

Teaching communication skills in family medicine: A qualitative study

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Abstract

Background:The ability of a doctor to communicate with patients effectively is one of the core competencies of a family physician. Teaching communication skills is a peculiar and challenging subject.

Objectives:This study was conducted to explore the perceptions of family medicine trainers, their teaching approaches, and their opinions about improvements in teaching communication skills.

Materials and Methods:The was a qualitative study. Both semi-structured interviews and a focus group discussion were used. The group of trainers was purposively selected and analysis was performed manually.

Results:Twenty-four trainers were interviewed. It was found that interviewees perceived teaching communication skills as something very important and interesting but challenging and difficult. Effective teaching of the subject was limited by curriculum design where time distribution between the hospital and family medicine training did not satisfy the requirement of teaching communication skills. Time constraints and the organization of patient services in family medicine teaching centers contribute to the challenges of teaching the subject effectively. The practice of and the attitudes toward effective communication skills teaching methods were variably perceived among this group of trainers. The assessment modalities as a final point in the whole process of teaching were not perceived as a discriminating indicator to the true level of residents' communication skills. Their main ideas for improvements were to give more emphasis to the teaching curriculum, to give it more weight in the final assessment of the board examination, and to establish standard teaching skills and attitudes toward the practice of communication skills in family medicine.

Conclusions:Communication skills teaching in family medicine is a complex area of training. Focused efforts are required in developing the curriculum and training standards.


KEY WORDS: Communication skills, family medicine, training

Introduction

There is no doubt that good doctor–patient communication skills improve both doctor's and patient's satisfaction and lead to better adherence of the patients to the management plan and thus, to better health outcomes.^[1,2,3] The use of effective communication skills with patients during the consultation process is one of the core learning and teaching objectives in family medicine teaching programs.^[4] Since the recognition of

the field of general practice and family medicine, consultation theories and models have been published in abundance.^[5] Several works have focused on the teaching approaches that could be adopted to build and develop effective communication skills among family physicians.^[3,5] There are some well-known methods of teaching consultation and communication skills such as analysis of video-recorded consultations, role playing using simulated patients and feedback, direct observation during the consultation, short half-day workshops, short lectures, and analysis of self-recorded consultations performed with mentor's feedback.^[1,3] Family medicine residency training program has recognized the importance of teaching communication and consultation skills, and considered it as one of the core curriculum teaching competencies.^[6]

The purpose of this study was to identify the family medicine trainers' perceptions and approaches of teaching communication skills, and to identify the different strategies, in the trainers' opinion, that could prove effective in improving the family medicine board residency training program.

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Methods

This was a qualitative study using interviews and a focus group discussion. The family medicine training program curriculum is a recognized comprehensive educational training program. Trainees spend 4 years in the program under vocational training in family medicine in addition to all medical and surgical specialties. For more than two decades, family medicine training has been designed for the residents to spend two-thirds of their training outside family medicine centers, and the residents usually start working in these centers in their final year. A new curriculum was implemented last year according to which trainees are assigned to family medicine centers yearly during the 4-year period of the training program.

A purposive sampling technique was used to select the participants for this study. The participants were selected from family medicine residents of different family medicine training centers to include different ages, training backgrounds, nationalities, and gender.

The semi-structured interview included few direct questions about interviewee's years of teaching experience in family medicine and the different teaching activities they were involved in. The core questions were included to explore the following areas: the views of the participants about the required competencies, the communication skills they should master, their perceptions of teaching communication skills to family physicians, their views of a good teaching program, their own approaches that they use during teaching the topic, the effect of the training periods that they spend outside the family medicine centers, and finally, their views about the assessment and whether they have any ideas for improvements in teaching the topic. The participants were asked to speak freely about the other core questions that were mentioned above without interruption until they stop talking, and then questions were asked around the same question till they had no more information to add. Interviews were audio-recorded, by the researcher, during the interview and permission for recording was asked before the interview began. All interviews were transcribed shortly after recording, notes were taken by listening to the records and reading transcripts again to identify common themes. After analyzing the first 5–6 interviews, another group interview was recorded, transcribed, and analyzed again. After the third group of interviews, the information started to be repeated, so more trainers, from outside the main group and outside the same city, were contacted to get different views on the topic. Most of the interviews were conducted directly in the offices of different teaching centers and few interviews were conducted telephonically. When the information from the interviews became saturated, the interviews were stopped. Twenty-four trainers were interviewed. The duration of the interviews varied from 14 to 43 min. The interviewees consist of an equal number of males and females. Their lengths of experience varied from 2 to more than 30 years, mostly approximately 10 years. They were all heavily involved in the training program by delivering lectures, conducting group teaching, facilitating learner-led activities, and teaching

trainees during their work with patients during consultation. A focus group was formed to discuss further issues related to some of the themes within the context of a group discussion where members may discuss them differently. An invitation was sent to all previously involved participants. Thirteen participants agreed to attend the focus group discussion. Consent was obtained from all the participants to conduct the interviews and to participate in the focus group discussion. Ethical approval was also obtained from research committee before starting the study.

Results

The main themes of the study were identified first by coding the scripts. The scripts were coded and categorized within the frames of the core questions that were discussed during the semi-structured interviews that served and reflected the objectives of the study [Table 1]. Themes were identified from the coded scripts (Figure 1).

The topic was described as highly important but difficult and challenging to the participants undergoing family medicine training.

Following are few statements:

It's the heart and soul of family medicine because we spend most of our work in consulting with patients, unlike other physicians who have a variety of daily activities such as rounds on inpatients, procedure and other interventions.

One of the most difficult topics to teach, needs extensive training, time consuming and requires extra resources.

It is challenging, a big challenge, teaching is affected by the flow of patients and the trainer's own consultation style.

Trainers described that interactive and clinical teaching are more effective than didactic teaching of communication skills [Table 2]. One of the trainers stated that "Role play in communication skills teaching is one of the important tools", whereas another trainer described the benefits of video-recorded consultations to residents in the following statement: "They will see themselves and comment on their own work."

Table 1: Coding categories for teaching communication skills as per interview scripts

Number	Code
1	Participants' perceptions
2	Participants' teaching approach
3	Participants' views of the required competencies
4	Effect of hospital training
5	Assessment views
6	Suggestions for improvements

Table 2: List of communication competencies and skills required as viewed by trainers during interviews

Number	Competencies and skills
1	Listening actively
2	Appropriate eye contact
3	Mirroring, echoing, reflecting and repeating
4	Adjusting voice tone with patients' voice tone
5	Reading and observing patients' nonverbal cues
6	Conducting a common understandable conversation with the patient
7	Observing signs of emotional state and reacting appropriately
8	Being nonjudgmental and emotionally detached from patients' problems
9	Being patient-centered
10	Exploring patients' opinions about their own problems and about their expectations
11	Negotiation skills

Trainers' expectations and descriptions of the resident's basic communication skills requirements were variable [Table3]. Most of the participants had confused views between the competencies and the skills during the expression of their views about the skills that family medicine residents should acquire during their training. An example of this was describing the clinical knowledge as a competency of communication skills:

First of all, knowledge is important; a good communicator with very poor knowledge is a positive danger!

Other descriptions of the required competencies were in the form of consultation tasks that should be performed during patients' encounters such as:

I expect a family physician to reach to a common ground with the patient, find a shared understanding of the problem and the management, which is an expected outcome that will only be reached if there is a good communication practice during the consultation.

The study participants perceived the duration spent outside family medicine during the training program negatively,

Really communication skills fade out during the trainees' rotations in hospitals.

In the area of assessment of resident's communication skills, participants had different ideas and these are listed in Table 3. Some of the statements include:

Assessment during the exam may be artificial.

Continuous process of assessment through frequent testing is better than waiting to the end.

The best way of assessment is during residents' true consultations; it would be marvelous by sitting-in or observing through cameras from outside the room.

Ideas on video-recording may be summarized in the following quote:

Video-recorded consultations are an excellent assessment tool, because they show if the trainee is using the communication skills in their real consultation.

The importance of the current examination process and the use of a checklist to highlight communication skills during simulated examinations were described by a trainer as:

The communication skills assessment in our exam checklist is the least thing to look for during assessment.

There is a need to assess both the clinical skills and communication skills each by a separate observer at the same time.

Trainers' suggestions for teaching communication skills improvement are listed in Table 4.

Some of the trainers' suggestions in the context of continuing training included statements such as:

Observing residents directly like 6 consultations over a long time 3-6 months least.

Table 3: Communication skills assessment modalities as mentioned by the trainers and their views about them

Assessment type	Trainers' views
Continuous and multiple assessments	Better than a single final assessment
Direct or indirect observation of residents during patient consultations	The best reflection of real communication skills practice
Simulated patients	Good assessment method
Checklist guidance during simulation	Crucial to the observation process
Video analysis of recorded consultations	Might be considered and could be done
Written exams (multiple-choice questions and modified essays)	Not effective methods
Oral exams	The least reflective to real practice
Combined methods (essay and video recording)	Could be a realistic approach
Patients' satisfaction	Might be considered as part of the complete assessment

Table 4: Summary of trainers' suggestions for improvement in the teaching of communication skills to family medicine board residents

Continuous training of communication skills throughout residents' training years
Increasing focus on the subject in the curriculum
Enhancing trainers' professional development by structured scientific programs
Standardizing the use of effective communication skills teaching and assessment methods such as simulations and video analysis
Acknowledging barriers posed by administration to teaching communication skills in a clinical setting

The following three statements clarify the point of standardization and governance:

All trainers, regardless of their different approaches, can agree on a list of communication skills that should be taught as basic competencies.

Provide the structure of the teaching clinics to enable the trainers' to observe and give the residents the needed feedback. This should be supported by the Saudi health commission for health specialties.

Improve checklist at simulation examination and give more weight to communication skills.

The role-model effect of the trainers on the residents' development of good communication skills was perceived as a significant component that plays an important part in teaching. One trainer stated:

I learnt from my teachers how to communicate much more than what I learnt from reading about communication.

Another trainer stated that it is a holistic approach:

Trainees should practice communication skills with everybody; the nurse, clerk, colleagues and patients till the trainee believes in his trainer communication skills.

Attitudes to patients care in communication teaching were discussed extensively by trainers during the focus group discussion:

Improve the attitude of patients' partnership, be more patient centered. We and our patients are standing on equal foot in this community. "I" the doctor is not superior to my patient and I am not in-charge of his or her health, but rather we're dealing with the problem together and to show respect for the patients.

The importance of video-recording as an effective teaching tool is again raised here as:

Video-recording has two sides of learning; one from your mistakes and another is from the patients reflection.

Discussion

This qualitative study has yielded important findings regarding teaching communication and consultation skills in the Saudi Family Medicine Residency Training Program. Trainers perceived teaching this topic as very important although difficult and challenging. The difficulties in teaching communication skills were mainly due to curriculum structure, training structure, and teaching process. In addition, assessment as the final point in the process of teaching and learning communication skills was perceived as a poor indicator. Four commonly mentioned areas seemed to be the major contributors to the difficulties experienced in teaching communication skills in this study. These areas include the amount of time that is spent in training family physicians within hospital specialties; the competencies that the trainees need to practice; the teaching methods; and the assessment [Figure 1]. Assessment has a higher contributing level as it might be another complex issue that may lead to the other three former areas.

Describing this complexity, Kurtz *et al.*^[3] stated, "Our experience over many years is that communication skills teaching and learning while highly rewarding, are complex and challenging tasks." The structure of the curriculum of family medicine mandates a hospital training as a major component of Saudi family medicine residency training as well as other reputable vocational training programs.^[4-7] There was a general impression that reducing the time of hospital training would improve the situation and that the adjustments that were made to the new curriculum would be promising in this matter and others, that is, decreasing the duration of hospital rotations. A question that might be raised is, whether this could be an opportunity or a threat in view of the unclear definition of the required competencies and other obstacles that will be discussed further.

Managing the service structure and processes of patient service with clinical teaching in an outpatient setting is a challenging quality issue. Clinicians mostly feel that it takes more time to listen to patients and explain; however, several studies have shown that there may not be much difference.^[2] The clinical setting in this study was described by the trainers as one of the best settings for teaching and assessing the true work of trainees with patients. However, teaching during true consultation is limited by some factors. For example, it is difficult to observe the use of the mixture of content skills, process skills, and perception skills required for proper assessment. In addition, observing and demonstrating important areas in physical examination, investigations, and other specified clinical skills is time consuming. Rehearsal and giving constructive feedback is a powerful tool in teaching communication skills, but seems very difficult in the presence of patients and with limited consultation time.^[3] Sunshine *et al.*^[8] conducted a nationwide study in American community health centers; they found that governance and administration complexities were the first two barriers to training family medicine residents in community health centers.

Trainers' development was also a point that was also raised as an improvement suggestion by trainers in this study. It is common within the complexity of this medical training environment for teaching communication skill to become uncomfortable and difficult. A structured approach to trainers' development with a focus on the communication skills teaching to facilitators and program directors is a mandate.^[3] Video-recorded consultation analysis and feedback together with role-play were described as powerful tools for teaching communication skills; these findings go along with an extensive literature review findings.^[9] Nevertheless, it has the practical limitations due to the barriers previously mentioned. Pendleton *et al.*^[10,11] described the use of video-recording and analysis as a learning-and-teaching approach to consultation. The potential of these tools in teaching communication skills has been described in different more recent studies.^[12,13]

Trainers' attitudes and behaviors affect the learning and teaching process to a great extent. A positive communication attitude and role-model behavior should be expected from trainers in all the situations. The attitudes of medical students were studied by Batenburg *et al.*,^[14] who found that professional attitudes do not change even after extensive communication skills training. However, extra efforts should be made by the medical educators to identify those residents at the early stage of their family medicine residency program. Assessment as a driving force to both teaching and learning was criticized by the interviewees as not reflecting the full scope of testing trainees' communication skills: the feeling that trainees show what they do during examinations is only for the sake of the examination. However, simulated patients can be used for both teaching communication skills and for assessment as was described long ago in the literature, and it has been used and recommended widely in the literature.^[1,3]

Conclusion

The difficulties in implementing effective training of communication skills are related to factors embedded in the curriculum design such as the duration spent in family medicine settings, the weight of teaching and assessing the subject, and variability of teaching methods. In addition, the organization of the family medicine training settings in terms of consultation time and communication teaching plays a part in determining the complexity. Standardization of effective communication skills teaching methods, namely video consultation, role-play, rehearsal, and feedback, was an important suggestion for improvement. Trainers' competencies and attitudes toward teaching the topic and toward their observed interpersonal and professional relationships were issues that were highlighted as challenges to teaching communication skills. The results of this study show that the duration spent by residents in the family medicine rotations should be increased and more efforts should be devoted for teaching communication skills to residents and trainers alike.

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