



ORIGINAL RESEARCH PAPER

Residents' Perceived Needs in Communication Skills Training across In- and Outpatient Clinical Settings

N Junod Perron¹, J Sommer¹, P Hudelson¹, F Demaurex², C Luthy³, M Louis-Simonet⁴, M Nendaz⁴, W De Grave⁵, D Dolmans⁵, C Van der Vleuten⁵

¹*Department of community medicine and primary care, Geneva University Hospitals, Switzerland*

²*Medical Education Development and Research Unit, CMU, ³Department of rehabilitation and geriatrics, ⁴Department of internal medicine, University of Geneva, Switzerland*

⁵*Department of education development and research, University of Maastricht, Maastricht, The Netherlands*

Published: 18 May 2009

Junod Perron N, Sommer J, Hudelson P, Demaurex F, Luthy C, Louis-Simonet M, Nendaz M, De Grave W, Dolmans D, Van der Vleuten C

Residents' Perceived Needs in Communication Skills Training across In- and Outpatient Clinical Settings
Education for Health, Volume 22, issue 1, 2009

Available from: <http://www.educationforhealth.net/>

ABSTRACT

Context: Residents' perceived needs in communication skills training are important to identify before designing context-specific training programmes, since learners' perceived needs can influence the effectiveness of training.

Objectives: To explore residents' perceptions of their training needs and training experiences around communication skills, and whether these differ between residents training in inpatient and outpatient clinical settings.

Methods: Four focus groups (FG) and a self-administered questionnaire were conducted with residents working in in- and outpatient medical service settings at a Swiss University Hospital. Focus groups explored residents' perceptions of their communication needs, their past training experiences and suggestions for future training programmes in communication skills.



Transcripts were analysed in a thematic way using qualitative analytic approaches. All residents from both settings were asked to complete a questionnaire that queried their sociodemographics and amount of prior training in communication skills.

Findings: In focus groups, outpatient residents felt that communication skills were especially useful in addressing chronic diseases and social issues. In contrast, inpatient residents emphasized the importance of good communication skills for dealing with family conflicts and end-of-life issues. Felt needs reflected residents' differing service priorities: outpatient residents saw the need for skills to structure the consultation and explore patients' perspectives in order to build therapeutic alliances, whereas inpatient residents wanted techniques to help them break bad news, provide information and increase their own well-being. The survey's overall response rate was 56%. Its data showed that outpatient residents received more training in communication skills and more of them than inpatient residents considered communication skills training to be useful (100% vs 74%).

Discussion: Outpatient residents' perceived needs in communication skills were more patient-centered than the needs perceived by inpatient residents. Residents' perceived needs for communication skills may differ not only because of their differing service priorities but also because of differences in their previous experiences with communication skills training. These factors should be taken into account when designing a training programme in communication skills.

Keywords: Residents, communication skills, needs, inpatient, outpatient

Context

Communication skills are a key element in clinical practice and an integral component of a clinician's skills (Silverman *et al.*, 2005). Research has shown that communication skills can be taught to and learned by medical students, residents and general practitioners (Aspegren, 1999; Langewitz *et al.*, 1998; Levinson & Roter, 1993) and that good communication skills have a positive influence on patients' satisfaction, health outcomes, can reduce malpractice claims and the human and economic costs of care (Brown *et al.*, 1999; Stein *et al.*, 2005).

Although various authors and international consensus statements provide comprehensive communication skills training models for medical education and clinical practice (Cole & Bird, 2000; Kurzt *et al.*, 2005; Makoul, 2001), few medical schools provide clinically-based continuous communication skills training programmes and too few physicians demonstrate such skills in their work (Veldhuijzen *et al.*, 2007). One reason for this common lack may be that communication guidelines and recommendations remain too general, including not being made specific to students' learning situations (Veldhuijzen *et al.*, 2007). Communication skills training might be more effective if the content and focus of training is adapted to the needs of learners' specific clinical learning settings.

Learning needs are influenced by personal, training and contextual factors (Goldstein & Ford, 2002). With regard to patient-physician communication, it is known that personal factors such as medical students' gender and linguistic/cultural backgrounds influence their perceptions of communication skills (Rees *et al.* 2002). The training itself seems to modify medical students' perspectives: the less experiential training they have received in communication skills, the less they consider communication as a skill that can be learned and used to improve patients' outcomes (Willis *et al.*, 2003). Professional experience itself also shapes learners' perspectives and needs. As young physicians progress in their training, self-representations change and their perceptions and attitudes towards psychosocial issues and patient-physician relationships evolve. Over time, physician-learners develop greater tolerance for vulnerability within themselves and learn to accept that there are limits in what they can do as physicians (Brent, 1981). They also feel more confident in their ability to deal with psychosocial issues (Adler *et al.*, 1980).



The importance of contextual factors has been highlighted recently in a study that showed that paediatric, gynaecology, surgery and medicine residents emphasized different communication norms, values and skills: paediatric and internal medicine residents emphasized reflective practice while surgery and obstetric and gynecology residents focused more on narrow skills and behaviour acquisition (Razack *et al.*, 2007).

Little is known about inpatient versus outpatient differences in communication challenges and training needs. In outpatient settings, patients are less ill, more emphasis is given to chronic disease care, the level of uncertainty in terms of diagnosis and therapeutic compliance is greater and patient contacts are brief and irregular but continuous over time (Bowen *et al.*, 2005). Outpatient physicians learn how to provide continuous and comprehensive care while inpatient doctors tend to develop more acute diagnostic and therapeutic skills (Wiest *et al.*, 2002).

Since these context-sensitive factors (patient conditions, priorities and learning environments) may influence students' perceived needs for communication skills, it is important to identify their perceptions in order to develop specific, targeted educational interventions and to increase learners' effectiveness in their later clinical practices.

Objectives

The first aim of the study was to explore the perceived needs in communication skills training among the residents of our medical school and evaluate to what extent needs differed according to the type of setting. The second aim was to assess the extent to which in- and outpatient residents had received training in communication skills during their post-graduate training and how useful they considered it to be.

Methods

Setting

In the Swiss medical training system, undergraduate training lasts six and a half years. A minimum of five years of post-graduate training is required to obtain a title of specialist. Residents typically train two to four years on hospital wards before moving to the outpatient setting in order to obtain the title of internist or general practitioner.

This study took place in two services of the Geneva University Hospitals, which serve a population of 450 000 inhabitants and has 2100 beds. The service of general internal medicine offers three years of training in internal medicine to about 80 residents. Out of these 80 residents, 40 work on the general internal medicine wards for a 12 to 18 month period and are supervised by 15 chief residents. During this period, they attend 4 sessions of training in basic communication skills. The remaining 40 residents rotate through different services and units (ICU, emergency, medical subspecialties, primary care) every four to six months (Figure 1).

In the general medicine outpatient service, 21 residents nearing the end of their postgraduate training spend one year in ambulatory care before completing their training and typically moving on to private practice. Most have already trained two to four years in inpatient internal medicine. During this final, outpatient year, residents attend 10 workshops on communication skills and have weekly reflective sessions on doctor-patient relationships. In this setting their work is overseen by ten clinical supervisors.



Our study was conducted at the service of general internal medicine (inpatient setting) and at the general medicine outpatient service at the Geneva University Hospitals.

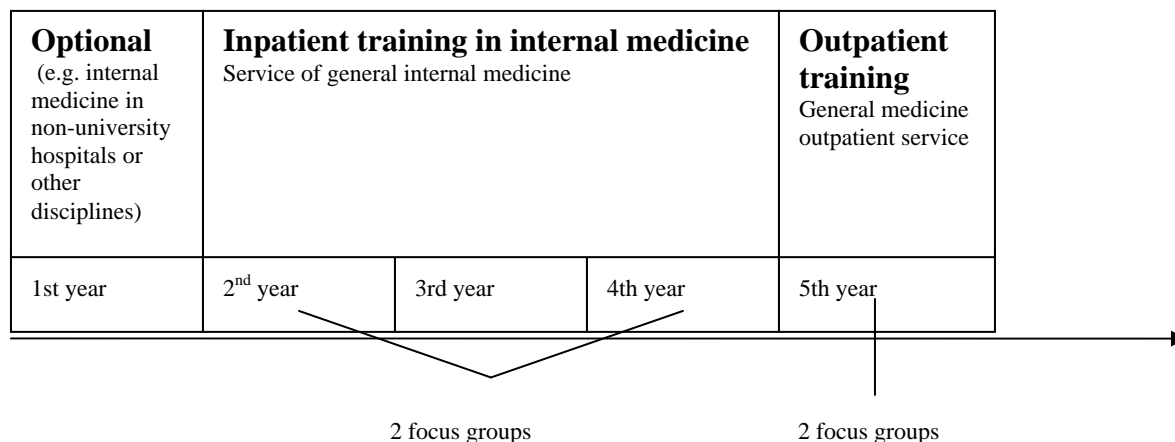


Figure 1: timeline of a standard resident’s training in our environment

Design

We chose a mixed method approach, which included a written questionnaire-based survey and focus groups (Johnson & Onwuegbuzie, 2004).

The focus groups

The questioning route was designed to identify residents’ perceived needs in communication skills training. In order to learn about residents’ perceived needs for communication skills in daily practice, the focus group guide included questions about residents’ perceived communication challenges, past training experiences (What was most useful to the residents? What would have been helpful but was not included in the training?), and suggestions for future training programmes in communication skills (What recommendations would residents make for a training programme in communication skills for their successors?).

We conducted four focus groups with a convenience sample of residents: NJP and JS conducted two focus groups with inpatient residents; FD and CL conducted two focus groups with outpatient residents. Moderators were external to the service in order to make participants feel free to express their views on communication skills without any pressure from their supervisors. The sessions were audio-taped and transcribed ad verbatim (NJP).

The questionnaire

The questionnaire was aimed at describing the amount of residents’ prior training in communication skills (Kurzt *et al.*, 2005; Laidlaw *et al.*, 2002; Silverman *et al.*, 2005). It contained items querying residents’ number of years of post-graduate training, the type of skills taught to them in post-graduate training (e.g. skills in collecting information from patients, in being empathetic, in exploring patients’ perspectives, in explaining, etc) and the instructional formats used during this training. Responses were



indicated on a 3-point scale: (1) never, (2) once or (3) several times. Socio-demographic data such as sex, age, year of graduation, existence of a specialist title, and pre-graduate training setting were also queried. Finally, participants were asked to rate how useful they found their post-graduate training in communication skills.

We conducted a pilot study with 15 physicians to verify that questions were understandable and relevant. This led to several changes in the format and content of the questionnaire. The revised questionnaire was sent to all residents on the general medical outpatient service and on the inpatient service of general internal medicine.

The study was approved by the Research Ethics Committee of the Geneva University Hospitals.

Analysis

Focus groups

A thematic analysis of verbatim transcripts was conducted in several phases (Miller & Crabtree, 1999). First, a group including two primary care physicians (NJP and JS), a physician working in medical education (FD) and an anthropologist (PH) read and discussed each of the focus group transcripts. Based on these discussions, a list of general topics was developed, including needed communication skills, past instructional methods and their perceived advantages and disadvantages, perceived benefits of good communication skills, trigger situations for learning communication skills, factors enhancing/inhibiting communication skills learning, feelings and beliefs about communication skills and suggestions for better training approaches. Next, codes were developed for sub-topics (e.g. within needed clinical skills, the sub-topics of learning to listen, to structure interviews, to take one's time with patients, to ask open-ended questions etc...). In the second phase of analysis, NJP, JS and PH individually hand-coded three transcripts, adding to the initial code list where necessary. This group met to discuss and resolve any differences in the way codes were understood and applied. In the third phase, NJP coded the remaining manuscript with agreed-upon codes using the qualitative data analysis software MAXqda©. The small group then read coded transcripts in order to discuss and correct any inconsistencies in the way codes were applied. Data display tables (key topics by focus group) were then created to facilitate the comparison of responses between residents working in inpatient and outpatient settings.

Questionnaire

Only participants who responded to all questions were included in the final analysis. Descriptive statistics (frequency tables, means, standard deviations) were used to describe exposure to communication skills and learning methods in post-graduate training as well as socio-demographic characteristics of the participants. We used the Chi-Square test with a significance level of 0.05 to look at differences in responses between residents in- and outpatient settings.

Results

Focus groups

Out of the 40 inpatient residents, 14 took part in focus groups (11 women and three men). Reasons for non-participation included lack of availability (eight on holidays, two on night-shifts), lack of time (eight taking licensing exams) or lack of interest (four).



Participants' and non-participants did not differ in their socio-demographic characteristics, except that participants were slightly older and had more clinical experience. Out of the 20 outpatient residents, 10 participated to the focus groups (seven women and three men). The main reason for their non-participation was a lack of availability due to scheduling conflicts. Participants' and non-participants' sociodemographic characteristics were similar.

The focus groups were designed to explore residents' perceived needs in communication skills and to assess whether these needs differed for residents training in the inpatient versus outpatient settings. Differences indeed emerged, described below.

Perceptions of needed skills and their benefits

Residents felt they needed communication skills especially in difficult clinical situations, but the nature of the skills needed differed depending on the clinical context. Outpatient residents talked about skills related to working with patients around chronic disease management and patients' social problems, while inpatient residents mentioned the need for skills to break bad news and to manage conflicts, especially with patients' families and patients with substance abuse issues.

Residents in the different settings also differed in the skills they most valued. Outpatient residents considered the following skills to be most useful: listening, showing empathy, exploring patients' perspectives and structuring the consultation. They felt that certain communication skills such as listening and using open-ended questions were therapeutic in and of themselves, while other communication skills helped them to elicit information from the patient, to strengthen the patient/provider relationship or to reinforce treatment compliance.

The notion of open-ended questions, it was a technique I didn't know before...it actually allows the patient to speak and us to remain silent... and I have discovered it has its own strength ... it is almost a therapeutic act in itself (Focus group (FG)4:Participant(P) 2)

Providing a structure to the consultation facilitated time management and was a way to avoid running overtime.

...it is not just about time, but also about the physician's and the patient's agenda to put in place at the beginning of the consultation, ... it avoids exceeding the time you can devote to the patient, prevents the physician or the patient from feeling frustrated. It actually allows you to organize the session, to say : "Here we are, we will talk about such and such a thing..." (FG4:P1)

In contrast, inpatient residents talked more about communication techniques used to break bad news and provide information to patients.

As far as I am concerned, I would have liked to have some advice on how to break bad news. (FG1:P7)

Inpatient residents focused more on the benefits for themselves, as physicians, of communication skills, and less on the benefits for patients. They felt that communication skills training helped them feel more confident, especially those who had just started working in clinical setting and felt overwhelmed by their lack of medical experience:



Ah, but I think it [role-play] was useful all the same because already during training periods, as soon as we started, we had the impression that, even if we were no experts in hyponatremia, we still managed to be convincing in a discussion and it is true I have never felt completely at a loss in an interview with a patient. (FG2:P2)

Inpatient residents also wished for more training in interprofessional communication.

Both in- and outpatient residents emphasized the importance of adapting information to their patients' needs and level of understanding and indicated that they would have liked more training in transcultural and linguistic issues.

Useful instructional methods

Residents valued "on-the-job" learning, including practicing and observing others. Watching others during ward rounds was used to identify examples of both good and inadequate communication. Beyond these approaches, residents preferred instructional methods that were close to their practice such as use of simulated patients and role-play in small group and observation of their own videotaped encounters under individual supervision.

Many residents considered learning how to handle their emotions to be part of communication training. Sharing difficult situations with peers, reflecting on their emotions, discussing strategies and gathering suggestions from external supervisors were highly valued and helped residents to better cope with their emotions, to increase their satisfaction and to better manage such situations.

I would say we need a psychologist or someone who knows about the doctor-patient relationship, but is also able to listen to us. As far as our emotional well-being is concerned, I think achieving it is our own professional responsibility, should be part of our training. But I also sometimes think that we should have adequate facilities at our disposal which would help us go on feeling well. (FG1:P8)

However, while the two inpatient groups wanted regular debriefing sessions to cope with their feelings and emotions, the fact that such sessions differed from normal training sessions and did not operate under clear guidelines was sometimes felt by some outpatient residents as disturbing and unsatisfactory.

Nature of the doctor-patient interaction

Residents who had worked in both outpatient and inpatient settings acknowledged that the work setting determined the nature of the doctor-patient interaction and influenced communication issues and challenges.

I think one doesn't establish a doctor-patient relationship in the same manner in an inpatient setting as in an outpatient one. In the latter, the patient leads his normal life; the short visit to the doctor is just a small part of one day, of a week within his family and professional routine, whereas, when he is hospitalised, he is removed from his usual life and social background. He adjusts to hospital life ruled by nurses and nursing aides, and occasionally at best by a doctor. It's all very different. (FG4: P4)



In the inpatient setting, patients were seen as passive and dependent, with residents ordering exams and treatments and delegating these tasks to nurses. In the outpatient setting, patients were seen as autonomous and independent people who had much more control over their own care. Residents viewed themselves as having to adapt to their patients' views and expectations, to motivate them and to negotiate common strategies in order to ensure quality of care and maintain trust.

... the nurse makes sure the patient takes his pills. In this respect, we still have some way to go in an outpatient setting where it is the patient who is responsible for taking his medicine regularly. It is the doctor's job to convince him to follow the prescribed treatment. (FG8:P2)

Service priorities

Residents pointed out that clinical priorities differed between the two settings. Inpatient work was highly biomedical and was characterized by working quickly, by making accurate diagnoses, by managing biomedical problems, and by avoiding medical errors. Doctor-patient communication issues were seen as secondary.

It is true that, by force of circumstances, the priority on the ward is for residents not to make big mistakes, for everything to run smoothly on the biomedical level. Thus a satisfactory relationship is of secondary importance for both the doctor and the patient (FG2:P3)

Working in an outpatient setting required giving more attention to the quality of the relationship and psychosocial aspects of care in order to build up a trustful relationship and to increase therapeutic compliance.

Also we become aware of the fact that, if we want the patients to accept their treatment, we must build a relationship with them, explain to them the reason for their treatment, whereas, when it is a nurse who hands it out, (FG3:P2)

The amount of training activities mirrored the values and priorities of the services on which they were training. Residents reported that the outpatient and rehabilitation settings offered regular and protected time for junior doctor-patient communication and relationship issues while the inpatient setting did not.

It is true that at the outpatient clinic, it is something important, it is valued...and they give you time for training, whereas, in the service of internal medicine most people couldn't care less, because it doesn't meet their needs. (FG3:P3)

Questionnaire

Out of 114 questionnaires mailed to residents, 64 completed questionnaires were returned (overall response rate 56%; inpatient response rate 52%; outpatient response rate: 70%). Inpatient and outpatient resident-respondents differed in terms of age, length of post-graduate training and in the presence of a title of specialist, with outpatient residents being older and more experienced (Table 1).



Table 1: Sociodemographic characteristics of resident-participants in the survey from inpatient and outpatient clinics

Sociodemographic data	Inpatient resident	Outpatient residents	p
	n=50	n=14	
Sex			
Women (n)	50% (25)	64.3% (9)	0.34
Men (n)	50% (25)	35.7% (5)	
Specialist title			
Yes (n)	6.0% (3)	21.4% (3)	0.08
No (n)	94% (47)	78.1% (11)	
Place of training			
Geneva (n)	81.3% (39)	46.2% (6)	<0.01
Switzerland (n)	18.8% (9)	38.5% (5)	
Foreign country (n)	-	15.4% (2)	
	Mean	Mean	
Age years (SD)	31.48 (3.8)	33.43 (3.8)	0.2
Years of post-graduate training (SD)	4.6 (3.3)	7.14 (3.4)	0.013

There were statistically significant differences in communication skills training between inpatient and outpatient residents (Table 2). A large majority of outpatient residents had received training in basic skills such as interview structuring, information gathering, demonstrating empathy etc., while fewer than half of inpatient residents had received such training. Outpatient residents had also received more training in cross-cultural communication and in working with interpreters. Neither group had received much exposure to issues like breaking bad news, managing difficult relationships and conducting interviews with families.

All (100%) outpatient residents and 74% inpatient residents considered training in communication skills to be very useful (p=0.03).

Table 2: Communication skills training reported by inpatient and outpatient residents based on questionnaire data[n1].

Themes	Inpatient residents			Outpatient residents			p
	Many times	Once	Never	Many times	Once	Never	
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	
To gather information	20 (40.0)	13 (26.0)	17 (34.0)	11 (78.6)	2 (14.3)	1 (7.1)	0.03
To explore perspectives	10 (20.0)	24 (48.0)	16 (32.0)	11 (78.6)	2 (14.3)	1 (7.1)	<0.01
To be empathic and legitimate emotions	19 (38.0)	18 (36.0)	13 (26.0)	11 (78.6)	2 (14.3)	1 (7.1)	0.03
To provide information	19 (38.0)	14 (28.0)	17 (34.0)	12 (85.7)	1 (7.1)	1 (7.1)	<0.01
To negotiate a decision	14 (28.0)	19 (38.0)	17 (34.0)	11 (78.6)	1 (7.1)	2 (14.3)	<0.01
To break bad news	7 (14.0)	19 (38.0)	24 (48.0)	3 (21.4)	6 (42.9)	5 (35.7)	0.67
To manage a difficult relationship	12 (24.0)	16 (32.0)	22 (44.0)	4 (28.6)	5 (35.7)	5 (35.7)	0.85
To guide patients in changing a behaviour	7 (14.0)	15 (30.0)	28 (56.0)	6 (42.9)	5 (35.7)	3 (21.4)	0.03
To interact with patients from different cultures	5 (10.2)	11 (22.4)	33 (67.3)	5 (38.5)	4 (30.8)	4 (30.8)	0.02
To communicate with an interpreter	3 (6.0)	7 (14.0)	40 (80.0)	7 (50.0)	6 (42.9)	1 (7.1)	<0.01
To conduct an interview with a third person	3 (6.0)	7 (14.0)	40 (80.0)	2 (14.3)	4 (28.6)	8 (57.1)	0.22



Analysis of responses to open-ended questions revealed that the most useful communication skill reported by all residents was structuring the interview (mentioned by 10 outpatient residents and 6 inpatient residents). Eight inpatient residents also mentioned that they valued learning how to break bad news while eight outpatient residents valued learning how to explore patients' perspectives and six felt that techniques for motivational interviewing were very useful.

Outpatient residents had also experienced a greater variety of instructional formats than inpatient residents, including practicing with standardised patients, watching videos, analyzing their own video-taped consultations, and direct supervision. Frequency of exposure to these methods was also more frequent among outpatient residents (Table 3). There were no inter-group differences in self-initiated learning methods, such as observing others and reading.

Table 3: Instructional methods for communication skills training reported by inpatient and outpatient residents through the questionnaire[n2].

Themes	Inpatient residents			Outpatient residents			p
	Many times n (%)	Once n (%)	Never n (%)	Many times n (%)	Once n (%)	Never n (%)	
Theoretical courses	17 (34.0)	14 (28.0)	19 (38.0)	7 (50.0)	5 (35.7)	2 (14.3)	0.24
Role playing	15 (78.9)	20 (40.0)	15 (30.0)	12 (85.7)	1 (7.1)	1 (7.1)	<0.01
To watch videos	7 (14.0)	21 (42.0)	22 (44.0)	11 (78.6)	2 (14.3)	1 (7.1)	<0.01
To have a direct supervision	0	11 (22.0)	39 (78.0)	6 (42.9)	5 (35.7)	3 (21.4)	<0.01
To interact with standardised patients	6 (12.0)	8 (16.0)	36 (72.0)	11 (78.6)	1 (7.1)	2 (14.3)	<0.01
To observe experienced clinicians	14 (28.0)	10 (20.0)	26 (52.0)	8 (57.1)	1 (7.1)	5 (35.7)	0.11
To videotape own consultations	1 (2.0)	18 (36.0)	31 (62.0)	6 (42.9)	5 (35.7)	3 (21.4)	<0.01
Personal readings	12 (24.5)	11 (22.4)	26 (53.1)	7 (50.0)	1 (7.1)	6 (42.9)	0.14

Discussion

These findings suggest that residents perceive the need for communication skills training in difficult situations and that their training needs differ according to the clinical setting in which they work. Inpatient residents want to learn more about how to transmit information, break bad news and manage conflicts with families and patients and to deal with patients with substance-abuse. At the same time, inpatient residents feel constrained by their setting, which gives priority to issues like diagnosis and rapid problem-solving of medical issues. In contrast, outpatient residents see more importance in listening skills, exploring patients' perspectives and structuring the consultation. They feel that communication skills are therapeutic and especially useful for empowering patients with chronic diseases and for supporting patients with psychosocial problems. Understanding patients' perspectives and building therapeutic alliances are key skills necessary for working in the outpatient setting.

Four explanations may account for the differences in perceived training needs in communication skills between residents training in the in- and outpatient settings: 1) their differences in the working patterns and requirements of the two settings 2) differences in the amount of time dedicated to communication skills training 3) the differences in residents' stage of professional development, and 4) their differences in future professional orientation.



Such differences correlate with differences of working patterns and requirements observed between in- and outpatient settings: in hospital settings, residents are asked to apply well-established strategies to diagnose and solve patients' problems and their training tends to focus on such aspects, while primary care residents have to learn to re-orient their practice away from the classification and treatment of diseases towards the care of the patient (Epstein *et al.*, 1999; Mechanic, 1995; Wiest *et al.*, 2002).

The differences in perceived needs and perceived benefits may also arise from the amount of time dedicated to communication skills training, the content and format of training as well as from the involvement of faculty in this field. The inpatient clinic tends to offer little protected time for training whereas it is generally offered on a regular basis in the outpatient clinic. Outpatient residents receive more training and are exposed to a greater variety of skills and learning formats in their training programme. Beliefs and behaviours are shaped by one's interaction with the environment. The more learners experience experiential and reflective training, the more they develop complex conceptual frameworks of effective communication (Willis *et al.*, 2003). Differences in the allocation of and resources to communication skills training provides learners with cues about what is valued by their faculty within each setting and reflects the "hidden curriculum" (Hafferty, 1998; Mann, 2002). Observed differences in residents' perspectives about communication skills may also reflect their pre-existing ideas and expectations regarding inpatient and outpatient work patterns and requirements.

Such differences in perceived needs and perceptions may also reflect differences in terms of residents' professional development. Due to the organization of training in our country and our institutions, outpatient residents are at the end of their training and thus tend to be older, more experienced and better trained in communication skills while inpatient residents are younger, often have little clinical experience and typically have received little training in communication skills. Post-graduate and continuous training can be seen as an ongoing developmental process of acquiring new skills, knowledge, attitudes and professional identity (Adler *et al.*, 1980; Brent, 1981; Fann *et al.*, 2003). The necessity for dealing with the psychosocial aspects of care and for developing interpersonal skills can be problematic for young residents, usually inexperienced and still struggling to arrive at a quick diagnosis and a prompt, definitive treatment (Adler *et al.*, 1980; Brent, 1981; Fann *et al.*, 2003). We observe that inpatient and outpatient residents' perspectives correlate well with the different stages residents go through during their three years residency, when moving from inpatient to outpatient care (Fann *et al.*, 2003; Light, 1975). In this process, young residents are described as highly self-centred and simply fighting to survive. As they gain experience, they give more importance to holistic models of care integrating self and patients and working with the patient (Fann *et al.*, 2003). However, little is known about the extent to which the working environment and residents' personal development and other factors interact to influence the residents' beliefs and perceptions about the importance of good doctor-patient communications.

Finally, differences of perceptions about communication skills may also reflect differences in perceived needs between residents who have chosen to become primary care practitioners who are generally more interested in psychosocial and communication issues versus residents who have not yet chosen their specialty or are clearly more interested in biomedical and technological aspects of care. However, the fact that inpatient residents consider exploring their own thoughts, feelings and emotions towards patients to be important in their training does not support such an explanation.

There are several limitations in our study. First, despite two reminders, the questionnaire non-response rate remained rather high in the inpatient residents' group. This may have biased the results as non-responders might have had different exposure to communication skill training than responders. Second, we conducted only two focus groups in each setting, and we may have missed some important points that could have come out with more groups. However, the remarks that came up in the two groups were quite similar, which suggests that we had, indeed, reached the point of saturation. Third, we interviewed a convenience



sample of residents who may not be representative of all residents from inpatient and outpatient settings. It is possible that we selected only residents interested in communication issues. However, we expect that had we included less interested residents, the observed group differences would have been greater. Fourth, our comparison groups cannot be considered truly independent groups because in our country residents generally train first in inpatient settings before moving to outpatient settings. Lastly, this needs assessment was conducted in a single training centre of a single country, which limits the generalizability of the findings. It would be interesting to explore whether similar differences appear in different training curricula and countries where residents do not train first in the hospital before moving to the outpatient setting.

Conclusion

Our findings suggest that our residents' perceived needs in communication skills are influenced by a variety of factors. In the inpatient setting where clinical work focuses on making diagnoses and managing biomedical dimensions of care and where the patient plays a more passive role, residents' perceived needs revolve around transmitting information and handling their own emotions. In the outpatient context, where patients are seen as more autonomous and empowered, more attention is paid to using communication tools that help manage time in the clinical encounter and increase patients' compliance with recommended care. However, residents in both working contexts and level of training express the need for skills in reflection and self-awareness

Prior exposure to communication skills training and the educational climate of their working setting also seem to influence residents' perceptions and use of communication skills. Further research is needed to clarify the degree to which these areas of influence interact, so that they can be used or integrated when developing a context-based training programme in communication skills.

Organizational priorities, residents' level of experience, training and emotional needs should be taken into account and carefully balanced when designing training programmes in communication skills since these factors predict training effectiveness (Alvarez *et al.*, 2004; Arthur *et al.*, 2003; Colquitt & LePine, 2000).

References

- Adler, R., Werner, E. R., & Korsch, B. (1980). Systematic Study of Four Years of internship. *Pediatrics*, 66(6), 1000-1008.
- Alvarez, K., Salas, E., & Garofano, C. M. (2004). An Integrated Model of Training Evaluation and Effectiveness. *Human Resource Development Review*, 3(4), 385-416.
- Arthur, W., Bennett, W., Edens, P. S., & Bell, S. T. (2003). Effectiveness of Training in Organisations: A Meta-Analysis of Design and Evaluation features. *Journal of Applied Psychology*, 88(2), 234-245.
- Aspegren, K. (1999). BEME Guide No. 2: Teaching and Learning Communication Skills In Medicine - A Review With Quality Grading Of Articles. *Medical Teacher*, 21(6), 563-570.
- Bowen, J. L., Salerno, S. M., Chamberlain, J. K., Eckstrom, E., Chen, H. L., & Brandenburg, S. (2005). Changing Habits Of Practice. Transforming Internal Medicine Residency Education In Ambulatory Settings. *Journal of General Internal Medicine*, 20(12), 1181-1187.



- Brent, D. A. (1981). The Residency As A Developmental Process. *Medical Education*, 56(5), 417-422.
- Brown, J. B., Boles, M., Mullooly, J. P., & Levinson, W. (1999). Effect Of Clinician Communication Skills Training On Patient Satisfaction. A Randomized, Controlled Trial. *Annals of Internal Medicine*, 131(11), 822-829.
- Cole, S. A., & Bird, J. (2000). *The Medical Interview: The Three-Function Approach*, Second Edition Edition, St.Louis: Mosby.
- Colquitt, J. A., & LePine, J. A. (2000). Toward An Integrative Theory Of Training Motivation: A Meta-Analytic Path Analysis Of 20 Years Of Research. *Journal Of Applied Psychology*, 85(5), 678-707.
- Epstein, R. M., Quill, T. E., & McWhinney, I. R. (1999). Somatization Reconsidered: Incorporating The Patient's Experience Of Illness. *Archives of Internal Medicine*, 159(3), 215-222.
- Fann, J. R., Hunt, D. D., & Schaad, D. (2003). A Sociological Calendar Of Transitional Stages During Psychiatry Residency Training. *Academic Psychiatry*, 27(1), 31-38.
- Goldstein, I. L., & Ford, J.K. (2002). *Training In Organisations*, Belmont, CA: Wadsworth.
- Hafferty, F. W. (1998). Beyond Curriculum Reform: Monfronting Medicine's Hidden Curriculum. *Academic Medicine*, 73(4), 403-407.
- Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed Method Research: A Paradigm Whose Time Has Come. *Educational Researcher*, (33),14-26.
- Kurtz, S., Silverman, J., & Draper, J. (2005). *Teaching And Learning Communication Skills In Medicine*, 2nd Edition, Oxford: Radcliff Publishing Ltd.
- Laidlaw, T. S., MacLeod, H., Kaufman, D. M., Langille, D. B., & Sargeant, J. (2002). Implementing A Communication Skills Programme In Medical School: Needs Assessment and Programme Change. *Medical Education*, 36(2),115-124.
- Langewitz, W. A., Eich, P., Kiss, A., & Wossmar, B. (1998). Improving Communication Skills-A Randomized Controlled Behaviorally Oriented Intervention Study For Residents In Internal Medicine. *Psychosomatic Medicine*, 60(3), 268-276.
- Levinson, W., & Roter, D. (1993). The Effects Of Two Continuing Medical Education Programs On Communication Skills Of practicing Primary Care Physicians. *Journal of General Internal Medicine*, 8(6), 318-324.
- Light, D. (1975). The Sociological Calendar: An Analytical Tool For Fieldwork Applied To Medical And Psychiatric Training. *American Journal of Sociology*, 80, 1145-1164.
- Makoul, G. (2001). Essential elements of communication in medical encounters: the Kalamazoo consensus statement. *Academic Medicine*, 76(4), 390-393.



Mann, K. V. (2002). Thinking About Learning: Implications For Principle-Based Professional Education. *Journal of Continuing Education in Health Professions*, 22(2), 69-76.

Mechanic, D. (1995). Sociological Dimensions Of Illness Behavior, *Social Science & Medicine*, 41(9), 1207-1216.

Miller, W. L., & Crabtree, B. F. (1999). *Doing Qualitative Research: The Dance Of Interpretation*, Thousand Oaks, CA: Sage publication.

Razack, S., Meterissian, S., Morin, L., Snell, L., Steinert, Y., Tabatabai, D., & Maclellan, A. M. (2007). Coming Of Age As Communicators: Differences In The Implementation Of Common Communications Skills Training In Four Residency Programmes. *Medical Education*, 41(5), 441-449.

Rees, C. E., Sheard, C. E., & McPherson, A. C. (2002). A Qualitative Study To Explore Undergraduate Medical Students' Attitudes Towards Communication Skills Learning. *Medical Teacher*, 24(3), 289-293.

Silverman, J., Kurzt, S., & Draper, J. (2005). *Skills For Communicating With Patients*, 2nd Edition, Oxon: Radcliff Publishing Ltd.

Stein, T., Frankel, R. M., & Krupat, E. (2005). Enhancing Clinician Communication Skills In A Large Healthcare Organization: A Longitudinal Case Study. *Patient Education and Counseling*, 58(1), 4-12.

Veldhuijzen, W., Ram, P. M., van der Weijden, T., Niemantsverdriet, S., & van der Vleuten, C. P. (2007). Characteristics Of Communication Guidelines That Facilitate Or Impede Guideline Use: A Focus Group Study, *BMC Family Practice*, 8, 31.

Wiest, F. C., Ferris, T. G., Gokhale, M., Campbell, E. G., Weissman, J. S., & Blumenthal, D. (2002). Preparedness Of Internal Medicine And Family Practice Residents For Treating Common Conditions. *JAMA*, 288(20), 2609-2614.

Willis, S. C., Jones, A., & O'Neill, P. A. (2003). Can undergraduate Education Have An Effect On The Ways In Which Pre-Registration House Officers Conceptualise Communication? *Medical Education*, 37(7), 603-608.