# HEALTH COMMUNICATION TRAINING FOR PHYSICIANS: A QUALITATIVE STUDY AMONG UFS MEDICAL STUDENTS

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## ABSTRACT

*Complaints from patients about their doctors' communication have been on the increase during the past decades. A certain group of researchers are of the opinion that doctors find themselves fully in the world of human sciences as they are working with psychologically-burdened people all the time, whilst others suggest that doctors are "pure" scientists, dealing only with diseases and sick bodies. In view of the overburdened schedule of medical students trying to cope with various medical curricula, communication as a fully-incorporated subject has not been high on the international agenda. However, a literature and applied research study has shown a definite shift of perspective toward the need for focused communication education. Although there is general agreement about the inferior quality of communication in the medical context emanating from health professionals, it is extremely difficult to pinpoint the locus of communication barriers. Medical students at the UFS, excluding first-years, were asked to participate in a qualitative study on the necessity of communication training in their formal curricula. The majority of students emphasised the need for practical communication training, and viewed the areas of empathy, listening, interviewing and nonverbal communication as crucially important. An emphasis on skills proved to be critical, whilst the students indicated a definite need for practical skills training during all years of training.*

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## INTRODUCTION

Communication in the health and medical contexts in particular, is essentially a critical process which can either improve or harm the potential of health care delivery. If health and medical care transactions and communication can be applied and executed in a systematic manner, the messages exchanged between the participants in the process can become more relevant and successful (Clift & Freimuth 1995) with positive outcomes for both the individual as well as society as a whole.

Across the globe all people are daily compelled to communicate with professionals in the health and medical context, very often in order to stay alive, and preserve vestiges of quality of life. It should be noted, however, that perceptions (even in the academic world) still prevail that medical services should not primarily be viewed as "human sciences" but rather as science *per se* (Barnlund 1976; Dickson, Hargie & Morrow 1993; Pendleton & Hassler 1983). Northouse and Northouse state emphatically that "[they] recognize that the increasingly complex and multifaceted nature of health care delivery requires professionals to have a broad understanding of communication. It also recognized that technological advances in health care demand high levels of sophistication in how people communicate with each other about health issues" (1992:xi). Tubbs and Moss (1994:215) suggest that "[f]or doctors to treat patients effectively, they must gain patients' trust and cooperation. It is for this reason that doctors are training medical students to increase their understanding of nonverbal communication and develop better listening skills".

A recent publication in this regard (Smith 1999) emphasises the inadequacies of medical care today, from the failure of health care professionals to see the person with the disease, to the many ways in which managed-care organisations jeopardise the doctor/patient relationship.

The circumstance in South Africa also demands that the general practitioner in particular, but actually all medical professional persons, should have proficient communication knowledge and skills to enhance quality medical care which contributes to the patient's general welfare and healing.

## HEALTH COMMUNICATION

Most early definitions of health communication limited it to the study of health care contexts. Cassata (in Clift & Freimuth 1995: 68)

defined health communication as "the study of communication parameters (levels, functions, and methodologies) applied in health situations/contexts". Others such as Kreps and Thornton say that health communication is "human interaction in the health care process" (in Clift & Freimuth *ibid.*). The latter is certainly a more pragmatic perspective to work from.

In a literature study on health communication, studies outside the health care context were primarily dominated by studies about health campaigns relaying information. More recently, and partly in response to the AIDS epidemic, health communication scholars have broadened their scope, even though they have still clung in part to the unfortunate dichotomy between interpersonal and mass communication.

Ellis and Whittington (in Dickson, Hargie & Morrow 1993) circumscribe the health context as one of the sub-sections of what is being called the "interpersonal professions". Any doctor gives directions and instructions, offers comfort and provides relief, interprets symptoms, receives information and message feedback and lastly completes assignments. The more effective and purposeful a doctor can communicate, the more successful he or she will be in the role of a "servant" of health and healing.

There is a definite relationship and connection between the doctor, being the communicator, and the patient as receiver. This "connection" is situated in the interactional message transfer between these two participants in the communication process. Both participants use certain codes to encode (formulate and construct) and decode (understand by breaking down) their messages during the process of message transmission and feedback, whilst the content of the messages in this case mainly centres around medical and health-related problems.

The desired result of communication – shared meaning – as the most important and crucial aspect of the process, emerges in health transactions from the interplay between the content and relationship dimensions of messages. Developing relationships is important because it influences how content will be interpreted. Given the multidimensional assumption of human communication, effective communication is more likely to be achieved when health professionals are equally attentive to both the content and relationship dimensions of messages (Northouse & Northouse 1992 : 8).

## COMMUNICATION BETWEEN DOCTORS AND PATIENTS

Much of the research on health communication has been done outside South Africa. The findings have been marked by contradiction and fragmentation about the locus of the communication problems between the doctor and his or her patient. As for South and Southern Africa, there is a definite lack of research on this issue.

In the available literature on health and medical communication, numerous references to problems about the quality of communication between the general physician and patient are found (Taylor 1995; Von Raffler-Engel 1990).

The crucial question emerges as how to study this doctor-patient-relationship. Patients' accounts are a valid method to test the relevance and reality of interviews or consultations, although the patient seldom has a complete grasp of the totality of the events. Nevertheless, they should be the final arbiters to determine how the doctor communicates, how they have experienced the treatment, and if they feel that they were taken seriously and treated with respect. (Elder & Samuel 1987:6).

A study sponsored by the California Medical Association documented the unfortunate consequences of patient dissatisfaction with the doctor-patient-relationship. It was found that the majority of adult urban patients were critical of their physicians' behaviour, particularly the lack of human warmth and failure to demonstrate real concern. Many patients have changed physicians on this basis alone (Bernstein, Bernstein & Dana 1974:10).

Too many patients are subjected to needless high stress levels as a result of professional persons in the health care context who either deny or are unaware of the importance and value of good communication.

A survey of 1 000 families in an industrial city of 350 000 located in the northeastern United States was undertaken by Korsch and Negrete (1972). While they found marked dissatisfaction with medical care in only 17 % of the cases, specific aspects warranted more criticism than others. Of the total respondents, 51% criticised physicians for their unwillingness to make house calls and for their insistence that a sick patient be brought to the office or to a hospital for examination, while 47% of these families also expressed dissatisfaction with the physician's management of his office practice, such as having to wait an hour or more beyond the appointment time before being seen (Bernstein, Bernstein & Dana 1974).

According to Ray (as well as informal discussions with locally qualified doctors) there are not many available and unoccupied hours during the medical student's training as doctor to give devout and focused attention to the development of communication skills and interactional knowledge contents. " ... students become involved with the 'clinical' side of medicine - taking histories, making tentative diagnoses, considering treatment options. However, there is little attention given in most medical schools to learning how to interact with patients. Communication skills are often given short shrift at this point, and students often feel this lack - they feel horribly inadequate for the task of talking to patients" (1993:12).

There is ample evidence of research on patient dissatisfaction, proving that health professionals and/or doctors are in dire need of certain interpersonal skills. Tubbs and Moss (1994:216) quote a Harris-sample which shows that patients changing from general physician, mainly do so as a result of dissatisfaction with doctors' poor communication knowledge and skills. Five of the seven general reasons for patients changing their doctors, centred around communication inefficiencies.

References to problems, questions and research are rife in available literature on health and medical communication, very often (as noted before) pointing to the problematic relationship between the physician and the patient (Taylor 1995; Von Raffler-Engel 1990; Porrit 1990; Calnan 1983). These studies mostly focus on different perspectives on critical factors affecting this important relationship between doctor and patient. "For doctors to treat patients effectively, they must gain patient trust and cooperation. It is for this reason that doctors are training medical students to increase their understanding of nonverbal communication and develop better listening skills" (Tubbs & Moss 1994:215). The crucial question still remains on which issues to focus during training, and how and when to undertake this training.

## RESEARCH PROBLEMS

Due to the qualitative nature of this study, the research problems are not put forth as falsifiable hypotheses. Explorative and open-ended research questions were being used to elicit the widest possible number of answers. The most prominent issues or problems relating to this study can be stated as follows :

- Determining whether medical students believe that they need specific communication knowledge contents, skills and insight to deal optimally with their future patients;
- Identifying those factors/themes determining or affecting the effectiveness of the communication process in a medical context, as well as the participants in the process, thus providing a list of issues critically important to quality physician-patient-communication;
- Attempting to isolate a study year(s) which students perceive as the best time for the training of these contents and skills; and
- Determining which teaching methods for the training of these knowledge and skills should be incorporated in order to advance the skills of future physicians.

## RESEARCH METHODOLOGY

The research in this study was approached from a qualitative angle in order to explore and interpret the troublesome doctor-patient-relationship. The primary aim was to gain a better understanding and rooted knowledge regarding the nature of the communication relationship between a doctor (general physician) and his/her patient(s). Written protocols (a questionnaire with complete open-ended questions and probes) were collected from a population of second-year to fifth-year medical students at the University of the Free State's Faculty of Health Sciences. After collection and analysis of the specified data, the related findings were applied in a scientific-responsible manner in order to provide certain points of departure for a tertiary training model of health communication for future doctors.

Maykut and Morehouse (1994:26) motivate the preferred qualitative angle chosen for this study when they state that a human investigator "can explore the atypical or idiosyncratic responses in ways that are not possible for any instrument which is constructed in advance of the beginning of the study". The interview schedule was drawn up after the development of a focus of inquiry based on the literature research. Typical probes – as in question 6 – were applied in order to go deeper into interview responses (Patton in Maykut & Morehouse 1994:95). This was done in order to gain a deeper understanding of the respondents' experiences and perspectives, particularly in view of the problematic nature of the research topic.

## COLLECTION OF DATA

It should be mentioned that it was particularly difficult to gain access to students via lecturers for the completion of the open-ended questionnaires consisting of six main areas of research. In some of the academic year-groups, lecturers merely stated that there was no time available in their classes for students to assist in this study, which may already signify one problem regarding communication: too little time for the study field of communication.

A total of 170 students participated by completing the questionnaire: 91 second-year students, 57 third-years, 12 fourth-year and 10 fifth-year students. No questionnaires could be gathered from the sixth- and seventh-year students who were mainly busy with hospital and community duty. It should be kept in mind that all of these groups had completed a semester course in communication — consisting of two theoretical lectures per week — in their first study year. No practical lecture periods had been offered as a result of crowded time-tables and curricula.

An open-ended questionnaire consisting of six questions were distributed with the help of one staff member concerned with curriculum planning and education at the Faculty of Health Sciences. The responses were noted as they appeared on the questionnaires and arranged according to frequency of responses in every category.

## RESEARCH FINDINGS

**(RAW DATA)**

| Year of study | 2nd year | 3rd year | 4th year | 5th year | Total | % |
|---|---|---|---|---|---|---|
| N = | 91 | 57 | 12 | 10 | 170 | 100 |

### 1. How important do you deem communication training for medical practitioners during tertiary study years?

| Response | 2nd year | 3rd year | 4th year | 5th year | Total | % |
|---|---|---|---|---|---|---|
| Critically/extremely important | 36 | 34 | 6 | 8 | 86 | 51 |
| Very important | 42 | 11 | 3 | | 57 | 34 |
| Important | 10 | 9 | | | 19 | 10 |
| Relatively important | 1 | | | 1 | 2 | 1 |
| Only important and necessary during clinical training years | | 1 | | | 1 | ,5 |
| Meaningful | | 1 | | | 1 | ,5 |
| Not important at all | 1 | 1 | | 1 | 3 | 2 |
| Skills will develop naturally in own time, no study/lectures needed | 1 | | | | 1 | ,5 |
| Of no value whatsoever | | | 1 | | 1 | ,5 |
| It is a waste of time since I can communicate without any training | | | 1 | | 1 | ,5 |
| No person should have to learn/study it — aspirant doctors must have the skills already in view of the importance thereof. They must be selected on the basis of human-orientated skills. | | | 1 | 1 | 2 | 1 |

## 2. Why do you see this type of training as important or not important?

| Response | 2nd year | 3rd year | 4th year | 5th year | Total | % |
|---|---|---|---|---|---|---|
| You interact with people all the time/medicine is a human science | 26 | 12 | 1 | 5 | 44 | 26 |
| To make patients feel at ease and to have them trust you | 17 | 9 | 3 | 2 | 31 | 18 |
| Communication is only link between doctor and patient | 18 | 6 | 1 | 3 | 28 | 16 |
| To get better patient histories and make correct diagnosis | 4 | 18 | 1 | | 23 | 14 |
| In medicine people should be approached holistically | 13 | 5 | | | 18 | 11 |
| It is important in order to form a correct diagnosis | 18 | | | | 18 | 11 |
| When people understand one another, you will get better solutions | 11 | 4 | | | 15 | 9 |
| To communicate better with patients | 13 | | | | 13 | 8 |
| Patients recuperate better if doctor is a good communicator | 10 | | | 1 | 11 | 6 |
| To explain treatment and diagnoses better to patient | | 3 | 1 | 4 | 8 | 5 |
| There are too many complaints that doctors are always in a hurry/are uninvolved/do not listen attentively | | 4 | 2 | 1 | 7 | 4 |
| To develop empathy | 6 | | | | 6 | 4 |
| To communicate better with other doctors | 6 | | | | 6 | 4 |
| Intercultural communication skills are crucially important | 5 | 1 | | | 6 | 4 |
| Bad communicators are useless doctors | 4 | | 1 | | 5 | 3 |
| Communication determines the quality of treatment | | 5 | | | 5 | 3 |
| To make better doctors who can communicate verbally | | 1 | 1 | 1 | 3 | 2 |
| Patients must be able to associate with doctor | 2 | | | 1 | 3 | 2 |
| To know what to say to patients | 3 | | | | 3 | 2 |
| To save time | 1 | 1 | | | 2 | 1 |
| Not all medical students have the necessary interpersonal skills or communication knowledge | | 2 | | | 2 | 1 |
| To make patients feel important and cared for | | 2 | | | 2 | 1 |
| Communication skills are important | 2 | | | | 2 | 1 |
| To enjoy what you are doing | 1 | | | | 1 | ,5 |
| Because people with whom you interact can differ widely | 1 | | | | 1 | ,5 |
| To prevent litigation | 1 | | | | 1 | ,5 |
| To cope with patients' emotions | 1 | | | | 1 | ,5 |

## 3. Describe the areas of communication knowledge and skills you see as most important for a General Practitioner?

| Response | 2nd year | 3rd year | 4th year | 5th year | Total | % |
|---|---|---|---|---|---|---|
| Empathy skills | 55 | 20 | 9 | 3 | 87 | 51 |
| Interviewing skills | 50 | 24 | 8 | 2 | 84 | 49 |
| Good listening skills | 41 | 24 | 7 | 6 | 78 | 49 |
| Nonverbal communication | 39 | 19 | 6 | 3 | 67 | 39 |
| Verbal communication skills | 18 | 15 | 2 | | 35 | 21 |
| Intercultural communication skills | 7 | 8 | | 1 | 16 | 10 |
| Interpersonal skills | 7 | 3 | 5 | 1 | 16 | 10 |
| Language skills/verbal skills | 8 | 1 | 3 | | 12 | 10 |
| Empathy and listening | 6 | | | | 8 | 4 |
| Understanding and patience for patient's inability to use or understand medical language | 3 | 3 | | | 6 | 4 |
| Develop trust between doctor and patient | 5 | 1 | | | 6 | 4 |
| Good examining skills and touch | 4 | 2 | | | 6 | 4 |
| To work patient-centered | 1 | 4 | | | 5 | 3 |
| Good conversational skills | 3 | 1 | | | 4 | 2 |
| How to convey bad news | | | 2 | 2 | 4 | 2 |
| Sign language for handicapped | 1 | 1 | 1 | | 3 | 2 |
| Communication with families and close-of-kin of patients | 2 | | 1 | | 3 | 2 |
| Basic skills to know that people also get sick psychologically/emotionally | | 2 | 1 | | 3 | 2 |

| | | | | | | |
|---|---|---|---|---|---|---|
| To avoid communication and understanding gaps | 2 | | | | 2 | 1 |
| Communication with personnel | | | 1 | 1 | 2 | 1 |
| A better understanding of death | 1 | | 1 | | 2 | 1 |
| To handle problem patients | | 2 | | | 2 | 1 |
| Conflict/confrontation | | | 2 | | 2 | 1 |
| To eliminate noise/interference in the communication process | 1 | | | | 1 | ,5 |
| Interpreting | 1 | | | | 1 | ,5 |
| Friendliness | 1 | | | | 1 | ,5 |
| For personal growth | 1 | | | | 1 | ,5 |

## 4. How should the communication training of knowledge contents and skills be provided?

| Response | 2nd year | 3rd year | 4th year | 5th year | Total | % |
|---|---|---|---|---|---|---|
| Practical skills training | 36 | | | | 36 | 21 |
| Practical sessions with pseudo-patients | 18 | 12 | 4 | | 34 | 20 |
| By means of video recordings of lecturers and self during interaction with patients | 20 | 3 | 3 | 2 | 28 | 16 |
| Practical sessions with patients and a lecturer present | 21 | 4 | | | 25 | 15 |
| Class and small-group discussions with individual participation with real patients and case studies | 13 | 6 | | 2 | 21 | 12 |
| During ward rounds with real patients | 3 | 4 | 4 | 5 | 16 | 9 |
| Practical sessions and seminars | | 12 | | | 12 | 7 |
| Direct observations of superiors | | 6 | 4 | 1 | 11 | 6 |
| Practical sessions with patients directly after a theoretical class | | 11 | | | 11 | 6 |
| Role-playing with co-students | 2 | | 1 | 1 | 4 | 2 |
| Lectures [theoretical] | 4 | | | | 4 | 2 |
| Attendance classes and follow-ups | 3 | | | | 3 | 2 |
| Interviewing with real doctors and patients | 2 | 1 | | | 3 | 2 |
| Discussions with patients about their communication experiences | | | 1 | 1 | 2 | 1 |
| Self-study | 1 | | | | 1 | ,5 |
| Individual evaluations | 1 | | | | 1 | ,5 |
| Workshops | | 1 | | | 1 | ,5 |
| Seminar once a month | 1 | | | 1 | 1 | ,5 |
| Doctors should be patients for a short time in hospital | 1 | | | | 1 | ,5 |

## 5. Which year of training for GPs would be best for communication training?

| Response | 2nd year | 3rd year | 4th year | 5th year | Total | % |
|---|---|---|---|---|---|---|
| Fourth year | 22 | 5 | 4 | | 31 | 18 |
| Third and fourth years | 8 | 8 | | 7 | 23 | 14 |
| All the clinical years | 5 | 13 | 4 | 1 | 23 | 14 |
| Third | 11 | 9 | | | 20 | 12 |
| All the years | 7 | 3 | | | 10 | 6 |
| First | 8 | 2 | | | 10 | 6 |
| First, second and third | 8 | | | | 8 | 5 |
| Fourth and sixth | 6 | | | | 6 | 4 |
| Fifth and sixth year | 4 | 1 | | | 5 | 3 |
| Hospital [house-man] year | 4 | | | 1 | 5 | 3 |
| First and fourth | 5 | | | | 5 | 3 |
| Sixth only | 1 | 4 | | | 5 | 3 |
| First and second year | 2 | 1 | | 1 | 4 | 2 |
| Second and third | 4 | | | | 4 | 2 |
| Third | | | 3 | | 3 | 2 |
| First and sixth | 2 | 1 | | | 3 | 2 |
| Second year onwards | 2 | | | | 2 | 1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Second only | 2 | | | | 2 | 1 |
| Fifth | | 1 | | | 1 | ,5 |
| None | 1 | | | | 1 | ,5 |

## 6. Are there any other additional remarks you want to mention in this regard?

| Response | 2nd year | 3rd year | 4th year | 5th year | Total | % |
|---|---|---|---|---|---|---|
| Definitely should not be taught only communication theory which does not learn students anything | 4 | 10 | 2 | 1 | 17 | 10 |
| Offer communication training as a curriculum subject without exams or tests | 8 | 6 | | | 14 | 10 |
| First year too early for training — forgotten by the time when we start seeing patients | 7 | 4 | | | 11 | 6 |
| No person can learn to communicate. Communication education is a waste of time since it cannot be learnt. | 3 | 2 | | | 5 | 3 |
| Languages should be included during communication training | 4 | | | 1 | 5 | 3 |
| Process of selection for medical students is wrong — the wrong people get selected | 3 | 1 | | | 4 | 2 |
| Doctors should also study psychology in addition to communication | 2 | | | | 2 | 1 |
| When fourth years start rounds, potential doctors do not have an idea how to talk to patients | | | 2 | | 2 | 1 |
| We must start seeing patients as soon as possible | 2 | | | | 2 | 1 |
| Lecturers must be more personal during training | 2 | | | | 2 | 1 |
| Communication is neglected in the medical discipline | 2 | | | | 2 | 1 |
| Communication training must optional to choose or not in own language | | 1 | | 1 | 2 | 1 |
| First years do not need communication yet | 2 | | | | 2 | 1 |
| First year course already helped us a lot | | 1 | 1 | | 2 | 1 |
| Doctors should be courageous | 1 | | | | 1 | ,5 |
| We should learn not to separate patients and people — treat them holistically | 1 | | | | 1 | ,5 |
| Most medical students have enormous communication problems and have grown only academically during study years | 1 | | | | 1 | ,5 |
| Doctors are far too superior to other people | 1 | | | | 1 | ,5 |
| Communication training and education must be offered every year to develop gradually | 1 | | | | 1 | ,5 |
| Doctors must learn patience as well | 1 | | | | 1 | ,5 |
| Useless in SA because of cultural diversity | 1 | | | | 1 | ,5 |
| Worse communicators should get more training that those who can communicate | 1 | | | | 1 | ,5 |
| People from the industry must give communication training | 1 | | | | 1 | ,5 |
| Lecturers must be chosen well for communication training | 1 | | | | 1 | ,5 |
| Most doctors are too impersonal and apathetic | | 1 | | | 1 | ,5 |
| Faculty does not view communication importantly enough | | 1 | | | 1 | ,5 |
| Skills must be learned before exposure to patients | | 1 | | | 1 | ,5 |
| Role models [lecturers] learn students wrongly as role models | | 1 | | | 1 | ,5 |
| Doctors should tell students more about communication case studies | | 1 | | | 1 | ,5 |
| Medical lecturers also need communication training | | 1 | | | 1 | ,5 |
| Qualified doctors should also go on refresher courses in communication | | 1 | | | 1 | ,5 |
| Personal counseling | | 1 | | | 1 | ,5 |
| Communication should be treated as all the other subjects during ward rounds | | | 1 | | 1 | ,5 |
| Medical profession must respect patients more | 1 | | | | 1 | ,5 |
| Communication training must be simple | 1 | | | | 1 | ,5 |
| We should know more about stress skills | 1 | | | | 1 | ,5 |
| Class members must communicate more with one another | 1 | | | | 1 | ,5 |
| First year communication was traumatic | | | 1 | | 1 | ,5 |

## INTERPRETATION AND DISCUSSION OF FINDINGS

It should be noted that the total of responses did not consistently equate with the number of respondents completing the questionnaires, as they had occasionally recorded additional comments supplementing the main focus of the question in certain cases and actually provided two thoughts or answers which did not fully correspond.

The responses to the six open-ended questions can be briefly summarised as follows:

**Question 1 : How important do you deem communication training for medical practitioners during tertiary study years?**

It is clear that the majority of these four groups of medical students in different academic years viewed the acquisition of specific communication knowledge contents and skills as very important, and even as crucially vital to their future careers as physicians. Should the following responses – critically/extremely important, very important, important and relatively important – be added up, a substantial 96% of the respondents seem convinced that communication training for medical doctors-to-be are not even debatable.

The third- and fifth-year students were particularly positive about the importance of communication training. Only a small number (six respondents or 4%) of the total respondents (170) viewed communication training as irrelevant and unimportant – a so-called waste of time – whilst one respondent stated that it should rather be focused on during the clinical years. It is interesting to note that two respondents commented on the selection process for doctors regardless of this question they had to answer. These latter two students found themselves in the more advanced fourth and fifth years of study, and may have begun to notice which students perform better than others when involved in communication. Of the total population, only two students (,5%) were of the opinion that their communication skills and knowledge were adequate, and that communication training was a mere waste of time. Another two students felt that communication skills would possibly develop naturally over time without any specialised communication training.

**Question 2 : Why do you see this type of training as important or not important?**

No less than 27 different responses to this question were noted before saturation point was reached, although several of the responses

overlapped in the sense that they could have possible referred to the same issue. "To communicate better with patients" and "(t)o know what to say to patients" could refer to one and the same skill and knowledge content, but it could very easily imply different skills as well. These two responses might have been concerned with the same knowledge contents and skills, but since the respondents chose different wording for their answers, it would be safe to assume that they referred to various skills and knowledge contents.

It seems clear that a substantial part of the respondents from all study years understood that they were dealing with human beings and therefore found themselves squarely in the world of human sciences, in spite of the fact that they were traditionally viewed as "scientists". It was also clear that many of them realised that communication was the only available tool to reach patients, and that it was the only method to win the trust of their patients. A tangible group indicated that better "solutions" and diagnoses could be found when the doctor and patient understood one another. Quite a number of students also indicated that better communication would enable them to make better diagnoses, conduct better interviews and thus elicit quality patient histories.

A small number of responses pointed to the idea that when patients understood their diagnoses and treatment better, they might also recover and recuperate sooner. The latest trend in popular medicine which views patients as holistic beings where illness can be caused by negative emotions, also received a bit of attention as some students referred to the aspect of "holistic" treatment and the "emotional understanding" of patients.

It could be established beyond doubt that students seemed to realise the vital importance of communication training in order to contribute to the healing and health maintenance of their patients. Specific skills and knowledge contents which were pointed out in the sense that these aspects could develop as a result of communication training, were empathy, intercultural communication, verbal communication and the understanding of patients' emotions.

**Question 3 : Describe the areas of communication knowledge and skills you see as most important for a General Practitioner (GP)?**

According to these medical students, the crucially important skills when dealing with patients in the health and medical context, were *empathy, listening, interviewing and nonverbal skills* (51%, 49%, 49% and 39%). Many related studies and literature refer to good

empathy as an advanced listening skill, whilst it also forms a major part of good interviewing skills. Listening skills can simultaneously be categorised under nonverbal skills, and these answers indicated that physicians-in-training might instinctively sense what their patients might need, but that they were not certain how to execute and apply these mentioned skills.

Language and verbal skills received an equally important portion of attention (35%) if responses such as "good conversational skills" and "understanding for patient's inability to understand medical language" were incorporated. It is noteworthy that the respondents also referred to the need for skills such as "friendliness", "psychological and emotional sickness" and "good examining skills and touch", which can be seen as a combination of psychological and communication skills and knowledge.

**Question 4 : How should the communication training of knowledge contents and skills be provided?**

The majority of students indicated that they would prefer practical skills training when dealing with communication training during their study years - 21% stated "practical skills training", 20% "practical sessions with pseudo-patients", 15% "practical sessions with patients and a lecturer present", another 7% "practical seminars and sessions" and 6% mentioned "practical sessions with patients after a theoretical class" as well as a substantial portion of 12% who would like to focus on "discussions with real patients and case studies". It is noticeable that only approximately 3% of all responses indicated a positive disposition towards any kind of theoretical classes and teaching.

**Question 5 : Which year of training for GPs would be best for communication training?**

An astounding range of responses to this question were noted. The third and fourth study-years seemed a popular choice (12%, 14% and 18% combine to a total of 44%). The responses of fifth-year students who are naturally more advanced with their studies should be noted : 70% of those felt that the third and fourth years would be best for communication training. The fourth-year medical students might also have a better perspective on communication needs, and they significantly responded in favour of training during the third, fourth and all the clinical years as well. Only twenty-five responses from the total population registered an inclination toward training in their first years, although 16% of these desired to combine first-year training with other study-years such as sixth – also a more supported choice -

and second. Less than 1% responded that no communication training was needed, whilst 6% were of the opinion that all the study-years should receive consideration for communication training.

**Question 6 : Any other additional remarks you want to make in this regard?**

The last open-ended question made provision for any related remarks that the respondents deemed necessary in this regard. A remarkable number of 38 different responses were noted. Of these responses, the plea for communication training in terms of skills and NOT theory was expressed strongly. It is also clear that medical students prefer to learn skills rather than theory, and this has been confirmed by the request that no class tests or examinations should form part of the training. Off-hand responses to previous questions again came to light: communication issues such as languages, interpersonal skills, stress management, intercultural communication skills and some psychological knowledge are of concern to these students.

Other remarks with regard to communication training for medical students might be summarised as follows: the wrong people got selected for medical training and better communicators should be taken in; medical lecturers and doctors might be more personal and less apathetic during training; communication was neglected in the medical discipline; medical staff seemed superior to other people; medical staff were impatient; and that the past theoretical first-year communication training was traumatic.

## SUMMARY

It appears as if medical students in most of the study-years at the UFS felt convinced of the vital necessity for communication training, both with reference to practical skills as well as knowledge contents. It seems as if the majority of these respondents have perceived the fact that they are dealing with human beings in the first place, and that specialised skills and techniques can be the key to improved communication, with endless benefits for both the doctor as well as the patient in terms of better diagnoses and treatment; more support and empathy from the professional's side; and increased emotional well-being which might positively enhance healing and recovery of sick patients.

It could be stated categorically that the largest portion of these respondents were adamant about the necessity of practical skills training, even in the face of no theoretical education. They expressed a need for more contact with real patients in practical contexts in order for them to be better prepared by the time that they came into contact with patients themselves.

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