

Communication Skills Appropriate to Context: Our Approach to Meeting the Training Needs of Interns

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Abstract

Objectives: To identify the core competency areas for teaching and training interns in communication skills followed by evaluating effectiveness of the training subjectively, based on student perception.

Methods: At the outset we identified five key areas where doctors faced difficulty in communication in their routine clinical practice. This was followed by a two day training programme to 160 interns consisting of videos, hand-outs, lectures and role plays with emphasis on deliberate practice of skills. At the end of the training, Intern's perception about the effectiveness of the programme and their self-perceived improvement in skills were assessed.

Results: The core competency areas listed by the doctors were: breaking bad news; dealing with a parent resistant to immunisation; communicating with the distressed patient and irritated bystander in casualty, explaining risks and procedures; and dealing with a patient with psychosomatic complaints. Interns responses to the training methodology based on the core competencies were overwhelming with 91% rating the training as effective. Role play was the most appreciated learning technique. Increased self-perceived immediate improvement in Communication skills was reported by 85% of Interns.

Conclusions: This exercise has helped us identify the key areas to be focused in communication skills training for interns in our setting, as well as design appropriate teaching learning methods to achieve the objectives. A systematic approach in developing a teaching-learning methodology stressing on the content and process of communication skills training relevant to the local context using a mix of experiential problem based and didactic methods should be stressed while framing a communication skill curriculum.

Key words: Communication skills training for Interns- teaching learning process-context specific

Introduction

In India, communication skills are often a neglected area in the present medical education curriculum. Communication skills training needs to start at the undergraduate level and extend up to Internship to ensure competency of a basic doctor. Most communication skills curriculums primarily focus on the aspect of "breaking bad news" while neglecting more crucial and commonly encountered issues related to patient compliance and education in the ambulatory setting in the Indian context .

It is heartening to note that the Medical Council of India's Vision 2015 document emphasizes the need for inclusion of communication skills in the medical curriculum. If this is to become a requirement in Indian medical schools a context-sensitive curriculum remains to be defined. In this context the investigators initiated a communication skills teaching programme for Interns with no prior training during their undergraduate days, at the start of the Internship. We adopted a systematic approach in developing a teaching-learning methodology, stressing on the content and process of communication skills training relevant to the local context, using a mix of experiential, problem based and didactic methods, the three complementary approaches to maximize learning.

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Aim and Objectives

The aim of our study was to identify core competency areas for teaching, learning and assessing communication skills at Intern level. In addition to this, a preliminary evaluation of interns' perceptions of the training process was conducted (Kirkpatrick Level I).

Materials and Methods

Identify core competency areas

Our first challenge was to identify the core competency areas in communication skills for training interns in the local settings. Forty five doctors working in Government health centres and the medical college were asked to list difficult-to-handle areas in doctor patient communication in routine clinical practice. A semi structured questionnaire was administered to the doctors for this purpose. The responses were analysed and five key areas identified. These findings became the basis of a training programme to impart skills based on the five priority areas.

Training process

Group teaching is the only feasible approach in Indian resource-constrained settings. A large group of 160 interns addressed the doctor patient issues using simulation videos based on the five identified priority situations. They were asked to note down what went wrong and what was good in each video relating to doctor patient interactions. This was supplemented with more learning techniques such as mini-lectures, user guides and finally role plays in groups of 10 each with peer feedback and deliberate repeated practice of skills. These composite learning techniques ensured the principles of adult learning. Interns were provided with checklists for peer feedback, incorporating items from the Calgary Cambridge scales for communication which measured the skills on five sequential tasks of doctor patient interaction, viz, initiating, gathering information, physical examination, explanation and planning and closing the session. Repeat practice sessions focused on the good points and rectifying problems noted in the initial role play as noted by peers and observer based on the checklist. Resource hand-outs were used to aid the entire training process.

Finally interns' rated their perceptions on a five point scale on how they felt about the overall programme, the effectiveness of each tool used for training, and a self-rating of improvement in their own communication skills

before and after the training. Data was compiled and analysed using SPSS Version 16.

Results

Core competency areas were identified based on the response rates of the forty five doctors. Majority of the participants (71%) responses were in favour of breaking bad news as the core competency area that needed top priority followed by dealing with a parent resistant to immunization (33%); communicating with the distressed patient and irritated bystander in a busy casualty setting (33%), explaining risks and procedures (30%); and dealing with a patient with psychosomatic complaints (11%). Intern's response to the training methodology was overwhelming with 91% rating the training as effective. 60% of interns rated role plays as the most effective learning technique, probably due to their impact on the affective domain. Regarding mini-lectures, their suggestion was to reduce the span of lectures and spend more time on role plays with repeated practice sessions. 85% of participants felt a self-perceived immediate improvement in communication skills following the exercise.

Discussion

The core competency areas identified by practicing doctors in the periphery breaks the misconception that in a busy outpatient department, communication skills may not be optimally applied (Chatterjee & Choudhury, 2011). Several studies have shown that in routine clinical practice often the patients' complaints and concerns are not elicited (Stewart *et al.*, 1979) and doctors often follow a "doctor centred" closed approach to information gathering (Byrne & Long 1976).

Communication skills training is to become a requirement in Indian medical schools. Against this background a context-sensitive curriculum remains to be defined since most models derive from experience in the west. It is reported that in communication skills courses, learners at all levels often start by saying that the curriculum being highly subjective, teaching methods seems to be a bag of tricks (Kurtz *et al.*, 2005). If such training is imported into India from other cultures, this comment may be even stronger. Taking these factors into account we tried to develop a context specific teaching learning methodology incorporating the content, process and perceptual skills. Mini lectures focused on the

content and introduced the Calgary-Cambridge guidelines followed by role plays and repeat practice sessions where the peers evaluated the group to enhance the process as well as the perceptual skills.

Preliminary evaluation of interns' perceptions of the training process conducted (Level I Kirkpatrick) shows that the teaching methodologies we experimented were effective to a large extent with emphasis on the essential ingredients of experiential learning such as defining the essential skills, observing the learners, descriptive feedback, use of video or audio recordings and reviews, repeated practice and rehearsal and active small group or one to one learning. We are in the process of developing quantitative assessment methods (Pre-post OSCE) for Communication skills for the next batch of Interns based on Calgary Cambridge guidelines validated in the local setting recognizing the fact that communication skills should be taught with the same rigour as the other basic medical sciences (Duffy, 1998).

Conclusion

This exercise has helped us identify the key areas to be focused in communication skills training to interns in our setting, as well as design the appropriate T-L methods to achieve the objectives. High acceptance of composite techniques for Communication skill training by our interns points to the need of developing a curriculum on communication skill teaching with its own subject matter, methodology and assessment methods. Evidence based

approach to Communication skills teaching and learning is crucial at this juncture.

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