Patient Education and Counseling xxx (2017) xxx–xxx

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

Review article

Face-to-face communication between patients and family physicians in Canada: A scoping review

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ARTICLE INFO

Article history:
Received 11 October 2016
Received in revised form 7 November 2017
Accepted 16 November 2017

Keywords:
Scoping review
Health communication
Patient-provider communication
Canada
Primary care
Healthcare

ABSTRACT

Objective: Patient-provider communication is critical in primary care. Canada's unique health system, population distribution, and cultural context suggest there is value in addressing the topic in the Canadian context. We conducted a scoping review to synthesize recent Canadian literature to inform practice in primary care settings and identify research agendas for patient-provider communication in Canada.

Methods: Using Arksey and O'Malley's framework we searched four literature databases: Medline, Web of Science, CINAHL and EMBASE. We extracted 21,932 articles published between 2010 and 2017. A total of 108 articles met the inclusion criteria. The articles were analyzed qualitatively using thematic analysis to identify major themes.

Results: Four major themes were identified: information sharing, relationships, health system challenges, and development and use of communication tools.

Conclusion: Our review identified a need for Canadian research regarding: communication in primary care with Aboriginal, immigrant, and rural populations; the impact of medical tourism on primary care; and how to improve communication to facilitate continuity of care.

Practice implications: Challenges providers face in primary care in Canada include: communicating with linguistically and culturally diverse populations; addressing issues that emerge with the rise of medical tourism; a need for decision aids to improve communication with patients.

Contents

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https://doi.org/10.1016/j.pec.2017.11.008
0738-3991/

1. Introduction

Communication, a key aspect of patient-provider interactions [1–5], is vital for patient adherence to medication and treatment plans [6], patient satisfaction, and participatory decision-making [6–8]. Good communication fosters more open disclosure between patients and providers, and thus aids diagnoses [9] and health outcomes [9,10]. Studies of patient-provider communication (herein referred to as PP communication) in primary care are especially important in settings, such as Canada, in which a primary care provider is the hub for most patients' needs, and a key gatekeeper to hospital or specialist care [11]. Communication in these contexts is distinctive because of the diverse array of health issues presented in general practice. Unlike engagement with emergency or specialist physicians, patients see their primary provider to address minor illnesses and injuries (e.g., colds/flu; a sprain), discuss chronic illnesses (e.g., hypertension, asthma), to get advice about whether they should see a specialist, and for primary prevention (e.g., screenings; periodic check-ups). PP communication in primary care is relevant to continuity of care, in that good communication can facilitate a patient's willingness to continue a relationship with their provider [12].

Herein we provide a synthesis of recent research regarding face-to-face PP communication in primary care in Canada. There is limited information about the scope of research regarding PP communication in the Canadian context. The majority of research is conducted in the United States (US) where health system differences make it inappropriate to assume that data should inform research and practice in Canada. There are fundamental differences in how healthcare is funded in Canada, as compared to the US where healthcare is largely offered through insurance payments and out-of-pocket. Canada's system is designed to provide healthcare free of charge on the basis of need (with some exclusions including optometry, dentistry, and pharmaceuticals) [13]. Roughly 70% of Canada's health expenditure is publically funded [14] with insurance and out-of-pocket payments covering the remaining 30%.

Canada's geographic and sociocultural contexts affect the provision of primary care and PP communication in primary care settings. With a population of ~34 M, Canada has one of the lowest human population densities in the world, with the greatest proportion of the population located in southern urban areas [13]. Canada has unique features regarding the uneven distribution of its rural populations. Due to relatively low populated remote regions, and challenging living conditions due to the cold climate, service provision for individuals living in remote communities, and to some extent rural areas, is a pressing problem that makes communication between patients and providers inconsistent and limited. There are also unique cultural factors to consider with regards to population distribution. Most new immigrants live in Canada's largest cities and have neither English nor French as their first language making PP communication in primary care difficult. Consequently, additional pressures are placed on health care facilities in large urban centres to provide services in ways that can overcome cultural and linguistic barriers [13]. Conversely, the majority of the country's Aboriginal (First Nation, Inuit and Métis) citizens live on rural reserves, land claim regions in the Arctic or in poorer city neighbourhoods [13]. Poor access to primary healthcare, as well as language barriers and historical disenfranchisement, have led to disproportionally higher levels of chronic diseases and conditions requiring primary services [13] and have created communication barriers between patients and providers that are difficult to overcome [13]. The projection for ever-increasing diversity of the Canadian population is likely to continue to alter the landscape within which primary healthcare providers communicate [15]. Another consideration for primary care in Canada's publically funded system is its aging population. Seniors will likely constitute 23% of the population by 2030 [16], leading to significant pressure on primary care providers to help manage age-related disease and increasingly communicate with caregivers and patients about disease management or treatment.

PP communication in primary care settings is viewed as increasingly important due to a recognition that current healthcare models focused on treatment, rather than prevention, are not sustainable [13]. Face-to-face communication remains the most common form of communication in primary care and is a well-established field of study internationally, with large bodies of work conducted in the US [6,8,9,17–20] and the UK [21–26]. This large body of work points to the need for evidence-based recommendations for primary care practice, and supports context-specific research. Therefore, the present scoping review examined current research on face-to-face communication between patients and their primary care physicians in the Canadian context with the aim of identifying Canada-specific recommendations for practice and suggesting agendas for future research in Canada.

2. Methods

2.1. Research design

Scoping reviews allow for a structured approach to gathering and reviewing literature, while being flexible enough to afford opportunities to construct and answer broad research questions [27]. Unlike systematic reviews aimed at critical appraisal and synthesis of research evidence, scoping reviews provide a preliminary assessment of the potential extent and scope of available research. According to Arksey and O'Malley, scoping reviews are also useful to summarize and disseminate research findings in specific areas of research, offering insight on the state of research for stakeholders who are unable to review the literature themselves. [27,28]. In line with the study purpose, we chose to conduct a scoping review with the aim of: 1. summarizing and disseminating research findings for practitioners who lack the time and resources to gather and synthesize such work; 2. identifying gaps in the literature (e.g. excluded population groups; knowledge regarding systemic factors shaping communication) in order to define future research agendas specific to the Canadian context, and ultimately inform clinical practice [27]. We used Arksey and O'Malley's five-step framework for scoping reviews [27,29]: 1) identifying the research question; 2) identifying relevant studies; 3) selecting studies for inclusion; 4) charting the data; and 5) collating, summarizing and reporting the results.

Please cite this article in press as: A. Armas, et al., Face-to-face communication between patients and family physicians in Canada: A scoping review, Patient Educ Couns (2017), https://doi.org/10.1016/j.pec.2017.11.008