



Interactional Physician-Patient Research: A Path to Better Medical and Marketing Outcomes

Doctors and patients talk to each other, but do the messages get through? The use of an interactional research method may improve the communication gaps between these two groups, resulting in better compliance and better outcomes.



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Doctors and patients see each other, but too many of them do not hear each other. Patients sometimes complain they have difficulty scheduling appointments with their doctors. Even when visits are arranged, appointments often result in professional-patient miscommunication. Such gaps, along with patients' fear of asking for clarification about what their doctors tell them, result in medical errors and lapses in patient compliance. In addition to placing patient health at risk, miscommunication can cause patients to waste substantial time, energy, and money while compensating for these problems.

A study in the *Archives of Internal Medicine* provided evidence of the communication problem, reporting primary care physicians who attempt to establish a rapport with their patients can talk so much about themselves they forget about the reason the patient came for the office visit. In addition, a recent *USA Today* article noted the lack of communication between doctors and their patients has become so common that the U.S. government, nonprofit agencies, and patient advocates have begun to form partnerships to improve doctor-patient communication in hospital settings. Decades of research has shown health care professionals and patients conflict frequently on how professionals interpret patient complaints and requests, what professionals tell patients about their condition and treatment, and how patients will respond to their doctor's recommendations. Professionals say they believe they communicate with their patients fully and clearly. Interviews with patients demonstrate they often have misinformation, lack information, and act contrary to what professionals say they recommend to them.

Given that professional-patient miscommunication occurs so frequently and compromises the effectiveness of

medical care and medical marketing communications, the discovery of what actually happens in face-to-face doctor-patient interactions should form part of the critical path that winds toward the improvement of patient health and pharmaceutical marketing outcomes.

The Typical Research Path

The usual route to obtaining information on doctor-patient interaction occurs in focus groups conducted separately with professionals and patients. These groups provide information and insights, but experience shows people often do not accurately report their own behavior. When individuals describe a conversation, they often leave out many of the particulars memory fails to store. In addition, they may make their actions and decisions sound rational—as if they fit a norm or standard that is considered “correct.” Moreover, when describing interactions, a “he said-she said” divergence often arises in the reportage.

Another Approach

An interactional research method yields a better understanding of what occurs in office- and hospital-based visits. This ethnographic approach includes observation of simulated interactions between doctors and patients. It enables pharmaceutical marketers to see and hear doctors and patients discuss conditions and treatments in real time rather than retrieving the interaction from memory. Stated another way, observing the parties role play in real time more closely simulates actual behavior than asking them to describe what they do in typical circumstances. During the process of viewing patients describe their problem, physicians probe to make a diagnosis and recommend treatment, and patients respond. Observers see and hear the miscues,

misreads, and missed opportunities that impede communication. Contrary to the notion that these simulations merely constitute play acting, doctors and patients revert quickly to their natural interactional patterns, much in the way that focus-group participants forget about the one-way mirror moments after the moderator explains it exists. These simulations produce superior results to those from real-world, “fly-on-the wall” observations, because they are unobtrusive. Optional moderator intervention, when desired, can help structure the session.

Interactional research does not always pave the best path to better doctor–patient communication or deeper marketplace understanding, but the methodology offers value to a wide range of issues. The technique proves useful when the doctor–patient dialogue drives a brand’s marketplace success (e.g., if a brand team advertises a product directly to the patient). Simulated exam-room interaction can help pharmaceutical companies understand why category or brand growth seems sluggish when market analysis does not reveal the cause. Interactional research with caregivers and physicians can illuminate understanding of how caregiver responsibilities, levels of comprehension, and biases affect treatment choices and outcomes. Finally, if a message that a pharmaceutical marketer expresses in professional communications does not filter down to patients, observing doctors discuss what they “know” about a treatment and a brand can help institutions improve message content and delivery.

The Research Protocol

The process of doctor–patient interactive research involves some special considerations. Recruitment includes patients who suffer from the target condition and doctors who treat the condition; the recruiters take care to ensure the doctors and patients do not know one another before the research interaction. In addition, patients must sign a release that confirms they are not receiving medical advice, and doctors are made aware of this stipulation. Before the interaction, doctors and patients are interviewed briefly to set the context and goals of the research.

When the interactive research design entails direct physician–patient interaction, the moderator introduces doctor–patient pairs in a focus-group setting, tells them to behave as if they are engaged in an office- or hospital-based visit, and then leaves them alone. The session begins when the patient presents the medical problem and the doctor asks questions. Both clients and a moderator observe the session through the focus room one-way mirror. Depending upon the needs of the research, the moderator may interrupt the process and step in to the interaction to stimulate discussion of specific issues if they do not arise naturally during the simulated “visit.” Clients also have an opportunity to request patients ask the doctor about a brand by name or mention a DTC advertisement.

After the interaction, the moderator separately debriefs each party. In regards to the patients, the moderator aims to learn how they felt about their visits. Did communication go well? What did they learn about the condition under discussion and treatment? Did they understand everything the doctor said? Would each patient comply with his or her doctor’s recommendation if the session had been a real visit?

In terms of the doctors, the moderator strives to understand how each physician felt about their individual visits. What factors led to making or not making a recommendation? How well did the doctor believe the patient understood his or her description of the diagnosis and treatment options? Did the physician believe the patient would comply with treatment recommendations had the session been a real visit?

An alternative research design involves a more typical moderator-led focus group, followed by interactive doctor–patient discussions. Doctors listen to a focus group of patients from an observation room as the patients discuss their knowledge, attitudes, and behavior regarding a specific problem and address the approach their physicians take to diagnosing and treating it. As the session unfolds, a moderator solicits reactions from physicians in the observation room concerning what they are hearing from the patients. Often, doctors find themselves astonished at the misinformation patients exhibit and the degree of emotional suffering some conditions cause. Following this session, the practitioners enter a focus room and discuss how they approach a condition during an office- or hospital-based visit, while patients go behind the mirror with the client. As this session progresses, the backroom moderator solicits reactions from the patients about what they are seeing and hearing. Patients often feel amazed when they hear health professionals talk about how much time they take explaining their diagnosis and treatment options, including treatment options that the patients never heard from their own doctors. Finally, the moderator brings the doctors and patients to discuss what they heard from one another.

Questions for doctor–patient interactional research are designed to be appropriate for a given marketer’s needs and objectives. The Sidebar includes typical areas of inquiry.

Case Study #1: A Skin Remedy

A well-known maker of prescription remedies for a skin condition is puzzled by the slow pace of prescriptions. The condition is widespread and treatable; the products have been through appropriate consumer testing and are established among professionals. What has gone amiss?

Observed interactions included “patients” with different profiles—whether they had sought professional help, the symptoms they presented with, and how they coped. This approach led to a variety of interactional scenarios. The group in this study included both primary care physicians and dermatologists.

Observations revealed the doctors did not know many patients do not schedule an appointment for the condition, because, although it can become uncomfortable and embarrassing, it does not prove life threatening. Patients tended to suffer in silence and forget about the problem between attacks. Furthermore, patients doubted physicians could even help them. In fact, they did not typically mention the condition to their doctors to inquire about a cure, but instead to gain hope. Patients wanted information, advice, and something to prevent or alleviate the problem, all of which would help them gain control over their ailment.

Patients did not realize hope does exist. They needed to know their condition was not abnormal or untreatable. In addition, they needed to realize if the first product the doctor prescribed did not work, the doctor should have told them about other remedies. Patients must understand they should return to the doctor for help, rather than give up on eradicating their condition.

Recommendations emerging from the interactions included communications that helped relieve patient isolation and encouraged them to seek treatment, as well as materials that informed doctors they must provide a concrete diagnosis, tell patients about various treatment options, and convince them to return if an initial treatment does not work. Physicians also needed to be better informed about and encouraged to choose treatments from the manufacturer's array of compounds.

Case Study #2: A Contraceptive Option

An innovative contraceptive is an improvement over other methods for certain women, but physicians and their patients remain stuck in their usual methods. Without a base of experience with the new product, physicians tend not to offer it to their patients. What is the best way to spark and shape this conversation?

Interactions were designed to establish different scenarios for the visit. First, a baseline of "normal" interaction was observed. In one scenario, the patient was instructed to ask "What's new?" then inquire about the new form or the new method by brand name. In an alternate interaction, the doctor was asked to review a range of available birth-control methods with the patient.

Observation revealed doctors did not realize patients felt less satisfied with their current birth-control method and more open to considering alternatives than they assumed. Patients did not know physicians would probably not inform them about new birth-control methods without being asked. Furthermore, physicians often felt reluctant to recommend a new form and tended to talk more about risks and side effects when introducing a new method than they did when describing a more established method.

Following these observations, it was recommended the manufacturer train doctors to increase their confidence in

SIDEBAR: KEY QUESTIONS TO ASK DURING DOCTOR-PATIENT INTERACTIONAL RESEARCH

How do the patients present their problems?

- How do they describe their conditions/symptoms?
- Do they request a specific treatment?
- Do they mention a brand name?

How do the doctors present treatment options and products?

- What options and treatments do they present?
- In what order do they present them?
- How much about the product or brand do the doctors explain?

How do physicians present risks and adverse events?

How do practitioners react to patient questions and visual cues?

- Do the doctors pick up on times when patients appear confused?
- How do the patients respond to the doctors when the information presented seems complex?
- Do the patients ask for clarification? If so, how do the doctors respond?

What patient words or actions are most likely to produce a specific brand recommendation/prescription?

- What doctor words or actions are most motivating to patients to adopt or accept a brand?

How do the doctors and patients express and resolve conflict or disagreements concerning the diagnosis or treatment recommendation?

What do doctors say or do to ensure compliance with a recommendation? How do the patients respond?

the new method, inform doctors certain patients are likely to be more interested than they believe in the new contraceptive, encourage practitioners to "finish the story" once they start describing the product, and give physicians the language and tools to discuss potential risks and side effects, as compared with older options.

Case Study #3:

An Alzheimer's Disease Treatment

When memory problems strike, a difficult dynamic among caregivers, patients, and physicians often ensues. Denial and evasion can lead to critical delays in starting a treatment that may slow the progress of the disease. How can physicians and families better deal with this sensitive issue and act more quickly to extend normal living?

Caregivers with different attitude profiles were asked to interact with physicians, providing a window on the tone and content of a variety of scenarios. Physicians' language was closely monitored to see what approaches, words, or phrases resonated most and produced the strongest interest and receptivity to treatment.

The interactions demonstrated caregivers may be unaware of medications that can slow the progress of the disease and that hearing a frank description of the disease and prognosis might increase their acceptance of adding a medication to their loved one's regimen. Moreover, caregivers did not know a difference existed between normal aging and disease-related memory loss that doctors can assess. Doctors seemed hesitant to use words like "dementia" or "Alzheimer's" when discussing a patient's condition.

The client was urged to develop communications that helped doctors discuss the problem earlier and more frankly with caregivers, including naming the condition to make its seriousness clear. The manufacturer was also encouraged to help doctors find the words to describe the advantages of medication, without feeling they are over-promising outcomes.

Conclusion

Interactional research does not provide a panacea for communication gaps between doctors and patients or a solution for every pharmaceutical marketing problem. When used for the right reasons, as the case studies illustrate, this method can prove valuable to pharmaceutical companies. Interactional research fosters a way to enhance product marketing communications with professionals and patients, increase sales, and contribute to improved patient health care outcomes. ■

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