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How Patients Think: Assessing Clinician Competence in University Settings

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RESEARCH ARTICLES

Chapter 1

How Patients Think: Assessing Clinician Competence in University Settings

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Introduction

The past academic year of 2014–2015 I completed an independent research study to observe how patients assess clinician competence within a university setting. The goal of the research was twofold: first, to look at patient-clinician interactions from the patient's perspective, and second to see if a patient's past experiences with clinicians have any effect on their current assessment of clinician competence. The study focused on college students at the University of New Hampshire (UNH), Durham campus. In the following paragraphs, I provide a summary of the research project, methodology, and outcomes.

As a recent graduate with a Bachelor of Science in Biomedical Sciences and an aspiring doctor, I found the lack of communication among medical students and their patients intriguing. A physician's role is to communicate with patients in an understandable, compassionate and attentive manner. Yet studies have found that medical students placed within a dehumanizing learning environment during medical school were unable to efficiently interact with patients. Such settings included anatomy and physiology labs where feeling rules were implemented, rules that distance first-year medical students "from the emotional consequences of dissecting human cadavers, performing autopsies, or killing animals" (Hafferty 1988, 354). Dr. Rafael Campo

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(2005) describes "distancing" as the process by which a physician removes themselves from the particulars of patient experiences of illness in order to render accurate diagnosis and treatment. However, medical students who learn to distance themselves early in their career become vulnerable to dehumanizing terminology and the pressures of unfeeling medical policies and economic incentive, and thus never have the chance to develop adequate patient-physician communication skills they will need later in their careers.

This concern was one of the driving factors that helped shape my study. In previous independent research projects I was able to lay a framework for the study of history and medicine, and for the study of the anthropological and social aspects of the practice of medicine. In the summer of 2012, I conducted literary research on the history of blood transfusions, which allowed me to understand what parts of the research process I enjoyed and which parts of medicine I wanted to explore. During the summer of 2013, I conducted further literary research and implemented a research survey consisting of 15 participants that compared communication between patient and physician in the current era versus the 1850s. During the 2013–2014 academic year, I studied the psychological effects of chronic illness in young adults and conducted informal interviews consisting of ten participants.

This recent project constituted my senior capstone thesis for my major. In addition, the project served to improve my research skills and writing skills, as well as publication experience. This study was financially supported by an INCO 790 (a research experience course offered by the Hamel Center for Undergraduate Research at UNH), and an Undergraduate Research Award. My project contributes to the social science literature on patient expectations and satisfaction by providing insights into how newly independent adults interact with clinicians, and by illustrating how age impacts health care experience. Finally, inasmuch as the students documented here

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reflect a segment of the national voting population, understanding how this sample population assessed clinicians can help inform and shape future health policy at the national level.

Methods for this study included: (1) compiling data from various medical and medical anthropology journals and online resources on the topic of patient expectations, satisfaction, and experience; (2) arranging and conducting semi-structured interviews with patients; (3) conducting a focus group with a sample of students; and (4) conducting an online survey to gather data on patient experiences with clinicians at UNH Health Services and elsewhere. All protocol for the interviews, focus group, and online surveys were approved by the Institutional Review Board (IRB) at UNH. Taken together, this study examined patients' assessments of competence among a wide range of health care providers and clinicians.

Discussion and Conclusion

This study was unique because it focused on the demographic of college students between the ages of 18–26. Few other studies have been conducted on this age group, although this should be a pivotal period of time to focus on, as college students often switch health care providers (e.g., from pediatrician or family physician to on-campus or other adult-focused health care providers). Additionally, many students must deal with the complexities of changing insurance providers. As students transition between lives at home with parental guidance to life on a college campus, many in this age range may encounter entirely novel and independent medical experiences, notably without the physical presence of parents or relatives. It is critical to understand how university students make decisions about health care providers, not only because as young voters these students will shape future health policies, but also because many students are medical professionals-in-training, and as such they will determine the everyday practice of health care in the years to come.

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This study aimed to probe the interactions between clinicians and college-aged patients by exploring how internal and external factors influence patient satisfaction within a health care environment (specifically within a university setting), as well as how these factors lead to differing assessments of clinician competence. Internal factors were defined as those taking place within a medical setting, such as a clinician's personality and mode of interacting with patients. External factors were defined as those outside of a medical setting, such as insurance coverage and proximity to the patient. The ways in which patients assess clinician competence is influenced by a number of both external and internal factors. However, my methods lent themselves better to collecting data on internal factors such as (mis)diagnosis, interaction with the clinician, and the clinician's personality. In addition, while external factors such as insurance coverage, residual fear, and proximity to health care influence a patient's assessment of clinician competence, it seems that events that take place within the medical setting are more revealing of how a patient assesses a clinician.

The data gathered from interviews, the focus group, and online surveys revealed that the personality and the attitude of a clinician are very important for determining patient assessment of clinician competence. For example, some focus group participants felt that health care providers who remembered personal details about their lives were attentive. Further, about 50% of online survey participants responded that unfriendly medical staff has prevented them from returning to a former health care provider (Figure 1.1). A second internal factor of importance in the assessment of clinician competence was that of diagnosis and misdiagnosis. This study found that a correct diagnosis and treatment plan encouraged successive visits to a health care provider (Figure 1.2).
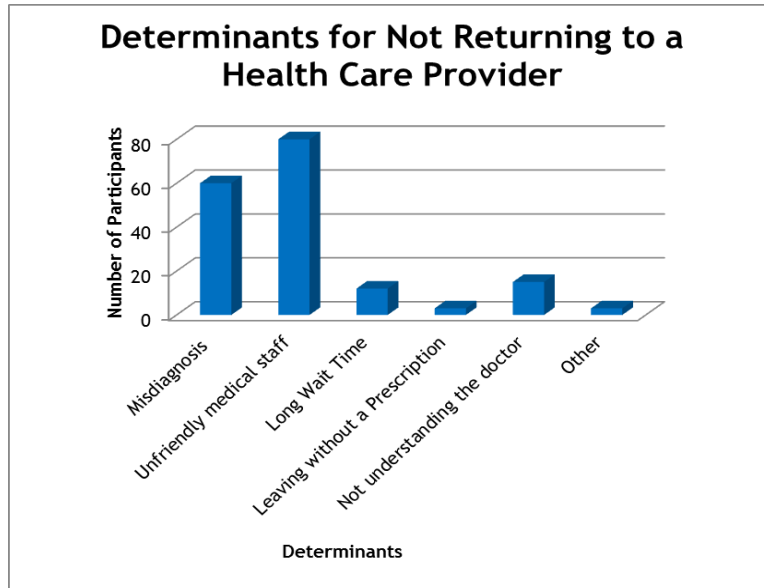
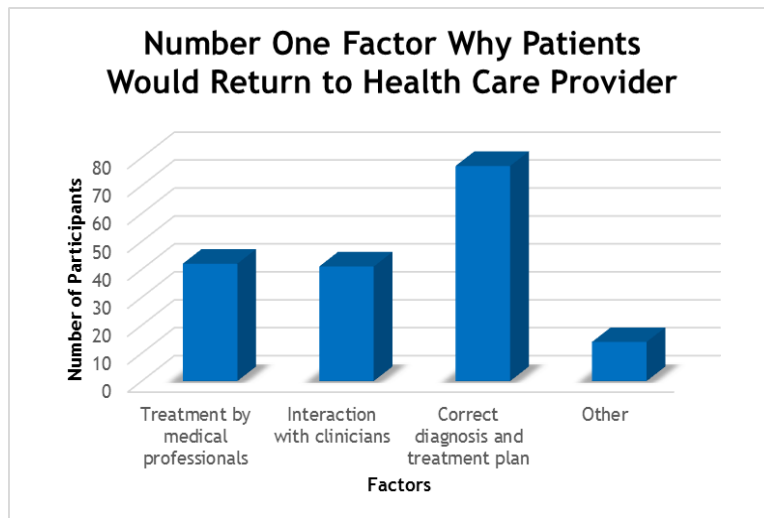Figure 1.1. Determinants for not returning to a health care provider.

Figure 1.2. Number one factor for returning to a health care provider.

In terms of external factors, how far a medical provider is located from one's home or place of residence greatly affects their experience with a clinician. Data obtained from interviews revealed that students who lived on-campus tended to go to the University Health Services if needed (Figure 1.3). If they were an out-of-state student with a lack of transportation this affected their choice and if they had a negative experience at University Health Services their

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health care options were limited and in some cases resulted in returning to University Health Services out of desperation. It was found overall that students tended to prefer health care providers off-campus than on-campus.

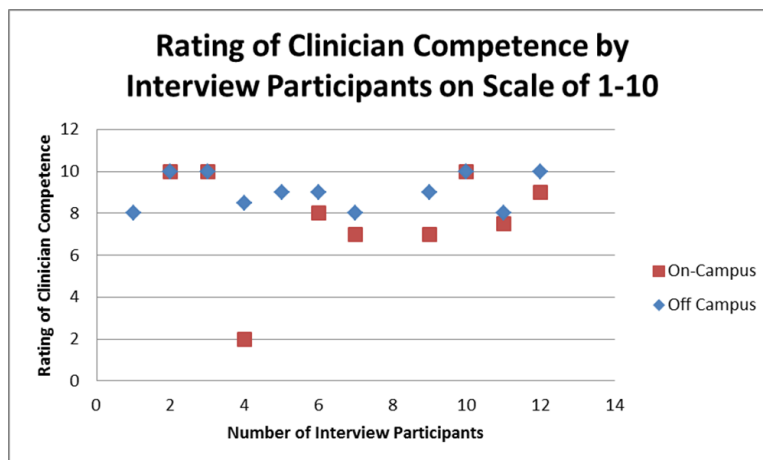**Rating of Clinician Competence by Interview Participants on Scale of 1-10**

Figure 1.3. Rating of clinician competence on and off-campus.

In addition, data obtained from the focus group and online survey indicated that there were some concerns about medical treatment and insurance coverage, meaning that people wouldn't want to be treated if they were unsure of their coverage status and that there was a correlation between the two. Insurance was associated with determining the kind of medical care received/treatment, the type of doctor seen, and access to preventative care. One focus group participant gave an example of having friends who, "have just grown up not going to the doctor because their parents couldn't afford it" and didn't have insurance, so they didn't go (Anonymous student, February 24, 2015). Data obtained from the online survey revealed that the presence of insurance coverage was the strongest determinant of whether a patient made an attempt to see a primary health care provider (Figure 1.4).
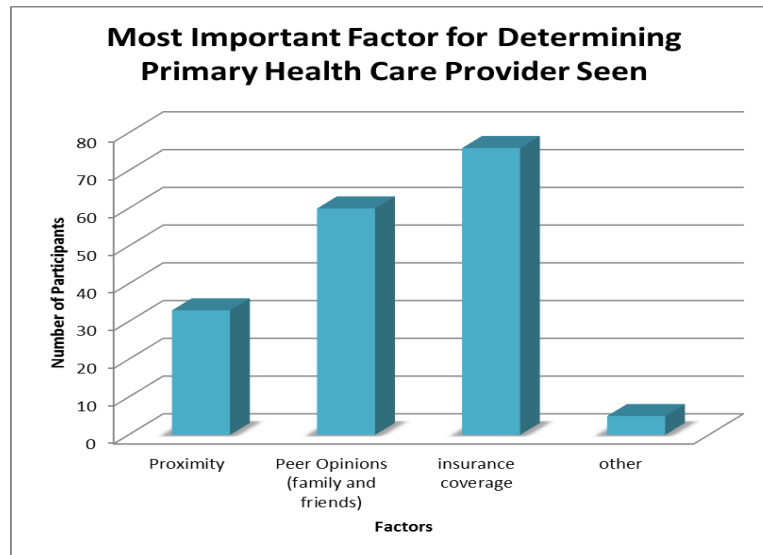
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Figure 1.4. Determinants of health care provider seen.

Overall, students who no longer rely on the guidance of parents or family reported less concern with external factors (e.g., insurance coverage) and more concern with internal factors (e.g., diagnosis). Perhaps unsurprisingly, students at the upper end of the age range had more experience navigating medical settings without parental or familial presence. The overriding concerns among all student participants were (1) to be treated with respect and (2) to be taken seriously, concerns that are likely related to the age of the sample population, most of whom have only recently reached adulthood. These findings thus add important insight to current literature on patient satisfaction, one that tends to focus on the point of view of older adults.

In terms of implications for clinical practice, the results of this study suggest that there is a real need for clinicians to be more aware of the social demands and cues of patients, both verbal and non-verbal. It has been shown that "affiliative nonverbal behavior (e.g., eye gaze and proximity) of the physician is related to higher patient satisfaction" and that physicians and patients tend to mirror nonverbal behavior and complement each other on other aspects of nonverbal behavior (Mast 2007, 315). Clinicians that can successfully engage their clients on a

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personal level would encourage positive interactions and connections to be formed between the professional and their patient. In addition, more time and energy should be spent educating medical professionals about the importance of relating and listen to their patients, particularly younger adult patients. Courses and workshops could easily be implemented within medical school curricula, a small change that could drastically decrease clinician-patient miscommunication and misinterpretation within the medical setting.

Balancing technology with hands-on diagnostic techniques could also enhance the clinician-patient relationship, allowing patients to develop a more thorough understanding of their health and health care needs. An example of this balance can be seen in the increasingly widespread use of computers within medical offices, where physicians can provide visual diagrams of a patient's health issue and how to regain health as a way to balance technology with hands-on technique. A personal example of this balance was exhibited in a recent visit to my dentist's office. Lying back on the dental chair with a video monitor in my line of sight, I was able to look at my teeth X-rays, receive in-depth explanations of the images from the dental assistant, and watch my own teeth cleaning with the use of a microscopic camera attached to one of the dental instruments. This approach within a medical setting is hypothetical but would serve to offer patients needed reassurance and a way in which to form a connection with a clinician, prompting a return to the medical setting. This suggestion does not take into consideration time or other factors that would be involved, but offers a simple method for balancing technology and physical technique.

Understanding patient assessment of clinician competence is critical for charting more successful medical systems that both patients and clinicians are satisfied with. In addition, research on the factors driving patient assessment lend insight into the background, actions, and

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expectations of both parties, revealing important similarities and differences in how each stakeholder group forms their perceptions. The student patient population of 18–26 years is a crucial sample to study, as it represents the next generation of voters who will make decisions on future health policy in our country. As medical settings become more technologized, and clinicians struggle to find a balance between technology and hands-on approaches to care, the concerns of the patient need to be brought to the fore and addressed before the communication gap in health care expands.

References

Campo, Rafael. 2005. "'The Medical Humanities' for Lack of a Better Term". *Journal of American Medical Association* 294: 9, 1009-1011. Print.

Hafferty, Frederic W. 1988. "Cadaver Stories and the Emotional Socialization of Medical Students." *Journal of Health and Social Behavior* 29: 4, 344-356. Print.

Mast, Marianne Schmid. 2007. "On the Importance of Nonverbal Communication in the physician-patient interaction." *Patient Education and Counseling* 63: 3, 315-318. Print.

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