

# Patient Perception as a Tool for Evaluation and Feedback in Family Practice Resident Training

Donna Falvo, PhD  
Carbondale, Illinois

This study was undertaken to investigate the feasibility and educational value of using patient perception as a form of feedback and evaluation of residents' patient teaching skills. The instrument for assessing patient perception was based on program objectives and was administered to 588 patients over a ten-month period. Individual results were distributed to the respective residents quarterly to enable them to identify strengths and weaknesses of their teaching skills as perceived by their patients. Discussion with a behavioral science faculty member followed. Residents as a whole believed the technique to be of educational benefit and found it helpful to compare their own perceptions of their degree of teaching to that of their patients. Patients reacted favorably to the procedure. The technique provided information to faculty by which they could both assist residents in enhancing their patient teaching skills and provide positive reinforcement for those skills in which residents already excelled.

A consultation between physician and patient is thought of as an opportunity to exchange information. It is expected that the patient will describe his/her symptoms to the best of his ability and that the physician will in turn provide the patient with information regarding the patient's condition and treatment. Until recently, the skill with which the physician delivered this information occurred by chance or through trial and error learning. Only recently has emphasis been placed on teaching these skills to students and residents.<sup>1</sup>

Although maximizing effective use of patient education is of increasing interest to all specialties, teaching patient education skills to physicians has

been of special interest in family practice, given the specialty's inherent philosophy of comprehensive, person oriented medical care. Formation of groups such as the National Task Force on Training Family Physicians in Patient Education,<sup>2</sup> as well as the independent development of patient education curricula in various family practice residency programs, shows evidence of a commitment to the concept.

To date, no guidelines have been established for implementing patient education skills into family practice residency curricula; therefore, several individual resident training programs have established their own performance objectives and methods of evaluation based on their own needs.<sup>3</sup> Although desired levels of patient teaching skill have been established by various residencies, assessment of residents' competence in actual use of these skills is often more difficult.

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From the Department of Family Practice, Southern Illinois University, Carbondale, Illinois. Requests for reprints should be addressed to Dr. Donna Falvo, Department of Family Practice, 404 West Main, Carbondale, IL 62901.

The Family Practice Residency Training Program, Southern Illinois University (SIU) School of Medicine, Carbondale, included a program for patient education in the curriculum in 1975. A need was recognized not only for evaluation of residents' skills in patient teaching, but also for providing feedback to residents regarding their level of patient teaching skills. A project was undertaken to design a mechanism based on the program goals and objectives which would assist residents to identify their own strengths and weaknesses in patient teaching, as well as to assist faculty in measuring the extent to which performance objectives had been reached.

## Methods

Patient education was defined in the Carbondale program as a communicative activity integral to medical practice and dependent on basic skills of behavioral science. Basic behavioral science skills were defined as those skills which utilize the physician/patient relationship as a therapeutic tool, namely communication and interpersonal skills. Patient education skill training was therefore integrated into the behavioral science curriculum. A basic goal of the patient education portion of the behavioral science curriculum was to promote the concept of the physician as a teacher and advisor who gives information, support, and encouragement. Emphasis was placed on the physician-patient interaction. Content of the interaction in the form of cognitive information, although an important part of patient education, was felt to be valuable only in the context of the process of the interaction itself.

Performance objectives, therefore, related not only to the residents' ability to deliver information to the patient, but to deliver information according to individual patient need. To establish patient need, the resident was to assess patient variables such as patient learning readiness, intellectual level, cultural level, and level of anxiety, or fears and concerns. Each encounter with the patient was viewed as an opportunity to conduct some form of patient teaching. Core content of *information* to be taught patients during routine office visits consisted of: explanation of condition for which patient sought medical advice; explanation of treatment prescribed; information regarding prevention of occurrence or recurrence of disease, if

warranted; and consequences of following or not following treatment.

Core components of the *process* during the patient teaching interaction were identified as: assessment of patient's need; listening to the patient's concerns; expressing understanding of the patient's concerns; identifying factors which might interfere with the patient's following the therapeutic regimen; and taking the patient's concerns into consideration when prescribing the therapeutic regimen.

A resident's patient teaching skills thus involved integrating the content and process of the physician-patient interaction.

Based on this premise, basic goals for resident performance of patient teaching were defined as the resident's ability to:

1. Include patient teaching during routine physician-patient encounter
2. Identify patient cues indicating need for and receptivity to information
3. Relay information to the patient within the patient's own framework of educational need
4. Identify factors which might interfere with desired behavior
5. Offer alternatives as needed and indicate specific consequence of alternatives
6. Integrate core components of content and process in the interaction.

Although technical aspects of the resident's patient teaching skills may be evaluated by outside observers, the patient can best evaluate whether their information needs were met, whether the resident listened to and understood their concerns, and whether the resident took those concerns into consideration when prescribing treatment. Perceptions of faculty observer and patient may vary greatly when assessing the actual quality of the interaction. For this reason patient perception was chosen as a method for evaluation of residents' performance in patient teaching.

A 12-item questionnaire was designed to measure patient perception of the interaction with the physician in regard to patient teaching as operationally defined by this program.\* Items on the questionnaire were based on the program goals. Questions were of forced response design on a

\*Questionnaire available on request by writing to Dr. Donna Falvo, Department of Family Practice, SIU School of Medicine, 404 West Main, Carbondale, IL 62901.

four-point scale with response choices varying from strongly agree to strongly disagree.

The field test phase of the project involved patients of four first year residents. Residents were told that a project was being conducted to investigate methods for providing them feedback regarding patient perceptions of their patient teaching skills. They were told that a second purpose of the project was to test a mechanism for evaluating the extent to which program goals had been reached. Residents were shown the questionnaire and told that results from patient responses would be tabulated for them individually. It was explained that summary sheets would be given to each of them at the end of three months, thus providing them with information concerning how patients viewed their teaching skills. No resident objected to the project, although some expressed some apprehension of results.

During the field test phase the questionnaire was initially to be distributed by the receptionist after the patient-physician interaction. A cover letter was attached explaining the purpose of the questionnaire and containing instructions regarding completion of the questionnaire. After several weeks, this method was aborted: it was found that the receptionist was hesitant to hand out the questionnaire and patients were reluctant to fill it out. It was difficult to discern whether reluctance of the patient to cooperate was due to the attitude of the receptionist when handing out the questionnaire or whether patients felt uncomfortable with rating their physician's performance.

A second method of questionnaire distribution was attempted. The second method involved utilizing a "patient interviewer" who, although possessing good interpersonal skills, possessed no medical knowledge, and who was thus unable to offer medical information which might alter patient perception of his/her interaction with the resident. A graduate student was used in this role. Responsibilities of the interviewer were to: administer the questionnaire; check for clarity of the questionnaire with the patient; assess patient's feelings about filling out the questionnaire; or if the patient refused to participate, to assess reasons why the patient had refused.

Patient participation dramatically increased with use of the student acting as "interviewer" as opposed to patient participation when the questionnaire was distributed by the receptionist with

cover letter. One hundred fifty-eight patients participated in the field test phase of the project. Few patients refused to participate, and those who did most frequently indicated limited time as the factor for refusal. At the end of the field test phase, patient responses to questionnaire items were tabulated for each resident. Patient response varied from very low to very high perceptions of teaching. Each resident was given sheets containing summation of response scores for their individual patients. Residents as a whole reacted favorably to knowing how their patients perceived them. Although stating that initially they were nervous knowing their patients would be questioned, they stated they soon forgot the procedure was taking place and returned to their natural approach to patient care.

The questionnaire was revised based on information gathered during the field test phase. The revised questionnaire was formally implemented as part of the feedback and evaluation system on July 1st with entry of three new first year residents into the residency training program. Goals of the project for the remainder of the year were to assess: (1) educational value of patient perception of residents as a form of feedback; and (2) value of patient perception in measuring extent to which program goals have been reached. First year residents were told of the project during orientation and no one objected or expressed undue concern at having their patients interviewed.

The graduate student once again acted as patient interviewer. Data were collected from patients by questionnaire for the next year. Questionnaires were administered to patients of 3 first year and 4 second year residents. There were no third year residents in the program at this time. Patients of each resident were selected randomly; however, an attempt was made to keep patient numbers relatively equal for each resident. Patients were told the questionnaire concerned their feelings about their interaction with their physician. They were asked only to use their experience with their physician to select their answers to questions. Patients were encouraged to be as honest as possible in answering each question and were told that their responses would remain anonymous.

Data were compiled and tabulated quarterly. Summation of patient response for each questionnaire item was tabulated in terms of percentage of

the total number of patients filling out the questionnaire for each resident. Each resident received sheets containing summations of his patients' responses for the three-month period. A behavioral science faculty member was available to discuss strengths and weaknesses with each resident. Group discussion then followed concerning methods of patient teaching.

## Results

The questionnaire was randomly administered to a total of 588 patients over a ten-month period. As a whole, residents stated they felt the project had been helpful in identifying patient perceptions of their strengths and weaknesses in patient teaching and found it interesting to compare their own perceptions of their degree of teaching with those of their patients. Residents expressed interest in continuing to receive this form of feedback although several felt a combination of faculty observation and patient perception might be more helpful.

Patients as a whole did not appear to be threatened or offended by the questionnaire and most of the time seemed flattered that their opinion was being sought. The extent to which patients inflated their response to items on the questionnaire could not be determined by this study, but patient response did vary in degree with individual questionnaire items and with individual residents. Patients did not appear to lose respect or confidence in their physician as a result of the questionnaire, but rather appeared to appreciate the opportunity to give their input. The procedure appeared to have a positive rather than negative influence on their feelings about the Family Practice Center itself.

Results from the questionnaire were also used to determine the extent to which program goals had been reached. Since individual questionnaire items were based on program goals, composite scores for each item provided feedback regarding the extent to which patients perceived residents as performing the desired behaviors.

## Comment

In addition to feedback about patient perceptions of their behavior and reinforcement of behavior, this technique seemed to serve another educational purpose for the residents. Using patient

perception as part of the feedback and evaluation system increased residents' awareness of the importance of considering patient feelings and perceptions when delivering health care. In addition, patients appeared to gain a sense of participation in their own health care which was a positive step in building rapport.

Patient perception, although providing a real world framework on which to evaluate resident performance, would be more beneficial with the addition of faculty observation of resident behavior as well. Although not feasible at the time in this program, without the component of observation it is difficult for faculty to assist residents in identifying and correcting behavior which patients perceive as less than adequate patient teaching. Through the process of observation faculty may be able to delineate more clearly the process involved in patient teaching.

Since questionnaire items were based on program goals, this technique, in addition to random faculty observation, can provide faculty with information regarding the extent to which program goals are being met in everyday practice.

Patient perception was found to be an important source of information for both residents and faculty. As a result of the project, and demonstrated acceptance of the procedure by residents and patients, the receptionist now distributes the questionnaire to patients on a regular basis without assistance from a graduate student. The procedure has been incorporated as a part of routine evaluation for residents in this program. A significant contribution for both residents and faculty was perhaps a heightened awareness of the importance of evaluating perceptions and goals within the context of actual patient practice, rather than in a simulated or ideal environment.

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