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Diagnostically fit for the future? The students' perspective.

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Abstract

Objectives: Medical students training incorporates learning how to take a medical history with an increasing focus on professional bedside manner and communication training. This study examined students' evaluation of the communication training classes at the Medical University of Vienna.
Methods: A survey based on a self-administered questionnaire with 16 questions about five main categories: social skills and communication, demeanour, expertise, ability to combine communicative and expert skills/knowledge was sent to students in their third, fourth, fifth and sixth academic year.
Results: The majority of students rated the communication classes positively, especially, they felt their communicative and social skills improved much. However, large deficits were pointed out in the transfer of expertise and the lack of improvement in the ability to combine communicative and expert skills/knowledge.
Conclusions: This data indicates the need for re-evaluation of the training of social and communicative skills at medical universities, especially we propose the integration of field specific history taking and communication frameworks.

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Keywords: Medical history taking, communicative training, medical students, physician-patient-communication, communicative skills, social skills.

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1. Introduction

A physician takes 120.000 to 180.000 medical histories on average through the course of his career (Lipkin 1995). Taking a medical history is a crucial skill, as during initial patient contact up to 76% percent of diagnosis have been shown to be made (Peterson et al. 1992). Literatures show that there is a correlation between quality of physicians' communication with the patient and patients' satisfaction (Van Dulmen et al. 1997; Goehuys 1998; Mallinger et al. 2005; Wilkinson et al. 2008; Venetis et al. 2009) and adherence to advices and prescriptions (Bultman. Svarstad 2000) the prevention of somatic fixation (Verhaak. Tijhuis 1994) and diminishing of incorrect medical treatments (Chen et al. 2008) or malpractice suits (Levinson et al. 1997; Tamblyn et al. 2007). Furthermore good and patient centred communication has an impact on the level of psychological distress and improvement of patients' health and functional status (Stewart et al. 2000; Kaplan et al. 1989; Chassany et al. 2006; Del Canale et al. 2012) and prevent of physicians' burnout (Graham et al. 1976; Travado et al. 2005).

Training these skills was historically taught implicitly, and were not automatically part of medical education curricula and even clinical training until more recent years (Kurtz 2009). They can and should however be taught and improved upon (Langewitz et al. 1998). Expert consensus currently advocates communication training as a core element of medical education (Makoul 2001).

The Medical University of Vienna (MUV) saw recent widespread curricular restructuring, especially in bedside teaching and communication training (Merl et al. 2000). During the second and third year students use roleplaying situations in group seminars, called Ärztliche Gesprächsführung A und B (ÄGF A and ÄGF B), to learn and practice general medical history taking. The goal is to learn to take a complete and well-structured anamnesis in an empathic and patient-centred way. During the fourth year, training focuses (ÄGF C) on challenges in communicating with patients in a psychiatric setting. Front lectures and textbooks provide background. Afterwards group seminars with simulated patient contact require students to successfully take mental states. The main aim is to learn to integrate theoretical knowledge in the communication and to manage the special setting with psychiatric patients.

In this study we want to evaluate the classes at MUV for communicative skills ÄGF A,B and C by asking the students after successful participation of them. In detail we want to find out whether, in the students' opinion, the given aims of each class can be achieved.

2. Method

For this study a self-administered questionnaire was developed. The statements given in the questionnaire were rated on a Likert-scale of -2 to 2, where -2 is "disagree strongly" and 2 is "agree strongly" or a scale of Grade A [1 - Very good], Grade B [2 - Good], Grade C [3 - Satisfactory], Grade D [4 - Sufficient] Grade E [5 - Insufficient].

The questionnaire included 14 questions about each ÄGF A/B and ÄGF C classified in 5 main categories (see Table 1). Furthermore two additional questions about ÄGF-C were asked.

Table 1.: Questionnaire with five main categories.

1.In General
In general, I liked ÄGF A/B or C.
2.Social Skills and Communication
Due to ÄGF A/B or C I learnt
to act in an ethically correct way.
to act in a polite way.
to act in an empathetic way
to allow the patient sufficient time.
to show interest in the patient.