

FOCUS GROUPS FINDINGS REVEAL BARRIERS TO TEACHING COMMUNICATION SKILLS TO MEDICAL STUDENTS

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ABSTRACT • BACKGROUND : In December 2002, 74 medical students in the second preclinical years at the American University of Beirut (AUB) attended a workshop on basic communication skills (CS). The students watched video clips which demonstrated different communication skills and stages of the consultation, and role-played to try out ways they could improve the consultation.

Their familiarity with the skills taught was assessed at the beginning of the workshop, immediately afterwards, and again six months later. There was a significant improvement noted immediately after the intervention but this apparent gain was lost at six months.

METHOD : Sixteen students, who attended the workshop, also attended two focus group discussions which were aimed to assess student recall of the communications skills workshop, and explore ways in which the students thought the knowledge gained could be maintained.

RESULTS : In general students thought that lack of exposure to patients at the time when the CS course was held, and a lack of consistency in CS coupled with poor faculty CS role modeling hindered their ability to maintain and practice good CS.

CONCLUSIONS : Teaching CS may be more effective if medical students are taught these skills when they are exposed to patients on a regular basis, and the training is maintained throughout the clinical years. However, more emphasis should be on reminding faculty members of their role as teachers and good communicating role models to students through workshops and seminars.

BACKGROUND

Numerous studies have confirmed the importance of communication between the physician and the patient [1-4]. Medical students' attitudes towards doctor-patient communication have for long been a concern among medical teachers, curriculum planners and policy makers [5-6].

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RÉSUMÉ • CONTEXTE : En décembre 2002, 74 étudiants en 2^e année de médecine à l'Université américaine de Beyrouth (AUB) ont participé à un atelier de formation sur les techniques fondamentales de communication (TC). Les étudiants ont visionné des clips vidéos démontrant diverses TC et les différentes étapes d'une consultation ; ils ont ensuite tenu le rôle du médecin et tenté de trouver comment améliorer la consultation proposée.

Leurs connaissances des TC enseignées ont été évaluées au début de l'atelier, immédiatement après et six mois plus tard. L'amélioration significative notée après l'atelier avait disparu au bout de six mois.

MÉTHODE : Seize étudiants ayant participé à l'atelier ont assisté à deux réunions de groupes destinées à évaluer ce qu'ils avaient retenu de la formation reçue et envisager quels moyens ils préconisaient pour garder le savoir acquis

RÉSULTATS : Les étudiants s'accordent à penser que les difficultés qu'ils rencontrent à maîtriser et à mettre en pratique des TC efficaces sont dues principalement au manque de contact suffisant avec les malades au moment où l'atelier s'était tenu, aux cours de TC peu structurés, et au manque d'encadrement satisfaisant par les enseignants.

CONCLUSIONS : L'enseignement des TC serait plus efficace s'il était intégré dans le cursus des étudiants en médecine lorsqu'ils se trouvent régulièrement en contact avec les patients, et s'il se poursuivait tout au long des années de formation clinique. Il est essentiel de rappeler aux membres de la faculté qu'ils sont aussi enseignants et qu'ils se doivent d'être de bons vecteurs de TC auprès des étudiants, utilisant à cet effet les séminaires et ateliers de formation.

Medical schools in the United States of America generally teach communication skills (CS) during the first or second medical year. In 1978, 35% of schools had a formal preclinical curriculum in communication skills, and by 1993 this increased to 65% [7]. This preclinical curricular approach provides limited reinforcement and training during the clinical years ; a long-standing concern supported by the early findings of a decline in communication skills during that crucial training [8].

The American University of Beirut (AUB) is a privately funded institution with a traditional '2 + 2' four-year curriculum on the American model. In December 2002, the Department of Family Medicine at the AUB devel-

TABLE I
PRE & 6 MONTHS LATER EVALUATION MEAN SCORE
FOR EACH AREA OF COMMUNICATION

	Pre-	6 months post- intervention	<i>p value</i>
Opening	0.7823	1.2549	0.004
Facilitation	0.4626	0.2941	0.032
Closed questions	0.2397	0.0196	0.013
Opened questions	0.4830	0.3922	1.000
Exploring knowledge	0.3197	0.1961	0.058
Confrontation	0.8973	0.9412	0.182
Summarizing	0.2857	0.5098	0.020
Physical exam	0.4490	0.6667	0.006

oped a culturally sensitive package (manual and video) to teach basic CS to second year medical students [9]. During a three-hour workshop the students reviewed eight video clips, critiqued the doctor-patient interactions, and attempted better versions of the communication through role-play. Then a facilitator suggested a better version when applicable. The baseline knowledge of the medical students was assessed by a pretest questionnaire that was repeated immediately after the workshop and six months later.

Fifty students completed the pre-, post- and 6-months-later evaluation forms. Mean overall score of these students was 3.96, 7.01, and 4.14 for the pre-, immediately post-, 6-months-later respectively. The immediate post-test showed significant improvement in knowledge. Knowledge was lost after six months ; however, there remained marginal improvement compared to baseline in three areas of CS : “opening”, “summarizing”, and “preparing the patient to physical exam” (Table I).

PURPOSE OF THE STUDY

This study used the focus group approach to explore the attitudes of medical student towards attaining and maintaining CS knowledge. Specific objectives for the focus group conducted among medical students were :

1. Clarify the reasons for not retaining the concepts learned during the CS workshop.
2. Identify how medical students project what they have acquired to their future practice.
3. List factors perceived by students as enabling or reinforcing the adoption of good CS.

SIGNIFICANCE OF THE STUDY

Focus groups are known to yield a great deal of information that cannot be acquired through other methods. The current focus approach demands that most efforts be spent on discovering the barriers for adequate CS learning and adoption. Such discussions will reduce the gap between the students and the CS trainers through uninhibited opinions. It will also permit the students to express their

ideas through responses that are not entirely encapsulated in reasoned answers to direct questions.

The findings of this study are likely to result in changes in the structure of the CS course which was newly introduced to the medical curriculum. Continuous incremental changes according to feedbacks from students will improve the course targets and reach the goals based on what the students and course planners see appropriate.

METHOD

Participants and procedure

In December 2004 a letter was mailed to all fourth year medical students (n = 74) to participate in a focus group. The students were offered three different dates for attendance. The invitation was further confirmed by a message to their pagers, as not all of the students were checking their mailboxes regularly. All students who showed up at the set dates were selected for the focus groups. Two focus groups discussions were conducted in December 2004.

For identification purposes, each participant in the focus groups was labeled by her/his gender followed by a number (F1: Female 1 and so on). All the participants had attended the intervention session, including the first pre- and post-tests. Oral consent was obtained from the participants. Anonymity and confidentiality were assured.

Data collection and analysis

Two consultants with an MPH degree and not known to the students were hired to conduct the focus group discussions. Both had previous experience in qualitative work and were present at each focus group. Each took turn in moderating the discussion or taking notes. The physician trainers in the CS workshop were not present during the discussions ; this ensured the students' comfort and freedom of speech.

The focus group discussions started by an introduction that raised questions and more specific topics concerning the intervention and assessment tool. The discussions were in English. Some students occasionally resorted to Arabic when they could not express themselves. Tape recorders were used to document the discussions.

The focus group discussions were transcribed into English and were analyzed thematically by the two consultants ; this ensured that the context is maintained and no data is lost. The transcripts were read several times and coded. Sentences that captured key ideas were highlighted for quotes. The codes and quotes were grouped onto a matrix according to emerging recurrent themes, and then were analyzed according to the main categories of the study objectives.

RESULTS

A total of 16 students participated : six females (F) and ten males (M), with an age range of 24-26 years. Eight students (F3, F6, M1, M2, M4, M6, M9, and M10) engaged well in the discussion and four students (F2, F4, M7, and

M8) were the least talkative. The remaining four students (F1, F5, M3, and M5) were moderately involved in the discussion.

The main items that emerged from the focus groups can be grouped under three headings : (i) Value of CS, (ii) Possible explanations for the difference in the pre- and two post-tests performances, and (iii) Changes needed to improve CS.

Value of communication skills

There was an agreement that good communication results in better data collection, better compliance, and better medical outcomes. Few mentioned quotes were :

"It's important for trust and compliance, patients will inform you more about their disease, their history... if you explain more about the disease, and spend time with the patient, this will improve the outcome." (F6)

"It's part of the treatment, because the patients will feel better psychologically." (M9)

"If I do not learn about communication skills I'll never be a good doctor." (F3)

Reasons for difference in the two post-tests performances

The differences in test scores were attributed to more than one factor. Almost all students commented on the timing of the workshop. They suggested that this activity should be moved to the end of the academic year when students were about to start their clinical training.

BOX 1

EXPRESSED REASONS FOR THE DIFFERENCE IN PERFORMANCE IN THE TWO POST-TESTS

Timing of the intervention

"We had never spoken to a patient in our lives, or anyone taught us how to." (M4)

"If you do not have experience in seeing patients, you will not learn much." (M9)

Convenience

"The mere fact that we are not remembering when we did it... shows we were not taking it that seriously." (M1)

Faculty factor

"Attending doctors rarely give feedback to students; they're together with the patients." (M2)

"We do not have role models... we had never seen a doctor doing it and telling us about it." (F3)

"... they are always busy."

"... not everybody has the same skill of course." (F6 & M9)

"Some stay the way they were and are very hard to change." (M9)

"While some even worsen especially under stress." (F6)

"Some attendants are bad role models, especially in breaking bad news." (F3)

"Others are good." (M3)

Convenience was another issue. The second post-test exam was at a time the students were busy preparing for their finals. So the priority at the time of the second post-test was for activities that will affect their grade point average (GPA).

Learning and retention of information cannot be acquired from one workshop. Skills learned need to be experienced over and over again. In general, during their physical diagnosis course, students do not get the chance to observe faculty while interviewing patients. Furthermore, students are not observed by faculty while interacting with patients. These lost opportunities for reinforcing the skills learned in the CS workshop may explain the deterioration in performance in the tests.

Box 1 summarizes the students' quotations explaining the difference in performance in the tests.

Changes to improve communication skills

There were two opinions relating to teaching CS. A group, included all the females, suggested a systematic approach entrenched in the curriculum. They justified that it would be more beneficial if given as a course and communication skills were stressed throughout their clinical exposure. They asked for continuous direct supervision and feedback from faculty. The other group, included some of the males, believed that CS couldn't be acquired in classrooms but through experience and feedback from patients. Both groups failed to reach a consensus in this respect – experiential vs. systematic learning.

Students asked in addition to watching, commenting on video scenarios, and practicing role-play (used in the intervention) to videotape their own interaction and discuss it with an expert in communication skills. They also suggested observing physicians in their actual interaction with patients, and get instructions on the spot.

Role of residents

Students highlighted the importance of learning CS from residents. They believe that residents who are well trained in CS are well placed to give them feedback from interactions with patients. They stressed the importance of urgently training residents in CS.

Quotations expressing the needed changes to improve communication skills are shown in Box 2.

DISCUSSION

Based on the above focus group sessions, it is evident that teaching communication skills in medicine is unique and not analogous to teaching other courses in the curriculum. Medical students, however, seem to be exposed to a hidden curriculum that places the acquisition of biomedical knowledge above and at times at odds with the development of awareness and relationship skills important to the patient-physician relationship [10]. While the students were tolerant to the trend of early learning about diseases without encountering diseased patients, they were more determined in their need to clinical encounters when learning CS.

BOX 2

QUOTATIONS EXPRESSING THE NEEDED CHANGES TO IMPROVE COMMUNICATION SKILLS

Systematic vs. experiential learning

"... We need sessions on general guidelines that always occur with patients... fine details can be learnt on our own." (F6)

"If it's without these sessions, it will take me a longer time and messing up to acquire those skills... If I'll ever acquire them!" (M10)

"You can see wrong things that should not be done, from patients' reactions to these acts." (M2)

"Our communication improves by our own experience. Over time, in any relationship with any human being, you start doing things that are better for the communication. You can't learn everything from one session, about all sorts of patients, because every personality has its own way of communication." (M9)

Learning methods

"Videotape the student's interaction with patients, and allow reviewing." (M10)

"[In evaluation] you ask us... when you had this situation, how would you react?" (M2)

"Prepare students with video before faced with real life." (M1)

"Certain scenarios can be faced with on video before you face them in real life... It gives us more confidence to deal with them when they arise." (M9)

Contrary to our results, some studies have indicated improvement in communication skills throughout the training years in medical school [11]. A recent study revealed that offering an integrated CS training program throughout the four years of the medical school resulted in greater overall effectiveness when compared with concentrated courses [12], as in our case.

Females were more likely to ask for structured teaching of CS, and held more affirmative stances in relation to importance of CS. Kaufman et al. reported that female students had more positive attitudes than male students, and that first and second year students had more positive attitudes than fourth year students [13].

The students in general asked for systematic methods or guidelines to be followed when teaching CS, as this may decrease inter-trainer variability and decrease learners' confusion. This is also in agreement with the literature, as faculty feedbacks to learners will be highly variable and contribute more to learners' perplexity [14]. Contrary to the expectations of some of our students who look at communication skills as a social skill acquired through familiarity, experience alone does not result in improved communications [15].

In accordance with some reports, students were explicit in their time preference and considered communication skills not a priority in their pre-clinical clerkship [16]. Many medical schools have revised their curricula to

include longitudinal clinical training of CS in the first and second years, in order to establish it as a well needed education that can increase the level of preparedness of the upcoming future physicians. At the time this article was written, the second year medical students at our center have already started being exposed to clinical encounters in private clinics.

Many students believed that communication skills can be learned and that most valuable ways of learning were observation, and being observed with a feedback from an attending, and residents. Resident teaching of medical students is effective, particularly for a skill which is novel. It may also be a good suggestion in this context to try near-peer teaching. Near-peer teachings have been reported to be beneficial for students as teachers and learners specially that the skill to be taught is not being mastered by their teachers in the first place [17].

The importance of role models was raised by the students. It was reported that an unacceptably large number of medical students were taught by physicians who seem to lack compassion and caring in their interactions with patients [18]. The difficulties, however, arise in finding a suitable time for these important physicians to transfer their skills [19]. Another challenge remains in how experienced are the teachers themselves in guiding a skill they acquired solely through experience and never trained in or learned. This raises an evolutionary approach about the need for reverse or retrograde education, namely involving physicians in communications skills learning rather than targeting students only. This is even more true if we consider that tutors in clinical settings see themselves primarily as clinicians or physicians responsible for patient care and only secondarily as educators.

Though students in this study valued role-play and videotapes in the acquisition of communication skills, they expressed their need to be observed and supervised with feedbacks during clinical encounters [16].

LIMITATIONS

The focus group discussions took place after two years of the intervention. Hence, a major limitation is recall bias. On the other hand, the two years the students had spent in the clinical years allowed them to shed light on the CS of residents and faculty.

CONCLUSIONS

Teaching of communication skills seems feasible and effective. Without specific training medical students' communication skills seem to decline during medical training. The deterioration in knowledge of CS concepts in this study was attributed mainly to lack of longitudinal emphasis on CS due to lack of exposure to patients and more importantly, the lack of role models that needs to be addressed in workshops to faculty about teaching communication skills.

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