Appendix

Communication skills questionnaire

Communication skills-patients (informative)

<table>
<thead>
<tr>
<th>Always</th>
<th>Frequently</th>
<th>Sometimes</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

1. Do you try to find out patients prior knowledge of disease before giving him the diagnosis
2. Do you use layman language
3. Do you only tell the truth
4. Do you discuss both short & long term treatment plans with your patients
5. Do you answer to patient questions/queries directly

Communication skills-patients (affective)

6. Do you try to find out the patient mental state before giving him the diagnosis
7. Do you explore the patient support system
8. Do you listen till patient satisfaction
9. Do you maintain eye contact / have attentive pose
10. Do you respond to patient’s emotion verbally / non verbally

Communication skills-professional

11. Do you feel comfortable, asking questions during ward rounds
12. Do you try to overcome linguistic barrier while talking to seniors
13. Do you think that your suggestions are not accepted by your seniors
14. Do you try to participate in clinical presentations
15. When the time comes, do you persuade your colleagues to perform their duties

Expert's Comments

A call to engagement

Effective communication is essential to quality medicine and therefore receives considerable research attention in the developed world. Studies have detailed four common, important dimensions of medical communication: clarity of information provided to the patient, mutual goals, an active patient role, and a warm, supportive, empathetic physician. [1]
Yet, little is known about medical communication in developing countries. This issue of the Journal includes a study that addresses this void. Avan et al have surveyed the perceptions of Pakistani resident physicians regarding their performance of key medical communication tasks. A study of perceptions reveals little about the residents’ actual competence to perform the tasks surveyed. It does, however, provide valuable insights into the residents’ confidence in their communication skills.

Understandably, residents from the multidisciplinary cohort—anesthesiology, radiology, and pathology—scored lower than residents in other cohorts on the informative and affective communication tasks surveyed. These specialties entail less direct, prolonged patient contact and require less need to understand the psychosocial status of patients. Abbreviated patient contact plausibly hinders communication skills development. Residents selecting these specialties may also be less interested in or comfortable with these communication domains.

The most interesting finding involved the residents’ confidence in communicating with professional colleagues. All resident cohorts reported strikingly lower scores on this scale. Three of four study cohorts gave professional communication approximately half their average ratings for the other communication domains. The residents perceived barriers to asking questions, establishing dialogue with seniors, offering suggestions, participating in clinical presentations, and encouraging colleagues’ conscientious performance. The authors attribute these results to the cultural context of the residencies surveyed. Still, what are the implications for training when residents are less confident about relating to colleagues than patients?

A learning environment that discourages communication promotes a considerably more passive resident role than is typical in developed countries. Optimal communications training involves personal attention, delineation and definition of necessary skills, and repeated observation with feedback and discussion. As residents’ clinical personalities emerge during training, they are particularly open to acquiring effective communication skills. But they must be guided through the process, engaged in dialogue with seniors and peers to explore, in an environment where they are not defending themselves from critique, the struggles that regularly challenge the very nature of their work. Avan and associates provide evidence that Pakistani residencies have yet to develop these characteristics. As such, their study may say less about the residents surveyed than the training programs educating them.

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References

Expert’s Comments

Communication skills and postgraduate medical training programs

It is now widely acknowledged that doctors require good communication skills to be able to deliver appropriate, high-quality medical care. Research has helped to elucidate some aspects of this complex topic. We know, for example, that some doctors in training possess better communication skills than others and that shortcomings are commonplace. Furthermore, we know that although the impact of initial medical posts affects different doctors in dissimilar ways, clinical experience alone does not address deficiencies. Thankfully, training programmes that utilise appropriate teaching methods do result in lasting, significant improvements in the communication skills of both relatively junior and senior doctors. However, almost all published research has been conducted in the USA, Canada and Western Europe. It would be unwise to assume that results generalise across different cultures. They may not. For example, it may be the case that patients in different parts of the world have distinct expectations and desires about how they would like their doctors to communicate. Similarly, depending on their location, young doctors may face substantial yet diverse barriers to developing their communication skills. Consequently, the authors’ contribution to the literature is most welcome.

There are two aspects of this paper that are especially noteworthy. First, the extent to which residents believe they possess relevant attributes is worthy of study, although under-researched. In view of the continuing drive toward self-directed learning, accurate self-reflection is essential if doctors are to