



Medical Education

Third year medical students perceptions towards learning communication skills: Implications for medical education

Elizabete Loureiro ^{a,*}, Milton Severo ^{a,b}, Paulo Bettencourt ^c, Maria Amélia Ferreira ^{a,d}

^a Centre for Medical Education, Faculty of Medicine of the University of Porto, Portugal

^b Department of Hygiene and Epidemiology, Faculty of Medicine, University of Porto, Porto, Portugal

^c Service of Medicine of the Hospital of S. João, EPE, Porto, Portugal

^d Institute of Anatomy, Faculty of Medicine, University of Porto, Porto, Portugal

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ABSTRACT

Objective: To analyze students' perceptions towards learning communication skills pre-and-post training in a Communication and Clinical Skills Course (CCSC) at a Portuguese Medical School.

Methods: Content analysis was used to describe and systematically analyze the content written by students ($n = 215$ from a total of 229) in an open-ended survey. In addition, content analysis association rules were used to identify meaning units.

Results: Students' pre-training definitions of communication skills were not specific; their post-training definitions were more precise and elaborated. Students perceived communications skills in Medicine as important (61%), but recommended that teaching methodologies (52%) be restructured. There appeared to be no connection between criticism of teaching skills performance and perceptions of the other aspects of the course.

Conclusion: Students' experiences at CCSC are associated with their perceptions of communications skills learning. Content analysis associations indicated that these perceptions are influenced by context.

Practice implications: Improvement of curricula, teaching and assessment methods, and investment in faculty development are likely to foster positive perceptions towards learning communication skills in these students.

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1. Introduction

Historically, medicine was dominated by the biomedical model, which placed more value on technical proficiency than on communication skills. The current focus, supported by evidence-based medicine, reinforces the need for curriculum to include communication skills of known effectiveness in improving health [1–6]. Communication skills curricula aim to develop effective communication with patients, family, colleagues and other health professionals in order to promote better inter-personal relationships [7,8], and to enhance sharing of information essential to establish a diagnosis and treatment plan [8].

Widespread acknowledgment of the importance of improved doctor–patient communication, and evidence that it can be taught, has contributed to the integration of communication skills into many medical school curricula in the UK, Northern Europe, USA and Canada [5,10–12]. However, there is great variation among

medical schools in the way and extent to which the communication skills are taught, and how they are assessed [10,13,14].

There are few qualitative studies that outline medical students' perceptions towards communication skills [27–29]. The aim of this paper is to report results of a content analysis of students' perceptions towards learning communication skills pre-and-post training in a Communication and Clinical Skills Course (CCSC) at a Portuguese Medical School. This is part of a larger study to look at communication skills teaching at medical schools in Portugal, which began with a quantitative pilot study to explore attitudes of 3rd year medical students towards the acquisition of competencies in communication skills [30]. No specific teaching, learning and assessment benchmarks are indicated in Medical Courses in Portugal, and none have an integrated curriculum of communication skills teaching. Most of the isolated courses that do exist are not adequately assessed and not significantly valued in terms of credits. The lack of integration and credit value may contribute to the unfavorable attitudes towards the learning of these specific and complex skills and their use later on, as research results from other countries have demonstrated [5,9,29,33,34]. Therefore, in our study to assess student perceptions a focus on integration and credit value seems of utmost importance.

* Corresponding author at: Centre for Medical Education, Faculty of Medicine of the University of Porto, Portugal. Tel.: +351 962442842; fax: +351 225513612.
E-mail address: emfl@med.up.pt (E. Loureiro).

2. Methods

2.1. Context of training

According to current statutes, i.e., Bologna model, Master Degree in Medicine at the Faculty of Medicine of the University of Porto (FMUP), is 6 years in duration and is organized in 2 cycles: (i) Degree in Basic Health Sciences (1st, 2nd and 3rd year) and, (ii) Master Degree in Medicine Clinical Learning (4th, 5th and 6th year [35]). Only during the Degree in Basic Health Sciences is there teaching in communication in medicine. During the second year, in Medical Psychology, students are introduced to clinical competence in communication skills, with practical sessions about the Doctor–Patient Relationship, focused on the clinical interview. Role-play among peers is the primary teaching method.

Throughout third year (basic cycle), students attend “Clinical Semiotics” which is a CCSC component. The objective is the development of skills in the doctor–patient communication and learning to structure clinical history and performance of standardised physical examination. Medical students are expected to learn to deal with problems in the doctor–patient relationship integrated in clinical situations. In total, 14 h of the course are dedicated to theoretical seminars and 28 h to practical sessions (focused on the physical exam). Practical sessions occur in the Service of Internal Medicine of the Hospital of S. João, EPE, with one weekly practice session per group, and real patients (ratio 6:1) with peer role-play.

Yearly curriculum evaluation indicates that students recognize CCSC as very important [36]. They have high expectations towards this course because it represents the first time they have contact with real patients in clinical settings. However, the CCSC course has two major problems. It has the least credits of all the third year courses. And the staffs are mainly volunteers, receive no formal training in communication skills teaching, represent various disciplines, and use a variety of teaching methods. In addition, variations in approach include inconsistency in providing feedback to learners and lecturing in classrooms rather than teaching students in the context of patient care in clinical settings. The theoretical seminars include an approach to communication skills, but not all staff integrate the skills into their practical sessions. The practical assessment of CCSC is based on two oral case presentations preformed by the students with real patients. These assessments, done by the teaching staff, are based on an overall subjective evaluation of the histories, with no standardized rating form.

2.2. Participants

A total of 229 students enrolled in CCSC during 3rd year (academic year 2006/2007) were included. The study was divided in two phases, and in both, students were asked to answer an open-ended survey about Communication Skills. Phase 1 (*pre-training*) occurred in the beginning of the academic year before students received in-depth training. Phase 2 (*post-training*), occurred at the end of the same academic year and after students had received an integrated training.

2.3. Materials

All students completed a demographic survey. The *pre-training* survey included questions about feelings towards communication with patients and the definition of Communication Skills. The *post-training* survey included questions related to the experience in CCSC, with identification of the most positive and negative aspects (see Appendix A). Students were asked to identify themselves so that the information obtained could be compared with their pre-training survey.

2.4. Content analysis

To form an overall impression, two of the professional researchers (EL and AF) assigned “meaning units” showing similarities into new, recoded groups (i.e., condensed meaning units). These groups were then carefully examined and discussed by all researchers in order to obtain a consensus version.

To complement the qualitative content analysis we used a data mining technique, association rules [37].

These rules identified typically connected condensed meaning units. For example a rule that said *A* implies *B* ($A \Rightarrow B$), means that both condensed meaning units *A* and *B* are said jointly more times that what would be expected if both meaning units were independent (Lift).

The lift is used to measure the magnitude of the connection (association), and has the following formula:

$$\text{Lift } (A \Rightarrow B) = \frac{P(A \wedge B)}{P(A) \times P(B)}$$

where the numerator is the probability that unit *A* and *B* are said together and the denominator is the probability of *A* multiplied by the probability of *B*.

If the resulting value of Lift is less than 1, then the occurrence of *A* is negatively associated with the occurrence of *B*. If the resulting value is greater than 1, then *A* and *B* are positively associated, meaning that the occurrence of one implies the occurrence of the other. If the resulting value is equal to 1, then *A* and *B* are independent and there is no association between them. The association rules were performed using the software Magnum Opus.

3. Results

3.1. Participant characteristics

Of the 229 students enrolled in CCSC, 215 completed phase 1, giving a response rate of 94%. During phase 2 we received 110 surveys (48%). In *pre-training* the mean age was 20.6 years with a standard deviation of 1.2 years; the majority of participants were female 73.0% ($n = 157$) and 27.0% ($n = 58$) were male. In *post-training* the participants had similar age (mean = 20.8 SD = 1.3 years) and similar sex distribution ($n = 75$ (68.1%) and $n = 35$ (31.8%), respectively for women and men).

3.2. Content analysis – pre-training

3.2.1. Definitions and relevance of communications skills in medicine

In *pre-training* phase, students stated that Communication Skills in Medicine (CSM) is the capacity to create empathetic relationship and skills of understanding (69.3%). The second most stated meaning unit demonstrated that students felt these skills were of utmost importance and indispensable to medical education (47.4%) (Table 1).

(s97) “... very relevant, good doctor – patient communication is crucial for diagnosis and treatment. The doctor must know how to listen to patients and make them feel heard”

3.2.2. Expectations towards CCSC learning experience

Students stated they were expecting to learn to cope with and to communicate with different types of patients and adopt more adequate postures (48.8%). They expected to (i) learn to take a clinical history and do a physical examination (23.3% and (ii) learn skills that could help them deal better with patients (22.8%) (Table 1).

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