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VIETNAMESE MEDICAL STUDENTS' ATTITUDES TOWARD THE DOCTOR-PATIENT RELATIONSHIP

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Abstract

Introduction: Patient-centred communication is important in developing an effective doctor-patient relationship. Evidence internationally suggests that communication skills in doctors are linked to good medical outcomes and higher patient satisfaction with the health care system. To date, there has been little research in Vietnam and most of the Mekong region into the development of patient-centred care among medical students. **Method:** A cross-sectional study of attitudes toward the doctor-patient relationship was conducted with 524 medical students across all years of the curriculum at the University of Medicine and Pharmacy at Ho Chi Minh City (HCMC UMP), Vietnam. Attitudes were measured with the Patient Practitioner Orientation Scale that measures “caring” (empathy for patients) and “sharing” (willingness to openly share information and collaborate with the patient in their treatment). The aim was to assess the extent to which the students are more, or less, patient-centred from the beginning to the end of the course. **Results:** 52.9% of the students were female and the mean age was 21.7 years. In contrast to findings in some Western and Middle Eastern countries, these Vietnamese students appeared to be more patient-centred in more senior years. In general, the scores for caring were higher than those for sharing. The caring attitudes were more positive after students had completed a communication skills subject, after gaining experience in field site practice, and after participating in extracurricular medical activities. Similarly, students who had completed prior study of communication skills and those who participated in field site practice had more sharing attitudes than others. **Conclusion:** Although there is a commonly expressed view that medical students become less caring and “tougher” with patients toward the end of their course, this study in Ho Chi Minh City suggested otherwise. It underlines the importance of training in communication skills for doctors, both in theory at the university and as a competency that is taught and systematically evaluated during clinical practice placements.

Key words: *patient-centred, doctor-patient relationship, medical students' attitudes, Vietnam.*

1. INTRODUCTION

Positive doctor-patient communication may lead to a variety of good clinical and social outcomes, and patient satisfaction levels are often high [1]. Patient-centred care, which takes into account their concerns and emotions, aims to improve the doctor-patient relationship and outcomes [2]. Stewart et al (2000) reported that patient-centred care influenced health status, reduced patient discomfort and worry, while simultaneously enhancing the efficiency of care, as measured by fewer diagnostic tests and referrals [3].

Recognizing this significant positive influence, most medical schools include patient-centred communication skills training in curriculum [4, 5] with training on both theory and practice. This important aspect of training has been described for medical students in many countries, with excellent examples from New Zealand [6] and Sweden [7]. However, it is important to consider that the quality and perceived benefits of training in communication skills are variable. According to a study by Egnew and Wilson (2010), students in the USA stated that there was inadequate emphasis

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and training on communication skills in their pre-clinical sessions to prepare them for practice. Many believed that the theoretical knowledge was not helpful to enhance understanding of interpersonal dynamics in ward-based clinical interactions [8]. There is a need for further research to understand the strengths and limitations of communication skills training in medical schools.

Quality doctor-patient interactions in terms of power-sharing and holistic care vary among cultures. Social norms in Asian cultures tend to favour a more formal doctor-patient relationship [9]. Many commentators, particularly in the media and among the general public, perceive that patients suffer unnecessarily, at least in part, because of limited communication with their doctors [10].

Most research into medical students' attitudes toward the doctor-patient relationship has used a validated instrument known as The Patient-Practitioner Orientation Scale (PPOS) [11-19]. The PPOS has two subscales related to "sharing", which measures the degree to which doctors share information clearly and promote joint decision-making regarding decisions about medical treatment, and "caring", which reflects the extent to which the doctor takes into account patients' expectations, feelings and life circumstances, and considers them to be important elements in the treatment process.

There is some evidence that medical students' patient-centred attitudes tend to deteriorate as they progress through the curriculum [12, 14-16, 18]. For example, Haidet et al (2000) used the PPOS to measure students' attitudes toward the doctor-patient relationship in the USA and reported that attitudes became more doctor-centred in the later years of the medical curriculum. A cohort study in Greece by Tsimitsiou et al (2007) indicated that patient-centred attitudes deteriorated at the end of clerkship compared to students' attitudes at the beginning of the clinical phase of training [16].

Characteristics of students, such as female gender, specialty of choice and year of study, may be associated with caring and sharing attitudes. Personal experience related to disease and medical care (by self, family or friends), work experience in

health care facilities, and students' perceptions of the communication skills of their teachers, professors and field-site mentors, may also influence patient-centred attitudes. To date however these issues have not been studied in Viet Nam.

The aim of this study was to explore the attitudes of medical students toward the doctor-patient relationship in a large medical school in Ho Chi Minh City. Predictor variables were adopted from prior research, and we included some new factors such as personal experience and students' perceptions of the attitudes and communication skills of their teachers. The practical purpose of the study was to make recommendations to inform possible improvements to the medical curriculum.

2. METHOD

2.1. The setting

The HCMC UMP has a 6-year medical curriculum, conducted over 12 semesters. It is divided into pre-clinical (including five semesters, mostly classroom and laboratory based curricula) and clinical curricula (involving seven semesters). In the fifth semester, there is a Health Education subject that focuses on training students in basic communication skills with patients, such as techniques for gaining medical history and information for the patient's medical record. From the sixth semester, the students study subjects with a clinical focus, and have regular field site visits to hospitals. In the eighth semester, the Medical Psychology subject concentrates on training students in essential skills when making first contact with patients and family and for ongoing communication with outpatients in the community. Apart from those two subjects, they also study specialized communication skills that are intended to be used with particular patient groups such as prenatal women, children and patients in specialized clinical settings such as obstetric and surgery departments [20].

2.2. Study sample and instrument

Attitudes toward the doctor-patient relationship were assessed among students from first to sixth year of the medical course at HCMC UMP in

April 2011, in the middle of the second semester. The survey included questions about demographic characteristics, students' personal experience with health care, and their perceptions of the attitudes and communication skills of their teacher and their mentors. Most questionnaire content was adapted from studies in other countries [12, 14-17, 19, 21]. Demographic questions were selected from the Vietnam Census survey questionnaire [22]. Regarding the assessment of the patient-centred attitudes, respondents were asked to rate their agreement or disagreement with 18 items of the PPOS on a 6-point scale [23, 24]. Item responses ranged from strongly agree to strongly disagree, from 1 (doctor-centred or paternalistic) to 6 (patient-centred or egalitarian). Higher score indicates a more patient centred attitude. This scale has been validated and used worldwide [11, 12, 15-17, 19, 24, 25]. The questionnaire was translated into Vietnamese by two bilingual public health professionals. The Vietnamese version was then back translated into English and checked against the original version to ensure semantic equivalence. The final Vietnamese version of the survey instrument was administered in a pilot study with participation of 30 third-year students and discussed in two focus groups with these students to assess the clarity and appropriateness of item wording. Based on the results of the pilot study and focus groups, some items were revised to suit Vietnamese socio-cultural context.

Sampling was achieved by obtaining lists of students in each year (30 study groups each year) from the training department. We then randomly chose 10 groups from the 30 groups in each year, resulting in 60 selected groups across the six years of medical students at HCMC UMP. The questionnaire was completed by 524 of the 525 eligible medical students invited to participate in this study (response rate = 99.5%).

2.3. Data analysis

SPSS 17 was used for data analysis. The Chi squared test (χ^2) was used to assess the significance of associations in the distribution of selected socio-demographic characteristics. T-tests and

one-way ANOVA were used to compare the means of two or three independent groups. A significance level of $\alpha = 0.05$ was used for all subsequent analysis. Correlation coefficients were calculated to examine associations between continuous variables. In order to determine the independence of the associations, a multiple regression analysis using Generalised Linear Model approach was performed by simultaneously controlling for potential confounding factors.

3. RESULTS

Out of 524 questionnaires available for analysis, the percentage of medical students in the clinical terms was 63.2%. The mean age was 21.7 (SD =1.93), more female than male (52.9% and 47.1%). The students came from many regions of Vietnam; one third had grown up in South Eastern of Vietnam (32.4%) and 26.2% and 22.3% came from Centre of Vietnam and Ho Chi Minh City, respectively. One-third of respondents said they followed a religion. Most participants (90.8%) reported their parents were married, and 9.2% reported parental marriage status as divorced, separated, or widowed. Over one-fourth of participants reported that they had at least one family member such as father, mother, sibling or grandparent who is a doctor. Approximately two third of the sample (64.9%) had studied a communication skills subject and 63.2% had some field site practice.

Caring and sharing across the curriculum

Both caring and sharing attitudes were significantly different across years in the course ($p < 0.05$). Females had higher scores than males for the total PPOS and separately for caring and sharing domains at the beginning of medical course. However, male students' caring and sharing scores were higher than female in the later years. By using the Tukey test to examine the true statistical difference of the overall attitude between each year of study, the figures showed that students in the fourth and fifth years had a higher overall attitude score than students in the beginning of the medical course. Regarding caring

attitude, the participants in the fifth year of study had a true higher score than those in the first and third years. In terms of sharing attitude, the fifth

year medical students were more likely to have a better sharing attitude score than those in the first year (figure 1 and 2).

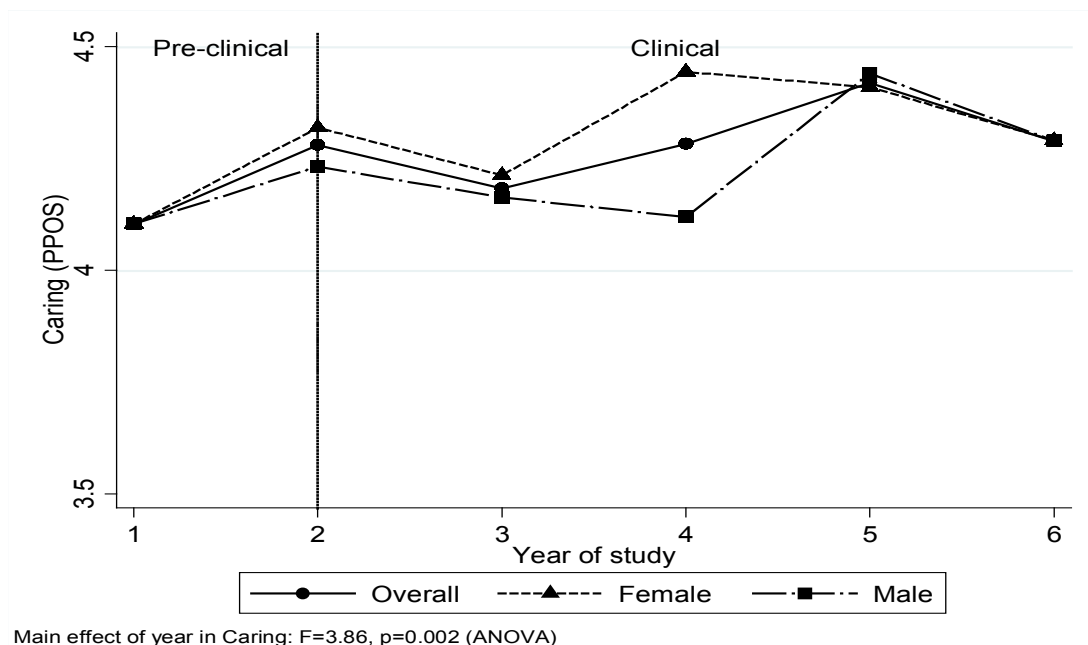


Figure 1. PPOS score (Caring) by year of study and gender (N = 524)

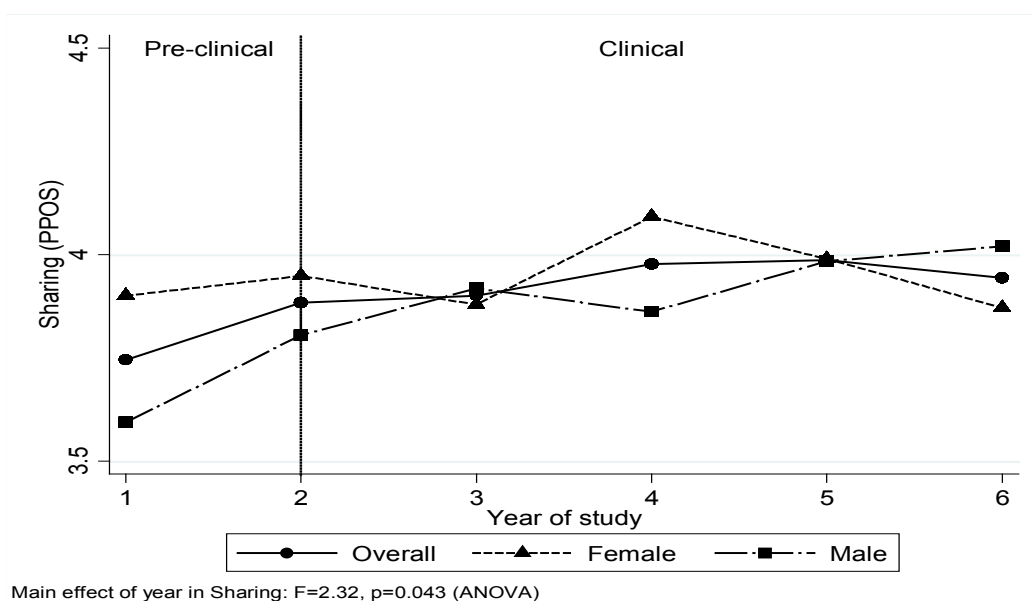


Figure 2. PPOS score (Sharing) by year of study and gender (N = 524)

There was no statistically significant association between students' attitudes and religion affiliation, specialty of choice, parental marital status, parents' education, parents' occupation, medical family background, or family economic status (self-reported). Participants who had studied any communication skills subject(s) were more likely

to have patient-centred attitudes, both for caring and sharing. Participants who perceived that the quality of training in these communication units was generally inadequate had more caring attitudes. In the same way, participants who considered that the communication skills training was impracticable had a more caring attitude.

In terms of association with field site visits, the score for both the overall attitude and the two sub-dimensions was higher in students practicing at hospitals. However, the frequency of field site visits was not significantly associated the overall and sharing attitudes of students. Students who

usually practiced at hospitals had a higher caring score. The total score of attitudes and scores on the two sub-dimensions were not associated with health work experience or general social activity participation but were associated with involvement in extracurricular medical activities (see table 1).

Table 1. The association between independent variables and the attitudes of medical students (n=524)

Variables	n	CARING		SHARING		TOTAL	
		Mean (SD)	p	Mean (SD)	p	Mean(SD)	p
Training curriculum							
Pre-clinical	193	4.20 (0.50)	*	3.82 (0.57)	**	4.01 (0.45)	**
Clinical	331	4.30 (0.53)		3.95 (0.54)		4.12 (0.45)	
Gender							
Male	247	4.21 (0.53)	*	3.85 (0.58)	*	4.03 (0.47)	*
Female	277	4.30 (0.51)		3.95 (0.53)		4.13 (0.44)	
Studied a communication skills unit							
Yes	340	4.31 (0.53)	**	3.94 (0.54)	*	4.12 (0.45)	**
No	184	4.17 (0.49)		3.84 (0.57)		4.00 (0.45)	
Practicability of communication skills unit (n=340)							
Yes	174	4.25 (0.53)	*	3.92 (0.51)		4.08 (0.44)	
No	166	4.37 (0.53)		3.96 (0.57)		4.17 (0.46)	
Adequateness of educational curriculum for communication unit (n=340)							
Yes	112	4.22 (0.48)	*	3.89 (0.53)		4.05 (0.42)	*
No	128	4.35 (0.48)		3.97 (0.55)		4.16 (0.46)	
Field site visit							
Yes	331	4.30 (0.53)	*	3.96 (0.54)	**	4.13 (0.45)	**
No	193	4.19 (0.50)		3.81 (0.56)		4.00 (0.44)	
Participating in any extracurricular medical activities							
Yes	192	4.36 (0.53)	**	3.94 (0.53)		4.15 (0.45)	*
No	332	4.20 (0.51)		3.89 (0.57)		4.04 (0.45)	
Employed in health care							
Yes	52	4.31 (0.50)		4.00 (0.50)		4.16 (0.42)	
No	472	4.25 (0.52)		3.89 (0.56)		4.07 (0.46)	
Participating in any social activities							
Yes	298	4.27 (0.53)		3.90 (0.53)		4.08 (0.44)	
No	226	4.25 (0.51)		3.92 (0.58)		4.08 (0.47)	
Attitude of supporter toward patients							
Good	337	4.26 (0.50)	*	3.90 (0.54)	**	4.08 (0.44)	***
Normal	168	4.23 (0.54)		3.86 (0.57)		4.04 (0.48)	
Bad	19	4.58 (0.60)		4.36 (0.50)		4.47 (0.41)	
Communication skills of supporter when communicating with patients							
Good	341	4.28 (0.48)	*	3.91 (0.52)		4.09 (0.43)	
Normal	171	4.20 (0.57)		3.86 (0.60)		4.03 (0.50)	
Bad	12	4.58 (0.55)		4.26 (0.57)		4.42 (0.48)	

Statistically significant at level: $p = *** < 0.001 < ** < 0.01 < * < 0.05$

Students who thought their academic or clinical mentor had a “bad” attitude to patients were more likely themselves to have a patient-centred attitude (both caring and sharing) than did those who thought their supporters had a good attitudes. This pattern was the same in students who recognized bad communication skills in their mentors compared to those recognizing good communication skills (table 1).

Among participants’ characteristics, gender, ethnicity, age, region (Mekong delta) and GPA were significantly correlated with the caring attitudes of medical students after controlling other factors. Female medical students and those

of Kinh ethnicity, higher age and higher GPA were more likely to have better caring attitude toward patients. Students who came from the Mekong delta had lower caring attitudes than others did. In terms of personal experience, involvement in extracurricular medical activities was associated with caring attitudes. In other words, participants who joined in any medical activities had better caring attitudes toward patients. Among factors related to the educational and professional environment, accessibility of most teachers to students and teachers spending time educating patients were associated with the caring score (table 2).

Table 2. Outcomes from multi-variable analysis of predictors of caring and sharing attitudes of medical students

Measured variable	Bo	B	S.E	t	p	R
CARING						
Participants’ characteristics						
Gender	-0.10	-0.09	0.44	-2.06	*	0.07
Ethnicity	0.21	0.20	0.08	2.44	*	
Age	0.02	0.03	0.01	2.37	*	
Region (Mekong delta)	-0.19	-0.16	0.06	-2.77	**	
GPA	0.11	0.08	0.03	3.00	**	
Personal experience						
How often having a communication skills unit	-0.03	-0.57	0.21	-2.75	**	0.40
Extracurricular medical activities	0.15	0.50	0.21	2.37	*	
Educational and professional environment						
Most teachers spend time educating patients	0.16	0.13	0.05	2.89	**	0.05
Most teachers are accessible to students	0.16	0.13	0.05	2.86	**	
Who supports students most at field sites (medical staff)	-0.20	-0.20	0.10	-1.99	*	
SHARING						
Participants’ characteristics						
Training curriculum	0.14	0.15	0.05	2.94	**	0.02
Gender	-0.10	-0.10	0.05	-2.15	*	
Specialty of choice (clinician-researcher)	0.23	0.29	0.15	2.00	*	
Personal experience						
Adequateness of the curriculum	-0.08	-0.53	0.24	-2.17	*	0.09
How long working in health care	0.09	0.30	0.12	2.59	**	
Educational and professional environment						
Who supports students most at field sites (medical staff)	-0.25	-0.25	0.11	-2.30	*	0.01

*Statistically significant at level: $p = *** < 0.001 < ** < 0.01 < * < 0.05$;*

4. DISCUSSION

Throughout the medical course in this university in Vietnam, the attitudes of students tended to become more patient-centred as they progressed in their study. This trend was also found with Brazilian medical students. However, it contrasts with the trend among studies in Greece and the USA, where attitudes in the later years were more likely to be paternalistic [12, 15, 16]. Although the attitudes of Vietnamese medical student had a tendency to be more patient-centred from the first to the fifth year, especially from the beginning of clerkship to the fifth year, their attitudes went down a little from the fifth year to sixth year. From the end of fifth year, they very often practice at hospitals and have to be familiar with the role of a real doctor. The trend for decline in patient-centred attitude could result from the pressure when practicing at hospitals. The pressure within hospital environments (especially overloaded admissions), from the assessment of the professor on students' performance and from the time pressure (no time to be concerned about feelings and expectations of patients and their relatives) hinder medical students from practicing their communication skills developed in the third, fourth and fifth years.

The difference in attitudes between males and females in this study is consistent with prior research. Females tend to be more empathic and more egalitarian than males in general. However, this study revealed that in the later years of medical training, female students were less likely to have a patient-centred attitude while males tended to be more patient-centred. It could arise from the tendency for women to adapt to the dominant institutional culture [26] which is generally doctor-centred in many countries.

Participants in this study had a better caring attitude during their clinical terms than pre-clinical terms. This pattern is similar to results from studies in Brazil and Singapore, but contrary to the results of studies conducted in Greece. In the present study, a possible explanation for an increase in the caring attitude was that participants were studying communication theory at the same time they were practicing with patients. They had enough time to

communicate with patients and to know patients' feelings and expectations. Communication is typically warm and personable between students practicing their skills with patients without the workload demands that practicing physicians would experience in a hospital setting.

In this study, very few participants had personal experience with illness or health care, and few had work experience in medical settings prior to their course. Thus, those without relatives in the profession had limited previous experience in the health care system before entering medical schools. This pattern in Vietnam is significantly different from Sweden where many students have work experience in health care before admission to medical universities. The mean age for admission to medical education in Sweden is 22 years, while in Vietnam it is around 18 years of age. Prior work experience in health care of Swedish medical students impacted significantly positively on high doctor-patient relationship [19]. Participation in extra-curricular health-related activities was significantly associated with the attitudes of participants. Through these activities, they could contact community health services and patients and thereby have more understandings about patients' expectations and feelings and develop a more patient-centred attitude. This pattern is different from the study in Brazil where no association was found between extracurricular activity participation and attitudes. The reason is not clear and need more studies in the future.

It was important to note that when students' assessments of their mentors' attitudes and communication skills were negative, they had more patient-centred attitudes themselves. The reason for these interesting results might be the different conception of students about a good role model of their teachers. If students have a truly good attitude towards patients, they will have higher standards in evaluating the attitudes of their teachers and other doctors toward patients.

The study has a number of limitations. The information was collected solely through self-administered questionnaire format, which might

result in recall bias. Further, the causal associations between explanatory factors and outcomes could not be firmly established due to the cross-sectional design. Generalization of these findings is limited by collection at a single medical institution in Vietnam. However, the curriculum at the HCMC

UMP is similar with that of the other medical education institutions in Vietnam as it is derived from the national curriculum. Further research is necessary to determine if the findings are indicative of overall trends in attitudes of medical students throughout Vietnam.

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