

COMMUNICATION

Teaching Medical Students What They Think They Already Know

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ABSTRACT **Objectives:** To discuss the problems encountered teaching interviewing skills to first year medical students and describe their responses to a structured workshop in interviewing skills.

Methods: Focus groups and a short evaluation questionnaire filled in by 56 first year medical students before and after a workshop in interviewing skills were used.

Results: All students evaluated their skills very highly prior to the workshop. After participating in the workshop, students evaluated their skills as lower than before.

Discussion: When communication skills are taught in an informal, unstructured manner, medical students might view this knowledge as unspecialized, repetitive, and even boring. It is suggested that employing a structured model for teaching doctor-patient communication skills awards psycho-social issues the status of formal knowledge. This can lead to students viewing communication skills as a relevant and consistent body of knowledge. Introducing a structured model can overcome two kinds of problems: over-confident students are formally introduced to unique aspects of medical interviewing, whilst those who lack confidence are offered a lifeline in the form of a structured model. Identifying possible sources of resistance to communications training has important implications for medical education as it allows for appropriate course planning and follow up.

KEYWORDS Doctor-patient relationship; doctor-patient communication; interviewing.

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Background

The medical school of the 21st century is faced with the awe-inspiring task of moulding medical students into competent doctors who are to function in a dynamic and volatile environment. This environment is characterized by an implosion of knowledge, the tension between specialization and inter-disciplinarity, the imperative of practising cost-contained medicine, and the general questioning of medical authority by an increasingly well-informed and consumer oriented public.

Despite the developments in scientific and technological methods of diagnosis and treatment, studies have shown that psycho-social elements constitute an integral part of good doctoring and therefore cannot be neglected. These studies have shown that attention to psycho-social elements of the therapeutic relationship enhances both patient and physician satisfaction (Clark *et al.*, 1999; Dorr-Goold & Lipkin, 1999), increases patients' co-operation and compliance (Lewis, 1994; Squier, 1990; Jeong *et al.*, 2001; Van Dulmen *et al.*, 2002) and diminishes the likelihood of legal suits being filed against doctors (Hickson *et al.*, 1994). However, systematically teaching medical students subjects and skills that can promote psycho-social interaction with patients are often neglected in the medical school curriculum (Novack *et al.*, 1993; Hargie *et al.*, 1998). This could be because psycho-social issues and related skills are not perceived as knowledge in the formal sense of the term. Rather, they are perceived as something which is implicit, taken for granted and common sense. Something that can be picked up in accordance with students' personalities, pre-dispositions and incidental role models (Glick, 1993; Benbassat & Baumel, 2001).

This last approach can prove problematic, as unstructured learning modules can often be misconstrued by students as less important than structured parts of the curriculum.

The purpose of our paper is to describe a workshop in which we attempted to rephrase communication skills training in terms of an objective, systematic corpus of knowledge and discuss students' responses to such a workshop. Possible sources of students' resistance to communications training are explored, and the implications of these findings are discussed in relation to teaching communication skills in the future.

The Setting

At Ben-Gurion University, the bulk of the curriculum in communications skills is taught in the first year of the 6-year medical school programme. The curriculum in communications skills comprises four stations: paediatrics, internal medicine, obstetrics and geriatrics. Students spend 16 hours (4 hours

per week) at each of these stations interviewing patients in small groups under the supervision of facilitators. The total time spent interviewing is 64 hours. Instruction is ongoing, informal and based on discussion and analysis of interviews with peers under leadership of supervisors. In recent years during de-briefing sessions held after completion of interviewing, students expressed dissatisfaction, stating that although interviewing patients was “enjoyable”, it was also “boring, static and repetitive” and “does not develop”. These remarks reflected the students’ general feeling that after a few interviews, they were proficient and had nothing more to learn from further practice. This feeling was not shared by the staff. In previous years, students were required to attend a short workshop prior to these interviewing sessions. In view of the complaints outlined above, we changed the framework of the workshop and presented medical interviewing as a formal, structured, and specific corpus of knowledge that should be learned. To achieve this end, the workshop was based on the three functions model of medical interviewing (Lazare *et al.*, 1995) promoted by the AAPP (American Association of Physician and Patient). This model conceptualizes the three functions of medical communication as relationship building, eliciting information, and patient education. The workshop had three units: eliciting information, relationship building and reflexivity. In the unit on eliciting information, students were instructed on how to open and close an interview, use appropriate transitions between the various sections of the interview and when to use open and closed questions. In the unit on relationship building, students were instructed on empathic listening and introduced to concepts such as showing respect, partnership and support for patients. In the unit on reflexivity, students were encouraged to explore their own personal attributes which could either facilitate or inhibit their ability to be good communicators. In general, each unit was divided into two parts: exposition of theoretical material and related skills and then practice in small groups of 14. The workshop lasted 6 hours and is schematically described in Figure 1.

Methods: The Questionnaire

Students were asked to complete a short questionnaire before and after the workshop. The questionnaire was anonymous, and a coding system was used in order to compare questionnaires. In the questionnaire, students were asked to evaluate themselves on a scale of 1–5 (1 = high; 5 = low) on a number of items including interviewing capabilities, the ability to understand others and the importance of communication skills in medical treatment. Percentages were calculated for each item, and chi square used to compare the pre- and post-workshop evaluations. We did not average out the categories within each item, as we were interested in the dispersal and changes within each category.

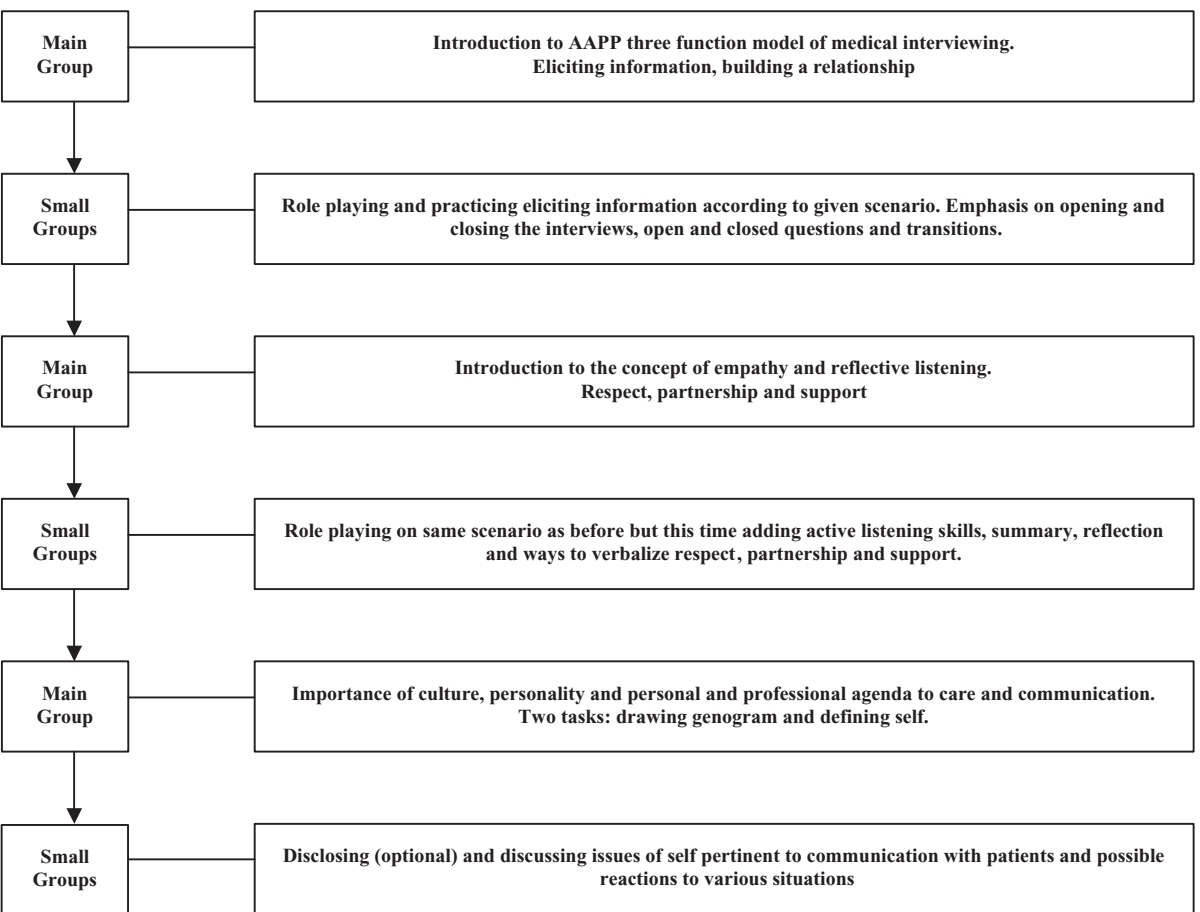


Figure 1. The communications skills workshop.

Results:

Fifty-six students (34 males and 22 females) participated in the workshop. The average age was 22 with a range of 18 to 26. Forty-five % said they had previous experience in interviewing.

Before the workshop 14.2% of the students felt that their interviewing capabilities were “very good”, and 69.6% evaluated them as “good”. On this latter item only 16% defined their capabilities in this area as “mediocre”, and not one student chose the options of “not good” or “not good at all”. After the workshop there was a decrease in students’ evaluation of their interviewing abilities. 10.9% of the students felt that their interviewing capabilities were “very good”, 52.7% rated them as “good”, 34.5% as “mediocre” and 1.8% as “not good”. This decrease was significant ($p = 0.006$). Before the workshop students also rated themselves highly on their ability to understand others. Of the group, 19.6% rated their ability in this field as “very good”, 71.4% as “good” and 8.9% as mediocre. Once again, none of the students chose the “not good” or “not good at all” categories. After the workshop there was a significant decrease ($p = 0.005$) in students’ evaluation of this ability. 10.7% rated themselves as “very good” in understanding others, 71.4% as “good”, 16.1% as “mediocre” and 1.8% as “not good”. The role of good communication in medical treatment was evaluated as “very important” by 92.8% of the students and “important” by 7.1%.

Discussion

Although success of workshops is generally measured in their ability to improve skills, we feel that the success of this workshop might be viewed as its ability to jolt students back to reality, and thereby possibly open the way for further learning.

The initial, high self-evaluation of interpersonal skills exhibited by these first year students probably stems from the perception of communication and interviewing skills as subjective and part of one’s personal make-up. When this is combined with a non-structured course, it can quickly lead to lack of interest, as expressed by the students in our focus groups, and engender resistance to learning. Showing students that a structured body of knowledge and techniques exist in the field of interviewing and communication can cause them to re-evaluate their capabilities and open the opportunity for learning. This is particularly noteworthy because almost half of the students said that they had some prior experience in interviewing. It is our contention, therefore, that adopting a formal, structured model in the introductory workshop in particular, and in the education of medical students, in general, can be beneficial on two counts: (a) students who are highly self confident are introduced to a specialized body of knowledge, in contrast to the taken-for-granted knowledge which they possess, causing them to re-assess their skills and (b) students who lack confidence or resist learning due to insecurity, are offered a lifeline in the form of a structured model which they can practice. Teaching a structured, formal model can therefore overcome two types of resistance that impede learning: that which stems from over-confidence and that which stems from insecurity.

Moreover, the addition of an element of reflexivity and introspection into the workshop provides a meeting ground between the model and the self,

encouraging a dynamic, personal process which can be monitored and discussed throughout medical school. Awarding communication skills the status of formal knowledge, whilst encouraging introspection, will help us show medical students what they don't know—and then enable us to teach them.

Findings similar to ours have been reported by Rees & Sheard (2003) who showed that students rated their communication skills slightly but significantly lower at the end of their course in communication skills and also that their positive attitudes towards communications skills declined from the start to the end of the course. Their explanation for these findings is that difficulties encountered by students during the course caused them to re-assess their skills, and therefore adopt less favourable attitudes. In our study we suggested the decline in students' self assessment of their communication skills might be a result of our presentation of communication skills as a formal, structured body of knowledge that they had to master. Whereas quite a large body of literature exists on positive evaluation and learning outcomes of courses in communication and interviewing, we feel that the findings we have presented, alongside those of Rees & Sheard (2003), have important implications for medical education, as they identify areas of resistance which have to be overcome in order to ensure assimilation of good communication skills in the long term. We suggest that our challenge as medical educators is to provide our students with a consistent and structured framework that will see them through difficulties and crises, and serve as a constant point of reference. Introducing a formal model of communication skills might be one way to achieve this.

Limitations of This Study and Directions for Future Research

Information presented in this study was obtained through a very short self-reporting questionnaire that covered different content areas. Although self-reporting questionnaires have their limitations, in this case we were interested in how entry-level students *subjectively* evaluated their skills and therefore feel that use of such a questionnaire was appropriate. There is the possibility that perception of organizational culture might have caused students to rate themselves highly on inter-personal skills due to social desirability. However, the decrease in ratings of self-evaluation after the workshop probably rules this possibility out.

Much more research is needed on effective ways of teaching medical students “soft” subjects, such as social sciences or communication skills, which are relatively new in the medical school curriculum. Future research should focus on factors which might promote or inhibit students' willingness to deal with these subjects alongside the body of research which deals with short term outcomes of specific courses and workshops and long term follow up of the effectiveness of various methods of instruction. Although our study is limited to a small sample of students, we hope that it might serve as a basis for further research in identifying initial difficulties which might impede learning and

teaching of new skills which are being incorporated into the education of medical students in the 21st century.

Acknowledgement

Dr. Fadlon would like to thank Prof. Shimon Glick for his enthusiasm, encouragement and ongoing intellectual contribution to her work.

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