Masters of Health Professions Education

A Research Thesis

On

The Learning and Practice of Surgical Residents on Whole Person Care: The Issue of Counseling.

School of Medicine, College of Health Sciences,

Addis Ababa University, Ethiopia

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The Learning and Practice of Surgical Residents on Whole Person Care: The Issue of Counseling.

Statement of the problem

Studies have shown that the perceived cleanliness of hospitals, the perceived empathy, experience and ability of health care workers, consultation duration, as well as educational status and occupation of patients are unique determinants of patient satisfaction in health institutions in Ethiopia[1, 2]. However, a study at Tikur Anbessa Specialized hospital identified a significant deficiency of communication skills among all categories of physicians in the hospital.[3]

In the Ethiopian health system, a significant proportion of health professionals do not show compassion, with lack of respect for their patients and families a common complaint and a common source of grievance [4]**.** Surgery in particular has many physical, emotional, mental and social implications for patients and requires a great deal of organization of facilities and human resources. Often there are many uncertainties which require life adjustments. A curriculum should enable trainees to learn the skills and ways of being necessary for whole person care; it should also help them counteract any negative role-modeling or other challenges they perceive in the hidden curriculum. This can in turn structure ways in which trainees' skills, knowledge, and attitudes in this area can be thought about and assessed from the time of admission to their training programs to graduation. In addition, developing ways of sharing information, teaching more complicated skills, and supporting lifelong behavior change will be as important a frontier as medical advances.[5] For this reason, this study will describe residents' perspectives as to how the general

surgical curriculum might try to address the concept of whole person care, and particularly the issue of counseling, in their training in the School of Medicine, Addis Ababa University.

Conceptual Framework

Change in the medical education system is at the core of the activities required to enable health professionals to understand and provide whole person care. This could occur in the form of formal training that is explicitly developed in the curriculum.[6] For example, cognitive theory emphasizes the importance of learners' understanding and processing of information, and many studies about teaching medical trainees to effectively counsel patients to encourage behavior change have focused on providing the trainees with didactic instruction. These include high-quality, high-level outcome studies and interventions that also included active learning strategies.[7]

According to Burdine, theory-informed practice is that behavioral science theories constitute the best available information on why people behave the way they do and practitioners aiming to change health-related behavior would do well to take advantage of this information.[8] Hochbaum *et al.* state that practitioners who doubt the usefulness of theories basically question the existence of a link between the abstract formulations that are theories and the realities of practice. Explicating principles for practice is a means of demonstrating such a link, of demonstrating the implications of theory for health education.[9]

However, training to understand and provide whole person care could also occur through what has been described by Eraut as informal learning. Eraut described a concept of tacit knowledge and tacit learning wherein people learn in the absence of overt teaching and in which the individual has no awareness of having learned.[6]

This tacit learning may occur through the "hidden curriculum"[10] which may either support or undermine different aspects of the intended curriculum.

During their professional educations, health care professionals are socialized to a set of responsibilities and expectations that define their professional identity. These responsibilities and expectations become so embedded in their professional identity they do not consciously think about them; rather they see their practices through them.[11] Role modeling is a major part of this hidden curriculum, and, according to Kumagai, such role modeling can result in three possible consequences: students' patient centered values could be maintained, compromised or rejected.[12] Coulehan has pointed out that the resolution of these challenges risks leading to a non-reflective professionalism in which people are unaware of the gap that exists between their espoused values and the behaviors they enact.[13] On the other hand, reflective learning between and among individuals that incorporates context to develop experience gives the opportunity for assimilating collective norms and values[13]. Hence having explicit theoretical and practical knowledge can give learners the "Standards" with which they can evaluate their practice and monitor their progress.

Literature review

In order to understand whole person care, it is important to first understand the concept of medical reductionism. Whereas medical holism entails considering the physical, mental and social components of an individual as a whole, medical reductionism can be defined as deconstructing a complex process into its component parts to enable better comprehension.[14] In 2008, Heng described Decartes' reductionist principle as having had a profound influence on medicine - similar to repairing a clock in which each broken part is fixed in order, investigators have attempted to discover causal relationships of the structures and functions of an individual and to treat each of those components accordingly.[15]

Medical reductionism may have multiple layers for different clinicians; for example, it has been pointed out that for Medical Microbiologists reductionism can have epistemological, ontological and methodological meanings.[16] However, it seems clear that for reductionists, in order to know how a system (or, in the medical context, a person) functions, a key form of analysis can be obtained from studying its parts.

The origins of holism, which is the opposite of reductionism, goes back to Aristotle who said “the whole is more than the sum of its parts”.[17] In other words, as Bereseden put it, “disease is more than the sum of disordered enzymatic and cellular interactions.”[18] Thornton discussed a whole person care model in which a person is defined as “an energy field that is open, infinite, and spiritual in essence, and in continual mutual process with the environment. Each person manifests unique physical, mental, emotional, and social/relational patterns that are interrelated, inseparable, and continually evolving.” In this model, spirituality is the foundation rather than an aspect of life, with the spirituality dimension described as a unifying force that integrated the four aspects of a person.[19]

It has been said that healing and cure are two faces of a Roman god, Janus [20]. Whole person care aims at healing rather than cure. Curing is an action carried out by the health care practitioner to eradicate disease or correct a problem,[20] while healing is a process leading to a greater sense of integrity and wholeness in response to an injury or disease that occurs within the patient. Such healing is facilitated, not caused, by the health care practitioner.[21] Health care practitioners should not limit themselves to curing a disease, but rather they should assist persons in the process of healing. This is not only a matter of knowledge and skill but also reflects where the power lies (or should lie) in the system. According to Hutchison there is a power shift from the health care worker to the patients as provision of care moves from curing to healing. In addition, in the healing model,

art predominates over scientific knowledge.[20] The marriage of cutting edge technologies with deeper understanding of human relationships will yield more powerful ways of helping individuals understand themselves and behave in healthy ways.[5]

Some universities, such as McGill University in Canada, have started to design a healing curriculum with a "patient at heart and science in hand" tagline. The objective of curricula like McGill's is to inculcate the respect for, and understanding of, the healing function as a basic prerequisite for trainee physicians who will work for the wellbeing of their patients.[20] Initiating such educational programs that help foster the ongoing growth and transformation of physicians in practice and other staff members is crucial to implementing the model of Whole Person Care. A key component of this Whole Person Care model is self-care and self-healing both for patients and providers.[14] The curriculum also needs to include structure and function (Physical), respect and empathy (Emotional), wisdom, imagination, and creativity (Mental), and counseling, communication, professionalism and leadership (Social/Relational) as core competencies.[20,21]

These ideas are not new. Over one hundred years ago, Flexner recognized the dichotomy between scientific knowledge and understanding the patient's social world.[22] He wrote: "So far we have spoken explicitly of the fundamental sciences only. They furnish indeed, the essential instrumental basis of medical education. But the instrumental minimum can hardly serve as the permanent professional minimum. It is even instrumentally inadequate. The practitioner deals with facts of two categories. Chemistry, physics, biology enable him to apprehend one set; he needs a different apperceptive and appreciative apparatus to deal with other, more subtle elements. Specific preparation is in this direction much more difficult; one must rely for the requisite insight and sympathy on a varied and enlarging cultural experience."[22]

Unfortunately, a hundred years after Flexner, this second category of more subtle elements is still not well-taught at most institutions. For example, according to a study in Makarare University's College of Health Sciences, the teaching and learning strategies at that institution did not adequately address core competencies like leadership, management, interpersonal communication and professionalism [23]. Among the barriers to achieving adequate Person Centered Medicine (PCM), we must continue to consider the insufficient emphasis on medical ethics, communication skills, medical psychology and psychiatry, medical sociology and public health disciplines within many training programs.[24]

Davies hypothesizes that communication and counseling are important determinants of: 1) the accuracy of the diagnosis; 2) the effectiveness of disease management; 3) disease/problem prevention; 4) patient satisfaction; 5) adherence to treatment; 6) the psychological well-being of the patient; 7) his/her understanding and treatment/management skills; and 8) professional satisfaction and level of stress.[25,26] Knowledge of the risks of unhealthy behaviors, of the benefits of behavior change, and of strategies to apply this information during patient interactions equips learners to conduct counseling. The individual clinician can also learn to be more effective in changing patient behaviors through improved interviewing and counseling skills.[27]Such counseling skills are a core aspect of communication skills in the surgical environment, and communication skills are a core element of delivering Whole Person Care. While I am interested in the broad issue of provision of Whole Person Care to Ethiopian surgical patients, in this initial study I therefore focused on understanding the phenomenon of patient counseling in the Ethiopian surgical education context.

Methodology

Study site

The study was conducted at the Department of Surgery, School of Medicine, College of Health Sciences, Addis Ababa University.

Research Question

How is patient counseling, a core element of the provision of Whole Person Care, perceived, learned, and practiced by surgical trainees at the Addis Ababa University College of Health Sciences?

Study population

The participants of the study are year II to year IV surgical residents. We made sure that we interviewed at least one resident from each year. After our first four interviews (chosen purposively to have one trainee from each year, to try to balance male and female trainees and to include trainees in different surgical subspecialties) we used a confirming-disconfirming snowball sampling strategy. We interviewed 8 residents to reach saturation with respect to our research question.

Study type

The study is a qualitative study using case study methodology. We collected data via individual interviews using a semi-structured questionnaire.

Ethical clearance

The study proposal was presented to the Institutional Review Board of the Medical Education Center of the College of Health Sciences. We obtained written consent from each participant before his/her interview. We ensured the confidentiality of the participants.

Conflict of interest

We obtained a research grant from the College of Health Sciences to cover the costs of this project.

Limitations of the study

This is a single institution study with a small sample size which makes generalizations difficult. There are not many studies in this area in Ethiopia which may make comparisons a problem.

Results

There are 120 general surgery residents, 18 females and 102 males, in the department of surgery. Eight surgical residents participated in this study. They were two second year, two third year and four fourth year residents. Four were females and four were males. The interview was made in Amharic (the working language in Ethiopia) and then translated and transcribed in English.

Why is Counseling Important?

Summary: The participants believed that creating awareness, acceptance of treatment modalities, compliance, improving outcome, mitigating medico-legal consequences and patient decision making are reasons that counseling is important.

All participants said that counseling helps in creating awareness of a patient's disease, explaining intended procedure and alternatives, and also helps in discussing complications and possible outcomes. It also can be used to elaborate on advantages and disadvantages of a certain procedure. It is also a very good opportunity to get informed consent from the patient.

Just more than half of the participants said that counseling makes it easier for patients to accept outcomes whether they are bad or good. One of the participants said it helps to decrease the refusal rate to surgical treatment.

About two third of the participants believe counseling improves patient outcomes. The reason they gave is that it makes them psychologically ready and enables them to take part in the treatment plan. The said that with counseling, patients will be adherent to treatment and in addition they will be cooperative with the management team. They also said it alleviates pain and that patients ambulate early making hospital stays shorter.

Some participants said it mitigates medico-legal consequences because it helps get informed consent easily and because it helps patients understand the condition so that decreasing prejudices and unnecessary prosecutions.

More than half the participants mentioned counseling is important for patients to reach decisions on the options of management and gives them autonomy on their choices.

What do Participants Do in Practice in Terms of Counseling?

Summary: When it comes to their practice, participants mainly focus on getting to know the social background of the patient, informing the patient about the disease, and understanding different perspectives on the patient's condition.

About a quarter of the participants said that getting to know the social background of patients helps in planning patient management and in creating good patient-surgeon relationships.

Only one participant mentioned that he tries to discuss the socioeconomic condition of the patient. Most of the others agreed that it is important to address the social, psychological and financial conditions of the patient but said that they do not do this in practice various reasons. One of the participants said that it is important to be selective in addressing the different components of counseling. He

said “In my opinion we should be patient selective while we give counseling for example, if you provide counseling for a farmer it might not be very useful but we have more educated people…”

In their practice, all participants said they inform patients about their disease, options of management, and possible complications. But they differ in the way they give the information. Many said full detailed information is important while one participant said it is better to give brief and simple information. Another participant said he gives only the positive aspects of the treatment in order to convince his patients.

How did Participants Learn about Counseling?

Summary: When asked about how they learned about counseling, participants said they learned by observation, by trial and error, by reading, and sometimes by taking courses.

About three quarters of participants mentioned observation as a way they learned about counseling. The observations were of their consultants and senior residents. One participant said he had had a chance to observe counseling sessions in Europe and said it is completely different from the way they do it in Ethopia in terms of organization.

About half of the participants said that they learned counseling on their own by trial and error. Two of the participants said that they had done some reading about counseling and then tried to use it in their context.

One participant stated she had had a theoretical and practical course about counseling during her Pediatric Psychiatry attachment. One participant mentioned

he had had some lessons about counseling when he took medical ethics. Otherwise the rest of the participants had not had any formal courses on counseling.

The nature of surgical practice and the freedom of exercise in patient care that surgical residents have are the opportunities to learn and practice counseling mentioned by the participants. Because surgery is associated with serious complications and difficult choices to make, trainees need to learn how to do counseling even if they aren't being formally taught it.

What are the Barriers to Learning Counseling?

There are a lot of barriers mentioned by the participants which make it difficult to learn counseling. According to most of the participants, it is given less attention by the Department. Participants believe that many of the consultants have the wrong attitude towards counseling. Some said that consultants do not give any attention to counseling and there is also a lack of commitment. Others said it is not considered as one of the competencies they are required to have and there is nothing about counseling during their assessment. Some also believe it is difficult to change the practice of their consultants.

Language was considered by some as a barrier to practice counseling while others say it is not. More than half mentioned low educational status of patients to be a challenge for practicing counseling whereas two participants said it is controversial – that there are uneducated people who understand very well during counseling and there are also some educated people who have difficulty in decision making during counseling and make the practice difficult.

Many of the participants said their working conditions (the environment and patient load) makes the learning and practice of counseling difficult. There is no separate room for counseling to keep patients' privacy and assure confidentiality;

discussions with patients have to happen in the presence of other patients. Many participants said that the patient load also creates time constraints in terms of allowing a good discussion. However, two participants said they didn't consider patient load to be a challenge.

Most participants considered their own level of understanding of counseling to be a challenge. They said it made it difficult to identify their own gaps. One of them said he hadn't even thought that there was such a thing as training in counseling.

What Did Participants Recommend?

The participants recommended the creation of training in counseling, the development of guidelines and protocols, and the establishment of a multidisciplinary approach.

They believed that training widens their scope of practice, improves their ability to identify gaps, and alleviates their frustrations. Some said it should be given as an introductory course while one participant said the teaching should focus on the practical aspects of counseling. Most of them believed that the teaching should be for all of the different professional groups who participate in surgical practice.

Discussion

Our study revealed that the surgical residents have some knowledge of counseling. They are aware of the key benefits of counseling. However, our participants didn't mention the importance of eliciting patients' beliefs and perceptions about their own illness, even though studies indicate that patients' understanding of their illness and their expressions of their own opinions and interpretations are the basis on which patients can approach health issues in collaboration with health professionals[25, 26, 27]. They also didn't discuss counseling as involving patients'

spirituality. Overall they demonstrated the lack of a patient centered counseling approach, embracing the disease/illness (or pathology/sick person) dichotomy rather than a holistic approach.

Even more significant is the discrepancy between their knowledge and their practice. Although they know very little about counseling, they try to practice counseling related to the disease they are treating and the social background of their patients. This discussion will address the knowledge gap and knowledge-practice discrepancy by analyzing two important aspects of counseling education in the study setting: the learning method and the learning environment.

The learning method

Our study found that one major learning method in our context is observation. This could result either in unconscious or conscious learning. When observational learning is coupled with reflection it changes to conscious learning. Studies show that successful learning occurs when learners practice skills with instructors giving guidance and proper feedback [13,28]. One of the most prevalent methods of observational learning is role modeling. However, studies estimate that less than fifty percent of role models are good (while the rest are reported to be poor) [29, 30]. Some therefore suggest the need for transformative learning, which encompasses reflection, conviction and action [31].

The residents said they learn by trial and error, which risks resulting in negative experiences for many patients. The best way to avoid this is through formal theory-informed learning. Theory informed learning would provide trainees with the best available information on how people behave the way they do[8] as well as with a means to link abstract formulations to practice[9].

Motivation is an important condition in learning that affects both learning and practice. As positive rewards to an activity motivate or reinforce learning, negative rewards demotivate learning. Ignorance of reward also negatively reinforces learning. Therefore, consultants need to have a change in attitude concerning counseling and the institution should develop a system of acknowledging performance in this area. Studies suggest that residents should ideally develop their own learning goals with the help and support of their supervisors [31]. Another motivational factor is formal assessment and our study found out there is lack of assessment system for counseling in the training of surgical residents. A study in Makarere University College of Health Sciences also showed a lack of clear plan for assessment, especially for the difficult-to-assess competencies like professionalism, communication skills and team work[23, 32].

The learning environment

For an education system to be effective the learning environment is as important as the learning methods. The learning environment plays an important role in enabling an effective teaching system and can enable better learning and practice of counseling. According to the Accreditation Council of Graduate Medical Education (ACGME) Clinical Learning Environment Review (CLER), the learning environment includes safety, data use, standardization, supervision, fatigue management and professionalism [33]. A quality learning environment is has a dynamic structure and process, highly motivated and valued staff, supportive relationships and team spirit, good communication, and valued learners [34].According to our study there are shortcomings in the learning environment experienced by the participants in our study in terms of space, organization, practice, and evaluation. Participants specifically suggested better work space, inter-professional consultations, and a multidisciplinary approach.

The development of a sound curriculum incorporating behavioral sciences is a challenge but is also important for proper learning of patient counseling. The Institute of Medicine (IOM) in the United States has suggested enhancing behavioral and social sciences content in the medical curricula and the United Kingdom General Medical Council has recommended that medical practitioners "know, understand, be able to apply and integrate clinical, basic behavioral and social sciences in medical practice" [35]. The behavioral sciences nevertheless remain underrepresented in many medical schools, including at Addis Ababa University.

Conclusion

This study has identified gaps in the learning method and learning environment of surgical residents that have affected their ability to provide patient counseling. We have provided concrete suggestions both for improving the methods of teaching and learning in this area and for enhancing the development of a better learning environment, thus fostering future surgeons' ability to provide this important component of Whole Person Care.

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Appendices

1. Interview guide

A. What are the importances of counseling?

B. How does your counseling practices look like?

C. How do you learn and experience counseling?

D. What are the opportunities and challenges you have in learning and practicing counseling? Elaborate in terms of training, environment, etc…

E. Are there things that would improve your ability to provide this kind of counseling? (Environment, training etc…)

2. Informed consent

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Advisors: Ayelet Kuper, Abdulaziz Hussein

Name of organization: School of Medicine, College of Health Sciences, Addis Ababa University

Name of sponsor: School of Medicine, College of Health Sciences, Addis Ababa University

Name of Project: The View of Surgical Residents on the Need for Behavioral Sciences as Part of Whole Person Care: The Issue of Counseling.

Introduction: this study is part of a Masters of Science in Health Professional Education program. It is a requirement for a graduation thesis.

Purpose of research: the study look as how surgical residents view their practice and training about surgical patient counseling and whole person care.

Research intervention: the findings of this research will be presented to the medical education center and relevant authorities of the School of Medicine, the College of Health Sciences and Addis Ababa University.

Participant selection: the participants will be surgical residents in years I to IV of their training. The first four will be selected purposefully (based on demographics), after which other participants will be selected based on snowball sampling.

Voluntary participation: participation in this study is voluntary

Procedure: a paid interviewer will interview each participant separately based on a semi-structured questionnaire. The researcher will not conduct the interviews since he is a faculty member in Surgery and knows many of the residents. The interviewer will anonymize the transcripts of the data before the researcher sees them to protect the identities of the residents.

Duration: the interview may take a maximum of two hours

Risks: there are no foreseen risks on the participant. The identities of the participants will be kept confidential.

Benefits: the study might come up with ways of improving residents' training for counseling of surgical patients

Reimbursements: no reimbursements will be made for the interview

Sharing the results: the results will be written up and presented as graduation thesis and it may also be presented in relevant academic forums and be published in relevant journals

Confidentiality: the identity of participants will always be kept confidential. Their names, photos or voices will not be discussed or represented in any medium.

Right to refuse or withdraw: each participant has the right to refuse participation or to withdraw from the study at any time

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