A STUDY OF UNIVERSITY OF ZIMBABWE MEDICAL STUDENTS’ ATTITUDES TOWARDS THE TEACHING AND LEARNING OF COMMUNICATION SKILLS.

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ABSTRACT

The purpose of this study is to determine the factors contributing to the attitudes of University of Zimbabwe MbchB (Bachelor of Medicine Degree) and BDS (Bachelor of Dental Surgery) Part 1, 2 and 4 students towards the learning of Communication Skills. The main instrument used to determine the attitudes of students is based on the work of Rees, Sheard and Davies (2002). Using the Communication Skills Attitude Score (CSAS), this study identifies both negative and positive attitudes towards the learning of Communication Skills. The Positive Attitude Scores (PAS) for 4th year students were significantly higher than those of year 1 and 2. Negative Attitude Scores (NAS) for 1st years and 2nd years, were higher than those in year 4. Positive Attitude Scores were heavily influenced by gender, age, and year of study. To determine the factors contributing to the attitudes, the researcher used a specially designed questionnaire with open ended questions. Some of the factors identified include, lack of fluency in the English language, traditional teaching methods at the University of Zimbabwe and the perception among students that the subject is a ‘soft’ social science which is too easy and which simply demands common sense.

KeyWords

Verbal and nonverbal, Communication Skills for Professional Purposes (CSHS102), ZIMSEC, Teaching and Learning
INTRODUCTION:

BACKGROUND TO THE STUDY
There is increasing evidence of good communication skills having positive influences on positive health outcomes such as patient satisfaction with health care, compliance with medication, correct diagnosis and reduction in malpractice claims. (Laidlaw et al: 2002, Kurtz: 2002) However, the teaching of communication skills which are important in health care have been met with a number of challenges including students' negative attitudes towards the learning of communication skills which manifest themselves in high absenteeism rates and a general belief among students that communication skills learning interferes with medical classes.

The majority of the students enrolled for Bachelor of Medicine Degree (Mbchb) and Bachelor of Dental Surgery (BDS) at the University of Zimbabwe are enrolled directly from High School. Such students would have studied science subjects such as Mathematics, Physics, Biology and Chemistry at Advanced Level. Student enrollment is mainly based on whether students have good passes in these subjects and not on whether they have passed or failed the Advanced Level ZIMSEC English Language and Communication Skills or Cambridge General Paper. Academic Communication Skills (CSH101) is taught to 1st year MbchB and BDS students in the first semester of their 1st year. The course is designed to assist students to adjust to university learning and to equip them with Academic Communication Skills such as listening, reading, citation, referencing and clarity of expression for the level of communication required at university.

Communication Skills for Professional Purposes (CSHS102) is the second course students are taught but this time, in the first semester of their second year. This course is designed to equip students with interpersonal and Health organizational communication skills which are invaluable for health professionals. The course covers areas such as Communication in Health Organisations, Bio-medical Ethics in Health Care and Non-Verbal-communication in Health Care. The main thrust of the course is that as Health Professionals they need to be aware of the importance of written, verbal and nonverbal communication in Health communication. For example, medical students have to be aware of when and how to touch patients as well as be able to explain why they are touching the patient in that way, as any misconstrued touching may result in legal difficulties such as sexual harassment lawsuits and malpractice litigation. This course in Communication Skills is taught to students before they go for clinical practice in their 3rd year. This will allow them to experience communication in practice in a professional setting. Verbal and nonverbal aspects of communication such as choice of language, politeness strategies, tone of voice, touch, facial expression and so on are put to the test in a real setting as students attend to real patients and display the professional communication skills they would have been taught.

Both Communication Skills courses are taught by lecturers from the Linguistics Department which falls under the Faculty of Arts. Most of the Lecturers who teach Communication Skills are holders of Master of Arts in English, Master of Arts in Language for Specific Purposes or Master of Arts in Applied Linguistics degrees. They are therefore well equipped and qualified to teach these courses.
Medical students’ attitudes towards Communication Skills learning have been addressed in many studies and medical students were found to have negative and positive attitudes towards the teaching and learning of communication skills. These include studies by Kaufmann (2001), Liddell and Davidson (2006) which used the Communication Skills Attitude Score (CSAS) created by Rees, Sheard and Davies published in 2002. The perceptions that medical students have about the learning and teaching of communication skills have also been shown to have an effect on learning outcomes. (Faye:1997, Kan and Akbas:2006) Attitudes according to Fishbein and Ajzen (1975) involve the evaluation by which students attach good or bad qualities to an idea or object. Attitude drives behavior and if students’ attitudes are changed then their behavior will also be changed. This means that if students are made to appreciate the importance of communication skills to their careers, then such a positive attitude may translate to better class attendance, better assignments and most likely, better health professionals.

Attitudes according to Fishbein and Ajzen (1975) have three main components; i) the affective component which is the way individuals feel and this may change after repeated exposure to situations; ii) the cognitive component, which is the way individuals think and which is closely connected to values which can change when convincing new knowledge is presented and iii) the behavioral component, which is the way individuals act towards a particular entity. Linked to these attitudes is Bloom’s (1956) Taxonomy of Education Objectives serves as a useful theoretical framework for this study as it explains the hierarchical nature of learning.

This taxonomy contains three domains of learning, namely the cognitive, affective and psychomotor domains. This study is mainly concerned with aspects of the affective domain which consist of attitudes, values, motivation and feelings towards information and an individual in learning. The lowest level in this hierarchical domain includes behaviors such as awareness of the importance of Communication Skills and willingness to pay attention to it. The next level is when students attend and react to the subject. This is followed by how students value Communication Skills. At this stage, students begin to associate feelings of value to the subject. In the next level the values are organized into priorities by contrasting different value systems. Finally students internalize values about what they are learning and they tend to believe in ways that are consistent with these values. To this end medical students’ attitudes towards Communication Skills learning may be crucial indications of the importance students place upon these skills which eventually influence communication behavior in clinical settings.

**METHODOLOGY**

The study was performed in the Faculty of Medicine of the University of Zimbabwe in Harare in 2012. The population of this study was comprised of one hundred (100) 1st year, one hundred (100) 2nd year and one hundred (100) 4th year MbchB and BDS students. To determine the attitudes of students towards the learning of Communication Skills, the Communication Skills Attitude Score questionnaire was distributed to the students (n=300). The CSAS was used in this study because it addresses the teaching and learning of Communication Skills specifically and because it is a tool that has been widely used and validated (Rees et al, 2002).

All students responded to the questionnaire giving a 100% response rate. The questionnaire had 26 item measures using a five-point Likert type scale (APPENDIX 1) which included positive and negative statements about Communication Skills training (see Appendix A). The item responses were as follows:

1. Strongly Agree  
2. Agree  
3. Neutral  
4. Disagree  
5. Strongly disagree
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 which are positively worded 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 which are negatively worded and the reversed score of item 1. Both scales ranged from 14 to 64 with higher scores indicating stronger positive or negative attitudes.

The questionnaire which the researchers adapted from Rees et al (2002) also asked for background information such as gender, age, marital status, year of study, previous work experience and whether the student had sat for the English Language and Communication Skills paper (ZIMSEC) or Cambridge International Examinations, General Paper at Advanced Level as the exam is not considered compulsory in most schools in Zimbabwe. It was noted that a number of students, not only in the Faculty of Medicine, but in other faculties as well had not sat for the Advanced Level exam as most schools do not consider the Communication Skills paper as important since it does not contribute any points to students University qualifications.

In addition, the questionnaire was also used to determine the factors contributing to the negative attitudes of students towards the learning of Communication Skills. This part of the questionnaire consisted of open-ended questions regarding why students have negative attitudes, as well as the effectiveness of communication skills teaching and assessment methods. Students were asked to provide suggestions on how the teaching of Communication Skills could be improved. In analyzing the data from the questionnaire the researchers also included their own observations made when teaching communication skills to Mbchb and BDS students.

**FINDINGS**

The study confirmed Rees, Sheard, and Mcpheeson (2002) findings that medical students had both positive and negative attitudes towards communication skills as it showed that MbchB and BDS students at the University of Zimbabwe had both negative and positive attitudes towards Communication Skills learning. Positive Attitude Scores (PAS) of students were higher for the 4th years (69%) followed by 2nd years (45%) and 1st years (40%). Negative Attitude Scores (NAS) of students were higher for the 1st years (60%), 2nd years (55%) and 4th years (30%). Female students and older students had a higher PAS amongst 1st years, 2nd years and 4th years compared to male students. Marital status and work experience seemed to influence attitude scores as married students and those who had prior working experience in a health institution seemed to have higher positive attitude scores than other students. Students who sat for the Advanced Level English Language and Communication Skills paper (ZIMSEC) or General Paper (CIE) at ‘A’ Level seemed to have a high Negative Attitude Score (NAS) as compared to students who had not sat for the paper.

The open-ended questionnaire revealed that 60% of the students were dissatisfied with the passive lecture based method of teaching. 20% of the students failed to relate the relevance of Communication Skills to their core medical subjects while 20% regarded the subject as time wasting and unchallenging believing it only demanded common sense. 59% reported that they did not prepare for lectures by reading about the subject in advance and more than 60% did not search for information to supplement teaching sessions. 30% agreed that they had difficulties following the lecturer and 40% also agreed they had difficulties taking notes in lectures. Interestingly, 15% did not know what they were expected to learn by the end of teaching sessions.
The majority of students especially, 1st years, considered themselves to be good communicators. This resulted in their being over confident about their abilities to communicate. The general resistance of students to Communication Skills learning manifested itself in high absenteeism and presumably, the development of passive learning habits which confirm the depressing and general belief amongst students that Communication Skills is ‘caught not taught’ and that Communication Skills classes interfere with medical classes.

Table 1: Demographic variables of students

<table>
<thead>
<tr>
<th></th>
<th>1st year</th>
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<th>2nd year</th>
<th></th>
<th>3rd year</th>
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<tr>
<td></td>
<td>MALES</td>
<td>FEMALES</td>
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<tr>
<td>Total Number of Students</td>
<td>70</td>
<td>30</td>
<td>78</td>
<td>22</td>
<td>75</td>
<td>25</td>
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<tr>
<td>Age – 18-20 years</td>
<td>20</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
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<tr>
<td>21-25 years</td>
<td>40</td>
<td>20</td>
<td>45</td>
<td>15</td>
<td>61</td>
<td>16</td>
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<tr>
<td>25-30 years</td>
<td>5</td>
<td>2</td>
<td>15</td>
<td>3</td>
<td>10</td>
<td>5</td>
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<tr>
<td>31 years and above</td>
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<td>3</td>
<td>15</td>
<td>2</td>
<td>4</td>
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<td>Marital Status – Single</td>
<td></td>
<td></td>
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<tr>
<td>Married</td>
<td>60</td>
<td>26</td>
<td>66</td>
<td>18</td>
<td>56</td>
<td>17</td>
</tr>
<tr>
<td>Divorced</td>
<td>8</td>
<td>3</td>
<td>10</td>
<td>4</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Previous work experience in a Health Institution</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>8</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Students who sat for ‘A’ level English Language and Communication Skills/ General Paper</td>
<td>58</td>
<td>21</td>
<td>49</td>
<td>18</td>
<td>61</td>
<td>17</td>
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</table>

**DISCUSSION OF RESULTS**

The CSAS revealed that University of Zimbabwe MbchB and BDS students have both negative and positive attitudes towards the learning of Communication Skills. Students’ year of study, sex, age and whether students sat for the ‘A’ level English Language and Communication skills paper seemed to influence students’ attributes.

**Year of Study**

The Positive Attitude Score (PAS) was higher amongst 4th years than that of 1st and 2nd year students who primarily deal with classroom lectures. 4th years would have spent more time interacting with actual patients and dealing with real as opposed to simulated patients in their 3rd and 4th years. The majority of the students seemed to appreciate the importance of effective Communication Skills as they regarded Communication Skills as being more relevant to their area of specialization. It is reasonable to assume that these differences in experiences would affect perceptions of the importance of Communication Skills learning and therefore reasonable to suggest that Communication Skills be taught before and after students would have been exposed to clinical settings.
Gender
In terms of gender differences, the finding that female medical students had more positive attitude scores (PAS) towards Communication Skills learning suggests that more efforts need to be made to emphasize the importance of Communication Skills to male students. This difference can also be attributed to the fact that female students seemed to be more proficient in the English language in which communication skills is taught. The researchers observed that female students performed better in class assignments and communication skills examinations. Female students were more willing to answer and ask questions in lectures than male students who seemed shy and were afraid of making grammatical mistakes. It seemed male students regarded it as acceptable for female students to make grammatical mistakes or to give wrong answers and unacceptable for male students to do the same.

Older students and those who had prior working experience also seemed to have a high PAS which the researchers attributed mainly to repeated exposure to the benefits of Communication Skills such as improved rate of patient recovery and job satisfaction. Such students seemed to use communication skills classes to link with communicative encounters during their working days. The researchers also observed that students who had previous experience in working in medical settings had a more positive attitude towards communication skills.

Students who sat for the ‘A’ level paper English Language and Communication Skills seemed to have a high Negative Attitude Score (NAS). This was attributed to misplaced over confidence in their abilities to communicate and the mistaken belief that relates the ability to speak fluent English to effective communication. Students occasionally referred to the fact that they had obtained a pass in O Level English hence they were good communicators and there was no need for them to study communication skills.

Institutional Attitudes
The second research questionnaire revealed that negative attitudes towards the learning of communication skills are related to lethargic institutional support. The majority of the students indicated that Communication skills lecturers were inaccessible making it difficult for them to consult on areas of difficulty. Lecturers of Communication Skills are housed in the Linguistics Unit and hence are treated as ‘outsiders’ or ‘foreigners’ by both medical students and staff in the Faculty of Medicine. This is compounded by the fact that offices for lecturers of communication skills are located in the Faculty of Arts far from where medical students have their lectures making the lecturers inaccessible to students. Inadequate time slots allocated to Communication Skills led many lecturers to rush through the course outline thereby making it difficult for students to grasp major concepts. For example MbchB and BDS First year students only have one communication skills slot on Friday 14:00pm to 16:15pm. Communication Skills lectures are slotted late in the afternoon when students are tired and according to the students this makes it difficult for them to concentrate. 10 % of the students indicated that they usually sleep in communication skills classes or will be studying for the other medical courses during communication skills lectures.

The large numbers of students for MbchB with an average of 200 students in a class makes lesson delivery difficult. The common lecture delivery methods for Communication Skills at the University of Zimbabwe are usually mass lectures focusing on subject content whereas Communication Skills lectures require a different approach. Focusing on the four language skills that make up the basis of Communication Skills such as Listening, Speaking, Reading and Writing, the exercises required to adequately cover these skills do not require mass lectures but a more Tutorial type of...
approach. However, given the number of students and time available, Communication Skills lecturers are forced to utilize teacher-centered lecture methods based mainly on content knowledge which does not develop transferable skills to students. Lecturers do not get a chance to interact individually with students or to attend to individual problems of students. In such mass lectures, lecturers tend to cover breadth instead of depth indicating that negative attitudes are also a result of how the subject is taught and assessed. Students are awarded a pass by obtaining an aggregate score of 50% in their assessments comprising of 70% examination and 30% coursework. The use of an aggregate score is designed more to distinguish among students than to assess students understanding of the fundamental concepts of Communication Skills, thus students tend to focus more on passing the examination than acquiring the requisite listening, speaking, reading and writing skills for academic as well as professional purposes.

**Time and time-tableing**

University of Zimbabwe medical students are also explicit in their time preference as they showed that Communication Skills is not a priority is their pre-clinical clerksmanship. For example, when students are to write a physiology test which follows after the Communication Skills lecture, the observation is that half the class does not attend the lesson, as they would rather prepare for the physiology test. Consciously or unconsciously, the attitudes of lecturers in the Faculty of Medicine also play a crucial role in “the growth, decay, and destruction of Communication Skills” as they unilaterally take over Communication Skills time slots. In many instances, students are forced to attend tutorials during Communication Skills lectures. It is thus evident that teaching Communication Skills in medicine is unique and not analogous to teaching other courses in the curriculum since medical students seem to place the acquisition of biomedical knowledge above and at times at odds with the learning of communication skills.

**Recommendations**

A Needs Analysis can be used to identity problems in the teaching of communication skills at the University of Zimbabwe. Students remain a valuable resource that should be utilized by curriculum planners to diagnose problems in course design and delivery. The findings of this study will help to design a Communication Skills course that meets the needs of University of Zimbabwe medical students. The teaching of Communication Skills at the University of Zimbabwe may be more effective if medical students are taught these skills when they are exposed to patients on a regular basis and the teaching should be maintained throughout the clinical years and after. This recommendation comes as a result of interaction with mature students who have already been exposed to situations in the field requiring academic and or professional communication skills as well as final year students who show a higher regard for Communication Skills.

**REFERENCES**


APPENDIX 1

Communication Skills Attitude Scale Questionnaire

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 for sessions on communication skills*
9. Learning communication skills has helped or will help facilitate my team-working skills
10. Learning communication skills has improved 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 by lecturers not from the Faculty of Medicine*
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*

*Items negative and the score is reversed

Anvik et al. BMC Medical Education 2007; 7:4