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Training matters

Teaching interview skills to preclinical medical students

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The early years of medical students' experience can clearly be important in shaping their attitudes for the future. Typically pre-clinical students are bombarded with basic science subjects and many express the view that it is difficult to see the relevance of much of their academic study to their ambition of working with people. The Behavioural Science Course which is generally held during the students' second year is one of the few courses which is devoted to the functioning of the whole person in society. Typically, this course includes psychology and medical sociology.

Interview skills are obviously important for all doctors and recently there has been an increasing interest in training medical students and junior doctors in effective interviewing (Maguire *et al*, 1978; Engler *et al*, 1981; Thompson & Anderson, 1982; Maguire, Fairburn & Fletcher, 1986a; Maguire, Fairburn & Fletcher, 1986b; Crisp, 1986). Maguire *et al* (1978) demonstrated that without interview skills training, students tended to use closed questions, have difficulty in keeping patients to the point, in beginning and ending interviews and were reluctant to cover psychological problems. It has also been shown that whereas most junior doctors had poor interviewing skills, those who had had interview skills training with feedback on their performance four to six years earlier remained better at obtaining accurate and relevant information from their patients (Maguire, Fairburn & Fletcher, 1986a, 1986b). This finding is particularly important in view of the finding that doctors become fixed in their style of interviewing soon after qualifying (Byrne & Long, 1976).

Most studies have involved clinical students who may have already developed poor habits. However, some studies in the USA have shown that pre-clinical students can learn to be better interviewers by specific teaching addressing interview skills but that many of these skills are forgotten and abandoned when the student enters clinical training (Engler *et al*, 1981). It is obviously preferable if interview skills teaching is commenced early in the medical curriculum before these habits have been developed.

In the light of this we decided to teach interview skills to a group of pre-clinical students in the year before entering clinical training as part of their Behavioural Science Course. This formed an introduction to an established programme of teaching communication skills throughout their undergraduate training which has been described elsewhere (Crisp, 1986). Our teachers were registrars in psychiatry who had previously undergone a training in interview skills (Drummond *et al*, 1988). It has been previously demonstrated that trainee psychiatrists can be effective teachers of interview skills after only brief training (Naji *et al*, 1986). We also felt it important to conduct a survey among the students about their own anxieties with regard to contact with patients. This was so that future workshops could be directed to those areas causing them the most anxiety. The efficacy of the sessions in addressing the students concerns was also measured.

The study

Sample

All 73 2nd year pre-clinical medical students attending a half day workshop on interviewing skills were asked to participate in this study. They were all in their 2nd pre-clinical year and had not had any experience of clinical firms working on hospital wards.

Measures

(a) Before session

At the start of the workshop the students were requested to list up to five things they thought would be most difficult or that concerned them most about interviewing patients. All forms and measures were completed anonymously by the students to increase honesty. These could be about anything and no suggestions were made by the teachers. On a scale of 0–3 they were asked to rate the severity of each concern [1 = mild, 2 = moderate, 3 = severe].

(b) At end of session

On a three point rating scale they were asked to assess how much their concerns had been addressed by the workshop [0 = not at all, 1 = slightly, 2 = adequately, 3 = excellently]. Any additional concerns or worries which may have arisen during the workshop could then be listed (space was available on the form for a maximum of five additional concerns).

Information was also obtained as to whether they had ever worked in a hospital (in any capacity), been an in-patient in hospital or been on a ward visit.

Interview skills workshops

The workshops concentrated on students learning by personal experience. Didactic lectures were, therefore, kept to a minimum and emphasis was placed on role-play and discussion. Demonstration videotapes of both effective and ineffective or poor interviewing skills were prepared by the workshop leaders and used as a springboard for discussion.

The topics covered during the workshops were directed at basic skill acquisition in the areas of greeting and seating a patient, how to begin an interview, self-introduction and orienting the patient to the purpose and form of the interview, role of seating, lighting, non-verbal communication, use of open and closed questions, verbal encouragement, summarising, reflection and ending the interview.

Analysis

Each of the worries listed by the students was placed in a category depending on its nature and content. For example, "I am worried that I may not ask the right question" and also "I am worried about obtaining correct information" were placed in the category of concerns about history technique. The results were analysed using standard SPSS.

Findings

Attendance rate

The 73 students who attended the workshops represent 52.6% of the 139 medical students time-tabled to attend.

Attendance fell dramatically when the timing of the workshops was changed from Monday mornings to Friday afternoons but understandably no other teachers were prepared to swap their teaching sessions into this least favoured slot.

Most common concerns

The concerns listed by the students were divided by the authors into 21 categories. In order of frequency these were:

history technique, e.g. asking the right questions/getting the right information (listed by 38 students, 52.1%)
bad news, death and terminal illness, e.g. breaking bad news, dealing with death and terminal illness (34 students; 46%)
putting the patient at ease/getting their trust and confidence, e.g. making the patient feel at ease (29 students; 39.7%)
embarrassing or personal questions and issues, e.g. asking personal questions (21 students; 28.8%)
self presentation, e.g. appearing competent (19 students; 26%)
understanding, e.g. understanding the patient (17 students; 23.3%)
starting, e.g. starting off the interview (10 students; 13.7%)
emotions: upset/compassion/involvement, e.g. dealing with upset patients (10 students; 13.7%)
giving information, e.g. giving patients as much information as they require (9 students; 12.3%)
difficult patients, e.g. coping with difficult patients (8 students; 11%)
tact, e.g. being tactful (8 students; 11%)
getting the patient to talk, e.g. maintaining the conversation (8 students; 11%)
language/communication problems, e.g. language barriers (8 students; 11%)
racism, e.g. encountering racist attitudes (7 students; 9.6%)
lack of knowledge, e.g. lack of medical knowledge (6 students; 8.2%)
other, e.g. talking to weird types of people (6 students; 8.2%)
deformity/handicap, e.g. patients' physical appearance, i.e. deformity (4 students, 5.5%)
age difference/barrier, e.g. age barrier especially early on (4 students; 5.5%)
timing, e.g. keeping to allocated time (4 students; 5.5%)
ending, e.g. how to finish a conversation (3 students; 4.1%)
violence/aggression, e.g. dealing with violent people (3 students, 4.1%).

Effect of having been on a ward visit, being a patient in hospital or having worked in a hospital

The number and type of concerns expressed were analysed using Anova to see what effects, if any, having been a patient in hospital, having worked in hospital or having been on a ward visit had. No significant differences were found. The students rated these concerns generally in the moderately worrying range and felt that the session adequately addressed most of their apprehensions. The exception was breaking bad news, death and terminal illness which were rated as serious concerns to students and were

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not covered by the workshop. This was because the whole workshop dealing with breaking bad news, death and dying was scheduled for later in the course.

Most common concerns at the end of the workshop

The types of concern given by the students as being raised by the workshop were almost identical to those listed at the beginning of the workshop; 32 (43.8%) of students reported no additional worries raised by the sessions.

Comment

This paper demonstrates that medical students approach the clinical part of their training with a number of apprehensions. Their feelings of inadequacy and immaturity are often as frequent and as worrying to them as specific worries about history technique and lack of medical knowledge.

One half day workshop addressed many of their anxieties. It has been shown that students with fewer such anxieties are rated as better interviewees by their teachers and are also more competent doctors preferred by their patients (Thompson & Anderson, 1982). Therefore our workshops may be expected to have improved their self confidence, competence and the way they are perceived by patients. Clearly such a brief introduction to interview skills can only be expected to have a very limited benefit to the students and needs to be viewed as a first step to an integrated programme of training in consultation skills which should continue throughout medical school. We believe that by introducing this subject early in a student's training helps to emphasise the fundamental importance of good communication skills for doctors. Further studies are needed to ascertain whether such a brief teaching session does have long-term effect.

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Careers in psychiatric specialities

4. Community psychiatry

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Definition

Community psychiatry is at present an ill defined specialty. The emphasis is on psychiatry practised in the community, often in the context of a community mental health centre (CMHC), although in-patient facilities are still an important component of most services.