

ORIGINAL RESEARCH PAPER

Student Attitudes towards Communication Skills Training in a Medical College in Western Nepal

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ABSTRACT **Context:** *Previous studies have shown that students have both positive and negative attitudes towards communication skills training. However, studies in Nepal are lacking.*

Objectives: *The present study was carried out to determine the positive and negative attitudes of student respondents using the previously validated communication skills attitude scale (CSAS) (see Appendix).*

Methods: *The study was carried out among third- and fourth-semester students at the Manipal College of Medical Sciences, Pokhara, Nepal. These students are in the pre-clinical part of their course and learn the basic science subjects through an integrated, system-based curriculum. Gender, age, nationality of the respondents, occupation of parents, medium of instruction at school, attitude towards communication skills training during the clinical years, and self-rating of communication abilities were recorded. Association of the positive and negative attitudes with these variables was determined using appropriate statistical tests ($p < 0.05$).*

Findings: *A total of 123 students participated in the study; 74 (60.2%) were male, and 104 (84.5%) had studied in English-medium schools. The median positive attitude score was 51 (inter-quartile range 7). Nationality and attitude towards communication skills training during the clinical years showed a significant association. The mean negative attitude scale score was 31.18 ($SD = 4.96$). A significant association was noted with attitude towards communication skills training during the clinical years. Both scales range from 13–65, with higher scores indicating stronger attitudes.*

Conclusions: *Communication skills training should be modified and strengthened. Formal courses during the clinical years are required. Training sessions for the faculty and further studies across different semesters and in different medical colleges in Nepal are needed.*

KEYWORDS *Education, medical, communication, learning, training, attitudes of health personnel, interpersonal communication.*

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Introduction

Patient interviewing and communication skills were traditionally considered to be simple skills not requiring specific teaching programs (Benbassat & Baumal, 2001). In 1969, it was first claimed that doctor-patient communication is a teachable skill (Morgan & Engel, 1969). Today most medical schools in the United States (Novack *et al.*, 1993) and United Kingdom (Hargie *et al.*, 1998) offer programs in interviewing and communication skills.

The Manipal College of Medical Sciences (MCOMS), Pokhara, Nepal, is affiliated with the Kathmandu University and used to admit 100 students for the MBBS course. However, since August 2003 the college has been admitting two classes of 75 students in January and August. The college admits students from Nepal, India, Sri Lanka, and other countries.

The revised curriculum of Kathmandu University has identified acquisition of communication skills as an important objective of the MBBS program (Kathmandu University, 2001). The ability to deliver drug-related and disease-related information in a meaningful way to the patient has been considered an important “transferable skill” (Shankar *et al.*, 2003b).

A few practicing clinicians have not acquired an appropriate attitude towards their patients and skills in communicating despite undergraduate education programs (de Monchy, 1992). Attitudes of doctors have been shown to be closely linked to communication skills and to influence the quality of medical care (Batenburg & Smal, 1997). An earlier study reported that students’ assessment of their ability to communicate effectively was poor, that gender was a significant predictor of level of skill, and that the benefits of training can be enhanced by involving hospital doctors in teaching and providing detailed feedback (Marteau *et al.*, 1991). Studies have shown that medical students value communication skills training and want more formal courses on the subject (Walker *et al.*, 1981; Rosenthal & Ogden, 1998). A qualitative pilot study has shown that some medical students have positive attitudes towards communication skills training while others have negative attitudes (Rees & Garrud, 2001). A study using a reliable attitude scale showed that the attitude of medical students towards communication skills training is significantly associated with a number of demographic and education-related characteristics (Rees & Sheard, 2002).

Training doctors how to “flex” their communication style, when necessary, to take into account personality differences between them and their patients can enhance outcomes (Clack *et al.*, 2004). One study demonstrated improvement in student attitudes following a communication skills course (Doherty *et al.*, 1992). In other works, an advanced course was rated highly by students and tutors (Towle & Hoffman, 2002) and preclinical students both accepted a communication skills course and were enthusiastic about supervised contact with patients (Knox & Bouchier, 1985). The Amsterdam attitudes and communication scale has recently been developed to assess medical students’ communicative behavior and attitudes (de Haes *et al.*, 2001). Finally, a review

concluded that all medical students should have communication skills training (Aspegren, 1999).

During the first two years of the MBBS course, the basic science subjects are taught under an integrated curriculum. There are frequent hospital visits and a combination of lectures and problem-based learning is used. Communication skills sessions are conducted in small groups by the Department of Pharmacology in collaboration with the Department of Medical Education. There are lectures on the doctor-patient relationship and factors influencing doctor-patient communication.

Studies of the attitudes of medical students towards communication skills training are lacking in Nepalese medical schools that admit students from different South Asian countries. The official and spoken language is Nepali. However, many students from other countries do not have a good working knowledge of Nepali. The majority of the students are educated in English-medium schools and find it difficult to communicate in languages other than English.

In south Asia, doctors often communicate in English with patients of higher socioeconomic groups. The languages used to communicate with patients of lower socioeconomic groups vary considerably. It would be very difficult to translate the questionnaire into numerous languages with very different scripts; thus, the questionnaire was administered in English, the medium of instruction.

The present study was carried out to:

1. Determine the positive and negative attitudes of the respondents towards communication skills training using the communication skills attitude scale (CSAS).
2. Describe any association of the positive and negative attitude score with the demographic and educational characteristics of respondents.

Materials and Methods

Recruitment Procedure

The study was carried out among the third- and fourth-semester students at MCOMS, Pokhara, during August 2004. These students had been taking communication skills training for more than a year and communicating with patients during frequent hospital visits. A total of 75 third-semester and 100 fourth-semester students were invited to participate in the study. The questionnaire was distributed to the facilitators of the problem-stimulated learning (PSL) sessions who handed them out to the students and collected them at the end of the sessions.

Assessment Instrument and Scoring

The communication skills attitude scale (CSAS) was used to collect information regarding student attitudes about communication skills training (Rees *et al.*, 2002a). The scale is presented in the appendix. The questionnaire

was first pilot tested with nine sixth-semester students: four Nepalese, four Indians, and one Sri-Lankan. Their data were not included in the final analysis.

The positive attitude scale (PAS) score was obtained by adding the scores of items 4, 5, 7, 9, 10, 12, 14, 16, 18, 21, 23, 25 and the reversed score of item 22. The negative attitude scale (NAS) score was obtained by adding the scores of items 2, 3, 6, 8, 11, 13, 15, 17, 19, 20, 24, 26 and the reversed score of item 1. Both scales range from 13 to 65 with higher scores indicating stronger positive or negative attitudes. The internal consistency of the two subscales as measured by Cronbach's α were PAS = 0.774 and NAS = 0.546.

Demographic and Educational Details

Demographic information is shown in the scale in the Appendix. Information was also collected on whether the student was government-selected or self-financing.

In the private medical colleges in Nepal, the self-financing students come from the affluent sections of society. The government-selected students come from more modest backgrounds. We wanted to study the association, if any, between socioeconomic class and attitudes towards communication skills.

Data Analysis

Descriptive statistics were used to identify the personal characteristics of the total sample and of the third- and fourth-semester students separately. The association of the dependent variables (PAS and NAS scores) with the independent variables (demographic and educational characteristics) was determined. Parametric tests (Student's *t*-test and ANOVA) were used for the normally distributed variables and non-parametric tests (Mann-Whitney and Kruskal-Wallis test) for the others ($p < 0.05$).

Multivariate statistics (stepwise multiple regression) were used to establish the best linear combination of independent variables to predict the dependent variables. The NAS score was normally distributed. However, the PAS score was positively skewed and was transformed using a square root transformation. SPSS version 9 was used for the statistical analysis.

Ethical Considerations

Approval was obtained from the Director of Student Affairs and the Academic Committee for carrying out the study. The respondents were given a broad outline of the objectives of the study, anonymity was maintained, and the students were free to either participate or refuse to do so.

Results

Demographic and Education-related Characteristics

A total of 123 students completed the CSAS satisfactorily – 81 of the 100 fourth-semester students (81%) and 42 of the 75 third-semester students (56%).

Age ranged from 18–23 years. The male-to-female ratio was 74 (60.2%) male to 49 (39.8%) female. Nepalese numbered 56, Indians 61, and Sri Lankans 6.

Of the respondents, 104 (84.5%) had studied in English-medium schools; 87 (70.7%) were self-financing; and 36 (29.3%) were government-selected. One hundred and eleven students (90.2%) were interested in literature, humanities, music and dramatics, either singly or in various combinations. Formal courses on communication skills during the clinical years of training were favoured by 108 respondents. The demographic and education-related characteristics of the respondents are presented in Table 1.

Students' Attitudes towards Communication Skills Learning

The median PAS score was 51 (inter-quartile range 7). The relationship between the dependent variable (PAS score) and the independent variables was explored using univariate statistics (see Table 2). Nationality, attitude towards communication skills training during the clinical years, and self-rating of communication abilities were found to be significantly associated. The three variables with a significant relationship with the PAS score were entered into a stepwise multiple regression model. Two variables, nationality and attitude towards communication skills training during the clinical years, were found to be significantly associated with the PAS scores. Overall, the best predictor of positive attitudes was the attitude towards communication skills training during the clinical years.

The NAS scores were normally distributed. The mean \pm SD score was 31.18 ± 4.96 . The relationship between the dependent variable (NAS score) and the independent variables was explored (see Table 3). There was a significant relationship with only one variable, attitude towards communication skills training during the clinical years of study ($p = 0.038$). Variables with a trend towards a significant relationship were entered into a multiple regression model. There was an inverse relationship between the NAS scores and attitude towards communication skills training during the clinical years.

Discussion

At MCOMS, both summative and formative assessment in communication skills is carried out as an objective structured practical examination (OSPE) station by two independent observers using a standardized checklist five or six times during the first four semesters (Shankar *et al.*, 2003a). These marks form part of the assessment in the practical examinations in pharmacology. The students are aware of this fact and it may have influenced their attitudes.

A previous qualitative study showed that students held both positive and negative attitudes towards different aspects of communication skills training; a few students reported being socialized into developing attitudes (negative) held by senior students and doctors (Rees *et al.*, 2002b).

Table 1. Demographic and educational characteristics of the student respondents by semester

Characteristic	Number of respondents		
	Third semester (<i>n</i> = 42) Number (%)	Fourth semester (<i>n</i> = 81) Number (%)	Total number (%)
Median Age	20	20	20
Range	18–21	18–23	18–23
Gender			
Male	26 (61.9)	48 (59.2)	74 (60.2)
Female	16 (38.1)	33 (40.8)	49 (39.8)
Nationality			
Nepalese	25 (59.5)	31 (38.3)	56 (45.5)
Indian	14 (33.3)	47 (58)	61 (49.6)
Sri Lankan	3 (7.2)	3 (3.7)	6 (4.9)
Occupation of parents			
Doctor	14 (33.3)	31 (38.3)	45 (36.6)
Others	28 (66.7)	50 (61.7)	78 (63.4)
Medium of instruction at school			
English	37 (88.1)	67 (82.7)	104 (84.5)
Vernacular ^a	5 (11.9)	14 (17.3)	19 (15.5)
Place of family residence			
City	22 (52.4)	47 (58)	69 (56.1)
Small town	15 (35.7)	25 (30.9)	40 (32.5)
Village	5 (11.9)	9 (11.1)	14 (11.4)
Method of selection	16 (38.1)	20 (24.7)	36 (29.3)
Government-selected			
Self-financing	26 (61.9)	61 (75.3)	87 (70.7)
Self-rating as a student			
Outstanding	0	6 (7.4)	6 (4.9)
Good	14 (33.3)	26 (32.1)	40 (32.5)
Average	27 (64.3)	46 (56.8)	73 (59.3)
Poor	1 (2.4)	3 (3.7)	4 (3.3)
Preferred subject for post graduate			
Medical specialities	16 (38.1)	22 (27.2)	38 (30.9)
Surgical specialities	18 (42.8)	34 (42.0)	52 (42.3)
Basic Sciences	2 (4.8)	4 (4.9)	6 (4.9)
Not decided	6 (14.3)	21 (25.9)	27 (21.9)
Courses in communication skills during clinical years			
Yes	38 (90.5)	70 (86.4)	108 (87.8)
No	4 (9.5)	11 (13.6)	15 (12.2)

(continued overleaf)

Table 1. (Continued)

Characteristic	Number of respondents		
	Third semester (n = 42) Number (%)	Fourth semester (n = 81) Number (%)	Total number (%)
Self-rating of communication ability			
Excellent	1 (2.4)	6 (7.4)	7 (5.7)
Good	15 (35.7)	26 (32.1)	41 (33.3)
Average	19 (45.2)	42 (51.8)	61 (49.6)
Poor	7 (16.7)	7 (8.7)	14 (11.4)

^aIn the vernacular medium schools the school subjects are taught in the local language; English is taught as a second or third language.

The median PAS score of 51 noted in the present study was comparable to that observed in a previous study, while the mean NAS score was higher (Rees & Sheard, 2002). The communication skills training sessions are conducted in English using simulated patients. There are no formal training sessions in communication skills during the clinical years. These may be partly responsible for the higher NAS score.

Unlike the previous study (Rees & Sheard, 2002), no significant relationship was observed between age and the PAS scores. The median age of students and of the English students was comparable but the range was less. A previous study suggested that older, mature students have more positive attitudes towards communication skills training (Rees & Garrud, 2001). The lesser number of older, mature students in this study may have been partly responsible for the lack of a significant relationship.

There was no difference in the PAS scores of male and female respondents. Previous studies support that female students have higher PAS scores and lower NAS scores (Rees & Sheard, 2002; Wiskin *et al.*, 2004). The present findings were not conclusive and further studies are required.

The students who were in favour of communication skills courses during the clinical years of training had a higher PAS score. In a previous study, students who felt that their communication skills needed improving had more positive attitudes (Rees & Sheard, 2002). Students with doctor parents had a lower PAS score. The reasons for this are not clear and can be explored in a future study. The students who rated themselves as excellent communicators had higher PAS scores than good, average, or poor communicators. However, the poor communicators had a higher PAS score than good or average communicators. The results from the literature are contradictory. Studies suggest that students with poorer communication skills more highly valued the opportunities offered by communication skills training courses (Aspegren,

Table 2. Univariate relationship between Positive Attitude Scale (PAS) score and demographic and educational characteristics^a

Characteristic	Median PAS score (inter-quartile range or SD)	<i>p</i> value
Age	51 (25–63)	0.872
Gender		
Male	51 (6.25)	0.723
Female	51 (7.5)	
Nationality		
Nepalese	52 (5.75)	0.009
Indian	49 (7)	
Sri Lankan	50.5 (13.25)	
Occupation of parents		
Doctor	50 (6)	0.06
Others	51 (8.25)	
Medium of instruction at school		
English	51 (7)	0.369
Vernacular	48 (11)	
Place of family residence		
City	51 (8)	0.201
Small town	51 (6)	
Village	54 (9.5)	
Method of selection		
Government-selected	51 (6.25)	0.140
Self-financing	50 (7)	
Self-rating as a student		
Outstanding	56 (8.25)	0.157
Good	51 (7.75)	
Average	51 (7)	
Poor	48 (6.75)	
Preferred subject for post graduate		
Medical specialities	51 (6)	0.495
Surgical specialities	50.5 (6)	
Basic Sciences	51 (14.25)	
Not decided	52 (10)	
Courses in communication skills during clinical years		
Yes	51 (8)	0.008
No	48 (3)	
Self-rating of communication ability		
Excellent	55 (4)	
Good	50 (6.5)	0.053
Average	51 (7)	
Poor	52.5 (10.25)	

^aMann-Whitney test was used for dichotomous variables and Kruskal-Wallis test for the others.

Table 3. Univariate relationship between Negative Attitude Scale (NAS) scores and demographic and educational variables^a

Characteristic	Mean NAS score (SD)	<i>p</i> value
Age	31.18 (4.96)	0.449
Sex		
Male	31.76 (4.84)	0.113
Female	30.30 (5.1)	
Nationality		
Nepalese	30.89 (5.05)	0.756
Indian	31.50 (5.05)	
Sri Lankan	30.50 (3.27)	
Occupation of parents		
Doctor	30.29 (4.79)	0.131
Others	31.69 (4.96)	
Medium of instruction at school		
English	31.18 (5.05)	0.984
Vernacular	31.16 (4.55)	
Place of family residence		
City	30.90 (4.71)	0.662
Small town	31.85 (5.22)	
Village	30.38 (5.69)	
Method of selection		
Government-selected	31.90 (4.97)	0.309
Self-financing	30.88 (4.96)	
Self-rating as a student		
Outstanding	28.83 (5.95)	0.445
Good	31.05 (5.25)	
Average	31.29 (4.7)	
Poor	34.00 (5.48)	
Preferred subject for post graduate		
Medical specialities	30.79 (5.33)	0.192
Surgical specialities	32.00 (4.65)	
Basic Sciences	33.00 (3.85)	
Not decided	29.74 (5.03)	
Courses in communication skills during clinical years		
Yes	30.83 (4.69)	0.038
No	33.67 (6.23)	
Self-rating of communication ability		
Excellent	29.86 (4.41)	0.777
Good	30.78 (4.09)	
Average	31.50 (5.4)	
Poor	31.57 (5.8)	

^aStudents *t*-test was used for dichotomous variables and ANOVA for the others.

1999; Rees & Sheard, 2002) while another study has demonstrated the opposite (Rees & Garrud, 2001).

The Nepalese students had the highest PAS scores followed by the Sri Lankans and the Indians. The Nepalese students are selected through entrance examinations and perform better academically compared to others. However, there was no significant nationality differences in the NAS score. There were only six Sri Lankans in the study and the low number may have influenced their scores. The simulated sessions are conducted in English, a language in which the majority of students are comfortable and so difficulties with the Nepali language may not account for the differences. In their future practice, the students would use English only in communicating with a minority of patients from the upper classes. This may have influenced the results.

There was a lack of statistical association between the majority of the demographic factors and the PAS/NAS scores. It may be that with increasing development, prosperity, and globalization, the groups are becoming more homogeneous. A uniform communication skills training methodology may be considered if these preliminary findings are corroborated by larger studies.

The present study had many limitations. The scale was administered in English and students may have interpreted the scale in a different manner compared to others. Cultural and socioeconomic differences may have influenced the results. OSCE marks obtained in communication skills and the PAS scores have not been compared as done in a previous study (Rees & Sheard, 2002). The low response of the third-semester students, especially the Indians and Sri Lankans, may have biased the scores. The third semester students were exposed to communication skills training for a lesser time period than the fourth semester. The influence of ethnicity/caste groups on communication skills, if any, was not analyzed because of the diversity in ethnic and caste groups. The small sample size (123 students) may possibly have lead to type II error. There was student diversity with respect to many demographic characteristics and this could have had an interrelated influence on the outcomes. This may be one of the reasons for the low alpha coefficient for the negative attitudes.

Conclusion

Considering the high NAS scores, communication skills training at MCOMS should be modified and strengthened. Real patients from the hospital should be used in addition to simulated patients. Formal training sessions should be introduced during the clinical years. A teacher training programme that will give teachers insight into both patient needs and problems of students in communicating with patients would be helpful (Benbassat & Baumal, 2001). The training sessions should be made more interesting and the importance of communication skills for a future medical career should be emphasized. Frank self-assessment of student skill levels should be encouraged. Clinical teachers,

as well as social and behavioural scientists can be involved in training during the basic science years. Further studies across different semesters and in other medical colleges are required to gain an insight into the problems of communication skills training in Nepal.

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Appendix

Communication Skills Attitude Scale (CSAS)

- Age: Sex: M/F Nationality:
- Occupation of father: Occupation of mother:
- Medium of instruction at school: English/Vernacular
- Place of residence: Metro city/Small town/Village/Others (specify)
- Semester of study: Govt. selected/Self-financing

I am interested in literature, humanities, music & dramatics: Yes/No. If yes, then which one?

How would you rate yourself as a student? Outstanding/Good/Average/Poor

My preferred subject for post-graduation:

If I had not been a doctor I would have been:

I would like formal courses in communication skills training during my clinical years: Yes/No

I would rate myself as an excellent/good/average/poor speaker.

Please read the following statements about communication skills learning. Indicate whether you disagree or agree with all of the statements according to the following scale: 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree and 5 = strongly agree. Write the whole number of your response near the statements. Please complete *both* sides of this scale.

1. In order to be a good doctor I must have good communication skills.
2. I can't see the point in learning communication skills.
3. Nobody is going to fail their medical degree for having poor communication skills.
4. Developing my communication skills is just as important as developing my knowledge of medicine.
5. Learning communication skills has helped or will help me respect patients.
6. I haven't got time to learn communication skills.
7. Learning communication skills is interesting.
8. I can't be bothered to turn up to sessions on communication skills.
9. Learning communication skills has helped or will help facilitate my team-working skills.
10. Learning communication skills has or will improve my ability to communicate with patients.
11. Communication skills teaching states the obvious and then complicates it.
12. Learning communication skills is fun.
13. Learning communication skills is too easy.
14. Learning communication skills has helped or will help me respect my colleagues.
15. I find it difficult to trust information about communication skills given to me by non-clinical lecturers.
16. Learning communication skills has helped or will help me recognize patients' rights regarding confidentiality and informed consent.

17. Communication skills teaching would have a better image if it sounded more like a science subject.
18. When applying for medicine, I thought it was a really good idea to learn communication skills.
19. I don't need good communication skills to be a doctor.
20. I find it hard to admit to having some problems with my communication skills.
21. I think it's really useful learning communication skills on the medical degree.
22. My ability to pass exams will get me through medical school rather than my ability to communicate.
23. Learning communication skills is applicable to learning medicine.
24. I find it difficult to take communication skills learning seriously.
25. Learning communication skills is important because my ability to communicate is a lifelong skill.
26. Communication skills learning should be left to psychology students, not medical students.

Thank you for taking the time to complete this questionnaire