Medical students' perceptions of their development of 'soft skills' Part II : The development of 'soft skills' through *'guiding and growing'*

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Abstract

Background

This paper reports on medical students' views on the ways in which their 'soft skills' were developed. It is the result of a study on soft skills among two groups of students before and after curriculum reform at the School of Medicine of the University of Pretoria. One of the aims of the reform was to provide more teaching and learning opportunities for the development of soft skills. Soft skills include professional interpersonal and social skills, communication skills, and professional and ethical attitudes.

Methods

As symbolic interactionism was used as the theoretical framework to guide the research, qualitative methods were used to collect the data. A purposive-theoretical sample of 42 final-year medical students from the traditional curriculum and 49 from the reformed curriculum was recruited. Data were collected by means of focus groups, individual in-depth interviews and autobiographical sketches.

Results

The same categories of comments emerged from the data collected from the study participants from both the traditional and the reformed curriculum. The students ascribed their behaviour related to soft skills to personality and innate features. They had varying opinions on whether soft skills could be taught, but there was as a strong feeling that teaching should focus on principles and guidelines for dealing with difficult situations. They believed that, in the end, they should take responsibility for their own development of soft skills.

Most participants felt they could at least grow through exposure to teaching activities and the observation of role models. They also indicated that they had developed their soft skills and constructed their own identity through their interaction with others. Their definition of situations was shaped by their interactions with doctors and educators, fellow students and other health professionals. Interaction with patients was considered the most important. For both groups of students their third year was a watershed, as it is the first year of more intensive patient contact and the beginning of serious learning from interaction with patients.

The views on the development of soft skills differed very little between the traditional and reformed curriculum groups, except that students who had followed the reformed curriculum felt more prepared through the increased teaching and training efforts. Further consideration needs to be given to the intention of the changed curriculum compared to the actual effect.

The way in which the participants in the study described their development of soft skills could be categorised as a complex interplay between 'being' and 'becoming'. Instead of using the word 'acquisition' of soft skills, 'development' seemed to be more appropriate. The metaphor of 'guiding' and 'growing' also captures the development of these skills better than the terms 'teaching' and 'learning'.

Conclusion

Teaching activities in the clinical years should be adapted with a view to facilitating the students' professional growth. New models for the development of medical educators should be created and institutional barriers should be investigated.

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Introduction

This paper reports on the ways in which undergraduate medical students perceived their development of soft skills before and after the curriculum reform introduced at the University of Pretoria in 1997. One of the aims of the reform was for more overt and focussed attention to be paid to the development of soft skills. Soft skills are understood to include interpersonal and social skills in a caring, professional doctor-patient relationship, communication skills, and professional and ethical attitudes. The development of these skills is intricately interwoven with the promotion of the personal and professional development of medical students[1,2] and the teaching and learning of communication, ethics and humanism.[3] As an element of monitoring the changes to the curriculum, a qualitative study was undertaken to compare students' views on and experiences of how they acquired and developed these skills before and after the curriculum reform.

Methods and findings

Symbolic interactionism was chosen as the theoretical framework to guide the research design. This allowed for the exploration of how medical students saw and defined their situation and how they constructed shared conceptualisations of their development of soft skills.[4]

Participants were recruited by means of purposive-theoretical sampling: 42 students from the last cohort of final-year students following the traditional curriculum (2001) and 49 students from the first cohort of final-year students under the new curriculum (2002) participated in the study. The sample was drawn from indigenously established student categories identified by the researchers and the students. These categories allowed for recruitment from the diversity of the student population with regard to gender, home language and race. Focus groups, in-depth individual interviews and autobiographical sketches were used as methods of data collection for both groups. A detailed exposition of the methodology has been given in another paper.[4]

The data were collected by eight of the authors. The same authors also did the data analysis for both curriculum groups. For the first round of analysis, the transcripts were divided between pairs of two authors each. Authors then shared their analyses in the group to confirm that the data from the various sources triangulated and to reach consensus on categories of interpretation. The same categories of comments emerged from the data collected from the participants from both the traditional and the reformed curricula, with slight differences between the two groups in some patterns within the categories. These will be elaborated on at relevant points in the paper. Although the initial comments of some students seemed to suggest that soft skills could not be taught, the majority of participants from both groups were of the opinion that some soft skills could be developed, not so much through formal lectures and presentations, but subconsciously and informally during ward rounds and other clinical activities. They also mentioned the same vehicles for personal growth and the development of soft skills. These include the formal teaching of soft skills, learning about soft skills through observation, and learning through their own experiences and interactions with patients, doctors and their peers.

Can soft skills be taught?

One of the strongest trends identified through the data analysis was a tension between differing views held by students on which aspects of soft skills could be taught and learned and which aspects could not, and the reasons for this. Some participants saw the **foundation for soft skills development** as innate, a question of being '*born with*' qualities such as warmth, love and '*that nice touch with patients*' (Afrikaans: '*daardie mooi aanslag vir pasiënte*'). Many students also referred to the importance of their own family background in laying the foundation for the development of appropriate soft skills.

Owing to the innate nature of some soft skills, some participants from both groups expressed scepticism as to whether soft skills could be **acquired or taught**. As one student put it:

I don't think soft skills can really be taught. Because what it basically is is what type of a person you are. Soft skills are being a good respectful person and if you respect your fellow man you can't learn a skill of respecting your patient at the bedside, walk out and disrespect a beggar on the street.

However, students from both year groups alluded to the belief that soft skills could nonetheless be **developed** – '*… even the people who do have it can refine [their] skills'*.

Students from both the traditional and the reformed curriculum emphasised that practising good soft skills was a matter of personal choice. Having the theoretical knowledge was not the same as putting it into practice, and in the end students had to take responsibility for their own development of soft skills – '*It surely depends on the individual how he is prepared to treat a patient*.'

The underlying view of the students was that the development of soft skills was **part of lifelong learning**. The process does not begin and end with medical studies. There were references to '*it's something you learn as a child*' (Afrikaans: '*dis van kleinsaf iets wat jy maar aanleer*'), as well as to '*a philosophy of life*' (Afrikaans: '*'n algemene lewensbeskouing*') that is conducive to the continuous improvement of professional behaviour – '*So as long as you have an inclination to self-improvement, in all aspects of your life, you are well on your way to be a "good" everything, included doctor*.'

Formal teaching activities

In the traditional curriculum, formal lectures and teaching activities on soft skills were part of the teaching time allocated to Family Medicine. In the integrated reformed curriculum, these activities are much more varied, are spread out over the six years and include role-players from a variety of disciplines.

Participants had varying opinions on the purposes and usefulness of the formal teaching of soft skills. Some of the **purposes** they highlighted were to learn '*balance*', to inspire '*self-examination*' (Afrikaans: '*selfondersoek*'), to be '*shown how to do it*' and to '*go through it [processes in doctor-patient interaction] academically and try to understand the system behind it*'. Aspects of soft skills that students felt could be taught included techniques for dealing with doctor-patient interactions, especially communication skills. Other types of content were considered difficult to transmit.

There was a strong feeling that teaching should **focus on principles** and '*guidelines for certain situations*', such as breaking bad news or dealing with difficult patients. Students following the reformed curriculum considered the formal training in soft skills to be help-

ful '*in the sense that you know that this is what is expected of you*'. Traditional curriculum students were of the opinion that the above aspects of soft skills had not been addressed sufficiently in their curriculum: '*They tell you it is important to introduce a patient. They don't tell you how and you sort of learn it yourself. How best it works for you.*'

Learning through observation

Participants mentioned two forms of observation that contributed to the development of soft skills: observing teachers (as role models) and observing the interplay between what had been taught formally and what was being practised. In both instances, observation could have one of two positive effects: it could either reinforce the values that students subscribed to and that had been taught formally, or students could distance themselves from particular unprofessional behaviours and practices. Two students commented as follows:

I learned, for instance, by watching how other people work in the wards. If someone works well with the patients and you can see that they are happy, then you decide for yourself that's how I'd like to be.
(Afrikaans: '*Ek het geleer deur voorbeeld, deur te sien in die saal hoe mense werk. As iemand goed werk met pasiënte en jy kan sien die pasiënt is tevrede, dan maak jy vir jouself [uit], jy weet dis hoe ek wil wees.*')

If you watch someone else doing something wrong you could at least say, but this is not how we are supposed to be doing it, because according to guidelines this is [not] expected behaviour from the professionals.

Observing poor role models in practice could, however, also lead to the imitation of similar behaviour by the students. The perceptions of the importance of the interaction between doctors (teachers) and patients are discussed in the next section.

'Hands-on' experience and interactions

The participants in the study indicated that they had developed their soft skills and constructed their own identity through their interaction with others. With regard to their working environment, they commented on how their definition of situations had been shaped by their interactions with doctors and educators, fellow students and other health professionals – *'You learn a lot about human nature by being exposed to such a broad spectrum of people and cultures'* (Afrikaans: '*'n Mens se mensekennis het baie vergroot omdat jy aan so 'n groot spektrum van mense blootgestel word, en kulture*').

In addition to learning from role models, **interaction with patients** was considered the most important way of developing soft skills: '*From actually doing it, being in the situation, that's where you learn to do it.*' Participants also referred to differential experiences of patient contact in the course of their studies – '*I think it even has to do with which patients you are exposed to and which patients then have an effect on what you learn or what you experience through that patient.*'

For both student groups, the third year was a watershed. It is the first year of more intensive patient contact and marks the beginning of serious learning from interaction with patients – '*Once you start working with people in the wards, you realise what a doctor actually does*' (Afrikaans: '*As jy eers met die mense in die sale begin werk, besef jy wat 'n dokter eintlik doen*'). Over time, the student-patient interactions and the constant exposure to difficult situations in the course of such interaction also taught the students greater self-confidence: '*We would handle [certain situations] much better now*' (at the end of the six years of study). A few students referred to the improvement in their skills as regards breaking bad news to HIV-positive patients and dealing with them, but on the other hand they also realised their limitations – '*At one moment I think I can tell her, but the next moment I realise that I have no idea how to tell this woman that she is HIV positive*' (Afrikaans: '*Dan dink ek ek kan vir haar vertel; dan kom ek agter ek weet glad nie hoe om vir hierdie vrou te sê sy is HIV positief nie*').

The students commented that the interactions between themselves and **the doctors** who taught them had a bearing on their development of soft skills. The same was true for other health professionals, especially nurses, with whom they interacted during clinical practice:

I think we learn heaps of things, how to get on with different people, narcissists and people with other problems, how to get on with them. I mean for a start take our profs! You need a lot of soft skills to get on with them without locking horns. Or if you do lock horns, to get out of the situation in one piece.
(Afrikaans: *Ek dink ons leer ook 'n magdom van goed, hoe om met verskillende mense, narsissiste en ouens wat ander probleme het, hoe om met hulle oor die weg te kom. Ek meen as ons profs begin vat van 'n punt af. Jy moet [vir] elkeen daar soveel soft skills nodig [hê] om met elkeen van hom oor die weg te kom, en nie met hom koppe te stamp nie. Of met hom koppe te stamp en veilig daar anderkant uit te kom.*)

Furthermore, students considered **peer discussion** to be an important means of developing soft skills. These discussions often take place in group work as part of the formal curriculum, or in informal interactions in the hospital corridors. One of the students interviewed said:

Talking to each other helps as well. Sometimes we often relate to what happens and we say 'Wow, you'll never guess. We saw this patient today and this and this.' And you say, 'Gee, how did they handle it?' You don't realise that you take knowledge in, but medical students talk a lot about what they see. So you take a lot in as well.

Discussion

The various socialising agents identified in our study (e.g. peers, faculty members, nurses and patients), as well as the nature of their interactions, also feature prominently in the literature.[5] Although most of the recent curriculum reforms include 'more emphasis on non-cognitive factors such as communication skills and teamwork in the selection process',[1] current evidence seems to suggest that the biomechanisms of disease are still the central focus in comparison with issues related to patients' preferences, concerns and emotions.[6]

The views on their development of soft skills differed very little between the traditional and reformed curriculum groups, except for students from the reformed curriculum seeming 'more prepared, and [feeling] that teaching and training efforts left then well-equipped with soft skills'.[7] Further consideration needs to be given to the intention of a changed curriculum compared to the real effect. In this regard, the following comment by Coulehan may be relevant: '… in an attempt to render professionalism more quantifiable, it may use skills and practices as surrogates for virtue.'[8]

Teaching and learning soft skills

The participants in our study referred to some techniques used in doctor-patient interaction that could be taught. This is in line with the overwhelming evidence in the international literature on the teaching of communication skills.[9,10] However, Coulehan and Williams refer to other values and virtues related to soft skills, namely empathy, compassion, attentiveness, fidelity and courage, that can neither be taught easily nor developed 'in a clinical factory'.[11]

For the development of soft skills, teaching approaches that focus on experiential learning – '*if you watch someone else*' or '*actually doing it*' – are more effective than the acquisition of facts.[1,9,12] Gordon's contention that 'personal and professional growth is grounded in experience' and that the formal teaching done is not enough to ensure that students will develop into responsible and competent doctors[1] corresponds with the view of our participants that soft skills can only be refined and further developed over time. Our students expressed the related view that, ultimately, the development of soft skills was an individual choice. Training alone is therefore 'not a sufficient condition for actual behavioural changes in daily practice'; the intention to change also has to be present.[13]

Diverse opinions were also expressed on the timing and content of the formal teaching of soft skills. Formal teaching normally takes place in the more junior years, whereas bedside teaching in the senior years may provide a more appropriate opportunity to reinforce certain guidelines and pointers, which some of the participants in our study felt were lacking in their training. Ramani and collaborators, for example, suggest that content areas for bedside teaching should 'include the teaching of medical ethics, demonstrating humanistic aspects of patient care, role-modelling professional behaviour, and learning to see the patient as an individual.'[14] O'Sullivan et al. allude to some of the advantages of community-based learning for learning about psychosocial issues in medicine, increasing students' awareness of patient autonomy and improving communication skills.[15]

Metaphors for the development of soft skills

The way the participants in this study described their development of soft skills could be categorised as a complex interplay between **being** and **becoming**. Some students referred to unchangeable, innate characteristics as part of their being. On the other hand, the students also indicated that they were becoming good doctors, *inter alia* by their ability to develop their soft skills in a constructive manner as part of a lifelong learning process.

A pedagogical implication of this interpretation is that, instead of talking about the acquisition of soft skills, descriptions such as the 'development' or 'refinement' of these skills seem more appropriate. Instead of using the terms 'teaching' (often associated with the transmission of factual knowledge and skills) and 'learning', it appears from the participants' comments that the metaphor of **guiding and growing** may capture this development process and the associated conscious and subconscious interventions and influences more aptly and comprehensively. Moreover, this pair of terms seems to offer a better description of the sharing of knowledge underpinned by a particular professional value system. The students suggested that, while guidelines on professional behaviour could be given, certain things could not be taught. Bedside teaching, by implication, is a form of guidance, where teaching is merely one of the dimensions of guidance. One of the dimensions of student growth is learning, but the concept of growth is crucially about the depth or extent of personal development, where students not only engage the mind, but also the heart.[8]

Conclusion and recommendations

With the increased emphasis on the fostering of patient-centred attitudes and behaviour, of which soft skills are an integral part, it is important to reflect on approaches that would enable medical students to grow in their practice of soft skills. Although 'effective teaching of professionalism remains elusive',[16] two important avenues are

- curriculum changes to accommodate appropriate educational methods and interventions in the clinical years, *inter alia* by
  - rethinking the way bedside teaching is done[17]
  - providing more frequent and/or more structured feedback to students on their progress[18]
- the design of a more structured model of staff development[17,19] to assist with the development of consultants, registrars and other health professionals so that they are able to lead and guide students through professional role-modelling

In order to institute such changes, environmental, organisational and structural issues (as part of the hidden curriculum)[20] that may constitute hindrances to the optimal development and practice of soft skills by staff and students should be investigated, especially the value accorded to teaching in comparison with research and service delivery.[14,21,22]

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Declaration of interest

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Ethical approval

Ethical approval for conducting this study was given by the Research Ethics Committee of the Faculty of Health Sciences, University of Pretoria (No S183/2001).

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