

Attitudes of Sri Lankan Medical Students toward Learning Communication Skills

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ABSTRACT

Introduction: The General Medical Council of the UK, advocates that by the end of their undergraduate course, medical students should be proficient in communicating with patients. However, the attitude of some medical students toward formal training in communication skills seems lukewarm. Although several studies on assessing attitudes of medical students on learning communication skills have been carried out in Europe and America, Asian studies are very few and literature in the Sri Lankan context is lacking. To explore the attitudes of first to fourth year medical students of the Faculty of Medicine, University of Peradeniya (FOMUP), Sri Lanka on learning communication skills and to identify possible factors that may influence student attitudes. **Methods:** A total of 675 students from year 1 to 4 of the FOMUP were asked to complete a modified version of the Communication Skills Attitude Scale. Items of its positive attitude scale (PAS) were analyzed together while negative items were considered individually. **Results:** Response rates ranged from 70% to 98% for the various year groups. There were no significant differences between the PAS for males and females and for those exposed to formal training and those who were not. The junior students scored significantly higher on the PAS than seniors. Most students of all the groups disagreed with the item “I don’t see why I should learn communication skills”. Approximately one-quarter of the students of each group endorsed the statement “Nobody is going to fail their medical degree for having poor communication skills”. Out of the students who have undergone formal communication training, almost one-third agreed that they find it difficult to take communication skills learning seriously. **Discussion:** Although medical students seem to have realized the importance of communication skills training for the practice of medicine, a significant minority have reservations on attending such sessions. Sri Lanka faculty will need to make a concerted effort to change this attitude through improving teaching and assessment strategies.

Keywords: Attitudes, communication skills learning, medical students, undergraduate

Introduction

Effective communication with patients is a well-established outcome of medical education worldwide.^[1-3] The General Medical Council (GMC) of the UK advocates that by the end of their undergraduate program, medical students should have acquired and demonstrated proficiency in communication.^[4,5] Research has shown that good communication skills can improve the patient–physician relationship and are related to positive health outcomes for patients, including better

compliance, satisfaction with care and benefits to physical and psychological health.^[6,7] In addition, good provider communication skills have been linked to more efficient health care organizations and effective health care delivery, provider satisfaction, and fewer malpractice lawsuits.^[8-11]

In response to the GMC’s recommendation, many medical educators have developed new communication curricula. This resulted in many studies being conducted world over on the attitudes of students on learning communication skills and the identification of factors affecting communication skills learning. The literature over the past decade or so revealed that many researchers had identified the existence of both positive and negative attitudes^[12-14] while some identified factors such as previous educational experiences, age, gender, and communicative ability as affecting the medical students’ attitudes toward communication skills learning.^[12,15-19]

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Although the review of the literature revealed many studies conducted in the Western context, studies in the Asian context are few^[14] and data in the Sri Lankan context are lacking. As described by Hofstede,^[20] in countries where there is a large power distance between people interacting, providing information to the less powerful person—such as a doctor's communication with the patient—is considered less important and therefore the information provided is often limited. In Sri Lanka the hierarchical nature of the health care system also results in a tendency to constrain information. With globalization and changes in societal demands of its physicians this situation is becoming less of a problem. Nevertheless, it remains important to study how students view communication skills learning/teaching in the Sri Lankan context.

In Sri Lanka, entrance into medical school is extremely competitive. Selection of students to state medical faculties is made by the University Grants Commission, the apex body in the Sri Lankan university system. Selection is based on students' performance in an advanced level examination, which is purely written and assesses students' knowledge in physics, chemistry and biology. While teaching and evaluation leading up to the advanced level examination is in students' native language, which is Sinhala or Tamil, medical education in Sri Lanka is carried out in English, a second language for all. This situation may also affect student attitudes on learning communication skills.

This study assesses the attitudes of Sri Lankan medical students across the years of study at the Faculty of Medicine University of Peradeniya (FOMUP) toward learning communication skills. We also sought to identify factors that may influence attitudes toward learning communication skills, such as gender, exposure/nonexposure to formal training in communication skills, and the duration of the course (seniority in the medical faculty) among a group of Sri Lankan students, which could be helpful in setting directions for planning such programs.

Methods

The FOMUP is one of the eight medical faculties in Sri Lanka. The curriculum in the FOMUP up to the year 2005 was discipline-based with preclinical, paraclinical, and clinical distinction maintained in relation to teaching/learning and assessment. In this curriculum formal teaching of communication skills was not a feature although opportunistic teaching and learning would have taken place. However, the subject benchmark statement in medicine agreed to by the committee of vice chancellors and directors and the University grants Commission of Sri Lanka in 2006 states that a graduate is required to be competent in interpersonal communication skills such as listening, explaining, mediating and negotiating with patients, care givers other health care professionals, and colleagues in

the native languages as well as English.^[21] The FOMUP, having realized the potential benefits of providing training in effective communication well before the statement was released, introduced a stream on Communication, Learning, and Research (CLR stream), which is conducted from year 1 to year 4 of the medical course. In the first two years of the medical course, a total number of 45 hours have been allocated per semester for this stream. In the second semester of the first year 15 hours were allocated for communication skills learning while teaching of English continued throughout the program. The module on communication skills was known as effective communication skills development through student assignments (eCSSA) program and its objective was to sensitize students to the principles in communication that need to be followed at the work place. The teaching/learning methods included role plays and student assignments carried out in small groups while the students were provided an opportunity to practice skills such as active listening, giving simple instructions, health education, teaching peers, letter writing, and expressing ones ideas during these sessions. Most of the sessions were task-based and the students received peer and teacher feedback. Assessment was through a written paper and two objective structured practical examination (OSPE) stations at the end of semester examination. It was noted that some students as well as teachers appear to have mixed feelings about the necessity of teaching/learning communication skills where the attitude is that it is a "soft skill", which anyway can be learned easily in contrast to the highly scientific facts in the medical curriculum.

Participants

A total of 793 medical students were invited to participate in this study consisting of 209 new entrants (group 1), 200 students in the first semester of year 2 (group 2), 201 students in the second semester of year 2 (group 3) and 183 students in year 4 (group 4).

Instrument

The original Communication Skills Attitudes Scale (CSAS)^[22] developed in the UK and used by researchers the world over was selected as the data collection tool.^[14,15,23] The CSAS consisted of 26 items each scored from 1 (strongly disagree) to 5 (strongly agree). The CSAS^[22] was pretested in FOMUP by administering it to three junior doctors. Pretesting was considered necessary because the questionnaire is in English and English is the second language in the Sri Lankan context. These junior doctors were asked to comment on the structure, language, and comprehensibility of the items in the questionnaire and to make other relevant comments. On the basis of their comments, the following changes were made to the CSAS:

Modifications

- Item 2; Original – I can't see the point in learning communication skills.
- Modified – I don't see why I should learn communication skills.
- Item 8; Original – I can't be bothered to turn up to sessions on communication skills.
- Modified – It's too much trouble to attend sessions on communication skills.
- Item 11; Omitted – Communication skills training states the obvious and then complicates it.
- Item 20; Original – I find it hard to admit to having some problems with my communication skills.
- Modified – I don't want to tell anyone that I'm having problems with my communication skills (item number changed to 19).

Procedure

After obtaining ethical approval from the Ethical Review Committee of the FOMUP, the modified version of the CSAS [Table 1] was administered to the above four groups of students after a scheduled lecture. The students were asked to record their student group, age, and sex on the questionnaire itself. Participation was voluntary and anonymous.

Students in groups 2 and 3 had completed the communication module (eCSSA) in the revised curriculum while those in group 4 had no formal training in communication skills. However, this was the only group that was exposed to in ward clinical teaching. Student group 1 was neither exposed to ward teaching nor the communication module stated above.

Data analysis

Data were grouped into two subscales, a positive attitudes scale (PAS) that consists of item numbers 4, 5, 7, 9, 10, 11, 13, 15, 17, 20, 21, 22, and 24 and a negative attitudes scale (NAS) that consists of items 2, 3, 6, 8, 12, 14, 16, 18, 19, 23, and 25. The Statistical Package for Social Sciences (SPSS) was used for data analysis including reliability analysis and the analysis of variance.

Depending on the Cronbach's alpha coefficient (more than 0.7 or not) it was decided whether to use a particular subscale score or items constituting a particular subscale for the analysis. Where a particular subscale score was used, comparison was made between males and females, junior and senior students, and those exposed to and not exposed to formal training in communication skills using the two sample t significance test.

Table 1: Percentage of students of each group that agreed with the communication skills attitudes scale items

	Group 4	Group 3	Group 2	Group 1
1. In order to be a good doctor I must have good communication skills	99	97	99	98
2. I don't see why I should learn communication skills	2	7	5	1
3. Nobody is going to fail their medical degree for having poor communication skills	19	25	24	28
4. Developing my communication skills is just as important as developing my knowledge of medicine	85	79	89	90
5. Learning communication skills has helped or will help me respect patients	96	88	96	94
6. I haven't got time to learn communication skills	30	10	19	17
7. Learning communication skills is interesting	74	62	69	75
8. It is too much trouble to attend sessions on communication skills	39	34	25	11
9. Learning communication skills has helped or will help improve my team-working skills.	94	89	90	96
10. Learning communication skills has improved my ability to communicate with patients	88	67	72	68
11. Learning communication skills is fun	49	47	54	61
12. Learning communication skills is too easy	23	16	14	12
13. Learning communication skills has helped or will help me respect my colleagues	88	84	83	91
14. I find it difficult to trust information about communication skills given to me by non-clinical lecturers	20	16	19	5
15. Learning communication skills has helped or will help me recognize patients' rights regarding confidentiality and informed consent	85	79	95	91
16. Communication skills teaching would have a better image if it sounded more like a science subject	47	37	26	37
17. When applying for medicine, I thought it was a really good idea to learn communication skills	66	64	74	68
18. I don't need good communication skills to be a doctor	5	4	0	4
19. I don't want to tell anyone that I'm having problems with my communication skills	25	18	21	13
20. I think it's really useful learning communication skills on the medical degree	94	90	95	92
21. My ability to pass exams will get me through medical school rather than my ability to communicate	45	3	44	35
22. Learning communication skills is applicable to learning medicine	85	74	72	76
23. I find it difficult to take communication skills learning seriously	38	35	46	22
24. Learning communication skills is important because my ability to communicate is a lifelong skill	93	87	95	93
25. Communication skills learning should be left to psychological students, not medical students	9	4	1	4

The negative items are in italics

Results

A total of 675 medical students responded to the CSAS. Response numbers were as follows: Group 1—198 students, 94.7%; group 2—140 students, 70%; group 3—156 students, 77.6%; and group 4—181 students, 98.9%. Mean age of group 1 students was 20.7 years with 50.5% females. Mean age of group 2 students was 21.7 years with 57.3% females. Mean age of group 3 students was 22 years with 50.6% females. Mean age of group 4 students was 23.5 years with 50.8% females.

As shown in Table 1, a vast majority of students (97.99%) agreed that in order to be a good doctor he/she must have good communication skills. This was validated by a vast majority disagreeing with the statements, 'I do not see why I should learn communication skills' (74–93%), 'I don't need good communication skills to be a doctor' (89–98%), 'I don't want to tell anyone that I'm having problems with my communication skills' (56–67%), 'Communication skills learning should be left to psychological students, not medical students' (78–90%).

In contrast, 19%, 25%, 24%, and 28% of the students of each group endorsed the statement "Nobody is going to fail their medical degree for having poor communication skills" [Table 1]. However, in comparison to other groups, more students of the group with the most clinical exposure disagreed with the statement (56%). Interestingly, the percentage of students who endorsed the statement, 'My ability to pass exams will get me through medical school rather than my ability to communicate' was 35%, 43%, 3%, and 45% for groups 1–4, respectively.

As shown in Table 1, a considerable proportion of students agreed with the following statements; 'I haven't got time to learn communication skills', 'I find it difficult to trust information about communication skills given to me by nonclinical lecturers' 'Communication skills teaching would have a better image if it sounded more like a science subject' (26–47%), 'I find it difficult to take communication skills learning seriously' (22–46%).

As depicted in Table 2 the Cronbach's alpha coefficient of PAS was above 0.7 and that of NAS was less than 0.7. Therefore, only the PAS was considered for analysis at the subscale level.

Negative attitude scale was found to have a low reliability coefficient [Table 2]; therefore, its respective items were analyzed individually.

As shown in Table 3 analysis of variance concerning positive attitude scale scores indicate a significant difference between the PAS scores of some groups of students. Bonferroni post hoc

multiple comparison indicated that the new entrants (group 1) had significantly higher scores compared with group 3 students, while fourth year students (group 4) scored higher than the second semester second year students (group 3).

As shown in Table 4, the PAS mean score of groups 1 and 2 (junior students) was significantly higher than that of groups 3 and 4, senior students. Thus the junior groups of students have more positive attitudes toward communication skills training.

There were no significant differences in positive attitude scores of the students who had been exposed to formal training in communication skills (groups 2 and 3) than groups who were not exposed to a formal training in communication skills (groups 1 and 4) ($t = -1.79, P = 0.074$). There was no significant difference between male and female students in their positive attitude scores towards learning communication skills [Table 5].

Table 2: Cronbach's alpha coefficients of the positive and negative attitude scales

Student group	Positive attitude scale PAS	Negative attitude scale NAS
1	0.77	0.34
2	0.76	0.42
3	0.79	0.62
4	0.77	0.45

Table 3: Means and standard deviations of the positive attitude scale scores among the four student groups, with ANOVA comparisons

Group 1 new entrants	Group 2 year 2 semester 1	Group 3 year 2 semester 2	Group 4 year 4	F (3,674)
4.03 (0.37)	3.99 (0.39)	3.81 (0.43)	3.97(0.41)	8.68*

* $P > 0.001$

Table 4: Mean positive attitude scale (PAS) score and standard deviations for the groups 1 and 2 and 3 and 4

Student group	Mean PAS score and (SD)	N
1 and 2 (junior)	4.01 (0.38)	338
3 and 4 (senior)	3.90 (0.43)	337

Table 5: Comparison of positive attitude scale scores of male medical students vs female medical students

	Male mean (SD)	Female mean (SD)	T value and (P)
Group 1	3.98 (0.87)	4.07 (0.78)	-0.92 (0.36)
Group 2	3.93 (0.86)	3.97 (0.87)	-0.94 (0.35)
Group 3	3.74 (0.92)	3.87 (0.82)	-0.27 (0.79)
Group 4	3.91 (0.89)	4.02 (0.86)	-0.76 (0.45)

Discussion

Compared with previous studies, a strength of the current study is its large sample size and the high response rates.^[14,17,19,23-25] In our study, we did not find a significant difference between the positive attitudes toward communication skills training of medical students who were exposed to formal training in communication skills and those who were not. In a previous study, Batenburg and Small^[17] also reported that medical students' attitudes did not change substantially as a result of a communication skills teaching intervention. These findings indicate that considerable effort may be needed to initiate a change in students' attitudes about communication skill training. In the FOMUP context, the communication module was held during the latter part of the first year of the MBBS program. If it had been held in the latter part of the second year or beginning of third year coinciding with the commencement of clinical training where students actually communicate with patients, health care workers and care givers, the curriculum could have been more valued.

Rees and Garrud^[12] have shown among a group of medical students in the UK that older, more mature students have more positive attitudes toward communication skills training. Subsequently Rees and Sheard,^[22] reported that younger students have more positive attitudes toward communication skills learning. Rees and Garrud also found that the strongest correlate of negative attitudes toward communication skills learning was when students report that their communication skills did not need improving. The Sri Lankan study similarly found that the most junior students had more positive attitudes than their senior counterparts. Wright *et al.*, based on a US study, reported that the fourth year students did not differ from first years in terms of attitudes toward communication skills training, but they had significantly higher confidence scores about communicating with patients.^[24]

Despite the current emphasis on communication skills training two other studies have also reported that the PAS scores do not increase significantly.^[23,26] The literature suggests that the learning context could have a negative influence on students' attitudes toward learning communication skills.^[27] Thus, it is possible, as indicated by Lunz and Bashuk,^[28] that during the course of the medical training Sri Lankan medical students also adopted the biomedical model of illness, which does not place much emphasis on communication skills during student training and evaluation. In the Biomedical model of illness, the emphasis is principally on diseases and their management as opposed to managing the illness of an individual. However, the fact that the positive scale score of the fourth year group of students (the only group with ongoing clinical training) was

found to be significantly higher than the second year group of students could be interpreted to reflect the positive impact of the clinical training on communication skills development.

Research has repeatedly shown that female medical students have more positive attitudes toward learning communication skills than males.^[15,19,29,30] Moreover, a recent meta analysis indicated that female physicians are more likely to perform more patient-centered communication behaviors, such as collaborative communication, empathic communication, and giving psychological information.^[29] We did not observe a significant male–female difference in positive attitudes toward learning communication skills. A study carried out in Nepal, had a similar outcome.^[14] Thus, it could be that in the South Asian setting male and female students do not differ in their regard for communications training. Perhaps this is a consequence of development and globalization that gender groups have become more homogenous.

In a recent study carried out among first year medical students in Indonesia, more than half indicated that their ability to pass exams will get them through medical school rather than the ability to communicate, and nearly half indicated that they find it difficult to take communication skills learning seriously.^[25] In the Sri Lankan context, approximately one-fourth of students endorsed this same notion. However, in comparison to other groups more students of the fourth year group, with the most clinical exposure disagreed with the statement while they also reported a significantly higher score for the positive attitude scale compared with the second years indicating that clinical training may have made them realize the importance of communication skills for graduation. It can be assumed that the format of the final year exam, which places more emphasis on communication skills, is a contributory factor.

Limitations of the study

We sought responses to a validated structured questionnaire. Since English is the second language, students may have had problems in interpreting the questionnaire. Focus group discussions exploring the factors perceived to contribute to negative attitudes could have reinforced the conclusions. The response rate in the group not exposed to the communication skills module was much higher than the group exposed to the communication skill module, which could have affected the results in terms of the respondent groups' relative representation of their underlying population.

Conclusions

Student perceptions generally see the relevance of good communication skills to medical practice but do not value the communication skills component in the undergraduate

medical curriculum. It could well be that the hidden curriculum facilitates the adoption of the biomedical model of illness, which discounts the importance of communication skills for physicians.

We recommend that the FOMUP make a concerted effort to change these negative attitudes of students by improving the teaching and assessment strategies of the communication curriculum. The faculty should provide opportunities for students to learn communication skills throughout the five-year undergraduate course and strengthen the training by conducting regular staff development workshops. Since assessment drives learning, it would be desirable to incorporate communication skills assessment in the final year examination.

Future research

A study exploring the attitudes of teachers would be helpful in drawing up strategies for staff development. A qualitative study to explore factors affecting communication skills learning during clinical training would also help the school develop a better program.

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