Article

Patient-centred continuing professional development for Canadian physicians

Brenda Lovell, Raymond Lee

Winnipeg, Manitoba, Canada
Brenda Lovell

University of Manitoba, Winnipeg, Manitoba, Canada
Raymond Lee

Corresponding author: *Brenda Lovell (brendalee.lovell@yahoo.ca or lovellb@cc.umanitoba.ca)*

Introduction. Improving clinical practice skills can enhance a patient-centred model of health care. The objectives of this study were to discover if physicians consider learning about elements of patient-centred care important, and whether the perceived importance is influenced by choice of medical speciality practised and/or number of years in clinical practice.

Methods. Of 310 surveys returned, a total of 268 physicians from one province in Canada were studied. On average, the participants had 16 years of practice experience with family medicine making up the largest component of the study cohort – 41%. Physicians were asked how useful learning about specific topics would be to improve their communication with patients from different cultural or socioeconomic backgrounds. The self-report measures were examined using mean differences among specialities, gender, and correlation with years in clinical practice.

Results. The mean scores were above the scale midpoint for all specialities. The correlation data indicated a negative relationship between years in clinical practice and 2 of the 6 variables studied. Women physicians rated learning about patients' health beliefs higher than men but men rated patient communication skills higher than women.

Discussion. Physicians rated the importance of incorporating principles of patient-centred care into their clinical practice highly, suggesting that they may benefit from practice interventions such as reflection.

AJHPE 2012;4(1):40-43. DOI:10.7196/AJHPE.129

Introduction

Global advancements in information technology and healthcare systems have resulted in better-informed health consumers with far-reaching effects for medical practice and health systems worldwide.[1,2] Significant numbers of patients are using the Internet to obtain health information on issues such as lifestyle factors, diseases, drugs and alternative therapies. This raises expectations and demands for higher standards of care.[2] In addition, increases in chronic and emerging diseases, and the drive towards more community-based care, have meant greater emphasis on patient-centred care.[1,3-5] The latter is best described as clinical care that recognises and responds appropriately to patients' desire for information.[6] These factors have increased the need for innovative educational interventions to support physicians addressing these demands.[3,7]

The increasing need for contextually relevant education has led to the emergence of continuing professional development as an approach to overcome some of the shortcomings of traditional continuing medical education.[7] The use of didactic teacher-centred methods, as the predominant method of teaching, has not led to improved practice or better patient outcomes.[4,5,8,9] Providing learning opportunities in the workplace, observation, experience and practice are suggested ways of facilitating the transfer of new knowledge and skills to the practice environment.[4] For example, in Uruguay, emphasis is placed on physician identification of learning needs that utilise student-centred teaching methods.[5] One hindrance to successful implementation is that the planning and financing of continuing education is occurring within health care systems facing cost and human resource constraints.[3-5] This has raised questions about how educational reforms to facilitate lifelong learning can be achieved.[3]

In the primary care context, patient-centred care incorporates principles that are key to the biopsychosocial model of care proposed by a number of medical writers, such as Engel.[10] Components of patient-centred care include: finding common ground to understand and respond to the patient's unique needs, and consideration of the patient's expectations of the physician.[10] Another component is practice knowledge, thought to originate from three sources: propositional knowledge derived from research and scholarship; professional craft knowledge, which may be tacit, gained from practice experience; and personal knowledge, comprised of intellectual and emotional maturity obtained from life experiences.[10,11] The blending of these different forms of knowledge optimises patient-centred care and efficient care delivery.[10,11]

Consideration of patient expectations of health care is important for a number of reasons, including the capacity to provide effective treatment, the influence that expectations have on health behaviours, adherence, and functional health status.[12] More importantly, patient interactions may serve as potential indicators of professional learning needs and improvement

required.[12] Patients' expectations vary with different health problems, and over time as their experience and education increases. In general, patients expect high standards of professional competence, information about their health problem, and patient-centred communication.[12]

Effective communication between physicians and their patients is a core clinical skill that is frequently included in residency and medical school curricula. However, providing patients with training in communication skills may lead to a more beneficial two-way engagement. Trained patients participated more actively in the medical interview, were more compliant, recalled symptoms more accurately, and recorded better physiologically measured health outcomes.[13] More investigation is needed to target the particular patient communication skills training needed for different clinical scenarios, methods of instructing patients, and how to assess their associated health outcomes.[13]

Increased patient diversity has resulted in increasing need for physicians to use a language interpreter while obtaining a medical history. Skills are required from both interpreter and physician to clarify the goals of the consultation and determine the main areas to be assessed.[14] Adequate information and training are needed to overcome the challenges associated with interpreter-mediated consultations. Suitable training programmes for physicians are, however, limited.[14,15] Physicians have indicated that continuing professional development seminars to understand the advocacy stances of interpreters, cultural teaching, and improving communication and empathy with patients of different cultures, would support enhanced patient care.[16]

Health beliefs are derived from factors such as family and cultural values, and personal experiences.[17] Values, beliefs and attitudes fashioned from one's unique life experience guide behaviours and practices. One's geographical place of residence and how one defines health are also important determinants of health beliefs and behaviours. For example, some rural Canadians view health from a role perspective, meaning that they are able to work and meet family obligations.[17] They also have higher poverty, shorter life expectancy, higher infant mortality, and engage in less prevention than urban Canadians. This is just one example of how divergent patient health beliefs can be, and emphasises the need for physicians to have the ability to adjust to combinations of differing values and behavioural patterns, reflecting on their own attitudes and experiences.[17]

Based on the preceding discussion of the literature, it is clear that training aimed at improving cross-cultural doctor-patient communication should address specific issues that include: *(i)* personal attitudes towards patients from different cultural and/or socioeconomic backgrounds; *(ii)* personal past experiences with people of different cultural and/or socioeconomic backgrounds; *(iii)* health beliefs of people of different cultural and/or socioeconomic backgrounds; *(iv)* expectations held by persons of different cultural and/or socioeconomic backgrounds about what a physician should do and how a physician should behave; *(v)* skills for working efficiently and effectively with interpreters; and *(vi)* patient communication and interaction skills.

Knowledge of these key factors that impact on the quality of cross-cultural doctor-patient communication can be evaluated using the Cross-Cultural Doctor-Patient Communication Needs Assessment tool.[18] Using elements of this assessment tool, we set out to determine the extent to which physicians would value learning about patient-centred elements of clinical care useful for their practice, and whether any variations in the perceived usefulness of these elements existed across: (*i*) physician gender; (*ii*) discipline/specialty practised; and (*iii*) number of years in clinical practice.

Methods

Survey data were collected during the fall of 2006 in the province of Manitoba, Canada. A self-report questionnaire was distributed through the provincial medical association's bimonthly newsletter to its members and by a direct mail-out from the researchers to the work addresses obtained from the College of Physicians and Surgeons of Manitoba's public-access website. The questionnaire's cover letter stated that the study's purpose was to examine how physicians interact and communicate with patients and cope with the demands of their practice. Permission to conduct the study was granted by the University of Manitoba Health Research Ethics Board. All completed questionnaires were mailed to the first author's university office address.

Of 310 participants, 42 returned questionnaires that were unusable for various reasons (e.g. no longer practised in the province, retired, served as administrators, or extensive missing responses) leaving 268 usable returns. Of the total respondents, 53% were from the provincial medical association and 47% were from the College of Physicians and Surgeons of Manitoba. Respondents were classified by specialty using an inductive approach. The physicians provided 33 distinct job descriptions, which were grouped into 10 specialties, with reference to the categories used in a prior research study.[16] These categories were: family medicine (*n*=110), internal medicine (*n*=50), paediatric disciplines (*n*=30), surgical disciplines (*n*=20), residents (*n*=20), psychiatry (*n*=19), anaesthesiology (*n*=10), and obstetrics/gynaecology (*n*=9). Specialties with 10 or fewer respondents were merged – anaesthesiology was grouped with internal medicine (*n*=60) and obstetrics/gynaecology were grouped with the surgical disciplines (*n*= 29). Respondents were in clinical practice for a mean of 16.5 years (standard deviation (SD) 11.05); the mean percentage of time spent in primary care was 68% (SD 24), and the mean number of minutes spent per patient consultation was 19 minutes (SD 14.76).

The importance of learning about cross-cultural communication needs was evaluated using six items from Section D of the Cross-Cultural Doctor-Patient Communication Needs Assessment.[18] The items evaluated were: *(a)* your own attitudes towards patients from different cultural and/or socioeconomic backgrounds; *(b)* your past experiences with people of different cultural and/or socioeconomic backgrounds; *(c)* health beliefs of people of different cultural and/or socioeconomic backgrounds; *(d)* expectations held by persons of different cultural and/or socioeconomic backgrounds about what a physician should do and how a physician should behave; *(e)* skills for working efficiently and effectively with interpreters; and *(f)* patient communication and interaction skills. Participants indicated how useful learning about these issues would be for improving communication skills with patients of different cultural and/or socioeconomic backgrounds using a 5-point response scale (1=not at all, 2=not very, 3=somewhat, 4=fairly, 5=extremely).

Results

Table 1 reveals two significant gender-based differences. Women physicians rated learning about the health beliefs of patients and patient expectations about how a physician should behave more useful than men physicians.The influence of specialty practised was compared using mean differences across

specialties. Table 2 indicates that there were no significant differences. Scores were at or above the scale midpoint for all statements, with the exception of residents and physicians practising in the surgical disciplines. Psychiatry, paediatrics, and internal medicine recorded the highest means for almost all of the six statements, and family medicine recorded the highest mean score for learning about how patients could improve their communication and interaction skills.

Table 1. Physician gender differences for the items evaluated

Education item	Male (*n*=159) Mean (SD)	Female (*n*=109) Mean (SD)	Cohen's d
(a) Your own attitudes toward different cultural and/or socio-economic backgrounds	3.14 (1.24)	3.02 (1.04)	0.10
(b) Your past experiences with people of different cultural and/or socio-economic backgrounds	3.32 (1.14)	3.27 (1.12)	0.06
(c) Health beliefs of people of different cultural and/or socio-economic backgrounds	3.84 (0.95)	4.11 (0.93)	0.48*
(d) Expectations held by persons from different cultural and/or socio-economic backgrounds about what a physician should do and how a physician should behave	3.68 (0.95)	4.03 (0.94)	0.34*
(e) Skills for working efficiently and effectively with interpreters	3.58 (1.10)	3.67 (1.07)	0.08
(f) Patient communication and interaction skills	3.45 (1.17)	3.19 (1.15)	0.22†

*$p<0.01$, two-tailed test.
†$p<0.05$, two-tailed test.

Evaluation of the relationship between years of clinical practice and cross-cultural doctor-patient communication skills needs was reported as Pearson's correlation coefficients. Table 3 reveals two significant relationships. The more years of practice physicians had the *less* they rated the usefulness of learning about the health beliefs of patients and patient expectations about how physicians should conduct themselves.

All six items evaluated in our study are indicators of patient-centred practice elements. Physicians practising in all the different specialties overwhelmingly indicated that learning about each of the six selected aspects of cross-cultural doctor-patient communication needs would be beneficial for career development and medical practice.

Discussion

This study demonstrates some important findings about the value Canadian physicians attach to learning about key aspects of doctor-patient cross-cultural communication. Our findings show that differences among physicians practising in the six major clinical specialties are not significant enough to warrant separate curricula or courses to teach cross-cultural communication skills. Nevertheless, the observed differences suggest that cross-cultural communication skills may be more highly valued in some specialties than others. For example, all specialties indicated that skills to work effectively with interpreters were important, but especially so for psychiatry. This could be because translating patients' thoughts and feelings during mental health assessments is particularly difficult for interpreters.[15] Family medicine scored the highest on patient communication skills. This may reflect the long-term nature of the relationships that family physicians have with their patients and the importance of self-care practices often carried out by their patients. Internal medicine and paediatrics scored well above the midpoint in all six statements, thereby indicating the importance they attach to all aspects of cross-cultural doctor-patient communication. This most likely reflects the need to develop a good understanding of how patients and their families manage chronic illness, thereby enhancing diagnostic and treatment outcomes.

Research has shown that women physicians use more communication skills and emotions with patients during medical consultations than men physicians.[19]This may reflect the importance women attach to relationship building, and may also explain why women physicians in this study expressed a greater need to learn about patients' health beliefs and expectations about how physicians should conduct themselves. Male physicians did, however, score above the midpoint of the response scale for both of these skills, suggesting that all physicians recognise the importance of these two aspects of cross-cultural doctor-patient communication.

A particularly interesting finding in our study was the observation that the longer physicians were in clinical practice the less they rated the usefulness of learning about the health beliefs of patients and patient expectations about how a physician should behave. This may be a sign that experienced physicians favoured clinical exposure as the better teacher, rather than continuing education activities such as seminars, lectures, etc.

One approach to improving physician-patient communication, based on actual clinical practice, may be the use of purposeful reflection. The latter can be used to analyse lived experiences, recognise knowledge gaps, and formulate learning needs.[3,11,20,21] Research among medical students and practising physicians has indicated that reflection and observation were effective learning strategies, and important for practice.[3,22,23] One approach may be the use of journal writing for reflecting on emotional reactions in daily practice, which may foster openness, awareness and stimulate learning about the impact of emotions on job satisfaction, morale and patient care.[24] Similarly, learning portfolios are useful for documenting reflective activities collected over a period of time, and can include a plan for undertaking learning, and documenting evidence of learning achieved.[3,23,25] The use of these educational tools to promote reflection may be an important way of enhancing physician-patient communication, especially in the cross-cultural setting, among busy practising clinicians where traditional continuing medical education activities may be of limited value. This is an avenue of research worth exploring.

Acknowledgements. The authors thank Celeste Brotheridge for her assistance with the data analysis.

An earlier version of this paper was presented by the first author at the 12th World Congress on Public Health, Istanbul, Turkey, 27 April - 1 May 2009.

Table 2. Differences across specialties on six items evaluated

	Residents (*n*=20) Mean (SD)	Family (*n*=110) Mean (SD)	Psychiatry (*n*=19) Mean (SD)	Surgical (*n*=29) Mean SD	Internal (*n*=60) Mean (SD)	Paediatric (*n*=30) Mean (SD)
(a) Your own attitudes toward different cultural and/or socio-economic backgrounds	3.10 (1.21)	3.07 (1.20)	3.47 (1.39)	2.72 (1.07)	3.17 (1.11)	3.15(0.99)
(b) Your past experiences with people of different cultural and/or socio-economic backgrounds	3.35 (1.31)	3.26 (1.09)	3.22 (1.56)	3.10 (1.21)	3.45 (1.03)	3.52 (0.89)
(c) Health beliefs of people of different cultural and/or socio-economic backgrounds	4.00 (0.86)	3.90 (0.93)	4.00 (1.05)	3.72 (0.80)	3.70 (0.96)	4.11 (0.92)
(d) Expectations held by persons from different cultural and/or socio-economic backgrounds about what a physician should do and how a physician should behave	3.95 (0.89)	3.89 (0.87)	4.00 (1.16)	3.62 (0.90)	3.77 (1.00)	3.86 (1.08)
(e) Skills for working efficiently and effectively with interpreters	3.55 (1.19)	3.56 (1.10)	4.22 (1.17)	3.38 (0.98)	3.78 (0.96)	3.78 (0.97)
(f) Patient communications and interaction skills	2.95 (1.00)	3.50 (1.13)	3.16 (1.77)	3.21 (1.15)	3.42 (1.15)	3.39 (0.96)

Table 3. Correlation between years of experience and the six items evaluated

(a) Your own attitudes toward different cultural and/or socio-economic backgrounds	0.00
(b) Your past experiences with people of different cultural and/or socio-economic backgrounds	-0.03
(c) Health beliefs of people of different cultural and/or socio-economic backgrounds	-0.13*
(d) Expectations held by persons from different cultural and/or socio-economic backgrounds about what a physician should do and how a physician should behave	-0.14*
(e) Skills for working efficiently and effectively with interpreters	-0.01
(f) Patient communication and interaction skills	-0.07

*$p<0.05$, two-tailed test.

References

1. Richardson B, Higgs J, Abrandt Dahlgren M. Recognising practice epistemology in the health professions. In: Higgs J, Richardson B, Abrandt Dahlgren M, eds. Developing Practice Knowledge for Health Professionals. London: Butterworth-Heinemann, 2004:1-14.
2. Underhill C, McKeon L. Statistics Canada. Health Information and Research Division. Getting a Second Opinion: Health Information and the Internet. Cat 82-003. Health Reports 19(1). Ottawa: Government of Canada, 2008.
3. Campbell CM, Gondocz T. Identifying the needs of the individual learner. In: Davis D, Barnes BE, Fox R, eds. The Continuing Professional Development of Physicians: from Research to Practice. Chicago: American Medical Association, 2003:81-95.
4. Mann KV. Reflecting on the challenges facing continuing medical education today. Med Educ 2005;39:546-557.
5. Margolis A, Alvarino F, Niski R, et al. Continuing professional development of physicians in Uruguay: Lessons from a countrywide experience. J Contin Educ Health Prof 2007;27(2):81-85.
6. Stewart M. Towards a global definition of patient centred care. BMJ 2001;322:1444-1445.
7. Sachdeva AK. The new paradigm of continuing education in surgery. Arch Surg 2005;140:264-269.
8. Davis D, O'Brien Thomson MA, Freemantle N, Wolf FM, Mazmanian P, Taylor-Vaisey A. Impact of formal continuing medical education: Do conferences, workshops, rounds and other traditional continuing education activities change physician behavior or health care outcomes? JAMA 1999;282:867-874.
9. Siddiqui ZS, Secombe MJ, Peterson R. Continuous professional development – development of a framework for medical doctors in Pakistan. J Pak Med Assoc 2003;53(7):1-4.
10. Stewart M, Brown JB, Donner A, et al. The impact of patient-centered care on outcomes. J Fam Pract 2000;49:796-804.
11. Higgs J, Andresen L, Fish D. Practice knowledge - its nature, sources and contexts. In: Higgs J, Richardson B, Abrandt Dahlgren M, eds. Developing Practice Knowledge for Health Professionals. London: Butterworth-Heinemann, 2004:51-69.
12. Wensing M. Patients' expectations of treatment. In: Jones R, Britten N, Culpepper L, et al., eds. Oxford Textbook of Primary Medical Care, vol 1: Principles and Concepts. Oxford: Oxford University Press, 2004:122-126.
13. Cegala DJ, Marinelli T, Post D. The effects of patient communication skills training on compliance. Arch Fam Med 2000;9:57-64.
14. KachurKrajic E, Altshuler L. Cultural competence is everyone's responsibility! Medical Teacher 2004; 26(2):101-105.
15. Farooq S, Fear C. Working through interpreters. Advances in Psychiatric Treatment 2003;9:104-109.
16. Lovell BL, Lee RT, Frank E. May I long experience the joy of healing: professional and personal wellbeing among physicians from a Canadian province. BMC Fam Pract 2009;10:18.
17. Thomlinson E, McDonagh MK, Crooks Baird K, Lees M. Health beliefs of rural Canadians: implications for practice. Australian Journal of Rural Health 2004;12:258-263.
18. Shapiro J, Hollingshead J, Morrison E. Primary care resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome them. Med Educ 2002;36:749-759.
19. Lovell BL, Lee RT, Brotheridge CM. Gender differences in the application of communication skills, emotional labour, stress-coping, and well-being among physicians. Archives, The International Journal of Medicine 2009; 2(3): 273-278.
20. Plack MM, Greenberg L. The reflective practitioner: reaching for excellence in practice. Pediatrics 2005;116:1546-1552.
21. Watling CJ, Brown JB. Education research: communication skills for neurology residents: structured teaching and reflective practice. Neurology 2007;69: 20-26.
22. Windish DM, Price EG, Clever SL, Magaziner JL, Thomas PA. Teaching medical students the important connection between communication and clinical reasoning. J Gen Intern Med 2005;20:1108-1113.
23. Parboosingh JT, Badat MC, Wooster DL. Individualized learning strategies. In: Davis D, Barnes BE, Fox R, eds. The Continuing Professional Development of Physicians: from Research to Practice. Chicago: American Medical Association; 2003:145-165.
24. Howard J. The emotional diary - a framework for reflective practice. Education for General Practice 1997;8:288-291.
25. Wilkinson TJ, Challis M, Hobma SO, et al. The use of portfolios for assessment of the competence and performance of doctors in practice. Med Educ 2002;36:918-924.