A STUDENT REVIEW OF DOCTOR-PATIENT COMMUNICATION SKILLS TRAINING IN THE UFS UNDERGRADUATE MEDICAL PROGRAMME

Mini-dissertation submitted as part of the structured Magister in Health Professions Education (M. HPE)
in the Division Health Sciences Education
Faculty of Health Sciences at the University of the Free State

CANDIDATE:
Dr Dirkie Swinfen
Clinical Simulation and Skills Unit
Faculty of Health Sciences
University of the Free State
Student number: 1991176015

SUPERVISORS:
Prof M.J. Labuschagne
Clinical Simulation and Skills Unit
Faculty of Health Sciences
University of the Free State

Prof G. Joubert
Department of Biostatistics
Faculty of Health Sciences
University of the Free State

31 January 2020

DECLARATION

I hereby declare that the research submitted here is the result of my own investigation. Where I sought help and advice, I acknowledged it. I am submitting this work for the first time at this university & faculty towards a Master's degree in Health Professions Education. I declare that it has never been submitted to any other university or faculty for obtaining a degree.

……..

Dirkie Swinfen 31 January 2020

I hereby relinquish copyright in favour of the University of the Free State.

…….

Dr Dirkie Swinfen 31 January 2020

DEDICATION

I would like to dedicate this work to Dr Dirkie Stander, who devoted her life to teaching medical and nursing students to care for their patients.

ACKNOWLEDGEMENTS

I wish to express my heartfelt thanks and appreciation to Prof Mathys Labuschagne for his patience, encouragement and attention to detail. Many thanks also to Prof Gina Joubert for her optimistic and dynamic approach. I learnt a lot about the art of giving feedback from both of you.

A special thanks to the medical students who contributed to this research.

I acknowledge my colleagues at the Clinical Simulation and Skills Unit for their practical help and advice over the last two years. My husband Tim and my sons Cornel and Dennis shouldered many extra responsibilities during this time – thank you!

I finally acknowledge the author of life, Jesus Christ for showing us the perfect example of how to be a teacher. Despite our imperfections, may we be useful in our service of Him.

"*What good is it for someone to gain the whole world, yet forfeit their soul*?"
Mark 8:36 (NIV)

TABLE OF CONTENTS Page

LIST OF ABBREVIATIONS & ACRONYMS

CBD	**Case-based discussion**
COT	**Consultation Observation Tool**
CST	**Communication Skills Training**
FoHS	**Faculty of Health Sciences**
HPCSA	**Health Professions Council of South Africa**
MBChB	**Bachelor of Medicine, Bachelor of Surgery**
Mini-CEX	**Mini Clinical Examination**
MSF	**Multi-source feedback**
OSCE	**Objective Structured Clinical Examination**
UFS	**University of the Free State**
WPBA	**Workplace-Based Assessment**

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

SUMMARY

One of the essential skills that a doctor requires is the ability to communicate well with patients. Not only does good doctor-patient communication improve patient outcomes, but doctors who communicate well enjoy their work more and are less likely to be litigated against. Communication skills training therefore needs to be a crucial part of the medical curriculum. There is currently very little information available as to how useful students find communication skills training at the University of the Free State, in particular during the clinical phase of their undergraduate studies. This research study focused on obtaining and analysing a review by medical students of the undergraduate doctor-patient communication skills training at the UFS. Aspects of the training that were investigated included the content, educational methods, assessment of communication skills and role modelling of communication skills.

The researcher performed a literature study, followed by a survey of fourth and fifth year undergraduate medical students at the UFS. The survey was conducted by means of an anonymous self-administered questionnaire. The content of the questionnaire was based on Harden's extended vision of the curriculum. The questionnaires were quantitatively analysed and open-ended questions were coded and qualitatively analysed, using grounded theory.

Of the fifth year students, 106 of 132 students took part (80.3% response rate), while 65 of 120 fourth year students took part (54.2% response rate).Students reported adequate training in history taking and were confident in their ability to take a thorough patient history. Limited training was reported in terms of breaking bad news and managing language and cultural differences. Students found small group interactive training sessions with simulated patients useful, as well as being observed by doctors when consulting with real patients.

Students reported multiple opportunities to practise communication with patients, but limited feedback and few opportunities to reflect and discuss how they could improve. Students commented on the inconsistency in terms of role models in the clinical educational setting. Some doctors modelled patient-centred care, while

others showed disrespect to patients. Students recommended that a greater emphasis should be placed on patient-centred communication training. Results of this study are mainly similar to other South African studies, but the preference for earlier clinical exposure came to the fore. Results of this study will be shared at several levels at the training institution, enabling further reflection, discussion and planning of doctor-patient communication skills training.

A STUDENT REVIEW OF DOCTOR-PATIENT COMMUNICATION SKILLS TRAINING IN THE UFS UNDERGRADUATE MEDICAL PROGRAMME

CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Communication is defined as “The imparting or exchanging of information by speaking, writing or using some other medium” and “The successful conveying or sharing of ideas and feelings” (Oxford Dictionary, 2018). Clinical communication is multi-faceted, including doctor-patient communication, communication with colleagues, written communication and presentation skills (Skelton, 2017:192). This mini-dissertation will focus on doctor-patient communication.

The aim of the study was to obtain a student review of the training of doctor-patient communication skills in the University of the Free State (UFS) undergraduate medical programme. This could identify potential strengths and weaknesses in the undergraduate training of doctor-patient communication so that educators can continue with good practice and address shortcomings in the curriculum or the delivery thereof. Students were asked to review the undergraduate training of doctor-patient communication skills at the UFS, in terms of the content of the communication skills curriculum, the educational methods used, opportunities to acquire communication skills and the assessment of communication skills.

The purpose of this introductory chapter is to provide a guide to this research project. Firstly, a brief overview of doctor-patient communication and the training of communication skills will be given. This will be followed by a brief outline of communication skills training in the UFS undergraduate medical programme. Subsequently, the aim of this study will be discussed, as well as the study design, methodology and ethical considerations. A schematic overview of the research process will be provided in the final part of the chapter. Figure 1.1 outlines the contents of chapter 1.

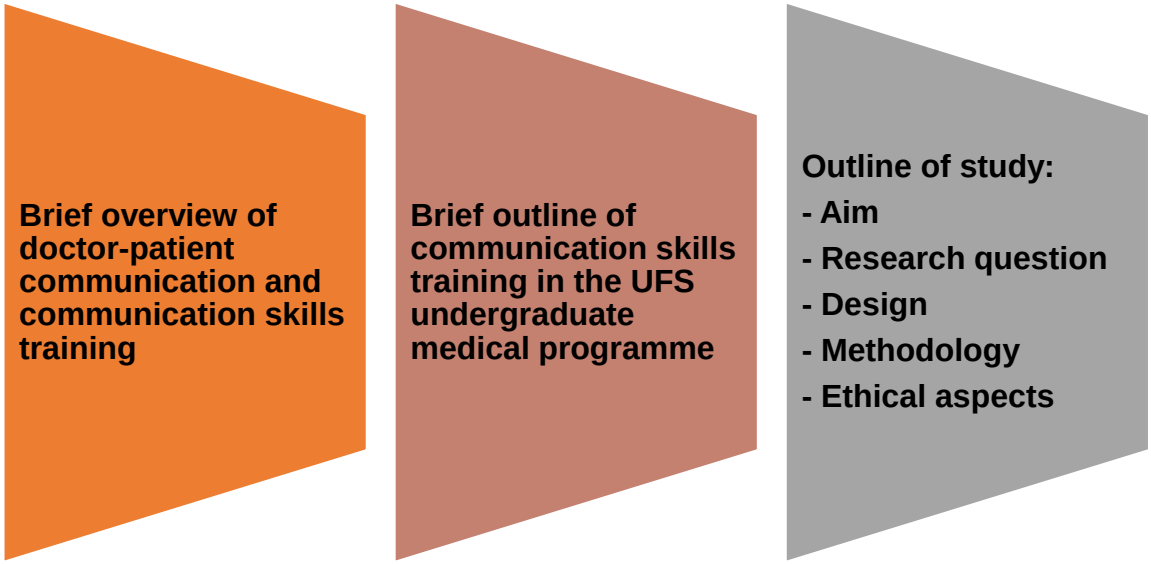

Figure 1.1 An outline of the contents of Chapter 1

1.2 BRIEF OVERVIEW OF DOCTOR-PATIENT COMMUNICATION AND COMMUNICATION SKILLS TRAINING

Patients often refer to the doctor's ability to communicate as the doctor's 'bedside manner'. "The accomplished doctor has a bedside manner that is humane and compassionate, empathetic and supportive" (Silverman, 2012:58). From personal experience, patients will recall how a doctor, who communicated well, allayed their fears and provided hope. On the other hand, patients may experience shame and humiliation if the doctor does not show compassion and empathy (Dolezal, 2015:567).

Beyond intuition, anecdotes and experiences, there is a strong evidence base for the benefits of good doctor-patient communication. When a doctor is able to communicate well, it leads to better patient outcomes (Derksen, Bensing and Lagro-Janssen, 2013:e80). Effective doctor-patient communication leads to greater adherence to treatment, increased patient satisfaction and improved clinical outcomes (Georgopoulou, Prothero, and Cruz, 2018:763, Haskard-Zolnierek and DiMatteo, 2009:826, Hojat, Louis, Markham, Fred, Wender, Rabinowitz and Gonnella, 2011:359, Rakel, Barrett, Zhang, Hoeft, Marchand and Scheder, 2011:390). In this way, the doctors who graduate from university help

to fulfil the social obligation that the institution has towards the community, known as social accountability (Matthews and van Wyk, 2018(b):1634).

The benefits of good communication are mutual as a good doctor-patient relationship leads to increased job satisfaction for doctors as well as reduced litigation (Huntington and Kuhn, 2003:157). This evidence provides the answer to the question of *why* clinical communication should be taught.

It is, therefore not surprising that communication skills training has been included in undergraduate medical curricula globally (Skelton, 2017: 188). Furthermore, there is evidence that medical students can learn communication skills in the patient-doctor relationship through training. Candidates with the poorest communication skills benefit the most from training (Aspegren, 1999:3). This debunks the myth that the ability to communicate well is an attribute that one naturally possesses and that cannot be learnt.

In the South African context, the Health Professions Council of South Africa (HPCSA) outlined the essential competencies that healthcare professional trainees must acquire in the following roles: “Communicator, Collaborator, Leader and Manager, Health Advocate, Scholar and Professional” (HPCSA, 2014:1).

The HPCSA adopted this framework with permission from the CanMEDS Physician Competency framework (Frank, 2005). It is obvious that communication skills are key to the role as a communicator, but upon perusing the guideline, it becomes clear that the ability to communicate well is a *sine qua non* for all the other roles as well. Figure 1.2 summarises the HPCSA competency framework.

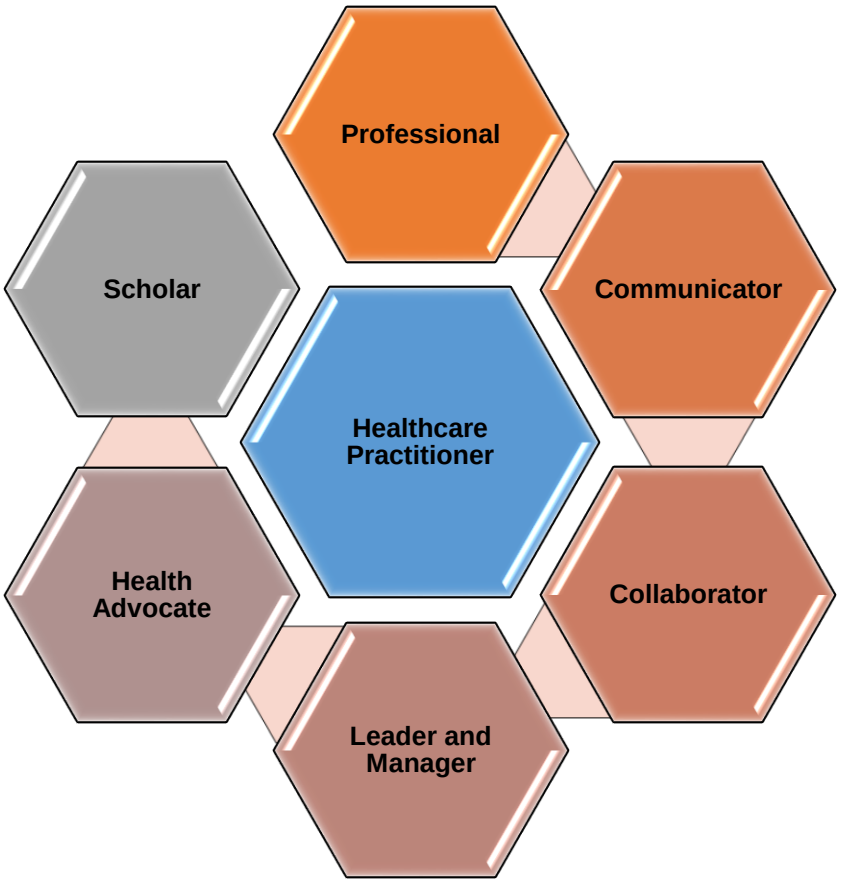

Figure 1.2 Essential competencies required of medical graduates (HPCSA, 2014:1)

When one takes into account the listed evidence and the HPCSA requirements, medical educators must include communication skills training as a key component of the undergraduate curriculum. Harden describes the curriculum as "*more than just a syllabus or a statement of content. It is about what should happen in a teaching programme – about the intention of the teachers and about the way they make this happen.*" (Harden, 2017:4).

Harden has developed an 'extended vision' of the curriculum, consisting of the following components: Learning outcomes, content, educational strategies, learning opportunities, educational environment and assessment. (Harden, 2017:5). These components can be seen in Figure 1.3.

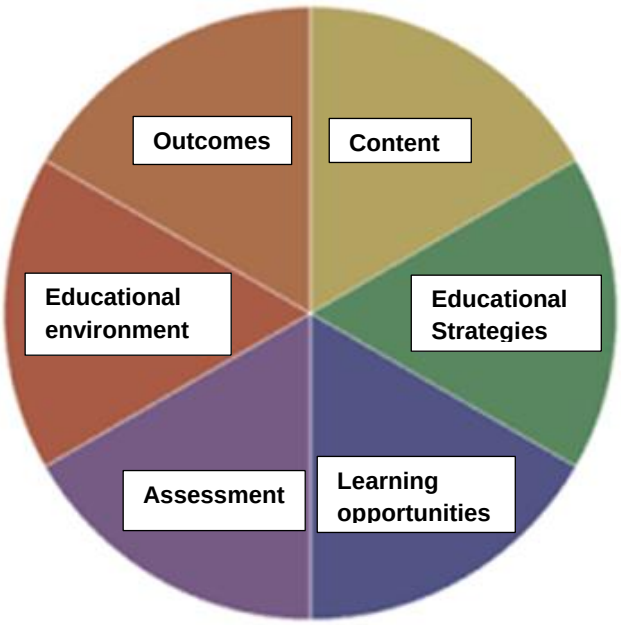

Figure 1.3 Harden's extended vision of the curriculum (Harden, 2017:5)

Harden's extended view of the curriculum can be used as a framework to examine the training that is provided. Table 1.1 outlines how this framework can be used to examine communication skills training.

Table 1.1 Using Harden's framework to examine communication skills training

Were the learning OUTCOMES clearly defined and communicated to students?
Did the curricular CONTENT and EDUCATIONAL STRATEGIES enable students to meet the required competencies?
Were there adequate LEARNING OPPORTUNITIES?
Is the SUMMATIVE ASSESSMENT of communication skills authentic and rigorous?
Is the FORMATIVE ASSESSMENT of communication skills characterised by constructive feedback?
Does the EDUCATIONAL ENVIRONMENT encourage the development of good communication skills?

1.3 SUMMARY OF THE MEDICAL UNDERGRADUATE COMMUNICATION SKILLS TRAINING AT THE UFS

The minimum duration of the MBChB undergraduate programme at the UFS is five years. The programme consists of three phases. Phases I and II are pre-clinical and contain foundational, behavioural sciences and basic medical sciences content. Phase III is the clinical phase of supervised training in the hospital or clinic environment. A diagrammatic representation of the programme structure appears in Appendix A.

Medical students receive lectures in communication skills during their introductory semester (Phase I). During the clinical skills module in Phase II, they receive small group tuition in clinical communication, as well as role-play with peers and simulated patients. Educators assess these skills in Phase II through formative and summative Objective Structured Clinical Examinations (OSCEs).

In Phase III, the Departments of Family Medicine and Psychiatry teach communication skills through formal lectures, while informal training of communication skills takes place during the clinical rotations. (Personal Communication, Van der Merwe, Director of Undergraduate Programme, Medical School, UFS: 2018). Table 1.2 provides a summary of the communication skills training in the MBChB programme at the UFS.

Table 1.2 Communication Skills Training in the UFS MBChB. Programme (Personal communication: Van der Merwe, L. MBChB Programme Director, Faculty of Health Sciences, University of the Free State)

Phase	Modules	Format
I	MDOC 1513 (Doctor and the Environment)	Lectures
	MPSY 1513 (Health Psychology)	Lectures
	MGEN 1513 (Generic skills including an introduction to Sesotho and Afrikaans)	Lectures
II	MCLI 2720 and MCLI 3713 (Clinical Skills)	Roleplay with peers, facilitators and simulated patients (SPs). Formative and summative OSCE
III	Interprofessional Education (IPE)	Interprofessional small group training with facilitators and simulated patients
	MFAM 5818/5828 (Family Medicine) MPSY 5814/5824 (Psychiatry) Other disciplines:	Lectures Small-Group Discussion Informal training during clinical rotations.

1.4 PROBLEM STATEMENT

There is no current student review of the training of doctor-patient communication skills in the MBChB curriculum at the University of the Free State. Therefore, limited knowledge exists regarding certain aspects of communication skills training, especially in terms of the informal learning occurring in the clinical milieu, the so-called hidden curriculum (Harden, 2017:6).

1.5 RESEARCH QUESTION

What are the findings of a student review of the doctor-patient communication skills training?

1.6 OVERALL GOAL AND AIM OF THE STUDY

The goal of the study was to contribute to the knowledge of the current doctor-patient communication skills training in the undergraduate medical programme at the UFS, in order to improve and fine-tune the training provided. Ultimately, a curriculum that cultivates patient-centred communication would help to train future doctors who are compassionate and effective in their clinical communication and in this way improve the quality of patient care.

The aim of the study was to obtain a student review of doctor-patient communication skills training. This may contribute to the evaluation of the programme and provide insights and direction in terms of further research.

1.7 SCOPE OF THE STUDY

This study is interdisciplinary as it explores Medicine, Clinical Communication and Health Professions Education. The research falls into the domain of curriculum development, as it focuses on communication skills training in the undergraduate medical programme.

1.8 VALUE AND SIGNIFICANCE OF THE STUDY

Analysis and interpretation of the questionnaires will enable reflection on doctor-patient communications skills training. This might enable educators to strengthen successful strategies and contemplate new strategies to continue the cultivation of patient-centred communication skills. A summary of research findings will be submitted to the following medical education leaders within the Faculty of Health Sciences at the University of the Free State:

- The Programme Director for the Undergraduate Medical Programme
- The Head of the School for Clinical Medicine
- The Head of the School for Biomedical Sciences
- The Head of the School for Pathology

Results will also be submitted for publication.

1.9 RESEARCH DESIGN AND METHODOLOGY

A research protocol was submitted to the Health Professions Education evaluation committee, and ethical approval was obtained from the Health Sciences Research Ethics Committee (HSREC) at the UFS. The Ethical Clearance number is UFS-HSD2019/0327/2506. Permissions were obtained from the Dean of the Faculty of Health Sciences, the Head of the School of Clinical Medicine, the Vice-Rector: Student Affairs of the UFS and the Vice-Rector: Research, University of the Free State.

A literature study was done to obtain a clearer understanding of the research problem that had been identified and to enable the design of a questionnaire. The literature study will be outlined in Chapter 2.

The researcher chose a quantitative, cross-sectional descriptive study design. Questionnaires were compiled by the researcher and used as a data collection tool to enable a student review of doctor-patient communication skills training in the undergraduate medical programme at the UFS. Undergraduate medical students at the UFS in their fourth and fifth years of study were asked to participate.

The anonymous questionnaire mainly consisted of questions of a quantitative nature, which were summarised by frequencies and percentages. There were some open questions that enabled students to express their views. This qualitative data was coded according to emerging themes to enable analysis. The research design and methods will be described more extensively in chapter 3. An overview of the execution of the study is provided in Figure 1.4. A schematic overview of the mini-dissertation can be seen in Figure 1.5.

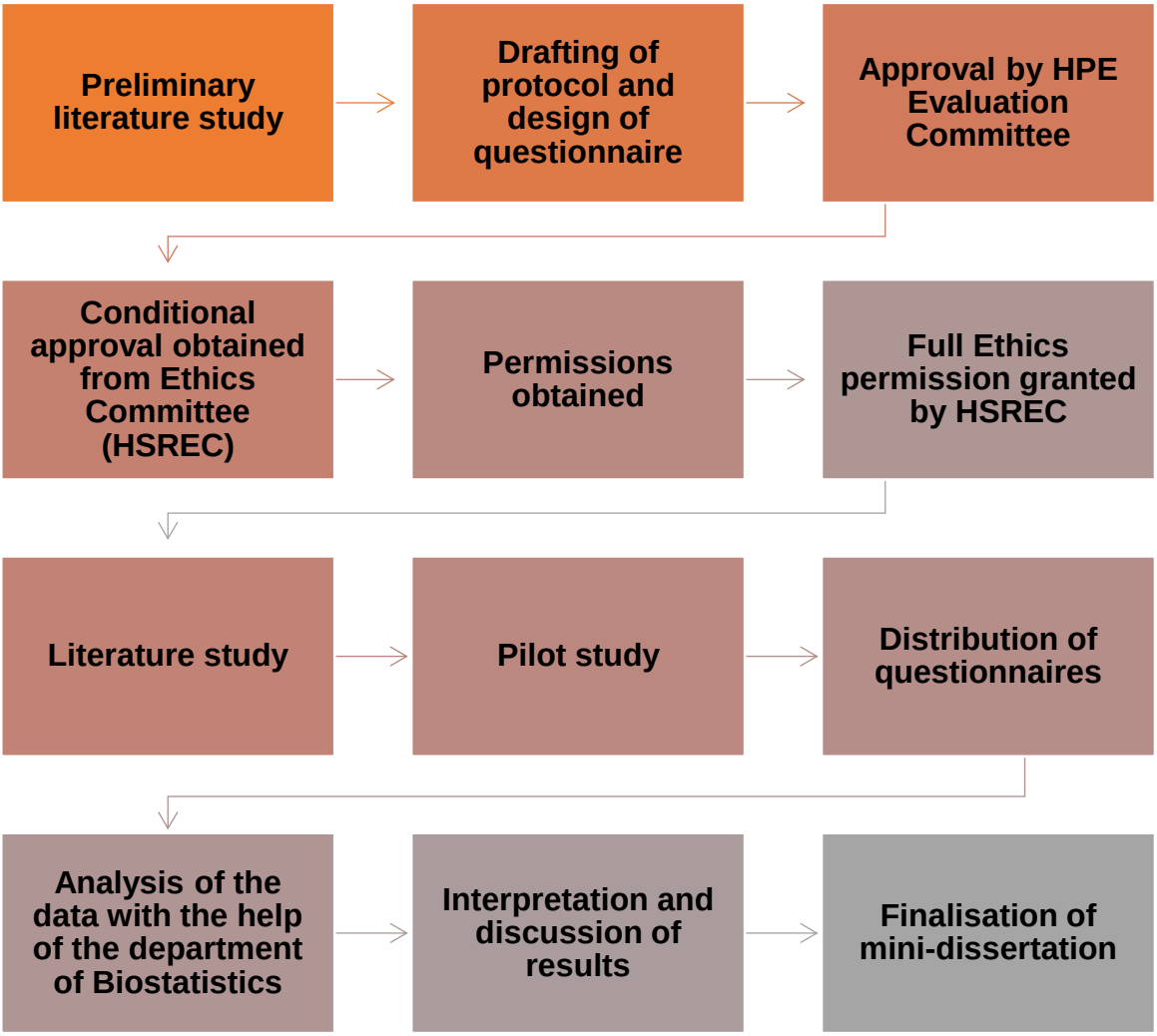

Figure 1.4 Overview of the execution of the study

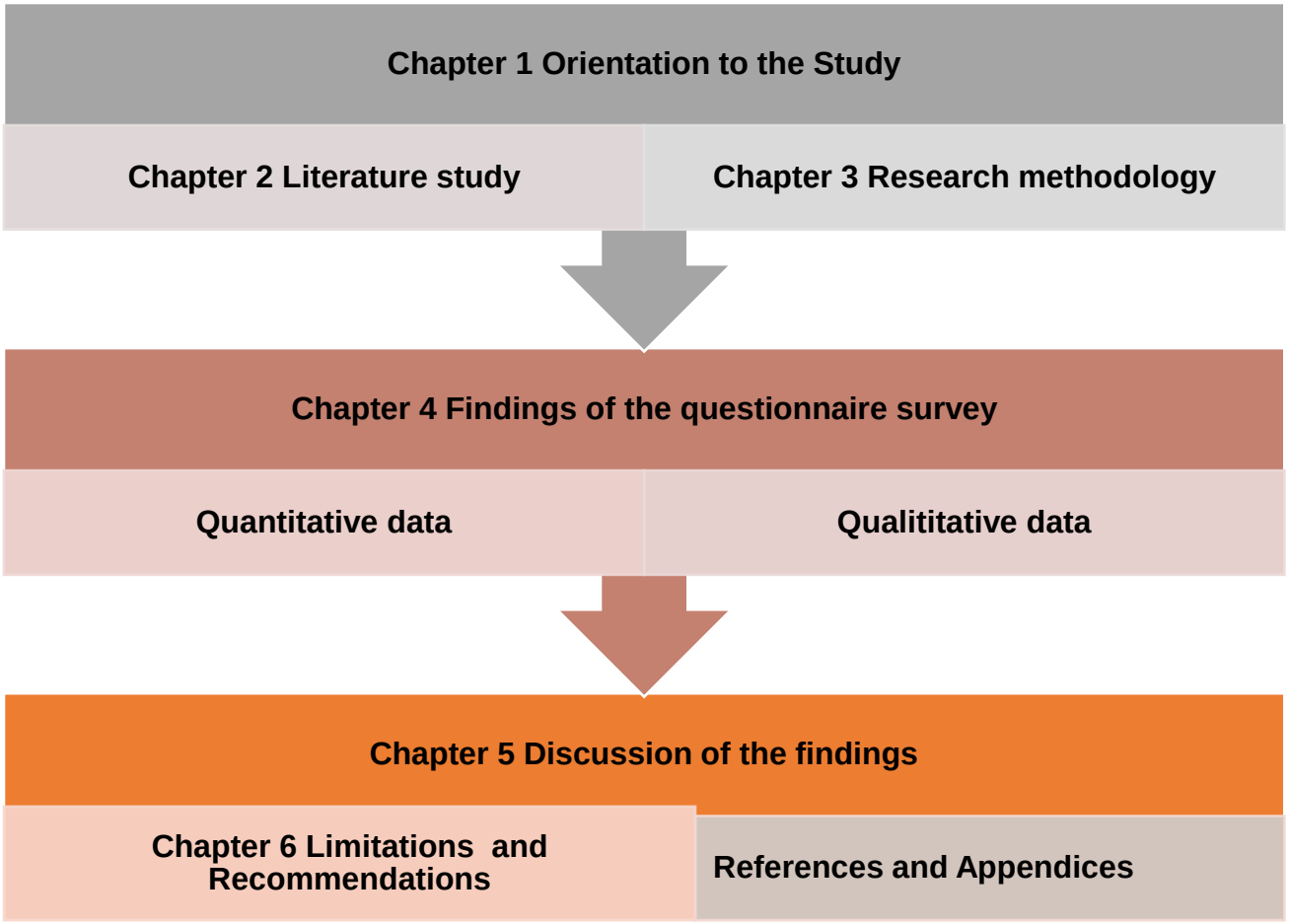

Figure 1.5 Schematic overview of the mini-dissertation

1.10 CONCLUSION

This chapter provided the reader with an overview of the study. Chapter 2 will focus on the literature study.

CHAPTER 2
LITERATURE STUDY

2.1 INTRODUCTION

Chapter 1 provided an introduction and background to the research study. This chapter consists of a literature study. The importance of doctor-patient communication will be examined, as well as the rationale of providing training in doctor-patient communication. The literature will guide best practices in the teaching and learning of doctor-patient communication skills in the global, African and South African contexts. Finally, the concept of a student review of the training programme will be investigated. Figure 2.1 outlines the three components of the chapter.

Figure 2.1 Components of the literature study

2.2 THE IMPORTANCE OF DOCTOR-PATIENT COMMUNICATION

Why should students be taught doctor-patient communication skills? Concerns regarding the overloading of the medical curriculum already exist (Dalley, Candela and Lindley, 2008:62). In the face of rapidly expanding medical knowledge, a focus on doctor-patient communication might seem extraneous. However, scrutiny of the medical education literature reveals that this skill is indispensable.

2.2.1 What is the evidence of the impact of doctor-patient communication globally?

Riedl and Schubler (2017:131) investigated the effect of doctor-patient communication on health outcomes by conducting a systematic review of the literature between 2000 and 2015. Studies that focused only on psychological or psychiatric consultations were excluded. The researchers looked at 42 studies and found that a strong therapeutic relationship had a positive effect on objective health outcomes in 60% of cases. Good doctor-patient communication even led to a reduction in healthcare costs, as less unnecessary investigations were done. In another study, doctor-patient communication, especially the perceived attitude of the doctor, was found to have an impact on the quality of life in patients with breast cancer (Zhou, Shen, Liu, Lin, Dong, and Li, 2014:5639).

A meta-analysis done in the USA by Haskard-Zolnierek *et al.* (2009:826) showed a positive correlation between doctor-patient communication and patient compliance. If there is a lack of effective communication, the risk of non-compliance with treatment can be up to 19%. A systematic review on the impact of doctor-patient communication in the outcomes of rheumatology patients revealed that effective doctor-patient communication was linked with better overall health, lower levels of active rheumatological disease, less overall organ damage and patients were more content with their care (Georgopoulou, Prothero, and Cruz, 2018:763).

The effect of empathy on patient outcomes in the European and North American general practice settings was examined through a systematic review (Derksen *et al.,* 2013:e76). The researchers found a strong correlation between the empathy of the doctor and lower levels of anxiety in the patients, empowerment of patients, satisfaction expressed by patients regarding their care and physical health outcomes. These outcomes included better diabetic control, as measured by glycosylated haemoglobin and lower levels of LDL cholesterol (Hojat *et al.*, 2011:359). Empathy towards patients led to a quicker recovery from the common cold (Rakel *et al*., 2011:390).

Good doctor-patient communication is also beneficial to doctors. Firstly, strong therapeutic relationships with patients are associated with greater job satisfaction and a smaller risk of burn-out (Aaronson, White, Black, Brown, Benzer, Castagna, Raja, Sonis and Mort, 2018:260). Secondly, patients are less likely to take legal action against doctors whom they respect and trust (Huntington and Kuhn, 2003:157).

2.2.2 What is the evidence of the impact of doctor-patient communication in the African context?

Wachira and co-workers concluded that physician communication behaviours have an important role in defining better adherence to care among HIV patients in Kenya (Wachira, Middlestadt, Reece, Peng and Braitstein, 2014:197). Scholars studied how the quality of communication of healthcare providers influence the perception of care given (Larson, Leslie and Kruk, 2017:e014888). The study was done in seven Sub-Saharan countries, involving 3898 facilities, 4627 healthcare providers and 16 352 caregivers of children. The researchers concluded that there were major shortcomings in communication between healthcare providers and caregivers of children. The poor quality of communication contributed to dissatisfaction with care and caregivers indicated that they would be unlikely to return to the healthcare facility in future.

2.2.3 What is the evidence of the impact of doctor-patient communication in the South African context?

In an article, titled “They don’t care about us…” Kelly and co-workers described the impact of doctor-patient communication on primary healthcare provision to the elderly in the Western Cape, South Africa. Participants, who felt that the communication from healthcare providers was poor, were less likely to adhere to treatment, while those who experienced patient-centred care was satisfied with their care (Kelly, Mrengqwa and Geffen, 2019:98). A study by a paediatric oncologist at the UFS described the effects of poor communication on patients and families: *“A single incident can cause parents intense and lasting emotional suffering. Parents described incidents that included insensitive delivery of bad news, feeling dismissed or patronised, poor and insensitive communication, and*

apparent disrespect for parents' judgment about their child's care. These events unsettled them and convoluted their experience" (Du Plessis, 2017:26).

The evidence mentioned above highlights the importance of doctor-patient communication. Studies exploring the experiences of patients help us remember why it is crucial for doctors to show empathy to patients. In the following section, the evidence for the effectiveness of communication skills training will be investigated.

2.2.4 What is the evidence of the effectiveness of communication skills training?

Buckman *et al.* posed the following question: "*Empathic responses in clinical practice: Intuition or tuition*?" (Buckman, Tulsky and Rodin, 2011:569). They concluded from their review of the medical education literature that empathy can be taught and should be taught as part of the undergraduate medical communication skills training programme. The meta-analysis by Haskard-Zolnierek *et al.* (2009:826) showed that communication skills training for doctors improved patient compliance with treatment.

An overview of systematic reviews evaluated the effectiveness of communication skills training for doctors (Berkhof, van Rijssen, Schellart, Anema, and van der Beek, 2011:157). Outcomes measured included self-reported improvement by participants, objective assessment of behaviour and patient-based outcomes. Patient-based outcomes included a report by the patient about the information exchange, change in health status, change in anxiety levels and compliance with treatment. The reviewers concluded that doctor-patient communication skills training is successful, provided that the following criteria are met: The training must be of adequate duration (at least one day), must be learner-centred and involve the practice of the skills required (Berkhof *et al.,* 2011:162).

2.3 BEST PRACTICE IN DOCTOR-PATIENT COMMUNICATION SKILLS TRAINING

Best practice in the components of communication skills training will be examined. The components have been outlined according to Harden's curriculum

framework/extended view of the curriculum (Harden, 2017:5). This framework consists of learning outcomes, content, educational strategies, learning opportunities, assessment and educational environment.

2.3.1 Learning outcomes

Communication is no longer seen as an optional extra but is regarded as an essential skill to be a competent doctor (Rider and Keefer, 2006:426). Kurtz, Silverman and Draper conclude that "*effective communication is essential to the practice of high-quality medicine*" (2005:27). The CanMEDS competency framework, developed by the Royal College of Physicians and Surgeons of Canada, specifies that doctors should be competent in the following roles: Medical Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar and Professional (Frank, Snell and Sherbino, 2015).

The regulatory body for the practice and education of health practitioners in South Africa, the HPCSA, obtained permission to adapt the CanMEDS competency framework for the South African context (HPCSA, 2014:1). This framework outlines the core competencies that the HPCSA requires South African medical trainees to achieve during undergraduate training (Van Heerden, 2012:21). Educators should make students aware of the benefits of communication skills training so that they can appreciate their vital importance (Quirk and Harden, 2017:5). Students should also be informed of the desired outcomes and requirements of regulators. Good communication from educators to students regarding the training programme will maximise the successful engagement of students (Ley, Kisielewska, Collett and Burr, 2019).

2.3.2 Content

In terms of the content of the communication skills curriculum, medical educators can refer to several international expert consensus statements. The aim of a consensus statement is to help medical educators to design their curriculum with a clear focus on best practice and the key communication skills required (Noble, Scott-Smith, O'Neill, and Salisbury, 2018:1712). A group of medical education scholars examined the main components of six consensus statements on the content of the medical communication curriculum, enabling a comparison of the

frameworks (Bachmann, Abramovitch, Barbu, Cavaco, Elorza, Haak, Loureiro, Ratjska, Silverman, Winterburn, and Rosenbaum, 2013:21).

Table 2.1 shows a summary of consensus statements on the content of the medical education communication curriculum. All these frameworks originated in Europe or North America.

Table 2.1 Summary of international expert consensus statements on the content of the communication curricula in medical education (Bachmann *et al*., 2013:21)

Consensus Statement	**Author(s)**	**Year of Publication**
1. Toronto	Simpson, Buckman, Stewart, Maguire, Lipkin, Novack and Till.	1991
2. Maastricht	Van Thiel, Kraan and van der Vleuten	1991
3. Kalamazoo	Makoul	2001
4. CanMEDS	Frank	2005, Revised in 2015
5. United Kingdom	Von Fragstein, Silverman, Cushing, Quilligan, Salisbury and Wiskin	2008, Revised in 2018
6. Basel	Kiessling, Dieterich, Fabry, Hölzer, Langewitz Mühlinghaus, Pruskil, Scheffer and Schubert	2010

The consensus statements are broadly similar in their definition of the key content of medical communication skills training programme (Bachmann *et al*., 2013:21). To conceptualize these constituent parts of the training programme content, The UK consensus statement on the content of medical curricula will be examined in more detail. The authors (Von Fragstein, Silverman, Cushing, Quilligan, Salisbury and Wiskin, 2008:1100) depicted the programme content as concentric circles resembling an archery target, referred to as 'the curricular wheel' (See Figure 2.2). This enables educators to appreciate the complexity and multiple spheres to consider in the teaching and learning of doctor-patient communication skills.

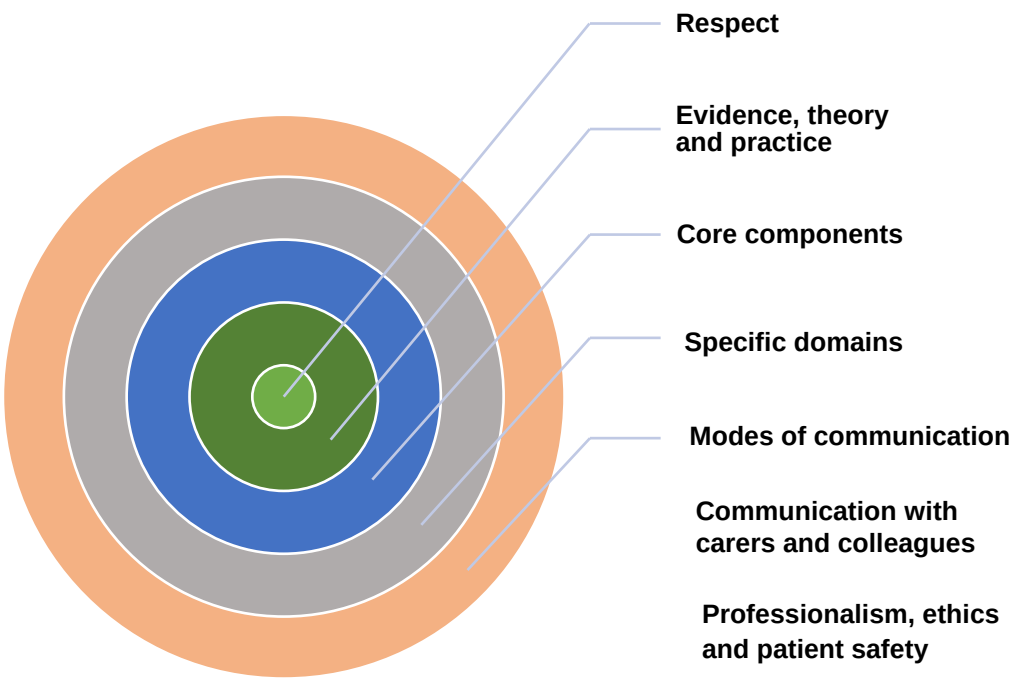

Figure 2.2: Example of the content of communication skills training; based on the UK consensus statement on the content of medical communication curricula (Von Fragstein *et al.*, 2008:1100).

The essential ingredient for successful doctor-patient communication forms the hub of the wheel, namely respect for others.

The next concentric circle is the evidence, theory and practice underlying communication skills training.

Thereafter the core components of the structured medical interview are listed, based on the Calgary-Cambridge guide (Kurtz *et al.*, 2005:38-56). The effective medical interview achieves the dual goals of obtaining biomedical information and building trust relationship with the patient (Kurtz *et al.*, 2005:40).

A further concentric circle depicts special circumstances such as breaking bad news and managing cultural diversity. Thereafter the modes of communication and 'communication beyond the patient' with relatives and colleagues are added to the compendium. The wheel is situated within the wider professional environment, to show the importance of issues such as patient safety, reflective practice and ethical considerations.

Central aspects of the curricular content pertaining to doctor-patient communication will be further investigated in the literature. These central aspects consist of the evidence, core components/skills and specific domains/specific skills. Figure 2.3 provides an overview of these central aspects.

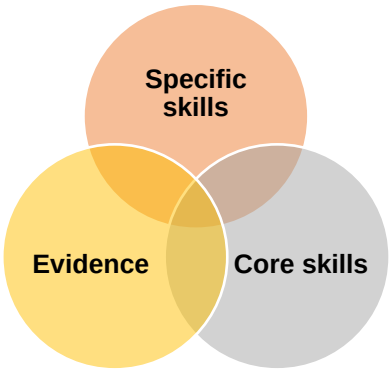

Figure 2.3 Central aspects of curricular content: based on the UK curricular wheel (Von Fragstein *et al*., 2008:1100).

2.3.2.1 Informing students of the evidence base underlying doctor-patient communication and communication skills training

Doctor-patient communication skills are often seen as 'soft skills', disregarding the hard evidence for its impact (Derkson *et al.*, 2013:e76). Many students believe that communication skills cannot be learnt or that it will be automatically acquired through experience (Kurtz *et al*, 2005:21). Medical educators can debunk these myths by pointing to the evidence that skilled communication can be acquired, and that experience is not a reliable teacher. "*While experience may be an excellent reinforcer of habits, it tends not to discern between good and bad habits*" (Kurtz *et al.*, 2005:21).

Medical educators should impress upon students the immense impact of doctor-patient communication on patients and doctors alike (*cf*. section 2.2). Secondly, educators should point to the evidence that skills for communicating with patients can be acquired through training and will not automatically be gained through experience (Aspegren and Lonberg-Madsen, 2005:543).

2.3.2.2 Developing core skills: Patient-centredness in the medical interview

History taking is a key part of the medical interview (Keifenheim, Teufel, Ip, Speiser, Leehr, Zipfel and Hermann-Werner, 2015:159). In his foreword to Teaching and Learning Communications Skills in Medicine by Kurtz *et al*, Platt describes how medical educators demonstrated history taking "*through gentle or curt inquisitions*" when he was a medical student: "*They had little concern with how the process felt to the patient and little technique beyond a barrage of close-ended questions*" (Platt, 2005:xi).

Kurtz, Silverman, Benson and Draper (2003:802) emphasised that history taking should not solely focus on gathering biomedical data to reach a diagnosis. Instead, communication skills should be combined with diagnostic interviewing skills as summarised in the modified Calgary-Cambridge framework (Kurtz *et al*, 2003:40). Biomedical information crucial for diagnosis can be skilfully gathered. Through active listening, empathy and responding to the patient's non-verbal cues, the therapeutic relationship is developed simultaneously (Kurtz *et al*, 2005:40). One of the main aims of the medical interview is to understand the patient's perspective of the illness and their concerns regarding the impact of the illness.

The UK consensus statement (Von Fragstein *et al*, 2008:1100) underscored patient-centredness as a key feature of patient care of high quality. This should be an essential part of any training in doctor-patient communication. Students must understand the need to commit to partnerships with patients and develop respect for the patient's choices and autonomy.

In the South African context, Archer (2017:219) identified factors that influence the development of patient-centredness in medical students: The background and attitudes of students and lecturers, norms established by role models, the sense of their own capability, knowledge and skills developed through training, the milieu within which they are trained in patient-centredness and, finally, how the patient-centredness of a student is assessed. It is thus clear that medical educators can address many of these factors.

Patient-centredness fits in with the concept of health dialogue and shared decision-making. Patients with type 2 diabetes mellitus who received treatment in the Free State Public Health Service participated in a study that investigated communication between healthcare providers and patients (Reid, Walsh, Raubenheimer, Bradshaw, Pienaar, Hassan, Nyoni and Le Roux, 2018:122). Patients reported that they need information that will address their particular concerns and needs. They found it helpful to receive the information in their home language. Patients wanted to ask questions but were reluctant to do so and rather asked other patients in the waiting room. Reid *et al.* constructed a model to improve the communication between healthcare providers and patients by training healthcare workers to have a healthy dialogue rather than a monologue. In this way, patients will not suffer from 'information poverty' and will be empowered to manage their illness better (Reid *et al*., 2018:131).

2.3.2.3 Developing specific skills

A plethora of specific communication skills could potentially be required in the doctor-patient relationship, so which of these should be taught in the undergraduate medical curriculum? Kurtz and co-workers (2005:204) reiterated that core communication skills remain the cornerstone of managing challenging consultations, but that additional skills may be required.

Ha and Longnecker (2010:39) outlined communication behaviours by doctors that can cause distress for patients and the doctors themselves. These include avoidance of conversations that might upset the patient and reluctance to let the patient contribute to the care plan (Ha and Longnecker, 2010:39).

It is thus clear that medical trainees need specific training for challenging situations such as breaking bad news, dealing with cultural diversity, explaining errors and defusing anger.

2.3.2.4 Breaking bad news

A systematic review and meta-analysis investigated the success of teaching interventions to improve the delivery of bad or difficult news. This review concluded that training interventions had a significant impact on trainee

confidence and in observed skills (Johnson and Panagioti, 2018:1412). A literature review by Alelwani and Ahmed (2014:3) reported similar findings regarding the effectiveness of preparing undergraduate students for this difficult task. However, they commented on the difficulty of ascertaining whether educational intervention affects patient outcomes in this sphere of research.

In the South African setting, Ganca, Gwyther, Harden and Meiring (2016:940) examined the communication needs of doctors when they had to convey a poor prognosis. The researchers found that many doctors found this task onerous. They theorised that exposure to palliative care training might equip doctors better for this task. The researchers recommended that all healthcare workers should be able to communicate a poor prognosis and that the training of these and other palliative care skills should be integrated into the medical curriculum (Ganca *et al.*, 2016:940).

Du Plessis (2017:26) reflected on the lasting impact of instances where bad news was not conveyed well in the paediatric oncology setting at a UFS training hospital (*cf*. section 2.2.3).

2.3.2.5 Managing language and cultural differences in the consultation

A systematic review of educational interventions to improve the cultural competency of students showed that these interventions were fruitful (Beach, Price, Gary, Robinson, Gozu, Palacio and Cooper, 2005:356). Cultural competency training improved the knowledge, attitudes and skills of medical students, while it also improved patient satisfaction (Beach *et al.*, 2005:356).

Training medical students to be culturally competent is very relevant to the South African context. South Africa has an estimated population of 58.8 million people, consisting of people of diverse cultures and with eleven official languages (Lehohla, 2016:39). Figure 2.4 shows the composition of the population in terms of home language spoken.

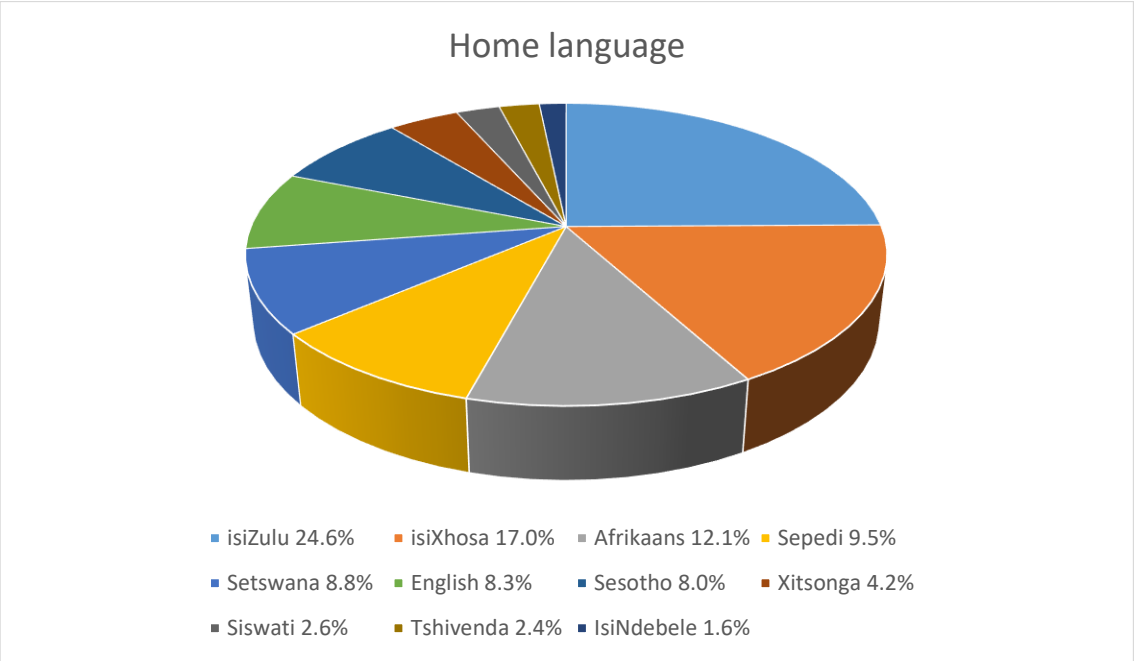

Figure 2.4 Composition of the South African population according to home languages spoken (Lehohla, 2016:39).

The diversity of cultures and languages has significant implications for doctor-patient communication and the teaching of communication skills, which has been investigated by many scholars. Van den Berg (2016:230) reviewed the South African healthcare literature and discovered that language barriers still significantly hamper the delivery of effective healthcare across South Africa. A study by Hussey (2012:189) drew attention to the fact that healthcare workers in the Eastern Cape were mostly English speaking, while many patients exclusively spoke isiXhosa. The language barrier affected the ability of healthcare workers to obtain a thorough history. Furthermore, the healthcare workers had the sense that it was more difficult to convey empathy and successfully deliver health advice because of language barriers (Hussey, 2012:189).

Matthews and van Wyk performed a qualitative study at University of Kwazulu-Natal to explore the perceptions of medical students and educators in terms of the communication skills curriculum and its role in the ability of graduates to meet the healthcare needs of society. They concluded that greater emphasis on the learning of local languages and cultural learning should form a part of the communication skills curriculum in Kwazulu-Natal to improve healthcare provision and social accountability (2018(b):1634).

2.3.2.6 Explaining medical errors

Through a literature study of the communication surrounding medical errors, Robbennolt (2009:376-382) discovered that doctors who explained medical mishaps and who offered an apology were able to resolve the issue more easily and that patients were less likely to take legal action against them. The General Medical Council (GMC), the regulator of medical practice in the United Kingdom, requires honesty and integrity of medical practitioners, including the 'duty of candour' when the medical team has made mistakes (GMC, 2015). As this remains a daunting task for medical practitioners, medical students should be prepared to face these situations. Educators from Georgia in the United States of America implemented an educational intervention to teach medical students how to offer an apology after the occurrence of a medical error (Gillies, Speers, Young, and Fly, 2011:400). The intervention consisted of a didactic element to clarify the purpose of the teaching, as well as opportunities to practise the skills in role-play scenarios with simulated patients. The students found the training useful and reported an increase in confidence in explaining medical errors. However, the authors reflected on the timing of the intervention in the first year of study and emphasised that the teaching should be reinforced at a later stage.

2.3.2.7 Defusing anger

Kurtz *et al*. emphasised the importance of having specific strategies to deal with anger (2005:177). Anger should not be ignored in the medical consultation and should be defused before it escalates. Tate (2018) points out that anger often occurs as a result of anxiety or frustration and that the root cause should be identified. A communication skills training module for oncology healthcare professionals were developed to help them manage anger in the medical consultation (Bialer, Kissane, Brown, Levin and Bylund, 2011:359). The module consisted of didactic teaching, video demonstrations and role-play and increased the confidence of participants to defuse anger in the medical consultation.

The international and South African literature regarding the content of the training programme helps medical educators to determine *what* should be taught and learnt in terms of doctor-patient communication skills. The question remains: *How*

should doctor-patient communication skills be taught and learnt? This is addressed by considering educational strategies.

2.3.3 Educational principles, strategies and methods

Educational strategies form part of Harden's curricular framework/extended view of the curriculum (Harden, 2017:5). In this section, the medical education literature will be probed, not only for strategies but also for educational principles and educational methods that may influence the effectiveness of training doctor-patient communication skills.

2.3.3.1 Educational principles

Harden and Laidlaw (2016:17) described four educational principles that increase the effectiveness of teaching and learning, which they call the FAIR principles. These include the provision of adequate FEEDBACK to the student, ensuring ACTIVE engagement of students in learning, recognising INDIVIDUAL learning needs and ensuring that content and educational strategies are RELEVANT. Of these principles, feedback and active learning will be further unpacked.

Constructive feedback can serve a four-fold purpose: Students can diagnose shortcomings in their learning and address these, they obtain a clearer idea of what is expected of them, the feedback motivates them and helps to remove uncertainties that can be stressful (Harden and Laidlaw, 2016:17). Kurtz *et al*. (2005:111) underlined the following principles underlying effective feedback: Keep the learning environment safe by discussing positives first, allow the learner to do a self-assessment first and finally, give recommendations rather than criticisms.

Active learning can serve as catalyst for students to reflect on their learning. Reflection can help students to understand themselves, others and situations better and thus lead to deeper learning (Sandars, 2009:686). An example of how educators can encourage active learning is by facilitating rather than lecturing during small group teaching, thus being the "*guide by the side, rather the sage on the stage"* (Harden and Laidlaw*,* 2016:19).

2.3.3.2 Educational strategies

Harden, Sowden and Dunn (1984:284) proposed the SPICES model to contrast traditional education strategies with newer strategies. SPICES stands for Student-centred, Problem-based, Integrated, Community-based, Elective-driven and Systematic strategies. These are contrasted with traditional educational strategies such as teacher-centred and information-based strategies. Harden (2017:7) suggested using the SPICES model as a curricular evaluation tool to identify where an individual training programme falls on the spectrum and if changes are required. Bennett and Lyons (2011:45-54) described using a programme based on problem-based, integrated and systematic educational strategies to transform communication skills training of undergraduate students.

Table 2.2 The SPICES model of curricular strategies (Harden *et al.*, 1984)

Newer educational strategies	**Spectrum**	**Traditional educational strategies**
Student-centred		Teacher-centred
Problem-based		Information-based
Integrated		Subject-based
Community-based		Hospital-based
Elective-driven		Uniform
Systematic		Opportunistic

2.3.3.3 Educational methods

There is significant evidence in terms of effectiveness and ineffectiveness of educational methods. Berkhof and co-workers conducted an overview of twelve systematic reviews. The overview aimed to identify effective training methods for teaching doctor-patient communication skills. They concluded that the best programmes were active and experiential. These included role-play, small group teaching and feedback. Lectures, demonstrations and written material were much less effective. (Berkhof *et al.*, 2011:152). Doctor-patient communication training should be anchored in real-life examples and practice (Yardley, Irvine, and Lefroy, 2013:495). T

The need for experiential learning with the following analogy: "*The fundamental rationale for role-play is that you cannot become a better communicator except*

by practising communication any more than you can become a good driver except by driving" (Skelton, 2013:246). Skelton further pointed out that the real value lies in the reflection and discussion that follow role-play, which can enhance insight so that students can apply the skills wisely and not in a 'mechanical' way. (Skelton, 2013:248).

Although students described lectures as boring and passive, Berkhof *et al.* (2011:160) found that a combination of didactic teaching and practical skills training enhanced the development of clinical communication skills. Kurtz *et al.* (2005:76) explained that didactic teaching provides the theoretical foundation and rationale for the practical training that follows.

2.3.4 Learning opportunities

Harden (2017:5) included learning opportunities as part of the extended vision of the curriculum. Looking at this aspect will help to answer the questions '*when*' and '*where'* doctor-patient communication skills can be taught.

In order to understand the availability of these learning opportunities better, we need to compare the two main ways in which medical curriculums are structured, namely the traditional structure versus the revised curriculum structure. Medical curriculums worldwide have conventionally been organised into pre-clinical and clinical phases so that students could achieve mastery of basic and applied medical sciences prior to starting their clinical rotations. This is known as the 'traditional' curriculum structure. This structure of the curriculum has been questioned, as scholars have observed that students struggle to find their professional identity and cannot see the relevance or importance of the subject knowledge (Harden, 2017:6).

In the revised curriculum structure or non-traditional curriculum structure, students receive clinical exposure from the start of the course, while basic sciences tuition continues until the completion of undergraduate training (Leinster, 2013: 20). This can be seen in Figure 2.5.

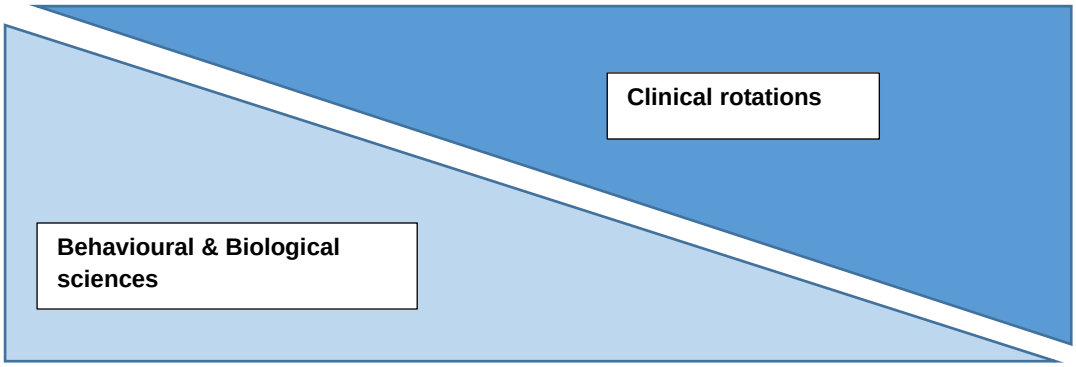

Figure 2.5: The revised curriculum structure (Leinster, 2013:20)

A Best Evidence in Medical Education (BEME) review revealed several benefits of early clinical exposure for medical students. It can play a role in finding their identity as medical professional, can affect their future career choice and makes the content of the medical curriculum more real to them (Dornan, Littlewood, Margolis, Scherpbier, Spencer and Ypinazar, 2006:3). An update of this review showed that an added benefit of early clinical exposure is that students gain a greater understanding of the patient's perspective of illness (Yardley, Littlewood, Margolis, Scherpbier, Spencer, Ypinazar, and Dornan, 2010:740).

Keifenheim *et al.* performed a systematic review of methods to train students in terms of history taking and found that the methods most frequently used and evidenced are interactive workshops in small groups. The training included role-play with simulated patients, followed by discussion and constructive feedback. Real patients are also sometimes asked to contribute to the training. The reviewers reported study findings regarding the teaching of interviewing skills early in the programme: "*Students in the early preclinical state might profit from approaches helping them to focus on interview skills and not being distracted by thinking about differential diagnoses or clinical management*" (Keifenheim *et al.*, 2015:159).

At the University of the Witwatersrand, South Africa, the undergraduate medical curriculum was reformed in 2003, to place a greater emphasis on the psychosocial aspects of patient care. Medical students had opportunities to witness clinical care of patients from their first year, by attending health care facilities one day per week. In the students' evaluation of the curriculum in their

final year, they still asked for more in-depth early clinical exposure, so the quantity and quality of early clinical exposure are also important factors to consider (McInerney, Green-Thompson and Manning, 2013:36).

The UFS Medical curriculum is mainly structured according to the traditional curricular model. However, it differs from the conventional curriculum in one way: The clinical skills module forms a bridge between the initial phases and the clinical phase. A representation of the UFS curriculum structure appears in Figure 2.6.

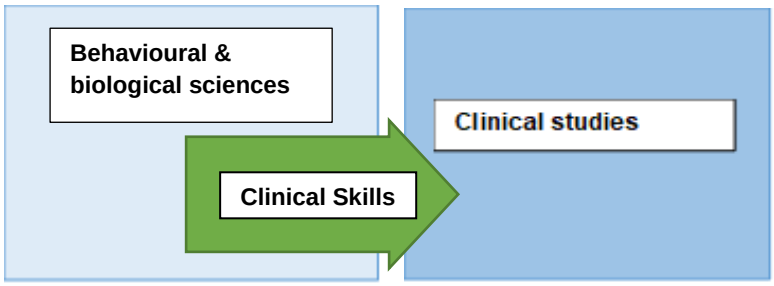

Figure 2.6: The UFS variation of traditional curriculum structure

In the Clinical Skills curriculum at the UFS Medical School, students learn the principles of patient-centred communication and have opportunities to practise communication skills (UFS, 2019). Students reported that they found Peer Physical Examination (PPE) helpful in terms of developing empathy and increasing their confidence in their communication skill (Hattingh, 2017:120).

Another way of structuring the undergraduate medical curriculum is the so-called 'spiral' (or helical) curriculum. In the spiral curriculum, the introduction of topics occurs in the initial phase. Educators then revisit these topics to ensure that students build on the initial foundation until competence is achieved. Von Fragstein *et al.* highlighted the importance of this type of communication skill curriculum: "*A properly planned communication curriculum provides opportunities for learners to review, refine and build on existing skills while simultaneously adding new skills and increasing complexity. If ongoing, helical communication programmes do not run throughout the course, students will fail to master*

communication" (2008:1101). Figure 2.7 shows a depiction of the spiral curriculum.

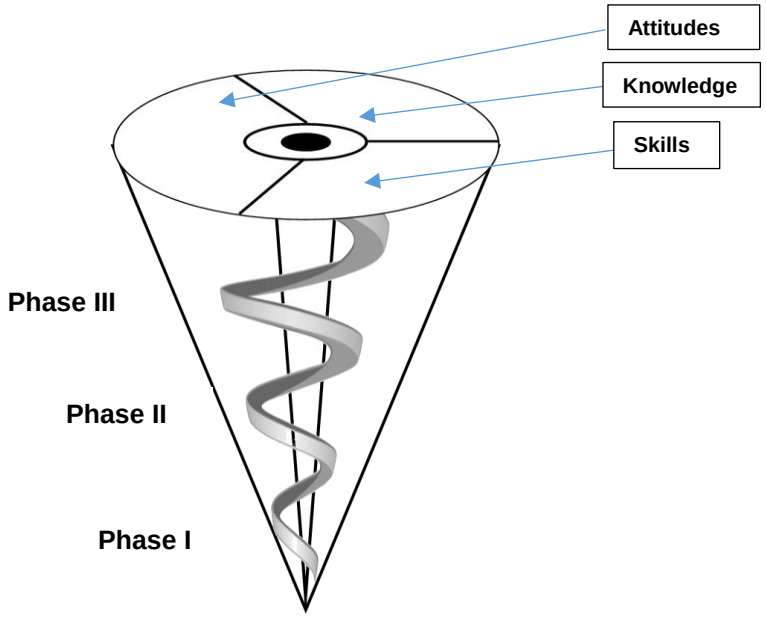

Figure 2.7: The spiral (or helical) curriculum (Harden, 2013:10)

Factors within the clinical training environment can affect learning opportunities. Burch (2007:70) described the impact of South African health policies upon medical training programmes, in particular, the learning opportunities in the clinical context: Closure of beds in academic training hospitals limit the clinical exposure of medical students, staff shortages limit the number of clinician-educators who can provide training to medical students, and clinical teachers often do not have any background in medical education. In the scramble to provide healthcare in settings with staff shortages and a high burden of disease (Burch, 2007:84-85), there is often not the opportunity to reflect on communication skills and how it can be improved.

2.3.5 Assessment

Assessment significantly influences student learning. (Harden, 2017:9). If communication skills carry little weight in assessment, it is difficult to convince students of its importance. The assessment of a skill is more complex than the assessment of the knowledge, as has been demonstrated in Miller's skills triangle (Miller, 1990:s63). This is depicted in Figure 2.8 below.

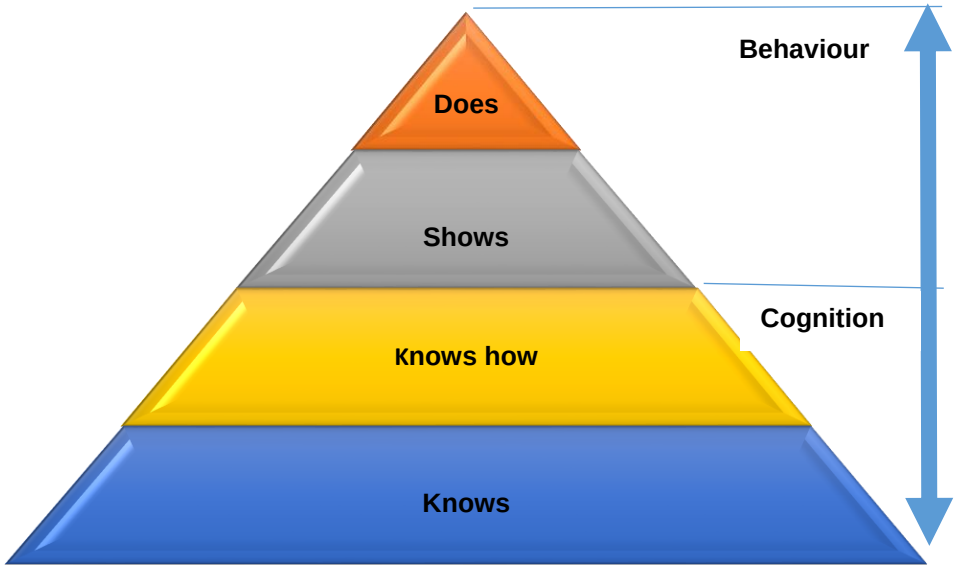

Figure 2.8: Miller's framework for clinical assessment (Miller, 1990:s63)

Mehay and Burns (2009:414) further developed Miller's skills triangle into a pyramid of clinical competence. (See figure 2.9 below). This shows how each stage of a clinical competency can be assessed during the development thereof. Written or oral tests can assess knowledge and understanding, but skills have to be assessed through practical assessments. The OSCE (Objective Structured Clinical Examination) is used globally to assess communication skills (Skelton, 2017:193). However, to ascertain how a student performs in the real-life clinical setting, assessment within the workplace is required. (Etheridge and Boursicot, 2017:268).

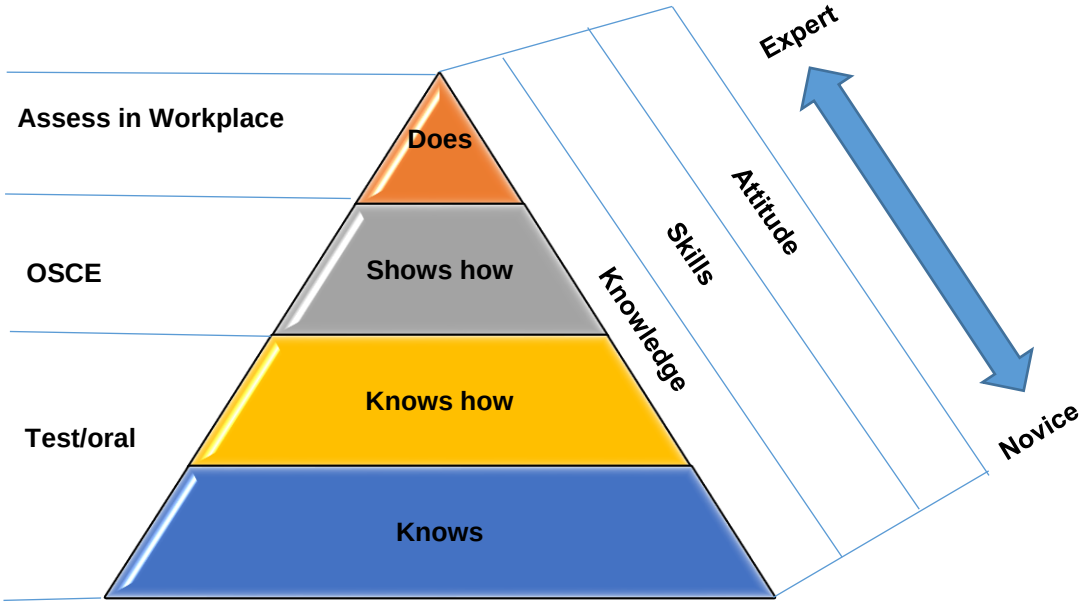

Figure 2.9: Miller's pyramid of clinical competence (Mehay and Burns, 2009:414).

Educators have been concerned that medical students are not adequately observed and given useful feedback during the clinical phase of their studies (Norcini & Burch, 2007:855). Educators have embraced evaluation tools such as the Mini Clinical Examination (MINI-CEX) and the Case Based Discussion (CBD) in the UK and USA (Etheridge & Boursicot, 2017:270-271). In primary care, the Consultation Observation Tool (COT) is used for formative assessment (Denney, 2007).

The OSCE is widely used to assess clinical and communication skills at the UFS in Phases II and III. Work-place based assessments are used in Phase III of the training (Personal Communication, Hanneke Brits, Chair of Phase III: Undergraduate MBCHB Programme: Department of Family Medicine, University of the Free State, Bloemfontein).

2.3.6 The educational environment

It will be futile to develop a communication skills curriculum when students sense that senior clinicians and educators at the medical school do not value communication skills. Therefore the right educational environment is crucial (Harden, 2017:10). Harden (2017:6) described the hidden curriculum as the informal learning that differs from the declared curriculum and the taught curriculum. Figure 2.10 shows Harden's depiction of the hidden curriculum.

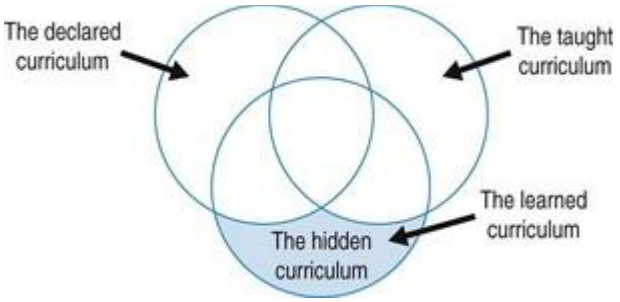

Figure 2.10: The hidden curriculum (Harden, 2017:6)

The content of the hidden curriculum is often taught implicitly through clinical role-modelling (Fryer-Edwards, 2002:58). Mahood described the process as "*More than the simple transmission of knowledge and skills; it is also a socialisation process. Wittingly or unwittingly, norms and values transmitted to future*

physicians often undermine the formal messages of the declared curriculum" (2011:983).

Researchers at the University of Pretoria, South Africa, explored the impact of positive and negative role-models on the development of professionalism and communication skills of undergraduate medical students (Joubert, Kruger, Bergh, Pickworth, Van Staden, Roos, Schurink, Du Preez, Grey and Lindeque, 2006:28). According to the students, the registrars had the greatest impact as role models with the specialist consultants slightly less influential.

Students defined a good role model as a caring, competent doctor whose excellent communication skills they could emulate. Students reported that there were good role models who inspired them, but they also saw examples of unprofessional practice that sapped their morale.

Some students followed the negative examples that they saw, thereby creating a cycle of unprofessional behaviour. However, other students used the negative role models as a deterrent not to behave in a similar manner (Joubert *et al.,* 2006). The authors recommended that there should be deliberate training of professionalism and communication skills for doctors who serve as teachers in the clinical environment.

2.4 THE ROLE OF A STUDENT REVIEW

Medical education is increasingly seen as a partnership between educator and student and the opinions and preferences of learners must be taken into consideration (Ley *et al.*, 2019:14). Kurtz and co-workers (2005:155) commented on the similarities in the facilitator-learner relationship and the doctor-patient relationship. Just as it is essential for doctors to listen to patients, so medical educators must show that they listen to students.

Researchers in Spain investigated the response of medical students to an experiential communication skills training programme characterised by role-playing with simulated patients in a small group setting (Ruiz-Moral, Gracía de Leonardo, Caballero Martínez and Monge Martin, 2019:90). Although students

described the training as very useful, several students described the exposure to small-group teaching and simulation as stressful. This alerted the educators to the fact that students might require increased support. Medical students were surveyed after the first and follow-up components of a helical training programme in the breaking of bad news (Brouwers; Bor; Laan; van Weel and van Weel-Baumgarten, 2018:1639). The response after the second phase of the programme was less positive than after the first phase, as students reported the need for a greater degree of psychological support and more comments on how to improve.

In the South African context, Matthews and van Wyk (2018(c):194) asked participants in the undergraduate medical communication skills training programme at the University of Kwazulu-Natal to make recommendations for the improvement of the communication skills training programme. The participants were educators, clinical teachers from the department of health and medical students. Recommendations included a greater focus on cultural competence and language development of IsiZulu. Respondents also advised a more standardised approach in training by using the HPCSA core competencies framework. Other suggestions were a greater emphasis on clinical educators as role models of good communication, a greater focus on patient-centredness and improvement of their own skills through reflection.

Medical educators at the Witwatersrand University in South Africa asked medical students to comment on their experience of a new medical curriculum. The researchers noticed the eagerness with which the students contributed and their thoughtful responses. The researchers concluded that this was testimony to the fact that the students were becoming reflective practitioners (McInerney *et al.,* 2013*).* It is therefore clear that a student review can aid educators in understanding the students and their experiences. In this way, it can help educators consider how the training programme can be improved.

2.5 CONCLUSION

In this chapter, the medical education literature was consulted regarding the importance of doctor-patient communication skills, the best practices in teaching and learning of doctor-patient communication, as well as the purpose of a student review of the training programme. In Chapter 3, the research methodology will be explained.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

The literature review in Chapter 2 summarised prior research in communication skills training globally and locally. In this chapter, the focus will be on the research design and methodology.

3.2 RESEARCH DESIGN

A cross-sectional, quantitative descriptive study design was used. The term cross-sectional refers to the fact that data was collected over a short period of time and not on multiple occasions or longitudinally. Quantitative refers to the viewpoint that the concept studied is observable and measurable. (Tavacol and Sanders, 2014:753).

Descriptive studies enable researchers to establish attributes of the subject under investigation (Leedy and Ormrod, 2010:182). These studies can contribute to the knowledge of current practice in medical education and can be used to fine-tune the training provided (Sanson-Fisher, Hobden, Waller, Dodd and Boyd, 2018:5).

Qualitative research helps researchers gain an understanding of underlying reasons, opinions, and motivations and they are not concerned with numerical values or statistical procedures to explain the results (Tavacol and Sandars, 2014:847). Despite the differences in approach and paradigm, quantitative and qualitative methods can be used to complement each other (Tavacol and Sandars, 2014:838). The study contained a qualitative element, which complemented the quantitative design.

3.3 RESEARCH METHODS

3.3.1 Literature Study

According to Botma *et al.* (2010: 63), the purpose of a literature study is to establish what is already known about the subject and whether knowledge or evidence is deficient. The literature study further helps the researcher to gain a

better understanding of the subject matter, to contextualise the research problem and establish a firm basis for the research.

Further to the preliminary literature review, the researcher performed an in-depth search to examine the following: What the effect of doctor-patient communication is on patient outcomes: which educational practices work well in terms of improving the communication skills of medical students and what role a student review can play in the evaluation of the training provided. The researcher specifically looked, not only for global literature but for research done at the UFS and other South African medical schools in terms of communication skills training for undergraduate medical students.

The search was conducted by means of the academic search engine EBSCO HOST, through the UFS online library service. The following databases were explored: Africa-Wide Information, CINAHL, Medline and Open Dissertation. The search mainly focused on articles published over the last ten years. Exceptions were made in the case of findings in older articles that were significant and relevant. Recent textbooks by experts in doctor-patient communication skill training were also consulted.

3.3.2 Target Population

The target population is the entire group that the researcher would like to study (Banerjee and Chaudhury, 2010:60). Fourth and fifth-year undergraduate medical students, who were training at the University of the Free State (UFS) in 2019, formed the target population of this study.

3.3.3 Description of sample and sample size

Researchers often use sampling when the entire population is not available. Guidelines suggest using the largest sample possible to minimise sampling error (Botma, Greeff, Mulaudzi, and Wright, 2010:124). To achieve a representative sample, the entire fourth year and fifth-year groups of medical students were asked to take part. As participation was voluntary, the number of students who completed the questionnaires dictated the sample size. Other medical student

year groups were not included as they did not have experience of all three phases of the undergraduate MBChB programme.

At the time of the study, there were 120 students in the fourth year class and 132 students in the fifth year class. The fifth-year class consisted of 115 students who started their training at the UFS and 17 students who were part of the Nelson Mandela Fidel Castro Medical collaboration programme and joined the programme in Phase III (Personal communication, Sulet du Plessis, Programme Organiser: Undergraduate MBChB Programme: Support School of Medicine, UFS: 2019).

3.3.4 Description of study methodology and data collection tool

In this study, a self-administered survey method was used in the form of an anonymous questionnaire. Questionnaires allow researchers to collect information from respondents in order to study a specific topic (Maree and Pieterson, 2014:155).

The researcher followed the guidelines provided by Botma and co-workers (2010:134) in terms of developing the questionnaire: A literature study was done to identify the key concepts in doctor-patient communication skills training (*cf.* Chapter 2). Using national and international literature contributed to the validity of the questionnaire and guided the development of the questionnaire. Following the literature study, a blueprint was created to define the key content.

The questionnaire was based on Harden's extended view of the curriculum (Harden, 2017:5). The purpose of the quantitative section of the questionnaire was to obtain a student review of the doctor-patient communication skills training in terms of the learning outcomes, the content, the educational strategies, learning opportunities, assessment and educational environment (Harden, 2017: 5). An example of the questionnaire has been included as appendix B.

Questions were placed in a logical order and kept free of jargon. Statements rather than questions were used, giving respondents the opportunity to agree or disagree, by choosing an option from a modified Likert scale. Open-ended

questions gave participants the opportunity to motivate their answers. They were given the chance to add comments at the end of the questionnaire. The researcher tried to keep the questionnaire as short and user-friendly as possible. Questions were stated in the positive to prevent confusion. Biased questions were avoided. The language used for the questionnaire was English, as that is the official language of tuition at the UFS.

3.3.5 Data gathering

Data gathering commenced a week after the pilot study in the first week of June 2019. Both the fifth year and fourth-year medical students have been subdivided into five student groups each during their clinical rotations The researcher approached clinical teachers of the five relevant clinical departments by e-mail beforehand and obtained permission for the distribution of questionnaires during the first week of each clinical rotation. The clinical teachers specified the most convenient time for the distribution. The timing of distribution was carefully planned in order not to coincide with any assessments or preparation for assessment. Distribution was linked with the orientation session to a new clinical rotation to avoid disruption in student training.

The researcher and colleagues from the Clinical Simulation and Skills Department and Department of Family Medicine distributed printed questionnaires to students. The students were reassured that participation in the study was voluntary and that they could withdraw at any time. For the sake of convenience, students were asked to consider immediate completion. Those who did not opt for immediate completion could insert their questionnaire into a sealed box held by their student group leader later in the day. The student group leaders returned these boxes to the researcher's office upon receipt of completed questionnaires.

3.3.6 The pilot study

Botma and co-workers describe the pilot study as 'a small-scale version of the study' (2010: 275). The pilot study is like a 'practice run' for the main event, as it helps to identify potential problems. In this way, it can improve the quality and the practical implementation of the study.

To conduct the pilot study for this research project, five undergraduate fourth-year medical and five undergraduate fifth-year medical students were randomly selected. Numbers were obtained from the website www.*random.org.* and students with the corresponding number on the class list were approached. They were asked to complete the questionnaire in the last week of May 2019. The pilot study indicated that the questions were phrased clearly. The pilot study established that it took approximately ten to fifteen minutes to complete the questionnaire. The questionnaire did not require adjusting prior to conducting the actual study, except for isolated typing errors. The data of the pilot study have been included in the study, seeing that there were no significant changes to the questionnaire following the pilot study.

3.3.7 Data analysis

Quantitative data analysis is used to quantify the problem by generating numerical data. This can be transformed into useable statistics. Quantitative data analysis differs from a qualitative analysis in that data is based on numbers rather than texts. (Tavacol and Sandars, 2014:753). The researcher entered the data into an Excel spreadsheet. The quantitative data analysis was done by the Department of Biostatistics at the University of the Free State. Categorical variables were summarised by frequencies and percentages, and numerical variables by medians and ranges.

For the qualitative analysis, answers to open-ended questions within each questionnaire theme were reviewed. The researcher identified subthemes, categories and subcategories emerging within each theme, by making use of grounded theory (Watling and Lingard, 2012: 852). The verification of categories was done through consensus meetings of the researcher with one of the study leaders. Reporting of results will be done in the following way: Each direct quote from respondents, will be followed by the study year of the participant, the questionnaire number and the gender of the respondent in brackets. For example [4.34f] means questionnaire number 34 of a female fourth year student. If the respondent did not disclose their gender, only the study year and questionnaire number will be provided.

3.4 VALIDITY, RELIABILITY AND TRUSTWORTHINESS

3.4.1 Validity

Validity shows whether sound reasoning guided the design and the interpretation of the research findings. "*Did the study measure what it set out to measure*?" (Botma, 2010:174). Using national and international literature contributed to the validity of the literature review and guided the development of the questionnaire. The use of open-ended questions coded into themes by the researcher with verification by the study leader increased the validity of the questionnaire. The high response rate of students increased the validity of the questionnaire.

3.4.2 Reliability

Reliability is the extent to which a measurement procedure can produce the same results when repeated (Scurwith and van der Vleuten, 2014:244). A target population was selected and the structured research instrument helped to ensure reliability. The use of a pilot study enhanced the reliability of the study because it enabled scrutiny before the onset of the main study.

3.4.3 Trustworthiness

Although the study is predominantly quantitative, the qualitative elements consisted of open questions interspersed throughout the questionnaire, which have been coded. Trustworthiness can be judged by Guba's four criteria (Guba 1981:87, Botma: 2010:292). These criteria are believability, relevance, dependability and confirmability. The supervision of the study leader and the involvement of the biostatistician helped to ensure trustworthiness by overseeing the coding and interpretation of the results of the open-ended questions of the questionnaire.

3.5 ETHICAL CONSIDERATIONS

3.5.1 Approval and permission

Ethical approval was obtained from the Health Sciences Research Ethics Committee of the UFS. The Ethics number obtained is UFS-HSD2019/0327/2506. Permission to conduct the study was granted by the Dean

of the Faculty of Health Sciences, the Head of the School of Clinical Medicine, the Vice-Rector: Student Affairs of the UFS and the Vice-Rector: Research, University of the Free State.

3.5.2 Informed consent

The researcher realised the potential threat to the voluntariness of the respondents, in their position as medical students at the UFS (Botma *et al.*, 2010:8). However, the researcher is not involved in the tuition of the fourth and fifth-year medical students, so it was unlikely that they would feel compelled to participate. The students were informed that completion of the questionnaire was voluntary and that they would not be penalised in any way for not taking part in the study. There were no academic, financial or culinary incentives for taking part. The purpose of the research was explained, namely the evaluation and potential development of communication skills training.

The researcher compiled an information document according to the specifications of the ethics committee. This was provided with the questionnaires and has been included as Appendix C. At the start of the questionnaire, each respondent was informed that completion of the questionnaire will be seen as consent, but that they could withdraw participation at any point. Written consent was not required, as the questionnaires were anonymous.

3.5.3 Right to privacy

The questionnaires were devoid of identifiable data. In this research project, the participants were anonymous and data was handled professionally.

3.6 CONCLUSION

This chapter presented the research design and methodology. The selection of participants, design and distribution of the questionnaires were discussed, as well as the data analysis. Attention was given to the reliability and ethical aspects of the research. In the subsequent chapter, the focus will be on the research findings.

CHAPTER 4
FINDINGS OF THE SURVEY

4.1 INTRODUCTION

In this chapter, the results of the questionnaire survey will be presented. The sample size out of which percentages were calculated, is indicated for each question. The reason for the variation in sample size is that some participants did not answer all questions.

Results for each year group will be presented separately, for the following reasons: Firstly, the fifth years had more exposure to clinical training due to their seniority. Secondly, there was a higher response rate in the fifth-year group, making this sample more representative. A total of 106 fifth-year students participated out of the 132 on the class list, making the response rate in this group 80.3%. This is in stark contrast with the fourth-year group, where only 65 of 120 students participated in the study, making their response rate 54.2%. The discrepancy in response rates will be discussed in chapter 5.

4.2 DEMOGRAPHIC DATA

Table 4.1 outlines the age and gender of the participants.

Table 4.1. Demographic data of participants

Age	**4th year students** (n=65)	**5th year students** (n=106)
Median Age	22	23
Age range	21-32	21-34
Gender	n=64	n=103
Female	34 (53.1%)	58 (56.3%)
Male	30 (46.9%)	45 (43.7%)

The majority of respondents were female. Fourteen respondents in the fifth-year group (13.2%) were part of the Nelson Mandela Fidel Castro Medical collaboration who joined the programme in Phase III. Consequently, these students reviewed only Phase III of the programme and this will be reflected in the results presented. Table 4.2 outlines the home languages of respondents.

Table 4.2 Distribution of respondents according to the home language spoken

Students' home language	4th years (n=57)	5th years (n=94)
Afrikaans	19 (33.3%)	54 (57.5%)
Chinese	1 (1.8%)	0
English	23 (40.4%)	14 (14.9%)
Gujarati	0	1 (1.1%)
IsiXhosa	4 (7.0%)	4 (7.0%)
IsiZulu	3 (5.3%)	11 (11.7%)
Sesotho	5 (8.8%)	11 (11.7%)
Setswana	2 (3.5%)	1 (1.1%)

Sesotho, which is the language spoken by the majority of patients that students encounter, was indicated as the home language of 8.8% of fourth-year students and 11.7% of fifth-year students. A third of fourth-year students and 57.5% of fifth years indicated Afrikaans as their home language, while 40% of fourth-year students, almost 15% of fifth-year students indicated English as their home language.

4.3 THEMES IN THE QUESTIONNAIRE

The questionnaire design was based on Harden's extended view of the curriculum (*cf.* Figure 1.3 & Section 3.3.4). An overview of the themes in the questionnaire is given in Figure 4.1.

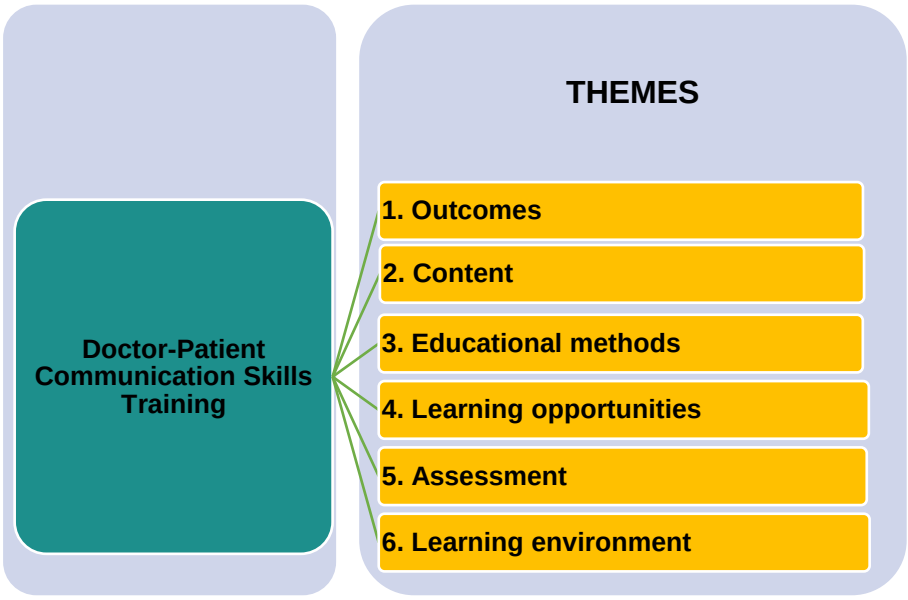

Figure 4.1 Overview of themes in the questionnaire

4.3.1 Theme One: Outcomes

Students were asked whether the outcomes of the communication skills training had been made clear to them. Their responses are summarised in Table 4.3.

Table 4.3 The outcomes of doctor-patient communication skills training & HPCSA requirements were made clear to the students

	4th year students (n=65)				**5th year students** Phase I (n=92) Phase II (n=92) Phase III (n=106))			
a) Informed of Outcomes	**Not at all**	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost always**
Phase I	16 24.6%	19 29.2%	21 32.3%	9 13.8%	14 15.2%	36 39.1%	26 28.3%	16 17.4%
Phase II	2 3.1%	20 30.8%	34 52.3%	9 13.9%	2 2.2%	19 20.7%	52 56.5%	19 20.7%
Phase III	4 6.2%	13 20.0%	28 43.1%	20 30.8%	0 0	2 13.2%	48 45.3%	44 41.5%
	4th-year students (n=65)				**5th-year students** Phase I ..(n=92) Phase II (n=92) Phase III (n=105)			
b) Informed of HPCSA requirement	**Not at all**	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost always**
Phase I	9 13.9%	8 12.3%	26 40.0%	22 33.9%	10 10.9%	26 28.3%	30 32.6%	26 28.3%
Phase II	2 3.1%	9 13.9%	34 52.3%	20 30.8%	5 5.4%	20 21.8%	37 40.2%	30 32.6%
Phase III	2 3.1%	6 9.2%	33 50.8%	24 36.9%	3 2.9%	12 11.4%	44 41.9%	46 43.8%

More than 70% of fourth-year students and more than 80% of fifth-year students reported that the expected outcomes of communication skills training had been made clear to them in Phase III. Small percentages of students reported this for the earlier phases.

More than 60% of students in both groups reported having been informed of the communication skills competencies required by the HPCSA in Phase I. Referring to Phase II; these numbers increased to 83% of fourth-year students and 72% of fifth-year students. In terms of Phase III, 87% of fourth-year students and 85% of fifth-year students reported that the HPCSA requirements had been made clear to them.

4.3.2 Theme Two: Content

Students were asked regarding the content of the communications skills training according to the following subthemes: Informed of an evidence base, breaking bad news, managing language and cultural differences, understanding the patient's point of view, explaining medical errors and defusing anger. Figure 4.2 gives an overview of this theme with its subthemes.

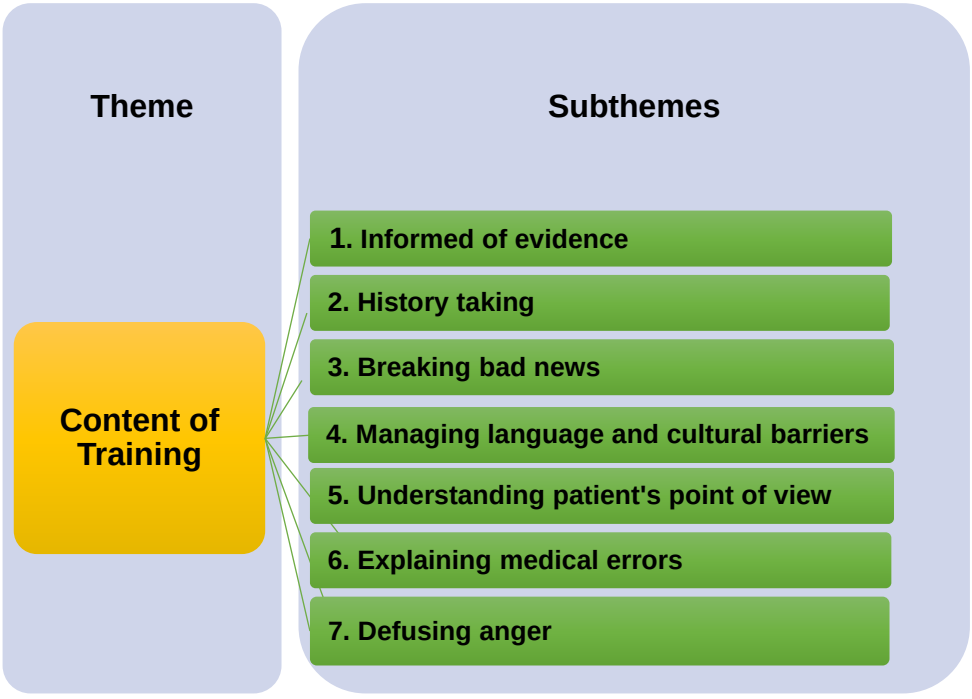

Figure 4.2: Overview of the subthemes under the Theme: Content

4.3.2.1 Content of Training: Subtheme 1: Informed of evidence

The first subtheme focused on whether students were told of studies that demonstrated the beneficial effects of good doctor-patient communication skills on patient outcomes. The responses of students appear in Table 4.4.

Table 4.4 Students were told of studies showing that good doctor-patient communication results in better patient outcomes

	4th-year students (n=65)				**5th-year students** Phase I (n=92) Phase II (n=92) Phase III (n=106)			
	Not at all	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost always**
Phase I	23 35.4%	20 30.8%	19 29.2%	3 4.6%	29 31.5%	29 31.5%	23 25.0%	11 12.0%
Phase II	17 26.1%	22 33.9%	22 33.9%	4 6.2%	15 16.3%	33 35.9%	30 32.6%	14 15.2%
Phase III	14 21.5%	20 30.8%	23 35.4%	8 12.3%	13 12.3%	29 27.4%	39 36.8%	25 23.6%

More than 50% of fourth-year students reported that they had not been told that good doctor-patient communication has a beneficial effect on patient outcomes during Phases I to III. The majority of fifth years reported that they had been told of the evidence base for communication skills in Phase III, but not in the earlier phases. There were no open questions in this subtheme.

4.3.2.2 Content of the Training: Subtheme 2: History taking.

Students were asked whether they received training in taking a thorough patient history, including a psychosocial history. The responses of students are summarised in Table 4.5.

Table 4.5 Students received training in history taking, including a psychosocial history

	4th-year students (n=65)				**5th-year students** Phase I (n=92) Phase II (n=92) Phase III (n=106)			
	Not at all	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost Always**
Phase I	33 50.8%	17 26.2%	4 6.2%	11 16.9%	31 33.7%	31 33.7%	17 18.5%	13 14.1%
Phase II	2 3.1%	14 21.5%	29 44.6%	20 30.8%	2 2.2%	20 21.7%	37 40.2%	33 35.9%
Phase III	0 0%	7 10.8%	17 26.2%	41 63.1%	1 0.9%	9 8.5%	35 33.0%	61 57.6%

According to most students in both groups, they were predominantly taught to take a patient history in Phases II and III. Students were then asked to rate themselves in terms of their history-taking skills, and their answers can be seen in Table 4.6 below.

Table 4.6 Students' self-rating regarding history taking

	4th year students (n=65)			5th year students (n=105)		
	Novice	**Average**	**Excellent**	**Novice**	**Average**	**Excellent**
History taking	**4 6.1%**	**33 50.8%**	**28 43.1%**	**0 0%**	**45 42.9%**	**60 57.1%**

It is evident that fifth-year students were considerably more confident in their history taking skills compared to the fourth years. Students were asked to motivate their self-ratings. Within this theme of the content of the communication skills training and the sub-theme of history taking, the following categories emerged: Amount of practice, training received, barriers to history taking and reflection on their own ability. These appear in Figure 4.3.

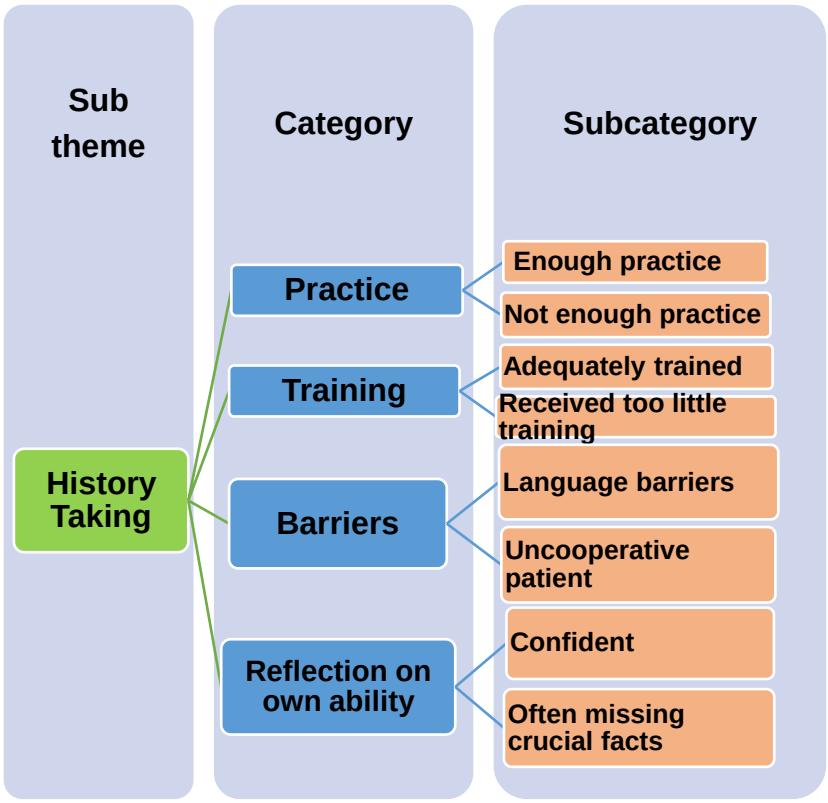

Figure 4.3: Categories and Subcategories emerging from Subtheme History Taking

The comments of students who rated themselves as excellent will be listed first. Students who rated themselves as excellent reported adequate training and opportunities to practise. Students who were confident in their own ability and rated themselves as excellent, explained: "*I have been taught to look at the patient holistically*" [5.48m], while another one said, "*I would say that 70% of the time I already know what is wrong with the patient from my history*" [5.40f].

One student attributed her excellent history taking ability to the Family Medicine Rotation [5.58f], while another said that it had been "*drilled more during the Internal Medicine Rotation*" [5.50m]. A student who rated herself as excellent reflected that "*you get a lot of exposure during semester 6 to 10, but it still depends on you as student to do your part*" [5.56f].

The comments of students who rated themselves as novices or average will be listed next. Many reported inadequate practice, while others commented on limited training: "*Taking history was mostly self-study. Many doctors did not teach or tell us why the history taken was not as good as it could be*" [5.88m].

A few students from both year groups cited language barriers as the reason for not being excellent at history taking. "*Most patients are Sotho speaking, difficult to communicate because of language barrier"* [5.6f], "*I can take patient history, but the only problem is the language, especially Afrikaans*" [5.76u]. One student mentioned that "*Psychosocial history in a non-cooperative patient can be very difficult*" [4.65f].

Students who rated themselves as novices or average reported experiencing similar challenges in their history-taking ability, namely missing crucial facts, struggling with their approach and with system-specific history. A few students reported not having adequate time to take a thorough history.

4.3.2.3 Content of the Training: Subtheme 3: Breaking bad news

Students were asked whether their training included practical sessions in breaking bad news. Their responses are outlined in Table 4.7.

Table 4.7 Students received training in breaking bad news

	4th-year students Phase I (n=64) Phase II (n=65) Phase III (n=65)				**5th-year students** Phase I (n=92) Phase II (n=92) Phase III (n=106)			
	Not at all	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost always**
Phase I	35 54.7%	23 35.9%	4 6.3%	2 3.1%	43 46.7%	35 38.0%	10 10.9%	4 4.4%
Phase II	11 16.9%	37 56.9%	14 21.5%	3 4.6%	25 27.2%	41 44.6%	20 21.7%	6 6.5%
Phase III	18 27.7%	29 44.6%	15 23.1%	3 4.6%	18 17.0%	47 44.3%	31 29.3%	10 9.4%

More than 70% of fourth-year students and more than 60% of fifth years reported that they had no training or limited training in breaking bad news throughout the different phases. Students were asked to rate themselves in terms of their ability to break bad news. Their responses are displayed in Table 4.8 below.

Table 4.8 Students' self-rating in terms of breaking bad news

	4th-year students (n=64)			**5th-year students** (n=106)		
Self-rating	**Novice**	**Average**	**Excellent**	**Novice**	**Average**	**Excellent**
Ability to break bad news	30 46.1%	33 50.8%	2 3.1%	40 37.7%	52 49.1%	14 13.2%

More than 86% of fifth years and almost 97% of fourth-year students described themselves as novices or average at breaking bad news. Students were asked to motivate their self-ratings. The following categories emerged from the subtheme 'breaking bad news': Limited opportunities to witness breaking bad news, no or very few opportunities to convey bad news, limited training in breaking bad news, concerns regarding role-modelling of this skill and finally a reflection on their own traits or challenges experienced. These categories with their subcategories appear in Figure 4.4.

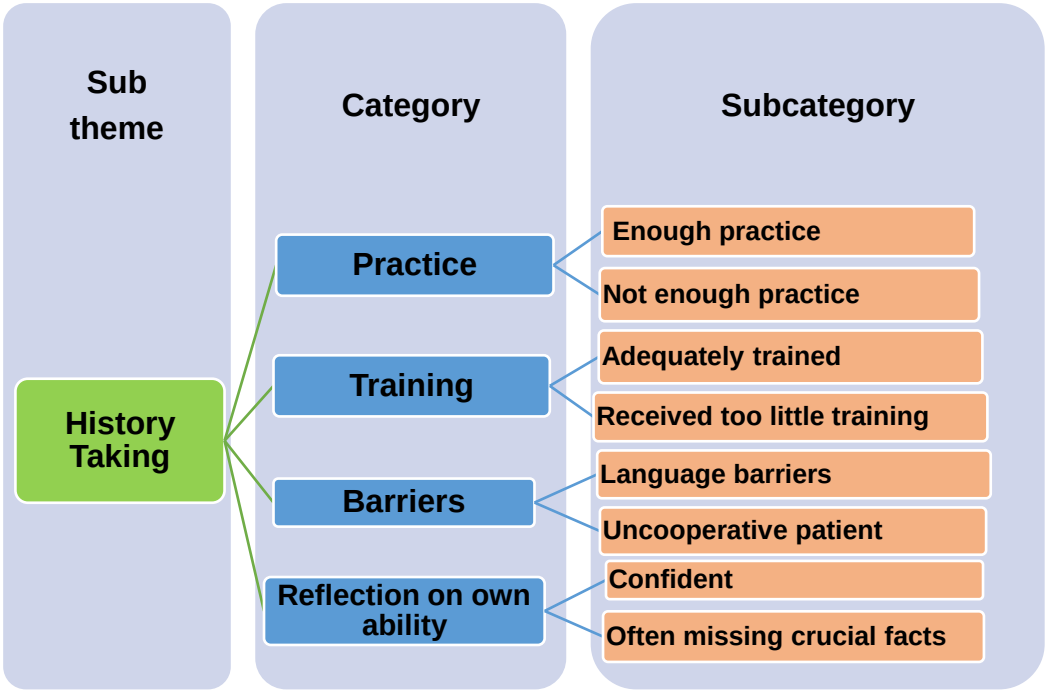

Figure 4.4: Categories emerging from the Content Subtheme: Breaking Bad News

The comments of students who rated themselves as novices or average will be listed first. Numerous fourth-year and fifth-year students reported a lack of exposure and training: "*I have never had practical training or even a simulated session on this topic*" [4.66f], *"No training received. Book knowledge does not help*" [4.46m], "*I recently had to break bad news. Retrospectively there are many things I could have done differently had I been better taught, not in a class but by doctors in practice. Class and practice are worlds apart"* [5.31f].

A few fourth-year students commented on the example set by doctors in the clinical environment: "*Doctors avoid talking about breaking bad news*" [4.14m], "*Practically I have only observed breaking bad news. Doctors are usually blunt and unsympathetic, which does not set a good example*" [4.63f]. A fifth-year student remarked, "*We always need to make the picture clear and explain to the patient after the registrar broke the news in an unprofessional and cold manner*" [5.100f].

A few students reflected on the challenge this skill poses: "*Not sure how to keep empathy and still be professional*", "*It's emotional"* [5.25f]. One fifth-year student commented that he had been described as extremely '*insensitive*' [5.23m].

Comments of students who rated themselves as excellent will now be listed: "*I have had to do it a few times, one time the patient's son came back to thank me for the way I handled everything*" [5.52f], "*I am a compassionate person. Training was also sufficient over the last two years"* [5.20m], "*During the MCLI modules we were taught how to break bad news as well as in the clinics during the surgery rotation*" [4.48m], Another student reported having done a counselling course and commented: "*most of the skill comes from non-medical training*" [5.50m].

4.3.2.4 Content of the Training: Subtheme 4: Training in managing language and cultural differences in the consultation

Students were asked about the training received in this skill. After that, they had to rate their ability to manage language and cultural differences in the consultation. Students' responses are summarised in Tables 4.9 and 4.10.

Table 4.9 Students received training in managing language and cultural differences

	4th-year students (n=65)				**5th-year students** Phase I (n=92) Phase II (n=92) Phase III (n=106)			
	Not at all	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost always**
Phase I	23 35.4%	23 35.4%	18 27.7%	1 1.5%	34 37.0%	39 42.4%	16 17.4%	3 3.3%
Phase II	12 18.5%	30 46.2%	20 30.8%	3 4.6%	18 19.6%	46 50.0%	24 26.1%	4 4.4%
Phase III	9 13.9%	25 38.5%	21 32.3%	10 15.4%	15 14.2%	39 36.8%	38 35.9%	14 13.2%

More than 60% of both student groups reported little training in managing cultural and language differences in Phases I and II. In terms of Phase III, 51% of fifth-year students and 52% of fourth-year students reported limited training.

Table 4.10 Students' self-rating in managing language and cultural differences in the consultation

	4th-year students (n=65)			5th-year students (n=106)		
Self-rating:	**Novice**	**Average**	**Excellent**	**Novice**	**Average**	**Excellent**
	13 20.0%	43 66.2%	9 13.9%	8 7.6%	73 68.9%	25 23.6%

More than two-thirds of students in both groups rated themselves as average in managing language and cultural diversity. Students were asked to motivate their self-ratings. The following categories emerged from the subtheme of dealing with language and cultural differences: Ability to respect cultural differences, ability to find a translator, language proficiency, training received and own cultural background. In Figure 4.5, these categories and subcategories are schematised.

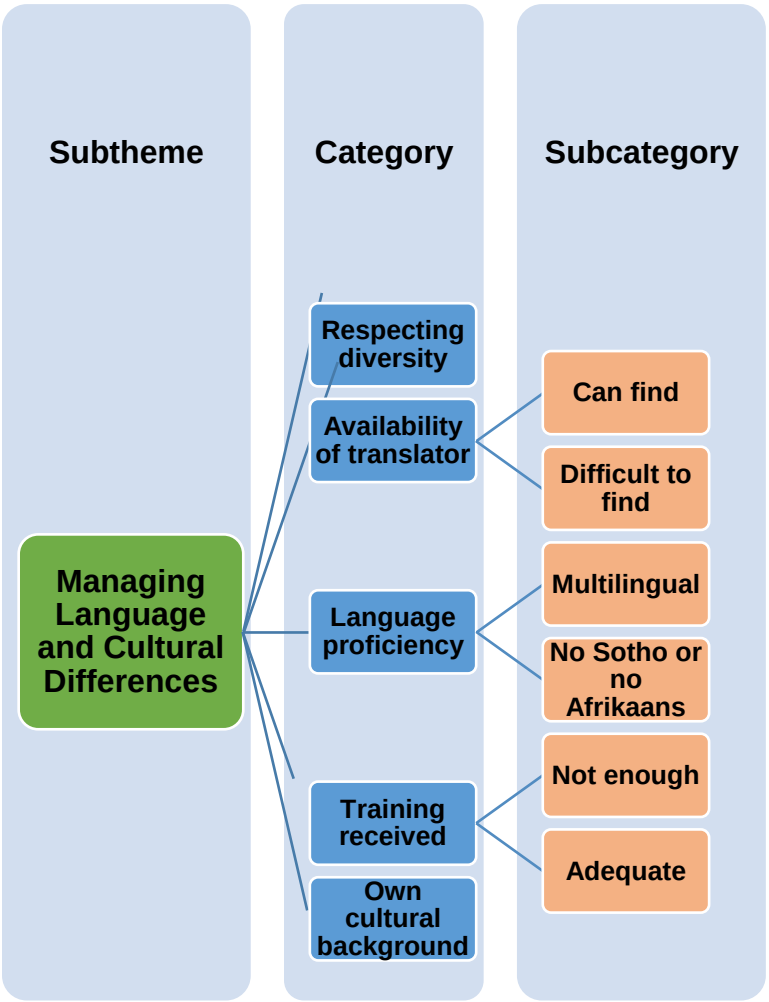

Figure 4.5 Categories & subcategories emerging from the subtheme managing language and cultural differences

Many students emphasised the importance of respect and understanding for those from other cultures. "*Because South Africa is a diverse country, we should always take other people's differences into consideration and respect them"* [5.32u], *"Being respectful is key"* [4.18m].

In terms of practically dealing with language differences, a number of students reported asking nurses or fellow students to translate, while a few students commented about the difficulty in getting someone to translate "*There are usually no formal translators available in clinical practice at the hospitals, so you are dependent on the sisters who are willing to help*" [4.6f]. Many students in both groups reported limited training in this aspect of doctor-patient communication. However, one student commented, "*Respecting cultural differences is often emphasised to us in our clinical skills training*" [5.104f].

Many students from both year groups commented on not being able to speak Sesotho but mentioned that they are in the process of learning. One student remarked, *"I struggle to speak Sesotho fluently, but I am learning*" [5.20m]. Another student said, "*Afrikaans is the problem*" [5.76m]. Many students rated themselves as excellent due to proficiency in multiple languages. "*I am fluent in quite a few languages, especially Sesotho and Afrikaans which are predominantly spoken in the Free State"* [5.40f]. One student who rated herself excellent, reflected: "*I come from a multicultural background and feel that this makes it easier to approach people of different cultures/languages*" [4.54f]

4.3.2.5 Content of the Training: Subtheme 5: Ability to understand the patient's point of view.

The fifth subtheme regarding the content of the training is whether training helped students to understand the patients' point of view. The responses of students are summarised in Table 4.11.

Table 4.11 Training helped students understand the patient's point of view

	4th-year students (n=65)				**5th-year students** Phase I (n=91) Phase II (n=91) Phase III (n=105)			
	Not at all	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost always**
Phase I	25 38.5%	25 38.5%	12 18.5%	3 4.6%	24 26.4%	31 34.1%	24 26.4%	12 13.2%
Phase II	6 9.2%	22 33.9%	34 52.3%	3 4.6%	13 14.3%	26 28.6%	41 45.1%	11 12.1%
Phase III	4 6.2%	11 16.9%	39 60.0%	11 16.9%	7 6.7%	14 13.3%	54 51.4%	30 28.6%

The students were asked to rate themselves in terms of their ability to understand the patient's point of view. The majority of fourth-years and fifth-years indicated that they received most training in understanding the patient's point of view during Phase III (their clinical rotations). Their self-ratings appear in Table 4.12.

Table 4.12 Students' self-rating in being able to understand the patient's point of view

	4th-year students (n=65)			**5th-year students** (n=105)		
	Novice	**Average**	**Excellent**	**Novice**	**Average**	**Excellent**
Ability to see the patient's point of view	3 4.6%	42 64.6%	20 30.8%	7 6.7%	56 53.3%	42 40.0%

Forty per cent of fifth-years rated themselves as excellent in this skill, compared to 30% of fourth years. There were no open questions concerning this subtheme.

4.3.2.6 Content of Training: Subtheme 6: Ability to explain medical errors

The following subtheme was the ability to explain medical errors and potentially offering an apology. Students were asked whether they received training in this skill and to provide a self-rating. Their responses are summarised in Table 4.13, while their self-rating appear in table 4.14.

Table 4.13 Students were taught how to explain medical errors and potentially offer an apology

	4th-year students (n=65)				**5th-year students** Phase I (n=90) Phase II (n=91) Phase III (n=105)			
	Not at all	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost always**
Phase I	37 56.9%	24 36.9%	3 4.6%	1 1.5%	47 52.2%	26 28.9%	13 14.4%	4 4.4%
Phase II	20 30.8%	33 50.8%	11 16.9%	1 1.5%	30 33.0%	37 41.0%	21 23.1%	3 3.3%
Phase III	12 18.5%	36 55.4%	14 21.5%	3 4.6%	20 19.1%	44 42.0%	30 28.6%	11 10.5%

Table 4.14 Students' self-rating of ability to explain medical errors and apologise if required

	4th-year students (n=65)			**5th-year students** (n=105)		
Self-rating	**Novice**	**Average**	**Excellent**	**Novice**	**Average**	**Excellent**
Ability to explain medical errors	32 49.2%	28 43.1%	5 7.7%	31 29.5%	56 53.3%	18 17.1%

Most students in both groups reported limited training in this skill. Forty-nine per cent of fourth-year students rated themselves as novices, while more than fifty per cent of fifth-year students rated themselves as average in explaining medical errors/apologising. There were no open questions in this subtheme of the questionnaire.

4.3.2.7 Content of the Training: Subtheme 7: Defusing anger

The final subtheme regarding the content of the training focused on the ability to defuse anger. Students were asked whether they received training in this regard, and their responses appear in Table 4.15. Their self-ratings are summarised in Table 4.16.

Table 4.15 The content of the communication skills training included learning to defuse anger

	4th-year students (n=64)				**5th-year students** Phase I (n=91) Phase II (n=91) Phase III (n=105)			
	Not at all	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost always**
Phase I	34 53.1%	23 35.9%	5 7.8%	2 3.1%	46 50.6%	29 31.9%	10 11.0%	6 6.6%
Phase II	27 42.2%	21 32.8%	15 23.4%	1 1.6%	34 37.4%	29 31.9%	21 23.1%	7 7.7%
Phase III	19 29.7%	24 37.5%	19 29.7%	2 3.1%	17 16.2%	43 41.0%	28 26.7%	17 16.2%

Table 4.16 Students' self-rating in terms of ability to defuse anger

	4th-year students (n=63)			**5th-year students** (n=104)		
	Novice	**Average**	**Excellent**	**Novice**	**Average**	**Excellent**
Ability to defuse anger	24 38.1%	32 50.8%	7 11.1%	23 22.1%	61 58.7%	20 19.2%

More than 55% of respondents in both groups reported limited training in defusing anger in Phase III. More than 50% of students rated themselves as average in being able to defuse anger. One student who rated herself as excellent, added next to her rating "*I run*" [4.3f]. This section of the questionnaire contained no open questions.

4.3.3 Theme 3: Educational strategies/methods

Students were asked to rate educational methods that they had been exposed to. The methods were ranked from 1, the preferred method, while 6 was the ranking for the least preferred method. Students had to indicate in which phase the method had been used or otherwise indicate 'not applicable'. A few students ranked the methods, although they indicated that they had never been taught according to the educational method. The median ranking that respondents gave to the various teaching methods used is shown in Table 4.17. The phases in

which different methods were used according to respondents are included in this table.

Table 4.17 Ranking of different strategies/methods to teach communication skills*

Teaching methods	**4th year students**				**5th year students**			
	Median ranking *	Used in Phase I	Used in Phase II	Used in Phase III	Median ranking	Used in Phase I	Used in Phase II	Used in Phase III
A Lectures	(n=63)	(n=53)	(n=53)	(n=53)	(n=103)	(n=74)	(n=74)	(n=86)
	4	42 79.3%	41 77.4%	32 60.4%	3	49 66.2%	47 63.5%	60 69.8%
B Small group practice with peers	(n=62)	(n=52)	(n=52)	(n=52)	(n=102)	(n=72)	(n=72)	(n=83)
	3	18 34.6%	45 86.5%	28 53.9%	3	16 22.2%	56 77.8%	53 63.9%
C. Small group practice with simulated patients	(n=63)	(n=51)	(n=51)	(n=51)	(n=100)	(n=70)	(n=70)	(n=80)
	2	8 15.7%	42 82.4%	28 54.9%	2	8 11.4%	46 65.7%	58 72.5%
D. Looking at videos of consultations	(n=63)	(n=50)	(n=50)	(n=50)	(n=100)	(n=71)	(n=71)	(n=83)
	3	12 24.0%	46 92.0%	24 48.0%	3	16 22.5%	54 76.1%	41 49.4%
E. Being observed by a doctor in a clinical area	(n=63)	(n=48)	(n=48)	(n=48)	(n=96)	(n=74)	(n=74)	(n=74)
	3	1 2.1%	18 37.5%	43 89.6%	2	8 10.8%	25 33.8%	60 81.1%
F. Video-recording of student consultation to evaluate skills.	(n=56)	(n=28)	(n=28)	(n=32)	(n=88)	(n=63)	(n=63)	(n=65)
	4	2 7.1%	23 82.1%	14 43.8%	3	5 7.9%	26 41.3%	33 50.8%

* The ranking of the preferred method was 1, while 6 was the ranking for the least preferred method

In terms of educational methods, both groups of students ranked small group practice with simulated patients the highest. The fifth-year students equally favoured receiving feedback after an observed consultation. The least preferred methods of most of the fourth year and fifth year students were lectures and video recording of student consultations for evaluation.

4.3.3.1 Phases in which the methods were used

More than 60% of students in both year groups indicated that lectures were used in all phases. Small group practice with peers was used most in Phase II according to both year groups. Fourth-year students indicated that small group practice with simulated patients predominantly took place in Phase II, while respondents in their fifth year indicated that this method was used most frequently in Phase III. More than 80% of students in both year groups indicated that the observation of a consultation, with feedback given, was mostly done in Phase III.

4.3.3.2 Motivation for preferred method

Students were asked to motivate their ratings of the methods. Within this theme of educational methods and subtheme of motivation for preferred methods, certain categories emerged, namely feedback received, learning real-time, able to practise and the fact that the method is interactive. This subtheme and its categories are summarised in Figure 4.6.

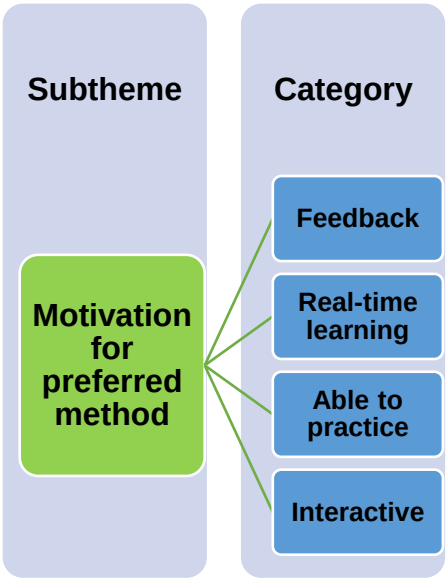

Figure 4.6 Motivation for preferred educational method

Many students valued feedback: *"Doctor can help you immediately to correct your errors"* [5.4f], *"It is important to know what you are doing wrong so you can fix it" [5.40f].*

Students appreciated the immediacy of direct observation as a method: *"Learning real-time from practising doctors is the best method" [5.31f], "Real-time evaluation" [5.34f].*

Students preferred practical methods: *"Being put on the spot is the best way to learn" [5.20m], "practical is better"* [5.11m], "*Simulated patients create a more hands-on experience*" [5.54m].

Students favoured interactive educational methods: "*Interactive sessions are easier to remember*" [5.75f], "*a simulated patient in a group give you a 'clinical setting' with an audience to give advice*" [5.56f] "*small groups are a calm way to learn*" [5.72m].

A few students expressed their support for lectures, due to "*Completeness and efficiency*" [5.51f], *"(It) gives a more broad insight than the other methods*" [5.68]. One student observed that *"Combined, the methods worked well" [*4.45f]

4.3.3.3 Motivation for least preferred method

Within the subtheme of motivation for least preferred methods, the following categories emerged: Challenges of peer practice, dislike of lectures and of watching video consultations. These can be seen in Figure 4.7

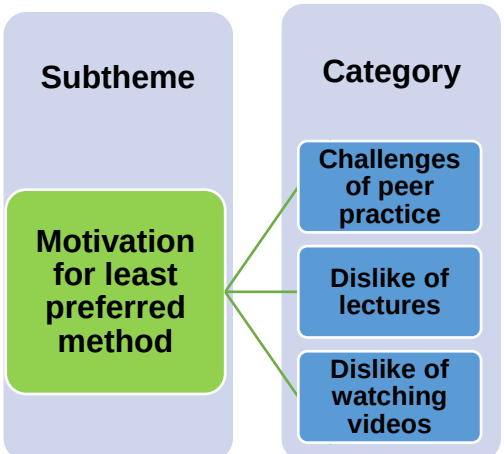

Figure 4.7 Motivations for least preferred method

Students reported challenges associated with peer practice, such as disorganisation and lack of experience. "*With peers, students tend to make a joke of everything*" [5.56f]. "*Small group practice: Often resulted in chaos*" [5.51f]. "*Learning from students who make mistakes might make me do the same*" [5.57f], "*you need someone with experience*" [5.3f]. One student seemed to perceive small group peer practice as a threat "*Hate it to be put on the spot"* [5.18m].

Many students offered comments regarding their dislike of lectures: "*Lectures are more tiring*" [5.11m]*, "Most lecturers only read slides and don't teach – waste of time"* [5.31f]*, "Very little offered. Doctors read slides when lecturing" [*5.35f], *"Lectures are usually long and boring when we are tired in the afternoon"* [5.75f], *"(I am) not an auditive learner"* [5.92]. *"Skills cannot be solely acquired through passive observation*" [5.45f].

Students took a dim view of watching videos of consultations: "*You hardly learn as there is no feedback or actual interaction with the patient"* [5.40f*], Videos are boring and terrible. Practice makes perfect"* [5.59m] *"too simple and obvious"* [5.68m]

4.3.3.4 Authenticity of simulated patients

Students were asked whether simulated patients were believable. Their responses appear in Table 4.18.

Table 4.18 Simulated patients were believable and made students feel like they were talking to real patients

4th-year students (n=64)				**5th-year students** (n=99)			
Not at all	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost always**
3 4.7%	23 35.9%	23 35.9%	15 23.4%	15 15.2%	37 37.4%	37 37.4%	10 10.1%

Most fourth-year students found simulated patients believable overall, while most fifth-year students commented that simulated patients were mostly not believable. Students were asked to motivate their answers. Within this theme of educational methods and subtheme authenticity of simulated patients, the

following categories emerged: the absence of signs, quality of the script/scenario and quality of acting, degree of preparedness and simulation models. These categories are outlined in Figure 4.8.

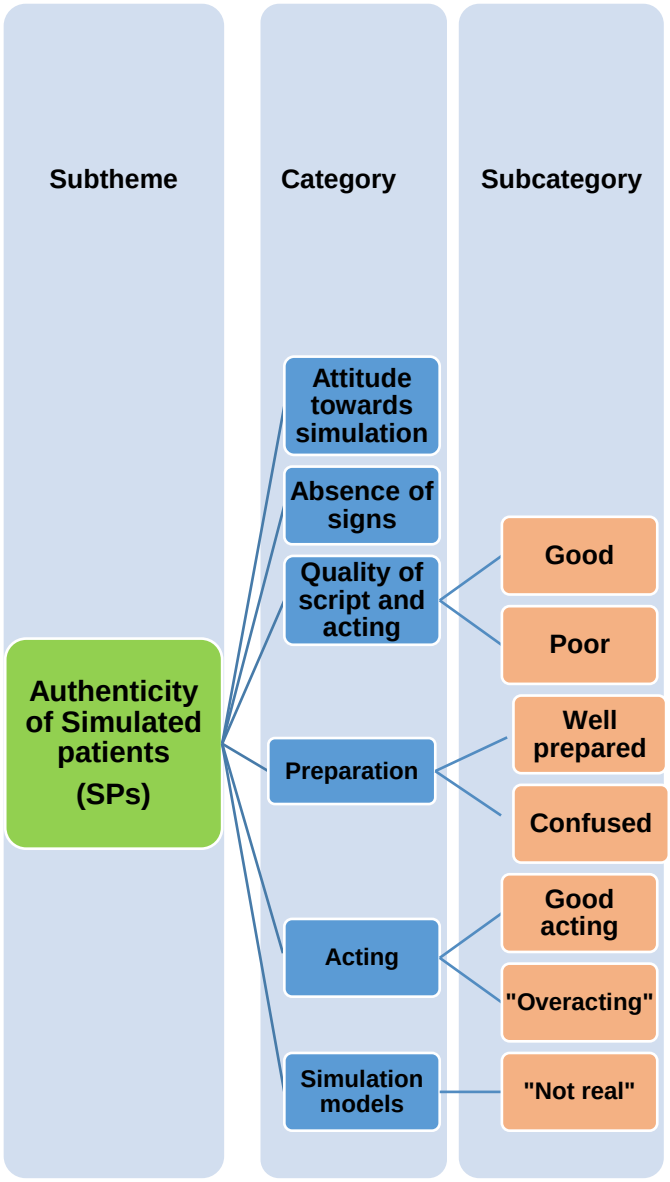

Figure 4.8 Factors influencing the perceived authenticity of simulated patients

The motivations of students who did not find SPs believable will be listed first: "*They weren't in a proper clinical setting, and there was no urgency"* [4.49f]. *"I absolutely detest working with simulated patients I have no way to start my approach especially when signs are absent" [5.105m].*

The quality of the script or the scenario was listed as a reason for finding SPs believable or not. One fourth-year student commented *"On some OSCE station*

doors the scenario will be an elderly male etc. and, in the room, you will get a young girl, which throws you off" [4.4f].

The preparedness of the SPs influenced their authenticity: *"Some were really unprepared"* [5.4f], *"Patients became confused upon receiving unexpected questions",* "*Patients were confused about their scenarios*" [5.38f], *"Especially history taking was confusing. Use medical students for these stations"* [5.56f], *"The patient was sometimes not told how to react properly"* [5.24f], *"Some patients had to be reminded what their symptoms were*" [4.8f].

The quality of acting influenced the credibility of the SPs: *"Some would really just regurgitate information they memorised. One could feel that the interaction was not genuine"* [5.40f], *"They just gave simulated answers, not like patients do"* [5.61m], *"They spoke from a page and answered accordingly" [*5.70m].

According to students, other patients 'overacted', *"Way too serious, over-analysis"* [5.59m], "*some patients over-exaggerated"* [5.96m], "*some actors tend to over-react and don't speak as fluently about their ailment as a real patient does"* [5.102f], *"They did not act very well. They overacted" [*5.64f].

The motivations of students who found SPs believable will now be listed:
A few students reported that SPs were well trained and prepared: "*Adequate detail about the scenario was always given. Simulated patients portrayed their conditions well and realistically overall*" [5.104f], "*They had scripted answers, and they answered like patients, it felt like real patients"* [5.1f], "*Patients were properly trained*" [5.78m], "*Simulated patients were normally well prepared*" [5.82f].

A few students praised the acting of the SPs: "*Good actors*" [5.28], "*They acted like real patients"* [4.19f], *"They were able to embrace the role and act accordingly"* [4.44], "*They were good in comparison to real patients I got from Phase III"* [5.11m].

Another student commented*: "It was good practice, gave an idea as to what communication with the patient in a clinical environment would be like."* [4.58f]

Some students thought that 'simulated patients' referred to models used in the simulation unit: "*An anatomical doll that blinks creepily is not a real patient. Real patients just seem grateful that someone is talking to them which is sad"* [5.30f]. *"A real patient is not replaceable. A simulated model is good to practise steps, but an actual patient is of course, much more complex and dynamic".* [4.66f]. However, one student remarked that *"Even the dolls feel like real patients"* [5.32u].

4.4.4 Theme 4: Learning opportunities

Students were asked whether they received enough opportunities to practise doctor-patient communication skills. Their responses are shown in Table 4.19.

Table 4.19 Students received enough opportunities to practise doctor-patient communication skills

Phase of training	**4th-year students** (n=64)				**5th-year students** Phase I (n=90) Phase II (n=90) Phase III (n=100)			
	Not at all	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost always**
Phase I	45 70.3%	14 21.9%	4 6.2%	1 1.6%	47 52.2%	35 38.9%	6 6.7%	2 2.2%
Phase II	8. 12.5%	23 35.9%	31 48.4%	2 3.1%	14 15.6%	26 28.9%	46 51.1%	4 4.4%
Phase III	1 1.6%	6 9.4%	32 50.0%	25 39.1%	5 5.0%%	13 13.0%	42 42.0%	40 40.0%

In the first question regarding learning opportunities, students indicated that they had adequate opportunities to practise communication skills in Phases II and III. Students were subsequently asked whether they had been given opportunities to reflect on situations when doctor-patient communication did not go so well and how they could have managed the situation better. The responses of the students are summarised in Table 4.20.

Table 4.20 Students were given opportunities to reflect on how their communication skills could be improved, after situations when the communication did not go well

	4th-year students (n=63)				**5th-year students** Phase I (n=88) Phase II (n=89) Phase III (n=100)			
Opportunities for reflection	**Not at all**	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost always**
Phase I	46 73.0%	13 20.6%	2 3.2%	2 3.2%	56 63.6%	24 27.3%	8 9.1%	0 0.0%
Phase II	23 36.5%	23 36.5%	13 20.6%	4 6.3%	30 33.7%	41 46.1%	18 20.2%	0 0.0%
Phase III	22 34.9%	22 34.9%	12 19.0%	7 11.1%	22 22.0%	50 50.0%	21 21.0%	7 7.0%

Students indicated that they lacked opportunities to reflect on how they could improve their communication skills throughout all the phases of training. There were no open questions at the end of this section of the questionnaire.

4.4.5 Theme 5: Assessment

Students were asked whether the content of assessments showed that communication skills were deemed important. They were also asked whether a continuous assessment of communication skills took place during the clinical phase. These results are summarised in Table 4.21.

Table 4.21 Student review of the assessment of doctor-patient communication skills

	4th-year students (n=63)				**5th-year students** Phase I (n=91) Phase II (n=91) Phase III (n=100)			
Content of tests confirmed the importance of communication skills	Not at all	Seldom	Often	Almost always	Not at all	Seldom	Often	Almost always
Phase I	31 49.2%	18 28.6%	11 17.%	3 4.8%	41 45.0%	29 31.9%	18 19.8%	3 3.3%
Phase II	16 25.4%	22 34.9%	22 34.%	3 4.8%	23 25.3%	37 40.7%	24 26.4%	7 7.7%
Phase III	15 23.8%	18 28.6%	23 36.%	7 11.1%	22 22.0%	28 28.0%	32 32.0%	18 18.0%
Content of exams confirmed the importance of communication skills	Not at all	Seldom	Often	Almost always	Not at all	Seldom	Often	Almost always
Phase I	27 42.8%	21 33.3%	12 19.%	3 4.8%	34 37.4%	30 33.0%	22 24.2%	5 5.5%
Phase II	10 15.9%	21 33.3%	26 41.3 %	6 9.5%	16 17.6%	29 31.9%	38 41.8%	8 8.8%
Phase III	8 12.7%	15 23.8%	26 41.%	14 22.2%	14 14.1%	18 18.2%	43 43.3%	24 24.2%
Doctor-patient communication skills have been assessed continuously	Not at all	Seldom	Often	Almost always	Not at all	Seldom	Often	Almost always
Phase I	37 59%	18 28.6%	7 11.1 %	1 1.6%	42 46.1%	29 31.9%	16 17.6%	4 4.4%
Phase II	13 20.6%	28 44.4%	20 31.8 %	2 3.2%	22 24.2%	38 41.8%	24 26.4%	7 7.7%
Phase III	14 22.2%	15 23.8%	23 36.5 %	11 17.5%	20 20.0%	25 25.0%	39 39.0%	16 16.0%

More than 70% of respondents in both year groups reported that the content of tests and examinations in Phase I did not reflect the importance of communication

skills. In terms of the content of assessments in Phase II, the majority of respondents indicated that communication skills were not emphasised. More than 60% of respondents in both groups indicated that the content of assessments in Phase III showed that communication skills were deemed important.

The majority of students in both groups did not feel that doctor-patient communication skills were continuously assessed during Phases I or II. In terms of Phase III, 54% of fourth-year students and 55% of fifth-year students indicated a continuous assessment of doctor-patient communication skills.

Students were asked to suggest the optimal method for assessing doctor-patient communication skills. This was an open question without options to choose from. Fourth-year students mentioned the OSCE most frequently as the best method for assessing doctor-patient communication skills, while the fifth year students most frequently mentioned assessment in the clinical setting. Other assessment methods included history taking and assessment during interactive practical sessions. Several students singled out the history taking assessment used during the Paediatric rotation. One student was of the opinion that assessments need to be tailored to the individual student, while another viewed assessment as ‘useless’.

The assessment methods mentioned by students are listed in Table 4.22, starting with the most frequently mentioned options first.

Table 4.22 Optimal assessment method(s) of doctor-patient communication according to students

Assessment method	4th year students (n=47)	5th year students (n=65)
OSCE	19 40.4%	10 15.4%
Practical assessment with a real patient with feedback/real contact with real patient/clerking patient/bedside practice/present to a doctor in the real situation/bedside practice/clerking patient/clinic or ward work	9 19.1%	16 24.6%
Practical sessions, peer practice, interactive sessions, simulation, tutorials	4 8.5%	12 18.5%
History taking station	0	9 13.8%
Clinical cases or long cases/presenting cases	2 4.3%	5 7.7%
Consultation/consultation with reflection	2 4.3%	2 3.1%
Observed by a doctor, evaluated by a consultant in a hospital situation	2 4.3%	2 3.1%
Oral scenarios/oral discussion/oral examination	3 6.4%	1 1.5%
Continuous assessment	0	3 4.6%
Ward round	2 4.3%	1 1.5%
Paper case/written	0	2 3.1%
Unsure/not applicable	0	2 3.1%
Any assessment with feedback	0	1 1.5%
Depends on the individual student – no best way	0	1 1.5%
Everywhere	1 2.1%	0
Evaluated by patient and doctor	1 2.1%	0
Video recorded simulation test of breaking bad news	1 2.1%	0
“Assessment is useless”	1 2.1%	0

Students were asked to motivate their choice of assessment method. Within this theme of assessment and subtheme of motivation for best assessment method, the following categories emerged: Need for feedback, practical and interactive method, contact with real patients and continuous assessment. These categories are summarised in Figure 4.9.

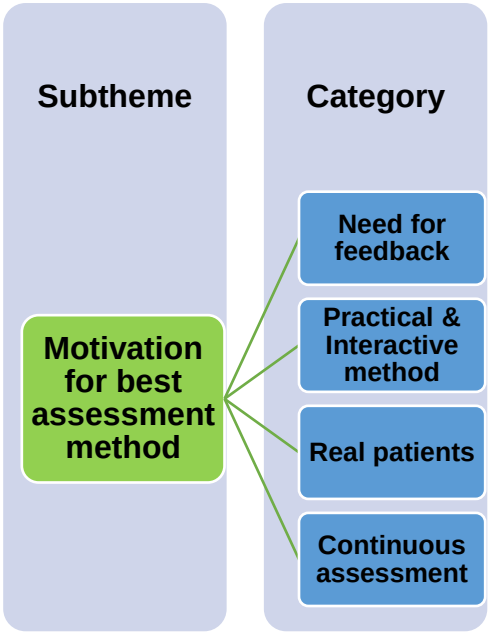

Figure 4.9 Motivation for the choice of optimal assessment method

Many students emphasised the need for feedback: "*An experienced doctor is able to view our skills and assess or provide feedback clearly so that we can adjust our skills accordingly*" [5.4f].

Many students highlighted the need to be assessed in the clinical setting: "*Real contact with real patients because then you are expected to behave professionally in real-life situations*" [5.48m]. A few students pointed out the need for continuous evaluation and motivated their answers in the following ways: "*Continuous evaluation in the wards and clinics by doctors told to assess for it (can't assess something if you don't know you have to assess it)"* [5.31f], *"Continued (assessment) throughout the rotation. That way, it is a better all-round picture"* [5.72m], "*Continuous clinical assessment. To take an overall assessment of the student, as an exam at the end of rotation doesn't correctly reflect a student's knowledge if they happen to have a bad day that day*" [5.2f].

One fourth-year student commented that "*Assessment is useless. People learn through real-life experience. You cannot teach someone to communicate; they must learn for themselves*" [4.18m].

Another fourth-year student suggested that some OSCE stations should "*purely test communication skills without the pressure of academic questions"* [4.63f].

4.4.6 Learning environment

Within this theme, students could comment on the learning environment, including the role-modelling of communication skills by senior doctors.

4.4.6.1 Was the learning environment conducive to the development of doctor-patient communication skills?

Students were asked whether the learning environment encouraged the development of doctor-patient communication skills. The responses of students are summarised in Table 4.23.

Table 4.23 The learning environment enhanced the development of good doctor-patient communication skills.

	4th-year students (n=62)				**5th-year students,** Phase I (n=90) Phase II (n=91) Phase III (n=105)			
	Not at all	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost always**
Phase I	30 48.4%	22 35.5%	8 12.9%	2 3.2%	35 39%	33 36.7%	18 20.0%	4 4.4%9
Phase II	5 8.1%	25 40.3%	29 46.8%	3 4.8%	13 14.4%	34 37.8%	32 35.6%	11 12.2%
Phase III	4 6.4%	14 22.6%	29 46.8%	15 24.2%	3 3.0%	19 19.0%	49 49.0%	29 29.0%

According to more than 75% of fourth-year students and more than 83% of fifth-year students, the learning environment in Phase I was not conducive to the acquisition of communication skills. In terms of Phase II, 51.6% of fourth-years and 47.8% of fifth-years found the learning environment beneficial. More than 70% of students in both groups indicated that the learning environment in Phase III helped them to develop their skills in doctor-patient communication.

Students were asked to motivate their answers. Students who indicated a positive learning environment ascribed it to increased opportunities for patient contact. "*Morning rotations allow students to interact with patients in Phase III*" [5.34f],

"*Students are given the opportunity to clerk patients in the ward and the clinic*" [5.45m].

Students who indicated that the environment was not conducive to developing communication skills, offered a variety of reasons. Within this theme of the learning environment and the subtheme of motivating why it did not enhance communication skills development, several categories emerged. These included workload and time pressure, the focus of training, feedback received, the attitude of patients and not feeling secure. Figure 4.10 outlines these categories.

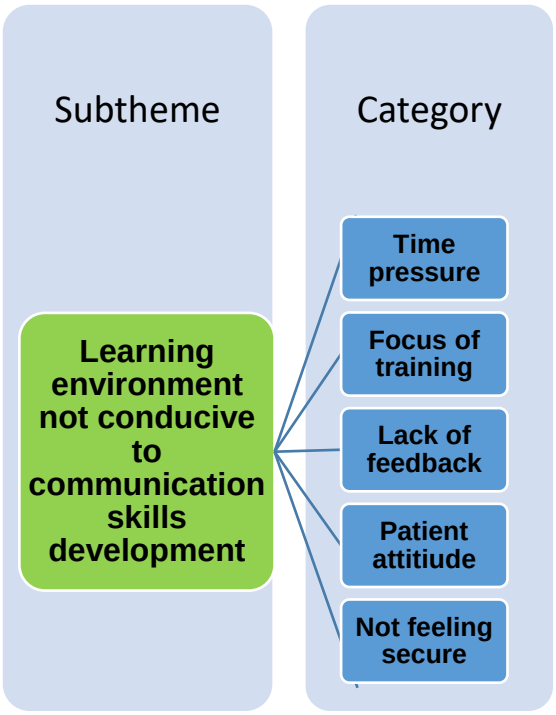

Figure 4.10 Reasons why students indicated that the learning environment did not enhance communication skills development

Students gave the following examples: *"You feel pressured and overloaded with the amount of patients"* [5.3m], "*not enough contact time" [4.29m], "time and crowding of rotation groups" [4.23], "everything is rushed" [4.46m]*.

In terms of the focus of training, students commented: *"The learning environment is very goal-orientated and not focused on patients' well-being"* [4.4f], *"We are more concerned about pathology than the patient"* [5.105m], *"Emphasis on getting signs and symptoms instead of patient"* [4.46m], "*You're chastised for*

'feeling too much' for your patients and wasting time listening to your patient" [5.30f], *"Communication skills are never emphasised* [4.22m], *"not enough emphasis on patient communication"* [5.94m], *"The clinical sim unit was the only time I felt doctor-patient communication was sometimes stressed"* [4.31m].

One fourth-year student indicated the lack of feedback: *"Students do not receive feedback on their ability and therefore never know if they have adequately acquired skills" [4.54f]*. A fifth-year student reported the effect of non-cooperative patients on the learning environment: *"Because sometimes you get patients who aren't cooperative, which is always a hassle to get information from"* [5.32u].

A fourth-year student made the observation *"Does not feel like a safe environment"* [4.52m]. The student did not elaborate on this comment.

4.4.6.2 Was patient-centred communication modelled by senior doctors?

Table 4.24 During the clinical rotations, patient-centred communication is modelled by senior doctors

4th-year students (n = 63)				**5th-year students** (n=100)			
Not at all	**Seldom**	**Often**	**Almost always**	**Not at all**	**Seldom**	**Often**	**Almost always**
5	32	17	9	6	45	34	15
7.9%	50.8%	27.0%	14.3%	6.0%	45.0%	34.0%	15.0%

58% of fourth-year students and 51% of fifth-year students indicated that senior doctors mostly did not model patient-centred communication. Students were asked to motivate their answers. From this subtheme of being a good role model in terms of doctor-patient communication, the following categories emerged, namely patient-centredness, professionalism and good mentoring of students. Figure 4.11 outlines these categories.

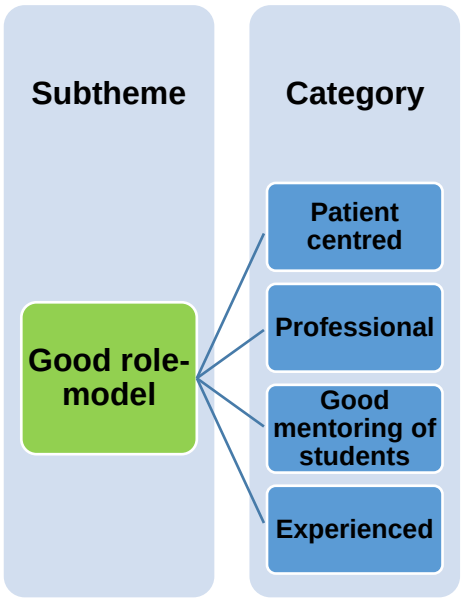

Figure 4.11 Reasons why students described doctors as good role models in terms of communication with patients

Students gave the following reasons for indicating that patient-centred communication was modelled to them: "*There was a lot of emphasis on patient-centred communication during clinical rotations"* [5.1f], *"Patient-centred communication is overall practised by doctors and emphasised to us by them"* [5.104f], *"They are very professional and patients always seem contented with their handling"* [4.27], *"Students are always mentored and so is interns by registrar and so on. There is always a consultant available close or a call away"* [5.77f], *"Because they are the ones who know the job better and they (are) experienced"* [5.47m].

Students who felt patient-centred communication was not modelled well, listed reasons such as the workload, not informing patients, disease-centredness and attitude of doctors. These categories and subcategories are summarised in Figure 4.12.

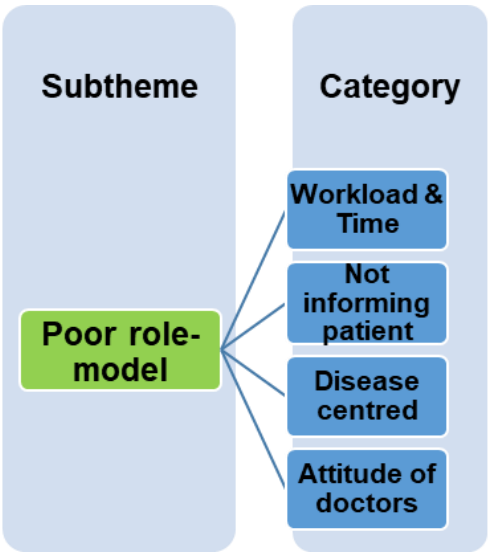

Figure 4.12 Reasons why students described doctors as poor role-models in terms of communication with patients

In terms of the workload, students described: "*Heavy workload & low staffing allow little to no time for a relationship with a patient*" [4.23], *"Often doctors are too busy/have too many patients and do not practise patient-centred communication"* [5.81f], *"Most doctors are too rushed to take a thorough history. Most learning comes from watching senior students* [4.54f], *"Doctors seem to always be in a rush"* [5.37m].

Many students gave examples of doctors not speaking to patients sufficiently: "*In some departments, you find that patients do not even know their diagnosis and no one says anything to the patient"* [5.74f], "*Some doctors don't talk to patients at all"* [5.64], *"The doctors sometimes ignore the patient and only talk to the students"* [4.19f]. *"(Doctors) don't tell patients what is going on"* [5.4f], *"The patients are often unsure and uninformed about their diagnosis and management"* [5.38f], *"We speak around the bed and then don't even tell the patient what is wrong"* [4.13f], *"Senior doctors talk over patients and not to patients"* [5.57f].

Some students mentioned an emphasis on the disease or the speciality, rather than on the patient: *"Students take a better and more detailed history than doctors. Registrars almost seem lazy and do not look at the patient in full, but only ask about the speciality they are in"* [5.40f], *"They just speak about the*

disease" [4.46m], *"(Patient-centred communication) doesn't happen"* [4.31], *"They do not include the patients the way we were taught to"* [4.53f].

Students expressed some of the following opinions regarding the attitude of doctors towards patients: *"Patients are not always respected*" [4.52], *"Many doctors are dismissive of patient's statements and questions, only a few are the exception"* [4.63f], *"Lots of doctors have a bad bedside manner and are too loaded with work to set a good example"* [5.63], *"Some doctors refuse to speak to patients even after we asked them if they could please do so*" [5.101], *"Not a lot are very good at speaking to patients (they were very abrupt*)" [5.54m], "*Some doctors really talk and listen to their patients, but others are f****** inhumane with how little regard they have for them. A lot of patients talk to students because they are too scared to ask the doctor and 'waste his/her 'valuable' time"* [5.30f].

Some students emphasised that the examples seen varied from doctor to doctor and between departments: *"Some doctors exhibit good communication skills, while others are demeaning and unprofessional*" [4.11f]. "*Depends on the department in which you work [5.11m], "depends on where you rotate"* [5.69f], *"Not all doctors share the same compassion" [5.20m], some doctors are good communicators, others less so" [5.31f]. Some doctors really care for patients and some don't"* [5.49f]. *"Only Family Medicine (models patient-centred communication)"* [5.28u]. *"Especially the Surgery rotation, I was shocked about the manner that the doctors treated their patients"* [4.4f].

One student commented on the communication of doctors with colleagues*: "Most doctors are loners and fighting with the nurses and with each other"* [4.8f].

4.5 STUDENTS VIEWS ON WHETHER COMMUNICATION SKILLS CAN BE LEARNT

Students were asked whether communication skills can be learnt. Their responses are summarised in Table 4.25.

Table 4.25 Communications skills cannot really be learnt: a person is either a natural communicator or not

4th-year students				5th-year students			
Strongly disagree	**Disagree**	**Agree**	**Strongly agree**	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**
17 27.4%	30 48.4%	11 17.7%	4 6.4%	23 22.8%	47 46.5%	25 24.7%	6 5.9%

More than 75% of fourth-year students felt that communication skills could be learnt compared to 69% of fifth-year respondents. There were no open questions in this section, yet one student wrote, "*Communication cannot be taught. Trying to teach people to communicate is useless; it is picked up with experience*" [4.18m].

At the end of the questionnaire, students were asked to state what they found useful in the training of doctor-patient communication skills, what they did not find helpful and to make recommendations in terms of improving the training.

4.6 ASPECTS OF THE TRAINING WHICH THE STUDENTS FOUND HELPFUL

Within this theme of what aspects were deemed useful, the following subthemes emerged: Attitude, skills, training and assessment. These are displayed in Figure 4.13.

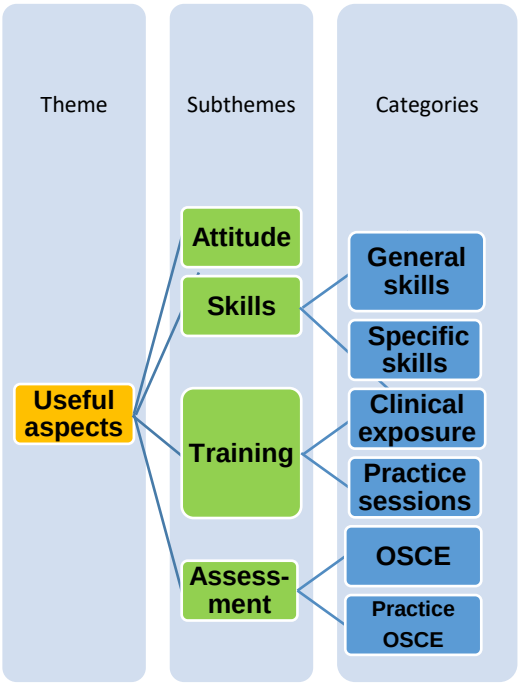

Figure 4.13 Aspects of doctor-patient communication skills training deemed most useful

4.6.1 Attitude

Students from both year groups mentioned the importance of the right attitude, such as being patient and being a good listener. "*Ability to hold conversation, sympathy and empathy, willingness to do*" [5.35], "*Listening to them, even if they just want to talk about their cat or grandchildren or whatever*" [5.30]. The students did not mention how the training contributed to the shaping of their attitude.

4.6.2 Skills

In terms of skills, they mentioned general skills as well as specific skills they found useful. In terms of general skills, examples included: "*Manners and introducing self*" [4.41m], "*Listening to the patient's worries and handling those worries is also important, an aspect we tend to forget*" [5.37m], "*Patients feel safe when you approach them with confidence, they open up when you approach them with professionalism*" [5.75f], "*Remembering not to use medical terms*" [5.101f].

In terms of specific skills, students mentioned how beneficial it is to be proficient in the language of the patient and the usefulness of a practical session on breaking bad news. One student found the emphasis on a good patient history beneficial: "*History taking, it is extensively practised*" [5.90m].

4.6.3 Training

Students from both year groups found two facets of the training particularly helpful: Practical clinical skills training and clinical exposure. "*Practice makes perfect*" [5.82f]. *"Practice: the more patients you see, the better your communication skills"* [5.80f].

Aspects of the clinical skills module that they found helpful include practice with peers and consultations with simulated patients, followed by feedback. "*MCLI* (Clinical Skills Module) *assisted us a lot with the history aspect and communicating with a patient"* [4.21f].

In terms of clinical exposure, they enjoyed being able to observe practitioners, as well as communicating with real patients themselves. "*Observing senior doctors in practice – especially during the elective period*" [5.27m].

One student mentioned a specific module in Phase I: "*MDOC was very helpful with Dr K in Semester 1. He approached it well and helped me*" [5.95m]. Others singled out simulations, Family Medicine cases as well as the history taking in their Paediatric rotation.

4.6.4 Assessment

The respondents specifically mentioned the OSCE and practice OSCE as beneficial elements of the training. "*OSCE preparation so that you do not make unnecessary mistakes in communication with a real patient"* [5.99f].

4.7 ASPECTS OF THE TRAINING WHICH STUDENTS FOUND UNHELPFUL

Within this theme, the following subthemes emerged: training method chosen, shortcomings in small group training, lack of training in specific skills and role models. Figure 4.14 depicts the subthemes and categories.

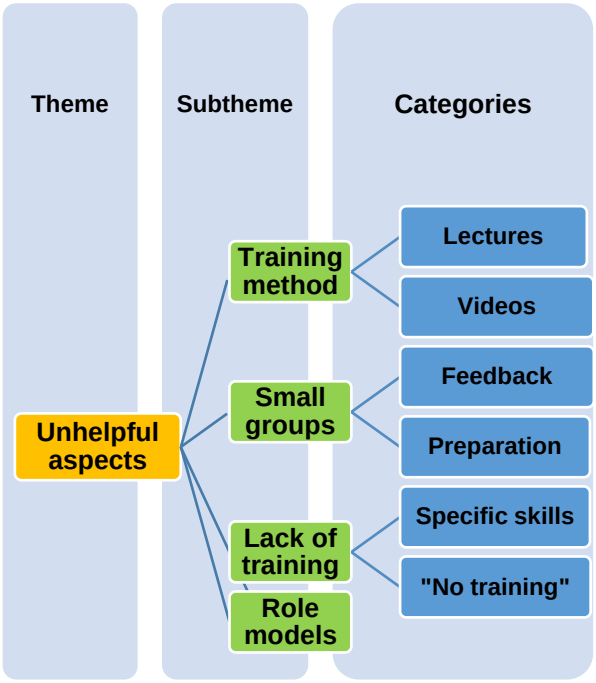

Figure 4.14 Aspects of the communication skills training which students found unhelpful

4.7.1 Training methods

In terms of training methods, many fourth-year and fifth-year students emphasised that lectures and videos were unhelpful in teaching them doctor-patient communication skills: "*Why do you need a lecture of how to treat another human being with respect and empathy?"[5.30f]. "Visimed videos of communication. Almost everyone was laughing and not taking it serious" [5.102f]. "MDOC in the first year as you don't see the need or importance in first-year as you don't have clinical exposure". [5.79f], "The modules in Semester 1 were very unhelpful with communication skills" [4.21].* One student mentioned the choice of assessment methods: "*Cases – stressful – should get an alternative*" [5.69f].

4.7.2 Organisation of small group training

In terms of small group practical sessions, the processes were criticized: One student described group simulation as "*chaos*" [5.60f]. Another commented on the absence of constructive feedback: "*When we practised on one another in the skills unit, there was no senior doctor to critique us and give us tips on how to improve.*" Another student commented: "*Working in a small group before having knowledge of the relevant session for that day was not helpful"* [4.16f].

4.7.3 Lack of training in certain skills

Students commented on the lack of training on specific skills such as breaking bad news and managing language and cultural barriers. A few students commented that they had received "*no training"* in communication skills: "*We did not really have training thus far*" [4.4f], "*We have received no training; only lectures"* [5.13f].

4.7.4 Role models

Some students mentioned the lack of good role models: "*The theory taught by academic personnel in Phase II is not often practised by hospital personnel in Phase III"* [4.63f].

Many students reported that all aspects of communication skills training had been beneficial.

4.8 RECOMMENDATIONS OF STUDENTS TO IMPROVE THE TRAINING OF STUDENTS TO IMPROVE THE TRAINING OF DOCTOR-PATIENT COMMUNICATION SKILLS

Within this theme, the following subthemes emerged: Timing of training, educational methods, the content of the training, the example of doctors and the willingness of patients. Figure 4.15 displays these subthemes and categories.

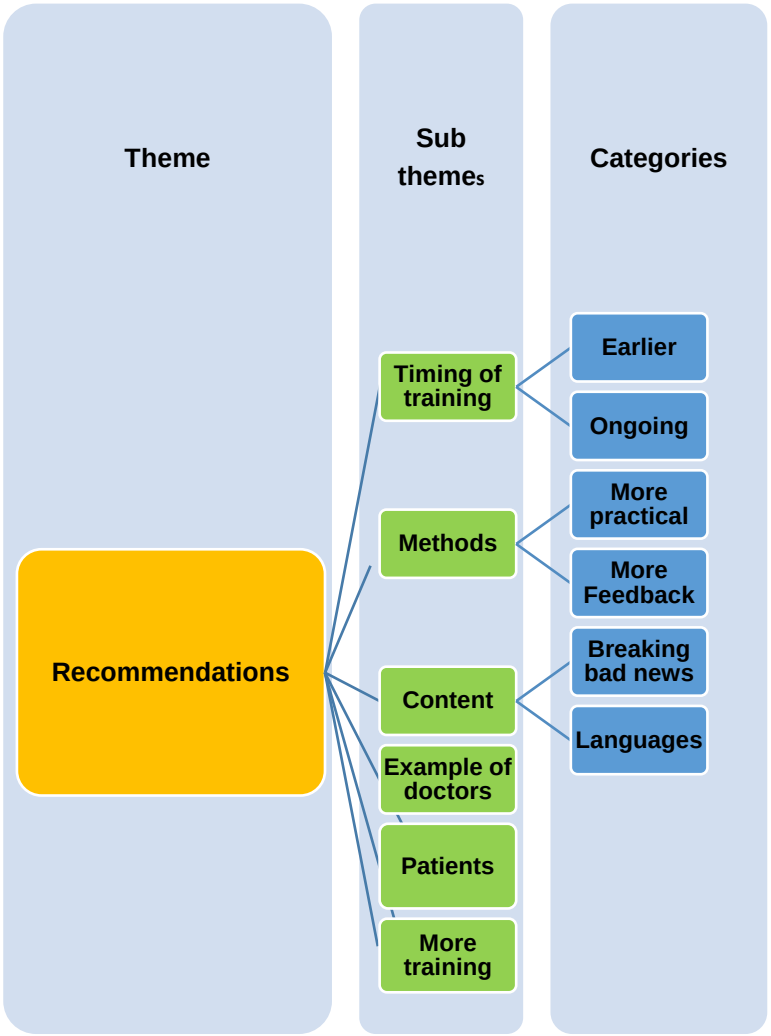

Figure 4.15 Students' recommendations to improve doctor-patient communication skills training

4.8.1 Timing of the training

In terms of timing of the training, many students recommended starting earlier with practical training of communication skills and continuing formal training into the clinical phase. One fourth-year student had the following vision for the communication skills training: "*In phase one, history taking training in the skills lab can already be implemented, clinical skills can be started from the first year in a more interactive way. E.g., a practical session on just the general history taking and JACCOLD so that it can build up from the pre-clinical years and students are already comfortable by the clinical years in Semester 6"* [4.6f].

Many students recommended earlier exposure to the clinical environment: "*More clinical exposure in Phase II*" [5.68m], "*Expose students to patients earlier in a clinical setting*" [4.9m], "*Often in Phase II students are shielded from it (patient interaction) and are expected in Phase III to be able to manage it. A guided approach in Phase II in practice in real situations are advised*" [5.51f].

Another student suggested placing the Family Medicine Rotation earlier in Phase III. "*Doctor-patient relationship is important in the management of the patient. Family Medicine is the one department that focuses more on doctor-patient communication. So, I think it would be beneficial to students to introduce Family Medicine Rotation earlier in the clinical Phase*" [5.74f].

One student recommended that formal communication skills training should be extended into clinical phase: "*During the clinical phase (semester 6 to 10), the ideal doctor-patient relationship should be refreshed in our minds as we are mostly exposed to a doctor-centred relationship"* [4.48m].

4.8.2 Educational and assessment methods

In terms of educational methods, students accentuated the importance of practical methods and receiving adequate feedback: *"Implement a more practical approach" [4.9m], "more practical scenarios with feedback"* [5.81f], *"More bedside education" [4.24].*

Students commented on the processes of assessment: "*Feedback with memo after every assessment to learn what we do wrong and how to correct (it)*" [5.53f], *"More believable patients in the OSCE"* [4.36f].

4.8.3 Content of the training

Students recommended that the content of the training should focus more on equipping students to break bad news: *"In Phase III the doctors should make an active effort to include us when they (are) breaking bad news"* [5.79f], "*Breaking bad news, I do not feel prepared to break bad news*" [5.90m], *"I would like training in the SPIKES protocol for breaking bad news"* [4.54f], "*How to break devastating news to a patient. How to react when a patient starts crying. How to not sound inconsiderate when asking them personal questions. How to explain medical conditions in an understandable way*" [4.11f].

Students further advised a greater focus on the teaching and learning of local languages: "*More comprehensive teaching of Sotho please*" [5.70m], "*Learning a second language can be extremely beneficial in improving doctor-patient communication*" [4.10m], "*More on managing language barriers*" [4.3f].

One student asked for more training *"on managing difficult patients"* [4.3f]. Another wanted a greater emphasis on history taking "*More history taking classes in skills (MCLI)"* [5.36f].

4.8.4 Example of doctors

Many students remarked on the importance of the example set by doctors during the clinical rotations. *"Best way of improving these skills is simply to imitate the senior doctors on how they interact with patients"* [5.46u], "*Listening and observing our senior doctors communicating with patients is everything*" [5.77]. *"Must be demonstrated by senior doctor"* [4.43m].

A few students remarked that there should be a greater emphasis by clinical teachers on communication skill training: "*Senior doctors should be taught the importance*" [5.57f], "*Academic knowledge does not make up for the inability to educate a patient on their illness"* [4.63f].

"*Communication skills should be assessed in some formal manner to force students to get into the habit of good communication skill. Doctors in the hospital should be held accountable for their poor communication skills. These skills form the practical examples for students and lead to generationally transferred poor communication skills*" [4.63f].

Another student commented on the attitude of doctors: "*Doctors let their egos get in the way of proper doctor-patient communication. Humility goes a long way"* [5.30f].

One student emphasised that students witness good and bad examples and ultimately have to choose their own behaviour. "*The skills can be taught, but not all doctors will use it; it depends on how that doctor's personal skills are and how sociable they are. Some doctors just don't care about how they speak to patients and some do. We see both daily and then decide how we want to be*" [4.12m].

4.8.5 Attitude of patients towards students

One student felt that patients should be made aware of the role they can play in student education: *"Patients in the hospital (need) to be made aware that there are students at the hospitals and they also need to learn, thus may increase cooperation from the patients"* [5.34f].

4.8.6 More training

Many students asked for more training and more time to be devoted to the training of doctor-patient communication skills. "*Make this (communication skills training) part of each rotation's requirements in the logbook"* [5.31f]. *"Please more training"* [5.66m], "*More training. It really lacks in our"* [5.49f]. *"Need more training on doctor-patient communication"* [5.78m]. *"More time should be spent on these skills"* [5.72m].

Many students answered not applicable or had no recommendations for improvement. One student wrote, "*Everything taught has been found to be useful in one situation or another*" [5.48m]. Another advised, "*Continue the good work*" [4.26]. One final comment was "*Thank you for conducting this research*".

4.9 CONCLUSION

This concludes the results of the study. In the following chapter, the findings will be discussed in greater detail.

CHAPTER 5
DISCUSSION

5.1 INTRODUCTION

The results of the questionnaire survey were presented in the previous chapter. In this chapter, a discussion of the results will take place. In the first instance, there will be a consideration of the discrepancy in response rates. Thereafter, the responses of students regarding different elements of the doctor-patient communication skills training programme will be appraised in the light of existing knowledge in the field. Subsequently, the respondents' suggestions for improving the training of doctor-patient communication skills will be considered. The components of Chapter 5 can be seen in Figure 5.1.

Figure 5.1 Outline of Chapter 5

5.2 OVERVIEW OF THE DISCREPANCY IN RESPONSE RATES

Possible reasons for the differences in response rates between fourth and fifth-year students (54.2% and 80.3% respectively), might be the fact that some distributors of questionnaires encouraged immediate completion, while others handed questionnaires out but asked students to complete the questionnaires in their own time.

5.3 KNOWLEDGE OF EXPECTED OUTCOMES

More than 80% of participants reported that educators informed them of the requirement to be competent in the role of communicator during phase III of their training, with slightly lower percentages for the earlier phases. This role forms

part of the core competency framework outlined by the Medical and Dental Training Subcommittee of the HPCSA (HPCSA, 2014:1).

Informing students of the desired outcomes is in line with the recommendations of Ley *et al.* (2019) that educators should elucidate the purpose of training regularly. In this way, students will know what is expected of them and can be optimally engaged in their training. More discussions regarding the aims of doctor-patient communication skills training in Phases I and II might be useful, as many students reported not being aware of the expected outcomes of the training in the earlier phases of training.

5.4 CONTENT OF THE TRAINING PROGRAMME

5.4.1 Knowledge regarding the evidence-base

More than 50% of respondents from both year groups indicated that they were not told of the effect of doctor-patient communication on patient outcomes in the first two phases. This was also true for fourth year students in terms of Phase III. The UK consensus statement on the content of communication curricula in undergraduate medical education, emphasises the importance of the evidence-base underlying the teaching and learning of communication skills (Von Fragstein *et al.*, 2008:1100). If students know the compelling evidence for the impact of doctor-patient communication, they might appreciate the necessity of acquiring communication skills. It may also challenge the misguided assumption that communication skills will improve automatically with experience even in the absence of training (Aspegren and Lonberg-Madsen, 2005:543).

5.4.2 Taking a thorough patient history, including psychosocial history

More than 75% of participants in both year groups reported frequent training in history taking during Phases II and III of the undergraduate medical programme. Most participants in the fourth year rated themselves as ‘average’. Students commented on the lack of specific feedback when clinical teachers deemed their history taking deficient. Many students reported that they omitted crucial parts of the clinical history or struggled to find the right approach. These self-reported problems are similar to the problems observed by experienced facilitators in their

trainees. Kurtz *et al.,* (2005:189) listed the following difficulties often encountered by trainees in terms of history taking: Getting the balance or timing wrong between using open and closed questions, not being thorough enough and not exploring the concerns of the patient adequately.

One of the reasons why students might be omitting crucial parts of the history might be an inability to integrate clinical reasoning with communication skills. Researchers at the John Hopkins University School of Medicine investigated the impact of an educational intervention to aid students with the integration of clinical reasoning and patient communication (Windish *et al.*, 2005:1108). The educational intervention consisted of small-group teaching involving role-play, structured reflection and feedback. Students who received this training were able to understand psychosocial aspects of illness better and simulated patients perceived them as more able to establish rapport compared to their peers.

Most final year students rated their ability in history taking as 'excellent'. A final year student reported that she knew the diagnosis just from taking the patient's history "70% of the time". This is similar to the findings of Roshan and Rao (2000:771), where history taking resulted in the diagnosis in 78.6% of cases studied. The reason why final year students had more confidence in their history taking skills was probably that they had more training and opportunities to practice.

5.4.3 Breaking bad news

More than 70% of all respondents reported little or no training in breaking bad news and more than 80% of respondents rated themselves as novices or average in terms of breaking bad news. In motivating their self-ratings, students explained that some clinical teachers avoided breaking bad news or delivered the news in an insensitive way.

This aligns with a literature review which showed that many qualified doctors have not received formal tuition in this task, find it difficult and stressful and might avoid the task altogether for fear of how the patient might react (Alelwani & Ahmed,

2014:51). Du Plessis (2017: 26) wrote about the long-lasting unsettling effect that the insensitive delivery of bad news could have.

The researcher recalls her own medical training. Tuition in breaking bad news consisted of a single lecture, in which it was emphasised to never use the words “I am sorry” as it could be seen as an admission of guilt. One incident in the clinical milieu stands out: A mother was told in the corridor of a busy casualty department that the resuscitation of her child had been unsuccessful. In this review, respondents describe similar experiences. Many students commented that they received a lecture on breaking bad news, rather than practical tuition. Others reported negative experiences in the clinical milieu.

A meta-analysis by Johnson and Panaglioti (2018:1400) investigated the effectiveness of training students in breaking bad news. They concluded that training interventions were successful in increasing student confidence and led to a noticeable improvement in skill. The training interventions used in these studies involved the combination of didactic and practical approaches, with role-play and feedback frequently used. The use of the SPIKES protocol was noted to be particularly effective (Johnson *et al.*, 2018:1412). The acronym stands for the following steps: “*SETTING up an interview; assessing the patient’s PERCEPTION; obtaining the patient’s INVITATION; giving KNOWLEDGE and information to the patient; addressing the patient’s EMOTIONS with empathic responses; STRATEGY and summary” (*Baile, Buckman, Lenzi, Glober, Beale and Kudelka*,* 2000:302).

Kurer and Zekrim (2008:203) accentuate the fact that conveying distressing news is a sensitive task that requires a sophisticated level of communication. It has a significant impact on the quality of the doctor-patient relationship and is, therefore, a vital competency that should be acquired. From the findings of the student review and the evidence in the literature, the need for more training in this area is clear. Obtaining the views of educators and clinical teachers regarding a possible interdisciplinary workshop for students would be a useful first step.

5.4.4 Training in managing language and cultural differences in the consultation

More than 60% of fourth-year students and 50% of final-year students reported limited training in managing language and cultural differences in the consultation. More than two-thirds of students rated themselves as average in this skill. Some students commented on the importance of respecting diversity. Others focused more on practicalities such as ability/inability to speak the patient's language or the availability of translators. Many students expressed frustration at the inability to find a translator in the clinical setting, while others avoided seeing patients with whom they did not share a language, by asking another student in their group to see the patient.

Sesotho is the language spoken by more than 70% of Free State residents (Lehohla, 2016). The researcher wanted to draw conclusions about the ability of medical students to communicate in Sesotho with their patients. However, just inquiring regarding home language did not shed any light on the Sesotho proficiency of individual students, as many students are bilingual or even trilingual. Students were not asked regarding their proficiency in Sesotho in the questionnaire. Thus, the number of students who are able to communicate in Sesotho with their patients, could not be ascertained.

However, many students used open-ended questions to report communication difficulties due to language discordance. Difficulties in communicating in Sesotho was not only mentioned by students who had Afrikaans or English as home language, but also by a few students who spoke isiZulu as home language and English as an additional language. Many students commented that they were busy learning Sesotho so that they could communicate with patients in their home language.

In a South African descriptive study, Matthews *et al.* (2018(c):194) asked students, medical educators and clinical teachers to recommend improvements in their communication skills training programme. One of the important recommendations was an increased focus on the teaching and learning of local languages and enabling of effective cross-cultural communication (Matthews *et*

al., 2018(c):194). In a South African case study, Matthews *et al.* (2018(a):112) looked at the cultivation of cultural competence in medical education. They examined the perceptions of final year medical students regarding cultural competence and found the students culturally aware and eager to be equipped to meet the healthcare needs of a culturally diverse group of patients. As no guidelines exist in terms of teaching cultural competence in the South African setting, the researchers advised further research, including analysing patient expectations of healthcare workers in terms of accommodating and understanding their culture.

Burch (2016:3) questions whether the concept of cultural competency is exaggerated and that the emphasis should instead be on language acquisition. She reasons that the ability to speak the patient's language would go a long way to achieve a better mutual understanding. Local languages have been included in the learning plan of most South African medical schools, including the UFS (cf. Table 1.2). However, the challenge in the South African medical education setting is that there are 11 official languages and that the languages spoken varies from region to region. A student who receives undergraduate training at the UFS, where Sesotho is widely spoken, might be placed in a different area within South Africa for internship and be unable to speak the local language.

There thus seems to be a place for teaching cultural competency and an approach to consultations where the patient and doctor do not share a language. One way that this competency could be developed, is by including culturally focused scenarios in small-group practice. Simulated patients from diverse patient groups can contribute to training sessions.

5.4.5 Training in understanding the patient's point of view

More than 70% of participants reported that they received training in understanding the patient's perspective in the clinical phase of their training. Final year students were more confident in their ability to understand the patient's perspective than fourth-year students were. This might be due to greater exposure to the clinical environment or could be due to attitudinal factors or seeing this modelled by clinical teachers.

Levinson, Lesser and Epstein explained the value of patient-centred communication: "*Patient-centered communication seeks to increase health care providers' understanding of patients' individual needs, perspectives, and values, to give patients the information they need to participate in their care; and to build trust and understanding between physicians and patients" (*Levinson *et al.,* 2010:1311).

Archer and Meyer (2018(a):171) performed a scoping review of the medical education literature to see if any strategies could help to inculcate a mindset of patient-centredness in medical trainees. The reviewers found a myriad of educational interventions that have been used to increase the ability of students to see the patient's perspective. These include didactic teaching to lay the theoretical knowledge base, small-group teaching, simulated patients, storytelling, observing clinical role models and mindfulness. The reviewers concluded that patient-centredness was a complex skill that required multiple educational interventions over a prolonged time, which need to be carefully planned and deliberately included in the training programme. Future research to gain the views of medical educators at the UFS regarding patient-centredness and ways to nurture this crucial quality could prove useful.

5.4.6 Guidance on how to explain medical errors

More than 60% of respondents reported limited training in explaining the case of medical errors in Phase III. Final year students were slightly more confident in managing communication surrounding medical errors than fourth-year students, possibly due to having seen these situations managed more often. However, this cannot be concluded, as students were not asked whether or how often they had encountered such events.

Robbennolt (2009:376) studied the literature surrounding the communication of medical errors and concluded that a prompt explanation and apology (if applicable), can lead to restitution in the trust-relationship between the doctor and the patient and reduce the risk of litigation. The regulator of medical practice in the United Kingdom, the General Medical Council (GMC), describes this as the 'duty of candour' and a core part of good medical practice (GMC, 2015). Medical

educators have implemented interventions to help students practise this skill and students found the training beneficial (Gillies, Speers, Young & Fly, 2011:400). The training of this skill forms part of the curricular content described in the UK consensus statement on the content of medical communication curricula (Von Fragstein *et al.*, 2008:1100).

Gillies *et al*. (2011:400) designed a module to teach first-year medical students how to explain medical errors and apologise to patients. Lectures were used, followed by role-playing scenarios with simulated patients. Students described an increase in their confidence to deal with medical errors as a result of the training module. Rocke and Lee (2013:551) pointed to evidence that an institutional policy of full and prompt disclosure of errors led to a decrease in malpractice claims. They advise clinical teachers to see medical errors as "teachable moments in doing the right thing" when they can model to their trainees how errors should be managed in an ethical way. A step-wise approach can be used, not dissimilar to that of breaking bad news.

This skill can thus be taught through a combination of didactic teaching and role-play sessions. More importantly, it should also be modelled to medical students by practising doctors. "*Modelling of appropriate disclosure by attending physicians is paramount to avoid the blame-shifting, minimizing, and rationalizing of errors that will likely be emulated by trainees"* (Rocke and Lee, 2013:552).

5.4.7 Defusing anger

More than 55% of respondents reported limited training in defusing anger in the consultation during Phase III of training, yet were moderately confident in their ability to deal with such a conflict situation. Participants were not asked in the questionnaire whether they had ever encountered anger or aggression in the clinical setting.

Maguire and Pitceathly (2003:534) observe that inability to manage difficult consultations can increase the risk of stress and burn-out in doctors. The authors suggest steps to follow in defusing anger in medical consultations, which will also reduce stress in the medical practitioner.

Bialer *et al.* (2011:359) developed a training module to enable healthcare practitioners to defuse anger in the patient consultation. Lectures, videos demonstrations and role-play sessions were used in the training. Once again, role modelling of this skill would be a powerful reinforcement of the training.

5.5 EDUCATIONAL STRATEGIES AND METHODS

Participants were asked to rate the educational methods used in the training of doctor-patient communication skills. Active and practical educational methods such as role-play and feedback were by far the most popular, while lectures and videos were exceedingly unpopular. Final year students also expressed a preference for direct observation followed by feedback in the clinical environment. The medical education research evidence supports authentic and active methods of teaching and learning of doctor-patient communication skills rather than didactic methods (*cf.* Chapter 2: Skelton *et al.,* 2013:246, Yardley *et al.*, 2013:495 & Berkhof *et al.*, 2011:152). Kurtz *et al.,* (2005:e1874) mention the use of didactic methods to provide a theoretical knowledge base for communication skills training. They emphasise that it should be used in conjunction with experiential methods such as role-play with simulated patients, followed by discussion, feedback and reflection. (Kurtz *et al*.:e1448).

Students were asked regarding the authenticity of simulated patients, and a wide range of responses was received. Out of the final year cohort, 53.6% of respondents felt SPs were not believable. On the other hand, 59.3% of fourth-year students found SPs believable. What could be the reason for this discrepancy? One possible explanation can be found in a study exploring student perceptions of the use of SPs in training (Giesbrecht, Wener and Pereira, 2014:241). The researchers discovered that students found scenarios with SPs more useful when they are near the transition between the academic and clinical phases of training. More senior students, on the other hand, valued interaction with actual patients more.

Respondents listed several reasons why SPs were not perceived as authentic: Visible confusion of the simulated patient during the role-play and ‘overacting’.

Because of the complex contribution of the SP to the training process, they require training in terms of the realistic role portrayal but also need to have an understanding of educational principles (Kneebone, Nestel and Bello, 2017:96). One way of increasing the authenticity of simulated patients would be to invest more time and expertise into the training of simulated patients.

Bokken, Rethans, Scherpbier, and van der Vleuten (2008:167) reviewed the medical education literature to establish the advantages and disadvantages of using real and simulated patients in student teaching. Most studies concluded that using simulated patients is as effective as using real patients for developing interviewing skills and empathy. Real patients, on the other hand, can provide "*unique insights from the patient's perspective*" (Bokken *et al.*, 2008:167).

5.6 LEARNING OPPORTUNITIES

5.6.1 Opportunities to develop doctor-patient communication skills

Most respondents indicated that there were limited opportunities to develop doctor-patient communication skills in the first phase of training, this increased to a moderate amount of opportunities in the second phase and multiple opportunities in the third (final) phase of training. A systematic review of the effect of early clinical exposure on the communication skills of students showed that it was beneficial (Littlewood, Ypinazar, Margolis, Scherpbier, 2005:388). There was an increase in the self-awareness of students and their confidence to approach patients increased. This early experience helped students to develop a more mature and empathic approach and to be more prepared for the later phases of their training (Littlewood *et al.,* 2005:388-389).

Earlier exposure to clinical medicine in the undergraduate medical programme at the UFS will be implemented in 2020, by rolling out a Community Service Learning Programme that will include visits to health facilities (Personal Communication: Sanet van Zyl, Chair of Phase II: Undergraduate MBCHB Programme: Department of Basic Medical Sciences, University of the Free State, Bloemfontein).

5.6.2 Opportunities for students to reflect on their communication skills

Participants in the study reported few opportunities to reflect on their own communication with patients, for instance, considering a different approach to an awkward consultation. During specific communication skills training modules, there is often an opportunity for discussion and reflection. However, formal communication skills training often occur in the preclinical phase (Levinson, Lesser and Epstein, 2010:1312). During the clinical phase, when students have the most patient contact, they have the fewest opportunities to discuss and reflect on patient consultations that did not go to plan. During the clinical phase of training, there is a greater focus on the medical management of patients rather than the honing of communication skills (Levinson *et al.*, 2010:1312).

A qualitative analysis of a teaching intervention to help medical students to deal with communication dilemmas demonstrated the benefits of collaborative and reflective approaches (Lutz, Roling, Berger, Edelhauser & Scheffer, 2016). Students were able to discuss challenging consultations that they had witnessed or experienced and with the help of an experienced facilitator and peers, were able to problem-solve and feel more resilient in terms of managing difficult consultations. It would be useful to explore the views of clinical educators at the UFS regarding reflective workshops and the feasibility of phasing it in for interns and eventually for medical students in their final year.

5.7 ASSESSMENT

According to participants, assessments in Phase III of their training emphasised the importance of communication skills, but this was not the case during the earlier phases. Students were asked to suggest the best ways in which doctor-patient communication can be assessed and they came up with a list of assessment methods. 40% of fourth-year students and 15% of fifth-year students mentioned the OSCE as the optimal way to assess doctor-patient communication skills. Almost a quarter of final year students thought that assessment of their communication in the actual clinical setting would be best.

Formative and summative OSCEs are used to test the clinical and communication skills of undergraduate medical students at the UFS in an integrated way in Phase

II of their training. Both the OSCE and Work-place based assessments are used to assess clinical and communication skills at the UFS in phases III (Personal communication: Hanneke Brits, Chair of Phase III: Undergraduate MBCHB Programme: Department of Family Medicine, University of the Free State, Bloemfontein). This fits in with the recommendation of Etheridge *et al.* (2013:310) that authentic assessment of complex skills needs to take place within the workplace *(cf.* Figure 2.10*).*

Skelton warns against the danger of reducing communication to a tick box exercise (2017:193). International experts in assessment concluded that the fact that an assessment method is objective does not necessarily mean that it is reliable. The importance of the subjective judgement of an expert to obtain a holistic assessment is emphasised (van der Vleuten, Schuwirth, Scheele, Driessen and Hodges, 2010:703). The reliability and validity of the assessment of communication skills can be improved by using a variety of different assessment methods and a variety of different assessors at different times, to create a clearer picture of the student's competency.

The OSCE has been validated for summative purposes, for instance, to confirm that students may graduate. Work-place based assessments should ideally be used in a formative way, by providing timely and constructive feedback in the clinical setting (Etheridge *et al.*, 2017:273).

5.8 EDUCATIONAL ENVIRONMENT

According to Harden (2017:10), the educational environment has a crucial influence on student learning. Genn (2001) defined the perceived educational environment as the learning climate and considered this learning climate as "*the soul and spirit of the medical curriculum"* (Genn, 2001:337).

In this study, more than 70 % of respondents described the clinical environment of Phase III conducive to the development of doctor-patient communication skills. However, a number of students identified hindrances to the development of communication skills, namely time pressure, a task-orientated approach of clinicians and lack of feedback given. In terms of the workload, students

described: “*Heavy workload & low staffing allow little to no time for a relationship with a patient*” [4.23], “*Often doctors are too busy/have too many patients and do not practise patient-centred communication*” [5.81f].

5.9 CLINICAL ROLE MODELS

O’Sullivan (2017:205) comments on the effects of the hidden communication curriculum, the tacit learning that takes place when students observe doctors interacting with patients. Students can feel confused and conflicted when they see unprofessional behaviour in the clinical setting that contradicts what they have been taught in the formal curriculum.

The question regarding the role modelling of patient-centred communication divided opinion. Over 40% of all respondents reported that senior doctors were often or almost always good role models. However, over 50% of students in both groups of students indicated that senior doctors seldom or never modelled patient-centred communication. Students who indicated that senior doctors were good role models, described them as “professional, experienced and good mentors”. Some students pointed out that some doctors were excellent role models while others were “d*emeaning and unprofessional*”.

Students who reported seldom seeing good examples of clinical communication voiced their concerns regarding the impact of the workload on clinicians, the failure to talk to patients, the focus on medical management and lack of empathy. Students described doctors as dismissive of patients, abrupt, unapproachable and even inhumane. One student concluded: “*Senior doctors talk over patients and not to patients*” [5.57f].

Matthews *et al*. (2018(c):197) identified similar themes in a study exploring communication skills training at the University of KwaZulu-Natal. A participant commented that the focus was on treating HIV rather than communication, while another student outlined the discrepancy between what is being taught and what is practiced in terms of communicating with patients.

Levine (2006:218) concludes that the effects of negative role models on medical students can be far-reaching. Students who witness how patients are treated harshly by qualified doctors may become disillusioned and cynical, while those who see positive role models feel affirmed in their professional role.

Joubert *et al.* (2006:28) found in a study at the University of Pretoria, South Africa that students respond to negative role models in one of two ways. They would either follow the example of the negative role model, thereby perpetuating the unprofessional behaviour. For other students, poor role models strengthened their resolve not to behave in that way.

A fourth-year medical student at the UFS explains this choice that students face eloquently: "*The skills can be taught, but not all doctors will use it; it depends on how that doctor's personal skills are and how sociable they are. Some doctors just don't care about how they speak to patients and some do. We see both daily and then decide how we want to be*" [4.12m].

O'Sullivan (2017:205) points out that academic and clinical teachers should model professionalism. Shortcomings in this area can be difficult to address directly but should be addressed through staff training and development. Levine (2006:218) remarks that doctors might be unaware of the fact that they are negative role models and that one of the aims of the training should be to make them more conscious of the example they set.

It would be useful to explore the attitudes and perceptions of registrars and other clinical teachers in terms of the part they play in portraying professionalism to future doctors.

5.10 STUDENTS VIEWS ON WHETHER COMMUNICATION SKILLS CAN BE LEARNT

More than 65% of students in both groups believed that communication skills can be developed. This fits in with the research evidence outlined by Kurtz *et al.* (2005:23-24) that communication skills can be learnt and can have a long-term impact on behaviour.

5.11 STRENGTHS AND WEAKNESSES OF DOCTOR-PATIENT COMMUNICATION TRAINING ACCORDING TO STUDENTS

5.11.1 Strengths reported by students

Students found the following aspects of doctor-patient communication training particularly useful: clinical exposure and interactive practical training sessions. This fits in with the four educational principles described by Harden and Laidlaw (2013:27) for increasing the effectiveness of teaching and learning, namely feedback, active learning, individualisation and relevance (FAIR). Practical training sessions usually involve feedback and active learning, while communication skills training in the clinical area is relevant and can allow the individual to hone their skills.

Students also mentioned specific skills and attitudes that helped communicate with patients but did not indicate how the training helped them to acquire these. These included patience, good listening skills, eliciting the concerns of the patient and avoiding medical jargon. Students underlined the importance of establishing a good rapport, as well as empathy. The aspects mentioned resembled the key skills in building the therapeutic relationship, as outlined in the Calgary-Cambridge guide (Kurtz *et al.*, 2003:802).

5.11.2 Shortcomings reported by students

Students reported the following shortcomings in the training: Not enough feedback, facilitation of peer practice could be improved, poor examples in the clinical setting, inadequate training in specific skills such as breaking bad news and managing language and cultural differences.

It seemed that students intuitively knew what would be good for them. They spontaneously mentioned aspects of the FAIR principles (Harden & Laidlaw, 2016:17) which were lacking at times.

5.11.2.1 Lack of feedback

The need for more feedback and more specific feedback was mentioned repeatedly. "*It is important to know what you are doing wrong so you can fix it*"

[5.40f], "*Students do not receive feedback on their ability and therefore never know if they have adequately acquired skills" [4.54f].*

The views of the students align with a systematic review of randomised controlled trials, which examined the effectiveness of different methods to teach communication skills (Smith, Hanson, Tewksbury, Christy, Talib, Harris, Beck, and Wolf, 2007:3). The reviewers concluded that feedback significantly improved the ability of students to establish rapport and improved their ability to gather diagnostic data. Feedback thus improves both the process and content of the communication within the consultation, as emphasised by Kurtz *et al.* (2003:802).

5.11.2.2 Teaching methods that did not actively involve the students

Students found passive instructional methods such as lectures or watching video consultations unhelpful. These were deemed a "*waste of time*", "*boring*" or "*tiring*". A student sagely remarked: "*Skills cannot be solely acquired through passive observation*" [5.45f]. Active teaching methods on the other hand, enthused the students: "*Interactive sessions are easier to remember*" [5.75f].

These preferences of the students concur with the evidence presented by Smith *et al. (*2007:3). They identified that discussions in the small group setting can be an efficient way to teach communication skills, as participants can play a more active role.

5.11.2.3 Individualisation

One student suggested that the assessment method should be adapted for each student. Although that does not seem like a viable option, it is important that educators make provision for students who might find small group sessions particularly stressful. For instance, a safe environment can be created by establishing clear ground rules regarding peer feedback (Kurtz *et al.*, 2005:111).

5.11.2.4 Relevance

Students doubted the relevance of the training, as they observed a disconnect between the recommended practices and actual practice: "*The theory taught by academic personnel in Phase II is not often practised by hospital personnel in*

Phase III" [4.63f]. Students also reported that content relevant to their daily practice was not covered adequately, for instance, the breaking of bad news and dealing with language and cultural differences: "*I do not feel prepared to break bad news*" [5.90m], "*More on managing language barriers* " [4.3f].

One way of making the teaching relevant is to involve patients earlier. This will help students to realise the purpose of learning communication skills. Medical educators in Australia (Bennett and Lyons, 2011:53) found that students thoroughly appreciate patient contact as part of communication skills training.

The content of assessments should confirm the relevance and importance of doctor-patient communication. Etheridge and Boursicot reiterated that assessment has an impact on the learning strategies that students use (2017:268). If communication skills form an integral part of informal and formal assessments, students are likely to attach more importance to the mastery of this skill, even before they might fully appreciate the intrinsic value thereof.

5.12 DISCUSSION OF THE STUDENTS' RECOMMENDATIONS

McInerney *et al.* (2013:5) examined the experiences and opinions of medical students after a change in the undergraduate curriculum at a South African medical school. The researchers commented on the depth of the responses received and the candour of the students. In a similar vein, the researcher was struck by the enthusiasm with which many respondents have participated in this student review. The industry of students in suggesting improvements to the training of doctor-patient communication skills was noticeable. From their recommendations, it was clear that they had reflected on this subject and wanted to contribute to the improvement and fine-tuning of the training.

The recommendations of students were wide-ranging and comprehensive. They will be discussed according to the following categories: Educator factors, healthcare sector factors, training factors and student factors. Figure 5.2 provides an overview of the categories in which students' recommendations fell.

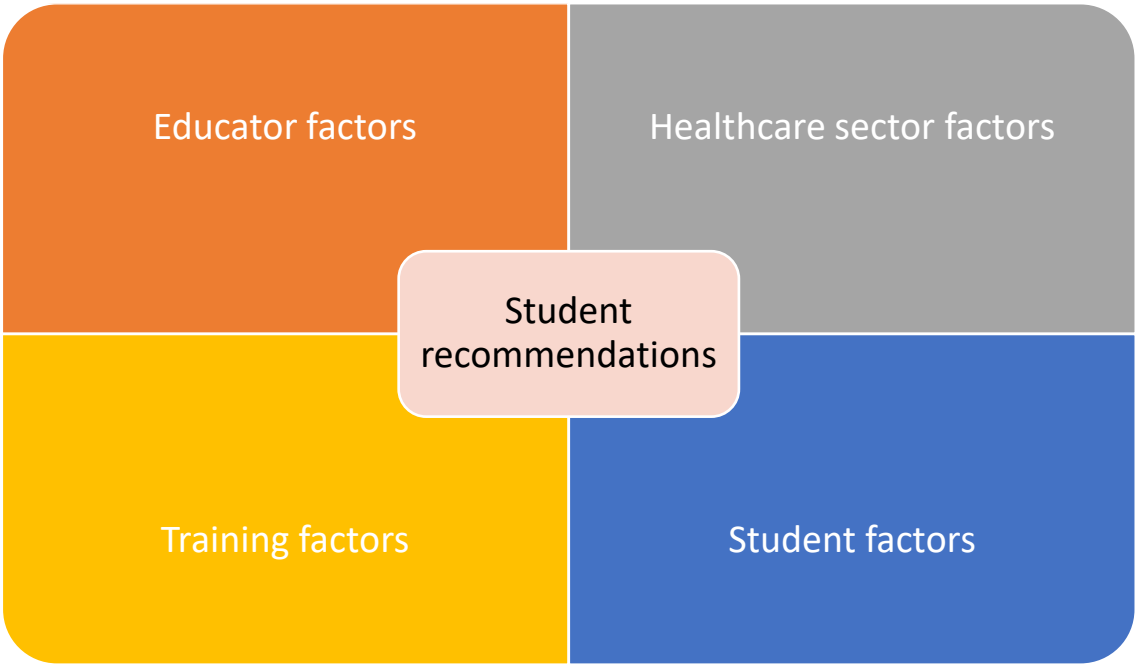

Figure 5.2 Overview of recommendations from the student review

5.12.1 Educator factors

Students highlighted the central role of educators and their influence on students. They reported learning a lot from observing the consultations of experienced, caring doctors, who were also good mentors to them. However, students remarked how the quality of communication varied from doctor to doctor.

Students recommended that senior doctors should receive training on the importance of communication skills, as they were shocked by the unprofessional behaviour witnessed in the clinical setting. Concerned regarding the attitude of some clinical teachers, students made a plea for greater humility of doctors when it comes to communicating with patients. Harden and Laidlaw (2016:4) bemoaned the fact that the clinical teacher is sometimes judged only in terms of clinical and teaching abilities, without considering attitudes and professionalism. They listed the following equation: "*Teaching effectiveness = Technical competencies x Approach to teaching x Professionalism*" (2016:5). The reason for the multiplication sign is evident. If any element is missing, the teaching effectiveness will be zero. All three of these aspects will affect whether a clinical teacher is an effective role model.

Therefore, it is a serious concern when clinical teachers demonstrate unprofessional behaviour in terms of their communication with patients. In this review, students described the manner of some doctors towards patients with words such as "*abrupt, blunt, cold, demeaning, dismissive, inhumane or unprofessional*" (*cf.* section *4.6.3.2*).

One student remarked about the fact that some students followed the negative role models, thereby perpetuating the patterns of poor communication. A student suggested that doctors should be held accountable for poor communication with patients. Matthews and van Wyk (2018(c):197) recommended that the performance indicators of clinical educators should include an appraisal of their professionalism and communication with patients. In the United Kingdom, this is assessed by obtaining multi-source feedback. This entails a centrally administered anonymous electronic survey, completed by patients, medical and non-medical and colleagues to comment on communication skills and professionalism (Wass and Barnard, 2017:289).

A systematic review of the medical education research showed that there is a decline in empathy among medical students as they progress through their course (Neumann, Edelhäuser, Friedrich, Tauschel, Fischer, Wirtz, Haramati and Scheffer, 2011:996). The reviewers speculated that the reason might be due to trainee distress and due to negative role-modelling, but further research is required.

A review of the literature on role-modelling in medical education revealed that there is a high prevalence of poor role-modelling by clinical teachers worldwide (Cruess, Cruess and Steinert, 2008:718). The researchers suggested several strategies for clinical teachers to be more positive role models. The first step is to be more aware of being a role model and analysing one's own performance, of making time for discussing the concept of role-modelling to students and to encourage them to reflect about this concept. Staff development is a way that organisations can try and combat the culture of negative role-modelling (Cruess *et al.* 2008: 720).

5.12.2 Health sector factors

Participants in the study commented on the workload and the pressure that clinical educators were constantly under within the public healthcare sector. This has also been described in the medical education literature. Burch (2007:70) alluded to the challenges in the clinical training environment, caused by bed closures in training hospitals, staff shortages and clinical teachers with no educational background.

Kurtz *et al.* (2005:27) emphasise the centrality of effective communication in delivering high-quality medical care. To help medical educators, staff development programmes might be required. Clinical teachers who are the busiest also need to access this training. A needs assessment could be useful to tailor staff development to the specific needs of educators.

5.12.3 Student factors

One student sagely commented about the choice that students had whether to follow the good examples of communication that they saw or to imitate the negative role models. This fits in with the perspective of Benbassat (2014:550) that the effect of role models does not depend solely on the educator. Instead, medical students should be encouraged to reflect on the behaviour of clinical teachers and develop discernment in terms of which behaviour to emulate.

In this student review, a few students underlined the obligation of students to engage in developing communication skills actively. One student recommended focusing on communicating well with every patient you come across in the clinical setting. This aligns with the educational principle of active learning and taking ownership of learning (Harden and Laidlaw, 2016:15).

5.12.4 Training factors

Multiple students asked that more time is devoted to communication skills training. Students recommended earlier clinical exposure, which is gradually phased in, to prevent the sudden immersion into the clinical environment at the start of Phase III. These suggestions are in line with the evidence that early

clinical exposure can help students to develop a patient-centred approach (Littlewood *et al*., 2005:388-389).

Students requested more bedside teaching of communication skills, to be observed and given feedback by experienced doctors and to be continuously assessed in terms of their communication with patients. In the literature, feedback was the key ingredient to the success of communication skills training according to a systematic review by Smith *et al.* (2007:3).

In terms of educational methods, students asked for more interactive practice sessions with simulated or real patients, emphasising their preference for active learning methods. This aligns with the existing knowledge in the field of medical communication skills training. Berkhof *et al*. (2011:152) concluded that role play, small group teaching and feedback were the most effective methods to cultivate communication skills, while didactic teaching could be used to support these methods.

Several students asked for practical training on breaking bad news, for language learning beyond Phase I of the training and for guidance on how to manage language and cultural differences in the medical consultation. Parallels are found in the literature: Ganca *et al*. (2016:940) found glaring deficiencies in the ability of doctors to convey a poor prognosis to patients, while Matthews and van Wyk *(2018(c):194)* established that there is a real need to address language and cultural competencies in the undergraduate medical programme.

One student suggested orientating students to the clinical phase by placement in Family Medicine as early as possible, due to the holistic approach and patient-centred care witnessed. Other students mentioned the usefulness of history taking strategies taught in Paediatrics. Another student commented that the importance of communicating well with patients had only been emphasised at the Clinical Simulation and Skills Unit. One student asked for the demonstration of communication skills competencies to be a requirement in the logbooks when they complete clinical rotations.

From the comments of students, it appeared that the approach to teaching communication skills in Phase III was not unified and coordinated between different clinical departments. These inconsistencies in communication skills training have been pointed out by researchers in the broader South African medical education context: At the University of KZN, Matthews and van Wyk (2018(c):197) recommended a more standardised, integrated and interdisciplinary approach, following their multi-perspective review of undergraduate communication skills training.

One student suggested that patients should be informed by doctors how they could help form the professional identity of the student so that patients would potentially see students in a more positive light.

5.13 CONCLUSION

This concludes the discussion of the study results. The next and final chapter will consist of the limitations of the study, the recommendations from the study and concluding remarks.

CHAPTER 6

LIMITATIONS OF THE STUDY, RECOMMENDATIONS AND CONCLUDING REMARKS

6.1 INTRODUCTION

The training of doctor-patient communication skills in the undergraduate medical programme at the University of the Free State was examined by means of a student review. A summary of the study has been provided at the start of this mini-dissertation. This chapter will outline the strengths and limitations of the study and recommendations for future research. Suggestions for the further development and planning of doctor-patient communication skills training in the undergraduate medical programme at the UFS will be made, followed by concluding remarks.

6.2 STRENGTHS AND LIMITATIONS OF THE STUDY

6.2.1 Strengths of the study

The high response rate, particularly of the fifth year student cohort was a strength of the study. Another strength is the unique glimpse the study offers into the opinions and views of students regarding multiple aspects of the undergraduate training of doctor-patient communication skills.

The data collection tool chosen enabled the researcher to engage a large number of participants and probe a vast area of medical education in a relatively small amount of time. The open-ended questions allowed students to reflect and respond to aspects of the training.

Many participants provided carefully considered answers, showing a level of maturity and professionalism, which was heartening. The anonymity of the questionnaire gave students the boldness to voice concerns regarding sensitive aspects such as negative role models in the clinical education setting.

6.2.2 Limitations of the study

Limitations of the study included the cross-sectional design, which provided only a ‘snapshot in time’ compared to longitudinal designs. In terms of the data collection tool, the options for self-ratings had not been based on a recognised model. A model often used to assess attainment of complex skills, is that of Dreyfus and Dreyfus (1980). Their model consists of the following phases in skills acquisition: “Novice, advanced beginner, competent, proficient and expert”. In terms of data collection, the procedure for distribution of questionnaires was not consistently applied. Some distributors encouraged immediate completion of questionnaires and some did not.

The researcher was restricted in the conclusions that could be made regarding the proficiency of students in Sesotho, as the researcher only asked regarding home languages. The fact that the study presented a review of the training solely from a student perspective, is a limitation as it means that the picture is not yet complete: the perspectives of patients and educators *inter alia* are missing. There might also have been some recall bias, as a long time period had expired since the students had been in Phase I of the programme. Therefore, firm conclusions regarding the strengths or weaknesses of the communication skills training programme cannot be reached at this point.

Documentation regarding all aspects of communication skills training in the undergraduate programme was not readily available. However, the mapping of communication skills training was not the focus of this study. Finally, the width of the scope of the study meant that some of the depth of the study had to be sacrificed, as each aspect could not be explored exhaustively. The researcher is aware that the exclusive focus on doctor-patient communication to the exclusion of all other types of clinical communication, might seem like an artificial and arbitrary divide, but this was only done to obtain a clearer focus.

6.3 RECOMMENDATIONS

6.3.1 Recommendations for future research

This study provided the viewpoint of medical students, examined in the light of the medical education literature. It would be worthwhile to obtain other perspectives as well.

- Research on patient satisfaction in terms of communication in healthcare consultations or exploration of patient needs in terms of the cultural competency of medical students and doctors.

- Exploring the attitudes of registrars and consultants in terms of being educators and role models and looking at the challenges they face. Are the demands made of them unrealistic or feasible?

- Obtaining relevant information from all the medical educators, in order to establish the full extent of communication skills training in the undergraduate programme at the UFS, to see where duplication exists or where content is lacking, so that an integrated and well-coordinated programme can be developed.

- Consider a qualitative study to explore in more depth the impact of negative and positive role models on undergraduate medical students. What do they tend to do when they are concerned that doctors are behaving in an unprofessional way towards patients?

6.3.2 Recommendations for implementation

- Changes to the clinical skills module (MCLI) to reflect the global consensus on the content of communication curricula (*cf.* section 2.3.2) can be made. Content can be expanded from the main focus on history taking, to include a focus on empathy and managing of specific challenges such as breaking bad news, defusing anger and managing medical errors. The

communication content can be integrated with clinical content and used to develop clinical reasoning skills.

- Simulated patients need more training to increase the authenticity of scenarios. Peer practice needs to be facilitated well, with an adequate facilitator/ student ratio.

- In order to expand the content of the communication skills training programme, educators will require further training in providing skilled feedback and in helping students to be more empathic. Experts in the field could be approached for assistance and to form a network of shared expertise. Clinical teachers can also be invited to the 'training the trainer' workshop.

- Planned visits of students to healthcare facilities in the Community Service Learning programme in Phase I should not only focus on familiarising students with disease patterns but should also endeavour to cultivate patient-centeredness.

- Educators across different phases of the training programme should meet to discuss how communication skills training can be coordinated. Lectures regarding communication skills can potentially be augmented with interactive small-group teaching sessions if practically feasible.

- A one-day workshop to train students in breaking bad news can be designed and implemented for the final year students. This workshop could potentially be piloted with interns to see what works well and what could be improved. Skilled facilitators and trained simulated patients will be required.

- An increase in the frequency of formative OSCE's both in Phase II and III of the training programme. A standardised approach in stage III is required to assess communication skills in the workplace and to document these assessments. The assessment needs to be done by a clinical teacher who

has had training in doctor-patient communication themselves. A reflective portfolio to log challenging communication scenarios can be considered.

- ❖ Unprofessional behaviour of doctors towards patients needs to be addressed. Possible ways to address this issue may be additional staff training in professionalism and role-modelling for all clinical teachers. Compulsory training in the principles and best practices of medical education should be considered. Anonymous multi-source feedback of professionalism and teaching skills could be required as part of the key performance indicators of clinical teachers.

6.4 CONCLUDING REMARKS

Doctor-patient communication is a vital component of patient care and medical regulators require doctors to practice patient-centred communication. Communication skills can be improved through effective training. The medical education literature offers evidence-based guidance regarding various aspects of communication skills training, including the outcomes, content, educational strategies, learning opportunities, assessment methods and the learning environment. In order for communication skills training to be effective, it needs to be taken seriously and not seen as an add-on to the programme. In this student review, it became evident that students lack confidence in their ability to manage communication challenges such as breaking bad news and defusing anger.

Students reported limited training in managing language and cultural differences in the consultation and asked for a greater focus on these aspects during their training. Students requested earlier clinical exposure and the literature confirmed that this could help students to understand the patient's perspective. Research evidence showed that effective training of communication skills combine didactic teaching, role-play, reflection, feedback and discussion. Students indicated in this review that they found these interactive training methods enjoyable and useful. However, communication skills are often still taught only through didactic methods. Teaching of communication skills in the pre-clinical phase must be augmented in the clinical phase by medical educators, through teaching and role-

modelling. Clinical teachers who ignore patients or speak to them harshly can leave students conflicted and disillusioned.

In this student review, many students expressed their concern regarding the way they have seen doctors communicate with patients. Staff development programmes should raise the profile of communication skills training, as well as clinical role modelling. Even from a utilitarian argument, good doctor-patient communication and positive role-modelling thereof make sense. Good communication with patients leads to happier, more compliant, healthier patients, which leads to happier doctors. It is not quite that simple, but there surely is compelling evidence that good doctor-patient communication is more than a nicety. That is why it needs to be an integral part of the carefully choreographed medical education programme.

REFERENCES

Aaronson, E.L., White, B.A., Black, L., Brown, D.F., Benzer, T., Castagna, A., Raja, A.S., Sonis, J. and Mort, E. 2018. Training to Improve Communication Quality: An Efficient Interdisciplinary Experience for Emergency Department Clinicians. *American Journal of Medical Quality* 34(3):260-265.

Alelwani, S.M. and Ahmed, Y.A. 2014. Medical training for communication of bad news: A literature review. *Journal of Education and Health Promotion* 3(1):51.

Archer, E., Bitzer, E.M. and van Heerden, B.B. 2017. Interrogating patient-centredness in undergraduate medical education using an integrated behaviour model. *South African Family Practice* 59(6):219–223.

Archer, E. and Meyer, I. 2018(a). Interventions aimed towards the development of patient-centredness in undergraduate medical curricula: A scoping review. *African Journal of Health Professions Education* 10(3):171-175.

Archer, E. and Meyer, I. 2018(b). Teaching empathy to undergraduate medical students: 'one glove does not fit all'. *Medical Education* 52(11):1191.

Aspegren, K. 1999. Teaching and learning communication skills in medicine: a review with quality grading of articles. BEME Guide No.2. *Medical Teacher* 21(6):3-12.

Aspegren, K. and Lonberg-Madsen, P. 2005. Which basic communication skills in medicine are learnt spontaneously and which need to be taught and trained? *Medical Teacher* 7(6):539–543.

Bachmann, C., Abramovitch, H., Barbu, C.G., Cavaco, A.M., Elorza, R.D., Haak, R., Loureiro, E., Ratjska, A., Silverman, J., Winterburn, S. and Rosenbaum, M. 2013. A European consensus on learning objectives for a core communication curriculum in health care professions. *Patient Education and Counselling* 93(1):18-26.

Banerjee, A and Chaudhury, S. 2010. Statistics without tears: Populations and Samples. *Industrial Psychiatry Journal* 19(1):60-65.

Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A. and Cooper, L. A. 2005. Cultural competence: a systematic review of health care provider educational interventions. *Medical care* 43(4), 356–373.

Benbassat, J. 2014. Role modeling in medical education: the importance of a reflective imitation. *Academic Medicine* 89(4):550-4.

Bennett, K and Lyons, Z. 2011. Communication Skills in Medical Education: An Integrated Approach. *Education Research and Perspectives*, 38(2):50-56.

Berkhof, M., van Rijssen, H.J., Schellart, A.J.M., Anema, J.R. and van der Beek, A.J., 2011. Effective training strategies for teaching communication skills to physicians: an overview of systematic reviews. *Patient Education and Counselling* 84(2):152-162.

Bialer, P., Kissane, D., Brown, R., Levin, T and Bylund, C. 2011. Responding to patient anger: Development and evaluation of an oncology communication skills training module. *Palliative & Supportive Care* 9(4):359-365.

Bokken, L., Rethans, J-J., Scherpbier, A.J.J.A. and van der Vleuten, C.P.M. 2008. Strengths and Weaknesses of Simulated and Real Patients in the Teaching of Skills to Medical Students: A Review. *Simulation in Healthcare* 3(1):161-169.

Botma, Y., Greeff, M., Mulaudzi, F.M. and Wright, S.C.D. 2010. *Research in Health Sciences.* Cape Town: Pearson.

Brouwers, M.H., Bor, H., Laan, R., van Weel, C. and Baumgarten, E. 2018. Students' experiences with a longitudinal skills training program on breaking bad news: A follow-up study. *Patient Education and Counseling* 101(9):1639-1644.

Buckman, R., Tulsky, J.A. and Rodin, G. 2011. Empathic responses in clinical practice: Intuition or tuition? *Canadian Medical Association Journal* 183(5):569–571.

Burch, V. 2007. *Medical Education in South Africa: assessment practices in a developing country.* Erasmus University: Rotterdam.

Burch, V. 2016. Cultural competence or speaking the patient's language? *African Journal of Health Professions Education* 8(1):3.

Campbell, J. and Wright, C. 2011. GMC Multi-Source Feedback Questionnaires Interpreting and handling multisource feedback results: Guidance for appraisers. https://www.gmc-uk.org/-/media/documents/guidance-for-appraisers---pms-45189197.pdf Retrieved on 30 January 2020.

Carraccio, C., Wolfsthal, S.D., Englander, R., Ferentz, K. and Martin C. 2002. Shifting paradigms: From Flexner to competencies. *Academic Medicine* 77(5):361-7.

Cruess, S.R., Cruess, R.L. and Steinert, Y. 2008. Role modelling—making the most of a powerful teaching strategy. *British Medical Journal* 336:718.

Dalley, K., Candela, L. and Lindley, J.B. 2008. Learning to let go: The challenge of de-crowding the curriculum. *Nurse Education Today* 28(1):62-69.

Denney, M.L. 2007. Selecting consultations for Consultation Observation Tools. *Pulse Today* http://www.pulsetoday.co.uk/selecting-consultations-for-consultation-observation-tools/10961017.article
Retrieved on 30 January 2020.

Derksen, F., Bensing, J., and Lagro-Janssen, A. 2013. Effectiveness of empathy in general practice: a systematic review. *The British Journal of General Practice* 63(606):e76–e84.

Dent, J.A. and Harden, R.M. (Eds). 2013. *A Practical guide for Medical Teachers* (4th ed.) London: Elsevier.

Dent, J.A., Harden, R.M. and Hunt, D. (Eds). 2017. *A Practical Guide for Medical Teachers* (5th ed.) London: Elsevier.

De Vos, A.S., Strydom, H., Fouche, C.B. and Delport, C.L.S. 2011*. Research at Grassroots for Social Sciences and Human Science Professions* (4th ed.) Hatfield, Pretoria: Van Schaik.

Dolezal, L 2015. The phenomenology of shame in the clinical encounter *Medicine, Health Care and Philosophy* 18(4):567-576.

Dornan, T. & Littlewood, S & Margolis, S. & Scherpbier, A. & Spencer, J. & Ypinazar, V. 2006. How can experience in clinical and community settings contribute to early medical education? A BEME systematic review. *Medical teacher* 28(1):3-18.

Dreyfus, S., and Dreyfus, H. 1980. A Five-Stage Model of the Mental Activities Involved in Directed Skill Acquisition.
https://apps.dtic.mil/dtic/tr/fulltext/u2/a084551.pdf
Retrieved on 31 January 2020.

Du Plessis, J.H.N. 2017. *Family experiences and viewpoints of palliative and supportive care for children with cancer: Can we do better?* (Unpublished dissertation for Master's degree in Philosophy) University of Cape Town.

Etheridge, L. and Boursicot, K. 2017. Performance and workplace-based assessment. In Dent, J.A. Harden, R.M. and Hunt, D. (Eds). *A Practical Guide for Medical Teachers (*5th ed*).* London: Elsevier.

Frank, J. R. (Ed.) 2005. *The CanMEDS 2005 Physician Competency Framework: Better Standards, Better Physicians, Better Care.* Ottawa: The Royal College of Physicians and Surgeons of Canada.

Frank JR, Snell L, Sherbino J, editors. 2015. *CanMEDS 2015 Physician Competency Framework*. Ottawa: Royal College of Physicians and Surgeons of Canada.

Fryer-Edwards, K. 2002. Addressing the hidden curriculum in scientific research. *American Journal of Bioethics* 2(4):58-59.

Ganca, L.L., Gwyther, L., Harding, R., Meiring, M. 2016. What are the communication skills and needs of doctors when communicating a poor prognosis to patients and their families? A qualitative study from South Africa. *South African Medical Journal* 106(9):940-944.

Georgopolou, S., Prothero, L., Cruz, D.P., 2018. Physician–patient communication in rheumatology: a systematic review. *Rheumatology International* 38(5):763-775.

Giesbrecht, E., Wener, P. and Pereira, G. 2014. A mixed methods study of student perceptions of using standardized patients for learning and evaluation. *Advances in medical education and practice* 5(1)241-55.

General Medical Council. 2019. Openness and honesty when things go wrong: the professional duty of candour.
https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong
Retrieved on 28 January 2020.

Genn, J.M. 2001. AMEE Medical Education Guide No. 23 (Part 1): Curriculum, environment, climate, quality and change in medical education–a unifying perspective. *Medical Teacher* 23(4):337-344.

Gillies, R.A., Speers, S.H., Young, S.E., Fly, C.A., 2011. Teaching medical error apologies: development of a multi-component intervention. *Family Medicine* 43(6):400-6.

Guba, E. 1981. Criteria for Assessing the Trustworthiness of Naturalistic Inquiries. *Educational Communication and Technology*, 29(2):75-91.

Ha, J. and Longnecker, N. 2010. Doctor-Patient Communication: A Review. *Ochsner Journal* 10 (1) 38-43.

Hafferty, F.W. and Gaufberg, E. 2017. The hidden curriculum. In Dent, J.A., Harden, R.M and Hunt, D. (Eds.). *A Practical Guide for Medical Teachers (*5th ed.) London: Elsevier.

Harden, R.M., Sowden, S and Dunn, W.R. 1984. Educational strategies in curriculum development: the SPICES model. *Medical Education* 18(4):284-97.

Harden, R.M. and David, M.H. 1995. AMEE Medical Education Guide No. 5. The core curriculum with options or special study modules. *Medical Teacher* 17(2):125-148.

Harden, R.M. and Laidlaw, J. 2016. *Essential Skills for a Medical Teacher: An Introduction to Teaching and Learning in Medicine* (2nd ed.) London: Elsevier.

Haskard-Zolnierek, K. B. and DiMatteo, M.R. 2009. Physician Communication and Patient Adherence to Treatment: A Meta-analysis. *Medical Care* 47(8):826–834.

Hattingh, M.G.M., 2017. *The experiences and attitudes of students and lecturers regarding peer physical examination in the Faculty of Health Sciences at the University of the Free State.* (Unpublished Mini-dissertation for Master's degree in Health Professions Education) University of the Free State, Bloemfontein.

Hojat, M., Louis D.Z., Markham, F.W., Fred, W., Wender, R., Rabinowitz, C. and Gonnella, J., 2011. Physicians' empathy and clinical outcomes for diabetic patients. *Academic Medicine* 86(3): 359–364.

HPCSA 2014. Core competencies for undergraduate students in clinical associate, dentistry and medical teaching and learning programmes in South Africa.
http://www.hpcsa.co.za/uploads/editor/UserFiles/downloads/medical_dental/MDB%20Core%20Competencies%20-%20ENGLISH%20-%20FINAL%202014.pdf.
Retrieved on 14 June 2018.

Huntington, B. and Kuhn, N. 2003. Communication gaffes: a root cause of malpractice claims. *Proceedings (Baylor University. Medical Center)* 16(2):157–161.

Hussey N. 2012. The language barrier: the overlooked challenge to equitable health care. *South African Health Review* 189–95.

Johnson, J. and Panagioti, M. 2018. Interventions to Improve the Breaking of Bad or Difficult News by Physicians, Medical Students, and Interns/Residents: A Systematic Review and Meta-Analysis. *Academic Medicine* 93(9):1400-1412.

Joubert, P.M., Kruger, C., Bergh, A-M., Pickworth, G.E., Van Staden, C.W., Roos, J.L., Schurink, W.J., Du Preez, R.R., Grey, S.V. and Lindeque, B.G. 2006. Medical students on the value of role models for developing 'soft skills' - "That's the way you do it. A*frican Journal of Psychiatry* 9(1):28-32.

Keifenheim, K., Teufel, M., Speiser, N.,Leehr, E., Zipvel, S. and Hermann-Werner, A. 2015. Teaching history taking to medical students: a systematic review. *BMC Medical Education* 15(1):159.

Kelly, G., Mrengqwa, L. and Geffen, L. 2019. “They don’t care about us”: older people’s experiences of primary healthcare in Cape Town, South Africa. *BMC Geriatrics* 19(1):98.

Kern, D.E. 2016. Overview: A Six-Step approach to Curriculum Development. In Thomas, P.A., Kern, D.E., Hughes, M.T., Chen, B. (Eds.). *Curriculum Development.* Baltimore: John Hopkins University Press.

Kiessling, C., Dieterich, A., Fabry, G.,Holzer, H.,Langewitz, W.,Muhlinghaus, I.,Pfruskil, S.,Scheffer, S. and Schubert, S. 2010.Communication and social competencies in medical education in German-speaking countries: The Basel Consensus Statement.: Results of a Delphi Survey. *Patient Education and Counseling 81(2):259-266.*

Kneebone, R.L., Nestel, D. and Bello F. 2017. Learning in a simulated environment, Dent, J.A., Harden, R.M., Hunt, D. (Eds), *A Practical Guide for Medical Teachers* (5th ed.) London: Elsevier.

Kohn, L.T., Corrigan, J.M. and Donaldson, M.S. 2000. *To Err is Human. Building a safer health system. Committee on Quality of Health Care in America.* Institute of Medicine. Washington, D.C: National Academy Press.

Kurer, M.A. and Zekri, J.M. 2008. Breaking Bad News: Can We Get It Right? *Libyan Journal of Medicine* 3(4):200-203.

Kurtz, S., Silverman, J., Benson, J. and Draper, J. 2003. Marrying content and process in clinical method teaching: enhancing the Calgary-Cambridge guides. *Academic Medicine* 78(8):802-9.

Kurtz, S., Silverman, J. and Draper, J. 2005. *Teaching and Learning Communication Skills In Medicine (2nd Ed).* Oxford: Radcliffe Publishers Limited.

Larson, E., Leslie, H.H. and Kruk, M.E. 2017.The determinants and outcomes of good provider communication: a cross-sectional study in seven African countries. *BMJ Open* 7(1):e014888.

Lazare, A. 1987. Shame and Humiliation in the Medical Encounter. *Archives of Internal Medicine* 147(9):1653-1658.

Leedy, P.D. and Ormrod, J.E. 2005 *Practical Research: Planning and Design (*12th ed.) Upper Saddle River, New Jersey: Prentice Hall.

Lehohla, P. 2016. Community Survey 2016 in Brief.
http://cs2016.statssa.gov.za/wp-content/uploads/2017/07/CS-in-brief-14-07-2017-with-cover_1.pdf
Retrieved on 19 January 2020.

Levinson, W.L., Lesser, C.S. and Epstein, R.M. 2010. Developing Physician Communication Skills For Patient-Centered Care. *Health Affairs* 29(7):1310-1318.

Ley, T., Kisielewska, J., Collett, T. and Burr, S. 2019. Improving communication for learning with students: expectations, feedback and feedforward. *MedEdPublish*, 8 (1):14.

Leinster, S. 2013. The undergraduate curriculum and clinical teaching in the early years. In Dent, J.A. and Harden, R.M. (Eds.). *A Practical Guide for Medical Teachers* (4th ed.) London: Elsevier.

Littlewood, S., Ypinazar, V., Margolis, S.A., Scherpbier, A., Spencer J. and Dornan, T. 2005. Early practical experience and the social responsiveness of clinical education: systematic review. *British Medical Journal* 331(7513):387-391.

Lutz, G., Roling, G., Berger, B., Edelhauser, F., Scheffer, C. 2016. *BMC Medical Education* 16:301.

Maguire, P. and Pitceathly, C. 2003. Managing the difficult consultation. *Clinical Medicine 3(6):*532-537.

Mahood, S. 2011. Beware of the hidden curriculum. *Canadian Family Physician*. 57(9): 983–985.

Makoul, G. 2001. Essential elements of communication in medical encounters: the Kalamazoo consensus statement. *Academic Medicine* 76(4):390-3.

Maree, K. and Pietersen, J. 2014. Surveys and the use of questionnaires. In Maree, K. (Ed.). *First steps in Research.* Pretoria: Van Schaik Publishers.

Matthews, M. and van Wyk, J. 2018(a). Towards a culturally competent health professional: a South African case study. *BMC Medical Education* 18**,** 112.

Matthews, M.G. and van Wyk, J.M. 2018(b). Exploring a communication curriculum through a focus on social accountability: A case study at a South African medical school. *African Journal of Primary Health Care and Family Medicine* 10(1): a1634.

Matthews, M.G. and van Wyk, J.M. 2018(c). Improving communication in the South African healthcare context. *African Journal of Health Professions Education* 10(4):194 – 198.

McInerney, P., Green-Thompson, L.P. and Manning, D.M. 2013. Experiences of graduating students from a medical programme five years after curricular transformation: A descriptive study. *African Journal of Health Professions Education* 5(1):34-36.

Medical dictionary:
https://medicaldictionary.thefreedictionary.com/health+assessment+questionnaire.
Retrieved on 18 June 2018.

Mehay, R, Burns, R. 2009. Miller's Pyramid of Clinical Competence. In: Mehay R, editor. *The Essential handbook for GP training and education*. London: Radcliffe Publishing Limited.

Miller, G.E. 1990. The assessment of clinical skills/competence/performance. *Academic Medicine* 65(9):s63–s67.

Neumann, M., Edelhäuser, F., Tauschel, D., Fischer, M.R., Wirtz, M., Woopen, C., Haramati, A. and Scheffer, C. 2011. Empathy Decline and Its Reasons: A Systematic Review of Studies With Medical Students and Residents. *Academic Medicine* 86(8):996-1009.

Noble, L.M., Scott-Smith, W., O'Neill, B. and Salisbury, H., 2018. Consensus statement on an updated core communication curriculum for UK undergraduate medical education. *Patient Education and Counseling* 101(1):1712-1719.

Norcini, J. and Burch, V. 2007: Workplace-based assessment as an educational tool: AMEE Guide No. 31. *Medical Teacher* 29(9):855-71.

O'Sullivan, H.M. 2017. Professionalism. In Dent, J.A., Harden, R.M and Hunt, D. (Eds.). *A Practical Guide for Medical Teachers* (5th ed.) London: Elsevier.

Oxford dictionary:
https://en.oxforddictionaries.com/definition/communication.
Retrieved on 29 January 2019.

Platt, F.W., 2005. Foreword. In Kurtz, S., Silverman, J. and Draper, J. 2005. *Teaching and Learning Communication Skills in Medicine (2nd Ed).* Oxford: Radcliffe Publishers Limited, ix-x.

Quirk, M.E. and Harden, R.M. 2017. Curriculum Planning and Development. In Dent, J.A. and Harden, R.M. and Hunt, D. (Eds.). *A Practical Guide for Medical Teachers. (5th ed.).* London: Elsevier.

Rakel, D., Barrett. B., Zhang, Z., Hoeft, T., Chewning, B., Marcjand, L. and Scheder, J. 2011. Perception of empathy in the therapeutic encounter: Effects on the common cold. *Patient Education and Counceling* 85(3): 390–397.

Reid, M., Walsh, C., Raubenheimer, J., Bradshaw, T., Pienaar, M. Hassan, C., Nyoni, C. and Le Roux, M. 2018. Development of a health dialogue model for patients with diabetes: A complex intervention in a low-/middle-income country. *International Journal of Africa Nursing Sciences* 8(1):122-131.

Rider, E.A. and Keefer, C.H. 2006. Communication skills competencies: definitions and a teaching toolbox. *Medical Education* (40):624–629.

Riedl, D. and Schubler, G. 2017. The Influence of Doctor-Patient Communication on Health Outcomes: A Systematic Review. *Zeitschrift fur Psychosomatische Medizin und Psychotherapie* 63(2):131-150

Ringstedt, C., Hodges, B. and Scherpbier, A. 2011. 'The research compass': An introduction to research in medical education: AMEE Guide No. 56 *Medical Teacher* 33(9):695-709.

Robbenolt, J.K. 2009. Apologies and Medical Error. *Clinical Orthopaedics and Related Research* 467(2): 376–382.

Rocke, D. and Lee, W.T. 2013. Medical Errors: Teachable Moments in Doing the Right Thing. *Journal of Graduate Medical Education* 5(4):550-552.

Roshan, M., Rao, A.P. 2000. A study on relative contributions of the history, physical examination and investigations in making medical diagnosis. *Journal of the Association of Physicians of India* 48(8):771–775.

Ruiz-Moral, R.,Gracía de Leonardo, C., Caballero Martínez, F. and Monge Martin, D. 2019. Medical students' perceptions towards learning communication skills: a qualitative study following the 2-year training programme. *International Journal of Medical Education* 10(1):90-97.

Sandars, J. 2009. The use of reflection in medical education: AMEE Guide No. 44. *Medical Teacher* 31(1): 685–695.

Sanson-Fisher, R., Hobden, B., Waller, A., Dodd, N. and Boyd, L. 2018. Methodological quality of teaching communication skills to undergraduate medical students: a mapping review. *BMC Medical Education* 18:151.

Schiekirka, S., Feufel, M.A., Hermann-Lingen, C. and Raupach, T. 2015. Evaluation in medical education: A topical review of target parameters, data collection tools and confounding factors. *German Medical Science* 13:1-19.

Schurwith, L. and Van der Vleuten, C. 2014. *How to design a useful test. In: Understanding Medical Education: Evidence, Theory and Practice.* Dundee: Association for the Study of Medical Education.

Skelton, J.R. 2013. Clinical Communication. In Dent, J.A. and Harden, R.M. (Eds) *A Practical Guide for Medical Teachers*. (4th ed.) London: Elsevier.

Skelton, J.R. 2017. Clinical communication. In Dent, J.A., Harden, R.M. and Hunt, D. (Eds.). *A Practical Guide for Medical Teachers.* (5th ed.) London: Elsevier.

Silverman, B.D. 2012. Physician behavior and bedside manners: the influence of William Osler and The Johns Hopkins School of Medicine. *Proceedings (Baylor University. Medical Center)* 25(1):58-61.

Simpson, M., Buckman, R., Stewart, M., Maguire, P., Lipkin, M., Novack, D. and Till, J. 1991. Doctor-patient communication: the Toronto consensus statement. *British Medical Journal* 303(6814): 1385–1387.

Smith, S., Hanson, J.L., Tewksbury, L.R., Christy, C., Talib, N.J., Harris, M.A., Beck, G.L., Wolf, F.M. 2007. Teaching patient communication skills to medical students: a review of randomized controlled trials. *Evaluation & the Health Professions* 30(1):3–21.

Tate, P. 2018. Consultation skills - Staying calm with angry patients.
https://www.gponline.com/consultation-skills-staying-calm-angrypatients/article/1051676
Retrieved on 22 January 2019.

Tavakol, M. and Sandars, J. 2014. Quantitative and qualitative methods in medical education research: AMEE Guide No 90: *Part II. Medical Teacher* 36(10):838-848.

University of the Free State: Faculty of Health Sciences: 2018. Rule book, SCHOOL OF MEDICINE UNDERGRADUATE QUALIFICATIONS
https://apps.ufs.ac.za/dl/yearbooks/315_yearbook_eng.pdf
Retrieved on 30 January 2020

University of the Free State, 2020. Clinical Skills and Simulation Unit. *https://www.ufs.ac.za/health/departments-and-divisions/school-of-biomedical-sciences-home/divisions/clinical-simulation-and-skills-unit*
Retrieved on 31 January 2020

Van den Berg, V.L. 2016. Still lost in translation: language barriers in South African health care remain. *South African Family Practice* 58(6): 229-231.

Van der Vleuten, C.P., Schuwirth, L.W., Scheele, F., Driessen, E.W. and Hodges B. 2010. The assessment of professional competence: building blocks for theory development. *Best Practice & Research: Clinical Obstetrics & Gynaecology* 24(6):703-19.

Van Heerden, B.B. 2012. Effectively addressing the health needs of South Africa's population: The role of health professions education in the 21st century. *South African Medical Journal* 103(1):21-22.

Von Fragstein M., Silverman, J., Cushing, A., Quilligan, S., Salisbury H. and Wiskin, C. 2008. UK consensus statement on the content of communication curricula in undergraduate medical education. *Medical Education* 42: 1100–1107.

Yardley, S., Littlewood, S., Margolis, S.A., Scherpbier, A., Spencer, J., Ypinazar, V. and Dornan. 2010. What has changed in the evidence for early experience? Update of a BEME systematic review. *Medical Teacher* 32:740-746.

Yardley, S., Irvine, A.W. and Lefroy, J. 2013. Minding the gap between communication skills simulation and authentic experience. *Medical Education* 47(1):495-510.

Wachira, J., Middlestadt, S., Reece, M., Peng, C-Y, J. and Braitstein, P., 2014. Physician communication behaviors from the perspective of adult HIV patients. *International Journal for Quality in Health Care* 26(2):190–197.

Wass, V.J. and Barnard, A., 2017. The assessment of attitudes and professionalism. In Dent, J.A. Harden, R.M. and Hunt, D. (Eds). *A Practical Guide for Medical Teachers* (5th ed.). London: Elsevier.

Watling, C.J. and Lingard, L. 2012. Grounded theory in medical education research: AMEE Guide No. 70. *Medical Teacher* 34(10):850-861.

Windish, D.M., Price, E.G., Clever, S.L., Magaziner, J.L. and Thomas, P.A. 2005. Teaching Medical Students the Important Connection between Communication and Clinical Reasoning. *Journal of General Internal Medicine* 20(12):1108-1113.

Zhou, Q., Shen, J-C., Liu, Y-Z., Lin, G-Z., Dong, H. and Li, K. 2014. Effects of doctor-patient communication on quality of life among breast cancer patients in Southern China. *Asian Pacific Journal of Cancer Prevention*, 15, 5639–5644.

PERSONAL COMMUNICATION:

Brits, H. Chair of Phase III: Undergraduate MBCHB Programme: Department of Family Medicine, University of the Free State, Bloemfontein, E-mail on 8 January 2020.

Du Plessis, S. Programme Organiser: Undergraduate MBChB Programme: Support School of Medicine, E-mail on 11 December 2018.

Van der Merwe, L. MBChB Programme Director, Faculty of Health Sciences, University of the Free State. E-mail on 13 October 2018.

Van Zyl, S. Chair of Phase II: Undergraduate MBCHB Programme: Department of Basic Medical Sciences, University of the Free State, Bloemfontein, E-mail on 16 January 2020.

APPENDIX A

DIAGRAMMATIC REPRESENTATION OF THE MBCHB PROGRAMME AT THE UNIVERSITY OF THE FREE STATE (UFS, 2018)

DIAGRAMMATIC REPRESENTATION OF THE STRUCTURE OF THE MBChB PROGRAMME BC834100									
PHASE 1	PHASE II				PHASE III				
YEAR 1		YEAR 2		YEAR 3		YEAR 4 (196C)		YEAR 5 (200C)	
Semester 1 (84C)	Semester 2	Semester 3 (152C)	Semester 4 (88C)	Semester 5 (104C)	Semester 6 (36C)	Semester 7	Semester 8	Semester 9	Semester10
MPSY1513 (12C) Health Psychology	MMEM1620 (0C) ** Membranes, Receptors and Principles of Pharmacotherapy	MMEM2618 (32C)	MURI2724 (16C) Urinary System	MRES3714 (16C) Respiratory System	MHEL3823 (12C) Health Policy and Service Provision	MINT 4810 (52C) Internal Medicine	MINT 4820 (52C) Internal Medicine	MIAM5810 (48C) Internal Medicine and Anaesthesiology	MIAM5820 (48C) Internal Medicine and Anaesthesiology
MDOC1513 (12C) The Doctor and the Environment	MANA1620 (0C)** Structure and Development of the Body (dissection programme)	MANA2618 (32C)	MHAE2724 (16C) Haematology and Immunopathology	MHEA3714 (16C) Health and Disease in Populations		MSUR4810 (48C) Surgery (Otorhino-laryngology/ Ophthalmology/ Orthopaedics)	MSUR4820(48C) Surgery (Otorhino-laryngology/ Ophthalmology/ Orthopaedics)	MSUR5810 (56C) Surgery (Orthopaedics, Urology and Trauma)	MSUR5820 56C) Surgery (Orthopaedics, Urology and Trauma)
MCHD1513 (12C) Concepts of Health and Disease	MMOL1620 (0C)** Molecules of the Body Metabolism	MMOL2618 (32C)	MCAR2724 (16C) Cardiovascular System	MNER3714 (16C) Nervous System		MPAE4818 (32C) Paediatrics and Child health	MPAE4828 (32C) Paediatrics and Child health	MPAE5816 (24C) Paediatrics and Child health	MPAE5826 (24C) Paediatrics and Child health
MHIS1513 (12C) Tissues of the Body		MDIS2614 (16C) Mechanisms of Disease	MGEN2724 (16C) Genital System	MEND3714 (16C) Endocrine System	MINT3820 (0C)** Internal Medicine (Psychiatry)	MOBG4818 (32C) Obstetrics and Gynaecology	MOBG4828 (32C) Obstetrics and Gynaecology	MOBG5816 (24C) Obstetrics and Gynaecology	MOBG5826 (24C) Obstetrics and Gynaecology
MANA1513 (12C) Structure and Development of the Body		MINF2614 (16C) Infections and Antimicrobial Drugs	MGAS2724 (16c) Gastrointestinal System	METH3714 (16C) Human Diversity, Human Rights and Legal Ethics	MSUR3820 (0C)** Surgery (Anaesthesiology)		MPSY4828 (32C) Psychiatry (Oncology)	MFAM5818 (32C) Family Medicine	MFAM5828 (32C) Family Medicine
MGEN1513 (12C) General Skills	MSSM1620 (0C)** Epidemiology, Biostatistics and Special Study Module (SSM)	MSSM2613 (12C)	MSSM2720 (0C) Epidemiology, Biostat. and SSM	MSSM3712 (8C) Epidemiology, Biostat. And SSM	MPAE3823 (12C)** Paediatrics and Child health MOBG3823 (12C)** Obstetrics and Gynaecology	MPSY4818 (32C) Psychiatry (Oncology)		MPSY5814 (16C) Psychiatry	MPSY5824 (16C) Psychiatry
Level 8 Total Credits: 860 National Hours: 8600	Learning Development Programme (LDO) of 6 months for students that failed		MCLI2720 (0C) ** Clinical Skills	MCLI3713 (12C)	MPSY3820 (0C)** Psychiatry	Community-based education	Community-based education		
	MIMA1620 Integrated Medical Assessment Module Mark		MIMA2720 Integrated Medical Assessment Module Mark						

MIMA1513 (12C) Integrated Medical Science Assessment

MIMA 2613 (12C) Integrated Medical Science Assessment

MIMA3713 (12C) Integrated Medical Science Assessment

Compulsory residency with an approved general practitioner – 2 weeks electives / Semester examinations

Final exit examinations at the end of 10

**Continuation

(UFS: FoHS: RULE BOOK, SCHOOL OF MEDICINE UNDERGRADUATE QUALIFICATIONS, 2018)

APPENDIX B

COPY OF THE QUESTIONNAIRE USED IN THE STUDY

FINAL QUESTIONNAIRE FOR STUDY TO OBTAIN A STUDENT REVIEW OF UNDERGRADUATE DOCTOR-PATIENT COMMUNICATION SKILLS TRAINING AT THE UFS

You have been asked to participate in a research study. Please note that by completing this questionnaire you are voluntarily agreeing to participate in this research study. You will remain anonymous and your data will be treated confidentially at all times. You may withdraw from this study at any given moment during the completion of the questionnaire. The results of the study may be published.

Biographic Data

i) How old are you?	**years**					
ii) What is your gender?						
iii) In which year of study are you?	**4th year**		**5th year**			
iv) What is your home language?						
v) In which phase did you start training at UFS?	**Phase 1 Semester 1**		**Phase 2 Semesters 2 to 5**		**Phase 3 Semesters 6 to 10**	

If you were not present during a certain phase of training, please indicate with n/a (not applicable)

Question 1: OUTCOMES

1.1 The outcomes of doctor-patient communication skills training were made clear to us.

Indicate your answers with an "x" in the relevant column.

	Not at all	Seldom	Often	Almost always
Phase 1				
Phase 2				
Phase 3				

1.2 We were told about the roles of the health practitioner as expected by the Health Professions Council of South Africa, such as Health Professional, Communicator and Collaborator.

	Not at all	Seldom	Often	Almost always
Phase 1				
Phase 2				
Phase 3				

Question 2: CONTENT

2.1 Educators told us about the studies that demonstrated the benefits of good communication skills for patient outcomes.

	Not at all	Seldom	Often	Almost always
Phase 1				
Phase 2				
Phase 3				

2.2.1 We received training in taking a thorough patient history, including a psychosocial history.

	No training	Limited training	Extensive training	Extensive training & practice
Phase 1				
Phase 2				
Phase 3				

2.2.2 How would you rate your ability to take a thorough history?

Novice	Average	Excellent

Motivate your answer:

……..

……..

……..

2.3.1 Doctor-patient Communication skills training included practical sessions in "Breaking bad news"

	No training	Limited training	Frequent training	Extensive training & practice
Phase 1				
Phase 2				
Phase 3				

2.3.2 How would you rate your ability to break bad news to a patient?

Novice	Average	Excellent

Motivate your answer:

……

……..

2.4.1 Doctor-patient communication skills training included learning how to manage language and cultural differences in the consultation.

	Not at all	Seldom	Often	Almost always
Phase 1				
Phase 2				
Phase 3				

2.4.2 How would you rate your ability to manage language and cultural differences in the consultation?

Novice	Average	Excellent

Motivate your answer

……

2.5.1 Doctor-patient communication skills training helped me to understand the patient's point of view.

	Not at all	Seldom	Often	Almost always
Phase 1				
Phase 2				
Phase 3				

2.5.2 How would you rate your ability to see the patient's point of view?

Novice	Average	Excellent

2.6.1 Doctor-patient Communication skills training involved explaining medical errors and potentially offering an apology to patients.

	Not at all	Seldom	Often	Almost always
Phase 1				
Phase 2				
Phase 3				

2.6.2 How would you rate your ability to explain medical errors and potentially offering an apology to a patient?

Novice	Average	Excellent

2.7.1 The content of the doctor-patient communication skills training included learning how to defuse anger.

	Not at all	Seldom	Often	Almost always
Phase 1				
Phase 2				
Phase 3				

2.7.2 How would you rate your ability to defuse anger?

Novice	Average	Excellent

QUESTION 3: Educational Methods

3.1 Which of the following methods of doctor-patient communication skills training did you find the most useful? Please rank the following methods, with 1 being your preferred method and 6 the least preferred method.

If the method was not used, indicate N/A for not applicable.

Indicate during which phase or phases of training the method was used.

Teaching Methods **1 is preferred method, 6 is least preferred method**	**Ranking** **(1 to 6)**	**Indicate phase(s) in which the method was used: (1, 2 or 3)** **(Can be more than one phase)**		
A. Lectures				
B. Small group practice with peers				
C. Small group practice with simulated patients				
D. Looking at videos of consultations. (Examples of good clinical communication and/or poor clinical communication)				
E. Being observed by a doctor or other healthcare professional while communicating with a patient in a ward or clinic & receiving feedback about your communication skills.				
F. Video-recording of student consultation for evaluation of doctor-patient communication skills.				

Explain the reason for choosing your preferred method in Question 3.1:

_____

Explain the reason for choosing your least preferred method:

_____

3.2 The simulated patients that we came encountered in practice sessions and OSCE situations were believable and made me feel like I was talking to a real patient.

Never	Sometimes	Often	Almost always

Motivate you answer: ……

……..

QUESTION 4 Learning opportunities:

4.1 We received enough opportunities to practise doctor-patient communication skills.

	Not at all	Seldom	Often	Almost always
Phase 1				
Phase 2				
Phase 3				

4.2 We have been given the opportunities to reflect on situations when our doctor-patient communication did not go well and how we could have managed it better.

	Not at all	Seldom	Often	Almost always
Phase 1				
Phase 2				
Phase 3				

QUESTION 5 Assessment

5.1 The content of assessments, such as tests, demonstrated to me that doctor-patient communication skills are viewed as important.

	Not at all	Seldom	Often	Almost always
Phase 1				
Phase 2				
Phase 3				

5.2 The content of examinations demonstrated to me that doctor-patient communication skills are viewed as important.

	Not at all	Seldom	Often	Almost always
Phase 1				
Phase 2				
Phase 3				

5.3 Doctor-patient communication skills of students have been assessed continously so that it can reflect everyday behaviour and attitudes.

	Not at all	Seldom	Often	Almost always
Phase 1				
Phase 2				
Phase 3				

5.4 What type of assessment is the best way to test communication skills in your opinion?

_____

Motivate your answer.

_____

QUESTION 6: Learning environment

6.1 The learning environment enhances the development of good doctor-patient communication skills.

	Not at all	Seldom	Often	Almost always
Phase 1				
Phase 2				
Phase 3				

Motivate your answer

_____
_____
_____

6.2 During our clinical rotations, patient-centred communication is modelled by senior doctors.

Never	Sometimes	Often	Almost always

Motivate your answer: _____

_____
_____

7. Doctor-patient communication skills cannot really be learnt: A person is either a natural communicator or not.

Strongly disagree	Disagree	Agree	Strongly agree

8. Are there any aspects of the doctor-patient communication skills training that you have found especially useful? Please motivate your answer.

_____

_____

_____

9. Are there any aspects of the doctor-patient communication skills training that you did not find particularly helpful? Please motivate your answer.

_____

_____

_____

10. Are there any further recommendations or comments you would like to make regarding the doctor-patient communication skills training?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Many thanks for your contribution to this research.

APPENDIX C

INFORMATION LEAFLET GIVEN TO POTENTIAL PARTICIPANTS

INFORMATION DOCUMENT

Study title: A STUDENT REVIEW OF DOCTOR-PATIENT COMMUNICATION SKILLS TRAINING AT THE UFS UNDERGRADUATE MEDICAL SCHOOL

Dear UFS Medical student

Date:

I, Dr Marankie Swinfen, would like to invite you take part in a research study. In this study, fourth year and fifth year medical students will be asked to review the undergraduate communication skills training programme. The aim of the research is to develop and improve the communication skills curriculum at the UFS Medical School.

What will the study entail? The study will consist of single questionnaire, which will help students to review the undergraduate communication skills curriculum. The questionnaire should take between ten to fifteen minutes to complete.

If possible, we would appreciate immediate completion for the sake of convenience. Completed forms can also be returned to the clinical group leader, in the sealed box provided, later in the day. There is no risk involved in participation and participation is anonymous.

Participation is voluntary. Refusal to participate will involve no penalty and there will not be any monetary or academic rewards for taking part.

Confidentiality: The information collected will be treated in a confidential way. Participants will remain anonymous. The findings of the study will be made known upon completion of the study.

Contact details of researcher(s) –
Dr Marankie Swinfen: Telephone number 051-4053848
SwinfenD@ufs.ac.za

Contact details of HSREC (Health Sciences Research Ethics Committee)
For reporting of complaints/problems:
Mrs Maré Marais (Head of Ethics Administration)
Tel no.: +27 51 401 7795
EthicsFHS@ufs.ac.za

Many thanks for considering participation in this study. Kind regards,

Dr Marankie Swinfen
Medical Officer at Simulation & Skills Unit

APPENDIX D

TURN-IT-IN REPORT

Thesis

by Marankie Swinfen

Submission date: 31-Jan-2020 04:45PM (UTC+0200)
Submission ID: 1249305434
File name: Combined_Chapters_1-6_D_Swinfen.pdf (3.34M)
Word count: 29818
Character count: 160393

A STUDENT REVIEW OF DOCTOR-PATIENT COMMUNICATION SKILLS TRAINING IN THE UFS UNDERGRADUATE MEDICAL PROGRAMME

CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Communication is defined as "The imparting or exchanging of information by speaking, writing or using some other medium" and "The successful conveying or sharing of ideas and feelings" (Oxford Dictionary, 2018). Clinical communication consists of many facets, including doctor-patient communication, communication with colleagues, written communication and presentation skills (Skelton, 2018:249). This mini-dissertation will focus on doctor-patient communication.

The aim of the study was to obtain a student review of the training of doctor-patient communication skills in the University of the Free State (UFS) undergraduate medical programme. This could identify potential strengths and weaknesses in the undergraduate training of doctor-patient communication so that educators can continue with good practice and address shortcomings in the curriculum or the delivery thereof. Students were asked to review the undergraduate training of doctor-patient communication skills at the UFS, in terms of the content of the communication skills curriculum, the educational methods used, opportunities to acquire communication skills and the assessment of communication skills.

The purpose of this introductory chapter is to provide a guide to this research project. Firstly, a brief overview of doctor-patient communication and the training of communication skills will be given. This will be followed by a brief outline of communication skills training in the UFS undergraduate medical programme. Subsequently, the aim of this study will be discussed, as well as the study design, methodology and ethical considerations. A schematic overview of the research process will be provided in the final part of the chapter. Figure 1.1 outlines the contents of chapter 1.

Thesis

ORIGINALITY REPORT

10%	5%	4%	8%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	scholar.ufs.ac.za:8080 Internet Source	1%
2	hdl.handle.net Internet Source	1%
3	amee.org Internet Source	<1%
4	www.jeehp.org Internet Source	<1%
5	Submitted to University of the Free State Student Paper	<1%
6	David Dixon. "Controlling quality in CME/CPD by measuring and illuminating bias", Journal of Continuing Education in the Health Professions, 03/2011 Publication	<1%
7	Submitted to University of Glasgow Student Paper	<1%
8	Submitted to University of Nottingham Student Paper	<1%

Thesis

ORIGINALITY REPORT

10%	5%	4%	8%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	scholar.ufs.ac.za:8080 Internet Source	1%
2	hdl.handle.net Internet Source	1%
3	amee.org Internet Source	<1%
4	www.jeehp.org Internet Source	<1%
5	Submitted to University of the Free State Student Paper	<1%
6	David Dixon. "Controlling quality in CME/CPD by measuring and illuminating bias", Journal of Continuing Education in the Health Professions, 03/2011 Publication	<1%
7	Submitted to University of Glasgow Student Paper	<1%
8	Submitted to University of Nottingham Student Paper	<1%
9	Submitted to Kenyatta University Student Paper	<1%
10	Submitted to University of Edinburgh Student Paper	<1%
11	Submitted to National University of Ireland, Galway Student Paper	<1%
12	uir.unisa.ac.za Internet Source	<1%
13	www.tandfonline.com Internet Source	<1%
14	Submitted to Chamberlain College of Nursing Student Paper	<1%
15	scholar.sun.ac.za Internet Source	<1%
16	Submitted to University of Newcastle Student Paper	<1%
17	Submitted to University of Cape Town Student Paper	<1%
18	MR De Villiers, M Van Heusden. "A comparison of clinical communication skills between two groups of final-year medical students with different levels of communication skills training", South African Family Practice, 2014	<1%

	Publication	
19	docplayer.net Internet Source	<1%
20	Submitted to University of Dundee Student Paper	<1%
21	Submitted to Massachusetts College of Pharmacy & Allied Health Sciences Student Paper	<1%
22	Jing Guo, Nicolas Singer, Remi Bastide. "A Serious Game Engine for Interview Simulation: Application to the Development of Doctor-Patient Communication Skills", 2014 6th International Conference on Games and Virtual Worlds for Serious Applications (VS-GAMES), 2014 Publication	<1%
23	Woodman-Pieterse, Emily C, Neilsen J De Souza, and Stephen J Vincent. "The influence of a novel simulated learning environment upon student clinical subjective refraction performance: A pilot study : Simulated learning and student subjective refraction Woodman-Pieterse, De Souza and Vincent", Clinical and Experimental Optometry, 2016. Publication	<1%
24	Submitted to University of Keele Student Paper	<1%
25	pinnacle.allenpress.com Internet Source	<1%
26	www.ourcommunity.com.au Internet Source	<1%
27	espace.library.uq.edu.au Internet Source	<1%
28	Submitted to University of Leeds Student Paper	<1%
29	"Problem-based Behavioral Science and Psychiatry", Springer Science and Business Media LLC, 2016 Publication	<1%
30	Shigeo Yamamura, Rieko Takehira. "Effect of practical training on the learning motivation profile of Japanese pharmacy students using structural equation modeling", Journal of Educational Evaluation for Health Professions, 2017 Publication	<1%
31	Submitted to University of Sunderland Student Paper	<1%
32	Submitted to University of Glamorgan Student Paper	<1%
33	Submitted to Concord University Student Paper	<1%

34	dovetailapp.com Internet Source	<1%
35	Submitted to La Trobe University Student Paper	<1%
36	repository.up.ac.za Internet Source	<1%
37	Submitted to Napier University Student Paper	<1%
38	Submitted to University of Birmingham Student Paper	<1%
39	Lyndall Serfontein, Marieta Visser, Mia van Schalkwyk, Cornel van Rooyen. "The perceived burden of care among caregivers of survivors of cerebrovascular accident following discharge from a private rehabilitation unit", South African Journal of Occupational Therapy, 2019 Publication	<1%
40	Submitted to University of Johannsburg Student Paper	<1%
41	pure.uva.nl Internet Source	<1%
42	Manuel Gardon, Carlos B. Pinheiro, Gervais Chapuis. "Structural phases of hexamethylenetetramine–pimelic acid (1/1): a unified description based on a stacking model", Acta Crystallographica Section B Structural Science, 2003 Publication	<1%
43	Silverman, J.. "Teaching clinical communication: A mainstream activity or just a minority sport?", Patient Education and Counseling, 200909 Publication	<1%
44	Submitted to Ghana Technology University College Student Paper	<1%
45	journals.sagepub.com Internet Source	<1%
46	Margaret S. Wool. "Teaching and Learning Communication Skills in Medicine (2e)", Health Expectations, 12/2005 Publication	<1%
47	purehost.bath.ac.uk Internet Source	<1%
48	Submitted to Hondros College Student Paper	<1%
49	Submitted to University of Luton Student Paper	<1%
50	Katrien Bombeke, Linda Symons, Etienne Vermeire, Luc Debaene, Sandrina Schol, Benedicte De Winter, Paul Van Royen. "Patient-centredness from education to practice: The	<1%

	'lived' impact of communication skills training", Medical Teacher, 2012 Publication	
51	academic.oup.com Internet Source	<1%
52	Submitted to Open University of Mauritius Student Paper	<1%
53	Submitted to University of St Andrews Student Paper	<1%
54	Submitted to The Hong Kong Polytechnic University Student Paper	<1%
55	Submitted to Adventist University of Health Sciences Student Paper	<1%
56	"EAPC 2010 Abstracts: Oral, Plenaries and Invited Lectures", Palliative Medicine, 2010. Publication	<1%
57	Submitted to University of Salford Student Paper	<1%
58	www.mededpublish.org Internet Source	<1%
59	Jonathan Matusitz, Jennifer Spear. "Effective Doctor–Patient Communication: An Updated Examination", Social Work in Public Health,	<1%
	2014 Publication	
60	Submitted to University of Bedfordshire Student Paper	<1%
61	Roshini Jain, Ch Chiech Chang, Mpho A Koto, Alden N Geldenhuys, Richard J Nichol, Gina Joubert. "Cannabis use and knowledge among medical students at the University of the Free State, Bloemfontein, South Africa", Journal of Child & Adolescent Mental Health, 2018 Publication	<1%
62	"Communication in Cognitive Behavioral Therapy", Springer Nature, 2011 Publication	<1%
63	"Abstracts 2007", Diabetologia, 2007 Publication	<1%
64	Submitted to University of Cambridge Student Paper	<1%
65	Submitted to University of Derby Student Paper	<1%
66	Submitted to University of Stellenbosch, South Africa Student Paper	<1%
67	pdfs.semanticscholar.org Internet Source	<1%

68	ulir.ul.ie Internet Source	<1%
69	W. F. Baile. "SPIKES--A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer", The Oncologist, 2000 Publication	<1%
70	Submitted to University of KwaZulu-Natal Student Paper	<1%
71	sajip.co.za Internet Source	<1%
72	Submitted to The University of Notre Dame Student Paper	<1%
73	www.um.edu.mt Internet Source	<1%
74	Submitted to University of Ballarat Student Paper	<1%
75	Submitted to University of South Florida Student Paper	<1%
76	Vimmi Passi, Samantha Johnson, Ed Peile, Scott Wright, Fred Hafferty, Neil Johnson. "Doctor role modelling in medical education: BEME Guide No. 27", Medical Teacher, 2013 Publication	<1%
77	strathprints.strath.ac.uk Internet Source	<1%
78	digiresearch.vut.ac.za Internet Source	<1%
79	Submitted to Assumption University Student Paper	<1%
80	dspace.nwu.ac.za Internet Source	<1%
81	www.effectsurvey.nl Internet Source	<1%
82	Submitted to California State University, Sacramento Student Paper	<1%
83	Submitted to Institute of Business and Technology (IBAT) Student Paper	<1%
84	www.intralinea.org Internet Source	<1%
85	digital.lib.washington.edu Internet Source	<1%
86	eprints.usq.edu.au Internet Source	<1%
87	ndabaonline.ukzn.ac.za Internet Source	<1%
88	Submitted to Foundation for Professional Development	<1%

Student Paper

89	"Characterizing Pedagogical Flow", Springer Nature, 2002 Publication	<1%
90	Submitted to Georgia Southern University Student Paper	<1%
91	Submitted to Anglia Ruskin University Student Paper	<1%
92	Submitted to Vrije Universiteit Amsterdam Student Paper	<1%
93	"Abstracts", Supportive Care in Cancer, 2006 Publication	<1%
94	etd.uwc.ac.za Internet Source	<1%
95	www.egms.de Internet Source	<1%
96	apps.ufs.ac.za Internet Source	<1%
97	Submitted to The University of Manchester Student Paper	<1%
98	www.ru.ac.za Internet Source	<1%
99	Petra Tiroke, Birte Sänger, Urs Mücke, Lea Berndt, Henrike Wittenbecher, Lorenz Grigull. "SICKO. Development of a Multi-Disciplinary Training-Concept for Paediatric Oncology", Klinische Pädiatrie, 2017 Publication	<1%
100	Rowan H Harwood, Rebecca O'Brien, Sarah E Goldberg, Rebecca Allwood et al. "A staff training intervention to improve communication between people living with dementia and health-care professionals in hospital: the VOICE mixed-methods development and evaluation study", Health Services and Delivery Research, 2018 Publication	<1%
101	Richard L. Street. "Communication in medical consultations: A review essay", Quarterly Journal of Speech, 1990 Publication	<1%
102	Submitted to University of Surrey Student Paper	<1%
103	Jan C. Wouda, Harry B.M. van de Wiel. "The communication competency of medical students, residents and consultants", Patient Education and Counseling, 2012 Publication	<1%
104	www.researchsquare.com Internet Source	<1%
	Submitted to University of Witwatersrand	

105	Student Paper	<1%
106	Submitted to University of Liverpool Student Paper	<1%
107	Steinert, Yvonne, Karen Mann, Angel Centeno, Diana Dolmans, John Spencer, Mark Gelula, and David Prideaux. "A systematic review of faculty development initiatives designed to improve teaching effectiveness in medical education: BEME Guide No. 8", Medical Teacher, 2006. Publication	<1%
108	Submitted to National University of Singapore Student Paper	<1%
109	Submitted to Trinity College Dublin Student Paper	<1%
110	Yesim Senol, Mustafa Ozdogan, Hakan Bozcuk. "Effects and Permanency of the Training Program “Communication with Cancer Patients” on the Opinions of Students", Journal of Cancer Education, 2012 Publication	<1%
111	Submitted to Institute of Research & Postgraduate Studies, Universiti Kuala Lumpur Student Paper	<1%
	www.didp-facts.com	
112	Internet Source	<1%
113	"Structural Competency in Mental Health and Medicine", Springer Science and Business Media LLC, 2019 Publication	<1%
114	O.W. Majid. "Assessment of clinical ability in the removal of teeth among undergraduate dental students: a longitudinal comparative study", British Journal of Oral and Maxillofacial Surgery, 2018 Publication	<1%
115	Submitted to Nanyang Technological University Student Paper	<1%
116	Suzanne E. Mazzeo. "Modification of an existing measure of body image preoccupation and its relationship to disordered eating in female college students.", Journal of Counseling Psychology, 1999 Publication	<1%
117	Submitted to Argosy University Student Paper	<1%
118	ar.scribd.com Internet Source	<1%
119	Caren Wu, Kevin McLaughlin. "Bridging the gender gap in communication skills", Advances	<1%

in Health Sciences Education, 2012
Publication

120	Diane Gasner, Doreen Cleave-Hogg. "A model for integrative learning: Bringing the clinic into a subject-centred curriculum", Physiotherapy Theory and Practice, 2009 Publication	<1%
121	www.centrumseksueelgeweld.nl Internet Source	<1%
122	Submitted to University of Wales Institute, Cardiff Student Paper	<1%
123	Submitted to University of College Cork Student Paper	<1%
124	Submitted to Queen Margaret University College, Edinburgh Student Paper	<1%
125	Submitted to University of Northampton Student Paper	<1%
126	vietnhim.com Internet Source	<1%
127	Submitted to University of the Western Cape Student Paper	<1%
128	www.eduworld.ro Internet Source	<1%
129	John Christensen, Wendy Levinson. "Implementing a behavioral medicine program in an internal medicine residency: A description of curriculum content, resources and barriers encountered", Psychology & Health, 1988 Publication	<1%
130	Amy E Gillis, Marie C Morris, Paul F Ridgway. "Communication skills assessment in the final postgraduate years to established practice: a systematic review", Postgraduate Medical Journal, 2015 Publication	<1%
131	Irwin Brown, Paul Licker. "Exploring Differences in Internet Adoption and Usage between Historically Advantaged and Disadvantaged Groups in South Africa", Journal of Global Information Technology Management, 2014 Publication	<1%
132	"SCIENTIFIC ABSTRACTS", Journal of General Internal Medicine, 2010 Publication	<1%
133	Deborah Christie, Sarah Glew. " A clinical review of communication training for haematologists and haemato-oncologists: a case of art science ", British Journal of Haematology, 2017 Publication	<1%

134	Submitted to University of Sheffield Student Paper	<1%
135	Submitted to Imperial College of Science, Technology and Medicine Student Paper	<1%
136	Submitted to University of Brighton Student Paper	<1%
137	Submitted to Chester College of Higher Education Student Paper	<1%
138	Submitted to University of Pretoria Student Paper	<1%
139	Submitted to North West University Student Paper	<1%
140	Lakshmi Chintala. "Capecitabine versus 5-fluorouracil in colorectal cancer: where are we now?", Oncology Reviews, 04/09/2011 Publication	<1%
141	Angela C. Weidner, John R. Gimpel, John R. Boulet, Mia Solomon. "Using Standardized Patients to Assess the Communication Skills of Graduating Physicians for the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Evaluation (Level 2-PE)", Teaching and Learning in Medicine, 2010 Publication	
142	Ryan, Rebecca, Nancy Santesso, Sophie Hill, Dianne Lowe, Caroline Kaufman, Jeremy Grimshaw, and Rebecca Ryan. "Consumer-oriented interventions for evidence-based prescribing and medicines use: an overview of systematic reviews", Cochrane Database of Systematic Reviews, 2011. Publication	<1%

Exclude quotes	Off	Exclude matches	Off
Exclude bibliography	Off		