http://dergipark.gov.tr/ijhmt/ Doi Number: 10.31201/ ijhmt.595677

Int Journal Of Health Manag. And Tourism 2019, 4(2), 129-139

IJHMT Editorial

International Journal Of Health Management And Tourism

WHAT ARE THE FACTORS AFFECTING THE INTERACTION BETWEEN THE PATIENT AND THE PHYSICIAN?

Fedayi YAĞAR[1]

[1] Kahramanmaraş Sütçü Imam University, Department of Health Care Management, TURKEY.
E-mail: fedayiyagar@hotmail.com

Received: 23.07.2019
Accepted: 16.09.2019

Abstract. In this review study, the factors affecting the interaction between the patient and the physician were investigated and the studies were taken into consideration for evaluation. The results of the investigations showed that the factors such as values, beliefs and opinions, gender of physicians, cognitive characteristics, behavior of physicians, race and ethnicity, social styles of patients, health status, informed consent, physician image, personal characteristics of patients and patient relatives have a significant effect in this regard. In the studies we reviewed, important findings were found to be highlighted under these headings. In particular, it was found that female physicians establish more empathy, that physicians with better cognitive characteristics are more effective in interaction, that well-informing the patient is beneficial, that nonverbal communication should be given importance in addition to verbal communication, that a good communication should be established with patient relatives, and that patient beliefs should be taken into consideration. In addition, elderly patients, patients with low literacy levels, and male patients were found to have more trouble in the interaction with physicians.

Keywords: Patient, Physician, Interaction, Healthcare, Factor Affecting

1. Introduction

The relationship between the patient and the physician is described as "the relationship in which the patient intentionally seeks help from a physician and the physician accepts and consents to the individual as a patient" (Honavar, 2018). The "traditional" patient-physician relationship, from the times of Hippocrates, has changed over the years, and the roles and attitudes have been revised. Patients who were passive in exchanging information with physicians became more active today, initiating a process of change. Similarly, the inclusion of a patient in more holistic consultations in a focused manner further accelerated this change (Nikiphorou and Berenbaum, 2018). After this change, a patient-centered approach has emerged, which is seen as a central component of quality health care today. This approach appears to provide many advantages both for the patient and the physician. From the patients' perspective, satisfaction levels will increase, health information levels will become better, personal care behaviors will change, admissions or hospital stays will decrease. From the perspective of physicians, however, job satisfaction levels and self-confidence will increase, stress and burnout levels will decrease (Casu et al., 2019).

It should be noted that individuals are a social entity, they have the need to understand others and express themselves (Parlayan and Dökme, 2016) and that this need is of vital importance, which creates an environment of unity, togetherness, honesty and trust between the patient and the service provider (Sosyal et al., 2017). In this context, the doctor-patient relationship is one of the most complex interpersonal relationships. It involves interaction between people in unequal positions, it is not usually voluntary, deals with vital issues, causes emotional burden, and requires close cooperation (Berry, 2007). A transition from a paternalistic approach to a patient-centered approach has taken place in line with the increased awareness of patients and physicians about their responsibilities, as well as the formation of an interaction between the patient and physician on an equality and partnership basis. As a result of this two-way relationship, four vital effects emerge on patient satisfaction. These are confidence (the patient feels a sense of trust towards the physician), knowledge (physician informs the patient well and considers his/her concerns), respect (physician's sincerity, sympathy and emotional support) and loyalty (continuity of care) (Honavar, 2018). When the relationship between the patient and the physician is examined, it is observed that physicians have more power because of the asymmetric knowledge they have, which determines the direction of the relationship. Therefore, factors such as the involvement of patients in the process, taking the patients' thoughts into account and providing an environment in which they can express their thoughts will create a strong relationship between the patient and the physician.

When we think that each organization has a different world in itself, unique characteristics, and wants to be successful, it turns out that having good communication skills is an inevitable condition.

Having a higher communication skill, which has an important place in the success of health institutions, will ensure a better relationship established with patients. Institutions that have effectively established the communication network will improve their service quality, improve the promotion of hospitals, increase the success rate in diagnoses and treatments, prevent spending time unnecessarily, and, most importantly, ensure patient satisfaction (Soysal et al., 2016). For this reason, the communication process between the patient and the physician must be managed effectively for the future of the institution and the employees. In addition, when we examine the importance of patient-centered approach in the present day, the role of the physician and the importance of listening actively are found to increase. In this context, the paths that physicians should take include waiting for the patient to finish his/her words, giving him/her time, asking open-ended questions, giving breaks, encouraging the patient to continue to talk, repeating what the patient said, summing up what the patient said, and reflecting the feelings (Okay, 2016). In a study conducted by Collins (2009), this process consists of four steps: collecting information, invitation, listening and acknowledgment. In the information collection phase, open-ended questions are asked to the patients and they are allowed to express their thoughts without guidance. Invitation refers to waiting for the patient to respond comfortably without any pressure by giving sufficient time. Listening includes taking into account and listen what the patient states. Acknowledgment refers to the acts of physician, showing that he/she is listening the patient, giving the impression that he/she is interested in the other party.

Effective patient-physician interaction is a central clinical function, and the resulting communication is the heart and art of medicine. It is also a central element in the provision of the health services. A good physician-patient communication has the potential to help manage patients' emotions, facilitate understanding of medical information, and help better identifying the needs, perceptions, and expectations of patients. Patients who have good communication with their physicians are more likely to be satisfied with their care and to share appropriate information, especially for the correct diagnosis of their problems, follow recommendations and comply with the treatment given. Satisfied patients are less likely to file formal complaints or initiate malpractice complaints. Satisfied patients are advantageous for physicians in terms of greater job satisfaction, lesser work-related stress, and reduced burnout (Fong et al., 2010).

As seen in the information given above, a better interaction between the patient and the physician has positive outcomes for both the patient and the physician. In this study, the factors that may affect this interaction were investigated and the most emphasized factors were evaluated as a result of the literature review.

2. Factors Affecting Patient-Physician Interaction

Many patients have some concerns when they go to the doctor. For example, hospitalization can be an uncomfortable experience, especially for the patient. In such cases, patients feel separated from family and friends. They find themselves in a condition where they are not used to, such as the loss of personal space, privacy and independence. These factors often cause them to feel very vulnerable, which likely to affect their interactions with health professionals. These factors include the characteristics of the physician (gender and experience level, particularly), the characteristics of the patient (including gender, social class, age, education and willingness to learn), differences in social class and education between the two parties, attitudes, beliefs, expectations, and situational factors (such as patient's burden, recognition, and the nature of the current problem) (Berry, 2007).

Some approaches have an important place in patient-physician interaction. For example, race, ethnicity, values, beliefs, and opinions can pose a significant obstacle for both physicians and patients. Similarly, cognitive characteristics, gender, behavior, and image of physicians, social styles, health status, informed consent of patients, the status and content of the disease, patient relatives and personal characteristics of patients are also considered important factors. In this context, these obstacles that are faced often today are evaluated in detail in the following.

2.1. Race and Ethnicity

Race and ethnicity are considered important cultural barriers to patient-physician communication. However, cross-cultural factors in patient-physician communication have largely been unexplored. There may be problems in communication due to cultural differences between patients and physicians, and disagreements may occur between the patient and the physician regarding issues such as explaining the cause of the disease. In the same way, racial and ethnic differences between physicians and patients can affect physicians' communication and decision-making. A study on this issue conducted with 1,816 adult individuals in the United States reports that African-Americans had less participation and less contact with the physician than others (white Americans) (Patrick et al., 1999). Likewise, a similar result was obtained in a study by Saha et al. (2003) conducted with 1,037 African-Americans, 3,488 Caucasians, 621 Asians, and 1,153 Hispanics in the United States. Their study examined whether there was a racial difference in the effect of patient-physician interaction on patient satisfaction, and found that Hispanics and Asians had less satisfaction than others.

2.2. Values, Beliefs, and Opinions

Like patients, physicians have also feelings, thoughts, and views they got from interviews. In this context, physicians may not be objective in the interviews and may be adversely affected in the relations with the patient. For example, an atheist physician will not be able to use God as a source

of solace for the patient. Similarly, a physician who believes that human life is entirely sacred will less likely to recommend euthanasia or termination of pregnancy. Indeed, where the physician will stand in the patient's private life is a debated issue. It is generally stated that physicians must be sensitive to all the patient needs and act according to the behaviors of patients (who may not want to explain their personal opinions) in order to improve the quality of care (Bulduklu, 2015). For example, in a study by Maclean et al. (2003) carried out with 456 patients in the United States, two-thirds of patients stated that physicians should acknowledge their beliefs. Likewise, one-third expressed their wish to ask physicians about their religious beliefs. Therefore, physicians should be aware that a significant minority of patients desires spiritual interaction.

2.3. Gender of Physicians

Contemporary studies discuss whether the gender of physicians is effective in communication with the patient. In general, it is stated that female physicians exhibit a more patient-oriented approach. It is reported that female physicians consociate more, empathize more, act more boldly, and visit the patient more (Mast and Kadji, 2018). In their study conducted with 76 physicians in Korea, Shin et al. (2015) have found results in line with the data expressed above. The study found that female physicians were more conversational than male physicians and had a more patient-centered approach. Similarly, in the study conducted by Hall et al. (2014) with 71 physicians and 497 patients in Norway, female physicians were found to be more patient-centered.

2.4. Cognitive Characteristics

Cognitive characteristics of physicians include learning, using their current knowledge to make judgment and the ability to make decisions. These skills are effective in communication with the patient. Physicians are trained in the areas such as symptoms of the disease, interpretation of the tests, taking histories from the patient and diagnosis. However, case study-based learning is often dominant in learning. Therefore, a good physician increases his/her level of knowledge through medical practices and interviews. The transfer of this information to patients is also of great importance for the effectiveness of the outcomes. For example, different treatments provided by the physician for the same condition may cause anxiety in the patient and this may adversely affect the patient-physician interaction (Bulduklu, 2015). The results of a study by Budych et al. (2012) conducted with 107 patients in Germany support these statements. According to people suffering from rare diseases, physicians' lack of knowledge and specialty about their diseases negatively affect the interaction established with the physician and often cause problems. At this point, the topic of asymmetric knowledge should be addressed. The physician-patient relationship is essentially asymmetrical. While physicians have knowledge of how to potentially remedy or improve a particular medical condition, the patient suffers from this condition and needs help. The

physician provides a health service that the patient must pay for, in other words, the patient is a customer or consumer. A physician is a specialist professional, while the patient is usually a person who has limited or no medical knowledge. These conditions can create a 'hierarchical relationship' in which the physician uses his/her specialist power and the patient acts like a passive recipient. This communication style can have a negative impact on the patient's experience on the health service. For this reason, it seems crucial to establish a kind of partnership in which asymmetries are reduced and the patient is treated equally, and to create a "reciprocal" relationship between the physician and the patient rather than a "hierarchical" relationship (Franceschi, 2018).

2.5. Physician Behaviors

The nonverbal behaviors of the physician as well as the communication he or she verbally establishes with the patient are of great importance. The nonverbal behavior of the physician, such as smiling, leaning towards the patient and making eye contact increases the interaction with the patient, which can affect the patient satisfaction. For example, in a good interaction with the patient (in line with nonverbal behavior), the patients will be able to express themselves more comfortably psychologically and the quality of diagnosis will increase (Mast, 2007). On the other hand, physicians' patient-centered approach can have a significant effect on the satisfaction of patients. The study carried out by Hall et al. (2014) in Norway can be cited as an example for this. In their study, the relationship between the gender of physicians and whether they are patient-centered were investigated and the effect of this condition on patient satisfaction was evaluated. As a result of their study, it was observed that patient-centered female physicians have more satisfied patients. In the same way, we can give an example of the study conducted on 222 stakeholders (such as managers, health workers and politicians) in Iran. At the end of the study, it was observed that one of the factors affecting health quality was physician behaviors (Mosadeghrad, 2014).

2.6. Physician Image

After their experiences with physicians, patients come to a number of conclusions about those individuals. These conclusions become common among other patients over time and create an image about the physician. This image can be effective in the interaction between the patient and the physician (Öcel, 2016). For example, in a study of 559 patients in Turkey by Öcel (2016), the effect of physician image on patient satisfaction was investigated. In their study, it was found that patient satisfaction is affected both by informing patients, which is a positive behavior of the physician, and monetary thinking of the physician, which is a negative behavior.

2.7. Social Styles of Patients

Patients are divided into four groups according to their social styles: analytical patient, guiding patient, caring patient and expressive patient. Analytical patients are those who are task-oriented,

who like to work alone, who respond slowly, who don't like changes, who love more stability, who are focused on the past in relationships, and who love more traditions. Guiding patients are those who are task-oriented, love to control, act immediately/directly, are not tacticians in relationships, and love to manage changes. Caring patients are relationship-oriented, who like to belong to a group, who are also good at one-to-one relationships, who focus on the present, who respond slowly, who avoid change, and who always choose the familiar. Expressionist patients are those who are relationship-oriented, love to stand out and communicate verbally within the group, focus on the future, who love the change, and see it as an opportunity (Desmond and Copeland, 2010).

2.8. Health Status

It is known that the interaction between the physicians and patients with good health status is more positive. Frustration and repeatability, particularly associated with treating patients with chronic conditions, can negatively affect physicians' interaction with patients (Roter and Hall, 2006). At this point, patients with chronic disease are expected to manage their disease-related decisions themselves, which requires taking part in treatment decisions as well. In most cases, treatment is initiated by a medical professional. It is essential that the patient can communicate effectively during these consultations. Patients need to be conscious and skillful about disclosing personal information about preferences, values and concerns (Alders et al., 2012).

2.9. Informed Consent

This process aims to protect patients and promote an enlightened ethics in patient-physician relations. There are four key points in informed consent. These are the risks of the procedure, the benefits of the procedure, alternatives to the procedure, and whether the procedure to be performed is diagnostic or therapeutic. Patients should be informed in detail about these issues. Well-designed forms of informed consent can support the use and retention of significant information and improve the quality of patient-physician interactions. Today, this practice is only used as a legal requirement. For example, in a study that examined 540 informed consent forms from 157 hospitals in the United States, only 26% was found to highlight the 4 key points given above (Bottrell et al., 2000).

2.10. Personal Characteristics of Patients

The age, gender and literacy status of the patients can be effective in their communication with the physician. Considering the age, the group in which physicians often experience the most problems in interaction and act reluctantly are the elderly. In particular, in cases where the age difference between physician and patient is greater, physicians consider medical issues and the psycho-social situations of patients less (Roter and Hall, 2006). From a gender perspective, women are more likely to admit for health care, are better able to communicate by asking more questions in their communication with physicians, and are better informed about their illnesses. Women's general

tendency to empathize more and their reluctance in conveying their feelings/thoughts is considered an important factor in this regard (Roter and Hall, 2006). In terms of literacy, patients with lower educational levels may have difficulty reading their prescriptions, appointment slips, tests and procedure preparation instructions, which may have a negative effect on their interaction with the physician. In the same way, patients with better educational level and higher socioeconomic background are known to be more in contact with physicians and to receive more descriptive/informative information about their disease (Roter and Hall, 2006). For example, a study of 294 patients was conducted by Roter (1977) in the United States for this purpose. In his study, an experimental group and a placebo group were formed and the experimental group was trained on asking questions to physicians about their diseases. After this training, it was observed that the experimental group asked more direct questions, became less satisfied, made more appointments, and interacted more negatively with the physician. Similarly, a study conducted in Taiwan examined the effect of health-related knowledge on interaction. In a study of 256 elderly patients, it was observed that patients could not actively participate in the process (Liang et al., 2013).

2.11. Disease Condition and Content

Whether or not the disease is a rare disease can have a negative impact. In the context of rare diseases, physicians often lack knowledge and experience, and therefore patients face a high degree of uncertainty. In particular, many of the treatments are considered experimental, which leads to questions about their safety and efficacy. Information can be inconsistent or contradictory, and the patient faces numerous treatment options from the respective health care providers, resulting in many uncertainities. Therefore, the traditional roles within patient-physician interaction may vary. This in turn can lead to different mutual role expectations resulting in role inconsistencies (Budych et al., 2012). Likewise, the content of the disease can also affect the level of interaction between the physician and the patient. For example, in the case of a sexual illness, patients have difficulty in communication with the physician and are unable to fully express themselves. On the other hand, the physician's limited time allocated for medical consultation also affects the process. In this context, patients should be able to express themselves clearly, and physicians need to make patients comfortable with their expressions and behaviors (Brandenburg and Bitzer, 2009).

2.12. Patient Relatives

Physicians' view of patient relatives as allies, not considering them as potential sources of problems, receiving their support, allocating them time, giving them tasks, and appreciating their assistance can contribute positively in their interactions with the patient (Desmond and Copeland, 2010).

3. Conclusions and Recommendations

This study aims to evaluate the factors affecting the interaction between the patient and the physician. As a result of the literature review, the most highlighted factors were identified in this regard. These factors include race and ethnicity (Patrick et al., 1999; Saha et al., 2003), values, beliefs and opinions (Bulduklu, 2015; Maclean et al., 2003), gender of physicians (Mast and Kadji, 2018; Shin et al., 2015; Hall et al., 2014), cognitive characteristics (Bulduklu, 2015; Budych et al., 2012; Franceschi, 2018), behavior of physicians (Mast, 2007; Hall et al., 2014), physician image (Öcel, 2016), social styles of patients (Desmond and Copeland, 2010), health status (Roter and Hall, 2006; Alders et al., 2012), informed consent (Bottrell et al., 2000), personal characteristics of patients (Roter and Hall, 2006; Roter, 1977), disease condition and content (Budych et al., 2012; Brandenburg and Bitzer, 2009) and patient relatives (Desmond and Copeland, 2010). It is observed that physicians are the group that has the most impact on these variables. Many factors, such as more empathy shown by female physicians, well-educated physicians with strong cognitive characteristics, paying attention to nonverbal behaviors as well as the verbal ones, taking the patient's beliefs into consideration, informing the patient in the best way and obtaining informed consent, appreciating patient relatives and having their support, were found to be evaluated and highlighted as factors that strengthen the interaction between the patients and physician. Considering the patients' perspectives, those who are relationship-oriented, literate, female and younger were found to establish better interactions.

Education can be given importance in order to improve the relationship between patient and physician. A study in Bosnia and Herzegovina provides important findings on this issue. In this study, physicians were divided into two groups and one group was trained. It was observed that physicians who received training had more empathy and understanding. In addition, it was determined that they pay more attention to patient background (Racic et al., 2017). In addition, a trust environment should be created to increase the interaction between the patient and the physician. A systematic review by Chandra et al. (2018) provides conclusive evidence. In this study, 17 articles were reviewed and emphasized that trust plays an important role and increases patient satisfaction. As a result, increasing the interaction between the patient and the physician positively is of great importance in terms of improving the quality of health. At this point, we can give an example of the work done on 222 stakeholders (such as managers, health workers and politicians) in Iran. At the end of the study, it was observed that one of the factors affecting health quality was physician and patient behaviors (Mosadeghrad, 2014).

The most important limitation of this study is the examination of barriers originating only from physicians and patients. We can give the waiting times as an example. In a study conducted on 200

people in Iran, it was observed that patient physician relationship was negatively affected by long waiting times (Torabipour et al., 2018). At this point, the impact of social media, which is one of the popular issues of today, should not be forgotten. It is stated that social media has negative effects as well as positive effects (George et al., 2013; Ventola, 2014).

References

Alders, I., Smith, C., Brand, P. and Dulmen, S. (2017). Does Patient Coaching Make A Difference In Patient-Physician Communication During Specialist Consultations? A Systematic Review, *Patient Education and Counseling*, 100(5): 882-896.

Berry, D. (2007). Health Communication: Theory and Practice. Typeset by Refine Catch Ltd, Bungay.

Bottrell, MM., Alpert, H., Fiscbach, R. and Emanuel, L. (2000). Hospital Informed Consent For Procedure Forms: Facilitating Quality Patient-Physician Interaction, *Arch. Surg*., 135:26-33.

Brandenburg, U. and Bitzer, J. (2009). The Challenge of Talking About Sex: The Importance of Patient–Physician Interaction, *Maturitas*, 63(2): 124-127.

Budych, K., Helms, TM. and Schultz, C. (2012). How Do Patients With Rare Diseases Experience The Medical Encounter? Exploring Role Behavior And Its Impact on Patient–Physician Interaction, *Health Policy*, 105: 154-164.

Bulduklu, Y. (2015). Hastalarla İletişim. Çizgi Kitapevi Yayınları, Konya.

Casu, G., Gremigni, P. and Sommaruga, M. (2019). The Patient-Professional Interaction Questionnaire (PPIQ) to Assess Patient Centered Care From The Patient's Perspective, *Patient Education and Counseling*, 102(1): 126-133.

Collins, S. (2009). Effective Communication A Workbook for Social Care Workers. Jessica Kingsley Publishers, London.

Desmond, J. and Copeland, L.R. (2010). Communicating with Today's Patient. Çeviren: Yamaç D, Tekin E. Günümüz hastasıyla iletişim. Elif Yayınevi, Ankara.

Fong, J., Anat, S. and Longnecker, N. (2010). Doctor-Patient Communication: A Review, *The Ochsner Journal*, 10: 38-43.

Franceschi, D. (2018). Physician-Patient Communication: An Integrated Multimodal Approach for Teaching Medical English, *System*, 77: 91-102.

George, DR., Rovniak, LS. and Kraschnewski, J. (2013). Dangers and Opportunities for Social Media in Medicine, Clin. Obstet. Gynecol., 56(3): 1-10.

Hall, JA., Gulbrandsen, P. and Dahl, FA. (2014). Physician Gender, Physician Patient-Centered Behavior, and Patient Satisfaction: A Study in Three Practice Settings Within A Hospital, *Patient Education and Counseling*. 95(3): 313-318.

Honavar, SG. (2018). Patient–Physician Relationship: Communication is The Key, *Indian Journal of Ophthalmology*, 66(11): 1527-1528.

Liang. C., Wang, K., Hwang, S., Lin, K. and Pan, H. (2013). Factors Affecting The Physician–Patient Relationship of Older Veterans With Inadequate Health Literacy: An Observational Study, British Journal of General Practice, 63(610): 354-360.

Mast, MS. and Kadji, KK. (2018). How Female And Male Physicians' Communication Is Perceived Differently, *Patient Education and Counseling*, 101(9): 1697-1701.

Maclean, CD., Susi, B., Phifer, N., Schultz, L., Bynum, D., Franco, M., Klioze, A., Monroe, M., Garret, J. and Cykert, S. (2003). Patient Preference for Physician Discussion And Practice Of Spirituality, *Journal of General Internal Medicine*, 18(1): 38-43.

Mosadeghrad, A.M. (2014). Factors Influencing Healthcare Service Quality, IJHPM, 3(2): 77-89.

Nikiphorou, E. and Berenbaum, F. (2018). Patient–Physician Interaction on Social Media: The Physician's Point of View, *European Medical Journal*. 2(1): 40-42.

Okay, A. (2016). Sağlık iletişimi. 3. Basım, Derin Yayınları, İstanbul.

Öcel, Y. (2016). Algılanan Doktor İmajı ile Hasta Memnuniyeti Arasındaki İlişkiyi Belirlemeye Yönelik Bir Araştırma, *Bartın Üniversitesi İİBF Dergisi*, 7(14): 341-364.

Parlayan, MA. ve Dökme, S. (2015). Özel Hastanelerdeki Hemşire ve Hastaların İletişim Seviyelerinin Değerlendirilmesi: Bir Hastane Örneği, *KSÜ Sosyal Bilimler Dergisi*, 13(2): 265-284.

Patrick, LC., Gallo, J., Gonzales, J., Vu, H., Powe, N., Nelson, C. and Ford, D. (1999). Race, Gender, And Partnership in The Patient-Physician Relationship, *JAMA*, 282(6): 583-589.

Racic, M., Kusmuk, S., Masic, S., Ivkovic, N., Joksimovic, V. and Matovic, J. (2017). Impact of The Physician-Patient Relationship on The Treatment Outcomes of Arterial Hypertension, OM, 23(1): 1-8.

Roter, DL. (1977). Patient Participation in the Patient-Provider Interaction: The Effects of Patient Question Asking on the Quality of Interaction, Satisfaction and Compliance, *Health Education & Behavior*,5(4): 281-315.

Roter, DL. and Hall, JA. (2006). Doctors Talking with Patients / Patients Talking with Doctors Improving Communication in Medical Visits. Second Edition. Greenwood Publishing, Connecticut.

Saha, S., Arbelaez, J. and Cooper, LA. (2003). Patient–Physician Relationships And Racial Disparities in The Quality of Health Care, *American Journal of Public Health*, 93(10): 1713-1719.

Shin, DW., Roter, DL., Roh, YK., Hahm, SK., Cho, B. and Park, H. (2015). Physician Gender and Patient Centered Communication: The Moderating Effect of Psychosocial And Biomedical Case Characteristics, *Patient Education and Counseling*, 98(1): 55-60.

Soysal, A., Öke, P., Yağar, F. ve Tunç, M. (2017). Örgütsel İletişim ve İş Tatmini Düzeylerinin İncelenmesi: Bir Özel Hastane Örneği, *Selçuk Üniversitesi Sosyal Bilimler Enstitüsü Dergisi*, 37: 243-253.

Soysal, A., Yağar, F., Koz, T. ve Tunç, M. (2016). Sağlık Kurumlarında Yönetici ve Diğer Sağlık Personeli Arasındaki İletişim Sorunları: Kahramanmaraş Halk Sağlığı Müdürlüğü Örneği, *Business and Economics Research Journal*, 7(3): 183-195.

Ventola, CL. (2014). Social Media and Health Care Professionals: Benefits, Risks, and Best Practices, P&T, 39(7): 491-499.

Torabipour, A., Badieenasab, P. and Dolatshah, M. (2018). Factors affecting the relationship between physician and patient in Ahvaz Community Health Centers, Iran J., Health Sci., 6(3): 45-32.