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# Satisfaction with a 2-day communication skills course culturally tailored for medical specialists in Qatar

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## Abstract:

**OBJECTIVE:** Health-care communication skills training may be particularly needed in the Arabian Gulf countries because of the variety of cultures within the physician and patient populations. This study describes the implementation and results of a communication skills training program for physicians in Qatar that assessed previous training, and effect of previous training on participants' course evaluations.

**MATERIALS AND METHODS:** We conducted a 2-day communication skills training course covering seven culturally adapted modules. Educational strategies included large and small group work with the standardized patient, demonstration videos, and lectures. At the end, participants completed a course evaluation survey. Data analysis performed with SPSS; frequencies and percentages were calculated, and Chi-square test applied to evaluate statistical significance.

**RESULTS:** A total of 410 physicians in Qatar have participated in the course over a period of 2 years. Evaluation ratings of the course were high. Participants rated the module on Breaking Bad News as the most useful, and the small group role-play as the most helpful course component. One-third of participants had previously participated in experiential communication skills training. There was no association between previous experience and evaluation of the course.

**CONCLUSION:** Physicians in Qatar positively evaluated a 2-day communication skills course, though the majority of participants did not have any previous exposure to experiential communication skills training.

## Keywords:

Communication skills, faculty development, medical education, physician-patient communication

## Introduction

Physician-patient communication is well recognized as an important component of good quality health care. Although much academic attention has been given to physician-patient communication and its improvement in the Western world, research on this topic has only recently begun in the Arabian Gulf countries. There is a growing interest in this part of the world in physician-patient communication, particularly in regards to the breaking of

bad news to a patient and family<sup>[1-3]</sup> and communicating with patients with diabetes.<sup>[4]</sup> The modest literature available suggests that physicians in the Arabian Gulf countries may benefit from some guidance on how best to communicate in a challenging culturally complex clinical environment. We are aware of only two such published communication skills training programs in this region. A 1-day workshop in Saudi Arabia for physicians, interns, and students received favorable reviews.<sup>[5]</sup> Educators in Oman published a 3-day curriculum for communication skills training, but no results were given.<sup>[6]</sup>

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Health-care communication is often influenced by both culture and religion. Salem and Salem<sup>[3]</sup> broadly generalized some of the beliefs and expectations about the delivery of bad news as illustrations of the differences between Eastern and Western cultures. They categorized these differences as health-care decisions; patient's perspective of bad news; the family's involvement in decision - making for a patient's illness. Further, they assert that in Muslim cultures, there is concern that a patient's knowledge of his illness will have a psychological impact leading to low self-esteem, in contrast to Western belief that patients have the right to be given the news whatever it is to make better decisions about their care. Finally, the illness experience is seen as a family event in Arabic and Muslim cultures, rather than a personal event as viewed in the West. It should be noted that these are broad generalizations that may not apply to all Muslim countries. Nevertheless, the multicultural makeup of some Arabian Gulf countries, although enriching, creates challenges in health-care communication.

Several factors led to the development and implementation of the training course being reported here. Hamad Medical Corporation (HMC) in Doha, Qatar, has been accredited by both the Accreditation Council for Graduate Medical Education-International and the Joint Commission International, leading to increased accountability for the quality of care, education, and patient safety. A previous study in Qatar found that the perceived quality of communication between doctor and patient was related to patient satisfaction.<sup>[7]</sup> In addition, published research demonstrates that people with different cultural backgrounds outside the mainstream of society generally have less access to health care and worse health-care outcomes.<sup>[8]</sup> It has also been shown that poor communication is the root cause of malpractice claims.<sup>[9]</sup>

Since March 2014, practicing HMC physician specialists applying for promotion to consultant positions (attending faculty) are required to take a communication skills course. The title "specialist" as used in our hospital typically refers to physicians who have completed a residency program followed by board certification, but who do not practice as completely independent consultants or attending physicians. The course prepares these physicians to assume important educational roles as faculty, and improve their delivery of healthcare. The restructuring of physicians' appointments at HMC as part of the recognition into an academic health system led to many such promotions. Thus, we had a ready pool of interested participants.

The objective of this paper is to describe the implementation of and participants' satisfaction with a

large-scale communication skills training program for specialists in Qatar. In addition, we posed the following research questions:

- What percentage of course participants had previously participated in communication skills training?
- Did previous participation in a communication skills training had any impact on the satisfaction with the current course?

## Materials and Methods

Participants were predominantly specialist physicians at HMC, a nonprofit public health-care system which provides health-care services throughout Qatar. HMC manages eight public hospitals and other health-care services and employs more than 23,000 people. Physicians are of many different nationalities, speak different languages, and had often attended medical school and/or had residency training outside of Qatar. At the time we began the program, there were approximately 1150 physicians who were specialists. The present study was approved by our Institutional Review Board.

We partnered with the Communication Skills Training and Research Laboratory at Memorial Sloan-Kettering Cancer Center (MSKCC, New York, USA) to run a communication skills training program culturally tailored for our institution. The program developed at MSKCC, the Comskil model,<sup>[10]</sup> describes a theory-based, hierarchical structure of health-care communication skills. There are other basic models that focus on the structure of a diagnostic visit.<sup>[11]</sup> While these are very useful for early learners such as medical students, they appeared too basic for more advanced learners. For the teaching of practicing physicians, we felt it necessary to have a model that was flexible for many types of medical consultations and allowed for a more learner-centered approach, based on the learners' strengths. The Comskil model met these needs. In addition, the skills-based Comskil model allowed for discipline and cultural adjustments.

The program comprised seven modules to be given on two consecutive days: breaking bad news, shared decision-making, responding to patient anger, working with interpreters, discussing prognosis, discussing end of life goals of care, and conducting a family meeting. The methods of teaching followed international best practice and mirrored the approach taken at MSKCC.<sup>[12,13]</sup> Each module began with a didactic presentation that reviewed relevant studies and explained suggested techniques and skills for that particular module, including demonstration trigger videos for a large group discussion. Four of the seven modules included

facilitator-led small group role-play sessions with trained standardized patients (SPs). The other three modules used large-group role-play sessions.

Role-play facilitators were healthcare physicians or other providers who had previously completed the course and had been identified as having an interest in becoming facilitators. Those who participated in this study attended a training course.<sup>[13]</sup> To keep their appointment, facilitators were required to participate twice during each academic year and attend one refresher course. There are 49 active facilitators at present. SPs are nurses who volunteered to participate in the program and completed a training course in January 2015.

Although we kept the core of the MSKCC Comskil curriculum, in terms of educational approach and the skills-based curriculum, changes were made in the modules to meet local and cultural needs. The names and patient backgrounds in the role-play scenarios were changed to be more consistent with those seen in our country. Locally used metaphors and terminology were employed. Studies from regional and culturally similar countries and information about hospital policies to the didactic sessions for topics such as breaking bad news and end of life discussion were added. We have also developed new local videos for some modules that show our own doctors meeting with simulated patients. We significantly changed the focus of two of the modules, to be better tailored culturally to our population. The module on “conducting a Family Meeting” was changed to place emphasis on how to respond to the historically cultural practice of families asking doctors to withhold the disclosure of life-threatening disease to patients and place strong emphasis on the role of the family from the Arab and Islamic perspectives. The module on “Working with Interpreters” was also changed to focus on working with untrained interpreters, as there is no department of trained interpreters. Finally, a variety of role-play scenarios were developed to meet different needs of the various disciplines: pediatrics, obstetrics and gynecology (OBGYN), medicine, critical care, surgery, and cancer. Because each small group was interdisciplinary, the facilitators had to guide the selection of a role-play that was available, or developed a new one within the group.

A 17-item online survey with Qualtrics survey software was sent to the physicians after the training. Three reminders were sent in a period of 10 days following the initial survey E-mail. Evaluation items included an overall 5-point scale rating of satisfaction (very dissatisfied-very satisfied); rating of how much the components of the training (e.g., presentation, role-play) helped improve communication skills using a 4-point

scale rating of the usefulness of the individual modules again on a 4-point scale. There were also open-ended questions on the strengths and weaknesses of the workshop. In addition, physicians were asked if they had ever participated in a communication skills training workshop that included role-play. Question was specifically asked about role-play as an indicator of experiential learning, which is widely accepted as the most critical part of communication skills training.<sup>[14]</sup>

Data were transferred from Qualtrics software (Provo, UT, USA) into SPSS version 22 (Armonk, NY, USA: IBM Corp) for analysis; frequencies and percentages were calculated, and statistical significance was tested using Chi-square test. To examine the role of previous experience on the ratings, dichotomous variables were created for satisfaction (very satisfied and satisfied vs. other), helpfulness of components (none/little vs. some/a lot), and usefulness of individual modules (completely useless/useless vs. useful/very useful). Because the number of participants who gave low ratings was small, a second set of dichotomous variables was created to split the highest ratings (very satisfied, a lot, and very useful) from the rest.

## Results

The 2-day course was offered 15 times from March 2014 to January 2016. It was attended by 410 physicians, 326 of whom completed the course evaluation yielding an 80% response rate. These physicians came from 26 departments, and the number of participants per course ranged from 21 to 39 (Average = 27.33).

Overall, participants were satisfied with the 2-day course, with 39.2% of the doctors responding very satisfied and 48.8% of doctors responding satisfied. As shown in Table 1, all modules received a high rating for usefulness. The module of Breaking Bad News received the highest combined ratings of useful and very useful. Participants found the small group role-play the most helpful component of the course for improving their communication skills, with 20% reporting “some” and 77% marking “a lot” [Table 2].

The most frequent response to the open-ended question on what was found the most useful was role-play, (27%). However, the majority (57%) of respondents answered this question by referring to a module topic, and “Breaking Bad News” was the most frequently quoted. These answers reinforce the ratings shown in Tables 1 and 2. Answers to the question on the improvement of the workshop were diverse, with suggestions on timing, length of course, logistics, role-play scenarios, videos, and having it more tailored to specific disciplines. Participants most frequently suggested the following

**Table 1: Physicians' ratings of usefulness of modules for their communication with patients**

Module	Useless and very useless		Useful and very useful		
	Very useless	Useless	Useful	Very useful	Useful + very useful
	%	%	%	%	%
Breaking bad news	0.0	0.9	46.1	53.0	99.1
Shared treatment decision making	0.3	1.3	42.3	56.2	98.5
Responding to patient anger	0.0	1.9	43.8	54.3	98.1
Discussing prognosis	0.3	1.6	46.8	51.3	98.1
Working with the untrained interpreter	0.3	4.4	46.2	49.1	95.3
Discussing death, dying and end-of-life goals of care	0.6	5.1	46.5	47.8	94.3
Conducting a family meeting	1.6	4.1	45.9	48.4	94.3

**Table 2: Physicians' ratings of helpfulness of components of communication skills workshop for improving communication skills**

Module	None or little		Some or A lot		
	None	A little	Some	A lot	Some + A lot
	%	%	%	%	%
Small group role-play	0.9	2.5	19.9	76.6	96.5
Videos during presentations	0.6	5.3	30.1	64.0	94.1
Didactic presentations	0.6	6.6	47.5	45.3	92.8
Large group role-play	0.9	7.8	40.6	50.6	91.2
Packet of course materials	2.2	14.0	43.5	40.3	83.8

topics for future workshops: Communication with other health-care staff, medical errors, adverse events, and requesting consent, as well as topics on specific specialties (e.g., communicating with parents of a young child).

One-third (33.3%) of the physicians reported that they had previous experience of communication skills workshops that included role-play. There were no differences between those with previous experience and those without, on any of the dichotomous ratings of satisfaction, helpfulness of course components, and usefulness of the modules.

## Discussion

Improving health-care communication is an important undertaking, particularly in Arab and Muslim countries of the Arabian Gulf region, where multi-cultural influences are at play. Overall, the doctors who participated in our training program reported that they were very satisfied and gave high ratings for the elements and modules of the course. They reported that the experience of role-play was the most useful for improving their own communication skills and that the module on breaking the bad news was the most helpful. These ratings were supported by respondents' answers to an open-ended question. Participants in a course implemented in Saudi Arabia also reported that role-play was a major strength of the workshop.<sup>[5]</sup> Although others have questioned whether "Western" approaches to education such as role-play work in non-Western countries,<sup>[6]</sup> our results, as well as those from the Saudi Arabian study, indicate

that experiential role-play could have cross-cultural effectiveness.

Communication skills training has not historically been part of medical education in this region, and some other regions where our doctors were trained. This is supported by the fact that two-thirds of the doctors who attended our course had never been on an experiential communication skills training course, though it is possible that they had participated in lectures or discussions related to communication in healthcare. It is interesting that previous experience with communication skills training was not associated with satisfaction with the course or evaluations of it. It may be that previous training was so varied in content, format, and had taken place so long ago that it did not impact the evaluations of this course in any systematic way.

Our experience may serve as a model for utilizing external expertise to initially implement a communication skills training program and subsequently build the capacity to sustain the program using only local resources. However, there are challenges to such a model. Transferring a western health-care communication curriculum into a multicultural Muslim Arab culture is not the easiest thing to do.<sup>[6]</sup> For instance, the cultural practice in some cases is to disclose the diagnosis of cancer or any life-threatening disease for that matter to the family but not to the patient.<sup>[3,15]</sup> Despite the hospital policy on patients' rights to information, the reality is that information is rather disclosed to families and withheld from patients. The module on breaking the bad news that does not take this into account is thus not culturally-sensitive.



Another example is the module on communicating with patients using interpreters. This assumes a healthcare system that has a professional interpreter program. The rapid demographic changes in Qatar, as well as the numerous languages, in excess of 40, spoken by the patient population, are barriers to such a program. Consequently, we adapted the module to suit working with untrained interpreters.

To make the program more applicable in Qatar, we initially adjusted the role-play scenarios to the local culture by changing the names and background characteristics of the patients. However, the didactic presentations cited Western studies and the physicians and patients acting in the exemplary videos were primarily Caucasian. In addition, the initial program was focused on cancer only, but since our groups were multidisciplinary we have eventually modified the presentations and created some videos of our own. However, more improvements are required. Creating videos with a local flavor seems to be a particularly important part of tailoring the curriculum to fit our cultural milieu.<sup>[5]</sup>

Building and retaining a core of dedicated and skilled instructors and facilitators also takes time. This has been the objective of our train-the-trainer courses, monthly e-newsletters, and refresher courses. We will continue to put resources into keeping our teaching faculty skilled and enthusiastic as participants, as the program is only good as long as there is continued engagement in teaching and interest as facilitators. Teaching new consultants as well as keeping a strong cadre of skilled instructors may also contribute positively to counteracting the "hidden curriculum," the implicit learning that happens outside the classroom, usually through the transmission of cultural norms and role modeling.<sup>[16]</sup> As trainees interact with the faculty who have participated in the workshop, it is our hope that they will increasingly become aware of models of good communication skills and patient-centered care.

Another consideration when organizing such large scale communication skills training programs is whether to teach the course using a multidisciplinary approach, as we have done, or focus on specific disciplines such as OBGYN<sup>[17]</sup> or cancer.<sup>[18]</sup> There are pros and cons to each approach. From a logistical standpoint, it may be more feasible to have participants from different departments come on the same day so that patient care is not unduly affected. In addition, participants seemed to genuinely appreciate meeting and learning from each other, although physicians reported that they would like to have more discipline-specific videos and role plays.

Limitations of this study include the lack of evidence of skills transfer to real encounters with patients. With diverse group of trainees from several hospitals, such a study would have been extremely difficult. Nevertheless, it is a limitation. Since the survey did not sought any demographic information, it is impossible to look for associations with gender, years of experience, etc. A further limitation is our inability to triangulate our data with precourse evaluation data, which was not collected.

Our future work includes continuing to fine-tune the implementation and curriculum of our program. We also would like to expand our module topics to include some of the challenging scenarios that the participants mentioned in their course evaluations. These include consent, discussion of adverse events, and communication with other health-care providers. Finding a feasible and effective way to measure the impact of the course on actual practice is also a priority.

## Conclusion

The result of the evaluation of this program conducted over a 2-year period shows that the communication skills training course was well accepted and was effective in helping our physicians learn new communication skills. As this program progresses, we hope to make a substantial and sustainable difference in the quality of care through improved communication skills.

Educators in non-Western countries may find that initially using Western-developed communication skills training programs with some cultural modifications may be feasible and acceptable. Role-play, in particular, seems to be an acceptable valuable teaching strategy.

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## Conflicts of interest

There are no conflicts of interest.

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