Management of doctor-patient relationship by teaching communication skills to resident doctors in Maharashtra

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Submitted By

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Under The Guidance of

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March 2019

CERTIFICATE OF THE SUPERVISOR

It is certified that the thesis entitled **"Management of doctor-patient relationship by teaching communication skills to resident doctors in Maharashtra"** which being submitted herewith for the award of the **Degree of Doctor of Philosophy (Ph.D.)** in the subject Management of **Tilak Maharashtra Vidyapeeth, Pune** is the result of original research work completed by **Dr. Kalidas Dattatraya Chavan** under my supervision and guidance.

To the best of my knowledge and belief the work incorporated in this thesis has not formed the thesis for the award of any Degree or similar title of this or any other University or examining body upon him.

Place: Pune **Dr. Deepak J. Tilak**

Date: 06 March 2019 **Signature of the Research Guide**

UNDERTAKING

I hereby declare that the thesis entitled **"Management of doctor-patient relationship by teaching communication skills to resident doctors in Maharashtra"** completed and written by me has not previously been formed as the thesis for the award of any Degree or other similar title upon me of this or any other University or examining body.

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LIST OF ABBREVIATIONS

%	:	Percentage
A	:	Agree
DA	:	Disagree
FFMQ	:	Five Facet Mindfulness Questionnaire
Freq.	:	Frequency
Govt.	:	Government
ICU	:	Intensive Care Unit
JAMA	:	Journal of the American Medical Association
LSCS	:	Lower Segment Caesarean Section
MEDS	:	Medical Education Designed for Seniors
No.	:	Number
OPD	:	Out Patient Department
OSCE	:	Objective Structured Clinical Examination
PG	:	Post Graduate
PSU	:	Primary Sampling Unit
SA	:	Strongly agree
SD	:	Strongly disagree
SD	:	Standard Deviation
SPSS	:	Statistical Package for the Social Science
Sr.	:	Serial
SSU	:	Secondary Sampling Unit
U	:	Uncertain
US	:	United States
UTI	:	Urinary Tract Infection
WHO	:	World Health Organization

Chapter I: Introduction

1.1. Introduction.

''Medicine is an art whose magic and creative ability have long been recognized as residing in the interpersonal aspects of patient-physician relationship'' [1]

The foundation of a quality healthcare service is the patients' "trust" in the healthcare, which is nurtured by the doctor patient relationship. Along with the proper medical knowledge and competent skillset, a doctor duly needs to demonstrate humanity, healthy behaviour, as well as sensible communication with patients which can build the sustainable 'trust' in the treatment offered by that doctor. The current medical education is enormously focused on providing competent medical knowledge in the anticipation of making competent doctors. Competencies focused on developing empathy in graduating doctors is required in medical education but those are not observed evident in the current scenario. The curricular learning of practical skills is offered up to an extent of fulfilment of academic competencies. The focus of training has been the intellectual development of the trainee and very little importance has been given to the development of emotional intelligence of the trainee. Very little emphasis has been to given to teach, grade, learn, develop, and demonstrate the appropriate attitude, behaviour and communication before graduation. Although the medical education did recently start emphasizing on the significance of doctor- patient communication and did start incorporating teaching of communication skills in many undergraduate and postgraduate programmes, still it is in its infancy in India. [2]

Over the years, the focus on providing holistic healthcare is thinning among medical students. Whether the students are the undergraduate students or the interns, junior or the senior resident doctors, their life has become busy and stressful which has influenced their lifestyle and thought process. Medical education has not been instrumental in initiating, endorsing and developing sensible attitude and conducive approach towards their patients. Unhealthy eating habits, lack of nourishing food, sleep, rest, overwhelming curricular workload and clinical workload due to the huge number of patient's intake incurring the paucity of per patient time, made it next to impossible to learn communication skills without any formal training. The trainees need to develop mindfulness, which will help them to focus on the present moment

and make them aware of the happenings around them. If this happens, they will be able to become attentive and thereby, their ability to grasp good skills will improve. Mindfulness will help the trainees to get involved in their work. This will help them to look at their patients in a holistic manner and refrain them from considering the patient just merely as the subject of treatment and an object of their academic learning. Mindfulness will help in creating awareness as well as acceptance of their current situation. The recognition of the importance of doctor patient relationship and communication skills in medicine has a reverberant relevance with the discipline of primary care physician. This discipline has long focused on the significance of the doctor patient relationship intrinsic to the optimum quality of health care delivery. [3]

The trainee doctors don't get a chance to learn and implement the communication skills required in the doctor patient relationship. Most of the patients coming to the government setup are not very demanding and may accept the minimal communication as long as they get their required treatment. Majority of the patients will speak the local language. Therefore, the trainee doctors don't require to enforce any other language other than the local language to converse in non-medical context with this category of patients. This continues throughout their training. This may lead to poor demonstration of empathy towards the patients and this leads to a major rift between the doctors and the patients. Apart from improper communication skills, some doctors may lack the practical skills also. Any of the above can hamper the confidence level of the developing doctor. Lack of confidence of the doctor may result in to an unacceptable behaviour with the patient by that doctor which may be perceived by the patient as an arrogance of that doctor. The scenario in the private setup is way different than this.

The access to information in recent times has become very easy. The patients come to a doctor with a lot of knowledge gained mainly from the internet. [4] They are able to verify the treatment process undertaken by the doctors and are prepared to question the doctor. Most patients are aware about certain unethical practices prevalent in the medical profession. Media has recently highlighted many incidents when patients have suffered at the hands of the doctors. This kind of regular news coverage has fuelled anger against the medical profession. Unfortunately, Even the ethical and professionally acclaimed doctors, have to face the undue anger of the society. When patients come to the doctors in a state of mistrust and anger, any lack

of communication does the job of adding fuel to the fire. [5] This can lead to an undue misunderstanding. The actual physical violence or attack is just the tip of the iceberg. The growing unhappiness and mistrust among the patients and relatives against the doctors and entire health care system is the major problem. In order to avoid the violence and litigations, the main aim and focus should be to develop trust and respect with the patients. Patients want doctors who treat them using their medical knowledge and skills as well as communicate with them effectively and ethically. [6]

Doctor plays a pivotal role in the health care sector. Interpersonal communication forms the backbone of the doctor patient relationship which in turn is important for desirable outcomes in healthcare delivery systems. Proper patient care and treatment despite utmost dedication and sincerity at times does not deliver a healthy patient at the end of the day. Undesirable and unpredictable outcomes like death on table, drug reactions and numerous other surgical and medical complications at times turn the serene environment in the corridors of health-care institutions into a battle field. Manhandling of doctors and healthcare staff by the agitated relatives of the patients have been on the rise.

The way in which a physician communicates information to a patient is equally important to that of the treatment patient is receiving. Patients who receive the proper information with proper communication, understands their doctors and are more likely to acknowledge health problems, understand their treatment options, modify their behaviour accordingly and follow their medication schedules. Various researchers have shown that effective patient-physician communication can improve a patient's health as equal to the drugs. In the past decade the physicians were good in communicating the information and treatment with soft skills in their rounds, which was beneficial to the students as well as they were learning all these skills along the bed side. In recent times, the communication and interpersonal skills of the physician-in-training are no longer viewed as immutable personal styles that emerge during residency, instead, they are viewed as a set of measurable and modifiable behaviours that can evolve.

Learning by observing the preceptor on site can be another way pertinent for the trainees to learn communication skills. If they do not get a good role model to learn communication, they are left to themselves to learn this vital skill. Many seniors are even sceptical currently about the role of communication skills in the

current medical practice. It is therefore very important for these skills to be taught in a standardised and uniform manner. Medical students and postgraduates are increasingly given instruction on techniques for listening, explaining, questioning, counselling, and motivating based on emerging literature on the value of effective communication. Since such techniques are central to delivering a full and tailored health prescription, 65% of medical schools now teach communications skills. [7]

In the present scenario of heath care, one of the worrisome facts is that the doctor patient relationship has reached at a low level, resulting in increased assaults on doctors and increased litigations against doctors by patients / relatives. Although the communication gap in explaining the Clinical entity to Patients / Relatives is emerging as major reason in worsening of this scenario, it could be certainly preventable. Proper and timely management of communication between Doctor and Patient/ Relatives may improve the situation. Resident doctors may have certain peculiar difficulties in effectively communicating with patients. They often find it difficult to explain the medical terminologies to patients. Doctors receive their training in English, discuss patient-related issues with their seniors in English but are expected to converse in one of the several regional languages while discussing with laypersons. As per the current system, trainees travel to other states for their training. In some cases, they have no knowledge of the local language. In this case, there are high chances of miscommunication, especially in sensitive clinical situations. This may also affect the involvement of the trainees in the daily patient matters. The trainees may also be focussing on their career goals, thereby, making them concentrate on their examinations. They may wish to just complete their training and return to their hometowns. This approach may be perceived by the patients in the body language of the trainees. There is a need to develop immense motivation amongst the trainees at the start of their career. When resident doctors communicate with patients, their message is loaded with information about biomedical issues but fell short on psychological support. It is possible that inappropriate interaction could result in missed communication, misinterpretation and may lead to conflicts. The same pattern of communication with an overload of medical jargon/ biomedical information is seen in conversations that resident doctors carry out with their professional colleagues. Another significant impact of inadequate communication could be in resident doctors losing confidence at an initial stage of their training, due

to lack of knowledge about it and the paucity of skills to implement specific communication strategies that they have to routinely use in their encounters with patients as well as colleagues.

Improving communication skills for residents is a challenge for all residency programs in the country. Addressing this improvement can have many beneficial effects including improved patient outcomes and high level of confidence that residents can acquire as capable physicians and surgeons. In order to make the resident more effective in communication skills, the residency programs must establish learning goals and expected outcomes to incorporate communication skills in postgraduate medical training. Accomplishment of better communication skills can be attained, if the importance of its teaching and training to residents is valued by residency program co-ordinators, and infrastructure is provided to foster an understanding of the patient's needs and social environment directly into patient care. These efforts to improve and measure communication skills are timely, as the barriers to effective communication between patients and physicians are growing. These barriers include patient anger and mistrust on doctors, language, lack of mindfulness, lack of emotional intelligence, high patient expectations, and availability of knowledge via internet and so on. Although there are evidences, still the average length of the patient-physician encounter has not improved in recent years. [8] Training needs to be offered at all stages of the medical career. This should begin at the start of the undergraduate training, followed by another module at the internship and finally at the start of the postgraduate studies. This can be structured to increase the complexity of the skills as the trainee progresses in the training. Postgraduate trainees without any formal training in communication skills may be less receptive to learn at a late stage of their life. Even then, majority take keen interest and the feedback from all trainees has been very encouraging. Majority of the trainees are convinced that this training must be a part of their postgraduate syllabus. This positive approach from the trainees makes us believe that a change is possible.

Therefore, the ideas and principles for incorporating communication skills in the practice should be taught to resident doctors to empower their perspective of vigilantly nurturing the doctor patient relationship in healthcare. The humanity, acts of love, altruism, and social intelligence are typically individual strengths while these need a fair and channelized implementation. An authority in the clinical interpersonal

and overall communication skills needs to teach and demonstrate these skills to the resident doctors first to enhance the hands-on learning process of resident doctors. There is an urgent need to manage the interpersonal relationship between the doctor and the patient. In my opinion, this can be best done by improving communication skills in the doctors. Resident doctors have a significant responsibility of managing a large number of patients. Teaching communication skills to resident doctors of Maharashtra will influence a very large patient population. For these reasons, the title "Management of Doctor-Patient Relationship by Teaching Communication Skills to Resident Doctors in Maharashtra," is assigned for my research project.

This study is focused on the requirement of teaching communication skills to the resident doctors for the management of doctor patient relationship with the special emphasis on the residential doctors in Maharashtra state since it has a potential to set an example by pioneering this venture. It is well known that, by all economic parameters, Maharashtra is the wealthiest state and the most industrialized state in India. This state has its own mark with respect to its rapid progress in a short time frame since establishment and range of population, geographical location, area, economy and cultural diversity. Being the richest state in India, Maharashtra has been the nation's most populous state as well as stands in the third position in terms of the total area.

1.2 Need for Enquiry and Research into Doctor Patient Communication- The Problem Statement

The health system in the country has changed drastically over the past few decades and it is also experiencing a shift in the way that the healthcare is delivered by the institution. Earlier, the doctors made house calls to treat the patients but now a days, doctors have become part of a managed care medical group and patients attend the hospital and seek the treatment in a brief visit. The way doctors and patients interact with each other is the major change seen in the current health care system. In the past, doctors use to withheld the medical information from the patients because, according to them it is in the interest of patient to not to know the information which is medically wrong. [9] The relationship began with an imbalance as the doctor being considered the expert and the patient being considered in need. That is the reason why doctor held more power and prestige than the patients and the patient was expected to passively follow the doctors. [10]

Occupational prestige of medical professionals particularly doctors is well documented by several studies. Physicians are constantly ranking at the top of occupational prestige. [11, 12] Our society is experiencing the power differentials between patients and doctors. [9] When the patients and doctors communicate in medical encounter, the power differentials are displayed through the traditional passive patient and the dominant paternalistic physicians [13] but, with the current healthcare climate, the traditional roles of doctor and patient have become inconsistent. The new roles have emerged and are comprised of engaged patients and supportive physicians [14], which the traditional model of paternalism was not affording. When it comes to development of doctor patient relationship, doctor patient communication during the medical encounter becomes an essential aspect. [15]

Communication is fundamental to the physician-patient relationship. Currently, poor communication is a significant problem affecting the medical profession. The Royal College of Physicians and Surgeons Can MEDS 2000 project recognizes that communication is essential to the provision of "humane, high quality care" by specialists. [16] Unfortunately, even a quick perusal of the literature reveals that physicians lack training and knowledge in how to communicate news effectively, and deal with the emotional response to such news. Even more concerning, studies show that communication skills do not improve and may even worsen in the course of training due to the perceived lack of value in effectively communicating on the part of more senior physicians, the lack of good role models and physical and emotional fatigue. [17]

When a person is diagnosed with a serious or life-threatening illness and is nearing the end of life, a sensible communication is crucial to convey the seriousness of the illness (as difficult and sad a task as this may be), the expected course and treatment alternatives including palliative care. Only through good communication can physicians convey their caring and empathy for dying patients and provide good quality end-of-life care. To focus the problem statement, it can be emphasized that deterioration of doctors' communication skills, nondisclosure of information, doctors' avoidance behaviour and resistance by patients are the major hindering factors for doctor patient communication. [18]

Over centuries, human lifestyle has changed drastically, especially so in the past few decades. This had led to increased stress and exhaustion. Due to this, the

need to communicate with others has increased a lot. These skills were never taught objectively in the past. Communication skills were considered subjective in nature. In recent times, it is felt that there can be an objective way to teach communication. There is a science involved in communication and this can have a structured approach to training as with other aspects of medical science. The science of emotional management, which plays a significant role in developing a good doctor-patient relationship, is also better understood. It is also felt that these skills can be retained over a period. There is no concrete evidence to suggest that training in communication skills can help in improving these skills.

Teaching communication skills in Residency program should set measurable outcomes for their skills development. Resident doctors come from different backgrounds, which can influence their receptivity and ability to learn these skills. This research involved a correlation of their personal, educational, family and other demographic background with their communication skills development.

The first step in developing these skills amongst resident doctors would include sensitizing them to learn these skills. At the same time, trainers will have to be prepared to activate the training program. If we have evidence to prove that the intervention in the form of training helps to improve the skills, then the training program can be developed at an organizational level. If this gets wide acceptance, there is a potential to include this in the syllabus. The next task should be to develop the assessment system in order to grade the skills. This whole process would be enhanced if evidence proves that these skills can be imparted to trainees. If the data at the level of resident doctors is supportive of training in communication skills, it would be clear that the training at the level of the undergraduate level would be even more effective.

Caring and painstaking communication of the doctor with the patient is a need of healthcare system today, which can be accomplished effectively by teaching the resident doctors in Maharashtra which has a great history with the demonstration of high-spirited evolution. Hope this project instigates the medical education to initiate such programs in Maharashtra for the medical students and resident doctors.

1.3 Aim and Objectives

1.3.1 Aim:

To improve the communication skills of the resident doctors for management of doctor patient relationship.

1.3.2 Objectives:

i. To design and implement intervention training module on communication skills to improve doctor patient relationship.
ii. To appraise the current status of knowledge regarding doctor-patient relationship amongst residents.
iii. To assess the perception of residents of Maharashtra about communication skills during healthcare.
iv. To examine and elucidate the efficacy of the intervention training module to improve the communication skills and doctor-patient relationship.

Chapter II: Review of Literature

The literature review was conducted in order to understand the concepts and various terms related to the research topic. This section enumerates the references those are supportive to various concepts and discussions used in this thesis and intends to unfold the meaning of each term to elaborate its reference to context. Some terms are considered with the understanding of the individual term with the reference of same term when it is used with any other term in the context of understanding this topic.

2.1 Importance of Communication Skills in Health Care.

Health Care is basically perceived as an organized provision of medical care to both individuals and society. At global level, this generic understanding of medical profession has been a focus of the graduation outcomes of the medical education. The healthcare has been a demand of mankind since his evolution. The increasing need manifested higher expectations from the healthcare system as well as from the healthcare providers. The way a doctor passes the information or communicates with patient is as important as the information itself. Communication skills are important because poor communication hinders the work and causes a lot of misunderstanding. The ability to communicate effectively and sensitively is the central dogma to all medical activities. [19] Doctor-patient communication doesn't always mean just the extraction of the patient history. Doctors have to attend to the needs, fears and concerns of the patients during consultation and take the patient as a whole. Doctors have to adopt a patient centric attitude. [20]

The patient's entire behavior towards a health is dependent on how he or she receives the communication. Patients, who are communicated better, are more likely to acknowledge health problems, understand their treatment options, modify their behavior accordingly and follow their medication schedules. It has been well established that, effective doctor patient communication can improve patient's health as quantifiable as many drugs. [21]

The phenomenon of Communication with patients during history taking, yet less often addressed in medical curriculum is revealed in Twelve Tips of Better Communication by Rahaman A and Tasnim S. [22] They also have focused on aspect

of proper communication with the patients is an important skill for the medical practice.

Overall health outcome in the form of quality medical care depends on effective communication between the patients and the doctors. Misunderstanding can occur at any stage of the medical field practice in any setting, but can be further aggravated by lack of compliance by patients, dissatisfaction, and negative health outcome and increase risk of malpractices. The poor communication skill and the weak support from the hospital management was another biomedical perspective of health. Communication between doctor and patient is not regarded as serious as the treatment part. The low awareness levels of patients and the work pressure from the doctors are the reasons involving both parties to become equally responsible. [23]

While looking at the entire process of health care, doctor patient communication stands as a major component. A well guided and effective process of doctor and patient communication can be a source of motivation, incentive, reassurance, and support. It also can increase the satisfaction towards job, patient's self-confidence, motivation and positive view of their health status, which ultimately influence the overall health outcome. Doctors with better communication and interpersonal skills can prevent the medical crises and the expensive interventions. It also helps to detect the problems earlier. This always helps to reduce the cost of health care, provide better support to the patients, gives high quality outcomes etc. There is a greater expectation of the collaborative decision-making by both doctors and patients to achieve common agreed goals and attain the quality of life. [18]

2.2 Rising Violence against Doctors:

Until recently, doctors and their patients enjoyed a good relationship on the basis of mutual love, respect and trust. For various reasons, this relationship has deteriorated, to the extent that there have been many instances of violence against doctors. Patient's relatives have attacked the treating doctors when there was health deterioration, loss of life or a financial disagreement and so on. These incidents involved the private practitioners as well as the resident doctors in training. [24]

A survey conducted at Maulana Azad Medical College, Delhi revealed that almost one in two doctors had suffered from violence at Public hospitals. This survey was conducted on 169 junior and senior resident doctors working at the Lok Nayak

and the G B Pant Hospital. Almost 75% faced verbal abuse, 51% were threatened and about 12% faced actual physical violence. [25] The trend of increased violence against healthcare workers is not limited to India. It is a phenomenon seen in various other countries also. In 2006, China experienced violent attacks on 5500 healthcare workers, while this number increased to 17000 in 2010. [26]

2.3 Being a Mindful Doctor

2.3.1 A Doctor's life (Being Mindful):

The occupational hazards such as anxiety, depression, substance abuse etc. have been largely focused by the researchers during the investigations of clinician's stress and burnout. [27-29] In order to overcome the challenges like this, mindful practice has been proposed which is expected to reduce stress and burnout among health care professionals through a number of pathways linked to the tenets underlying the philosophy of practice. [30]

The doctor needs to perform with due diligence which needs a particular ability for imparting or exchanging of information or news which can bring in the confidence about the healthcare, the doctor and this relationship as well. Interactions in and about personal and intimate issues, involvement of emotion with the question of life and death, patient to patient variability of diseases and conditions, needs, expectations, facility and unpredictable upcoming situations can make nature of this relationship "unpredictable" and "sensitive". The elegance of this relationship literally points out the requirement of perpetual and successful dealing and controlling; a respectful management. Thus, the medical profession is quite demanding in terms of the physical and mental commitment that is expected from the doctor. It is utmost required for the doctor to maintain a good physical and mental well-being which can enable them to perform at the optimum standard. This should persistently percolate the due respect, maturity and mindful understanding for each patient, all the time, in all the circumstances. The optimum level of attention and efficiency is expected, so that the manual error of a doctor should not lead to any undue impacts on the health of the patient. The individual features of mindfulness, communication and the affect have been shown to have an effect on the quality of care and the safety. [31]

The presence of mind of the doctor has a direct impact on the decisions regarding patient's healthcare. In some situations, the outcomes may be unfavorable,

in spite of all the best possible care given to the patients. These sudden unexpected outcomes are not always under human control. The high intensity of work experienced consistently by doctors, conflicting time demands and heavy professional responsibility in systems where physical and social resources are deficient always stands as threat of medicolegal action. [32] In such times, the doctor-patient relation can get strained. These factors can lead to stress, anxiety and a feeling of burnout over a period of time.

The concept of being mindful is gaining an extensive acceptance and popularity, especially in the medical world. Being a mindful doctor is a prime need of medical profession. Mindfulness is defined as a psychological process in which attention is focused on living in the current moment. Jon Kabat - Zinndrawing on his long experience and many studies at the University of Massachusetts Medical School in Worcester, described mindfulness as the practice of moment-to-moment, open-hearted awareness, focused in the present moment.[33]

The advantages of mindfulness include, relaxation, improved concentration, less distraction, better psychological state, better compassion and empathetic behavior. One of the techniques includes focusing attention on the breathing and abdominal movements. In this process, numerous thoughts will come and mind will wander into the past or the future too frequently. Over a period, the mind will come under control and the distracting thoughts will reduce and bring a feeling of relaxation. [34]

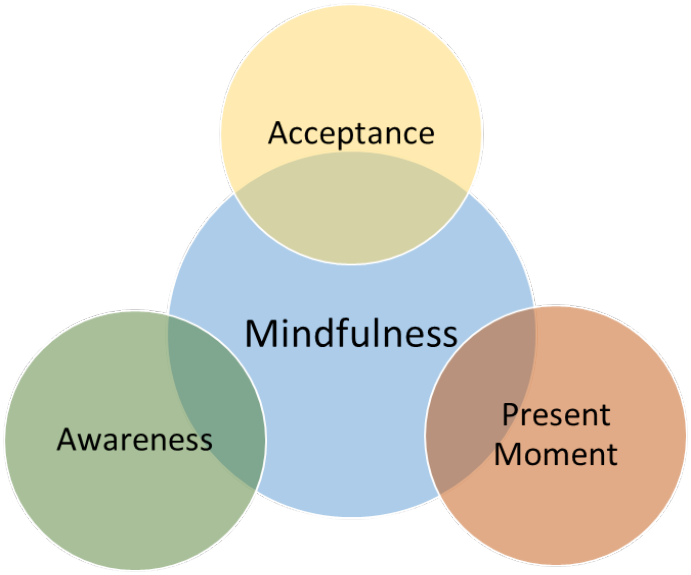


Fig. 2.1 Components of Mindfulness

Components of mindfulness include those of awareness, as well acceptance of the circumstances and courage of living in the present moment. Fig. 2.1 explains key components of mindfulness. Different phases of mindfulness as mentioned in literature include appropriate alignment of emotional intelligence by mindfulness and self-compassion leading to resilience which can prevent or overcome the state of burnout. Fig. 2.2 explains the different phases involved in mindfulness.

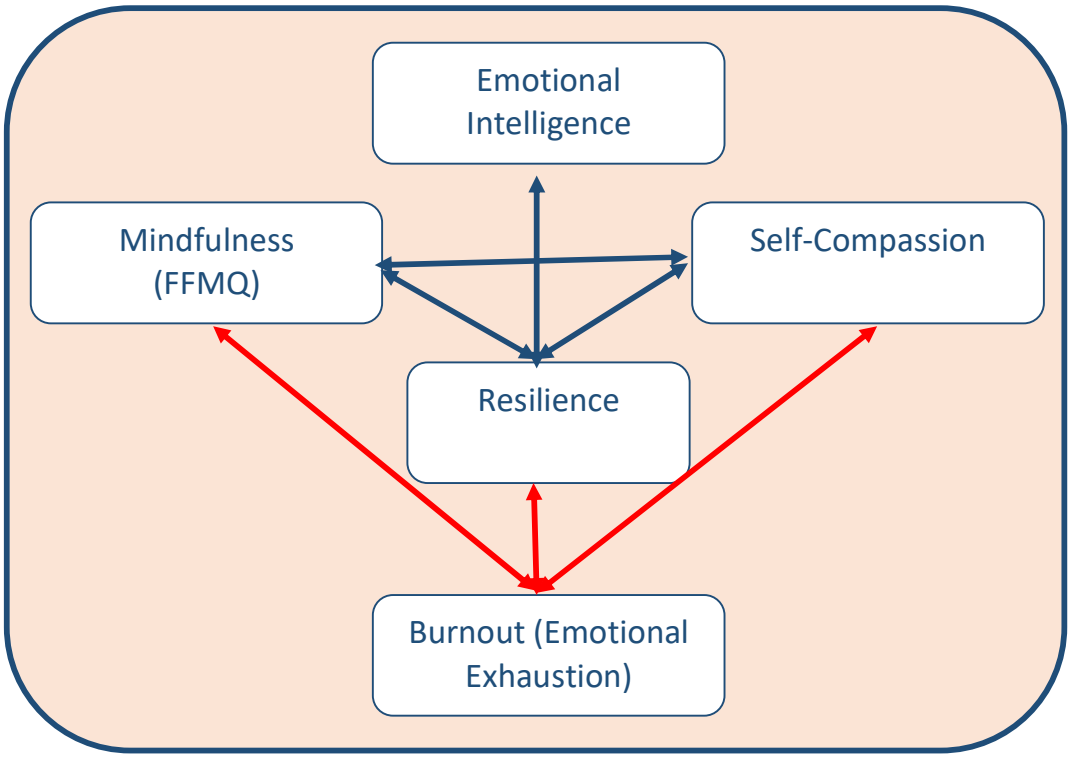


Fig 2.2 Phases of mindfulness

2.3.2 Emotional Intelligence:

Emotional Intelligence is defined as the ability of the individuals to be able to recognize, control and express their own emotions and those of the people they are dealing with to think and act in order to control the situation and obtain the best possible outcome. Various studies have shown that individuals with higher emotional intelligence enjoy better mental health and have better performance in their lives. [35] Emotional intelligence has been found to be a very good predictor of resident well-being. It was strongly predictive of resident well-being, emotional fatigue and even depression. [36]

Studies on resident physicians have shown that men and women show similar emotional intelligence. There are no gender differences and both, men and women, will benefit equally from specific training in emotional intelligence. [37]

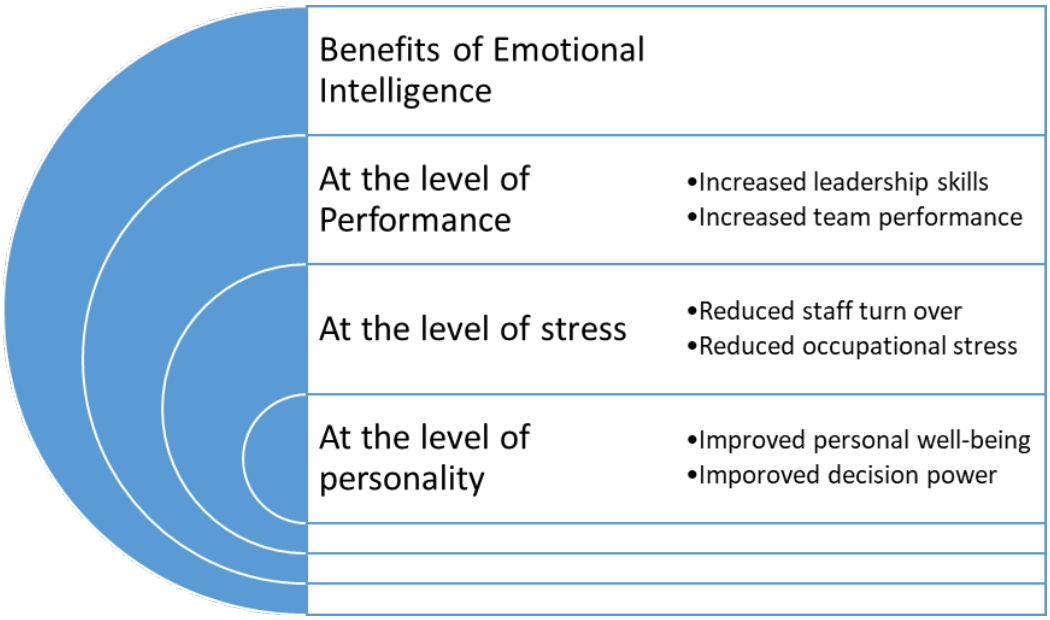


Fig. 2.3: Benefits of Emotional Intelligence

Empathy training protocol used to train residents and fellows has shown significant improvement in physician empathy. This goes to prove that the quality of care in medicine can be improved by integrating empathy training in the medical education. [38] It has also been found that resident doctors who have experienced some form of illness have been more empathic with their patients. It is one of the ways in which the residents can acquire empathy skills, other than formal training. [39]

2.3.3 The role of Motivation and Attitude in Behavioral change

The medical training has some objectives and these objectives are to make a good clinician, at the same time, the doctor must be a good communicator, a good professional, a good leader, a team player, and a lifelong learner. The medical graduates in India must have all these qualities. Training is defined as a planned learning experience designed to bring about permanent change in an individual's knowledge, attitudes or skills. [40]

It appears that the current syllabus is focused on making highly intelligent and knowledgeable doctors. Mindfulness, emotional intelligence, attitude, behaviour and

communication skills, that are also vital for a doctor in caring for patients have not been developed. This lacuna in the current syllabus has resulted in difficulties for the doctors to perform their professional roles. The patient expectations are high and this has led to a very big gap between doctors and patients. [41]

Stages of training:

i. Motivation to participate in the curriculum

ii. Knowledge, Skills and Performance

iii. Change in behavior

iv. Meaningful professional, who is service oriented and socially responsible

Motivation is the most fundamental requirement at the start of a healthcare professional training. The trainees must come into the training and feel that the syllabus is good for them. If the trainees come into the profession by choice, they are very likely to enjoy their training. The motivated trainees will go ahead and acquire the knowledge and the necessary skills. [42]

Most trainees in healthcare training are intelligent and they are able to acquire the required theoretical knowledge. At the same time, emphasis must be laid on developing good practical skills. Highly intelligent and knowledgeable doctors without good practical skills are unable to offer the best medical care, which the patients deserve. Elevated levels of motivation, proper knowledge and practical skills along with virtuous social interaction will help in developing an appropriate attitude. This will eventually lead to a positive change in their behavior. The medical profession is not about an individual. Medical profession is about the society. Trainees should come into this profession with the attitude of service for humanity. When knowledge and skills are imparted on the basis of serving the society, then the behavioral change will be seen. If the trainees come into this profession for their selfish gains and acquire knowledge and skills, their conduct will be detrimental to the society. This is an important part of the training, which the doctors need to understand.

In order to set up a private practice, apart from the medical knowledge and skills, doctors need lot more other administrative skills such as time management, administration, financial skills and people management skills. Apart from the medical

stress, the stress of paperwork, the stress of managing a hospital, the stress of money, the stress of staff can become very challenging for a doctor to cope. The stressful events all together among the medical personnel may manifest itself in several different outcomes. [42-44]

Therefore, they must be good at time management. Doctors have to be good at prioritizing their work. Highly important and highly urgent is to be done first. Whatever is highly important and less urgent to be done next, low important but highly urgent subsequently, and low important, low urgency, never to be done. Presentations, professional work, exams, studies, all these things can be maintained well in the diary. Due to this high level of stress, not only the individual doctors get affected but also his/her family life, marriage and social life. [45, 46]

In medicine, teamwork is of utmost importance. The anaesthetists, the surgeons, paediatricians, gynaecologists, pathologists, radiologists and different faculties have to work together. The team can come together only with the help of good communication. Inside the hospital, to perform operations, to conduct OPD and to look after the wards is all a team effort. The doctor is expected to be a leader in the society. They have to educate and motivate people around them to have better health. They have to improve the healthcare qualities and as leaders, doctors have to play a vital role in disease prevention. Doctors have to be more givers than takers and obviously they are considered as Gods only because they sacrifice a lot of their personal time, their comfort and their family time to provide health to their patients. Therefore, the concept of giving must be encouraged into the medical students rather than the concept of a profit-making business model. To be able to practice as givers, doctors need intrinsic motivation. This will inspire doctors become socially responsible.

2.4 Basics of Communication Skills

The ability to convey or share ideas and feelings effectively is called Communication. These skills do not come automatically by birth, but they can be acquired by anyone. With practice, Communications skills get better and the improvement can be almost endless. Good communicators enjoy the benefits and are able to live a happy personal and professional life. These skills are essential in every kind of relationship around a person. Good communicators are liked by all and many

seek their company. They are able to give joy to others and in the process are deeply happy people. [47]

2.4.1 Communication Process

The communication process includes interdependent parameters such as an encoding by the sender, the message, decoding of that message by the receiver and then feedback from the receiver as well as sender which can be influenced by barriers at any level (Fig. 2.4). It is also contingent upon the type of communication used for communicating. Various ways are used by various people for the communication on various levels and reasons.

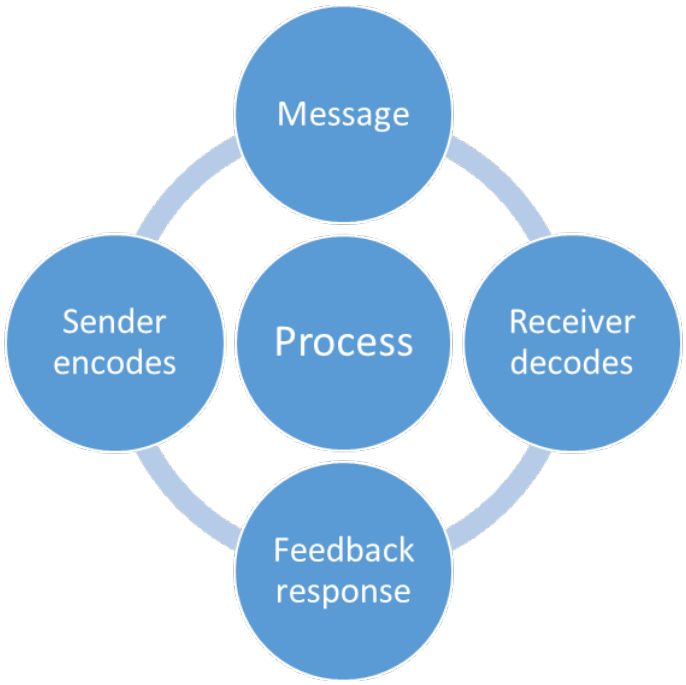


Fig. 2.4: Communication Process

2.4.2 Types of Communication

There are five types of communications viz. Written communication, Verbal or Oral communication, Non-verbal communication, Images and Visual communication, Multimedia communication (Fig.2.5).

Written Communication:

Written communication is suitable for the literate community because it requires writing skills. In Medical profession, written form of Communication is also legally important. The medical records in out-patients, in-patients and in operation

theatres should be maintained in a proper format. Inability to maintain records will amount to medical negligence in the court of law. In the current atmosphere, this skill has become even more important. [48] A specially designed written communication tutorial and the feedback of the written communication from the resident doctors to the medical students has been shown to improve the written note keeping of the medical students. [49] Educational programs giving knowledge of documentation in the process of litigation has helped resident doctors to improve their note keeping and staff interaction. [50]

Verbal Communication:

Verbal or Oral communication is in the form of spoken words such as conversations, phone calls, speeches, announcements and so on. This is a common form of communication, because it is instant in nature and helps in speeding up the work of an organization. There is evidence to show that resident doctors resort to bluntness and evasiveness in disclosing complex information to patients. Some residents talk in the neutral language when the situation warrants and empathetic language. This results in poor communication. [51] Resident doctors have been found to use medical jargons frequently. It is important that they use the "teach back "technique to establish rapport with the patients, but in reality, this was done in only 22% cases. [52]

Many resident doctors are known to dominate the discussions when they talk to their patients. They are also found to use much more complex language as compared to the patients. [53] It is very important that doctors changing duties make every effort to handover the full and complete information about the patient care to the incoming doctor. If the handover, verbal and written, is not effective due to improper communication between doctors, there is uncertainty of decision making and leads to suboptimal care of the patients. [54]

Non-verbal Communication:

Non-verbal communication is in the form of gestures such as facial expressions, hand movements, posture, eye contact, listening and so on. It is known that if the verbal communication leads to any confusion in the patients mind, they tend to rely upon the non-verbal body language. This is because the body, from head to toe, reflects the state of our mind. Research has proven that the most important

component (55%) is non-verbal communication followed by 38% of vocal communication and 7% of verbal communication. [55]

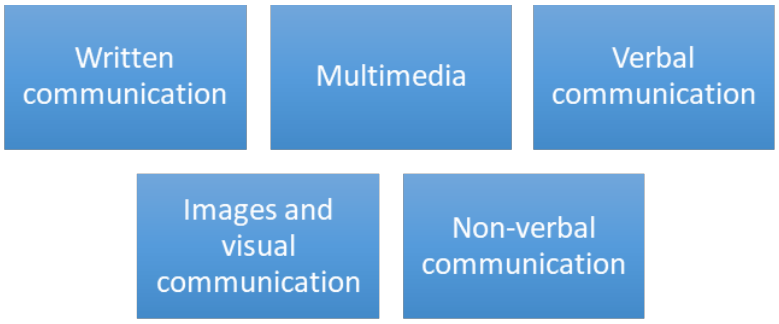


Fig. 2.5- Types of communication

Telephonic communication:

Doctors need to use the telephonic communication effectively to get the best care to their patients. The telephonic communication skills are very poorly developed in the Indian system of education. [56]

2.4.3 Barriers to Good Communication:

Communication appears to be an easy process but it fails very frequently with disastrous implications. This happens because there are numerous barriers that affect the communication cycle. This includes lack of knowledge, skills, confidence, language barrier, intellectual barrier, external distractions and similar factors in the receiver. Due to this failure, the message, ideas or the emotions are not conveyed properly from the sender to the receiver. It is important to identify these factors to make successful communication. [57]

During a consultation, there can be various types of interruptions such as use of computer, knock on the door and mobile ringtones. It is found that such distractions lead to patient dissatisfaction about the consultation. It has been found that interruptions make patients feel that they should have spoken more. It is very important that the doctor does not interrupt the patient when they talk. Care should also be taken to avoid any external distractions during the consultation. [58]

Research has shown that a process of Mirroring with the patient is important to establish a good rapport with the patient. This involves connecting with the patient according to their background in order to make them comfortable. As each patient

presence differently, a careful observation and assessment will reveal certain characteristics, which should be identified and replicated so that a rapport is built

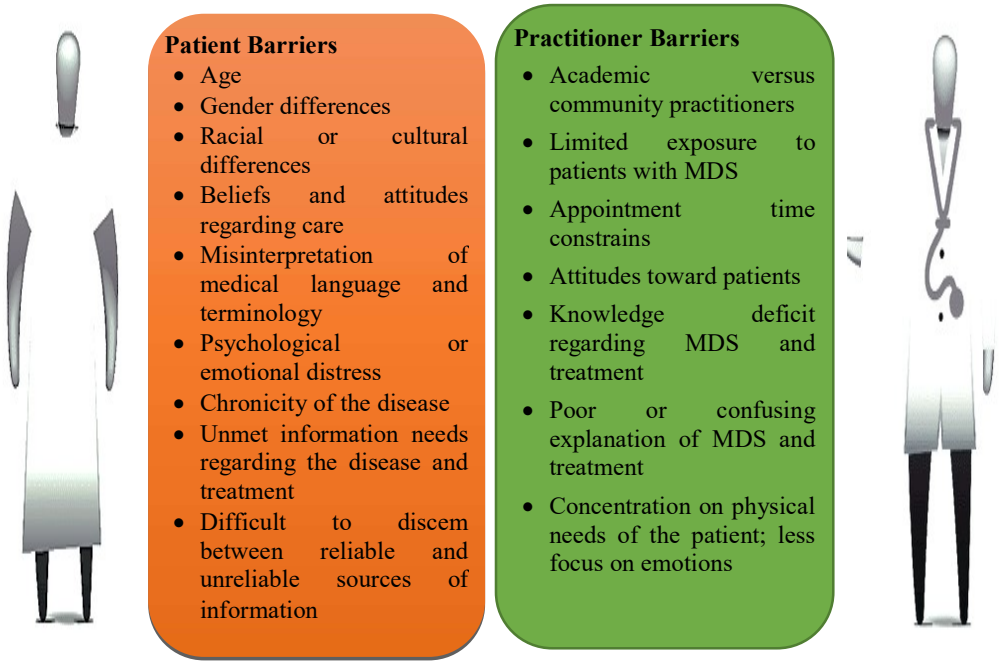


Fig. 2.6- Barriers of Communication

In studies on the dynamics of doctor-patient interaction, efforts have been made to study subjective aspects of communication (emotion-related communication) in an objective (systematic) way. [59] Doctors do more talking than listening. A study published in 1999 in the Journal of the American Medical Association (JAMA) found that 72% of the doctors interrupted the patient's opening statement after an average of 23 seconds. An average of only 6 seconds more was taken by the patients who were allowed to state their concerns without interruption. Doctors often ignore the patient's emotional health. [60]

A standardized patient evaluation test was developed by the National Board of Medical Examiners to assess physicians' communication skills in the US Medical Licensing Examination. The shift in patients' expectations regarding health communications has occurred as more patients take active roles in information gathering and decision making. Many medical schools have established programs to respond to these new expectations. [61]

Language is a system of symbolic communication involving the coding of meaning, which serves different functions. We are concerned mainly with the communicative function of language. However, in addition to verbal (the use of language) communication, non-verbal elements may also play a role in communication. Both of these may operate in a compatible and supportive manner, or may be in conflict in providing communication between the doctor and patient. The effectiveness of communication may be defined in terms of outcomes or effects such as patient satisfaction, or in terms of shared meanings and understandings. However, variations in the speech of persons as well as differences in language may diminish the effectiveness of communication. [62]

During the face-to-face doctor patient encounter, both verbal and nonverbal skills play a crucial role. Studies on doctor patient relation have reported that high number of patients don't understand or remember what their doctors tell them about diagnosis and treatment due to the insufficient communicative competence and extensive use of medical jargon. However, on the other side, greater participation and involvement of patients in the encounter would also improve satisfaction, compliance and the outcome of treatment. Patients need to be encouraged to participate in making decisions about the management of their treatment plan, provided that they are informed properly and on time. Hence, informed patients are likely to be more satisfied and possibly more compliant with doctor's recommendations because building a successful rapport largely depends upon the effectiveness of communication between patient and doctor, the validity of the patient expectations and the ability of the doctor to fulfil them. [63]

2.5 DOCTOR-PATIENT RELATIONSHIP.

2.5.1 The Patient's cycle.

The patient gets worried about their health problem due to which they visit the doctor. They come with ideas, concerns and emotions relating to their health issue. If they like the given advice and understand their condition, then they will follow the advice. They will hopefully take the treatment and get better, which will give them a positive experience. There are three types of patients. The one where they are in control of their life, they do regular exercises, they are very controlled in diet, they take good rest, they try to be stress free, and these are the sorts of patients who would

like to ask a lot of questions. These patients are likely to take more time during consultations, but it is important for a doctor to avoid any irritation. The second type of patient is the one who believes that any health issues are beyond the control of themselves and also the doctor. They believe in destiny and will not be keen to participate in the consultation. In that case, it will be the art of the doctor to make the patient talk and give information. Finally, the third type of patient considers doctors to be very powerful. They assume that the doctor can restore their health and they feel wise to just follow the doctor, who has an authoritarian style. [64]

2.5.2 The Doctor's cycle.

The doctor comes to this consultation with the knowledge, skills, attitude, behavior, and the communication skills. They may be hungry or tired, but they are expected to be attentive and alert, so that they can take care of the patient. Once they go through this consultation, hopefully patient gives them a positive feedback, a good life experience, good outcome, and the doctor's confidence and positivity goes up. [65]

Attitude is a complex psychological state of mind based on the experiences gathered by a person during their life. This is not something that can be just changed overnight. It is a summary of one's whole life. When it comes to medical graduates, it is thought that first MBBS students are too early to be taught anything about being a doctor. In fact, it is the reverse. Medical students are already at a mature stage in their life. These skills have to be taught in schools and in the junior colleges. Unfortunately, the current education system has laid emphasis on the subjects, emphasis on the theoretical knowledge, emphasis on scoring marks, getting graduation, getting some sort of a job, earning money. Attitude, behavior, and communication skills are not taught in the schools and colleges. This leads to a fixed attitude and behavior leading to a particular type of a personality. This will be difficult to change as the medical students go further in their training, as they gain experience and as they get more confident. They are less open to suggestions and less open to change themselves. It seems important to offer this training to medical students as early as possible. [65]

The attitude of the treating doctor has a huge role to play in counselling of patients. The personal belief of the treating physician can lead to bias, which can negatively impact the ability of the doctor to give the proper information and arrive at

a shared decision. [66] Traditional residency training program has focused on knowledge and skills development and given little attention to the development of the professional and humane skills that would influence the attitude and behavior of the doctor. [67]

2.5.3 Doctor-Patient relationship.

This relation involves two individuals. Each have got their own attitude, own behavior, and own communication. When they try to talk to each other, then their attitudes and behaviors may not match. It is important to understand how a relationship develops. It goes through stages.

Stage 1- is about acquaintance, when the two parties meet for the first time, like a doctor-patient. You have looked at the patient and you have realized that the person has come to you for help. The next part is a build-up. You shake hands. You greet the patient. You start a conversation. You try to understand what is happening and you build up the relationship to next level.

Stage 2-is about the continuation of the relationship. If all goes well, this is where the relationship can be at its best. If something goes wrong, the trust will break and the relationship will deteriorate and eventually end. This happened between doctors and patients. The trust has been lost and the relationship is now very fragile. One has to start all over again now to rebuild the doctor-patient relationship.

When two human beings are trying to understand each other, then there has to be some sort of an alignment between the two of them. The minds have to connect with each other. If there is honesty, love and respect, automatically the minds will start aligning. If there is purity, compassion, kindness, the hearts will start to connect with each other and then that beautiful relation starts and you enjoy that company. If unfortunately, it does not happen that way, then obviously it goes the other way and that leads to the problems of any relationship. [68]

To create the best possible patient-doctor relationship needs many skills. Managed care environments present more challenges to and opportunities for effective communication and maintenance of patient–physician relationships. Emphasis should be on teaching these skills effectively using seminars, videotaped reviews, direct observation of visits, standardized patients, and other strategies whose effectiveness are based on evidence. [69]

The concept of patient physician communication is based on both a skill and as a way of mindful "being in relation" to the other. Summarizing research and theoretical analyses, the two approaches are differentiated. The skill-focused approach to communicative competence relies heavily on observed behaviors; the mindful being-in-relation approach emphasizes the received effects of the relationship on the participants. [70] Patient-physician communication is an integral part of clinical practice. When the communication is done well, it produces a therapeutic effect for the patient, as has been validated in controlled studies. Formal training programs have been created to enhance and measure specific communication skills. [71]

According to the survey results published in July 2005, physicians believe that they are highly skilled at interacting with patients and that they display an attitude of respect and consideration for the patient when they are interacting, but this is not recognized to be the case by medical consumers; in other words, there is a large gap between the self-image of physicians and the image of physicians held by medical consumers. [72]

Good communication between doctors and their patients is the cornerstone of good doctor-patient relationship. There is enough evidence to confirm that there are too many problems in the doctor-patient communication that leads to poor patient care. [73] It has been found that 54% of the patient complaints and 45% of the patient concerns are not elicited by the doctors. [74]

2.6 COMMUNICATION IN SPECIAL SITUATIONS.

2.6.1 Responding to Strong Emotions.

When people face traumatic life changing events, they are likely to develop strong emotions. Communication can be in the form of simple history taking for pain in the abdomen or pain in the chest or headache or bleeding. In certain situations, such as death, complications or any unexpected losses, there are intense emotions and the role of communication becomes even more important. In these conditions, the communication skills become even more difficult because the patient is less receptive, less eye contact, not willing to listen and has a different state of mind. If the patient has a bad news to be given such as cancer, amputation of the leg or some sort of a complication that has happened post-surgery, then of course these communications can be very challenging. Breaking bad news has a different level of skill that is

required and that is to be mastered. These are special situations, you do not come across routinely, but when they arise, they are not handled well; the patients are likely to get very angry. [75]

2.6.2 Technique to Breaking Bad News

The most important part is to prepare before disclosing a bad news. This is called setting up of the interview. It is a good strategy to check the patient's perception about the medical condition to begin with. When the patient confirms the need to know more about the condition, further information should be given in the ask-tell-ask fashion. One must be truthful and honest in sharing the details. This will lead to emotional turmoil and the doctor must be ready to handle this emotional turmoil. It is important at this stage to focus attention on managing the emotions rather than concentrating on the medical information sharing. The doctor may have to face abusive language, but it must not be taken personally. In some cases, the patient and relatives may be very understanding. This leads to a very cordial atmosphere throughout the interview. After the interview, the doctor must make the arrangements for further follow up so that the patient can get continuity of care. [76]

Formal training in breaking bad news given to resident doctors has been shown to improve their ability to break a bad news. These skills can be improved and will lead to development of confidence amongst the trainees. [77]

2.6.3 Dealing with an Angry Patient

When a patient gets angry, it is important not to dismiss the anger. The reason for the anger must be acknowledged. Anger is a temporary reaction to a given situation and will eventually reduce after some time. It is essential to avoid further triggers, otherwise, the anger will flare-up. Attentive listening and careful explanation should be offered throughout the outburst of anger. After sometime, the anger settles down, and the person becomes calm and is able to talk. In the angry state, if you have not done the right things, if you have not said the right words, then the patient's anger will flare up. Poor communication is such situations is like adding oil to fire and good communication is like putting water on to the fire. [78]

It has been established that, good doctor patient communication is important as it has multiple impacts on various aspects of health outcomes. The positive impacts of this includes higher compliance to therapeutic regimens in patients, better health

outcomes, higher patient and clinician satisfaction and a decrease in malpractice risk. If extra efforts are taken to improve communication and relationship with patients, it would help to reduce complaints, improve compliance and reduce unnecessary investigation. To this end, family medicine academics should take the first step to study this area of medicine which is currently under researched. [79]

When the communication is used to establish and maintain what will likely become a long-term partnership is possible with the general relationship between the physician and the patient. As indicated by health communication research, physicians who have apt communication skills in the patient-physician relationship develop a platform of trust behaviors. The researchers have reported prior findings, claiming that effective communication cannot exist in the absence of a solid, trusting physician-patient relationship. [80]

2.7 TRAINING IN COMMUNICATION SKILLS.

Communication skill learning starts at home from childhood, from teenage days to adulthood. Communication can be learned at school, junior college and during medical education. There are numerous opportunities to learn communication skills, but unfortunately it is not so easy to teach this skill. Communication is an art which forms the bases of a good Doctor-Patient relationship. Each person is capable of learning communications skills, but this needs training. In the past the importance of communications skills in medical training was not very highly appreciated. Over the ears, the syllabus had no room for communications skills training and assessment. It was felt that these skills are subjective and formal training could not be designed. [81]

The challenges for communication skills training include:

- To design a Module for training
- To design methods of training
- To design assessment of these skills
- To develop faculty

Communication skills in healthcare are a lifelong learning process. This should begin at the start of the Medical career. These skills should be taught throughout the undergraduate education along with the development of the right attitude, behavior and ethics. Simple skills such as history taking and educating the

patient will form part of early education. Slightly advanced skills such as negotiating, counselling and consenting can be offered towards the end of undergraduate education. Post graduate resident doctors have more responsibility as they are dealing with more complex conditions. They may encounter anxious patients, angry patients, depressed patients, which needs higher skills of communication. Breaking bad news is a common requirement during the post graduate education. Due to this, communication skills training should be offered to all post graduate resident doctors at the start of their residency program. The training can be conducted through numerous ways that have been designed for communication skills training like observation of the seniors, watching video presentations, watch self-performance, Role playing, simulated patients, Group discussions etc. [82,83] Seniors who are good at communication can become role models for the trainees to learn. For this to happen, the trainees should be attentive and motivated. In this manner, they can absorb the right skills. There is evidence to suggest that when the skills are being demonstrated by the teachers in a complex situation, it is important for them to make the trainees aware of the skills being taught. This could include values of compassion towards the patients or certain acts that are meant to make the patient comfortable. [84]

The 1960's decade has observed a dramatic increase in the teaching of patient communication skills as a formal component of the medical curriculum. Until then, communication skills were generally subsumed under the heading of "bedside manner," which was to be observed and imitated as the clinical clerk and medical resident participated in teaching rounds with the senior clinicians who served as their mentors. More and more formal didactic courses, patient simulation techniques, and various forms of programmed instruction, supervised practice, and specific feedback from instructors and observers trained in patient communication skills has replaced the current apprenticeship approach. A study during 1979 revealed that 96% of the institutions responding reported formal courses in communication skills in their curricula. Of the courses reported, less than 20% were more than five years old. [85]

Communication skills can be easily taught at courses, are learnt easily, but are easily also forgotten if not maintained by practice. The most effective point in time to learn these at medical school is probably during the clinical clerkships, but there is no study which has specifically addressed this question. The training should use experiential methods and primarily address problem-defining skills. To be effective,

communication skills training should be given within clinical clerkships only. The evidence for this is at present indirect, but is congruent with adult learner theory. Attention should be paid to the fact that men are slower learners at communication skills courses than women. [86]

Research on the effectiveness of communication training for practicing physicians usually does not address the practical questions that face health care leaders, such as how sceptical clinicians accept training programs about interpersonal skills, what elements of marketing and design enhance enrolment in programs, and how such training affects the clinician's frustration with patients. [87] There is an important connection between positive physician communication and patient satisfaction. However, the medical consultation is an extremely complex event. [88]

Chapter III: Research Methodology

This chapter describes the adapted material and structured methods which exists for studying the outcome of a training module intervention in the context of communication skills among resident doctors for better management of doctor patient relationship. Based on literature review, pilot study and earlier research, as well as the contextual and behavioural challenges of the subjects involved in the research, a number of important features for conducting the research and achieving the outcomes are summarized and justified as below.

3.1 Study design

As this research was committed to describe and interpret the participant's pre and post intervention impressions about communication skills, an interventional study design was used for the research.

3.2 Study setting

The study setting was the Medical Colleges having postgraduate courses and rendering the patient care involving residents using diagnostic and treatment facilities in the teaching hospital. There are total 48 medical colleges affiliated to Maharashtra University of Health Sciences for providing medical education in the state. Out of these 13 colleges are providing only undergraduate course, 28 colleges are providing both Under Graduate as well as Post Graduate Courses. However, 7 institutes are offering exclusive post-graduate education.

3.3 Study Population

The study population was the resident's doctors of first year to third year, from randomly selected medical colleges of Maharashtra having postgraduate courses in clinical subjects i.e. Anaesthesiology, Respiratory Medicine, Dermatology, Venerology and Leprosy, Otorhinolaryngology, General Medicine, General Surgery, Obstetrics and Gynaecology, Ophthalmology, Orthopaedics, Paediatrics, Psychiatry, Radio-diagnosis as well as Community Medicine and Pathology for more than three years and affiliated to Maharashtra University of Medical Sciences, Nasik. Total approved intake for the year 2016-17 was taken into consideration. The total intake of the post graduate courses of all colleges was 2185 students with actual admissions of

1745. Hence, 1745 students per year was considered as base data and this number was multiplied by multiplying factor 3 to get the study population for three academic years because the study was targeted to all three-year PG students. Hence, the total target population was 5235 students.

3.4 Sample Size

Required sample size was calculated using G* power software [89, 90]. Following parameters were considered for calculating the sample size, based on the findings of the pilot study.

1. Type 1 error (α error) = 0.05
2. Type 2 error (β error) = 0.2
3. Power = 1 – β = 0.8
4. Effect size = 0.15
5. Tails = 2 (Two tailed)

Considering above parameters, the required sample size was 368.

3.5 Study period

The study was conducted for the period of two years between February 2017 and January 2019.

3.6 Research Questions

Primary Research question

Can the use of a 'training module' improves the knowledge and attitude regarding communication skills?

Secondary Research question

Is 'the change' in knowledge and attitude dependent upon any socioeconomic factors?

3.7 Hypothesis

3.7.1 Null hypothesis

Training Program using training module makes no significant change in the baseline knowledge regarding communication skills in resident doctors.

3.7.2 Alternate hypothesis:

Training Program using training module makes a statistically significant change in the baseline knowledge regarding communication skills in resident doctors.

3.8 Inclusion and Exclusion criteria

Inclusion Criteria:

1. Medical colleges affiliated to Maharashtra University of Health Sciences.
2. Medical colleges having post graduate courses in clinical subjects as well as Community Medicine and Pathology for more than three years.
3. The resident doctors pursuing post graduate medical education under Maharashtra University of Medical Sciences.

Exclusion Criteria

1. Medical Colleges not willing to accept the intervention and not willing to take part in the study.
2. Medical colleges who conducted the training on communication skills before the study.
3. The resident doctors not willing to undergo the training on communication skills.

3.9 Sampling Technique

In order to meet desired sample level, a multistage sampling was used. The primary sampling unit of the study was Medical colleges and the secondary sampling unit was residents studying in clinical subjects as well as Community Medicine and Pathology.

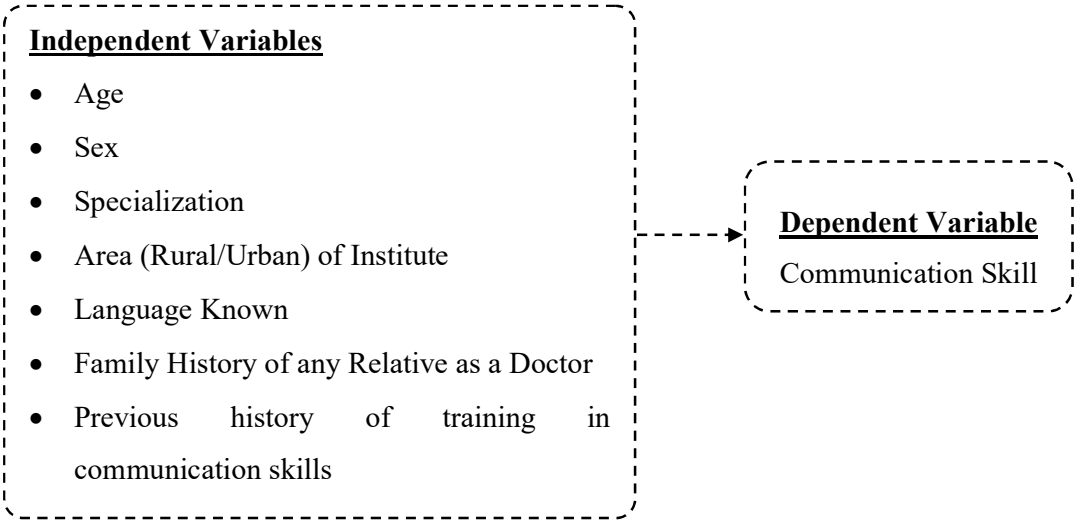
Primary sampling unit (PSU) - Medical Colleges

Initially all the medical colleges fulfilling inclusion criteria were listed alphabetically and numbered. A random number generator service available on internet was used to generate the random numbers and select the medical institutes corresponding to those generated random numbers. A total of 10 medical colleges were selected from these available medical colleges.

Secondary sampling unit (SSU) - Residents

The total sample size for the study was 368. This sample size was equally distributed in 10 selected colleges. Hence, it was desired that atleast 36 samples per college will be enrolled in the study. However, wherever the residents were less than the desired number because of less intake/admissions, the desired sample size was achieved from other colleges selected for the study.

3.10 Dependant and Independent Variables



3.11 Designing Training Module and Study Intervention.

The study intervention was designed by taking reference from the literature mentioning the doctor patient relation and communication skills. The intervention was training module on "Communication Skills in Health Care'' designed with five sections as mentioned below. (Annexure – I)

Section 1 - Being a Mindful Doctor

Section 2 - Basics of Communication Skills

Section 3 - Doctor-Patient Relationship

Section 4 - Communication in Special Situations.

Section 5 - Training in communication Skills

Mindfulness meditation is available as one of the effective Mind-body intervention for work stress and other stress-related problems. A non-judgmental

attention to experiences of the present moment, including emotions, cognitions, and bodily sensations, as well as external stimuli can be described as Mindfulness. [91, 92] It is a practice in which the individuals maintain attitudes such as openness, curiosity, patience, and acceptance, while focusing their attention on a situation as it unfolds. Thus, mindfulness is congruent with the overarching goal in medical practice to cure disease when possible and meet suffering in a compassionate manner. [93] In this way, mindfulness can be seen as a set of skills that facilitates the healing aspects of the clinician-patient encounter. [94] The origin of mindfulness intervention in clinical setting is from Unites States and currently many countries have started showing interest in mindfulness among doctors. Many schools in United Nations have started offering mindfulness opportunities within their curriculum. [95] Hence, the mindfulness was set as a first section to design a module on communication skills.

A basic medical process always seeks an effective correlation between physician and patient. The most important part of medical art is the physician's ability to communicate friendly with his patient and it is necessary for the physician to learn this ability. [96] An effective communication skill between physician and patient is important part of clinical functions and construction the effective therapeutic physician-patient interpersonal relationship. It is called the heart and art of medication. [97] Hence, the basic communication skill was included as second section in the training module. Likewise, Section 3 on Doctor Patient relationship, Section 4 on Communication Skills in Special Situations and Section 5 on training in communication skills were designed for the training module.

A core competency for physician training in many countries is acquisition of communication and interpersonal skills. [98,99] An effective communication skills program always involves multi-session and multi-disciplinary, uses multiple methods, and have opportunities for demonstration, discussion, reflection, practice and feedback. [100,101]

All the sections of the module were composed with learning objectives and expected outcomes. Appropriate teaching methodology involving didactic lectures, activities, group discussions, role plays, group activities etc. [102] were involved in the modules. As mentioned in the literature depicted to communication skills, the experimental methods like role plays, or interaction with simulated and real patients were used. [103,104] The materials and resources required for the training module were

mentioned in each section. The module timing was worked out before implementing the module and it was mentioned in the module in order to achieve uniformity in the implantation/teaching the module.

The duration of each section was 75 minutes. The training was conducted by a specially trained person at all the centres, to avoid the bias.

3.12. Data Collection Tool

The study was aimed to evaluate the effectiveness of the training module intervention in communication skills among the resident doctors. A structured proforma was designed and questionnaire was validated (Annexure II). The proforma design was subdivided in to four parts as follows.

Part A - Personal Particulars

Part B - Consent

Part C - Pre Test Training Questionnaire

Part D - Post Test Training Questionnaire

Part C and D was further subdivided into two sub sections i.e. a and b. The details of these subsections are as follows.

a) Close ended questions on five point Likert scale to record the impression of respondents on five sections of intervention training module as mentioned below.

   i. Being a mindful Doctor
   ii. Basics of communication skills
   iii. Doctor patient relationship
   iv. Communication in special situation
   v. Training in communication skills.

   Each section consisted of five questions to which the study subject responded. Responses to each one of the question was recorded using a five point Likert scale [105] 1 to 5 (1. Strongly disagree (SD), 2. Disagree (DA) 3. Uncertain (U) 4. Agree (A) 5. Strongly agree (SA)).

b) Open-ended questions intended to gather information relating to the current status of communication skills.

3.13 Pilot Study

A pilot study was conducted involving 106 samples from 2 colleges. The outcome of the pilot study was used to fine tune the pre and post-test study questionnaire. The data collection methodology was also tested in the pilot study. The effect size determined in the pilot study was used to estimate the required sample size for this study.

3.14 Data Collection

Selected institutes were visited personally by the investigator to get the required permissions from the local authorities and to finalize the schedule for the study. The finalised schedule was communicated to all the resident doctors from the clinical subjects as well as Community Medicine and Pathology from the first year to the third year, and then they were appealed to participate in the study.

On the scheduled date, the investigator personally conducted the study by following the pre-determined protocol. All the participants were initially briefed about the study. They were explained about the possible outcomes, benefits and risks in the study. All the relevant queries were answered to the participant's satisfaction, before the actual start of the study. The primary data was collected from the residents before training in Part A and B of the proforma (Annexure II). The pre-test impressions of the resident doctors were recorded in Part C of the same proforma. After the data collection the communication skill workshop was conducted as per the training module (Annexure I) and immediately after the workshop, the post intervention data collection was carried out in Part D of the same questionnaire.

3.15 Data analysis

Initially, all the responses were analysed individually and then the section wise analysis was done. Wilcoxon Sign rank test was used to test the statistical significance in pre and post responses. After analysing the individual responses, a quantified score was calculated for each of the five above mentioned sub sections. To calculate the quantified score, all five questions in a sub sections were considered. Initially, it was determined whether all the five questions showed either increase or decrease in mean score after intervention. If any of the question showed increase in post intervention score, while rest showed decrease (or vice versa), the responses were adjusted to facilitate calculation of correct mean. Quantified scores (pre and post intervention) for

each sub sections were tested for significant differences using Wilcoxon sign rank test.

To determine the effect of socio demographic variables in change in score for each sub section, a linear regression model was used, in which change in quantified score was used as dependent variable and various socio demographic variables were used as independent variables. If any of the regression coefficient was found to be significant, it was concluded that the change in score, for that sub sections, was significantly correlated with that variable. SPSS 21 was used for statistical analysis.

Open ended questions were analysed using the grounded theory for the qualitative data analysis. [106] The thematic network analysis was utilized as our framework for analysis, as described by Attride Stirling [107]**.** More selective and inductive codes were generated using the answers given by the respondents for the open ended questions. Discrepancies in coding and re-coding were resolved by consensus, and led us to organically identify several trends and patterns around the central study theme of 'Communication Skills' in the post test after intervention.

3.16 Ethical Considerations

There were no aspects of the study which would cause any risk to the respondents involved in the research. The research was conducted with the participants who were informed appropriately and who wished voluntarily to be a part of the study. The confidentiality of the data has been insured and the data has been used only for the purpose of the research. Then the study was conducted among the willing participants after obtaining their consent in Part B of the study questionnaire.

3.17 Limitations of the study

The present study was undertaken on the basis of self-reported measures of "Management of Doctor-Patient Relationship by Teaching Communication Skills to Resident Doctors in Maharashtra". As the nature of the self-reported measures, the data obtained is predominantly a reflection of the respondents' perception to the items requested. Therefore, it cannot always be interpreted as actual facts. Some resident doctors may be less receptive to the intervention module because of the attitude they carry. In some cases, an unacceptable attitude and behaviour can be tough to influence. Finally, each resident doctor will interpret the research questionnaire

differently. The resulting misinterpretation of the question can lead to some inaccuracies in the collected data.

Lastly, as the pre and post intervention data is collected immediately before and after the intervention, sustainability of the benefits of the intervention over a longer duration of time cannot be tested, neither it is claimed.

3.18 Operational Definitions

Following definitions were used in the study

I. **Resident doctor:** The resident doctors are a category of graduates who are learning while clinically practicing what they have theoretically and clinically achieved from their graduation outcomes. Residency or postgraduate training is a stage of graduate medical education.

II. **Communication**- Communication is the process of transmitting feelings, attitudes, facts, beliefs and ideas between living beings.

III. **Communication skill:** An ability to convey information, facts and ideas to any other person or group of persons, in the way, language or words which they can understand.

IV. **Management** – Management' is indicated as the process of dealing with or controlling things or people. Judicious use of means to accomplish an end. These are the basic considerations of the definition of management in the context of this thesis which emphasize the control and organization of something.

V. **Doctor:** Doctor is a registered medical practitioner who is qualified to treat the patients.

VI. **Patient**: The patient means the person receiving or registered to receive medical treatment can be impatient due to any reason, like the diseased condition, paucity of information, expectation of treatment and speedy recovery.

VII. **The doctor–patient relationship-** Physician-Patient Relationship can be defined as "a consensual relationship in which the patient knowingly seeks the physician's assistance and in which the physician knowingly accepts the person as a patient."

Chapter IV: Analysis and Interpretation

The main focus of the study was to manage the doctor patient relationship by teaching communication skills to resident doctors. The study also aimed to understand the efficacy of 'Training Module' in improvement of communication skills in the form of knowledge and attitude among the resident doctors in the public and private teaching hospitals in the state of Maharashtra. However, an attempt was also made to study the role of external factors in baseline as well as improved communication skills among the residents. To address those questions results are presented below and supported by the relevant statistics.

This chapter also elaborates the interpretation and discussion based on the results obtained to achieve the research objectives and answer the research questions as well as prove the research hypothesis. In this section, the findings of the pre-test perception and post-test change in the perception after teaching the communication skill to the residents is discussed in view of the various earlier studies and the statistical tests. After brief review of the questions and as per the expected outcomes, results are discussed including interpretations that attempt to provide the logical explanation. To support the research outcome and discussion, the findings are also supported by similar studies and research done by other researcher. The statistical analysis was performed for five sub questions under five sub sections to study the change in quantified knowledge and attitude as presented in the results. Effect of various socio-demographic factors in change in quantified knowledge and attitude in relation to five sections of the study is also presented and discussed subsequently.

The study was conducted across 10 medical colleges in the state of Maharashtra involving 201 male and 176 female students with 53.7 % and 46.7 % contribution by respective genders. Although it was expected to involve equal study respondents from all the colleges, the number of respondents varied from a minimum of 7 from Institute of Naval Medicine INHS ASHWINI, Colaba, Mumbai, to maximum of 72 from Grant Government Medical College, J. J. Hospital, Byculla, Mumbai.

Table 4.1: College-wise distribution of the study respondents.

Sr. No	Name of the College	Male		Female		Total	
		No.	%	No.	%	No.	%
1	Grant Govt. Medical College, J.J. Hosp. Byculla, Mumbai	38	18.9	34	19.3	72	19.1
2	Government Medical College, Aurangabad	37	18.4	27	15.3	64	17.0
3	Dr. Vasantrao Pawar Medical College, Nashik	33	16.4	21	11.9	54	14.3
4	Dr. Vikhe Patil Foundation Medical College, Ahmednagar	28	13.9	24	13.6	52	13.8
5	Bombay Medical College & Hospital, Mumbai	25	12.4	24	13.6	49	13.0
6	Seth G. S. Medical College & KEM Hospital, Mumbai	19	9.5	12	6.8	31	8.2
7	Lokmanya Tilak Medical College, Sion, Mumbai	5	2.5	15	8.5	20	5.3
8	Topiwala National Medical College, Mumbai	4	2.0	12	6.8	16	4.2
9	K. J. Somaiya Medical College, Mumbai	6	3.0	6	3.4	12	3.2
10	Institute of Naval Medicine INHS ASHWINI, Colaba, Mumbai	6	3.0	1	0.6	7	1.9
	Total	201	100	176	100	377	100

The variation was because of the differences in intake verses actual admission for the respective year as well as the duty schedule of the residents. Non willingness of residents was also one of the reason why few colleges had little representation in the study.

4.1 SOCIODEMOGRAPHIC BACKGROUND OF THE STUDY RESPONDENTS.

The sociodemographic parameters as well as the external factors influencing the communication skills studied are age, gender, subject specialty, area of residence, any close relative of the respondent as doctor, any communication skill workshop/training attended before participation in this study and the knowledge about the local language of practicing region.

Table 4.2: Age and Gender wise distribution of the study respondents

Sr. No.	Age Group	Males		Females		Total	
		Freq.	%	Freq.	%	Freq.	%
1	< 25	12	5.97	23	13.07	35	9.28
2	25-30	168	83.58	145	82.39	313	83.02
3	31-35	17	8.46	7	3.98	24	6.37
4	> 35	4	1.99	1	0.57	5	1.33
	Total	201	100	176	100	377	100

It is seen from table 4.2 that, total 53.3 % participants of the study were male residents and 46.7 % were female residents. Total 83.02 % residents were from age group 26-30 with 83.5 % males and 82.39 % females from individual groups. This was followed by 9.28 % residents from age group < 25 with 5.97 % males and 13.07 % females. 6.37 % residents represented age group 31-35 with 8.46 % males and 6.37 % females. The least representation was from age group > 35 with only 1.33 % residents. Hence, age group 26-30 in the subsequent results and discussion will represent the major perceptions and impressions from the resident doctors.

Table 4.3: Specialty wise distribution of study respondents

Sr. No.	Specialty	Males		Females		Total	
		Freq.	%	Freq.	%	Freq	%
1	General Medicine	35	17.4	14	8.0	49	13
2	Paediatrics	20	10.0	27	15.3	47	12.5
3	General Surgery	39	19.4	8	4.6	47	12.5
4	Orthopaedics	31	15.4	2	1.1	33	8.8
5	Ophthalmology	12	6.0	20	11.4	32	8.5
6	Obstetrics and Gynaecology	4	2.0	25	14.2	29	7.7
7	Radiology	17	8.5	7	4.0	24	6.4
8	Otorhinolaryngology	11	5.5	12	6.8	23	6.1
9	Dermatology, Venerology and Leprosy	7	3.5	13	7.4	20	5.3
10	Anaesthesiology	6	3.0	14	8.0	20	5.3
11	Pathology	4	2.0	16	9.1	20	5.3
12	Psychiatry	7	3.5	8	4.6	15	4.0
13	Respiratory Medicine	6	3.0	7	4.0	13	3.4
14	Community Medicine	2	1.0	3	1.7	5	1.3
	Total	201	100	176	100	377	100

Specialty wise distribution of the residents as revealed from table 4.3 shows that, highest study respondents were from General Medicine with 13 % of total having 17.4 % males and 8 % females among respective genders. This was followed by General surgery and Paediatrics residents with 12.5 % each specialty. In this group male residents were more in general surgery (19.4 %) and female residents were more in Paediatrics (15.3 %). Orthopaedics and Ophthalmology residents were 8.8 % and 8.5 % respectively with more representation by male in orthopaedics (15.4 %) and females in Ophthalmology (11.4 %). Obstetrics and Gynaecology, Radiology and Otorhinolaryngology were represented by 7.7 %, 6.4 % and 6.1 % residents respectively, however Dermatology, Venerology and Leprosy, Anaesthesia and Pathology was represented by 5.3 % residents for each subjects in the study group. This was followed by Psychiatry, Pulmonary Medicine and Community Medicine with 4 %, 3.4 % and 1.3 % respectively. Table 4.2 gives overall idea about the distribution of the residents enrolled in the study with the specialty they are pursuing. In the subject wise residents enrolled in the study, General Medicine, General Surgery, Orthopaedics and Radiology had more male residents than the female residents. On the other hand, Paediatrics, Ophthalmology, Obstetrics and Gynaecology, Otorhinolaryngology, Dermatology, Venerology and Leprosy, Anaesthesia, Pathology, Psychiatry, Pulmonary Medicine and Community Medicine specialties had more female residents that the male residents. Interestingly, this factor may prove good indicator for studying the influence of the external factors in Knowledge and Attitude before and after intervention of the study.

Table 4.4: Distribution of study respondents as per the area of residence, close relative of respondent as doctor, earlier participation in communication skill workshop and knowledge about local language.

Parameter	Response	Male		Female		Total	
		Freq.	%	Freq.	%	Freq.	%
Area of Residence	Urban	178	88.56	157	89.20	335	88.86
	Rural	23	11.44	19	10.80	42	11.14
Close relative of the respondent as a doctor	Yes	92	45.77	76	43.18	168	44.56
	No	109	54.23	100	56.82	209	55.44
Participation in communication skill training / workshop earlier	Yes	51	25.37	38	21.59	89	23.61
	No	150	74.63	138	78.41	288	76.39
Knowledge about local language	Yes	138	68.66	110	62.50	248	65.78
	No	63	31.34	66	37.50	129	34.22

Total 88.86 % resident doctors from the study were from urban background and only 11.14 % were from rural background. The distribution of male and female residents in the respective group of urban and rural is almost same. An attempt was also made to know the background of the participant in the form of any close relative in the medical profession. Total 44.56 % residents said that they have at least one member from their close relatives as a doctor, however 55.44 % residents are representing the families with no close relatives in the medical profession. Frequent training doctors in the communication skill can necessarily improve the overall health care delivery. Hence, It was tried to know whether the participants were exposed to any communication skill workshop or training before the study intervention. Only 23.61 % residents revealed that, they have undergone the training of communication skills in the past. However, around 76.39 % residents were not exposed to any formal training in communication skills. Language plays important role in establishing the communication between the doctor and patient which leads to a better patient care. In the present study, around 65.78 % residents were able to read, write and speak the local language of the region where they are practicing. On the other hand, 34.22 % residents were using alternative language to communicate with the patients.

4.2 EFFICACY OF TEACHING THE COMMUNICATION SKILLS TO RESIDENT DOCTORS WITH STRUCTURED TRAINING MODULE

It is seen in recent past that, Indian society is experiencing a growing awareness regarding patient's rights. The established quotations says that a doctor owes a duty of care to his patient. The medical ethics or bioethics is also saying that a doctor owes certain duties to the patient who consults him for illness. The doctor patient relationship in the modern days is seen with the view that every doctor, at the public or private hospital or elsewhere, has a professional obligation to provide his services with due expertise for protecting life. To bring to his task a reasonable degree of skill and knowledge and to exercise a reasonable degree of care is the duty owed by a doctor towards his patient. With this background and the objectives of the study, this section of the results describes the knowledge and attitude of the resident doctors towards the communication skills and doctor patient relationship before and after the intervention. The comparative tables of the study outcomes are presented and elaborated in this section. The p value was also calculated and explained accordingly.

4.2.1 BEING A MINDFULL DOCTOR

Table 4.5 elaborates various aspects of Being Mindful Doctor as reflected from the resident's point of view before and after the intervention.

In modern days of medical profession, a doctor patient relation is mostly based on the amount of consultation charges to be paid by the patient which many time becomes a reason for the conflicts affecting the doctor patient relation. It is true and well accepted by both medical and non-medical people that the medical profession has to an extent become commercialized and there are many doctors who have departed from the Hippocratic Oath for making money. However, just because of some bad apples, the entire medical fraternity cannot be blamed or branded as lacking in integrity or competence. Hence, it becomes important to know the residents perception and their attitude towards role of money in providing reasonable care to the patient. With this regard, an attempt was made to understand the impression of resident doctors on their duty towards patient care and the role of consultation charges. It is seen from table 4.4 that, 48.8 % residents strongly disagreed to the statement that, doctors should provide the reasonable care only when patient pay the fees. However, after the intervention of teaching communication skills to the residents

the number has slightly increased to 55.2 %. This was followed by 34.5 % residents who disagreed to the statement before the intervention and 24.1 % residents after the intervention. Hence, total 83.3 % residents before the intervention and 79.3 % residents after the intervention were against the fact of money minded practice where the consultation charges will determine the patient care. Only, 10.6 % doctors before intervention and 14.6 % residents after intervention agreed to the fact that it is the money which determines the reasonable patient care. However, the p value here reflects that the results obtained are not statistically significant.

Table 4.5: Knowledge and attitude of the resident doctors on various parameters of "Being a Mindful Doctor"

Parameter	Scale	Pre-Test Score		Post-Test Score		P Value
		Freq.	%	Freq.	%	
Doctor has a duty to provide reasonable care to a patient only when a patient pays the fee	Strongly Disagree	184	48.8	208	55.2	0.682
	Disagree	130	34.5	91	24.1	
	Uncertain	23	6.1	23	6.1	
	Agree	22	5.8	28	7.4	
	Strongly Agree	18	4.8	27	7.2	
Emotional intelligence has an important role in team building	Strongly Disagree	8	2.1	9	2.4	<0.0001
	Disagree	6	1.6	7	1.9	
	Uncertain	25	6.6	13	3.4	
	Agree	172	45.6	96	25.5	
	Strongly Agree	166	44.0	252	66.8	
A Doctor has a duty to completely cure the patient	Strongly Disagree	19	5.0	20	5.3	0.552
	Disagree	88	23.3	85	22.5	
	Uncertain	73	19.4	75	19.9	
	Agree	136	36.1	126	33.4	
	Strongly Agree	61	16.2	71	18.8	
Health is defined as complete physical and mental well-being of the patient	Strongly Disagree	11	2.9	22	5.8	<0.0001
	Disagree	19	5.0	42	11.1	
	Uncertain	11	2.9	16	4.2	
	Agree	185	49.1	161	42.7	
	Strongly Agree	151	40.1	136	36.1	
Mindfulness can help to prevent burnout in the doctor	Strongly Disagree	6	1.6	4	1.1	<0.0001
	Disagree	7	1.9	4	1.1	
	Uncertain	39	10.3	18	4.8	
	Agree	194	51.5	125	33.2	
	Strongly Agree	131	34.7	226	59.9	

Emotional intelligence is important to control and express one's emotions, and to handle interpersonal relationships judiciously and empathetically. With this

reference, an attempt was made to understand the perception of resident doctors on the role of emotional intelligence in team building. Around 89.9 % residents agreed that, emotional intelligence is important in team building. Out of this around 44 % residents strongly agreed to this fact. After the intervention this number has straightaway gone as high as 66.9 %, they strongly agreed that emotional intelligence has important role in team building. Overall number of residents agreed to this fact after intervention was 92.3 % as compare to 89.9 before the intervention. However, the percentage of residents who did not agree with the statement and uncertain about it was reduced from 10.3 % to 7.7 % after the intervention. The overall change was highly significant with $P<0.0001$.

All patients approaching to a doctor expects medical treatment with all the knowledge and skill that the doctor possesses to bring relief to his medical illness. Doctors and hospitals are expected to provide medical treatment with all the knowledge and skill at their command and secondly they will not do anything to harm the patient in any manner. Though a doctor may not be in a position to save his patient's life at all times, he is expected to use his special knowledge and skill in the most appropriate manner keeping in mind the interest of the patient who has entrusted his life to him. Therefore, an attempt was made to understand the perception of the resident doctors regarding their duty to completely cure their patients. 60 % residents agreed that doctor has the duty to completely cure the patient. Out of this, 16.4% strongly agreed to it. After the intervention, 19.8 % residents strongly agreed towards a doctor’s duty in completely curing the patients. This was followed by slight decrease in the percentage of residents agreeing to it i.e. from 60 % to 52.2 %. However, the percentage of residents who did not agree with it and uncertain about it was not changed, it remained same i.e. 47.7 %. The data however was not statistically significant.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States. With this background WHO also defines health as complete physical and mental wellbeing not just absence of disease. Hence, all doctors should carry the equal impression of health and render the health care from the same point of

view. Therefore, to know the perception regarding health, all the residents were asked how much they agree or disagree with the statement 'Health is defined as complete physical and mental well-being of the patient'. 89.2 % residents agreed that health is the complete physical and mental well-being of the patient. Out of which 40.1 % residents strongly agreed to the statement. The percentage of residents who agreed with the statement reflected change from 88.9 % to 78.8 %, after the intervention was carried out. While, the percentage of residents who were uncertain about it and disagreed with the statement; was also affected and the percentage of such students was found to be changed from 10.8 % to 21.1%, after the intervention. The results obtained are highly significant in favour of the alternative hypothesis with $P < 0.0001$.

Mindfulness is a simple form of meditation that allows people to really live in the moment, to be aware and attentive during everyday activities. Studies suggest that this can help physicians provide better care for their patients and help them to avoid burnout. In the stressful incidences mindfulness always help in maintaining the doctor patient relationship. Hence, the study also focused on understanding the awareness of resident doctors about mindfulness. The impression of resident doctors was recorded against a statement of 'Mindfulness can help to prevent burnout in the doctor'. Study revealed that around 86.2 % residents agreed to the fact that mindfulness can help to prevent burnout in doctors. Out of which 34.7 % residents strongly agreed to it. There was a significant increase in the percentage of residents, strongly agreeing to the statement from 34.7 % to 59.9% communication skill training with structured module. This was followed by remarkable decrease in the percentage of residents who just agreed to the statement, i.e. from 51.5 % to 33.2 %. Hence, the training had strong impact on the residents and maximum residents were turned from just agree to strongly agree. On the other side the percentage of residents who were uncertain about it and were disagreeing with the statement, changed from 13.8 % to 7 %, after the intervention. The results are highly significant and against the null hypothesis with $P < 0.0001$.

4.2.2 BASICS OF COMMUNICATION SKILLS

Table 4.6 gives an idea about the pre-test and post-test score of basic of communication skills among the resident doctors in the study group.

Even if it is a best medical advice in the world, it won't do patients much good if they cannot understand it. When a doctor does not speak the same language to his patient, there is always a level of uncertainty on whether the patient actually understands what doctor is talking about. It is an instant barrier between doctor and patient. Proceeding with a procedure requires the full understanding of the risks and benefits. It always takes quite a bit of explaining and time even when someone is from same language background to make an informed decision. The translated language loses the essential message. There is always an uncertainty that even a mediator gives the translated message to the doctor that confirms the consent of the patient; it is never clear as it would for the doctor to actually get this consent from patient him/herself. With regard to this, an attempt was made to assess the impressions of the respondents on language of communication between doctor and patient.

It is seen from table that, there were 70 % residents who agreed to the statement before the intervention was done. Out of which 23.3 % residents strongly agreed with the statement. With the intervention, the residents agreeing to the fact was increased to 73.2 %. Following this, there was a slight change in the percentage of residents who strongly agreed to the statement after the intervention, i.e. from 23.3 % to 30 %. However, the percentage of the residents who were uncertain about it and disagreed with the statement, changed from 30 % to 26.8 %, which was a positive change noticed after intervention. However, the results are statistically not significant.

Table 4.6: Knowledge and attitude of the resident doctors on various parameters of "Basics of Communication Skills"

Parameter	Scale	Pre-Test Score		Post-Test Score		P Value
		Freq	%	Freq.	%	
Doctor needs to talk in layman's language with all patients coming to him	Strongly Disagree	17	4.5	24	6.4	0.074
	Disagree	47	12.5	32	8.5	
	Uncertain	49	13.0	45	11.9	
	Agree	176	46.7	163	43.2	
	Strongly Agree	88	23.3	113	30.0	
The doctor should inform the patient of all the treatment choices available, their pros and cons and arrive at a shared decision with the patient	Strongly Disagree	8	2.1	10	2.7	0.196
	Disagree	3	0.8	5	1.3	
	Uncertain	11	2.9	9	2.4	
	Agree	136	36.1	107	28.4	
	Strongly Agree	219	58.1	246	65.3	
Empathy gets reduced during the period of medical training	Strongly Disagree	22	5.8	20	5.3	<0.0001
	Disagree	67	17.8	43	11.4	
	Uncertain	80	21.2	56	14.9	
	Agree	171	45.4	188	49.9	
	Strongly Agree	37	9.8	70	18.6	
Listening is the same as hearing the spoken words	Strongly Disagree	90	23.9	110	29.2	0.606
	Disagree	143	37.9	114	30.2	
	Uncertain	51	13.5	43	11.4	
	Agree	61	16.2	70	18.6	
	Strongly Agree	32	8.5	40	10.6	
Medical knowledge without emotional intelligence is useless	Strongly Disagree	14	3.7	21	5.6	0.011
	Disagree	42	11.1	30	8.0	
	Uncertain	66	17.5	59	15.6	
	Agree	169	44.8	136	36.1	
	Strongly Agree	86	22.8	131	34.7	

Shared decision making with patient's participation in the medical practice always results in increased patient knowledge, adherence, and improved outcomes. If

patient is known about all options available, they can play active role in decisions related to their health care. This is being increasingly thought of as the model of choice for complex medical decisions involving more than 1 rational treatment option. Keeping in view the importance of shared decision making with the patient, it is perceived that doctors should carry the same impression as that of the experts. Hence, to assess the knowledge and attitude of the resident doctors towards the patient's choices and their right to information they were asked about 'The doctor should inform the patient of all the treatment choices available, their pros and cons and arrive at a shared decision with the patient'. The results disclosed that there were 94.2 % residents who agreed with the statement, in which 58.1 % residents strongly agreed to the statement. After the intervention, the percentage of residents agreeing to the statement changed to 93.7 %. While the percentage of residents who were uncertain and disagreed with the statement changed from 5.8 % to 6.4 % after intervention. The results are statistically not significant.

Altruistic feeling among the medical students is one of the most important factors that promote communicational skill; it is basically doing the non-selfish activities in order to benefit others. Empathy with the patients is one of the obvious indexes of altruism among physicians and medical staff. Empathy is very much important in the physician-patient relationship. It is general impression that, a student's empathy gets declined during medical school education. Hence, residents were asked about their opinion towards decrease in empathy during the period of medical training. Table explains that, 55.2 % residents agreed to the statement. Out of this, 9.8 % residents strongly agreed with the statement. After communication skill training, percentage of residents agreed towards the statement was increased from 55.2 % to 68.5 %. The results also stated that there was a significant change in the percentage of residents strongly agreeing to the statement, i.e. from 9.8 % to 18.6 %. On the other side, the percentage of residents who were uncertain about it or were disagreeing with the statement remarkably changed from 44.8 % to 31.6% which is good improvement. The results obtained are highly significant with $P < 0.0001$.

A holistic approach involving considerations beyond treating a disease is what is required in the process of curing the patient. It seeks several skills in a doctor along with technical expertise. An attention to the Para verbal and non-verbal components of the communication including patient listening are frequently neglected but equally

important component of doctor patient relationship. The perception of resident doctors regarding, listening as one of the important communication skill as hearing the spoken words; was recorded. Around 23.9 % residents strongly disagreed to the fact that listening is same as hearing the spoken words. This was followed by 37.9 % residents who disagreed and 13.5 % residents were uncertain about the fact. It is also seen that, 24.7 % residents agreed with the statement, out of which 8.8 % residents strongly agreed. After intervention the results stated that, 29.2 % residents agreed with the statement, as compared to the results before intervention, i.e. 24.7 %. This was followed by minor change in the percentage of residents strongly agreeing with the statement i.e. from 8.5 % to 10.6 %. The results are statistically not Significant.

Is has been well established that, emotional intelligence is essential for all human interactions. The emotional intelligence helps a person understand and regulate their own emotions and use them for effective human interactions. Emotional intelligence is of great importance in Medicine, a profession that thrives on human interactions. For the effective clinical practice there is increasing interest in the recent times on the importance of emotional intelligence. Only medical knowledge in the effective practice is of no use unless associated with emotional intelligence. The importance of emotional intelligence is not just limited for providing good clinical care, it is also important for managing all the human relationships that happen as part of the medical treatment process. It is revealed from perception of residents that, 44.3 % residents agreed to the fact that medical knowledge without emotional intelligence is useless. After the intervention percentage of residents agreed was reduced to 36.1 %. Around 22.8 % residents were strongly in favour of the statement that, medical knowledge without emotional intelligence is useless. However, this number has increased up to 34.7 % after the intervention. Total residents who either disagreed or uncertain about the relation of emotional intelligence and medical knowledge was 32.3 %, this number was slightly reduced to 29.2 % after the test. The results are significant with $P < 0.01$.

4.2.3 DOCTOR-PATIENT RELATIONSHIP

The knowledge and attitude towards doctor patient relationship is reported in table 4.6 for the pre and post-test.

The social aspects of doctor patient relationship have been proved to be very much effective in establishing effective treatment outcome. An effective interaction as well as communication between doctor and patient is a central clinical function that cannot be delegated. Most of the essential diagnostic informationis soght by interview and the physician's interpersonal skills also largely determine the patient's satisfaction and compliance and positively influence health outcome. There is therefore a clear and urgent need to improve the doctor patient relation. With these background residents were asked their opinion and it is revealed that, majority of the residents were sure that there is urgent need to improve the doctor patient relation. Around 91.3 % residents enrolled in the study have reflected their favour towards agreement to improve the doctor patient relation. However, the post test results showed that, with the training of communication skill has improved this percentage to 94.9 %. Significant increase was reported in the residents favouring a strong agreement towards the statement from 46.2 % to 63.9 %. This shows that, communication skill workshop has brought a positive change in the mind-set of the residents about their understanding of doctor patient relationship. However, only 8.7 % residents were towards disagreement or uncertain about need of improving the doctor patient relation, although, this number was reduced to 5 % after intervention. The results are highly significant with $P < 0.0001$.

Table 4.7: Knowledge and attitude of the resident doctors on various parameters of "Doctor-Patient Relationship"

Parameter	Scale	Pre-Test Score		Post-Test Score		P Value
		Freq	%	Freq.	%	
There is an urgent need to improve the current doctor-patient relationship	Strongly Disagree	4	1.1	3	0.8	<0.0001
	Disagree	13	3.4	5	1.3	
	Uncertain	16	4.2	11	2.9	
	Agree	170	45.1	117	31.0	
	Strongly Agree	174	46.2	241	63.9	
Strict laws by Government will definitely stop violent attacks	Strongly Disagree	16	4.2	21	5.6	<0.0001
	Disagree	37	9.8	59	15.6	
	Uncertain	60	15.9	84	22.3	
	Agree	107	28.4	138	36.6	
	Strongly Agree	157	41.6	75	19.9	
It is the patients fault that get confused because of google information	Strongly Disagree	10	2.7	23	6.1	<0.0001
	Disagree	49	13.0	93	24.7	
	Uncertain	99	26.3	92	24.4	
	Agree	148	39.3	132	35.0	
	Strongly Agree	71	18.8	37	9.8	
Doctors can avoid violent attacks with the help of good attitude and behavioural skills when dealing with patients and relatives	Strongly Disagree	4	1.1	0	0	<0.0001
	Disagree	26	6.9	5	1.3	
	Uncertain	50	13.3	27	7.2	
	Agree	167	44.3	167	44.3	
	Strongly Agree	130	34.5	178	47.2	
Violent attacks on doctors are happening only because of media	Strongly Disagree	24	6.4	34	9.0	0.058
	Disagree	139	36.9	158	41.9	
	Uncertain	139	36.9	106	28.1	
	Agree	54	14.3	65	17.2	
	Strongly Agree	21	5.6	14	3.7	

A trust between the patient and physician is an implicit, fundamental building block of clinical medicine. A trust from both sides i.e. patient's trust of his physician and vice versa is inherently related, and both are crucial for healthcare partnerships. A patient perception of injustice within the medical sphere, related to profit mongering, knowledge imbalances and physician conflicts of interest is one of the most prominent

forces driving patient physician mistrust. Patient physician mistrust precipitated medical disputes leading to the violent resolution such as physical and verbal attacks against physicians. Laws and policies from the government is looked as an important strategy to prevent such disputes especially physical attacks. Majority of the residents (70 %) were of the opinion that strict laws by Government will definitely stop violent attacks on the doctors, however after the training of communication skills, only 56.5 % residents were of the same opinion as that of before the training. The percentage of strongly agreed residents was drastically reduced for 41.6 % to 19.9 %. The residents who were not sure about the role of laws in preventing the violent attacks were 29.9 %. After the training, this number was further increased to 43.5 %. The results are highly significant with P is less than 0.0001.

In the current era of technology at our fingertips, it is very easy to use the Internet for medical information. In recent past health informatics has become very popular. The Internet can be an excellent source of information, however when it comes to health, it can also lead to misinformation, because not all websites are accurate, and there is often marketing involved with sites. The information accessed from google may lead to increased patient anxiety and poor choices, and it may delay diagnosis and treatment of an illness. Patients always tries to cross check the treatment advice of the doctor with the interned and it is general impression that, the internet sources especially google creates lot of confusion among the patients about the treatment. Around 39.3 % residents agreed before and 35 % residents agreed after the intervention. Before the intervention 15.7 % residents and after the intervention 30.8 % residents were either disagreed or strongly disagreed that it is not the patient's fault that they get confused because of google information. However, there was not much change in the opinion of residents before and after the intervention. The results are highly significant with P is less than 0.0001.

Health professional always feel uncertain in dealing with violence and aggression. A violent, abusive or aggressive patient may be behaving anti-socially or criminally. There is always a cause for aggression. There are many causes and the combination of various factors together including personality, physical symptoms or intense mental distress, and extrinsic factors, including attitudes and behaviours shown by various stakeholders, the physical environment, and restrictions that limit the patient's movement or actions. Hence, of the doctor's show good communication

skills there are chances that the aggression by the patient or relatives may be resolved without turning into violence. Around 34.5 % residents strongly agreed before and 47.2 % after the intervention that doctors can avoid violent attacks with the help of good attitude and behavioural skills when dealing with patients and their relatives. However, 44.3% residents were towards the agreement with the statement before the intervention and after the intervention it did not changed. The impression of the residents those were not in favour of the role of doctor's attitude and behaviour skills before the intervention was significantly improved and it changed from 21.3 % to 8.5 %. The results are highly significant with $P < 0.0001$.

India is not the only country facing violence against its medical practitioners; today this is a global phenomenon. Violence against doctors is on the increasing all over the world. The incidents of violence against doctors are reported on a daily basis across India, some resulting in grievous injuries. The media on the other hand is known to publicize the incidences and act against the doctors for publicity purpose. And it is said that, the Indian society if a very good follower of media. Everyone knows the role of media in changing the community attitude and behavior. When the residents were asked about the same, most of them (36.9 %) disagreed to the statement which was further increased to 41.9 % after the training. This was followed by the residents who were uncertain (36.9 %) about Media's role in violent attacks on doctors which was slightly reduced to 28.1 % after the intervention. Results are statistically not significant.

4.2.4 COMMUNICATION IN SPECIAL SITUATIONS

Communication in special situations is always regarded as special task. Hence, it was a studied as one of the important parameter. The response of the resident doctors on various aspects of communication in special situations is presented in table 4.8.

There are many reasons which could lead to turn the patient in to anger or violent situation. It may be because they are distressed, scared, have unrealistic treatment expectations or are overly demanding. Sometimes these behaviors may be the result of previous bad experiences. It is beneficial to explore these factors and try to gain an understanding of why patients may be behaving in this way. Individual professionals working within a complex system are unlikely to have much direct

control over the environment, especially areas such as the emergency department or acute admissions areas where the chances of patient or relative turning in to violence are more. Hence, the doctors should know which the best strategy to handle such patients. Keeping in view the same fact, residents were asked about following aggressive approach to curb the situation. Most of the residents were against the aggressive approach of the doctors in handling the angry patients. Total 85.4 % residents felt that this is not the correct strategy to deal with the angry patients. Even after intervention there was no change in the impression of the residents about their approach of handling the angry patients. The results are statistically significant with $P < 0.02$.

Any information related to health that drastically alters the life of the patient is termed as bad news. And conveying bad news requires skilled communication which is not at all easy. The amount of truth to be disclosed is subjective. A properly structured and well-orchestrated communication has a positive therapeutic effect. This is a process of negotiation between patient and physician, but physicians often find it difficult due to many reasons. They feel incompetent and are afraid of unleashing a negative reaction from the patient or their relatives. It is important for doctors to understand the situation and the location where they can disclose the information. When asked about it, 27.3 % residents strongly disagreed that, bad news can be disclosed at any location in the hospital outside the ICU. After the intervention 42.4 % residents strongly disagreed to this fact. However, another 45.4 % residents before the intervention and 35.8 % residents after the intervention disagreed. The results are highly significant with $P < 0.001$.

There are situations where, doctors need to break the bad news even though they don't feel secure. Especially when it comes to individual private practitioners, they are not left with any alternative rather than breaking the bad news. This always increases the chance of turning the patient's relatives in to violent situation and ultimately results in to attacks on the doctors. There is a common understanding among the doctors of public hospitals that, the armed security guards will help to reduce those incidences where doctors are attacked by patients. Hence, an attempt was made to understand the impression of residents on use of armed security guards to stop attacks on doctors giving bad news. Overall, 35.3 % residents agreed to the fact and after intervention it was slightly reduced to 22.3 %. Out of this around 7.4 %

strongly agreed and after the intervention it was further reduced to 3.7 %. However, there were about 35.8 % disagreed on the fact and after intervention it was increased to 53.3%. Around 28.9 % were uncertain about the statement and after intervention it gets slightly decreased by 24.4 %. The results are highly significant with P < 0.0001.

Table 4.8: Knowledge and attitude of the resident doctors on various parameters of "Communication in Special Situations"

Parameter	Scale	Pre-Test Score		Post-Test Score		P Value
		Freq	%	Freq.	%	
The best way to handle an angry patient for the doctor is to take an aggressive approach	Strongly Disagree	156	41.4	215	57.0	0.020
	Disagree	166	44.0	106	28.1	
	Uncertain	36	9.5	28	7.4	
	Agree	8	2.1	12	3.2	
	Strongly Agree	11	2.9	16	4.2	
Bad news can be disclosed at any location in the hospital outside the ICU	Strongly Disagree	103	27.3	160	42.4	0.001
	Disagree	171	45.4	135	35.8	
	Uncertain	61	16.2	44	11.7	
	Agree	35	9.3	29	7.7	
	Strongly Agree	7	1.9	9	2.4	
Armed security guards will stop attacks on doctors giving bad news	Strongly Disagree	45	11.9	77	20.4	<0.0001
	Disagree	90	23.9	124	32.9	
	Uncertain	109	28.9	92	24.4	
	Agree	105	27.9	70	18.6	
	Strongly Agree	28	7.4	14	3.7	
"Half information about the bad news can be given to the patient to reduce their distress	Strongly Disagree	88	23.3	125	33.2	0.004
	Disagree	115	30.5	111	29.4	
	Uncertain	76	20.2	53	14.1	
	Agree	81	21.5	64	17.0	
	Strongly Agree	17	4.5	24	6.4	
If your senior colleague is harassing you, it is best to keep quite	Strongly Disagree	176	46.7	203	53.8	0.359
	Disagree	125	33.2	91	24.1	
	Uncertain	33	8.8	38	10.1	
	Agree	26	6.9	29	7.7	
	Strongly Agree	17	4.5	16	4.2	

Breaking the bad news is not only difficult but also unavoidable part of healthcare for physicians and patients alike. One of the most difficult communication tasks faced by health care professionals is breaking bad news, such as disclosing an alarming diagnosis or conveying poor prognosis. This task is described as one of the most stressful by the physician's as patients relate experiences of receiving bad news from physicians whose approach was insensitive or inadequate. Bad news is an unavoidable part of healthcare although difficult for physicians to communicate and for patients to hear. Generally, giving half the information about the bad news to reduce the stress is practiced by many individuals. Hence, in present study an attempt was made to understand the perception of residents on giving half information about the bad news to the patient to reduce their stress was recorded. Table shows that, overall 53.8 % residents disagreed on giving half information about the bad news to reduce their stress. Out of this around 23.3 % residents strongly disagreed to this fact and after the intervention strong disagreement was increased to 32.2 %. However, there were 26 % residents agreed to the fact of giving half information about the bad news to reduce the stress but after the intervention there was a huge decreases rate of about 23.4 % in agree group. Only, 20.2% of patients were uncertain about the statement where there was decrease in the percentage of about the 14.1 % after the intervention. The results are statistically significant with $P < 0.004$.

With growing instances of harassment against junior doctors being reported from across the country, the issue is drawing adequate attention. Numerous instances of harassment of junior doctors have been reported recently. Some of the junior doctors have taken extreme steps because of not able to bear the pressure. Hence, it is studied as one important component in the study. Some residents think or feel that, if the senior colleague is harassing, then it is best to keep quiet to protect oneself from getting unemployed or demoted. With this regard the attempt was made to understand the resident's perception on same fact. It is seen from table that around 46.7 % resident strongly disagreed to this statement and after the intervention there was a slightly increased to 53.8 %. Only, 11.4 % resident before intervention and 11.9 % resident after intervention agreed to the fact that, if your senior colleague is harassing, it is best to keep quite. And also there were 8.8 % were uncertain about the statement and the percentage gets increased to 10.8% after the intervention. The results are statistically not significant.

4.2.5 TRAINING IN COMMUNICATION SKILLS

The last parameter on which the perception, knowledge and attitude of the residents recorded was training in communication skills. The results are presented in table 4.9.

Now days, the teaching pattern is becoming more knowledgeable and helps the person to handle any sort of incidence which comes at the workplace. However, there are certain misconceptions about medical curriculum that it doesn't involve the components or teaching which is necessary for the medical professional handle all untoward incidences at workplace. With this regard, an attempt was made to understand the impression of current teaching pattern towards making the individuals capable to handle all untoward incidences at workplace. It is seen that, 52.3 % disagreed on the fact and after intervention there was a slight increase to 59.7 %. Overall, 26.8 % residents agreed on the fact out of this around 7.4 % strongly agreed on it. And after the intervention there was slight increase of about 9.8 %. However, there were about 21 % who were uncertain about the statement. Results obtained are statistically not significant.

Like many other people based professions, communications skills are essential for medical practice. It is a backbone over which lot of areas of patient care rests such as, first contact patient interviews, probing for associated and additional problems, counselling the patient, explaining treatment options, its complications and advising follow-up. Good communication between patient and doctor builds confidence, improves compliance, and reduces mistakes and mishaps, thereby reducing malpractice suits. If the knowledge of surgical skill, medicine, and clinical acumen is the craft of medical practice, then the communication skills is the fine art. The attempt was made to understand about impression of residents towards the role of communication skills in handling untoward incidences at workplace and its inclusions as a subject in curriculum for undergraduate and post graduate studies. About 78.8 % residents agreed on the fact out of this around 32.9 % were strongly agreed. And after the intervention there was an increase in the percentage of about 87.3 %. Out of this around 56 % were strongly agreed on the fact that, the communication skills to handle the untoward incidences at workplace are a science and should be included as a subject in curriculum. Around the 7.1 % disagreed before intervention and 6.1 %

disagreed after intervention. Only, the 14.1 % were uncertain before the intervention which decreased to 6.6 % after the intervention. The results are highly significant with $P < 0.0001$.

Table 4.9: Knowledge and attitude of the resident doctors on various parameters of "Training in Communication Skills"

Parameter	Scale	Pre-Test Score		Post-Test Score		P Value
		Freq	%	Freq.	%	
Current teaching pattern makes you capable to handle all untoward incidences at workplace	Strongly Disagree	70	18.6	79	21.0	0.348
	Disagree	127	33.7	146	38.7	
	Uncertain	79	21.0	46	12.2	
	Agree	73	19.4	69	18.3	
	Strongly Agree	28	7.4	37	9.8	
Communication skill to handle untoward incidences at workplace are a science and Its inclusion as a subject in curriculum	Strongly Disagree	11	2.9	7	1.9	<0.0001
	Disagree	16	4.2	16	4.2	
	Uncertain	53	14.1	25	6.6	
	Agree	173	45.9	118	31.3	
	Strongly Agree	124	32.9	211	56.0	
Uniform specific standard operating protocols are needed to handle incidences at workplace	Strongly Disagree	2	0.5	6	1.6	<0.0001
	Disagree	21	5.6	10	2.7	
	Uncertain	31	8.2	26	6.9	
	Agree	203	53.8	169	44.8	
	Strongly Agree	120	31.8	166	44.0	
Regular communication skill training workshops must be conducted in every healthcare institution	Strongly Disagree	5	1.3	8	2.1	<0.0001
	Disagree	13	3.4	6	1.6	
	Uncertain	26	6.9	11	2.9	
	Agree	185	49.1	140	37.1	
	Strongly Agree	148	39.3	212	56.2	
Communication skill training should be a part of high school and junior college education	Strongly Disagree	8	2.1	8	2.1	<0.0001
	Disagree	12	3.2	8	2.1	
	Uncertain	17	4.5	15	4.0	
	Agree	166	44.0	116	30.8	
	Strongly Agree	174	46.2	230	61.0	

In a workplace, it is necessary to follow the specific standard operative protocols and by following these protocols, individuals can handle the incidence at

workplace. However, these uniform protocols should be written with sufficient detail to ensure that someone with limited experience or knowledge of the procedure, but with a basic understanding, can successfully conduct the procedure in a safe manner even when unsupervised. The protocols should be written in a logical, step-by-step, concise and easy-to-read format. This will avoid the conflicts between doctors and patients. To understand the perception behind these residents were asked whether uniform specific standard operative protocols are needed to handle incidence at workplace. Overall, 85.6 % resident agreed to the statement out of which 31.8 % were strongly agreed. And after intervention the percentage was slightly increased to 88.8 %, out of this 44 % were strongly agreed. Only, the 6.1 % were disagreed on the fact and after intervention it was decreased to 4.3 %. Only, the percentage of residents who were uncertain was 8.2 % before and 6.9 % after the intervention. The results are highly significant with $P < 0.0001$.

Last two decades have experienced advances in science and technology which have revolutionized medical services in recent past. A multidisciplinary approach is recommended in the management of most medical ailments. Communication between doctors and the patient and relatives has been viewed seriously. Patients have different psycho-social needs and tailoring the communication to the patients' requirements is highly valued. Communicating the key points during each step of the patient's journey is now considered to be an essential criterion for good medical practice and improves the job satisfaction of doctors. The undergraduate and postgraduate courses in medical education have tried to keep pace with the changes and several curriculum modifications have taken effect. Hence, keeping in mind the importance of communication skill it is expected that this should be offered as frequent training program for the medical undergraduates. Hence, the impression of

residents on conduction of regular communication skills training workshop in every healthcare institution were recorded before and after intervention. There were about 88.4 % residents agreed on regular conduction of communication skills training workshop in every healthcare institution, out of this around 39.3 % strongly agreed. However, after the intervention it was slightly increased to 93.3 % out of this around 56.2 % residents strongly agreed on the approach. Only 4.7 % residents disagreed for regular conduction of communication skill workshop which was decreased to 3.7 % after intervention. Only 6.9 % were not sure about this. The results are highly significant with $P < 0.0001$.

Communication skills are one of the elements of generic skills that are essential among every individual. The communication skills are one of the important factors of the education. So, the attempt was made to understand the impression of residents on making communication skills training as a part of high school and junior college education. It is reported that, 90.2 % residents agreed to it and after intervention 91.8 % residents favoured for making communication skill as compulsory component. Only, the 5.3 % disagreed to it, after intervention this was decreased to 4.3 %. Overall, there was no change in the strongly disagree group after intervention. The results are highly significant with $P < 0.0001$.

4.3 ROLE OF COMMUNICATION SKILLS IN DOCTOR PATIENT MANAGEMENT

There were five open ended questions in the questionnaire, intended to qualitatively judge the change in baseline understanding about the communication skills, its importance and barriers. The responses, during pre and post-test, were analysed by noting the qualitative change in the responses.

Table 4.10: Importance of Communication Skills in management of doctor patient relationship- Pre-test analysis

Codes	Important Issues Discussed in pre test	Themes Identified
Critical Situation Evaluate the patient Doctor Patient Relationship Sensitivity of patients	Handling critical situations. Best treatment Change one's perception,	Keeping the attention to experiences occurring in the present moment.
Proper Communication Express Emotions Interpersonal relationship	Connect and empathies with patient and relative. Key to avoid and handle bad situations. Builds team work in coherence. Understanding others emotions Patient can explain "full" problem. Understanding patient in better way.	Importance of emotional intelligence and role of empathy.
Ego Time Stress Knowledge Gender Cost Trust Social Issues Attitude Impatience Poor Listening	Language, educational qualification, lack of knowledge, ego, lack of attention, extra working hours, physical exhaustion etc.	Barriers of communication between doctor and patient/relatives.
Patients Education Convincing the patient	Proper communication skills helps to convince the patients	Prevention of violence with proper communication.
Regular sessions Role Play Proper Guidance Seminars Debates	Daily conversations, during rounds, workshops Teaching of communication skills to undergraduates.	Importance of Communication skill training.

Table 4.11: Importance of Communication Skills in management of doctor patient relationship- Posttest analysis

Codes	Important issues discussed in post test	Themes generated
Avoid Confusion Better Approach	Mindfulness helps avoiding the untoward incidences Mindfulness helps to avoids bad situations and violence. Mindfulness teaches importance of being attentive to the present situation.	Mindfulness is helpful in Medical Profession.
Understand patients' needs Better relationship Handle own and patients emotions	Emotional intelligence is the key to develop interpersonal relationship, Emotional intelligence is required to develop good communication between doctor and patient, It is the key to empathetic behaviour.	Emotional Intelligence helps in developing interpersonal relationship.
Ego Knowledge Age Stress Medical Skills Cultural Differences Social Awareness Body language	Physical, emotional, psychological, language, attitude, perception, lack of devoted time are the barriers in good communication skill.	Various dimensions of human behaviour act as a barrier for good communication.
Education of Relatives Proper communication Convince the patient with skills	Breaking the death with proper communication will help to avoid violence on doctors.	Importance of communication skills in special situations.
Regular Sessions Flow Chart Seminars Debates Role play Group Discussions	Workshops, setting examples, demonstrating communication skills in front the juniors while working. Participants also expressed the importance of inclusion of such modular training in their curriculum.	Integrating communication skills in the formal education.

An attempt was made to know the impression of resident doctors on various aspects related to selected study parameters from the module. Open ended questions were asked at the end of questionnaire during pre and post-test. The thematic analysis of the qualitative data was performed using grounded theory. The main themes of the study were identified first by coding the scripts. The scripts were coded and categorized within the frames of the core questions that were discussed during the semi-structured interviews that served and reflected the objectives of the study. Themes were identified from the coded scripts both pre-test and post-test.

The resident doctors have emphasised on various aspects of the communication skills for better management of doctor and patient relationship. Following were few statements by the respondents toward role of mindfulness in medical profession.

''Mindfullness can help to prevent burnout in Doctor''

"It helps in making better approach towards patient care"

''Mindfulness helps to avoid confusion with relatives and patients''

''Mindfulness is helpful in the medical profession by reducing a collapse with patient's relatives. It also improves doctor patient relationship.''

The residents also gave some productive statements towards role of emotional intelligence in developing interpersonal relationship. Following were few statements.

"It helps in creating better relationship with patient and relatives'

''Emotional intelligence helps to know which patient needs more help''

''It improves interpersonal relationship, educational status, emotional status and reduces cultural differences.''

''it helps to control the emotions and also to understand others in order to understand them''

It was important to get the perception of residents about the barriers they are facing in good communication. Following were few statements from the residents.

"The main barriers in the communication are not limited to the knowledge and attitude but also extended to lack of patience, cultural differences, aggression etc.''

Residents perception about role of communication skill in breaking the bad news and preventing the violence on doctors was recorded in following statements were made by the residents.

"Communication skills during breaking bad news will definitely prevent the violence provided that the relatives have known though out that doctors have done their best for the patient"

Teaching communication skills to the residents was one of the major aspects of the study. Hence, when the residents were asked about it following statements were recorded.

"Communication skills should be taught during the under graduation through lectures and workshop"

In thematic analysis of post-test assessment, five sub themes were generated from the codes recorded from the data (Fig. 4.1). First sub theme have elaborated the perception and improved knowledge level of the resident doctors about the importance of mindfulness in the medical profession. The data revealed that the resident doctors have good insight about the mindfulness and its role in the medical profession. Second sub theme generated was 'Emotional Intelligence helps in developing interpersonal relationship' which gives idea about overall understanding and improved perception and knowledge of resident doctors about emotional intelligence. Third theme generated was the outcome of residents understanding about various dimensions of human behaviour which acts as a barrier for good communication. Integrating communication skills in the formal education was the fourth theme generated from the data which emphasises on the importance of teaching communication skills to the doctors during undergraduate as well as other level of education.

The fifth sub theme was 'Communication skill is important in special situations' giving overall insight of residents about the breaking bad news to the patients. The theme has shown improved knowledge level of the residents after the

training communication skills. The global theme generated from the data was 'Communication Skills helps better doctor patient management' which explains how the communication skills will help to manage the doctor patient relationship in better way. To summarize the role of communication skills in doctor patient mangment, it is seen that, there was improved perception regarding importance of mindfulness or keeping the attention to experiences occurring in the present moment. There was improved perception regarding importance of emotional intelligence and role of empathy. The participants have identified correctly the barriers of communication between doctor and patient/relatives. The participants have identified the importance of continuing communication skill workshops as well as importance of inculcating and practicing these skills in front of juniors, so that they can also adopt the same practices. They expressed that such modular training can also be incorporated in the curriculum communication skills through open ended questions.

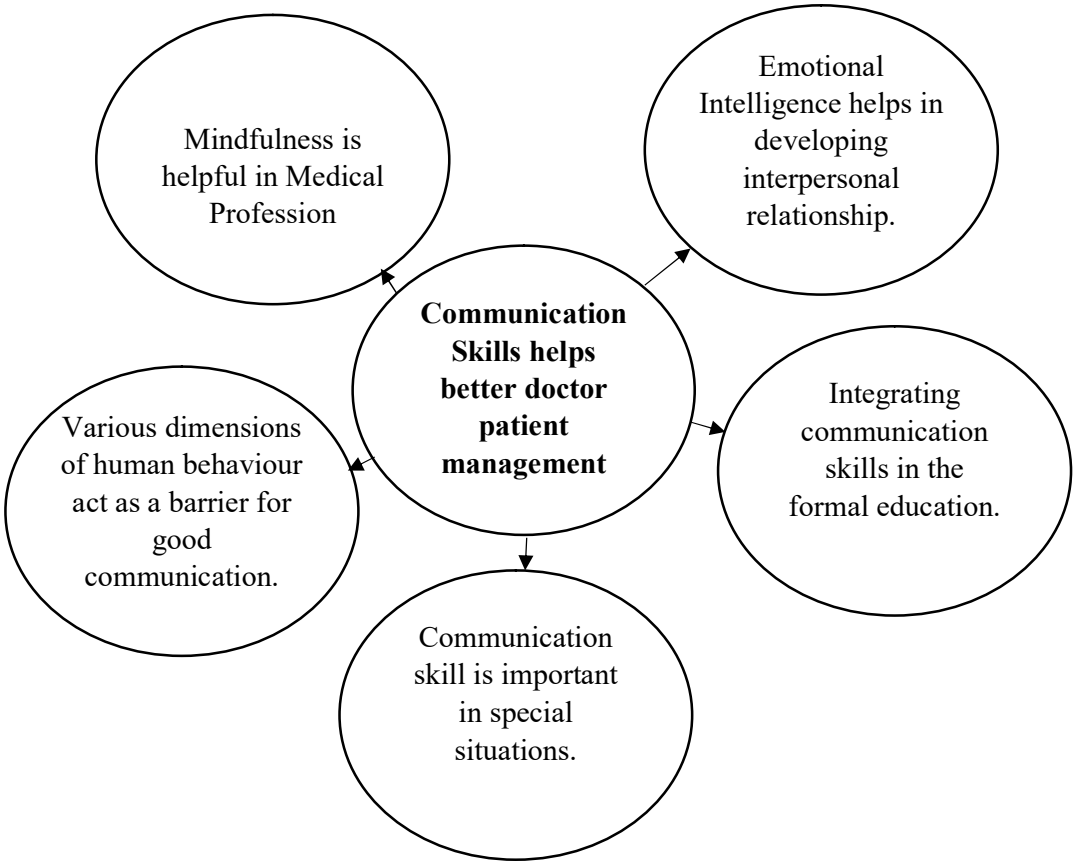


Fig. 4.1 Thematic analysis of role of communication skills in doctor patient management

4.4 CHANGE IN QUANTIFIED KNOWLEDGE AND ATTITUDE AFTER TEACHING COMMUNICATION SKILLS TO RESIDENT DOCTORS.

Teaching communication skills to the Post graduate students of Medical Sciences using structured module through the workshop was main intervention of the study. The interventional studies of this kind were carried out by many researchers to improve the communication skills among the doctors [108] and they have reported significant change in the student's overall communication competence as well as their skills of relation building and shared decision making. [109]

An experiential communication skills training model of relationship-centred communication successfully improved participating physicians' self-reported empathy and burnout [110]. This indicates that the knowledge and attitude in relation to being mindful doctor can be achieved after proper intervention and the present study was able to increase it with an intervention in the form of training module. The statistics which follows the discussion has also proved the same fact.

Table 4.12: Change in quantified knowledge and attitude in relation to "Being a mindful doctor."

Test	Mean	SD
Pre-test*	4.03	0.53
Post-test*	4.09	0.54
Z-value (Wilcoxon-test)	2.42	
P value	0.015	
Effect size	0.12	

*Quantified knowledge was calculated by transforming the pre and post scores in question number 1.

Table 4.12 shows that there was significant difference in the pre and post scores for quantified knowledge in relation to "being a mindful doctor" (p=0.015). So the training in the communication skills to the resident doctors resulted in significant change in the quantified knowledge and attitude in relation to "being a mindful doctor", suggesting that the intervention was effective in improving the communication skills limited to that part.

It is likely that most of the trainees in healthcare chose the profession with the mind-set of making a good living. This involves charging fees for the services

offered to the patients. This attitude is reflected in the answers given by the trainees. The communication module did not make a significant impact on the trainee's mind with regards to charging fees for the services provided. Most trainees are probably not mentally ready to work in an altruistic manner. They must be feeling insecure, because they may have come to this profession with a mind-set of making monetary gains for themselves. Service orientation and socially responsible attitudes should be checked at the time of entry into the profession. The trainees may be exposed to this kind of commercial attitude in their surroundings. If the encouragement for years before entering the profession was about the status of the profession and not the service component, it will take time for us to change this ingrained thought process.

The concept of mindfulness is still new for many. When this is introduced to the trainees, the acceptance and behavioural change will depend upon the receptivity of the trainee for such ideas. The challenge is to help them to realise the importance of being mindful and then to motivate them to adopt this into their daily practice. It would be more beneficial if such ideas are developed in the students from early years of their education. As most trainees were in the age group of 26 to 30 years, this is a late stage in life for them to be willing to learn a new concept. This also applies for service orientation and altruism.

As emotions are a part of everyone's life, the idea of emotional intelligence is much easier to inculcate in the trainees. Each human being possesses empathy. It needs a special skill to be able to demonstrate empathy. When the trainees realise this technique, they are able to adapt themselves quickly.

It is a general misconception amongst most people that the doctor's job is to cure patients every time. In modern medicine, cure is rare, comfort is mostly and counselling is always. If the trainees think in this manner, they will realise the importance of good communication. Giving comfort and counselling someone is an art, which has to be learnt. Each individual is capable of learning this in varying degrees as per their personal capabilities. The question about curing patients reflects that most doctors are also thinking that they are curing patients each time. This could be the reason for the data to be not statistically significant for this question.

The medical profession has a huge task of restoring patient's well-being. This does not only include making them physically well, but also their mental and social

well-being. Most trainees are not having much social involvement. Most of their time is spent in gathering knowledge and acquiring skills in the medical colleges and hospitals. The focus of their work is on treating patients. It is very important that trainees are actively involved in prevention of disease. This will help them to connect with the social fabric and develop social responsibility.

It is seen from table 4.13 that, there is highly significant change in the quantified knowledge and attitude of the resident towards the basics of communication skills after the intervention of teaching. In the study conducted by Catherine *et.al*, 2011, it was reported that students receiving professional development teaching in the communication skills were judged to be better at using silence, not interrupting the patient and keeping the discussion relevant, which are most important components of communication skills. [111]. Another study conducted by Michael et.al., 2003 on the effect of communication skill training on medical student's performance also reported that, dedicated communication curricula significantly improved student's competence in performing skills known to affect the outcome of care. [112]

Table 4.13: Change in quantified knowledge and attitude in relation to "Basics of communication skills"

Test	Mean score	SD
Pre-test*	3.76	0.54
Post-test*	3.87	0.62
Z-value (Wilcoxon-test)	3.89	
P value	<0.0001	
Effect size	0.20	

*Quantified knowledge was calculated by transforming the pre and post scores in question number 9.

Table 4.13 shows that there was significant difference in the pre and post test scores for quantified knowledge in relation to "basics of communication skills" ($P<0.0001$). So intervention resulted in significant change in the quantified knowledge and attitude in relation to "basics of communication skills", suggesting that the intervention was effective in improving the communication skills limited to that part.

The study also focused the basics of doctor patient relation as one of the important component of communication skill training module developed for the intervention The main focus of this intervention was to understand the student's perception, knowledge and attitude towards need for change in current doctor patient relationship. The importance given laws in preventing the violent attacks on the doctors needed assessment. The role of misleading online sources of health information creating confusion in the patients needed to be understood. Similarly, the perception of the doctors about the role of the media in creating violent attacks by the patients needed evaluation. Finally, it was important to check if the doctors felt that they could reduce the attacks on the doctors by using good behavioural skills. It is seen from table 4.14 that, the knowledge and attitude of the resident doctors towards basic doctor patient relationship was significantly improved after teaching the communication skills through a structured training module. A randomized control trial done among dental students in India also highlighted that a course on communication skills improved the student-patient interaction leading to a good doctor patient relation [113]. In a study by Joekes et al., it was found that students who received training in communication skills as a part of professional development showed significant improvement compared to their counterparts.[111] The students exposed to intervention showed significant improvement in the post-test assessment. In another study involving medical students undergoing surgical clerkship, improvement was noted in communication skills after a six-hour training workshop. [114]

All trainees undergo their medical training in English language. They are expected to speak with the patients in the local language. 34.22% of the trainees were not familiar with the local language. They have the dual task of communicating with a different language and also to use non-medical terminology. Although, learning a new language is possible, it is not that easy, given the busy schedule of the resident doctors. The intervention was not about improving the language skills of the trainees. Hence, it appears from the pre and the post scores that the trainees did not show a significant change in their perception about the role of the language skills in communication.

Listening is a very important skill to acquire. In the current atmosphere of medical education, there is not much emphasis on these skills. Trainees are not well-

versed with this skill. The data gathered from this question, shows that there is no significant difference in the pre and the post test scores. More emphasis will have to be made on teaching this skill. The trainees are mostly dealing with poor and uneducated patients. They are mostly busy due to the excessive workload and they are always short of time. Due to this, their listening skills are not very well developed. This may improve when the training is given at regular intervals over a period of time. If the trainees can see demonstrations of these skills, they are very likely to learn the art of listening.

Table 4.14 shows that there was significant difference in the pre and post test scores for quantified knowledge in relation to "basic doctor patient relationship" ($P<0.0001$). So intervention resulted in significant change in the quantified knowledge and attitude in relation to "basic doctor patient relationship", suggesting that the intervention was effective in improving the communication skills limited to that part.

Table 4.14: Change in quantified knowledge and attitude in relation to "Basics Doctor Patient relationship"

Test	Mean score	SD
Pretest*	3.59	0.45
Posttest*	3.72	0.46
z-value (Wilcoxon-test)	5.04	
P value	<0.0001	
Effect size	0.26	

*Quantified knowledge was calculated by transforming the pre and post scores in question number 13 and 15.

Communication in special situation is always important in healthcare setting. Hence, in present study various sub parameters studied under communication in special situations are doctors aggressive approach to handle angry patient, location of disclosing bad news, role of armed security guards to stop the attacks on the doctors while disclosing the bad news, half information about bad news to the patient to reduce the stress and keeping quite while receiving harassment from senior colleagues. The pre and post test scores of this parameter have shown significant difference proving the effectiveness of the training module in changing the knowledge and attitude of the resident doctors.

Irene *et.al*, reported the positive outcomes of structured, comprehensive training program which were replicated in different samples they studied. These positive outcomes were reflected, each year, in statistically significant increases in confidence, self-rated by participants, and in communication skills, assessed by external observers. [115] Amy et.al. also reported increased skill levels compared with resident's baseline ratings. These changes were statistically significant with very large effect sizes on nearly all measured dimensions, and reported improvements held at 3 months after course completion. Their results also suggested that, in the medical ICU setting, a brief, on-site, theoretically informed communication program that is integrated into clinical training for internal medicine residents is associated with strongly positive family member outcomes and significant improvements in residents' perceived communication skills. [116]

Most trainees, during their undergraduate and their postgraduate education, have witnessed communication styles of seniors, which are mainly traditional in nature. Shared decision making is not the most common way in which most communication would take place. Due to this, the concept of involving the patient in decision-making is slightly difficult for the trainees to grasp. At the moment, it is a theoretical concept for them as they have rarely experienced this practically. In most of the government or private hospitals, the patients come from lower socio-economic strata. They may be less literate and may not have the habit of asking many questions to the doctors. Due to this, most trainees may not get many opportunities to learn this skill. There is also a pressure of time, due to which they are unable to shared decision making.

There is a general understanding that the media has played a significant role in spoiling the doctor- patient relationship. The negative incidences have highlighted by the media, have brought some of the unethical practices in the public domain. This has influenced the public opinion about the doctors, leading to loss of trust in the profession. Most discussions on this topic amongst medicos will suggest that media is to be blamed for this situation. The aim of the question about the role of media was not to decide if the media is responsible or not. The main purpose was to know if the doctor can gain trust of the patients even if the media has portrayed such an image. Many trainees did realise that a good attitude and behaviour will still be able to develop a good doctor-patient relationship.

Table 4.15: Change in quantified knowledge and attitude in relation to "Communication in special situation."

Test	Mean score	SD
Pre test	2.26	0.65
Post test	2.06	0.73
z-value (Wilcoxon-test)	-5.95	
P value	<0.0001	
Effect size	-0.31	

Table 4.15 shows that there was significant difference in the pre and post test scores for quantified knowledge in relation to "communication in special situation" ($P<0.0001$). So intervention resulted in significant change in the quantified knowledge and attitude in relation to "communication in special situation", suggesting that the intervention was effective in improving the communication skills limited to that part.

The assessment of perception, knowledge and attitude towards current practices and need of training in communication skill from the resident's perspective was carried out. Various subgroups assessed in this category were capability of current teaching pattern in handling untoward incidences at workplace, inclusion of subject on communication skills in undergraduate and postgraduate courses, uniform standard operating protocol to handle incidences at workplace, frequent communication skill workshops in healthcare institutions and inclusion of communication skill training at high school and junior colleges. After recording all the responses of the residents before and after intervention, it is reported that the training module was very much effective in imparting the knowledge and change in attitude in relation to training in communication skills. The studies have proved that, communication skills tend to decline with time unless they are regularly recalled and practiced [117, 118]. Structured communication skills training is still needed in graduate training and should be tailored to junior doctors' needs and work context in order to be successful and well perceived. [119]

Table 4.16: Change in quantified knowledge and attitude in relation to "Training in communication skills."

Test	Mean score	SD
Pre-test*	3.99	0.60
Post-test*	4.19	0.66
z-value (Wilcoxon-test)	6.44	
P value	<0.0001	
Effect size	0.33	

*Quantified knowledge was calculated by transforming the pre and post scores in question number 21.

Table 4.16 shows that there was significant difference in the pre and post test scores for quantified knowledge in relation to "Training in communication skills", ($P<0.0001$). So intervention resulted in significant change in the quantified knowledge and attitude in relation to "training in communication skill", suggesting that the intervention was effective in improving the communication skills limited to that part.

So, table 4.12 to 4.16 shows that the intervention was successful in improving the communication skills in all five sections of communication skills, as defined in this study.

4.5 EFFECT OF VARIOUS SOCIO-DEMOGRAPHIC FACTORS ON CHANGE IN QUANTIFIED KNOWLEDGE AND ATTITUDE AFTER TEACHING COMMUNICATION SKILLS TO RESIDENT DOCTORS

One of the research questions of this study was to explore the potential predictive effect of various socio-demographic variables on the baseline communication skill and the changed knowledge and attitude of the resident doctors after intervention. The linear regression was performed to assess role of various socio-demographic factors for change in quantified knowledge and attitude in relation to five selected sections of the study. With the help of linear regression, the effect of gender, subject specialty, area, any relative as doctor, attended any previous workshop in communication skills and knowledge of local language on five parameters was studied.

Effect of selected socio-demographic factors in mindfulness was studied with group of five sub questions. It is seen from table 4.16 that, the intervention in the form of teaching communication skills with focus on mindfulness was equally effective in all these subgroups except the dichotomous variable – history of previous workshop.

Sabina and Enedina also studied age and gender differences in mindfulness and reported that age group is playing important role in mindfulness as they found in their study that older participants' scores were higher than for younger participants. [120] The other studies have also demonstrated that older adults demonstrate a higher degree of emotional control [121], as well as a greater tendency to focus on the present moment [122, 123].

Level of education is significantly associated with increased engagement in mindfulness based practices as mentioned by Henry *et.al.* in the study entilted Engagement in Mindfulness Practices by U.S. Adults: Sociodemographic Barriers. They have also mentioned that, men were found to be less likely than women to engage in mindfulness practices. [124]

Table 4.17: Effect of various socio-demographic factors in change in quantified knowledge and attitude in relation to "Being a mindful doctor."

Socio-demographic factors	Beta	95% CI for Beta	p-value	Adjusted R^2-value
Gender	.026	-0.08765 to 0.14641	0.62	
Subject specialty	.031	-0.01228 to 0.022701	0.56	
Area	.020	-0.15062 to 0.223197	0.70	
Doctor Relative	.007	-0.11056 to 0.12687	0.89	12.7%
Attended previous workshop	-.112	-0.28866 to -0.01407	0.03	
Speak and understand local language	-.042	-0.17531 to 0.07482	0.43	

The linear regression was performed to assess role of various socio-demographic factors for change in quantified knowledge and attitude in relation to "being a mindful doctor." Regression coefficients were non-significant (except - attended previous workshop), suggesting that the intervention was equally effective in all these subgroups except the dichotomous variable – history of previous workshop.

The improvement in quantified score was 0.11, if the study subject has attended previous workshop.

Learning basics of communication skill is an art and it is perceived that this art is affected by various sociodemographic factors in both the ways. Hence, an attempt was made to assess effect of various socio-demographic factors in change in quantified knowledge and attitude in relation to basics of communication skills. The results which are presented in table 4.17 indicates that the intervention of teaching communication skills to the resident doctors was equally effective in all sub groups with respect to selected socio demographic parameters viz. gender, Subject specialty, Area, Doctor Relative, Attended previous workshop and the knowledge of local language. Many studies earlier indicate that the communication style differ within men and women [125]. The research has shown that women and men use language differently. Shakeshaft argues that when women communicate, their speech is less likely to be centred on impersonal subject matter, more likely on emotional and personal issues, and they talk less and listen more than men [126]. In the study conducted by Avan *et.al*., they have reported difference in levels of communication skills with the subject specialty. They found that, total informative communication index was lowest for multi-disciplinary and highest for surgical residents. Total affective index was lowest for multi-disciplinary and highest for medical residents. [127]

Table 4.18: Effect of various socio-demographic factors in change in quantified knowledge and attitude in relation to "Basics of communication skills"

Socio-demographic factors	Beta	95% CI for Beta	p-value	Adjusted R^2-value
Gender	0.02813	-0.09532 to 0.168162	0.59	
Subject specialty	0.082691	-0.004 to 0.035381	0.12	
Area	0.064815	-0.07733 to 0.343481	0.21	
Doctor Relative	0.028482	-0.09662 to 0.170659	0.59	1.7 %
Attended previous workshop	-0.05471	-0.23778 to 0.071329	0.29	
Speak and understand local language	-0.02842	-0.17948 to 0.102089	0.59	

The linear regression was performed to assess role of various socio-demographic factors for change in quantified knowledge and attitude in relation to

"Basics of communication skills". All regression coefficients were non-significant, suggesting that the intervention was equally effective in all these subgroups.

Basic doctor patient relationship can also be affected by various sociodemographic factors of the doctor. In past, doctors were left to make the decision at their own, today however there is a new alliance between the doctor and patient, based on co-operation rather than confrontation, in which the doctor must understand every patient as a unique human being. Thus patient centred care has replaced a one-sided, doctor-dominated relationship in which the exercise of power distorts the decision-making process for both parties [128]. Although less studied it is evident that the physicians' personal demographic characteristics influences their clinical practice. Interestingly, physicians' practice biases seem to echo the health biases of the groups from which they emanate. [129]

The researchers have also emphasized that, Physicians need to be conscious that their own demographic characteristics and perceptions might influence the quality of prevention counselling delivered to their patients [130].

The role of gender of doctor in doctor patient relation is widely studied, many researchers have reported that, female physicians appear to be less dominant verbally during the visit than male physicians. Female physicians spend more time with their patients than male physicians [131, 132] and they talk more than male physicians [133, 134]. This helps in building the relation with the patient.

Table 4.19: Effect of various socio-demographic factors in change in quantified knowledge and attitude in relation to "Basic Doctor Patient relationship."

Socio-demographic factors	Beta	95% CI for Beta	p-value	Adjusted R^2-value
Gender	0.0542	-0.17139 to 0.041765	0.23	
Subject specialty	0.008101	-0.00391 to 0.027949	0.14	
Area	0.086564	-0.17577 to 0.16467	0.95	
Doctor Relative	0.054982	-0.11231 to 0.103919	0.94	1.3%
Attended previous workshop	0.063587	-0.18957 to 0.060502	0.31	
Speak and understand local language	0.057922	-0.16326 to 0.064531	0.39	

The linear regression was performed to assess role of various socio-demographic factors for change in quantified knowledge and attitude in relation to "Basic Doctor Patient relationship". All regression coefficients were non-significant, suggesting that the intervention was equally effective in all these subgroups.

Special situation in the health care where the communication has to play vital role are, emergency departments, ICU and the chronic diseases departments where the bad news has to be disclosed. The bad news is either in the form of death or diagnosis of a chronic disease like cancer. During such special situations if the doctor is not carrying adequate communication skills the conflict may arise. Conflict can evoke feelings of helplessness, frustration, confusion, anger, uncertainty, failure, or sadness, hence it is always challenging. Every doctor therefore must recognize these feelings and develop skills to identify problematic responses in the patient or themselves to de-escalate the situation and enable the relationship problems to be turned into a clinical success. [135] The non-significant regression coefficients in relation to communication special situations suggests that the intervention in the form of teaching communication skill in special situations was equally effective in all these subgroups.

Table 4.20: Effect of various socio-demographic factors in change in quantified knowledge and attitude in relation to "communication in special situation."

Socio-demographic factors	Beta	95% CI for Beta	p-value	Adjusted R^2-value
Gender	0.052076	-0.08172 to 0.252783	0.32	
Subject specialty	-0.0941	-0.04765 to 0.002352	0.07	
Area	0.03567	-0.17423 to 0.360021	0.49	
Doctor Relative	-0.01295	-0.19101 to 0.148322	0.80	1.5%
Attended previous workshop	0.053304	-0.09337 to 0.299073	0.30	
Speak and understand local language	0.008315	-0.16438 to 0.1931	0.87	

The linear regression was performed to assess role of various socio-demographic factors for change in quantified knowledge and attitude in relation to "communication in special situation". All regression coefficients were non-

significant, suggesting that the intervention was equally effective in all these subgroups.

Doctors have different innate talents; they are not born with excellent communication skills. If adequate motivation and incentives are provided for self-awareness, self-monitoring, and training, doctors can definitely understand the theory of good doctor-patient communication, learn and practice these skills, and be capable of modifying their communication style. [135, 136] Many studies have reported the improvement in doctor-patient communication after communication skills training. [137, 138] Some researchers have said that medical education should go beyond skills training to encourage physicians' responsiveness to the patients' unique experience. [139]

Researcher have suggested that, communication skills need to be reinforced and practiced frequently throughout the course to be applied by professionals in their future careers [140, 141]. Medical students themselves, and several professional bodies, have acknowledged the need to incorporate communication skills training within the formal curriculum [142, 143, 144]. Although few researchers feel that, the real challenge is to seamlessly integrate communication skills training with clinical training, but they have suggested ways to include training and assessment of communication and interpersonal skills for Indian medical students within the existing curriculum. [145]

Many researchers have emphasized that, a good communication skills training program should be multi-session and multi-disciplinary, use multiple methods, and have opportunities for demonstration, discussion, reflection, practice and feedback [100, 101]. On the same basis an assessment of role of socio demographic background of doctors on perception of doctors about need of communication skill training was assessed. The non-significant regression coefficient suggests that the intervention in the form of the teaching communication skills was equally effective in all subgroups.

Table 4.21: Effect of various socio-demographic factors in change in quantified knowledge and attitude in relation to "Training in communication skills."

Factors	Beta	95% CI for Beta	p-value	Adjusted R^2-value
Gender	0.043411	-0.08589 to 0.213767	0.4	1.7%
Subject specialty	-0.09925	-0.04382 to 0.000973	0.06	
Area	-0.02512	-0.29795 to 0.180636	0.63	
Doctor Relative	0.052981	-0.07366 to 0.230318	0.31	
Attended previous workshop	0.025105	-0.13234 to 0.219217	0.63	
Speak and understand local language	-0.04097	-0.22358 to 0.096651	0.44	

The linear regression was performed to assess role of various socio-demographic factors for change in quantified knowledge and attitude in relation to "training in communication skills". All regression coefficients were non-significant, suggesting that the intervention was equally effective in all these subgroups.

So, table 4.16 to 4.21 shows that the intervention was equally effective in sub groups of the study respondents, and change in score was not significantly correlated with these socio-demographic variables.

Thus it can be concluded that the intervention module is effective in improving the communication skills in all five sections as defined in this study. Also the intervention is equally effective in all substrata of the study population, irrespective of the socio-demographic variables.

Chapter V: Conclusion

5.1 Conclusion

1. The pre test study has shown that there was varied knowledge about the communication skills among the resident doctors. The residents have shown very superfacial attitudes and behaviours towards mindfulness, basic communication skills, doctor patient relationship, communication in special situations and training in communication skills.
2. There was significant difference in the pre and post test scores for quantified knowledge in relation to being a mindful doctor, basics of communication skills, doctor patient relationship, communication in special situation, and training in communication skills.
3. The study outcome is indicating that training module on "Communication Skills in Health Care" resulted in significant change in the quantified knowledge and attitude of the resident doctors in relation to "all five sections mentioned suggesting that the intervention was effective in improving the communication skills among the resident doctors.
4. The intervention was equally effective in all substrata of the study population, irrespective of the socio-demographic variables.
5. It is concluded that, improved knowledge in the communication skills of the resident doctors will help to improve and manage the doctor patient relationship.

5.2 Recommendations

1. As it is seen in the present study that, use of training module improves the communication skills among the resident doctors, it is therefore recommended that this module of "Communication Skills in Health Care'' should be integrated in post graduate teaching of medical colleges across the country.
2. As revealed from the study outcome, regular communication skill workshops must be conducted in every healthcare institution to improve the communication skills for good doctor patient relationship.

3. Teaching communication skills should form an important component of secondary and higher schooling in order to inculcate the basics of communication among students at an early age.
4. To develop uniform specific standard operative protocols for the healthcare settings to handle incidences at work places resulting due to lack of communication skills.

5.3 Future Scope for Study

1. Although the study has concluded that the teaching communication skills to the resident doctors improves the knowledge and attitude which can help for better management of doctor patient relation, there is a scope to study whether this improved knowledge and attitude really turns in to the practice.
2. Hence, this study opens up the new horizon to explore the management of doctor patient relationship by professionally sound communication skills after improvement in the knowledge and attitude of the residents.

1) Hall JA, Roter DL, Rand CS. Communication of affect between patient and physician. J Health Soc Behav 1981;22(1):18-30
2) Shukla AJ, Yadav VS, Kastury N. Doctor-Patient Communication: An Important But Often Ignored Aspect in Clinical Medicine. J Indian Academy Clinical Med 2010;2(3):208-11
3) Samuel YS Wong, Albert Lee. Communication skill and Doctor Patient Relationship. Medical Bulletin 2006;2(3):7-9
4) Reents S. Impacts of the internet on the doctor-patient relationship: the rise of the internet health consumer. New York; Cyber Dialogue: 1999;245-48
5) Sundeep Mishra. Violence against Doctors: The Class Wars. Indian Heart J 2015;67:289-92
6) Madhiwalla N, Roy N. Assaults on public hospital staff by patients and their relatives: an inquiry. Indian J Medical Ethics 2006;3(2):17-21
7) Jensen BF, Gulbrandsen P, Dahl FA, Krupat E, Frankel RM, Finset A. Effectiveness of a short course in clinical communication skills for hospital doctors. Results of a crossover randomized controlled trial. Patient Educ Couns 2010;7-13
8) Kalet A, Pugnaire MP, Cole-Kelly K, Janicik R, Ferrara E, Schwartz MD, et al. Teaching communication in clinical clerkships: models from the Macey initiative in health communications. Acad Med 2004;79(6):511-20
9) Starr Paul. The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry. New York: Basic Books, Inc. 1982;727-32
10) Parsons Talcott. The Social System. Routledge & Kegan Paul Ltd. 1951;132-37
11) Hauser Robert M, David L. Featherman. The Process of Stratification: Trends and Analyses. New York: Academic Press. 1977
12) Nakao Keiko and Judith Treas. The 1989 Socioeconomic Index of Occupations: construction from the 1989 occupational prestige scores. GSS Methodological Report No. 74. Chicago: National Opinion Research Center, 1992
13) Charles C, Whelan T, Gafni A. What Do We Mean by Partnership in Making Decisions about Treatment? British Medical Journal 1999;319:780-82

14) Alexander Jeffrey A, Larry R. Hearld, Jessica N. Mittler and Jillian Harvey. Patient-Physician Role Relationships and Patient Activation among Individuals with Chronic Illness. Health Services Research. 2012;182-85
15) Roter Debra L and Susan Larson. RIAS: Roter Interaction Analysis System: Utility and flexibility for analysis of medical interactions. Patient Education and Counseling 2002;46:243-51
16) Laura Hawryluck. Communication with Patients and families, University of Toronto. 2000.
17) Kennedy DM, Fasolino JP, Gullen DJ. Improving the patient experience through provider communication skills building. Patient Experience J 2014;1(1):56-60.
18) Jennifer Fong Ha and Nancy Longnecker. Doctor-Patient Communication: A Review. The Ochsner Journal 2010;10:38-43
19) Ramesh Ramasamy, Sathish Babu Murugaiyan, Rachel Shalini, Kuzhandai Velu Vengadapathy, Niranjan Gopal. Communication skills for medical students: An overview. Communication skills for medical students: An overview. J Contemp Med Edu 2014;2(2):134-40
20) Perera HJM. Effective Communication Skills for Medical Practice. J Postgraduate Institute Med 2015;2:E20:1-7
21) Jeffrey D. Robinson. Non-verbal communication and Physician Patient Interaction, Review and New Directions. Rutgers University 2006;437-49
22) Aminur Rahman and Saria Tasnim. Twelve Tips for Better Communication with Patients during History-Taking. The Scientific World J 2007;7:519–24
23) Sarbani Kattel. Doctor Patient Communication in Health Care Service Delivery: A Case of Tribhuvan University Teaching Hospital, Kathmandu, North South University, Bangladesh, 2010;727-32
24) Chauhan V, Galwankar S, Kumar R, Raina SK, Aggarwal P, Agrawal N, et al The 2017 Academic College of Emergency Experts and Academy of Family Physicians of India position statement on preventing violence against health-care workers and vandalization of health-care facilities in India. Int J Crit Illn Inj Sci 2017;7(2):79-83.
25) The Times of India. 1 in 2 Doctors Face Violence at Public Hospitals: Study – Times of India. Available from: http://www.timesofindia.indiatimes.com/ city/delhi/1-in-2-doctors-face-violence-at-public-hospitals-study/articleshow/ 57740477.cms [Last accessed on 22nd Mar 2017].

26) Over 75% of Doctors Have Faced Violence at Work, Study Finds – Times of India. Available from: http://www.timesofindia.indiatimes.com/india/Over-75-of-doctors-have-faced-violence-at-work-study-finds/articleshow/47143806.cms. [Last accessed on 15th Mar 2017].
27) Gunderson L. Physician burnout. Annals Internal Med 2001;135:145–48
28) Miller MN, McGowen KR. The painful truth: physicians are not invincible. Southern Medical J 2000;93:966–73
29) Shanafelt TD, Habermann TM. The well-being of physicians. American J Med 2003;114:513–19.
30) Julie Anne Irving, Patricia L. Dobkin, Jeeseon Park. Cultivating mindfulness in health care professionals: A review of empirical studies of mindfulness-based stress reduction (MBSR). Complementary Therapies in Clinical Practice 2009;15:61–66
31) Real K, Fields-Elswick K, Bernard AC. Understanding Resident Performance, Mind fullness and Communication in Critical Care Rotations. J Surg Educ 2017;74(3):503-12
32) Geoffrey J Riley. Understanding the stresses and strains of being a doctor. Med J Aust 2004;181(7):350-53
33) Kabat-Zinn J. Full catastrophe living. Using the wisdom of your body and mind to face stress, pain, and illness. New York, NY: Dell Publishing; 1990;823-27
34) Mikulas WL. Mindfulness: Significant Common Confusions. Mindfulness. 2011;2(3):85-87
35) Ryan RM and Deci EL. Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. Am Psychol. 2000;55:68-78
36) Lin DT, Liebert CA, Tran J, Lau JN, Salles A. Emotional Intelligence as a Predictor of Resident Well-Being. J Am Coll Surg 2016;223(2):352-58
37) McKinley SK, Petrusa ER, Fiedeldey-Van Dijk C, Mullen JT, Smink DS, Scott-Vernaglia SE, et al. Are there gender differences in the emotional intelligence of resident physicians? J Surg Educ 2014;71(6):e33-40.
38) Riess H, Kelley JM, Bailey RW, Dunn EJ, Phillips M. Empathy training for resident physicians: a randomized controlled trial of a neuroscience-informed curriculum. J Gen Intern Med 2012;27(10):1280-86

39) Roberts LW, Warner TD, Moutier C, Geppert CM, Green Hammond KA. Are doctors who have been ill more compassionate? Attitudes of resident physicians regarding personal health issues and the expression of compassion in clinical care. Psychosomatics 2011;52(4):367-74

40) Campbell JP, Dunnette MD, Lawler EE & Weick KR. Jr. Managerial behavior, performance and effectiveness. New York: McGraw-Hill. 1970.

41) Schwarz MR, Wojtczak A. Global minimum essential requirements; a road towards competence-oriented medical education. Med Teach 2002;24:125-29

42) Lindo JLM, McCaw-Binns A, LaGrenade J, Jackson M, Eldemire-Shearer D. Mental well-being of doctors and nurses in two hospitals in Kingston, Jamaica.West Indian Med J 2006;55(3):81-85

43) Felton JS. Burnout as a clinical entity-its importance in healthcare workers. Occup Med (Lond) 1998;48:237-50

44) Gianakos I. Gender Roles and Coping with work stress. Sex Roles. Jun 2000;42(11/12):1-13

45) Maslach C, Schaufeli WB, Leiter MP. Job burnout. Annu Rev Psychol 2001;52:397-422

46) McManus IC, Winder BC, Gordon D. The causal links between stress and burnout in a longitudinal study of UK doctors. The Lancet 2002;359:2089-90

47) http://www.careerizma.com/skills/communication-skills/ [last accessed on 10th Sept. 2018]

48) https://study.com/academy/course/communication-in-the-workplace-help-course.html [last acceseed on 15th Nov. 2018]

49) Melvin L, Connolly K, Pitre L, Dore KL, Wasi P. Improving medical students' written communication skills: design and evaluation of an educational curriculum. Postgrad Med J 2015;91(1076):303-38

50) Drukteinis DA, O'Keefe K, Sanson T, Orban D. Preparing emergency physicians for malpractice litigation: a joint emergency medicine residency-law school mock trial competition. J Emerg Med 2014;46(1):95-103

51) Branson CF, Chipman JG. Improving surgical residents' communication in disclosing complications: A qualitative analysis of simulated physician and patient surrogate conversations. Am J Surg 2018;215(2):331-35

52) Howard T, Jacobson KL, Kripalani S. Doctor talk: physicians' use of clear verbal communication. J Health Commun 2013;18(8):991-1001

53) McCarthy DM, Leone KA, Salzman DH, Vozenilek JA, Cameron KA. Language use in the informed consent discussion for emergency procedures. Teach Learn Med 2012;24(4):315-20

54) Arora V, Johnson J, Lovinger D, Humphrey HJ, Meltzer DO. Communication failures in patient sign-out and suggestions for improvement: a critical incident analysis. Qual Saf Health Care 2005;14(6):401-07

55) https://study.com/academy/lesson/oral-communication-definition-types-advantages.html [Last accessed on 10th Oct. 2018]

56) Telephone T.A.L.K.: a telephone communication program. Pediatr Emerg Care 1991;7(2):76-79

57) https://www.toppr.com/guides/business-correspondence-and-reporting/communication/interpersonal-skills-listening-skills-and-emotional-intelligence/ [Last accessed on 15th Oct. 2018]

58) Rhoades DR, McFarland KF, Finch WH, Johnson AO. Speaking and interruptions during primary care office visits. Fam Med 2001;33(7):528-32

59) Ligaya B. Changes in doctor-patient communication in general practice. 1984

60) Gregory V. G. O'Dowd. Doctor-Patient Communication: An Introduction for Medical Students 2004;273-76

61) Cynthia Haq, David J. Steele, Lucille Marchand, Christine Seibert, David Brody.Integrating the Art and Science of Medical Practice: Innovations in Teaching Medical Communication Skills. Family Med 2004;36(suppl-1):43-50

62) Derrick Aarons. Doctor-patient communication in government hospitals in Jamaica: McGill University, Montreal, February, 2005.

63) Nataša M. Bakić-Mirić, Nikola M. Bakić. Successful doctor-patient communication and Rapport building as the key skills of medical practice Medicine and Biology 2008;15(2):74-79

64) https://www.healthdesign.org/sites/default/files/TransforMed_ReducingCycleTime.pdf [last accessed on 10th Oct. 2018].

65) Frates EP. The Five Step Collaboration Cycle: A Tool for the Doctor's Office. Int J Sch Cog Psychol 2015;2:144-46

66) Stolman CJ, Castello F, Yorio M, Mautone S. Attitudes of pediatricians and pediatric residents towards obtaining permission for autopsy. Arch Pediatr Adolesc Med 1999;148(8):843-47

67) Markakis KM, Beckman HB, Suchman AL, Frankel RM. The path to professionalism: cultivating humanistic values and attitudes in residency training. Acad Med 2000;75(2):141-50
68) Sussan Dorr Goold, Mack Lipkin Jr. The Doctor–Patient Relationship Challenges, Opportunities, and Strategies. J Gen Intern Med 1999;14(1):26-33
69) David C. Dugdale, MD, Ronald Epstein, MD, Steven Z. Pantilat, MD, Time and the Patient–Physician Relationship, JGIM 1999;14(Suppl-1):25-34
70) Kathy Zoppi, Ronald M. Epstein. Is Communication a Skill? Communication Behaviors and Being in Relation, Family Med 2002; 34(5):319-24.
71) John M. Travaline, Robert Ruchinskas, Gilbert E. D'Alonzo, Jr, Patient-Physician Communication: Why and How. JAOA, 2005;105(1):35-40
72) Hiroyasu GOAMI. The Physician-Patient Relationship Desired by Society, JMAJ 2007;50(3):115-24
73) Simpson M, Buckman R, Stewart M, Maguire P, Lipkin M, Novack D, et al. Doctor patient communication: the Toronto consensus statement. BMJ 1991;303(6814):1385–87
74) Paice E, Heard S, Moss F. How important are role models in making good doctors? BMJ 2002;325(7366):707-10
75) Maguire P, Pitceathly C. Key communication skills and how to acquire them. BMJ 2002;325(7366):697-700
76) Margaret Quinn Rosenzweig. Breaking bad news: A guide for effective and empathetic communication Nurse Pract. 2012;37(2):1–4
77) Sarah M Hilkert, Colleen M. Cebulla, Shelly Gupta Jain, Sheryl A Pfeil, Susan C Benes, Shira L Robbins. Breaking bad news: a communication competency for ophthalmology training programs. Surv Ophthalmol 2016;61(6):791-98
78) Quirt CF, McKillop WJ, Ginsberg AD, et al. Do doctors know when their patients don't? A survey of doctor-patient communication in lung cancer. Lung Cancer 1997;18(1):1–20
79) Royal College of Psychiatrists. Who cares Wins. 2005. http://www. rcpsych.ac.uk/pdf/whocareswins.pdf [Last accessed on 5h March 2017].
80) Linda E. Bambino. Physician Communication Behaviors That Elicit Patient Trust. East Tennessee State University, May 2006.
81) https://www.pryor.com/training-categories/communication-skills/ [Last accessed on 10th Oct. 2018].

82) https://www.mindtools.com/CommSkll/RolePlaying.htm [Last Accessed on 15th Oct. 2018].
83) https://www.sastra.edu/nptel/download/Prof%20GPRagini/pdf_New/Unit%2026.pdf [Last accessed on 20th Oct. 2018].
84) Eskedal GA. Symbolic role modeling and cognitive learning in the training of counselors. J Counsel Psychol. 1975;22:152–55
85) J. Gregory Carroll. Verbal communication skills and patient satisfaction, evaluation &the health professions. 1990;13(2)168-85
86) Knut Aspegren. Teaching and learning communication skills in medicine: a review with quality grading of articles, Guide Series Editor: Pat Lilley, Production and Desktop Publishing: Molly Gunn and Lynn Bell, AMEE 1999.
87) Terry S. Stein, Thriving in a Busy Practice: Physician–Patient Communication Training, Effective Clinical Practice, 1999;20(2):72-77
88) Darian Allicia Galyon Allicia Galyon. The Physician/Patient Interaction: Patient Satisfaction, Communication Apprehension, and Health Locus of Control, University of Nebraska at Omaha, 1999.
89) Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. Behavior Research Methods, 39, 175-191.
90) Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. Behavior Research Methods, 41, 1149-1160.
91) Kabat-Zinn J. An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. Gen. Hosp. Psychiatry 1982;4:33–47
92) Baer RA, Lykins EL, Peters JR. Mindfulness and self-compassion as predictors of psychological wellbeing in long-term meditators and matched nonmeditators. J. Posit. Psychol. 2012;7:230-38
93) Hutchinson TA, Hutchinson N, Arnaert A. Whole person care: Encompassing the two faces of medicine. Can. Med. Assoc. J. 2009;180:845-46
94) Dobkin PL. Mindful Medical Practice: Clinical Narratives and Therapeutic Insights; Springer: Cham, Switzerland, 2015.
95) Barnes N, Hattan P, Black DS, Schuman-Olivier Z. An Examination of Mindfulness-Based Programs in US Medical Schools. Mindfulness 2016.

96) Ha J, Longnecker N. Doctor-patient communication: a review. The Ochsner Journal. 2010;10(1):38-43

97) Arora N. Interacting with cancer patients: the significance of physicians' communication behavior. Soc Sci Med. 2003;57(5):791–806

98) Accreditation Council for Graduate Medical Education. General Competencies: ACGME Outcome Project 2001. Available from: http://umm.edu/professionals/gme/ competencies. [Last Accessed on 3rd October, 2015].

99) The Royal College of Physicians and Surgeons of Canada. The Can MEDS 2005 Physician Competency Framework. Ottawa, Canada. Royal College of Physicians and Surgeons of Canada; 2005. Available from: http://www.royalcollege.ca/portal/page/portal/rc/common/documents/canmeds /resources/publications/framework_full_e.pdf. [Las Accessed on 3rd October, 2015]

100) Rosenbaum ME, Ferguson KJ, Lobas JG. Teaching medical students and residents skills for delivering bad news: A review of strategies. Acad Med. 2004;79:107-17

101) Brown RF, Bylund CL. Communication skills training: Describing a new conceptual model. Acad Med. 2008;83:37-44

102) Mehta PN. Communication skills – Talking to parents. Indian Pediatr. 2008;45:300-04

103) Rees C, Sheard C, McPherson A. Medical students' views and experiences of methods of teaching and learning communication skills. Patient Educ Couns. 2004;54: 119-21

104) Hellen K. MBERIA. Communication Training Module. Int J Humanities Social Sci 2011;1(20):112-15

105) Likert Rensis. A Technique for the Measurement of Attitudes. Archives of Psychology 1932;140:11-15

106) Jennifer Attride-Stirling. Thematic networks: an analytic tool for qualitative research. 2001. Qualitative Research, SAGE Publications (London, Thousand Oaks, CA and New Delhi) Vol. 1(3):385-405.

107) Stirling J A. Thematic networks ; an analytic tool for qualitative research. Qual. Res.2001; 1(3):385–405. Doi :10.1177/146879410100100307

108) Losh DP, Mauksch LB, Arnold RW, Maresca TM, Storck MG, Maestas RR, Goldstein E. Teaching inpatient communication skills to medical students: an innovative strategy. Acad Med. 2005; 80(2):118-24.

109) Yedidia MJ, Gillespie CC, Kachur E, Schwartz MD, Ockene J, Chepaitis AE et al. Effect of Communications Training on Medical Student Performance. JAMA. 2003;290(9):1157-65

110) Adrienne Boissy, Amy K. Windover, Dan Bokar , Matthew Karafa, Katie Neuendorf, Richard M. Frankel, James Merlino, and Michael B. Rothberg. Communication Skills Training for Physicians Improves Patient Satisfaction. JGIM. 1998;755-61

111) Katherine Joekes, Lorraine Noble, Angela Kubacki, Henry WW Potts and Margaret Lloyd. Does the inclusion of 'professional development' teaching improve medical students' communication skills? BMC Medical Education 2011;11:41

112) Michael J Yedidia et.al. Effect of Communication Skill Training on Medical Students Performance. JAMA 2003;290(9):1157-65

113) Sangabppa S. Communication Skills Course in an Indian Undergraduate Dental Curriculum: A Randomized Controlled Trial. J Dental Educ 2013;77(8):1092-98

114) Adina K, Regina J, Mark S. et al. Teaching communication skill on the surgery clerkship. Med Educ Online. 2005;10:16

115) Irene P Carvalho et.al. Teaching communication skills in clinical settings: comparing two applications of a comprehensive program with standardized and real patients. BMC. Med Educ. 2014;14:92-5

116) Amy M. Sullivan, Laura K. Rock, Nina M. Gadmer, Diana E. Norwich, and Richard M. Schwartzstein. The Impact of Resident Training on Communication with Families in the Intensive Care Unit. Resident and Family Outcomes. 2016;13(4):512-21

117) Aspegren K. BEME Guide No.2: Teaching and learning communication skills in medicine – a review with quality grading of articles. Medical Teacher. 1999;21:563-70

118) Van Dalen J, Kerkhofs E, van Knippenberg-Van Den Berg BW, van Den Hout HA, Scherpbier AJ, van der Vleuten CP. Longitudinal and concentrated

communication skills programmes: two dutch medical schools compared. Adv Health Sci Educ Theory Pract. 2002;7(1):29–40

119) Noelle Junod Perrona, Johanna Sommerc, Martine Louis-Simonetd, Mathieu Nendaz. Teaching communication skills: beyond wishful thinking. Swiss Med Wkly. 2015;145:w14064

120) Sabina Alispahic, Enedina Hasanbegovic-Anic. Mindfulness: Age and Gender Differences on a Bosnian Sample. Psychological Thought, 2017;10(1):155-66

121) Gross JJ, Carstensen LL, Pasupathi M, Tsai J, Skorpen CG, & Hsu AY. Emotion and aging: Experience, expression, and control. Psychology and Aging 1997;12(4):590-99

122) Mogilner C, Kamvar SD, & Aaker J. The shifting meaning of happiness. Social Psychological & Personality Science 2011;2(4):395-402

123) Sturgess MA. Psychometric validation and demographic differences in two recently developed trait mindfulness measures (Unpublished master's thesis, Victoria University of Wellington, Wellington, New Zealand). 2012

124) Henry A. Olano et al. Engagement in Mindfulness Practices by U.S. Adults: Sociodemographic Barriers. The Journal of Alternative and Complementary Medicine. 2015;21(2):100-02

125) Adler S, Lanley J, & Parcker M. Managing women. Buckingham: Open University Press. 1993

126) Shakeshaft C. Women in educational administration. London: Sage. 1989

127) Avan BI, Raza SA, Afridi HR. Residents' perceptions of communication skills in postgraduate medical training programs of Pakistan. J Postgrad Med 2005;51:85-91

128) Ambika Prasad Mohanty. Doctor-Patient Relationship. Beyond Medicine. Chapter 219. Pg-1011-13

129) Jeffrey T. Berger. The Influence of Physicians' Demographic Characteristics and Their Patients' Demographic Characteristics on Physician Practice: Implications for Education and Research Academic Medicine 2008;83(1):100-05

130) Anne-Cécile Schieber, Cyrille Delpierrea, Benoît Lepagea, Anissa Afrited, Jean Pascalc, Chantal Casesf, Pierre Lombrailg, Thierry Langa, and Michelle Kelly-Irving. Do gender differences affect the doctor–patient interaction during

consultations in general practice? Results from the INTERMEDE study. Family Practice 2014;31(6):706-13

131) Bernzweig J, Takayama JI, Phibbs C, Lewis C and Pantell RH. Gender differences in physician-patient communication: evidence from pediatric visits. Arch Pediatr Adolesc Med 1997;151:586–91

132) Meeuwesen L, Schaap C and van der Staak C. Verbal analysis of doctor-patient communication. Soc Sci Med 1991;32:1143-50

133) Hall JA, Irish JT, Roter DL, Ehrlich CM and Miller LH. Gender in medical encounters: an analysis of physician and patient communication in a primary care setting. Health Psychol 1994;13:384-92

134) Law SA and Britten N. Factors that influence the patient centredness of a consultation. Br J Gen Pract. 1995;45:520-24

135) Lee SJ, Back AL, Block SD, Stewart SK. Enhancing physician-patient communication. Hematology Am Soc Hematol Educ Program. 2002;1:464-83

136) Roter DL, Hall JA, Aoki Y. Physician gender effects in medical communication: a meta-analytic review. JAMA. 2002;288(6):756-64

137) Harms C, Young JR, Amsler F, Zettler C, Scheidegger D, Kindler CH. Improving anaesthetists' communication skills. Anaesthesia. 2004;59(2):166-72

138) Bensing JM, Sluijs EM. Evaluation of an interview training course for general practitioners. Soc Sci Med. 1985;20(7):737-44

139) Stewart M, Brown JB, Donner A, et al. The impact of patient-centered care on outcomes. J Fam Pract. 2000;49(9):796–804

140) Rider EA, Hinrichs MM, Lown BA. A model for communication skills assessment across the undergraduate curriculum. Med Teach. 2006;28:127-34

141) Laidlaw TS, MacLeod H, Kaufman DM, Langille DB, Sargeant J. Implementing a communication skills programme in medical school: Needs assessment and programme change. Med Educ. 2002;36:115-24

142) Learning objectives for medical student education. Medical School Objectives Project. Washington DC: Association of American Medical Colleges; 1998.

143) Simpson J, Furnace J, Crosby J, Cumming A, Evans P, Friedman M et al. The Scottish doctor – learning outcomes for the medical undergraduate in Scotland: A foundation for competent and reflective practice. Med Teach. 2002;24:136-43

144) General Medical Council. Tomorrow's doctors: Outcomes and standards for undergraduate medical education. London: GMC. 2009. Available from: http://www.gmcuk.org/Tomorrow_s_Doctors_1214.pdf_48905759.pdf. [Last Accessed on October 3, 2015].

145) Jyoti Nath, Modi, Anshu Jugesh Chhatwal, Piyush Gupta and Tejinder Singh. Teaching and Assessing Communication Skills in Medical Undergraduate Training. Indian Pediatrics. 2016;53:497-505

Training Module on "Communication Skills in Health Care"

Essential Ideas to Convey

• To convey the importance of mindfulness and emotional intelligence amongst the health care providers.
• To impart the knowledge about the importance of basic communication skills amongst health care providers with regard to following parameters.
  ◦ Verbal and non-verbal communication.
  ◦ Good Eye contact for communication.
  ◦ Good Writing Skills.
  ◦ Effective expression of empathy.
  ◦ Art of Listening.
• To improve doctor patient relationship by teaching importance of attitude, behavior and communication skills in doctor-patient management.
• To bring the knowledge regarding communication in special situations to manage the angry patients, breaking bad news, deal with sensitive gathering etc.
• To facilitate the understanding of importance of training in communication skills and different ways to learn communication skills.

SCHEDULE OF THE WORKSHOP		
Time	**Section**	**Topic**
09.00 am to 09.30 am		Registration and Pre-test
09.30 am to 10.45 am	Section 1	Being a Mindful Doctor
10.45 am to 12.00 pm	Section 2	Basics of Communication Skills
12.00 pm to 01.15 pm	Section 3	Doctor - Patient Relationship
01.15 pm to 02.00 pm	**LUNCH BREAK**	
02.00 pm to 03.15 pm	Section 4	Communication in Special Situations
03.15 pm to 04.30 pm	Section 5	Training in Communication Skills
04.30 pm to 05.00 pm		Post-test and Valedictory

INSRUCTIONS TO THE TRAINER
1. BEGIN THE SESSION WITH INTRODUCTION. *(Ensure good start to the session. Good start with introduction will help in convincing ideas more effectively among the group)* • Begin this session by brief introduction of everyone in the room. Ensure that all the participants in the room should call each other by name after introduction. Repeat the introduction if necessary so as to enable all to remembers individual's name. • Briefly introduce the workshop and explain the entire schedule of the workshop. Enable the participants to ask the questions on workshop schedule and solve their queries. • Introduce the faculty and the facilities at the workshop venue. • Use this session to warm up the participants.
2. SET THE GROUND RULES FOR THE WORKSHOP • Ask all the participants to set their own rules for the workshop. Ask all the participants to share their ideas and contribute to set the ground rules for the workshop. Keep this session open ended and motivate the participants to contribute to the rules as they only have to follow it. These are in no particular order. These rules may change from group to group. Select those that are appropriate to current group's needs. Limit the number of ground rules to 10-12. Make sure that all rules set are culturally aware ground rules and values-based ground rule. All rules should arise from common sense practices of an individual. • Ground rules should be specific, visible to everyone (pasted in the room,

preferably in front of the participants), derived with group input and then agreed to by all group members, and malleable (in other words, adaptable as needed throughout the workshop). Ground rules should follow some basic principles regarding their creation and use. If the facilitator thinks that the group is deviating from the ground rules, he can always point to the rules and make the participants realize that they only have set the rules. Following are few examples for ground rules.

- Everyone's input is equally valued.
- Be timely: Start and end the session on time, take brief breaks, and be ready to start when breaks are over.
- Only one conversation will go on at once (unless subgroups are working on a topic).
- Respect each speaker: Don't take part in side conversations; listen and ask clarifying questions.
- Discussions and criticisms will focus on interests, not people.
- No idea is bad.
- Be supportive rather than judgmental.
- No phone calls are allowed during the session.
- No finger-pointing—address the issue, not an individual.
- Don't interrupt someone is talking.
- Criticize ideas, not people.
- Be fully present.
- Call one another by their first names, not "he" or "she."
- Listen more, talk less.

SECTION-1		
Title	**BEING A MINDFUL DOCTOR**	
Objectives	By the end of this session, the participants will be able to - • Understand and explain the meaning of being mindful • Recognize and incorporate the importance of emotional intelligence in medical practice • Become be receptive to learn from outside and from within • Prepare yourself mentally and physically to remain enthusiastic in the service of others • Develop and demonstrate a sense of social responsibility	
Materials	**PowerPoint A** : Mindfulness, Emotional Intelligence and Health **PowerPoint B** : Service Orientation and Social responsibility Role of a Doctor, Leadership, Importance of Team. **Handout 1.1** : Mindfulness, Emotional Intelligence, Health. **Handout 1.2** : Role-play – Emotional Management	
Advance Preparation	• Ensure readiness of PowerPoint A and PowerPoint B. • Make enough copies of handouts for distribution.	
Training Activities	**ACTIVITY**	**DURATION**
	Step 1 - Interactive Session	5 Min
	Step 2 - Definitions of Mindfulness, Emotional Intelligence and Health (Exercise)	15 Min
	Step 3 - PowerPoint A- Mindfulness, Emotional Intelligence and health	15 Min
	Step 4 - Role-Play on Emotional Management	20 Min
	Step 5 - PowerPoint B – Service Orientation and Social responsibility	20 Min
	Total Session Time	75 minutes

Instructions to the Trainers	• Make sure that all participants are warmed enough to start the session. • Encourage the participants verbally and nonverbally involving the use of words, phrases, and gestures that indicate attention and the wish of the person to continue speaking. **Examples**: **Verbal Encouragement** • I see • I understand • I get it • That is clear • Uh-huh • I hear you! **Nonverbal Encouragement** • Nodding your head • Mirroring the speaker's facial expression (e.g., smiling when then speaker smiles, frowning when the speaker frowns) • Use handouts at as per the number and title at desired places. • Use Assessment Sheet1 at the end of session 1 to assess the performance of candidates in response to session 1

Detail Steps	**STEP 1- INTERACTIVE SESSION** Discuss the following concepts **Interactive Discussion** ▪ Role of Health in the life ▪ Givers ▪ Matchers ▪ Takers ▪ Medical Profession-Giving Happiness ▪ Unethical Practices ▪ Medicine as noble Profession ▪ Role of Spirituality in Modern Life • Discuss the role of health in the life of every human being. • Explain the concept of Givers, Takers and Matchers to help them understand the limited role of money in providing service to their patients. • Givers are those who give more than they take • Matchers are those who take as much as they give • Takers are those who take more than they give • Medical profession is about giving happiness to people by looking after their health. No other profession has any better privilege than this. People come to the doctor with hope and trust. They handover their lives to the doctors. In this situation, the doctors are supposed to perform the duties to the best of their abilities. Making a business out of people's illness is unacceptable to people. The great doctors have been the true givers, majority are matchers and some like to make business in this profession with profit.

- Highlight some of the unethical practices that damage the trust of the patients.
- Explain why medicine is a noble profession, not a business.
- Introduce the role of spirituality in modern human life.

STEP 2 -DEFINITIONS OF MINDFULNESS, EMOTIONAL INTELLIGENCE AND HEALTH (EXERCISE 1.1)

- Ask the participants to open the **handout 1.1** and write the definitions for Mindfulness, Emotional Intelligence and Health. This should take maximum 10 minutes.
- Request the participants to share their definition of being Mindful. Conduct a group discussion.

STEP 3 - POWERPOINT A - MINDFULNESS, EMOTIONAL INTELLIGENCE AND HEALTH

- At the end of the exercise, show them the slide with definitions of the above terms and explain the terms in detail.

POWERPOINT A- MINDFULNESS, EMOTIONAL INTELLIGENCE AND HEALTH

- The importance of affordable and accessible healthcare system.
- Importance of clean and ethical medical practice
- **Mindfulness**
  - Definition
  - Advantages
  - Components of Mindfulness
- **Emotional Intelligence**
  - Definition
  - Advantages
  - Components of Emotional Intelligence
- **Health**
  - Definition
  - The value of health for all

	• Explain mindfulness and tell • The advantages of being mindful. Tell them that being mindful makes them live in their present moment. This makes them more alert, aware and attentive, thereby, enhancing their perceptions, ability to learn and enable them to be in control of the situation. • Ask participants to fix their thought for 20 seconds on a given thought, such as, "Please fix your thought on the Communication Skills workshop and none other" • Ask how many of the participants could ONLY think of the Communication Skills workshop without getting distracted by any other thought. • Ask the participants about how they would be able to control their mind. • Explain about the importance of meditation in achieving a mindful state. • Request the participants to share their definition of Emotional Intelligence. Conduct a group discussion. • Explain the concept of Emotional Intelligence to the participants. Explain that the current education and the syllabus focusses heavily on the intellectual development. • Tell the participants about the role of the Conscious, Subconscious and the Unconscious minds in becoming self-aware. • Tell the participants that Emotional intelligence plays a very big role in the decision making process along with the intellect. • Help the participants to understand the importance of Emotional intelligence. It is important to highlight the role of Emotional Intelligence in avoiding burnout and improving resilience. • Ask a participant to volunteer the definition of health. Conduct a group discussion.

STEP 4- ROLE-PLAY ON EMOTIONAL MANAGEMENT (EXERCISE 1.2)

- Ask participants to open **handout 1.2**. A role-play to demonstrate Emotional Intelligence.
- A Detail mark sheet is given to each participant. They must observe the performance and assess the performer as pass, average or fail.
- Take the positive feedback of the audience and then the negative remarks. Display the mark sheet on the screen and discuss each expected skill that had to be demonstrated during the role-play.
- Demonstrate the same task to help candidates understand the proper communication.

STEP 5- POWERPOINT B – SERVICE ORIENTATION, SOCIAL RESPONSIBILITY, TEAM AND LEADERSHIP

POWERPOINT B- SERVICE ORIENTATION, SOCIAL RESPONSIBILITY, TEAM AND LEADERSHIP

- Duties of a Doctor
- Importance of Team building in healthcare
- Leadership qualities for a doctor to possess

- Show different clinic-social conditions and take their opinion on the next appropriate step in these conditions. Help them understand the duties of a Doctor.
- Show an audio-visual on the life of a doctor to remind them of their life's story.
- Ask if any participant has served the society in any manner in their own time, with their own money and without getting anything in return as benefit.

A doctor as a leader should be able to inspire his colleagues and influence them to be able to accomplish the set goals. There has to be an ability to have a vision and find the path that will lead to the goal. The doctors should have good impersonal skills to be able to develop trust and build a team.

Motivation is the energy to do something. It is very important for a leader to be motivated so that the team feels energised.

Team player:

Team is defined as a group of separate individuals with different backgrounds, resources and skills that complement each other working together to a common goal. In healthcare, the common goal is to give service to the patients by delivering health in an effective way. Explain the role of communication in team building.

Building Trust:

This is done by following means:

- By creating a non-threatening workplace atmosphere
- By maintaining clear and transparent communication between all
- Being reliable and becoming a role model by to influence the behaviour of the team

HANDOUT 1.1
Exercise 1.1-Exercise on Mindfulness, Emotional Intelligence

Q.1 Define Mindfulness

Q.2 Define Emotional Intelligence

Q.3 Define Health

Note: Definitions for reference

(Do not print these definitions on handout, keep it for reference purpose only)

Mindfulness - Mindfulness is the basic human ability to be fully present, aware of where we are and what we are doing, and not overly reactive or overwhelmed by what's going on around us.

Emotional Intelligence - refers to the ability to identify and manage one's own emotions, as well as the emotions of others to get a desired outcome.

Health - "State of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

HANDOUT 1.2

Exercise 1.2- Role-play on Emotional Management

Case Scenario

You are a junior doctor in Medicine. Mrs Sonali, a 25-year-old lady was admitted with severe UTI. You prescribed Augmentin to her this morning, but failed to realize that she is allergic to this medication. There was no severe reaction when the nurse administered the drug, but now there is some rash and patient is angry that she was given the drug to which she has known allergy. She wants to meet you about this.

Objectives of the Session:

- To assess rapport building skills
- To remain mindful
- To demonstrate emotional intelligence
- To be honest and apologise for the mistake
- To have the courage to appreciate the patient for the feedback
- To demonstrate the ability to use the given information for improvement in services
- To manage the emotions and get the desired outcome
- To be able to reasonably satisfy the patient

Instructions to the Role player	
Clinical station	Counselling – Emotional Intelligence
Name of the patient	Mrs Sonali Rane
Age / Sex	25 / Female
Education / Occupation	Bank clerk
Presentation	After the injection given by the nurse, she has developed some rash and itching on her hands.
Symptoms	Disturbed patient. When rash and itching was felt, she called the nurse. The patient was told that she was given injection Augmentin.
Medical history	Known allergy to Augmentin. Admitted to ICU once for severe allergic reaction when Augmentin was given.
Surgical history	History of LSCS 2 years ago.
Family history	Nil
Psychosocial history	She is a busy lady and wants to be at work tomorrow. The symptoms will delay her resumption at work.
Role	The lady is very angry, because the injection Augmentin was given in spite of informing the doctors about the same at the time of admission. She cannot believe the negligence of the treating doctor. In her opinion, the doctors do not care and now she cannot trust them for any further treatment. For the interest of other patients, she would like to lodge a complaint to the higher authorities against the doctor.

ASSESSMENT SHEET 1			
Counselling - Emotional Intelligence **Name of Candidate:** **Name of the observer:**			
Task	**Done**	**Needs to Improve**	**Not Done**
Introduction			
Eye Contact			
Listening			
Empathy			
Does not dismiss anger			
Allows patient to vent her anger			
Accepts responsibility for the error and apologizes for mistake			
Offers good explanation to the patient			
Invites questions			
Advises patient on hospital complaints procedure			
Makes a shared plan with the patient			
Thank and Reassure			

Observer Information

Global (Overall) Assessment Score:

1	2	3	4	5	6	7	8	9

1	-	Totally inadequate	- Numerous serious shortcomings
2	-	Poor	- Numerous and/or Serious shortcomings
3	-	Marginal	- Numerous deficiencies
4	-	Below Average	- Some deficiencies
5	-	Average	- 50th centile of the class
6	-	Above Average	- 51 to 75th centile of the class
7	-	Good	- In the upper 25th centile of the group
8	-	Excellent	- Upper 10th centile of the group
9	-	Outstanding	- The best out of ten

Quick assessment chart:

1 to 4	-	Clear Fail	- Below Average performance
5	-	Just Pass	- Average performance
6 to 9	-	Clear Pass	- Good performance

SECTION-2	
Title	**BASICS OF COMMUNICATION SKILLS**
Objectives	By the end of this session, the participants will be able to - • Learn different types of communication skills • Understand the value of verbal and non-verbal forms of communication • Express empathy effectively • Learn the art of listening • Understand the importance of good eye contact • Learn the importance of good writing skills
Materials	PowerPoint C : Written communication and Telephonic communication PowerPoint D : Verbal and Non-verbal communication Handout 2.1 : Write medical notes Essential Telephonic Communication Skills Handout 2.2 : Role-play – History taking and mark sheet
Advance Preparation	• Make enough copies of handouts for distribution • Ensure readiness of PowerPoint C and PowerPoint D
Instruction to trainer	• Facilitative participants use the following communication techniques: ◦ Active listening ◦ Body language ◦ Verbal and nonverbal encouragement ◦ Appropriate questioning techniques ◦ Paraphrasing and clarification • Facilitative participants to use body language means, the use of facial expression, posture of the body, the position of different

<table>
<tr><td></td><td colspan="2">parts of the body (arms, legs, eyes), gestures, space, and seating.
• Use handouts as per the number and title at desired places.
• Use Assessment Sheet 2 at the end of session 2 to assess the performance of candidates in response to session 2.</td></tr>
<tr><td rowspan="6">Training Activities</td><td>ACTIVITY</td><td>DURATION</td></tr>
<tr><td>Step 1 - PowerPoint C-Communication</td><td>10</td></tr>
<tr><td>Step 2 - Write Medical Notes, Essential Telephonic Communication Skills</td><td>15</td></tr>
<tr><td>Step 3 - Role-Play On History Taking</td><td>30</td></tr>
<tr><td>Step 4 - PowerPoint D-Types and Barriers of Communication</td><td>20</td></tr>
<tr><td>Session Time</td><td>75 minutes</td></tr>
<tr><td>Detail Steps</td><td colspan="2">STEP 1-POWERPOINT C- WRITTEN COMMUNICATION AND TELEPHONIC COMMUNICATION
• Begin this session by discussing the definition of Communication.
Communication is a Two-way process of reaching mutual understanding, in which participants not only exchange (encode-decode) information, ideas, feelings and emotions using written, verbal, non-verbal or visual media to create and share meaning.
<u>POWERPOINT C- WRITTEN COMMUNICATION AND TELEPHONIC COMMUNICATION</u>
• Definition of communication
• Types of Communication
• Written communication
• Telephonic communication</td></tr>
</table>

- Ask the participants to explain the different types of communication. Discuss.
    - Written
    - Verbal or Oral
    - Non-Verbal – Actions and postures
    - Images and visual
    - Multimedia – A combination of all above

STEP 2- WRITE MEDICAL NOTES, ESSENTIAL TELEPHONIC COMMUNICATION SKILLS (EXERCISE 2.1)

- Ask participants to open **handout 2.1.**
- **Introduction to Written Communication- 15 minutes**

  Ask all participants to document the inpatient notes of the patient details given in the handout 2.1. Give 05 minutes to write the notes and 10 minutes for discussion.
- **Introduction to Telephonic Communication – 15 minutes**

  Ask two participants to discuss a patient care over the phone. Others are asked to listen carefully. At the end of the conversation, invite comments, positive first and then the negative comments. Discuss the etiquettes for a good telephonic conversation.

STEP 3 - ROLE-PLAY ON HISTROY TAKING
(EXERCISE 2.2)

- Ask participants to open **handout 2.2-**A role play to demonstrate oral communication skills. - **20 minutes**

  Role play – for History taking - 10 minutes

  Interactive Discussion - 10 minutes
- Bring forward a participant to perform the given task. A Detail mark sheet is given to each participant. They must observe the performance and assess the performer as pass, average or fail.
- Take the positive feedback of the audience and then the negative remarks. Display the mark sheet on the screen and discuss each

expected skill that had to be demonstrated during the role-play.

- Demonstrate the same task to help candidates understand the proper communication.
- Discuss the importance of presentation, introduction, eye contact, listening, empathy and speaking in non-medical language.

STEP 4 –POWERPOINT D- TYPES AND BARRIERS OF COMMUNICATION

POWERPOINT D- TYPES AND BARRIERS OF COMMUNICATION

- Verbal communication
  - Value of actual spoken words
  - Value of voice to nation - volume, speed, pause
- Non-verbal communication
  - Presentation
  - Eye contact
  - Listening
  - Empathy
  - Non-medical language
- Barriers to communication

- Ask the participants about the importance of the non-verbal, verbal and voice to nation during oral communication.
  - Verbal communication - Questions, Clarifying, Paraphrasing, Summarizing
  - Non-verbal - Presentation, environment, eye contact, listening, touch
    - Facial expressions, Movements, Posture
  - Voice modulation - Tone, pitch, volume, speed, pause, stress

	• Discuss the barriers to communication • **Physician factors:** Attitude of the doctor, including emotional burnout, negative bias against a health condition... • **Time pressure** Too many people and other noise distractions Disturbed mind-set, stress, physical exhaustion, sleep deprivation Inadequate training, lack of knowledge Lack of required clinical and communication skills Language barrier • **Patient factors:** Mentally disturbed state – Anger, demanding nature, manipulative behaviour, intoxicated Psychiatric conditions – mood disturbances and personality disorders Physical illness – multiple health issues Poor education Financial constraints Beliefs that are difficult to change Language barrier

HANDOUT 2.1

Exercise 2.1-Write medical notes, Essential Telephonic Communication Skills

Case Scenario

A 35-year-old lady presents with right sided abdominal pain of acute onset since last night. She has history of minimal bleeding per vaginum. Her last menstrual period was 6 weeks ago. On examination, she appears uncomfortable. Pulse – 100/min, BP-110/70 mm of Hg. Abdomen is tender and there is slight guarding on the right side. Her Hb is 10gm% and Urine pregnancy test is positive. There is a strong suspicion of ectopic pregnancy. The plan is to admit her, observe her closely, intra-venous access and keep her nil by mouth. Arrange an urgent transvaginal ultrasound scan.

- **Writing medical notes:** Tell the participants that the following patient was seen by them on the ward round and the clinical findings are given as below. Please document the above in the patients inpatient file.
- Ask **one** of the participants to explain his documentation style. Discuss the do's and don'ts of written patient note keeping. Explain the format for writing medical notes as follows:

	Date/Time	Grade / Specialty	Patient name/No
Subjective			
Objective			
Assessment			
Plan			
	(Doctor) Name, Number, Signature		

Use black ink, 3 identity features of patient, write legibly, do not use abbreviations, for any corrections, make a single strike through.

- Telephonic Communication – 15 minutes

Case Scenario

Doctor A, is a Junior Gynecological resident. He is managing Mrs Rita Sohoni, a 35 year old lady who has presented with acute onset right iliac fossa pain since yesterday. She has some nausea, but no vomiting. No other significant symptoms. Temperature, pulse and blood pressure are normal. She has raised white cell count, negative urine pregnancy test and the sonography does not show any obvious cause for the pain. Please ring Dr B, a senior resident in general surgery to take surgical opinion and manage the patients further**.**

Obtain positive and negative feedback from all participants. Discuss the importance telephonic communication and the rules for the same. Explain the importance of connecting to the people at the other end of the telephone.

Situation	Introductions + Patient details
Background	Patients clinical progress
Assessment	Probable diagnosis
	Examination findings
Recommendation	Would you be able to come
	Any tests you would like me to do
	Anything else I could do to manage
	Can I just repeat our discussion?

HANDOUT 2.2

Exercise 2.2-Role-play on History Taking

Obtain history from Mrs Trupti Shah, a 35 year old lady, with history of right sided lower abdominal pain.

Objectives of the session:

- To assess communication skills
- To demonstrate empathy
- To take the medical history
- To listen carefully and answer all questions to patient's satisfaction
- To reassure and at the same time be honest
- Explain the possibilities to the patient
- Define the further process such as examination and investigations
- To explain treatment options without jumping to conclusions
- To make the patient feel good at the end of the consultation

Instructions to the Role player:

Clinical station	Counselling – Emotional Intelligence
Name of the patient	Mrs Trupti Shah
Age / Sex	35 / Female
Education / Occupation	Housewife
Presentation	Pain in the right tummy, which started yesterday, but kept increasing. Painkillers have not helped.
Symptoms	Pain in the right lower tummy. The pain is localised and kept her awake in the night. She never had this pain before. It is almost continuous. It is dull in nature. It increases on walking, but does not get better on lying down. She feels nausea, but did not vomit, No bladder and bowel symptoms.

Medical history	History of pelvic tuberculosis 3 years ago. Took treatment for 9 months. Suffers from infertility. Her last period was 6 weeks ago, but periods can be irregular. This is more so since she has put on weight in the last 6 months.
Surgical history	Nil
Family history	Her elder sister died of breast cancer at a young age
Psychosocial history	The history of cancer in her sister is playing on her mind. She feels this pain could be similar to her sister. She fears that she may die. This is making her pain worse.
Role	A very anxious lady. She is very afraid and depressed. Due to her infertility, she is very unhappy. She has also put on weight, which has disturbed her. On top, her sisters death at a young age is bothering her. She wants you to tell her what is happening. She does not want any operation. She hates hospitals and does not want to get admitted.

ASSESSMENT SHEET 2			
History taking for abdominal pain **Name of Candidate**: **Name of the Observer:**			
Task	**Done**	**Needs to improve**	**Not Done**
Introduction			
Eye Contact			
Listening			
Empathy			
Non-Medical language			
Is Ectopic considered			
Other differential diagnosis considered			
Offers good explanation to the patient about further examination and investigations			
Invites questions			
Offers support			
Makes a shared plan with the patient			
Thank and Reassure			

Observer Information:

Global (Overall) Assessment Score:

1	2	3	4	5	6	7	8	9

1 - Totally inadequate - Numerous serious shortcomings
2 - Poor - Numerous and/or Serious shortcomings
3 - Marginal - Numerous deficiencies
4 - Below Average - Some deficiencies
5 - Average - 50th centile of the class
6 - Above Average - 51 to 75th centile of the class
7 - Good - In the upper 25th centile of the group
8 - Excellent - Upper 10th centile of the group
9 - Outstanding - The best out of ten

Quick assessment chart :

1 to 4 - Clear Fail -Below Average performance
5 - Just Pass -Average performance
6 to 9 - Clear Pass -Good performance

SECTION-3	
Title	**DOCTOR – PATIENT RELATIONSHIP**
Objectives	By the end of this session, the participants will be able to - • Understand the patient cycle during their illness • Understand the Doctor cycle when treating the patients • Display the role of Attitude, Behavior and Communication Skills in Doctor-Patient relationship • Learn the types of Doctor-Patient relationships • Know the reasons and the measures to avoid violence against Doctors
Materials	PowerPoint E : Doctor Patient relationships PowerPoint F : Violence against doctors Handout 3.1 : Role-play on Consenting for a procedure Handout 3.2 : Role Play on Counselling
Advance Preparation	• Make enough copies of handouts for distribution • Ensure readiness of PowerPoint E and PowerPoint F
Instructions to the trainers	• The role of the trainer here is to enable learning to the participants. • Give more chance to participants in this session as many participants are likely to share their real life experience in this session. • Use handouts at as per the number and title at desired places. • Use Assessment Sheet3.1 and 3.2 at the end of session 3 to assess the performance of candidates in response to session 3.

<table>
<tr><td rowspan="6">Training Activities</td><td colspan="2">ACTIVITY</td><td>DURATION</td></tr>
<tr><td>Step 1 -</td><td>PowerPoint E – Doctor Patient relationships</td><td>10 Minutes</td></tr>
<tr><td>Step 2 -</td><td>Role-Play On Consenting For A Procedure</td><td>20 Minutes</td></tr>
<tr><td>Step 3 -</td><td>Role Play On Counselling At The Time of Discharge</td><td>35 Minutes</td></tr>
<tr><td>Step 4 -</td><td>PowerPoint F- Violence Against Doctors</td><td>10 Minutes</td></tr>
<tr><td colspan="2">Session Time</td><td>75 minutes</td></tr>
<tr><td>Detail Steps</td><td colspan="3">STEP 1- POWERPOINT E – DOCTOR PATIENT RELATIONSHIPS

<u>POWERPOINT E- DOCTOR PATIENT RELATIONSHIPS</u>
• The patient cycle
• The doctor cycle
• Types of doctor-patient relationships
• The role of attitude, behavior and communication in a good doctor-patient relation

• Discuss the patient and the doctor cycle when they meet during the consultation.
• Discuss the types of doctor-patient relations

Paternalistic: This is largely a one-way communication, wherein the doctor gives the minimum legally required information to the patients. The deliberation and even the decision of the treatment is done by the doctor. This is an authoritative style by the doctor.

Mutual (Shared): In this form; there is a two-way communication in which the doctor gives all relevant information to the patient. There is deliberation by the doctor</td></tr>
</table>

and the patient and the decision is taken in a joint manner.

Consumerism: In this form, the patent is aggressive and keeps an upper hand during the conversation. They have their own ideas about their treatment and may not be willing to listen to the doctor's opinion.

- Discuss the role of Attitude, Behaviour and Communication Skills in the development of an Inter-personal relationship between the doctor and the patient.

  Attitude is the complex psychological state of mind involving emotions, beliefs and opinions of an individual due to the experiences of their entire life.

  Behaviour involves the actions that an individual takes based on their attitude.

STEP 2- - ROLE-PLAY ON CONSENTING FOR A PROCEDURE (EXERCISE 3.1)

- Ask participants to open **handout 3.1-** A role-play to demonstrate oral communication skills- Consenting for a procedure - **20 minutes**

  Role-play – Consenting - 10 minutes

  Interactive Discussion - 10 minutes

- Bring forward a participant to perform the given task. A Detail mark sheet is given to each participant. They must observe the performance and assess the performer as pass, average or fail.
- Take the positive feedback of the audience and then the negative remarks. Display the mark sheet on the screen and discuss each expected skill that had to be demonstrated during the role-play.
- Demonstrate the same task to help candidates understand the proper communication.
- Explain the phenomenon called "The Curse of Knowledge".
- Discuss the role of Attitude, Behaviour and Communication in developing good interpersonal relationships.

STEP 3- ROLE PLAY ON COUNSELLING AT THE TIME OF DISCHARGE (EXERCISE 3.2)

- Ask participants to open **handout 3.2-**A role-play to demonstrate oral communication skills- Counselling at the time of discharge - **35 minutes**

  Role-play – Consenting - 15 minutes

  Interactive Discussion - 20 minutes

- Bring forward a participant to perform the given task. A Detail mark sheet is given to each participant. They must observe the performance and assess the performer as pass, average or fail.
- Take the positive feedback of the audience and then the negative remarks.
- Demonstrate the same task to help candidates understand the proper communication

STEP 4-POWERPOINT F- VIOLENCE AGAINST DOCTORS

- Discuss the increasing violence against doctors.
- Ask for the reasons for violence against doctors.
- Request the participants to explain steps that should be taken by the government, doctors and the patients to enable us to avoid violence against doctors

POWERPOINT F- VIOLENCE AGAINST DOCTORS

- Increase in violence against the doctors
- The role of the doctors
- The role of the patients
- The role of the media
- How to avoid violence
- The role of the government, doctors and the patients

Handout 3.1

Exercise 3.1-Role play on Consenting for a procedure

Case Scenario

Mrs Sujata Joshi is a 34-year-old woman who has been admitted for laparoscopy to investigate her pelvic pain. Please obtain her consent.

Objectives of the session:

- To assess communication skills
- To demonstrate empathy
- To take the medical history
- To listen carefully and answer all questions to patients' satisfaction
- To reassure and at the same time be honest
- To give the information in a reassuring manner
- Explain the possible complications and manage the emotions of the patient
- To give the feeling that the patient is in charge of the proceedings
- To make the patient feel good to go ahead at the end of the consultation

Instructions to the Role player:

Clinical station	Consent for laparoscopy
Name of the patient	Mrs Sujata Joshi
Age / Sex	34 / Female
Education / Occupation	Receptionist in a company

Presentation	Admitted to the hospital with abdominal pain for laparoscopy. Her tests have been done, including bloods, urine and sonography. There is no clear diagnosis for the pain.
Symptoms	Lower abdominal pain, which has been increasing over the last few weeks. Painkillers and hormonal medications have not helped.
Medical history	History of weight gain. She is taking thyroid medications.
Surgical history	History of previous laparoscopy 3 years ago.
Family history	Father and mother are both diabetic
Psychosocial history	She is very uncomfortable. She would still like to avoid the operation.
Role	She is very worried about being put to sleep. She thinks she may not wake up. Her friend had a laparoscopy and was complaining that it was very painful. She wants to know all the possible complications. She feels she may die during the operation.

ASSESSMENT SHEET 3.1

Consent for Laparoscopy

Name of Candidate:

Name of the Observer:

Task	Done	Needs to improve	Not Done
Introduction			
Eye Contact			
Listening			
Empathy			
Non-Medical language			
Explains the procedure			
Explains the possible complications			
Reassures the patient			
Invites questions			
Offers support			
Makes a shared plan with the patient			

Observer Information:

Global (Overall) Assessment Score:

1	2	3	4	5	6	7	8	9

1 - Totally inadequate – numerous serious shortcomings
2 - Poor - Numerous and/or Serious shortcomings
3 - Marginal - Numerous deficiencies
4 - Below Average - Some deficiencies
5 - Average - 50th centile of the class
6 - Above Average - 51 to 75th centile of the class
7 - Good - In the upper 25th centile of the group
8 - Excellent - Upper 10th centile of the group
9 - Outstanding - The best out of ten

Quick assessment chart :

1 to 4 - Clear Fail - Below Average performance
5 - Just Pass - Average performance
6 to 9 - Clear Pass - Good performance

Handout 3.2

Exercise 3.2-Role play on Counselling

Case Scenario

Mr Suhas Verma, 51-year-old man is being discharged after a recent myocardial infarction. Counsel him about the medications to control his hypertension and diabetes that he must take. He needs to be also counselled to give up his habit of smoking.

Objectives of the Session :

- To assess rapport building skills
- To give the information in a non-threatening manner
- To demonstrate empathy
- To allow the patient to express concerns
- To be clear that the medications need to be taken as instructed
- To show understanding, but still be clear that smoking cannot continue
- To give instructions about physical activities and diet
- To come to a shared understanding about the further treatment
- Arrange for follow up

Instructions to the Role player:

Clinical station	Counselling – Discharge after Myocardial infarction
Name of the patient	Mr Suhas Verma
Age / Sex	51 / Male

Education / Occupation	Chief Executive of a Company
Presentation	Chest pain that was diagnosed to be due to myocardial infarction
Symptoms	Chest pain radiating to the shoulders with excess sweating 4 days ago. Now this has settled and discharge has been planned for today. Before going home, the doctor wanted to discuss the further treatment process.
Medical history	Hypertension since 10 years being treated with two different medications. Sugar has been up and down since last 3 years. Currently on medications.
Surgical history	History of laparoscopic cholecystectomy for gall stones
Family history	Father is a known hypertensive. Mother has expired.
Psychosocial history	Very stressed due to the job responsibilities. Always on the go. Hates to be taking so many medications. Not always punctual with medications. Sugar has been uncontrolled. Very aggressive personality. Now very worried.
Role	Anxious aggressive person. Happy to be discharged. Wants to resume normal routine soon. Cannot give up smoking. He has tried many times in the past.

ASSESSMENT SHEET 3.2			
Counselling at discharge **Name of Candidate:** **Name of the Observer:**			
Task	**Done**	**Needs to improve**	**Not Done**
Introduction			
Eye Contact			
Listening			
Empathy			
Non-Medical language			
Counseling about medications for hypertension & Diabetes			
Counseled about giving up smoking			
Counselled about diet, weight and lifestyle measures			
Invites questions			
Offers support			
Makes a shared plan with the patient			
Thank and Reassure			

Observer Information:

Global (Overall) Assessment Score:

1	2	3	4	5	6	7	8	9

1 - Totally inadequate – numerous serious shortcomings
2 - Poor - Numerous and/or Serious shortcomings
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9 - Outstanding -The best out of ten

Quick assessment chart :

1 to 4 - Clear Fail -Below Average performance
5 - Just Pass -Average performance
6 to 9 - Clear Pass -Good performance

SECTION-4		
Title	**COMMUNICATION IN SPECIAL SITUATIONS**	
Objectives	By the end of this session, the participants will be able to - • Learn to handle angry patients • Learn the skills to break a bad news such as death • Understand the importance of dealing with relatives with sensitivity • Know the value of good communication with colleagues and subordinates in building a good team	
Materials	PowerPoint G : Breaking Bad News PowerPoint H : Informing Death, Handling angry patients Handout 4.1 : Breaking Bad News – Role-play Handout 4.2 : Breaking News of Death – Role-play	
Advance Preparation	• Make enough copies of handouts for distribution • Ensure readiness of PowerPoint G and PowerPoint H	
Instructions to Trainers	• The main role of trainer in this session is to control the participants as they are likely to get carried away • Use handouts at as per the number and title at desired places. • Use Assessment Sheet4.1 and 4.2 at the end of session 4 to assess the performance of candidates in response to session 4.	
Training Activities	**ACTIVITY**	**DURATION**
	Step 1 - Definition Of Bad News	10 Minutes
	Step 2 - Role Play On Breaking Bad News	20 Minutes
	Step 3 - PowerPoint G - Breaking Bad News	10 Minutes
	Step 4 - Role-Play On Breaking News Of Death	25 Minutes
	Step 5 - PowerPoint H - Informing Death, Handling Angry Patients	10 Minutes
	Session Time	**75 minutes**

Detail Steps	**STEP 1- DEFINITION OF BAD NEWS** Enlighten the participant with following definition of bad news during health care delivery **Bad News:** Any undesirable information, which adversely and seriously affects an individual's view about the future is called a bad news. This is one of the most difficult task faced by healthcare professionals. Patients expect a honest and transparent disclosure of the information. The skill of the doctor has a significant impact on the ability of the patient to cope with the news. **STEP 2- ROLE PLAY ON BREAKING BAD NEWS (EXERCISE 4.1)** • Ask participants to open **handout 4.1-**A role play to demonstrate oral communication skills- Breaking Bad News - **20 minutes** Role play – Breaking Bad News - 10 minutes Interactive Discussion - 10 minutes • Bring forward a participant to perform the given task. A Detail mark sheet is given to each participant. They must observe the performance and assess the performer as pass, average or fail. • Take the positive feedback of the audience and then the negative remarks. Display the mark sheet on the screen and discuss each expected skill that had to be demonstrated during the role-play. • Demonstrate the same task to help candidates understand the proper communication. **STEP 3-POWERPOINT G - BREAKING BAD NEWS** **POWERPOINT G- BREAKING BAD NEWS** • The skill to break a bad news • The six step approach to break bad news

- **Discuss the six step approach in breaking bad news.**

  S - Prepare the **Setting** to break the bad news

  P - **Perception**- Explore the patient's perception of their medical condition. This is their current understanding of what is happening to their health.

  I - **Invitation**- Obtain an invitation from the patient to share the further information about their medical condition that is available to you.

  K - **Knowledge-** Share the further information about the patient's treatment process that is available to you. Use a lot of verbal and non-verbal skills.

  E - **Empathy-** Manage the emotions that may develop.

  S - Offer further **support** to the patient to help them recover to the fullest and as fast as possible.

STEP 4- ROLE-PLAY ON BREAKING NEWS OF DEATH (EXERCISE 4.2).

- Ask participants to open **handout 4.2-**A role play to demonstrate oral communication skills-

Breaking News of Death	- **25 minutes**
Role play – Breaking News of Death	- 10 minutes
Interactive Discussion	- 15 minutes

- Bring forward a participant to perform the given task. A Detail mark sheet is given to each participant. They must observe the performance and assess the performer as pass, average or fail.
- Take the positive feedback of the audience and then the negative remarks. Display the mark sheet on the screen and discuss each expected skill that had to be demonstrated during the role-play.
- Demonstrate the same task to help candidates understand the proper communication

STEP 5- POWERPOINT H - INFORMING DEATH, HANDLING ANGRY PATIENTS

POWERPOINT H- INFORMING DEATH, HANDLING ANGRY PATIENTS

- Informing Death
- The stepwise approach to inform death
- The skills required to manage an angry patient

Discuss the principals involved in managing angry patients

- **Active listening**- This helps to acknowledge anger. Avoid dismissing anger.
- **Show empathy**- This is an effort to show an understanding of the patient feelings
- **Explore solutions and ways ahead**- This helps to calm the patient.
- **Achieve closure** – Support plan for follow up and future treatment should be agreed.

Handout 4.1

Exercise- 4.1 –Role Play on Breaking Bad News

Case Scenario

Mrs Roshni Palkar, 43-year-old woman, with right breast lump had a biopsy 2 weeks ago. Report shows cancer. Break the News to her.

Objectives of the session:

- To begin the counselling appropriately
- To ensure that the right setting is prepared
- To check the patients knowledge about the condition
- To keep the conversation to and fro to get the patient talking
- To use the verbal and non-verbal skills to give the information
- To be clear in speaking about the cancer
- To manage the emotional outburst appropriately
- To give space for the patient to express her feelings
- To restart the conversation at a right moment
- To maintain good composure throughout to give a sense of confidence
- To be clear to the patient, but still keep the hopes alive
- To give proper support and make clear plans for further treatment

Instructions to the Role player:	
Clinical station	Counselling- Breaking Bad News
Name of the patient	Mrs Roshni Palkar
Age / Sex	43 / Female
Education / Occupation	Housewife, Mother of two children – 4 and 7 years age
Presentation	Breast lump that was investigated
Symptoms	Lump felt in the breast.
Medical history	History of diabetes on insulin
Surgical history	History of two Caesarean sections
Family history	History of diabetes in father and mother
Psychosocial history	She is a homemaker. A calm person normally, but now eager to know the test report. She is not fully aware that cancer is also a possibility
Role	She is calm in the beginning, because she is not aware that there is a real possibility of cancer in her case. She reacts with shock to this information. She cannot believe the news being given. She breaks down into tears. She is shocked and immobilised. When she recovers, she wants to know more. Is the cancer advanced? Does she need an operation? Will she survive? How long does she have. She wants to have a second opinion

ASSESSMENT SHEET 4.1			
Breaking Bad News **Name of Candidate:** **Name of the Observer:**			
Task	**Done**	**Needs to improve**	**Not Done**
Introduction			
Eye Contact			
Listening			
Empathy			
Non-Medical language			
Prepares setting for the interview			
Checks the patients level of knowledge & understanding			
Shares the report clearly			
Handles emotions			
Invites questions			
Offers support			
Makes a shared plan with the patient			
Thank and Reassure			

Observer Information:

Global (Overall) Assessment Score:

1	2	3	4	5	6	7	8	9

1 - Totally inadequate – numerous serious shortcomings
2 - Poor - Numerous and/or Serious shortcomings
3 - Marginal - Numerous deficiencies
4 - Below Average - Some deficiencies
5 - Average - 50th centile of the class
6 - Above Average - 51 to 75th centile of the class
7 - Good - In the upper 25th centile of the group
8 - Excellent -Upper 10th centile of the group
9 - Outstanding -The best out of ten

Quick assessment chart :

1 to 4 - Clear Fail -Below Average performance
5 - Just Pass -Average performance
6 to 9 - Clear Pass -Good performance

Handout 4.2

Exercise 4.2-Role Play on Breaking News of Death

Case Scenario

Mrs Savitri Jadhav 65 year old mother of Mr Santosh Jadhav, was admitted with high-grade fever to ICU in a critical condition this morning, but she is dead now. Break this news to her relatives and explain what happened.

Objectives of the session:

- To choose the right setting
- To be prepared with the right details about the recent treatment.
- To check the patients knowledge about the condition
- To keep the conversation to and fro to get the patient talking
- To use the verbal and non-verbal skills to give the information
- To be clear in speaking about the death
- To demonstrate empathy and manage the emotional outburst appropriately
- To give space for the patient to express his feelings
- To restart the conversation at a right moment
- To maintain good composure throughout to give a sense of confidence
- To answer all questions patiently without showing any agitation
- To give proper support and make clear plans for further proceedings

Instructions to the Role player:	
Clinical station	Counselling – Informing Death
Name of the relative	Mr Santosh Jadhav and the relatives
Age / Sex	45 / Male
Education / Occupation	Service / Middle class
Presentation	ICU – Relatives have been waiting outside
Symptoms	Mother in ICU
Medical history	Mother was admitted with fever this morning, but she was conscious and talking at home. She has diabetes for which is taking regular medications. Her blood pressure was recently found to be high, but she was poor in taking her medications.
Surgical history	Nil
Family history	Nil
Psychosocial history	Patient was admitted in the ICU and the relatives have been waiting outside eagerly. They have no proper facilities at the ICU waiting area. They have already spent over Sixty thousand rupees for her medications. They cannot afford this treatment. They do not understand much about what is going on.
Role	The relatives are crowding around the doctor to know the condition of Mrs Jadhav. They cannot believe that she has died. They feel that they have been cheated. They have spent a lot of money and still their mothr has died. They feel that the hospital has been negligent. They were not informed about her progress from time to time. An hour ago, one of the nurses who came out of the ICU had told them that all is fine.

ASSESSMENT SHEET - 4.2

Informing Death

Name of Candidate:

Name of the Observer:

Task	Done	Needs to improve	Not Done
Introduction			
Eye Contact			
Listening			
Empathy			
Non-Medical language			
Prepares the setting			
Checks the perception of the relatives			
Obtains invitation to share information			
Shares the knowledge			
Offers support and handles emotions			
Makes a shared plan with the patient			
Thank and Reassure			

Observer Information:

Global (Overall) Assessment Score:

1	2	3	4	5	6	7	8	9

1 - Totally inadequate – numerous serious shortcomings
2 - Poor - Numerous and/or Serious shortcomings
3 - Marginal - Numerous deficiencies
4 - Below Average - Some deficiencies
5 - Average - 50th centile of the class
6 - Above Average - 51 to 75th centile of the class
7 - Good - In the upper 25th centile of the group
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9 - Outstanding -The best out of ten

Quick assessment chart :

1 to 4 - Clear Fail -Below Average performance
5 - Just Pass -Average performance
6 to 9 - Clear Pass -Good performance

SECTION-5	
Title	**TRAINING IN COMMMUNICATION SKILLS**
Objectives	By the end of this session, the participants will be able to - • To understand the importance of learning communication skills • To understand the different ways to learn communication Skills • To understand that practice is vital to be good in real life situations • To prepare their own workshop for teaching communication skills to others
Materials	Observing, Videotaping self, watching videos, Group discussions, Role playing, Simulated patients, performing with real patients PowerPoint I : Communication Skills – Why, What, Where, When, How to teach and learn. Organizing a communication skills workshop. PowerPoint J : Various modes to learn communication skills Handout 5.1 : Design a communication skills workshop Handout 5.2 : Create an OSCE station to teach management of an angry patient
Advance Preparation	• Make enough copies of handouts for distribution • Ensure readiness of PowerPoint I and PowerPoint J
Instructions to the trainer	• The trainer should try to extract maximum from the participants based on training received in earlier four sections for developing training in communication skill. • Tell participants that you would like them to work in groups. • Ask participants to draw their own "thought maps" on a sheet of notepaper • Use handouts at as per the number and title at desired places.

<table>
<tr><td rowspan="6">Training Activities.</td><td>ACTIVITY</td><td>DURATION</td></tr>
<tr><td>Step 1 - PowerPoint I- Communication Skills – Why, What, Where, When, How To Teach And Learn. Organizing A Communication Skills Workshop</td><td>10 Minutes</td></tr>
<tr><td>Step 2 - Design A Communication Skills Workshop</td><td>15 Minutes</td></tr>
<tr><td>Step 3 - Create an OSCE Station To Teach Management of an angry Patient</td><td>20 Minutes</td></tr>
<tr><td>Step 4 - PowerPoint J -Various Modes To Learn Communication Skills</td><td>30 Minutes</td></tr>
<tr><td>Session Time</td><td>75 minutes</td></tr>
<tr><td>Detail Steps</td><td colspan="2">STEP 1-POWERPOINT I- COMMUNICATION SKILLS – WHY, WHAT, WHERE, WHEN, HOW TO TEACH AND LEARN. ORGANIZING A COMMUNICATION SKILLS WORKSHOP
Enlighten the participants with following concepts using PowerPoint.
• Communication Skills – Why, What, Where, When & How to teach and Learn communication.
• Ask the participants about how they would teach communication skills to their junior residents, medical students and the nursing students. These methods include:
▪ Lectures
▪ Group Discussions
▪ Role plays
▪ Simulated patients
▪ Video demonstrations
▪ Self-recorded video observation
▪ To observe role models in real life
▪ To perform in real life situations</td></tr>
</table>

POWERPOINT I- Communication Skills – Why, What, Where, When, How to teach and learn.

Organizing a communication skills workshop

- Ways to learn communication skills
- The need for self-motivation
- The role of observing carefully
- The administrative skills
- The teaching skills

STEP 2- DESIGN A COMMUNICATION SKILLS WORKSHOP (EXERCISE 5.1)

- Ask participants to open **handout 5.1-** The participants must work in groups. Divide all participants in groups of 6 or 7. Each group must prepare their own design for communication skills training - 15 minutes
- After the 15 minutes, ask two groups to come forward and discuss their design. Invite comments and additions from other groups.
- Interactive Group Discussion – 15 minutes

STEP 3- CREATE AN OSCE STATION TO TEACH MANAGEMENT OF AN ANGRY PATIENT

(EXERCISE 5.2)

- Ask participants to open **handout 5.2-** The participants must work in groups.
- Ask the groups to create an OSCE station regarding an angry patient. This should include instructions to the performer, role player and the mark sheet for the examiner. – 15 minutes
- Ask couple of groups to come forward and present their scenarios.

STEP 4- POWERPOINT J -VARIOUS MODES TO LEARN COMMUNICATION SKILLS

- Discuss the OSCE designing with the other participants-30 minutes

POWERPOINT J- VARIOUS MODES TO LEARN COMMUNICATION SKILLS

- The skill to design OSCEs
- The vital role of practicing role- plays
- The need to include communication skills training in the syllabus.
- The need for the healthcare trainees to get socially connected

HANDOUT 5.1

Exercise 5.1-Design a communication skills workshop

Case Scenario

As a resident doctor, you are supposed to design a communication skills workshop for the undergraduate students in the first year of MBBS. Plan the workshop so that the students can understand and learn about communication skills.

Tips for organizing the communication skills workshop:

- Decide the target audience – Trainee level and Numbers of trainees
- Take advise from the seniors
- Prepare the program by selecting the topics and make a schedule
- Choose the right faculty and inform them
- Decide the forms of presentations
- Fix the venue
- Nominate a coordinator and distribute roles to various members
- Spread the word
- Design leaflets, banners and messages on the social media
- Create the stationary and make the required copies
- Arrange for water, tea/coffee and possible snacks/ lunch
- Prepare a budget
- Be ready on time and conduct the session
- Obtain the feedback from the participants

HANDOUT 5.2
Exercise 5.2-Create an OSCE station to teach communication with an angry patient
Prepare instructions for the candidate to perform **Prepare script for the Role player** **Prepare an assessment sheet for the examiner** **Examples of angry patients:** • Intraoperative complications • Wrong operation being performed • Patient condition not improving even after prolonged treatment • Costs of the treatment keep rising during the treatment • Different healthcare professionals give conflicting information to the patient. • Delayed diagnosis leading to increased pain and suffering to the patient • Cancellation of the patient appointment at the last moment • Sudden death of a patient • Breaking a serious bad news such as the birth of an abnormal child and amputation

PROFORMA

"Management of Doctor-Patient Relationship by Teaching Communication Skills to Resident Doctors in Maharashtra"

Part A
Personal Particulars

1. Name of Resident :…… ……
2. Age : …….. yrs
3. Sex : M / F (√)
4. Year of Residency:…… ……
5. Subject of Specialty : …..……
6. Name & Address of Institution of Residency: : …..……
7. Area : Rural/ Urban (√)
8. Details of Educational Background:

Educational Qualification	Name of Institute	Location of Institute	Govt/ Private	Year of Passing
S.S.C.				
H.S.C.				
Under Graduate				
Post Graduate				

9. Any close Relative who is a Doctor : Yes / No (√)
10. Contact Address : ……
11. Email : ……
12. Phone/Mobile No : …… Do you have WhatsApp?: Yes / No
13. Have you attended any Communication skill seminar/workshop: Yes / No
14. Language Known : <u>Tick mark (☑) the most appropriate response</u>

    MARATHI/ HINDI/ ENGLISH If any please Specify:……..

Part B
Consent

I …… whose particulars are mentioned above have been explained and fully understood the various aspects of the study entitled: **"Management of Doctor-Patient Relationship by Teaching Communication Skills to Resident Doctors in Maharashtra"**

1. In the language I understand, and I hereby voluntarily consent to participate in the study.
2. I have received an explanation of the nature, purpose, duration and expected effects of the study and what I will be expected to do. My questions have been answered satisfactorily.
3. I understand that my participation in the study is voluntary and that I may refuse to participate or may withdraw from the study anytime, without any penalty.
4. I understand that my identity will not be revealed in any publication.
5. I agree to take part in the above study.

Name of the resident	**Name of the Investigator administering consent**
Signature of the resident	**Signature of the Investigator administering consent**

Date:

Place:

Name:_____

Part C – Pre Test Training Questionnaire

a) Tick mark (☑) the most appropriate response you fill in concern with the Questionnaire asked as follows -

1. Strongly disagree (SD), 2. Disagree (DA) 3. Uncertain (U) 4. Agree (A) 5. Strongly agree (SA)

Sr	Items	SD	DA	U	A	SA
	Section 1 – Being a Mindful Doctor					
1	Doctor has a duty to provide reasonable care to a patient only when a patient pays the fee.					
2	Emotional intelligence has an important role in team building					
3	A doctor has a duty to completely cure the patient.					
4	Health is defined as complete physical and mental well-being of the patient					
5	Mindfulness can help to prevent burnout in the doctor					
	Section 2 – Basics of Communication Skills					
6	Doctor needs to talk in layman's language with all patients coming to him.					
7	The doctor should inform the patient of all the treatment choices available, their pros and cons and arrive at a shared decision with the patient.					
8	Empathy gets reduced during the period of medical training					
9	Listening is the same as hearing the spoken words					
10	Medical knowledge without emotional intelligence is useless					
	Section 3 – Doctor-Patient Relationship					
11	There is an urgent need to improve the current doctor-patient relationship					
12	Strict laws by government will definitely stop violent attacks					
13	It is the patients fault that they get confused because of google information					
14	Doctors can avoid violent attacks with the help of good attitude and behavioural skills when dealing with patients and their relatives.					
15	Violent attacks on doctors are happening ONLY because of the media					

Section 4 – Communication in Special Situations						
16	The best way to handle an angry patient is for the doctor to take an aggressive approach					
17	Bad news can be disclosed at any location in the hospital outside the ICU					
18	Armed security guards will stop attacks on doctors giving bad news					
19	Half information about the bad news can be given to the patients to reduce their distress					
20	If your senior colleague is harassing you, it is best to keep quite					
Section 5 – Training in Communication Skills						
21	Current teaching pattern makes you capable to handle all untoward incidences at workplace.					
22	The communication skills to handle untoward incidences at workplace are a science and should be included as a subject in curriculum for undergraduate and postgraduate studies.					
23	Uniform Specific standard operative protocols are needed to handle incidences at workplace.					
24	Regular communication skills training workshops must be conducted in every healthcare institution					
25	Communication skills training should be a part of high school and junior college education					

b) Write your opinion for the following questions in brief:

1. Explain how mindfulness is helpful in the medical profession?

   _____

2. Explain the role of emotional intelligence in developing interpersonal relationship?

   _____

3. Name five barriers for good communication?

   _____

4. Do you feel proper communication about death of patient to the relatives will prevent violence with doctors?

   _____

5. Name the methods that can be used to teach communication skills to your juniors

   _____

Suggestions, if any: _____

_____

Name:_____

Part D – Post Test Training Questionnaire

a) Tick mark (☑) the most appropriate response you fill in concern with the Questionnaire asked as follows -

1. Strongly disagree (SD), 2. Disagree (DA) 3. Uncertain (U) 4. Agree (A) 5. Strongly agree (SA)

Sr	Items	SD	DA	U	A	SA
	Section 1 – Being a Mindful Doctor					
1	Doctor has a duty to provide reasonable care to a patient only when a patient pays the fee.					
2	Emotional intelligence has an important role in team building					
3	A doctor has a duty to completely cure the patient.					
4	Health is defined as complete physical and mental well-being of the patient					
5	Mindfulness can help to prevent burnout in the doctor					
	Section 2 – Basics of Communication Skills					
6	Doctor needs to talk in layman's language with all patients coming to him.					
7	The doctor should inform the patient of all the treatment choices available, their pros and cons and arrive at a shared decision with the patient.					
8	Empathy gets reduced during the period of medical training					
9	Listening is the same as hearing the spoken words					
10	Medical knowledge without emotional intelligence is useless					
	Section 3 – Doctor-Patient Relationship					
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18	Armed security guards will stop attacks on doctors giving bad news					
19	Half information about the bad news can be given to the patients to reduce their distress					
20	If your senior colleague is harassing you, it is best to keep quite					
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21	Current teaching pattern makes you capable to handle all untoward incidences at workplace.					
22	The communication skills to handle untoward incidences at workplace are a science and should be included as a subject in curriculum for undergraduate and postgraduate studies.					
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   _____

3. Name five barriers for good communication?

   _____

4. Do you feel proper communication about death of patient to the relatives will prevent violence with doctors?

   _____

5. Name the methods that can be used to teach communication skills to your juniors

   _____

Suggestions, if any: _____

_____