Education in Medicine Journal ISSN 2180-1932

COMMENTARY
Volume 6 Issue 4 2014
DOI:10.5959/eimj.v6i4.311
www.eduimed.com

Empowering the Patient through the Development of Core Competencies

Vijay Rajput[1], Krysta Contino[2], Marcus Henning[3]

[1]Ross University School of Medicine, Miramar, Florida, USA. [2]Medicine Resident, Department of Medicine, Cooper University Hospital, Camden, New Jersey, USA. [3]Centre for Medical and Health Sciences Education, Faculty of Medical and Health Sciences, University of Auckland, New Zealand.

ARTICLE INFO

Received : 11/09/2014
Accepted : 20/10/2014
Published : 01/12/2014

KEYWORD

Patients
Empowerment
Medical education

ABSTRACT

The following paper reflects on the impact of the physician core competencies defined by the Accreditation Council for Graduate Medical Education of USA. In this commentary paper we have mirrored these core competencies so that the perceived patient perspective can be heard. As medical educators we feel it is important to consider the views of the main stakeholder in medicine, namely the patient, and to draw on our experiences as clinicians and at times patients ourselves. We further consider patient rights as the driving force that directs the development of core competencies through the cultivation of active and fruitful dialogue with their physicians. This paper will also likely to open the door to further research in this area.

© Medical Education Department, School of Medical Sciences, Universiti Sains Malaysia. All rights reserved.

CORRESPONDING AUTHOR: Dr Marcus Alexander Henning, Centre for Medical and Health Sciences Education, Faculty of Medical and Health Sciences, University of Auckland, Private Bag 92019, Auckland 1142, New Zealand, Email: m.henning@auckland.ac.nz

Introduction

In 1996, the Accreditation Council for Graduate Medical Education (ACGME) of USA defined six “core” competencies for medical doctors, which have been used to gauge physicians, residents, and students with respect to specific healthcare performance measures (1). As medicine evolves towards a more patient-centered model, we feel it is important to meet the needs of the patient and to enable them with core competencies. This would engender more constructive consultations with medical doctors through the development of patient autonomy and engagement (2).

In this commentary article, we have framed the notion of patient competency in line with seven core competencies, of which six (core competencies 2 to 7 below) are mirror images of those defined for medical doctors by ACGME (1). This paper aims to draw attention to creating a more collaborative process between medical doctor and patient so that patients can engender more understanding about, and contribute more fully to, their care.

Core competency 1: Patient rights

In their paper, Mann and coworkers posed a synthesis between health and human rights (3). Patients are unique beings living in societal

frameworks paying taxes and insurance levies. Consequently, it is reasonable to assert that, in OECD (Organization for Economic Cooperation and Development) member countries, the governing bodies have ethical, moral, and legal responsibilities to provide the best possible health care. Therefore, a key patient core competency relates to having knowledge about their rights, regional health policies, health potentialities and access to appropriate health services.

Core competency 2: Patient care

According to ACGME the goal of patient care is to be "compassionate, appropriate, and effective for the treatment of health problems and the promotion of health (4)." This patient competency relates to enabling patients to make healthcare decisions based on the information presented to them with the view to making their health needs clear, and to working towards maintaining a healthier lifestyle. Patients need to be involved in and ultimately retain the authority of their treatment options. They need to know the benefits and burdens associated with each treatment decision so that they can make educated choices regarding their care. Informed consent is established through open and focused dialogue between patient and medical doctor. This approach engenders an 'informative model' whereby medical doctors respect their patients' values and present facts through considered engagement (5).

Core competency 3: Medical knowledge

The pillar of medical knowledge includes "established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavior) sciences and the application of knowledge to patient care (4)." This is an ever-expanding aspect of medicine as science and advancing technology continue to produce new diagnostic and treatment modalities (6). The amount of research being conducted throughout the world continues to grow exponentially. It is important that patients work with physicians to enhance their medical knowledge through utilization of appropriate and accessible technology. Easy access to information technology can enable patients to understand their symptoms and diagnosis. In this way they are empowered, enabling them to better manage their diagnoses and to regain control over their healthcare options; however, we recognize the obvious information gap and that patients may not fully understand all aspects of their illness (7). In most cases they may not fully grasp the science behind their disease, how it interacts with other medical conditions, or the ways the various treatments work. Nonetheless, inevitably the more knowledge they have the more they can contribute to their own well-being and understand their doctor's perspective on how the disease affects their body (8).

Core competency 4: Practice -based learning and improvement

Practice-based learning and improvement "involves investigation and evaluation of one's own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care (4)." When patients walk through the door of their physicians' offices, they are likely to have expectations that they are receiving the best possible care (9). There is a sense that patients can be supported so that they are proactive about working with their doctor to ensure an accurately defined diagnosis . It is imperative that patients have knowledge of the rationale behind the treatment options. Ultimately, one way of creating effective dissemination of information is access to patient networks, whereby patients in similar situations could discuss their experiences with the various treatment options; ultimately, the thought is that this would help patients develop understandings of treatments and prognosis (10).

Core competency 5: Interpersonal and communication skills

Interpersonal and communication skills "result in effective information exchange and teaming with patients, families, and other health professionals (4)." Patients inevitably benefit from open dialogue regarding their medical conditions, illnesses, options for treatment, states of health,

and prognoses. It is imperative that patients have an accurate depiction of their illnesses and treatment plans. . With the advancement of technology, the way in which communication occurs between doctors and patients is different to 50 years ago, especially with the advent of social networking websites and advances associated with communication and information technology (11). The internet and social media are integrated into everyone's daily routine. Patients and medical doctors live in a new era of instant gratification. Patients could benefit from being technologically skilled to enhance communication processes through email, Skype or text messaging rather relying solely on the phone. Although information technology has many benefits, it can impede physicians' ability to give their undivided attention as they are often interrupted with cell phone calls, text messages, and emails which may impede a patient's right to equitable treatment (12).

Core competency 6: Professionalism

Professionalism is defined as "commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population (4)." As a competency, patients can be informed regarding the desired professional attributes associated with medical practice. For example patients can be made aware of professionalism in terms of cultural responsiveness (13, 14) which is at the forefront of medical education throughout the world. Patients may have different cultural values and norms in relation to their medical doctors, and therefore, care by their attending physician needs to be exercised in a culturally responsible manner. Furthermore, patient information needs to be protected. It is expected that both patients and doctors uphold the principles of professionalism to enact open and respectful dialogue.

The flipside of knowing about physician responsibility is being aware of patient accountability. There is a need for patients to take responsibility for certain actions concerning their own health care. Schmidt (15) notes that there are aspects of medical care required of the patient. These include the need for self-care, to treat healthcare staff respectfully, to keep and manage appointments, provide accurate contact details, to follow advice and treatment, ask questions, use medicines and facilities appropriately, prevent the spread of infection and so forth.

Core competency 7: Systems based practice

Systems-based practice refers to "actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value(4)." When patients are sick, they go to physicians to gain information to understand their condition. It is important that patients are aware of, and competent in, how to obtain and access appointments with specialists. Ideally, patients (or significant support persons) need to be competent in accessing essential resources such as, monetary assistance, transportation, essential technologies and communication aids (16).

Final comments

Patients are likely aware that societal obligations are complex and paradoxical. At one level democratic and civilized societies purport to look after all contributing members of that society, but at another level there is an implied competiveness that promotes inequality and inequity. We think, however, that the patient perspective is a fruitful source for further informing medical education. It would be our research aim to further investigate the notion of patient competency and the level of engagement between medical doctors and how this informs the learning of medical practice. For example, some difficult but important areas for further research include: considering how patients would learn to meet these competencies and, more specifically, how patients learn the skills required for shared decision making?

References

1. The Accreditation Council for Graduate Medical Education. The Accreditation Council for Graduate Medical Education 2014 [cited 2014 January 31]. Available from: http://www.acgme.org/acgmeweb/
2. Barry CA, Bradley CP, Britten N, Stevenson FA, Barber N. Patients' unvoiced agendas in general practice consultations: qualitative study. BMJ. 2000;320(7244):1246-50.
3. Mann JM, Gostin L, Gruskin S, Brennan T, Lazzarini Z, Fineberg HV. Health and human rights. Health and Human Rights. 1994:6-23.
4. Accreditation Council for Continuing Medical Education. Some examples of desirable physician attributes from ACGME [cited 2014 January 31]. Available from: http://www.sfn.org/~/media/SfN/Documents/Annual%20Meeting/examples_physician_attributes.ashx
5. Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. JAMA. 1992;267(16):2221-6.
6. The Johns Hopkins University, The Johns Hopkins Hospital, Johns Hopkins Health System. A Time for Transformations 2012 and Beyond; Available from: http://www.hopkinsmedicine.org/about/downloads/biennial_report_120308.pdf.
7. Makaryus AN, Friedman EA, editors. Patients' understanding of their treatment plans and diagnosis at discharge. Mayo Clinic Proceedings; 2005: Elsevier.
8. Street Jr RL, Makoul G, Arora NK, Epstein RM. How does communication heal? Pathways linking clinician–patient communication to health outcomes. Patient education and counseling. 2009;74(3):295-301.
9. Williams S, Weinman J, Dale J, Newman S. Patient expectations: what do primary care patients want from the GP and how far does meeting expectations affect patient satisfaction? Family practice. 1995;12(2):193-201.
10. Cheong LH, Armour CL, Bosnic-Anticevich SZ. Primary health care teams and the patient perspective: A social network analysis. Research in Social and Administrative Pharmacy. 2013;9(6):741-57.
11. Griffiths F, Cave J, Boardman F, Ren J, Pawlikowska T, Ball R, et al. Social networks–The future for health care delivery. Social science & medicine. 2012;75(12):2233-41.
12. Mandl KD, Kohane IS, Brandt AM. Electronic patient-physician communication: problems and promise. Annals of internal Medicine. 1998;129(6):495-500.
13. Beagan BL. Teaching Social and Cultural Awareness to Medical Students:" It's All Very Nice to Talk about It in Theory, But Ultimately It Makes No Difference". Acad Med. 2003;78(6):605-14.
14. Chapman DM, Hayden S, Sanders AB, Binder LS, Chinnis A, Corrigan K, et al. Integrating the Accreditation Council for Graduate Medical Education Core competencies into the model of the clinical practice of emergency medicine. Ann Emerg Med. 2004;43(6):756-69.
15. Schmidt H. Patients' charters and health responsibilities. BMJ. 2007;335(7631):1187-9.
16. Timmons A, Gooberman-Hill R, Sharp L. The multidimensional nature of the financial and economic burden of a cancer diagnosis on patients and their families: qualitative findings from a country with a mixed public–private healthcare system. Supportive Care in Cancer. 2013;21(1):107-17.