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Resident physicians' attitudes and confidence in communicating with patients: A pilot study at a Japanese university hospital

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ABSTRACT

Objective: This study aimed to explore the relationships among physicians' confidence in conducting medical interviews, their attitudes toward the patient–physician relationship, and undergraduate training in communication skills among resident physicians in Japan.
Methods: Participants were 63 first-year resident physicians at a university hospital in Tokyo. The Physician Confidence in the Medical Interview scale (PCMI) was constructed based on the framework of the Calgary–Cambridge Guide. Additionally, participants' attitudes toward the patient–physician relationship (Patient–Practitioner Orientation Scale; PPOS), undergraduate experience of communication skills training, and demographic characteristics were assessed through a self-reported questionnaire.
Results: The internal consistency of the PCMI and PPOS scales were adequate. As expected from the undergraduate curriculum for medical interviews in Japan, residents had relatively higher confidence in their communication skills with respect to gathering information and building the relationship, whereas less confident about sharing information and planning treatment. The PCMI was associated with a more patient-centered attitude as measured by the PPOS.
Conclusion: These scales could be useful tools to measure physicians' confidence and attitudes in communicating with patients and to explore their changes through medical education.
Practice implications: Residency programs should consider including systematic training and assessment in communication skills related to sharing information and planning treatment.

1. Introduction

Numerous studies have confirmed the importance of communication skills for medical professionals. Communication skills training is now internationally accepted as an essential component of medical education [1].

With increasing attention to communication skills in medical education, physician characteristics that may influence the quality of communication have been intensively studied. Traditionally, behavioral theories have paid close attention to one's attitudes (or beliefs) and self-efficacy (i.e., confidence in one's ability to successfully execute the behavior required to produce the desired outcomes) as important predictors of one's intentions and actual behavior [2]. Previous studies have explored the effect of physicians' attitude and confidence regarding communication with patients on their actual communication behaviors and on patient outcomes. It has been reported that physicians' attitudes toward patient-centered and shared decision-making was related to more favorable communication behaviors, such as more engagement in emotional exchanges and the use of fewer closed-ended questions, as well as better patient outcomes, such as higher satisfaction and treatment adherence [3,4]. Also, physicians' self-efficacy or confidence was associated with better ability to recognize patients' needs for information and with higher patient satisfaction [5]. Although some studies have found that physician attitudes and confidence may not predict actual performance [6], these characteristics have been considered important from an educational standpoint because they can be changed through education, unlike many other physician characteristics, such as age, gender, and race. Additionally, self-reflection, i.e., the process of assessing one's confidence and attitude in communicating with patients per se, may provide an important educational benefit for physicians.

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Until recently, especially in Japanese culture, communication competence was considered primarily to be an inherent ability or character trait rather than a set of skills to be acquired through education and practice. In 2001, the Report of the Coordinating Council on the Reform of Medical and Dental Education advocated guidelines for innovative changes to Japanese medical education, proposing an exemplary model of an undergraduate medical education curriculum [7], in which interpersonal relationships with patients and medical interview skills were included as important components. Furthermore, in 2005, the Objective Structured Clinical Examination (OSCE) was officially introduced as a method of assessing clinical competencies achieved through the preclinical core curriculum. Since then, many medical schools in Japan have undergone major curriculum reforms and have started to provide at least some lectures on and practice in medical interviews.

Specific competence in communication skills expands as physicians advance from novice to expert in the practice of their specialty [8]. Most courses for undergraduate students emphasize training in basic interviewing skills, whereas courses for physicians are directed toward more complex skills [9]. Among the three functions of the medical interview (i.e., gathering data to understand the patient's problems, developing rapport and responding to patients' emotions, and educating and encouraging patients to adhere to treatment recommendations) [10], the focus of communication skills training in undergraduate medical education in Japan has been on the first two. However, before completion of a residency, physicians should demonstrate competence in applying the essential communication skills to the full range of clinical situations relevant to their specialty [8]. However, the extent to which resident physicians have confidence in their communication skills is unclear. Furthermore, communication skills training in postgraduate education has not been as well established as that in undergraduate programs. Residents are expected to learn from their everyday interactions with patients and from observation of more senior physicians. Thus, it seems likely that what they learn during the residency program will vary depending on their attitude or motivation regarding communication with patients. Assessing the current status and relationship of physician's confidence and attitude would be useful in considering communication skills training in postgraduate education.

This study aimed to explore resident physicians' confidence in medical interviews and its relationship to their attitude toward the patient–physician relationship and their previous experience of communication skills training at medical school in Japan.

2. Methods

2.1. Participants and procedures

A total of 72 resident physicians entered a junior residency program at a university hospital in Tokyo in 2013. They were invited to participate in this questionnaire survey during the orientation sessions just before starting the residency program. Residents were informed both orally and in writing that participation was voluntary and would not influence their evaluation in the residency program. Participants received an Amazon gift certificate of 500 yen (approximately $5) in return. In total, 67 resident physicians returned a completed consent form and the questionnaire (response rate: 93.1%).

Study procedures were approved by the Institutional Review Board of Graduate School of Medicine, the University of Tokyo.

2.2. Measures

2.2.1. Physician Confidence in the Medical Interview (PCMI)

Based on the Calgary–Cambridge Guide to the medical interview [11] and the Macy Model of doctor–patient communication [12], a framework of physicians' communication competence required for medical interviews was introduced in a Japanese textbook on the

Table 1
Physicians' Confidence in the Medical Interview (PCMI): item content and means.

	Mean	SD
Initiating the session	**2.83**	**0.40**
(1) Establish initial rapport (greet the patient, obtain the patient's name, introduce oneself, etc.)	3.12	0.44
(2) Elicit all of patient's problems or reasons for the consultation	2.64	0.54
(3) Negotiate an agenda taking both patient's and physicians' needs into account	2.72	0.57
Gathering information	**2.86**	**0.47**
(4) Encourage patient to tell the detailed story of the problem(s) in his/her own words	2.88	0.56
(5) Actively listen, facilitating patient's responses verbally and non-verbally	3.07	0.59
(6) Clarify patient's statements that are unclear, and periodically summarize to organize the information	2.63	0.60
Providing structure	**2.59**	**0.51**
(7) Share the flow of the interview with the patient	2.79	0.62
(8) Summarize at appropriate points and structure the interview in a logical sequence	2.58	0.65
(9) Attend to timing and keep the interview on task	2.40	0.65
Building the relationship	**2.75**	**0.46**
(10) Demonstrate appropriate non-verbal behavior (showing empathy, note taking, etc.)	2.94	0.57
(11) Actively respond to patient emotions verbally	2.67	0.66
(12) Encourage patient to participate in the decision-making process (share own thought processes, intent of the question, and the flow of the consultation)	2.63	0.52
Explanation	**2.51**	**0.49**
(13) Provide the correct amount and type of information	2.33	0.59
(14) Share information in a way that aids accurate recall and understanding	2.54	0.59
(15) Achieve shared understanding about the problems	2.66	0.59
Planning	**2.63**	**0.49**
(16) Encourage patient to participate in decision-making process to the level that they wish	2.61	0.63
(17) Negotiate a mutually acceptable plan	2.61	0.58
(18) Check with patient about whether he/she agrees and is comfortable with the plan	2.67	0.61
Closing the session	**2.94**	**0.41**
(19) Summarize the session briefly and clarify the plan of care	2.90	0.50
(20) Assure that there is a plan for unexpected outcomes and follow-up	2.96	0.56
(21) Thank the patient with appropriate parting statements	2.96	0.53
Overall, achieve an interview that is fully satisfactory and accepted by the patient	**2.69**	**0.56**

Note: Each item was rated on a 4-point scale with higher scores indicating greater confidence.