

The need of Attitude and Communication Competencies in Medical Education in India

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Abstract :

Medical student attitudes towards communication skills are important for curriculum planners and teachers. There is an increasing need for instruments to monitor changes in specific components of attitudes among students in medical school. Various studies have indicated that medical student attitudes towards communication skills training influence perceptions of the importance of these skills and they may eventually influence the learning and adoption of communication skills in the clinical setting. In addition, attitudes towards communication skills training are also likely to be related to medical student assessments of their ability to communicate effectively with patients.

Keywords : Attitude, Communication Skills, Medical Students, Medical Education

Introduction

India is one of the major stake holder in the contribution of world's disease burden. At the same time, the Indian Health Care and Medical Education are facing many challenges in the standards. With the highest number of Medical Colleges in the world, there is a marked shortage of teachers. Additionally, although recent advances in medicine have been understood and adopted by many medical and health science institutions, the same is not true for methods and strategies in medical education.

The state of medical education in India presents a scenario marked by rhetoric and wishful thinking rather than concrete steps in right direction. The search for a need-based curriculum is not new. It has been felt for ages, but the curriculum has not really changed. It is an oft-repeated criticism that our medical colleges are producing graduates who at the current scenarios are not well equipped to tackle the health care needs of the society¹. While the Indian graduates generally possess reasonably sound knowledge of medical science, they are often found short in the performance of clinical skills, and problem-solving abilities which form the core of clinical competence. Also, there is growing level of mistrust among the public for the medical profession as one hears of cases of negligence, misconduct, and unethical practices leading to legal suits. There is

increasing public demand for the accountability, transparency and quality assurance among the health professionals. While the commercialization of medical profession is cited as a common reason for the dilution of quality, doubts have been raised regarding the quality of training. Are the graduate doctors well trained to perform their clinical responsibilities? Are they aware of their ethical, moral and legal responsibilities?². In terms of training how much of our current curriculum has these in the syllabus?

There is an urgent need for educational leaders to come forward with strategies to overcome this crisis in medical education and initiate reforms at the earliest. Curricula need to be better aligned with health needs and changing methodologies. Developments in the field of medicine and allied health sciences need to be adopted and assessment systems need to be modernized. These are critical in order to maintain educational standards and, as a result, quality of graduating doctors produced by the system.

The key to successfully initiating and implementing these and other reforms is educational capacity building through faculty development. As a result, faculty development in medical education is gaining momentum in India. Medical Education Units can play a critical role in faculty development and thus contribute to educational improvement and reforms in a major way.

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History

The World Health Organization (WHO) recognized the importance of training medical teachers as early as 1965 and suggested creation of three levels of training - the specialists in education, the leaders in the field of education who could integrate the science of educational research into institutional programs and the educational practitioners who would be trained in the basic skills of classroom or clinical teaching.

In 1969, it set up Centre's for development of medical education at the University of Illinois and University of Southern California, which served as International Teacher Training Centres. Regional Teacher Training Centres (RTTC) and further National Teacher Training Centres (NTTC) were set up in some medical colleges, including a few in India. The first such centre was set up at the Jawaharlal Institute of Post Graduate Medical Education and Research (JIPMER), in Pondicherry, India in 1976. These programs were supported by WHO grants until 1984 and subsequently by the government of India until 1999. More such faculty development initiatives were organized in the form of the Centre for Medical Education and Technology (CMET) at the All India Institute of Medical Sciences (AIIMS), New Delhi and the setting up of Medical Education units by motivated teachers in a few medical colleges in Manipal, Mumbai, Ludhiana, Belgaum, Bangalore and Visakapatnam. The Medical Council of India (MCI) initiative in this direction in the year 1999 requires every medical college to have a medical education unit (Medical Council of India, 1997). Although this directive has resulted in a fast paced establishment of medical education units all over India, their function is far from satisfactory in most institutions (Bansal & Supe, 2007).

FAIMER (Foundation for Advancement in Medical Education and Research), Philadelphia, is a non-profit organization of ECFMG (Educational Commission for Foreign Medical Graduates), USA that supports faculty development in education through fellowships. It has a unique curriculum in that it combines basic education principles, teaching skills, leadership and research skills, as well as networking with fellow educators from all over the country and international experts in its programme. Presently, it is being offered in collaboration with three regional centres at Christian Medical College, Ludhiana, GS Medical College, Mumbai and PSG Institute of Medical Sciences, Coimbatore and has successfully taken these activities to a large group of medical teachers in India in a very short period of time (Burdic et al., 2007). Fellow in medical education (Advance course in

medical education), MCI, India is another venture by MCI which has started in 2014 and the nodal centres in India have taken up the responsibility of preparing faculty for training in medical education.

FAIMER & FIME are in recent decades, training and introducing teaching methods which have been implemented in some medical curricula that aim at fostering communication and group work skills.

Also, a variety of communication skills training programs have been found to improve providers knowledge, attitude and skills,^{1,2} there are a number of issues that may impede the success of communication skills training, especially among medical students.³ Previous research suggests that variables such as attitudes towards communication skills training, attitudes towards the value of medical communication skills, medical student experience within the clinical setting and demographic variable may all influence the success of a communication skills training program.^{4,5}

Perception of attitude towards communication skills

Several researchers have found that attitudes toward communication skills training are an important antecedent to acquiring communication skills. Medical students' attitudes toward communication skills training may be important indicators of the importance they place upon them and they may eventually influence communication behaviors in clinical settings.⁶

In 2000 Kaufmann et al⁷ constructed the Attitude Towards Medical Communication Scale with 41 items and used it in a cross-sectional study on 203 students in their first, second and fourth year respectively. This study showed that female students had more positive attitudes than male students, and that first and second year students had more positive attitudes than fourth year students.

In 2001 de Valck et al⁸ presented a questionnaire measuring students' attitudes towards full disclosure versus non-disclosure in breaking bad news. Following one cohort of students for three years (53 students responded in all three years) they found that students became more in favour of non-disclosure as they progressed through medical school.

In 2002 Rees et al⁹ published the Communication Skills Attitudes Scale (CSAS), which measures students' attitudes towards learning communication skills during medical school. This 26 item measure uses a five point Likert-type scale and it includes positive and negative statements about communication skills training. All negative CSAS items were reverse coded for analysis, so that higher scores on all items indicated more positive

attitudes toward communication skills training. The reliability coefficient for all CSAS items was 0.87. This scale has until spring 2006 been used and validated in three different studies in the UK involving from 216 to 490 students¹⁰⁻¹² and one involving 123 students in Nepal.¹³ Although in most cross-sectional studies, these studies report that female students have more positive attitudes than male and that students early in medical school have more positive attitudes than students later in medical school. In addition, having recently attended communication skills teaching tends to predict less positive attitudes towards learning such skills.

In 2004 Liddell et al¹⁴ published the use of a questionnaire measuring medical students' attitudes towards five groups of consultation skills, one of which was communication skills. They performed a cross-sectional study of three consecutive classes of 357 final year students before and after attachments in general practice and a Consulting Skills Program. After the program, attitudes towards communication skills were more positive.

Attitudes involves evaluations by which we attach good or bad qualities to a topic or an organization or a person. Attitudes drive behavior. If we can change a person's attitude we may change his or her behavior.¹⁵ Attitudes have three main components: affective (the way we feel), cognitive (the way we think) and behavioural (the way we act) towards a particular entity.¹⁵ Affective attitudes reflect emotional reactions and may change after repeated exposure to situations involving the goal for the attitude.

Cognitive components of attitudes are believed to be more fundamental and constant over time and more closely connected to basic values.¹⁶ Cognitive attitudes are difficult to influence but may change when new knowledge is presented; provided the knowledge is convincing and the presenter is credible.¹⁷ Behavioural attitudes are manifestations of underlying cognitive and affective attitudes. There is evidence that changing behaviour by training new ways of acting in professional situation may influence the more fundamental aspects of attitudes without targeting them directly.¹⁸ There is need for assessment tools enabling teaching and curriculum planners to monitor changes in specific components of attitudes among students during medical school. The use of such tools may also facilitate comparisons between different medical schools. Such comparisons are important because differences in teaching methods and/or curriculum designs, thereby helping medical educators in finding new ways of improving and refining teaching in medical schools.¹⁹

Conclusion :

Medical students' attitudes towards learning communication skills may be more complex than previously described. Conducting studies on medical students' attitudes towards learning communication skills will be useful for monitoring attitudinal change among students during medical school as well as making comparisons between different medical schools, making it possible to improve and refine curricula and teaching methods in communication skills.

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