Development and Pilot Implementation of an Assessment-Based Communication Skills Curriculum for Medical Interns to Emphasize Doctor Patient Relationship

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Abstract: Background & Objectives: The relationship between good doctor-patient communication and improved health outcomes is well established. Communication skills cannot be adequately learnt by mere observation of the experienced physician. Methods: A curriculum was developed and piloted in a workshop to teach aspects of doctor-patient communication to medical interns. Key features of the curriculum were use of Cohen-Cole and Bird's three function approach, with emphasis on the understanding and responding to the patients' emotions using verbal and non verbal communication, listening and empathy. A pre- and post training assessment using scenarios based on common clinical situations was conducted before and after an interactive workshop. Fifteen of sixteen designated interns attended the training. Results: Pre- and post workshop assessment scores were recorded and analysed. These were highest for the history taking skills station and lowest for the lifestyle change station. Feedback was taken from the interns and faculty who assessed the students. Students appreciated the chance to participate in the workshop and could recognise what aspects of their communication needed to be improved. Faculty could appreciate the detailed planning required. Conclusion: Communication with patients is the most powerful diagnostic tool of a clinician. The three function approach is an effective model because of its focus on the emotional aspect of patient interaction. This training can serve as a reasonable foundation for interns before their graduation. [S Marathe Natl J Integr Res Med, 2018; 9(1):73-79]

Key Words: Communication Skills, Assessment, Interns, Three function approach, Curriculum, Doctor-patient relationship

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Introduction: Communicating with patients is the core clinical skill for the practice of medicine. A doctor must be able to collect necessary information from the patient in an efficient manner to make the right diagnosis, provide emotional support to relieve acute distress and communicate in a manner that leads to development of trust and treatment compliance.

Research evidence to warrant formal communication skills teaching and assessment in the curriculum is compelling.[1,2,3] The various aspects doctor patient communication that have been extensively researched over last two decades show better patient satisfaction, improved treatment compliance and increased physician satisfaction.[2,3,4] Systematic training of the students in communication skills is therefore necessary and several models have been implemented.[2,5,6,7,8] While curricula in communication skills are established and widely followed in medical schools across several countries, in the Indian context, the attention of stakeholders has been drawn more recently, following adverse doctor-patient interactions attributed to poor communication by the attending doctor.[9,10,11,12] The emphasis on communication skills competence in the Vision 2015 document[13], the Revised GME (Graduate Medical Education) draft document[14] and introduction of the ATCOM (Attitudinal & Communication Skills) module in faculty development programmes[15] by the Medical Council of India are steps in the right direction.

Disease and illness are caused by a combination of biological, psychological, and social factors. To treat the patient and restore their health requires addressing all the three factors by the treating doctor. The medical interview serves as a clinical tool to facilitate the interaction. It is also the task on which clinicians spend most of their time in a practice.[16] In order to elicit information well, it is extremely important to make the patient comfortable to open up, so that s/he is able to share the details of the problem. Thus, the medical interview entails history taking that involves eliciting information from the patient in a manner that is conducive, informative and addresses their concerns. The three function approach[1,2] is developed to reflect the above attributes of the bio-psychosocial model of illness, and therefore aligns well with the WHO definition of "health", in its 1948 constitution, as "a state of

complete physical, mental, and social well-being and not merely the absence of disease or infirmity." [17]

We describe a curriculum that was developed and piloted to teach communication skills to medical interns, who did not receive any prior formal training in communication skills and would be receiving their undergraduate degree in a few months. The teaching tool is a workshop, with an assessment based instructional design, using the three function approach as described below.

Methods: The curriculum - Based on the three function approach[1,2], a curriculum to teach communication to interns was developed. The goal of the curriculum was that the student should be a competent communicator while interacting with a patient. The objectives were to acquaint the students with the general aspects of communication such as verbal, non-verbal and the role of listening, importance of empathy, attitudinal skills and other elements of doctor-patient communication. Breaking bad news in a variety of situations was also included.

The Three function approach (Cohen-Cole and Bird): The three function approach was chosen to delineate aspects of a doctor patient interaction. Key elements of the three function approach include -

- Gathering data to understand the patient's problem
- Developing rapport and responding to the patient's emotions
- Educating, motivating and negotiating with the patient

For the first function, the emphasis is on using appropriate verbal communication and body language while questioning and listening to the patient, to draw out information from the patient accurately and efficiently. The importance of verbal and non-verbal communication for being able to perform this function accurately and effectively is highlighted. While learning about importance of listening, the learners also understand the importance of empathy in doctor-patient interaction.

The second function is given a lot of importance in this model, as it is seen to be the one that needs to be learnt over and above the history taking or data gathering function. It is the one that encompasses the psychosocial aspect. The elements include observation and acknowledgement of emotion in the patient (reflection), acceptance of patient's emotions (legitimation), letting the patient know the desire to help (offering support) and to involve the patient in planning/choice of treatment (partnership) throughout the interview, showing respect for the patient using attentive listening, nonverbal signals and verbally (respect).

The third function is educating, motivating and negotiating with the patient. Educating patients about their illness and motivating them to adhere to treatment plans combines the understanding based on the above two steps to determine the next course of action. It involves ensuring that the patient understands the plan, agrees and accepts it and demonstrates willingness to implement it. It also includes negotiation skills, in case they need to convince a patient (and family if required) to get an agreement on the treatment or management plan for best patient outcomes in the given context.

Assessment: To elicit skills identified using the three function approach in patient situations, an objective structured communication skills exam (OSCE) was developed to observe and assess doctor-patient communication in four common clinical situations likely to be encountered by the interns (Table 1).

Table 1: Situations and competencies identified to assess and teach elements of the medical interview

Station Name	Competencies
History Taking	Information gathering ii. Dealing with anxious patients iii. Demonstrate five response skills (reflection, legitimation, support, partnership & respect)
Taking Informed Consent	Clearly explain of procedure ii. Resolve all queries of the patient iii. Inform about associated risks
Change in Lifestyle	i. Elicit patient's understanding of the illness ii. Discuss treatment plan iii. Negotiate and convince the patient
Weaning Practices	i. Assess understanding of the patient ii. Identify/elicit reasons for compliance failure iii. Offer support

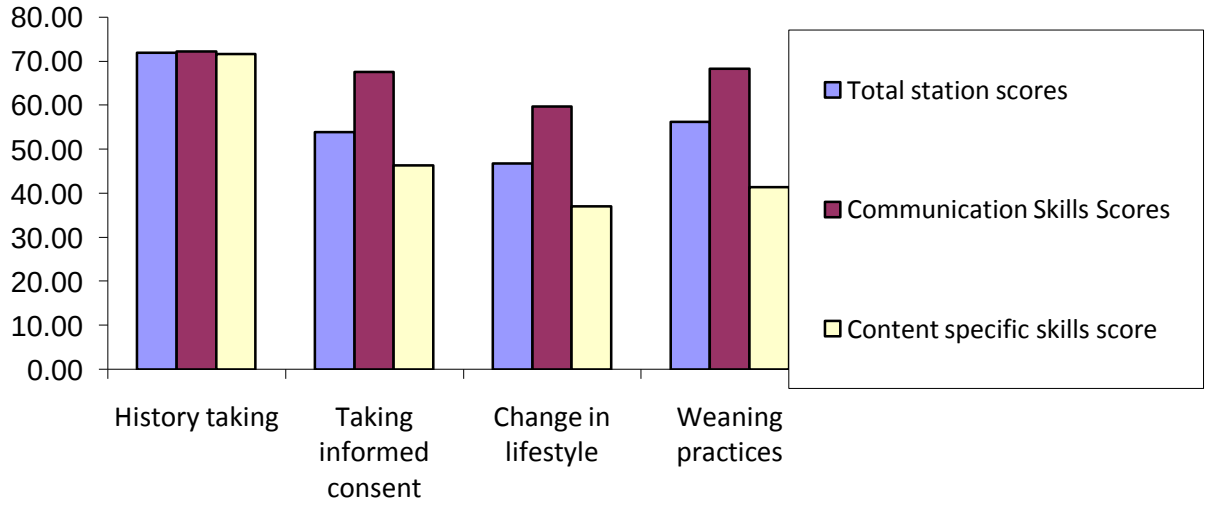
For each of the situations, scenarios, objectives, tasks and checklists were developed and finalised by

consensus between the authors (Appendix 1). Each checklist had an overall communication competency list and station (scenario) specific competencies. Hence each checklist had both general and some specific attributes to be assessed. (Annexure 1) It was decided to conduct a pre-workshop OSCE to assess students' performance prior to training. Task related instructions were designed for all stations for students and assessors. Standardised patients were trained to portray the scenarios with accuracy and consistency. Both content and communication were assessed for each situation. The length of each station was 10 minutes. The curriculum was organised in the form of an 8 hour workshop, consisting of a two hour sensitisation the day prior, followed by a six-hour full day workshop the subsequent day. The presentations, activities, handouts and other resource materials for students were prepared using the three function approach as reference. Medical undergraduate faculty were included to assess the participating interns on the pre-workshop OSCE, and observe the training. Institutional Ethics Committee approval was taken.

Intervention: Sixteen interns posted in the department of community medicine were enrolled for the workshop. They had already completed their internship rotations in other clinical departments such as medicine, paediatrics, surgery and obstetrics and gynaecology. Informed consent was taken from all participants. The training started with an assessment on the four OSCE stations. Each intern's interaction with the standardised patient was directly observed by a faculty member who observed and marked on each station. This was followed by the workshop. The format was highly interactive, with opportunity to assess, learn, practice and reassess the defined skills and competencies. A post workshop OSCE was conducted on the same stations observed by the same assessors. At the end of the workshop, the interns were asked to reflect on their learning. A retro-pre self-assessment by the interns was also conducted. Open ended questions were used to obtain feedback from interns and faculty. Participants were asked to describe what went well, what could be better and their opinions about the OSCE experience.

Results: Fifteen of sixteen designated interns attended the training. Table 2 shows the communication scores and content specific scores for each OSCE station. The content specific scores were highest for history taking, followed by informed consent and weaning practices and least for lifestyle change. The communication skills scores were highest for the history taking station and lowest for the lifestyle station.

Figure 1: Pre- and Post Training Station-wise OSCE Scores



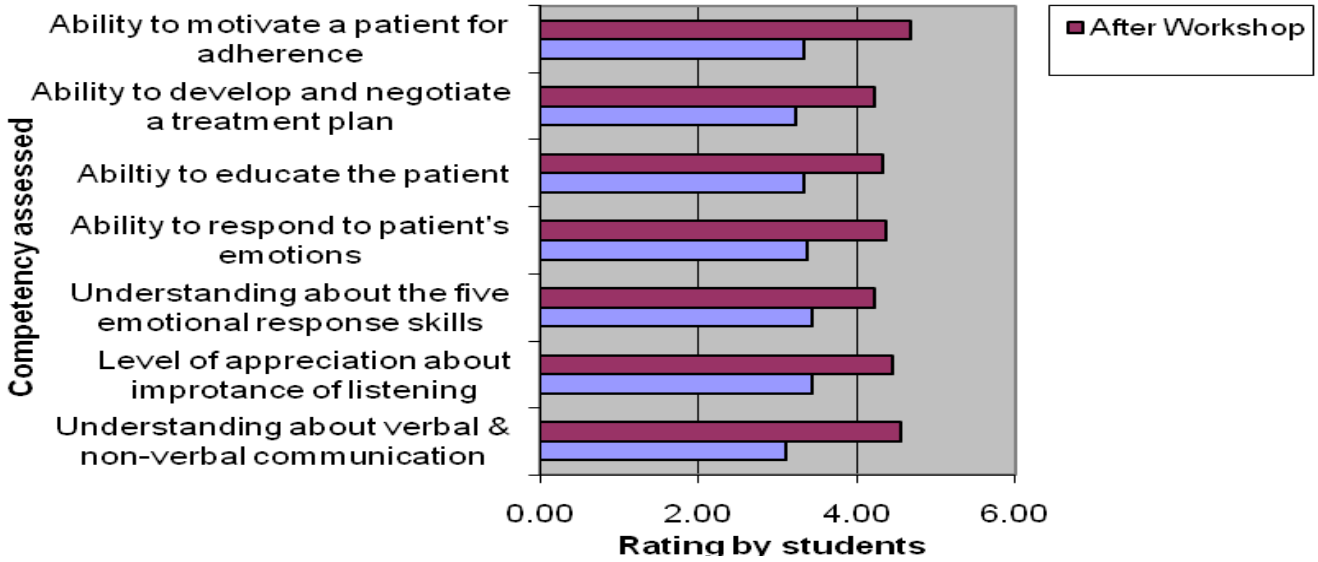
Feedback: Students appreciated the chance to participate in the workshop and express their views, use of role plays and interactive discussions. They could recognise what aspects of their interviewing skills needed to be improved as well as the importance of listening. Use of a systematic approach to take informed consent was observed for the first time and much appreciated. The OSCE format was

liked because it eliminated bias due to its standardisation uniformity and systematic approach.

The situations were relevant and most participants had encountered similar situations in their internship rotations. They also expressed desire to learn from more case scenarios and suggested that the curriculum could be introduced from earlier years of clinical training. 77% were comfortable with standardised patients while 23% were not so comfortable.

Faculty feedback revealed that as they were oriented to the format prior to the workshop they recognised the detail that had gone into the exercise in the planning phase. They liked the interactive instructional format, including role plays, checklists and opportunity to practice marking the checklists during the orientation training. Use of standardised patients was also well accepted. A retro-pre assessment using a scale of 0 to 5 to assess improvement in competencies following the training showed consistent gain (Figure 2).

Figure 2: Interns' self perception about their communication competencies (retro-pre assessment)



Discussion: A communication skills curriculum for graduating interns was systematically developed and successfully implemented. The key strengths of the intervention were the three function approach that emphasises understanding of patients' emotions, acquisition of skills to provide emotional support throughout the encounter and the curricular design which was performance centred. The contextual tasks and active engagement workshop design were added strengths to optimise transfer of learning.

The three function approach is one of the earliest models of doctor-patient communication emphasising a shift from the biomedical to bio psychosocial model of disease.[18,19] It delineates the emotional skills into various components which are otherwise difficult to learn and translate into a new behaviour. It has been successfully implemented elsewhere.[2,20]

We chose the curricular model with care and studied it in depth, to ensure contextual relevance to integrate with existing knowledge, practices and prior learning regarding history taking. The three function approach made it easy to relate to the task being performed, rather than simply a list to be checked off. Aspects that were emphasised in the sessions related to generic skills such as listening, non-verbal and verbal communication. Communication techniques to understand and deal with emotions, empathy and breaking bad news were additions to the clinical and history taking skills interns had already learnt in clinical rotations as students. This gave a sense of adding to their existing skills rather than giving the feeling of learning something that was totally new.

A unique aspect was that the assessment (OSCE) was designed along with the objectives of each station. Thus the objectives and assessment were aligned in a true sense. The use of tasks to assess performance as a trigger at the very beginning of the workshop further emphasised alignment of the teaching-learning with

assessment as well as brought out the learning gaps for both the student and the observing teacher. This instructional design strategy is in alignment with established and widely used curricular models[21.] The gain in performance on various tasks is indicative of the learning. Scores on simpler stations were higher (History taking) as compared to stations that were more complex (Lifestyle change) and involved negotiation and motivation tasks. The OSCE format was appreciated by students who saw it as a fair and unbiased method of assessment. For the teachers, OSCE was an opportunity to observe performance, which is a neglected aspect in current assessment practice in India.

The workshop format used active engagement techniques, was interactive, assessed competence, demonstrated required skills through role plays. Sharing of experiences was novel and liked by the interns as conventional learning is didactic without much opportunity for interaction. The interns' reflection on learning lead to sharing of insights and determination of actions that they did not perform earlier, but recognise and will do now. Reflection also gave them a process for being able to use opportunities in future for furthering their own learning.

The relationship between student centred instruction, deep learning approaches and positive learning outcomes is demonstrated in literature. [22,23] We sought to build a student centred curricular approach that would enthuse both students and faculty, by demonstrating a teaching-learning and assessment process that they found meaningful. The curriculum was relevant, with realistic tasks and easy to relate to, for both participants and faculty because of similar situations encountered in rotations by the interns.

The faculty too gained the insight that passive learning or learning by observation is not enough. It also emphasised the need for teachers to role model the desired communication skills. For the authors it was an opportunity to learn the finer nuances of doctor-patient communication and understand the complexities involved.

A lot of factors need to go into planning the faculty development for communication skills teaching, as the faculty have no prior exposure to a formal curriculum. Willingness to adopt the curriculum by faculty needs an internal conviction rather than an externally driven approach. Thus the communication model and the instructional strategy must be robust. The three function approach combined with an assessment based learning strategy that actively engaged the students was successful in achieving the objective of implementing the communication skills curriculum. Adequate resources must be available for successful adoption and integration into the curriculum.

Introduction of ATCOM by the MCI has enhanced the interest in teaching and learning communication skills. Other efforts from India have also reported positive results in terms of skill acquisition and attitudes of participating students and faculty.[24,25] While the introduction of communication skills will benefit the undergraduate students, through this study we attempt to provide a module that can serve as a "crash course" for interns, who missed the training in their undergraduate years.

This was a pilot for only one group of interns. After implementation, we soon realised that a simple addition of immediate feedback to participants on each station can convert the assessment into a powerful teaching tool. The curriculum was implemented towards the end of undergraduate training. Learning a skill requires repeated practice. Therefore earlier introduction of the curriculum is important. The potential for expansion through vertical and horizontal integration must be realised.

Conclusion: Communication with patients is the most powerful diagnostic tool of a clinician. Learning to use it well is not an optional skill. It must be mastered for its key benefits of better patient outcomes, patient satisfaction and physician satisfaction. The three function approach is an effective model because of its focus on the emotional aspect in building upon the prior learning of the interns during their undergraduate years. A training that emphasises learning of emotional skills, is designed with an assessment focus and engages learners actively, combined with feedback can serve as a reasonable foundation for interns before they leave the precincts of their alma mater for learning and self improvement in the future years.

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