

The effects of a community based interviewing skills training program on primary health care level doctors of Bangladesh

Md. Anayet Ullah^a, Md. Jawadul Haque^b

Abstract

Background: The ability to communicate with a patient effectively has been described not only as an artistic aspect of clinical care but also as a central clinical function that cannot be ignored. Communication problem in medical practice is very common in Bangladesh. **Objective:** To develop and conduct a short term training program on interviewing skills among the primary health care level doctors of Rajshahi district with a view to evaluate its effects on doctors' interviewing skills. **Methods:** This study was conducted among the primary health care level government doctors of Rajshahi district at Puthia Upazila health Complex. All the doctors working at the 9 Upazilas of Rajshahi district constituted the study population. Total 36 participants were selected by stratified random sampling. This course was scheduled over 5 sessions of 25 hours, 5 hours in each day for 5 days. The effectiveness of this training program was evaluated by analyses of the pre and post assessments of participants' behaviors / techniques of interview and also by analyzing participants' self assessment of the program. Data were analyzed by computer using SPSS 16.0. Paired t test was applied to find out any significance difference between the pre and post assessment score of the participants' performance. **Results:** Overall mean score for the beginning, managing and ending of the interview were significantly improved from 2.30 ± 1.11 , 9.63 ± 3.70 and 0.72 ± 0.70 to 6.38 ± 1.46 , 22.63 ± 2.46 and 4.36 ± 0.54 due to this training. The grand total mean score of the interview was also significantly ($p < 0.000$) improved from 12.72 ± 4.60 to 32.91 ± 4.67 after this training. Most (94.44%) of the participants strongly agreed that this type of teaching course should be included in the curriculum of undergraduate medical students. **Conclusion:** This type of short training program may be one of the best way to develop communication skills of the present and future doctors.

Key words: interviewing skills, doctors, Bangladesh.

Introduction

Communication skills are those with which (1) the doctor-patient relationship is created and maintained; (2) verbal information and clarification relevant to the solution of the patient's problem, is gathered; and (3) the solution to the problem is negotiated.^{1,2} The ability to communicate with a patient effectively has been described not only as an artistic aspect of clinical care but also as a central clinical function that cannot be ignored.^{3,4} Most of the essential diagnostic information's arise from the doctor-patient interaction during the consultation, and the physician's interpersonal skills also largely determines the patient's satisfaction and compliance, diagnostic efficiency and positively influences health outcomes.^{3,5,6} Explaining and understanding patient concerns, even when they cannot be resolved, results in a significant fall in anxiety.⁷ Patients are most satisfied with the health provider who is warm, friendly, concerned, and empathetic.⁸ Communication problems in medical practice are very common. For example, in a study (Stewart et al 1979)⁹ in England, 54% of patient complaints and 45% of patient concerns are not elicited by physicians. In another study (Backman & Frankel 1984)¹⁰ patients were interrupted by physicians so

soon after they began describing their presenting problems(on average within 18 seconds) that they failed to disclose other significant concerns. Most complaints by the public about physicians deal not with clinical competency problems, but with communication problems.¹¹

In Bangladesh there is also serious communication problems in medical practice. 45% patients, attended at the government primary health care level facilities, don't know how and when to take their medicines.¹² A poor level of comprehension among the patients might have been expected due to this. These type of communication gaps might lead to patients' dissatisfaction. Ullah et al. in a study,¹³ it was found that dissatisfaction of the rural people on government health care facilities due to non-cordial behavior of providers is an important obstacle in obtaining ANC by them. only 37% people are satisfied with the government health care facilities in Bangladesh.¹⁴ Increasing public dissatisfaction with the medical profession is, in good part, related to deficiencies in clinical communication.¹⁵ Communication failures / problems of health care providers in their clinical practice specially doctors is one of the important reason which is responsible for this situation.

^aDepartment of Community Medicine, Barind Medical College, Rajshahi, Bangladesh.

^bDepartment of Community Medicine, Rajshahi Medical College, Rajshahi, Bangladesh.

Correspondence to :
M A Ullah
md.anayet_u@yahoo.com

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The reasons for communication failures are complex and include characteristics of both patients and doctors, and the system of health care delivery. However, one of the primary reasons for the sorry state of affairs is the inadequacy of the most doctors in communication skills to interview the patient during their consultation.¹⁶ So a formal training course of the health care providers on communication skills needed to interview (interviewing skills (behaviors/techniques)) a patient during their consultation may improve the unwanted situation.

In this study researchers attempted to develop and conduct a short term training program on interviewing skills (communication skills needed during interviewing a patient) among the doctors working at the primary health care level of Rajshahi district with a view to evaluate its effects on doctors' communication skills during interviewing a patient.

Methods

This study was conducted among the government doctors working at the primary health care level (Upazila and below) of Rajshahi district. All the doctors working at Upazila Health Complexes (UHCs), Union Sub-Centers (USCs) and Health & Family Welfare Centers (H&FWCs) of 9 Upazilas in Rajshahi constituted the study population. Total 36 participants were selected by stratified random sampling 4 from each Upazila of Rajshahi: two from UHC and two from either USC or H&FWCs.

Teaching program

The total 36 participants were trained into three phases, 12 doctors of 3 Upazilas in each phase. The teaching program was conducted in a rural setting at Puttia Upazila Health Complex (UHC). It includes inpatient, outpatient and emergency services. This UHC acts as a field site training center for the students of all the Medical colleges in Rajshahi district. All types of educational facilities are available there. There are excellent accommodation facilities for the participants and the teachers in this institution. This program focused on the development of doctors' interview behavior and their ability to conduct a good interview. This training program was designed to allow the doctors to gain theoretical concepts and to develop skills through lectures, tutorials, practices with real patients and feedback. This course was scheduled over 5 sessions of 25 hours, 5 hours in each day for 5 days. The first day lecture session addressed the concepts of the medical interview and the interview behaviors/ techniques needed to perform these tasks. In 2nd day session participants observe an

ideal doctor-patient interview on video and discuss this with the tutorial group. Then participants were divided into 6 pairs. Every participant took turns to play the role of doctor and patient. The participants who played the patient role gave feedback immediately to their peer after the interview. The facilitators monitored the practice and gave feedback to the participants. Three practice and feedback sessions were conducted on the 3rd, 4th and 5th day with real patients at the out patients' department.

Evaluation

The effectiveness of this pilot program was evaluated by analyses of the pre and post assessments of participants' behaviors / techniques of interview and also by analyzing participants' self assessment of the program.

The pre- and post- assessments of the participants' behaviors / techniques of interview were done by watching the previously recorded videotape of a real patient's consultation by each participant, with the help of interview rating scale (IRS). IRS included 25 interview behaviors / techniques which were divided into three sections: beginning, managing and ending the interview. The items in the rating scale were selected from two sources Maguire et al.(1978)¹⁷ & Cormier et al. (1984)¹⁸. The behaviors/techniques of the beginning and ending of the interview, were noted as being either present (scored as 1) or absent (scored as 0). The techniques/behaviors included in the section of managing the interview were more complex, in that case, a 5-point frequency scale was used. Participants' self assessment was done by Self Assessment Rating Scale (SARS). SARS was designed for the participants to evaluate the relevancy, adequacy / appropriateness and effectiveness of this course. It included 9 statements regarding the program. A Five point scale was used for each item with the following designation: 1'strongly agreed(SA)', 2'agreed(A)', 3'undecided(UD)', 4'disagreed(DA)', and 5'strongly disagreed(SDA)'. Participants responded according to their judgment. There was a provision for participants' detailed comments in this scale in which he expressed his additional opinions if necessary.

The videotape recording of the real patient's consultation was done within 15 days before and after the teaching program in the same situations with her prior permission of them. The participants' self assessment was done at the end of the program.

Data analysis

Data were entered in the computer and processed using SPSS for windows. Descriptive analytical

techniques involving frequency distribution, computation of percentage, mean and SD were calculated for both pre and post situations. Paired t test was applied to find out any significance difference between the pre and post assessment score of the participants' performance.

Results

Before this training, none of the rural doctors assured the patient about the confidentiality of their interview, elicit the patient's expectation and settled the agenda in the beginning of their interview. But after the training they significantly improved these skills. The doctors scored high mean score (0.92, SD±0.28) for the opening question in the beginning of their interview initially. After the training, every doctor used open question (mean score 1.00) in the beginning of their interview. Overall mean score for the beginning of the interview was significantly improved from 2.30 (SD±1.11) to 6.38 (SD±1.46) due to this training (Table 1).

Table 1. Comparing the mean scores of the individual skill / technique used by doctors for the beginning of the interview in the pre- and post-training assessment sessions. N = 36

Skill/technique	Pre-training mean score (±SD)	Post-training mean score (±SD)	t	df	P
Give a verbal greeting to patient	0.19 (0.40)	0.89 (0.32)	7.94	35	.000
Establish direct eye contact	0.44 (.50)	1.00 (0.00)	6.61	35	.000
Give a verbal / nonverbal indication where to sit	0.50 (0.51)	0.83 (0.38)	3.41	35	.002
Assure the patient that the interview contact is confidential	0.00 (0.00)	0.19 (0.40)	2.90	35	.006
Opening question	0.92 (0.28)	1.00 (0.00)	1.78	35	.083
Encouraging to complete & expanding the open question	0.11 (0.32)	0.64 (0.49)	5.20	35	.000
Elicit the patient's expectation	0.00 (0.00)	0.36 (0.49)	4.44	35	.000
Screening for other symptoms and problems	0.08 (0.28)	0.83 (0.38)	10.24	35	.000
Agenda setting	0.00 (0.00)	0.25 (0.44)	3.41	35	.002
Describing higher expectation for the patient	0.05 (0.23)	0.39 (0.49)	3.76	35	.001
Overall score*	2.30 (1.11)	6.38 (1.46)	14.89	35	.000

* Maximum score 10.0 (10 items)

During managing the interview, the doctors scored lowest mean score (0.19 ± 0.57) for showing empathy before the training comparing with other items. After training the mean score was significantly improve to 2.33 (± 0.63). Pre-training mean scores of all the techniques for managing the interview were significantly improved after training. Overall doctors' pre-training mean score for managing the clinical interview was 9.63 (± 3.70). It became more than double (22.63 ± 2.46) in post-training assessment (Table 2).

Table 2. Comparison of the doctors' performance for the managing the interview on the basis of the interview rating Scale in the pre- and post-training assessment sessions. N = 36

Skill/technique	Pre-training mean score (±SD)	Post-training mean score (±SD)	t	df	P
Open question	1.44 (0.73)	3.0 (0.33)	12.08	35	.000
Silence	0.91 (0.64)	2.52 (0.50)	12.61	35	.000
Facilitating	0.36 (0.63)	3.38 (0.69)	17.47	35	.000
Clarifying	1.22 (0.95)	1.79 (0.55)	3.74	35	.001
Putting up verbal & non-verbal leads	0.08 (0.36)	1.06 (0.50)	12.55	35	.000
Simple language	1.88 (0.70)	2.72 (0.45)	6.18	35	.000
Avoid jargon	1.97 (0.89)	2.63 (0.54)	5.04	35	.000
Showing empathy	0.19 (0.57)	2.33 (0.63)	17.74	35	.000
Provide sufficient and appropriate information	1.05 (1.14)	2.41 (0.87)	8.01	35	.000
Shared decision making	0.47 (0.87)	1.72 (0.88)	9.30	35	.000
Overall score*	9.63 (3.70)	22.63 (2.46)	21.90	35	.000

* Maximum score 40.0 (10 items)

At the ending of the interview, none of the doctors did not sincere wish for the future welfare of the consulting patients. The pre-training mean score of this item was 0.00 (± 0.00), it was increase to 0.94 (± 0.23) after training. Give the patient final opportunity to disclose any problem, and Give support and reassurance were the second and third lowest mean scored techniques. The post-training mean scores of both the techniques were significantly increased to 0.97. Overall mean score was significantly improved from 0.72 (SD± 0.70) to 4.36 (SD± 0.54) after the training (Table 3).

Table 3. Comparing the mean scores of the individual skill / technique used by doctors for the ending of the interview in the pre- and post-training assessment sessions. N = 36

Skill/technique	Pre-training mean score (±SD)	Post-training mean score (±SD)	t	df	P
Give the patient final opportunity to disclose any problem	0.05 (0.23)	0.97 (0.16)	19.62	35	.000
Review of whole consultation in short	0.083 (0.28)	0.47 (0.50)	4.71	35	.000
Give support and reassurance	0.16 (0.37)	0.97 (0.16)	12.04	35	.000
Scheduling of follow up	0.41 (0.50)	1.0 (0.00)	7.00	35	.000
Sincere wish for the future welfare	0.00 (0.00)	0.94 (0.23)	24.39	35	.000
Overall score*	0.72 (0.70)	4.36 (0.54)	26.20	35	.000

* Maximum score 5.0 (5 items)

Of the total 36 doctors, 34 (94.44%) doctors strongly agreed that this type of teaching course should be included in the curriculum of undergraduate medical students. More than 88% of the doctors strongly agreed that this course experience was relevant to the training of future physicians and increased their awareness about the importance of interviewing skills.

Most (80.56%) of the doctors strongly agreed that Opportunities to practice interviewing patients were not sufficient in this course (Table 4).

Table 4. Distribution of the doctors' responses to the different statement regarding this teaching program. N= 36

Statement	Strongly agree (SA) n (%)	Agree (A) n (%)	Undecided (UD) n (%)	Disagree (DA) n (%)	Strongly disagree (SDA) n (%)
1. The objectives of the teaching course have been clearly stated.	21 (58.33)	15 (41.67)	00 (00.00)	00 (00.00)	00 (00.00)
2. The content covered by this course was relevant to the objectives	22 (61.11)	14 (38.89)	00 (00.00)	00 (00.00)	00 (00.00)
3. The course experience was relevant to the training of future physicians	32 (88.88)	04 (11.12)	00 (00.00)	00 (00.00)	00 (00.00)
4. Total time of the course was sufficient	00 (00.00)	00 (00.00)	03 (8.33)	13 (36.11)	20 (55.56)
5. Opportunities to practice interviewing patients were not sufficient in this course.	29 (80.56)	07 (19.44)	00 (00.00)	00 (00.00)	00 (00.00)
6. The course was enjoyable	16 (44.44)	20 (55.56)	00 (00.00)	00 (00.00)	00 (00.00)
7. This course increases my awareness about the importance of interviewing skills.	32 (88.88)	04 (11.12)	00 (00.00)	00 (00.00)	00 (00.00)
8. I think that now I am able to interview a patient more effectively than before.	10 (27.78)	26 (72.22)	06 (16.66)	00 (00.00)	00 (00.00)
9. This teaching course should be included in the curriculum of undergraduate medical students	34 (94.44)	02 (5.56)	00 (00.00)	00 (00.00)	00 (00.00)

Discussion

All the participating doctors in this course were rural primary health care level doctors. They were working at the rural health clinics which are the first contact points for the rural patients who present a wide variety of problems, physical, psychological as well as social. The pre-training data in this study has clearly shown that the rural doctors had failed to effectively communicate with the patients. It reflects the failing of traditional history taking training of the doctors during their studentship at tertiary level hospital to develop skills to communicate effectively with rural patients. There is also an important myth "that merely leaving students / doctors around patients for a time is likely to be good for them and they are bound to pick up all sorts of balanced social view-points from exposure to the 'splendid animals' by some sort of intellectual osmosis".¹⁹ However, this myth has been also seriously questioned by this study. Because the doctors in this study has been working with rural patients for the long time at least more than 5 years.

The quality of the doctor-patient relationship is a major determinant of whether or not patients' expectations will be met and favorable health outcomes achieved. Current thinking on models of health care reflects an ever-growing shift away from the traditional paternalistic models of the doctor-patient relationship, towards more patient-centered models that involve patients in decision-making and focus on the wider psychosocial issues, which influence the illness experience.²⁰ According to WHO, the number of mentally ill people in Bangladesh is about 8.4 million i.e., 7% of the total population. In the different sources of data in Bangladesh, it was noted that about 30% of patients, who visit the general practitioners, have psychosocial, not biomedical problems.²¹ Clearly, then, physicians must give emphasis the biomedical, as well as the psychosocial domains, in order to provide optimum care for their patients. The psychosocial domain encompasses a patient-centered, as opposed to purely physician-centered, medical consultation with interviewing skills including elicit the patient expectation, agenda setting, listening, showing empathy, shared decision making, give support and reassurance, sincere future wish for the well-being, etc.²² This bio-psychosocial approach, combination of biomedical and psychosocial domains, was nearly or completely absent among the rural doctors in this study. Researches show that

physicians, who use a bio-psychosocial approach to patient care, have more patient satisfaction.^{22,23} So the interviewing skills of the rural primary health care level doctors should be improved.

Comparisons of the mean scores of the doctors' interviewing behaviors between pre and post communication skills training program has clearly shown that communication skills training program significantly improved the doctors' interviewing skills. This finding supports previous studies.²⁴⁻²⁶ This short term training program consisted of a series of participatory experiential techniques like small group discussion, role play, practice and feedback. This program also facilitated the doctors to discover the socio-cultural and psychological factors, which have been demonstrated to be so important in patient care,²⁷ through experience with real patients in the rural community setting and from the inevitable variations in individual styles of interview. Others studies have also demonstrated significant improvement in the interview skills of the participants due to such type of training program in which participants were firstly informed about these skills by handout with demonstration video tape recording of real consultations. They were then given opportunities to practice interviewing real patient, followed by feedback and discussion with a tutor.^{17,28} Similar findings were also obtained by Kendrick & Freeling (1993)²⁹ and Armstrong et al. (1979)³⁰ when they used this type of training program in the setting of general practice. This reflects the consistent finding in educational and training literature that experiential / active learning formats (group discussion, role play, practice and feedback etc.) are the effective learning situation.^{25,31} The results of this study also suggest that it is effective and fruitful within the context of a busy outpatient setting in rural community based hospitals / clinics for the primary health care level doctors.

There was a strong approval for this training program from the participating rural health care level doctors. They considered that this type of short training course was very useful and effective to them. Since Bangladesh government now urgently searching the strategy to improve the communication skills of the present and future doctors, this type of short training program may be one of the best way to develop communication skills of the present doctors (already passed). For the future doctors, Bangladesh Medical & Dental Council already incorporated the teaching of communication skills through the department of Community Medicine in

present undergraduate medical curriculum, but unfortunately it is not still implemented. there are so many factors responsible for this sorry and unfortunate situation. Important one of them may be the bioengineering ideology in medical care. Much of the resistance to training in communication skills seems to stem from the dominance of the bioengineering ideology. This approach stresses the present signs & symptoms, diagnosis and physical intervention. This approach usually ignores patient's emotion, satisfaction and compliance. It encourages doctors to maintain a physician-centered patient consultation.³² This ideology is firmly established in medical practice in Bangladesh and adhered to by the more powerful departments within medical college. So, now it is necessary to motivate the concerning stockholders specially medical teachers specially of this particular powerful departments and students to develop positive attitude regarding this.

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