<tr>
<td>“Too much paperwork... too confusing when you first walk in. You don’t know where to go or what to do.”</td>
</tr>
<tr>
<td>“I was told to come back Monday for a blood test, because they don’t do blood tests after 12:00. It was very annoying.”</td>
</tr>
<tr>
<td>“The admissions testing should all be done on one floor.”</td>
</tr>
</tbody>
</table>

Table 22.5. Patients’ most memorable experiences: representative responses

<table>
<thead>
<tr>
<th>Facilities/Accommodations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive Statements:</strong></td>
</tr>
<tr>
<td>“The birthing room facilities were peaceful and beautiful.”</td>
</tr>
<tr>
<td>“I have gone to college previously in New York State. The health service building here is much better that what I am used to.”</td>
</tr>
<tr>
<td>“I loved having my own shower in my room.”</td>
</tr>
<tr>
<td><strong>Negative Statements:</strong></td>
</tr>
<tr>
<td>“The ER is very dirty.”</td>
</tr>
<tr>
<td>“Get a nicer waiting area. Chairs are uncomfortable.”</td>
</tr>
</tbody>
</table>
Table 22.6. Patients’ most memorable experiences: representative responses

<table>
<thead>
<tr>
<th>Quality/Quantity of Information Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive Statements:</strong></td>
</tr>
<tr>
<td>&quot;The night before my operation the doctor explained the operation to me. This relaxed me.&quot;</td>
</tr>
<tr>
<td>&quot;The physician explained everything in detail.&quot;</td>
</tr>
<tr>
<td>&quot;When you need to buy a product at the pharmacy, they are never too busy to give you recommendations.&quot;</td>
</tr>
<tr>
<td><strong>Negative Statements:</strong></td>
</tr>
<tr>
<td>&quot;Doctors should tell patients results of tests, and give more information about patient’s illness.&quot;</td>
</tr>
<tr>
<td>&quot;The emergency room should keep you informed as to why you are lying there for so long.&quot;</td>
</tr>
</tbody>
</table>

Table 22.7. Patients’ most memorable experiences: representative responses

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>(General Statements, Convenience, Cost)</td>
</tr>
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</table>

| Positive Statements: |
| "Everything very nice." |
| "Convenient." |

| Negative Statements: |
| "Would go (to another facility) if I could wait." |

What do these findings tell us? To be sure, these results say nothing definitive about how patients were actually cared for. They do, however, tell us a great deal about how patients perceive they were treated, and perhaps more interestingly, about the criteria they use in evaluating the quality of care they receive. By implication, the study also tells us about probable sources of satisfaction and dissatisfaction among patients, and helps us understand the basis upon which images of health services are formed.
The findings from these projects argue convincingly that patients in a variety of health care settings place a very high premium on personal treatment, interpersonal communication, and relationships in forming their impressions of a health care institution and its staff.

As can be discerned from the sampling of patient responses, the research also indicates that all staff play a vital role in creating the experiences which are most critical and memorable to patients. Nurses, nurse practitioners, receptionists, other staff, as well as physicians are mentioned in patient's comments. For instance, in the case of the ambulatory care facility (Ruben, 1990a, 1990b, 1992a; Ruben, Christensen & Gutman, 1990), nurses and nurse practitioners were most often mentioned. They were referred to in 34.3% of the narratives on memorable experiences, and generally in a positive context (60.6% positive vs. 39.4% negative). Physicians were mentioned in 29.2% of the recounted scenarios (64.3% positive vs. 35.7% negative). Receptionists and other non-technical staff were recalled in 26% of the noted experiences, with a majority (56.0% vs. 44.0%) positive.

Again, it is important to remember that these results refer to patient perceptions. However, it is equally important to remind ourselves of the many reasons why the patient perspective and relationship quality are important. Beyond contributing to a patient's satisfaction or dissatisfaction with health care systems in general, relationship quality impacts upon patient compliance and the course of treatment. It also forms the basis for the reputation and image of individual staff members and health center as an organization, influences the probability of malpractice litigation, and facilitates or impedes the appropriate utilization of health care facilities.

Origins of the Problem: Communication Pathologies

At the heart of the linkage between communication and health care is the interpersonal communication dynamics between caregivers and patients, and the nature of the relationship which evolves as a consequence of the interaction. Unfortunately caregiver-patient communication and relationships are as problematic as they are important, embodying all the complexity and challenge—and even greater stress—than is present in other professional-lay encounters.

In the most basic terms, interpersonal communication is a process of sending and receiving messages in an effort to coordinate meaning. Influencing what would seem to be a very simple process are a number of factors, some having to do with the people, some the messages they create, some the channels through which messages are exchanged, and some the context in which the interaction occurs.

As individuals, we bring our own unique needs, values, attitudes, styles, cultures, and perspectives to interpersonal communication encounters. Each of us has a number of relationships in our lives where communication works well, and the outcomes are very satisfying to the parties involved. In such circumstances, communication works as efficiently and effectively as it does because of the compatibility between sender and receiver in terms of needs, priorities, styles, culture, and perspective.
Barriers to Quality Relationships

When incompatibilities of various kinds exist, interpersonal communication and the development of relationships is a much greater challenge. Caregiver-patient communication is perhaps the prototypical example of this circumstance. One fundamental reason has to do with differences in needs the individuals bring to the situation. For their part, caregivers bring a number of professional needs to their encounters with patients, including the desire for an accurate medical history, information pertinent to diagnosis of the presenting problem, efficient information exchange and patient compliance and cooperation. Patients enter the situation with needs that only partially correspond to those of the physician including, not only clinical care, but also needs for information, explanation, attention, reassurance and empathy.

As with the teacher and student, the attorney and client, or the librarian and the information seeker, the relationship between the caregiver and the patient is characteristically asymmetrical, in that expertise and power are unevenly distributed. And while both parties to such relationships can be said to have a common purpose, they seldom share common perspectives.

Physicians, nurses, lab techs, receptionists, administrators, and other staff come to encounters as knowledgeable professionals, "at home" in the environment in which the interactions are occurring, seeing patients on a schedule that they set. Factors such as time pressures, job stress, the burden of paperwork, threat of malpractice, difficult patients, interpersonal stress and problems of coordination and repetition present barriers for the caregiver. Nonetheless, caregivers are familiar with terminology and protocols, comfortable with the tasks at hand (medical histories, physical exams and diagnostic procedures), and generally equipped with substantial experience regarding the range of medical problems and circumstances which present themselves.

Health care providers make their judgments of the quality of care using clinical and technical criteria—Have correct diagnostic procedures been followed? Were appropriate treatment protocols adhered to? Was testing conducted in a technically correct manner? (Droste, 1988; Siegel, 1986)

In contrast, patients come to the relationship "looking for help" in some form. They do so in an environment that is unfamiliar—one that they often perceive as intimidating. Patients must schedule the encounter at the convenience of the caregivers, and often have to wait to be seen. Frequently they enter the interaction anxious about their health, and lacking medical knowledge or relevant professional expertise. For the patient, even "routine" history taking, physical exams, and tests are often uncomfortable, because they call for levels of verbal disclosure and physical contact normally reserved for intimate relationships. And, depending upon the outcome of these encounters, patients may be faced with the need to comply with recommendations for behavioral change, undergo additional testing, or accept continuing uncertainty about their health status.

Caregivers make assessments of quality of care based on clinical and technical criteria, clinical and technical skills or competencies of providers, and the manner in which patients are treated medically. Since most patients and family members lack the knowledge necessary to assess the clinical quality of the care they receive, their evaluations emphasize relationship
quality, the interpersonal communication skills and competencies of caregiver, and the manner in which they are treated personally. (Korsch, et al., 1972; Ruben, 1986, 1992a, 1992b, 1995, 1990a, 1990b; Ruben & Ruben, 1988; Ruben, Christensen & Guttman, 1990; Ruben & Stewart, 1998; Steiber, 1988).

Over the course of a hospital stay or a visit to a physician’s office, a patient is likely to have any number of encounters—each of which in subtle and not so subtle ways shapes the impressions which are formed of the quality of the health care givers, the organization, and by extension, health care. If those encounters include a receptionist who seems to lack compassion, a physician who doesn’t seem to be paying attention, or a nurse who seems impolite, the seeds of dissatisfaction are easily planted.

**Critical Incidents in Physician-Patient Communication**

Given the potential range of incompatibilities in needs, goals, and perspectives, is it any wonder that despite the best intentions by all parties, caregiver-patient encounters are plagued by incomplete communication, mistrust, and misunderstanding? The stories patients have to tell provide many examples:

- After weeks of pain and visits to several physicians, a patient has been referred to a “highly-regarded neurologist.” The patient introduces herself and began to describe the problem. The neurologist explained that it wasn’t necessary to hear her symptoms, that the examination and test results would tell her everything she needed to know.

- A patient considering a vasectomy had a number of questions and concerns, and scheduled a consultation visit with a urologist. When the patient asked about possible side effects or complications, the physician responded, “There’s really no evidence to suggest that there are negative side effects, but who knows. We thought Thalidomide was safe, too.” The patient says that he had some concerns about the procedure. The physician handed him a pamphlet “which will answer all the questions,” and told him to call the receptionist to schedule the procedure if he decided to go ahead with the procedure.

- A patient who was previously operated on for breast cancer discovered several new lumps and a cough which her physician described as “suspicious.” She was sent to a nearby X-ray group for chest X-rays. The tests completed, the woman was asked to return to the crowded waiting room while the pictures were developed. In ten minutes, the radiologist walked into the waiting room and announced loudly across the still-full waiting room that he had developed the X-rays and had just spoken to the woman’s physician. The patient is told to take the X-rays and go immediately to the emergency room of the hospital to meet with the physician.
From the patient point of view, each of these instances is a critical incident in terms of relationship quality. In each, there is a loss of confidence, trust, and information, and of the potential for quality health care. This occurs not for the lack of good intention, nor of quality of the clinical skill, but rather for the lack of effective interpersonal communication.

**Insights from the Factory**

Nothing is more fundamental to caregiver-patient encounters than interpersonal relations, as we have seen. And in this regard, these situations are not wholly unique. As we shall see, some of these same issues emerge as equally important in other settings, and consideration of these can provide valuable insights for improving our understanding of the underlying dynamics of healthcare relationships.

**"The Western Electric Studies"**

What has come to be called "The Hawthorne Effect" was first discovered by F. J. Roethlisberger and William J. Dickson in a two-year study of workers at the Western Electric Company Hawthorne Works in Chicago. Their study was described in detail in the book *Management and the Worker* (1941).

The research focused on working conditions, morale, and productivity. Roethlisberger and Dickson set up experimental work rooms and groups to study the impact of such factors as the length of the work day, length of work week, and the introduction of breaks during the day. Who would have guessed that what began as a rather routine study would produce results the researchers came to refer to as "astonishing" (Roethlisberger & Dickson, p. 87).

Much to their surprise, the researchers found that regardless of what specific changes they introduced into the experimental environment—whether they shortened working hours, days and weeks, for instance—worker productivity improved. Every change they made in the subject's environment seemed to increase productivity. They assumed the finding must somehow be the result of some unrecognized factors in the experimental environment, so they systematically examined the relationship between environmental factors and variations in productivity. Still they found no explanation. By the end of the two-year study, efforts to explain the increased productivity had led to an examination of every imaginable explanation including environmental factors, worker fatigue and monotony, wage incentives, and method of supervision. They went to such levels of detail as to test for the possible impact of temperature, humidity, even seasonal variation.

After all was said and done, their conclusion was this: Differences in productivity were not due to specific changes in the experimental design. Rather, greater productivity resulted from the positive interpersonal relationships and unusual level of supervisor attention that was present in the experimental group at every phase of the research. The experiment had fostered closer working relations, and established greater confidence and trust by workers in supervisors than was present in the normal working group situation. Supervisor-worker relations in the experimental room were discovered to have more the flavor of an office than a shop, creating an atmosphere in which workers had become the focus of a considerable amount of attention from too management. And, indeed i
had been the increased attention, along with productive relationships between workers, which heightened productivity.

**Insights from the Classroom**

**Pygmalion in the Classroom**

In their classic book, *Pygmalion in the Classroom*, Robert Rosenthal and Lenore Jacobson (1968) reported on their research on the impact of teacher expectations on students' intellectual development. They argued persuasively that when teachers expect high or low performance from particular students, their own behavior toward these students is sufficiently different to produce these outcomes through a "self-fulfilling prophecy." That is, if I as a teacher believe John to be a talented child, I'll treat him as if he were talented, and he will be influenced to become talented because of my expectations.

Further studies examined this contention in some depth. Not all studies produced the so-called "pygmalion effect," and controversies swirled as to whether these inconsistencies were the result of inappropriate research methods, or whether there were underlying problems with the theory.

Despite occasionally inconsistent findings, the weight of evidence supports the original theory: *Teachers' beliefs that particular students are of superior or inferior ability tend to lead to student achievement levels consistent with the expectations.* When teachers expectations are high, student performance matches these expectations; conversely, when teachers have low expectations, lower levels of performance result (Seaver, 1973).

**A Study of Adaptation to Junior College**

In 1986, John Herrling, a doctoral candidate in the Rutgers Graduate School of Education undertook a thesis study designed to gain a better understanding of dynamics of student adaptation to junior colleges. It is well documented in the literature that attrition rates are very high during the first semester of enrollment, and a chief goal of this study was to try to identify the factors leading to this outcome. Herrling designed a qualitative, ethnographic study in which he met with students at several points during the semester for open-ended, taped conversations about the process of adapting to college, with the goal of gaining an in-depth understanding of the dynamics of adaptation and attrition processes from a student point of view.

In designing the study, the researcher felt it very important to select an appropriately large enough initial sample of students. Otherwise, if too many students dropped out during the semester, he would be unable to make comparisons between "drop out" and "adapter" groups at the conclusion of the study. Herrling determined that the average first semester attrition rate for the institution where the study was taking place was 30-40%. He wanted the final sample size to be in the range of 20, so he began with a random sample of thirty-two students. He reasoned that even with a 40% dropout rate, he would be left with a study population of 19 or 20 students who would complete the first semester.

Herrling was to be very surprised by his results in this regard. At the end of the first semester, only 3 of the 32 students had left the college—an attrition rate of 9%—rather than the usual 30 to 40%.
What are we to make of this finding? At first, the researcher feared that somehow his initial sample had been a biased one. He carefully considered a variety of possibilities. However, in reexamining the demographics of his sample, he confirmed that the group was a very representative one in terms of high school grades, SAT scores, curriculum being studied, and so on and so on. After much deliberation and careful analysis of the tapes and transcripts from the interviews he concluded that rather than being an unfortunate circumstance of an unrepresentative sample, the low attrition rate in the study group was instead a truly significant finding in its own right. Unlike the typical group of college students, this group of 32, in effect, had their own personal counselor meeting with them regularly throughout the semester, talking with them, and taking a genuine interest in their concerns and in their experiences.

The Moral?

What lessons do these studies hold? In some respects these three studies were quite different. The Western Electric study focused on the workplace; Pygmalion, the classroom; and the Herrling study, adaptation to college. Yet, at the same time each of these is a study of relationships. Collectively, the “Hawthorne effect,” “the Pygmalion effect” and the “Herrling effect” demonstrate the incredible power of quality relationships. Moreover, they provide a persuasive lesson about the remarkable significance of being noticed, paid attention to, listened to, believed in and cared about.

Insights from Human/Animal Interaction

The pet store—or more specifically human/animal interaction—is a neglected, but nonetheless a valuable source of lessons regarding relationship quality.

Pet stores sell pets and pet supplies. They are generally crowded with shoppers cooing and smiling at creatures through the glass and screens. A moment ago it was suggested that pet stores sell pets. Actually, it may be more accurate to say, they sell potential companionship. There are the cute little bunnies, cuddly kittens, exotic fish, high- and low-verbial birds, and perky puppies. And for the less “warm and fuzzy” types there are snakes, rats and gerbils and cousins of all colors, shapes and sizes.

It appears that there is much to be learned about quality human relationships from pets, and interesting research has been done on pets and the impact of the relationships we have with them. For instance, one study found that the introduction of pets into the lives of terminal cancer patients (Muschel, 1984) or geriatric patients (Brickel, 1986) has significant positive consequences psychologically and socially. Other studies (Friedman, Katcher, Lynch & Thomas, 1980) have suggested that pet ownership is a strong predictor of one-year survival among post-coronary patients. Research also shows that older people (65 and over) who are closely attached to a pet are less likely to exhibit symptoms of depression (Garrity, Stallones, Marx, & Johnson, 1989). Researchers (Garrity et al., 1989) have also indicated that individuals
with greater attachment to pets have better mental health. In essence, these studies suggest that attachment to—having a significant relationship with—a pet may serve the same beneficial role as significant human attachments in times of stress, providing not only a source of companionship, but an aid to health and relaxation.

A particularly striking piece of research takes this perspective a bit further to examine whether pet ownership has an effect upon the extent of use of physician services (Siegel, 1990). And, remarkably, the study finds that elderly individuals with pets had fewer contacts with doctors (total doctor contacts and respondent-initiated contacts) than those without pets. Even more remarkably, the study found that individuals with stressful lives, who did not own pets, had significantly more doctor contacts than did non-pet owners (10.37 contacts per year vs. 8.38, p < .005).

Are all pet relationships equally effective in this regard? Apparently not. Dogs seem to make better relationship partners than cats or birds. For individuals who did not own a dog, doctor contacts increased as levels of stress increased (10.39 contacts for high stress individuals compared to 8.37 for low stress, p < .01). However, for dog owners with high and low levels of stress, there was not a significant difference between their total annual number of doctor contacts (Siegel, 1990). This result did not occur for the owners of both cats and birds.

Thus, this study tells us that older people who don’t have pets can expect more doctor contacts than individuals with pets. Furthermore, individuals with pets—particularly dogs—are helped by these relationships in times of stress (Siegel, 1990).

There are lessons to be learned from our relationships with pets, dogs in particular—lessons about relationships and what makes them work. What is it, exactly, that dogs do for their part in relationships that apparently makes them such ideal relationship partners? Some dogs provide protection. But this is certainly not the case with the majority of pet dogs. Even if they lack the ability to protect their owner, they may still be wonderful companions. Actually, the reason dogs are capable of being such great pals is that they exhibit a number of the qualities that are highly valued in human companions. Dogs are attentive, interested, trusting, loyal and tolerant. They are non-argumentative, and seem able at times to demonstrate compassion and empathy. Some are even masters of good eye contact. Collectively, these behaviors provide a sense of security and reassurance and confirm our sense of worth as human beings.

Several years ago when I was working on this project, I overheard an interesting conversation that is very much to the point. The topic was dogs and the comment that particularly caught my attention was: “To your dog, it doesn’t matter what you look like, whether you’ve had a good day or bad, whether you have performed brilliantly or ineptly that day, how you feel or what you say. You walk in the door and your dog comes running up to you and wags its tail like you’re the most important, wonderful person in the world . . . and loves you.”

Whether we take our lessons from patients, the literature, the factory, the school or the pet store, a common theme emerges. High-quality relationships are a valued, valuable and all-too-scarce resource in healthcare encounters, and in contemporary life, in general. In each of these settings, there is the opportunity
to apply an understanding of human communication to form more productive and satisfying relationships. Nowhere is this need more pressing than in healthcare, where the consequences of poor communication and inadequate relationships can have devastating, even life-threatening consequences.

Notes

1The research consisted of surveys of a total of 3,668 patients at six institutions in the Northeast: Acute Care Hospital (Community): Random sample—1,000; returns—253; response rate—25.3%. Acute Care Hospital (Urban): Random sample—381; returns—96; response rate—25.2%. Acute Care Hospital (Community): Random sample—1,000; returns—226; response rate—22.6%. Acute Care Hospital (Suburban): Random sample—927; returns—338; response rate—36.5%. Rehab Hospital (Regional): Total patient population was surveyed—360; returns—130; response rate—36.1%. Ambulatory Care Center (University)—random point of departure interviewer-aided surveys at three sites—200; returns—200; response rate—100%.

References


