AN ATTEMPT AT HUMAN RELATIONS LEARNING AND ITS RESULTS

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The "Human Relations Committee", formerly the "Interview Committee", was inaugurated before the start of the "Medical Education MD Program 90" and has been addressing the task of providing consistent training of communication skill (doctor-patient relation). The department of psychiatry is deeply involved in communication skill training, and for that reason it has been centered on psychiatry.

In this paper we report having planned and implemented the 3rd year clinical interview training sessions using "simulated paper patients" and the 4th year clinical interview training sessions in which direct patient interviews are attempted, and assessed the results. (1) Practical role-play using simulated paper patients in the 3rd year would seem to be even more valuable if it was linked to tutorial programs. (2) Even when a student has acquired textbook knowledge, it is fairly difficult to reconstruct role play interviews in three-dimensions, and experiential learning by the role play method seemed necessary to strengthen clinical diagnostic ability. (3) It is necessary to determine the optimal time for training in the 3rd year. (4) The 4th year practical training by means of direct interviews with real patients had a powerful impact on the students, and thus it seemed that it should be included in the series of major simulation learning sessions. (5) Evaluating role-play learning is important, and it will be necessary to examine the method of evaluation.

In the future there will be great changes in medicine, and we will enter an age when physicians who are capable of providing psychological approach will be more and more in demand. The role of interpersonal relations and attitude education will grow, and the involvement of the department of psychiatry is likely to become more important.

Introduction

The "Interview Committee" was inaugurated with Professor Toshiko Takemiya as chairperson in 1988 at the request of the late President Morimasa Yoshioka, before the start of the "Medical Education MD Program 90". In 1993 the name of the committee was changed to the "Human Relations Committee", and has been addressing the task of providing consistent training of communication skill. At present the committee consists of 25 members from 17 departments and clinical divisions of Tokyo Women's Medical College Hospital, the Daini Hospital, and Shiseikai Daini Hospital, and the committee also enjoys the collaboration of supporting members. The educational objectives to the committee are: (1) to enable good communication in a brief time at the first meeting (with a patient), (2) to inculcate the basics of attitudinal and verbal expression skills, (3) since communication is considered necessary not only between the physician and patient and the patient's family but with the
staff as well, to enable good rapport to be developed in a limited time in line with some aim and achievement of goals, whether between two individuals, between an individual and several persons, or between an individual and a group, and (4) to enable students to properly summarize and record the content of an interview, discussion, or debate.

Items 1 to 4 above are the educational targets, and efforts are being made to achieve them in parallel with human biological knowledge. Communication, interviews, and counseling are available as communication skills. Communication becomes more skillful as a result of using the interview technique for training, and counseling comes to be performed during the course of the interviews. It is not an overstatement to say that psychiatric treatment begins in the interview and ends in the interview. Thus, the interview method, which is indispensable to psychiatric diagnosis and treatment, is exploited, as is, in communication skill education, and role playing, which is important as a means of training in medical interview techniques, was originally devised as a treatment method for patients with neuroses. In role playing, a problem situation is established and the participants are asked to play certain roles in the situation given and discuss it, with the aim of sounding out the issues and solutions. J.L. Moreno was the originator of psychodrama, a group psychotherapy technique. Psychodrama is still being used to treat schizophrenia, alcoholism and neuroses, and role playing is one of the techniques employed in it.

Based on the above, education in communication skills is closely related to psychiatry, and that is the reason for centering it in the department of psychiatry.

At the present time three members of the committee are from the department of psychiatry. They are in charge of the 1st year role-play workshop, lectures, and the 3-days introduction to psychiatry practical training sessions\(^3\), and they are also involved in the implementation of plans for several training sessions.

In this paper we report having planned and implemented the 3rd year clinical interview training sessions using "simulated paper patients"\(^*\) and the 4th year clinical interview training sessions in which direct patient interviews were attempted, and assess the results.

*Simulated paper patient: A patient model in which a hypothetical patient and disease history are created to serve as a case when real patients cannot be used.

Methods

1. Clinical interview practical training sessions in the 3rd year

This originally was the first fourth year psychiatric training session, but this year, it was conducted during the 3rd year.

The groups consisted of about 30 students each, and the training sessions were held on three days, October 9, 11, and 16, 1996. It was decided to use "simulated paper patients" in the initial attempt, and the approximately 30 students were divided into two groups, and two committee members supervised them at two sites.

The purpose of this training session was "To learn through role playing experience how to elicit useful information appropriate to the patient's age from among multiple complaints and make a diagnosis". Each time the complaints changed and illnesses were made appropriate to the patient's age. Three patients were created each time, making a total to nine patients in all (Table 1).

The method consists of (1) breaking each group of about 15 students into smaller groups (A~C), and supervising 1~3 patients in each. The roles of leader/secretary, physician, and depending on the case, family members, friends, coworkers, etc., are assigned, and all of the members of each group participate. (2) One to three descriptions of the cases that have been created are handed out to all of the students in group A, except the person playing the physician, and about 30 minutes is allowed for them to understand and evaluate the nature of the
Table 1  Chief complaints and diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Oct 9(Wed)</th>
<th>Oct 11(Fri)</th>
<th>Oct 16(Wed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1: School child</td>
<td>Dizziness</td>
<td>Headache</td>
<td>Low-grade fever</td>
</tr>
<tr>
<td>Case 2: Adult (under 40 years old)</td>
<td>Orthostatic regulation disorder</td>
<td>Meningitis</td>
<td>Influenza</td>
</tr>
<tr>
<td>Case 3: Aged (over 75 years old)</td>
<td>Vertebrobasilar insufficiency</td>
<td>Depression</td>
<td>Depression</td>
</tr>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

case in each group. The diagnosis is never mentioned in the case descriptions. (3) The student playing the physician’s role is only told the patient’s chief complaint, age, and sex. (4) A table and chairs for the role play are placed in the front of the 3rd year classroom, and the session is started with the student playing the physician calling the patient and companions in. (5) The secretary organizes what the physician elicits from the patient on the blackboard, and the role play is brought to a close after about 10 minutes. (6) The secretary, now assuming the role of leader, listens to the evaluations of the interview by student members B and C, who have been listening. (7) Next, they listen to the impressions and reflections of the students who played the roles. (8) The human relations committee members who participated as observers then make their comments. (9) The teacher then reveals the diagnosis, explains the illness and symptoms and comments on the interview, and Group A is finished. The same procedure is then followed for groups B and C. (10) When all of the groups have finished, an evaluation and written impression of the training session are submitted. (11) Finally, the training session is discussed by all of the participants, and the first session is concluded (13:00〜16:00). The second and third sessions are conducted in the same manner.

2. The 4th year clinical interview practical training sessions

These training sessions were conducted by using the same format as conventional role play as a recapitulation of practical training up until the 3rd year4〜6) and as motivation for clinical diagnosis7). However, since only some of the students could participate in the role play, and it was boring and unpopular for the other students who wanted to participate too, this time all of the members of the committee were asked to cooperate, and since nine of them were able to participate, the students could be divided into nine groups. In addition, as their initial attempt, we decided to have patients of all of the members participate and get them to permit direct interviews.

The theme of this training session was “For the student to engage in communication with the patient and learn through experience how much information could be elicited, how to be able to record what was heard, and how to report the results before a large audience”. The objective was “To elicit the diagnosis, background factors, the patient’s mental status, opinion of communication with the attending physician, treatment, and the hospital, impression, etc., by directly interviewing the patient”.

The method was as follows. (1) The committee sent a letter of request to the patients in advance and obtained their consent to participate, then on the day scheduled, they met the attending physician together in the seminar room. (2) After the training session had been explained to the students, they proceeded to the various seminar rooms. (3) The interview was started with the physician providing only the patient’s name and age. (4) The interview was brought to a close after about 40〜50 minutes. (5) After recording the patient’s evaluation of the students, they returned to the hospital. (6) The information elicited during the interview
was then summarized in accordance with a certain format. (7) Everyone gathered in the classroom, and each group reported for about 5~6 minutes. (8) The supervising physicians made their comments. (9) The students submitted a self-evaluation and a report of their impressions on “How did you feel when you came into contact with the patient”, and the session was concluded (training session time: 13:00~16:00). A list of the patients for each group is shown in Table 2.

### Results

1. Results of the 3rd year training sessions

Material already presented in clinical lectures was assumed for the “simulated paper patients” used in these sessions, but it was the first time for the students, they playing the physician, the patient, and the family were confused, and the interviewing related to the disease did not proceed smoothly.

1) Self evaluation: The self-evaluation method in “Evaluation and impressions of clinical role playing”, which is already being used in communication skill training sessions, was used for self-evaluation of this training session (Table 3). A 5-grade rating from basic knowledge to attitude toward training was used for I. “self evaluation” and a 3-grade rating: “A” (yes), “B” (fairly or moderately), and “C” (no), was used for questions regarding the training format. The evaluations were tabulated, and the results are shown in Table 3. A total of 95 students participated in the training session, but because some did not respond to all of the questions, the totals for all of the items are not the same.

For II, “impressions”, the students were asked to write their impressions of the training session.

As a consequence, the students’ self evaluations in relation to basic and clinical knowledge, interviewing method, and diagnosis were very poor, with “5” being rare, few ratings of “4”, and with “3” being the most common rating, accounting for about half. In contrast, the results for attitude toward the practice session were good with 33 replied “5”, and 49 replied “4”. To the question, “Was this format a good method of learning?”, 43 replied “A” (yes) and 52 replied “B” (fairly). To the question, “Are you interested in this method of learning?”, 54 replied “A” (yes) and 41 replied “B” (moderately), accounting for about half of the students, and thus the format was evaluated as good and as being of interest to the students.

![Table 2 List of groups and patients](image-url)
Table 3  Evaluation and impression of clinical role playing

<table>
<thead>
<tr>
<th>Year</th>
<th>Participant No.</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Self evaluation</td>
<td></td>
</tr>
</tbody>
</table>

| Basic knowledge | 5 (2) | 4 (22) | 3 (54) | 2 (10) | 1 (6) |
| Clinical knowledge | 5 (2) | 4 (16) | 3 (40) | 2 (18) | 1 (18) |
| Interviewing method | 5 (3) | 4 (25) | 3 (45) | 2 (1) | 1 (1) |
| Diagnosis | 5 (5) | 4 (13) | 3 (36) | 2 (16) | 1 (10) |
| Attitude toward the practice sessions | 5 (33) | 4 (49) | 3 (13) | 2 (0) | 1 (0) |
| Do you think this format is a useful method of learning? | yes | fairly | no |
| | A (43) | B (52) | C (0) |
| Are you interested in this method of learning? | yes | moderately | no |
| | A (54) | B (41) | C (0) |

II. Please write any other opinions you have below.

2) Students’ written impressions: Concerning their impressions when playing the physician's role, many wrote such things as they did not know anything about the disease and found the interview painstaking, that their minds were a complete blank and they did not know what questions to ask the patient. The impressions of the patients' and families' roles included comments that they were glad to understand how the patients and their families felt, that they were able to imagine such things as what they would do if they were a parent with a child who became ill, and that since they were unfamiliar with the disease, the conversation did not flow from the symptoms in the case descriptions. Other comments included that they had never been able to use what they had learned about human relations before, that the classes were important to them because the knowledge they had studied in textbooks and in their notes had become three-dimensional, that these practical training sessions were valuable because when they became physicians it would seem like a continuation of what they experienced that day, and that they should have been allowed to prepare in advance before the role plays.

3) Comments of observers who attended the sessions: “While it was only natural because the students were unfamiliar with the diseases, the role playing was on the same level as a first year class, however, I became aware of a variety of things when I heard everyone's evaluation after each of the role plays, and I thought that they were valuable”, “I wish that they had used their imaginations and expanded more on the case descriptions in their performances, that they had relied on their intuition”, and “they should have taken up more current topics such as HIV and anorexia”.

2. Results of the 4th year training sessions

1) Self evaluation: The same method of evaluation shown in Table 2 was used as the self-evaluation method for the training session.

I. The individual evaluations were tabulated, and the results are shown in Table 4. The total of 99 students participated in the training session.

II. The students were asked to write their impressions thus: “How did you feel when you interviewed the patients?”

The results showed that despite having studied the diseases before, about half each answered “3” or “4” for basic and clinical knowledge, while 36 replied “4” and 52 replied “3” for interviewing method, and 49 replied “4”, 34
Table 4  Evaluation and impression of clinical role playing

<table>
<thead>
<tr>
<th>Year</th>
<th>Participant No.</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic knowledge</td>
<td>5 (0) 4 (52) 3 (45) 2 (2) 1 (0)</td>
<td></td>
</tr>
<tr>
<td>Clinical knowledge</td>
<td>5 (2) 4 (43) 3 (45) 2 (9) 1 (0)</td>
<td></td>
</tr>
<tr>
<td>Interviewing method</td>
<td>5 (1) 4 (36) 3 (52) 2 (9) 1 (1)</td>
<td></td>
</tr>
<tr>
<td>Diagnosis</td>
<td>5 (10) 4 (49) 3 (34) 2 (6) 1 (0)</td>
<td></td>
</tr>
<tr>
<td>Attitude toward the practice sessions</td>
<td>5 (41) 4 (51) 3 (7) 2 (0) 1 (0)</td>
<td></td>
</tr>
<tr>
<td>Do you think this format is a useful method of learning?</td>
<td>yes</td>
<td>fairly</td>
</tr>
<tr>
<td>A</td>
<td>(74)</td>
<td>B</td>
</tr>
<tr>
<td>Are you interested in this method of learning?</td>
<td>yes</td>
<td>moderately</td>
</tr>
<tr>
<td>A</td>
<td>(79)</td>
<td>B</td>
</tr>
</tbody>
</table>

II. How did you feel when you interviewed the patients?

Table 5  List of evaluation

Please answer the following questions.

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you feel that the doctor’s attitude was sympathetic?</td>
<td>yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Did the doctor seem trustworthy?</td>
<td>yes</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>3. Were you able to say everything you wanted to say during the interview?</td>
<td>yes</td>
<td>(4)</td>
<td></td>
</tr>
<tr>
<td>4. Did the doctor summarize your illness well?</td>
<td>yes</td>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>5. Did the doctor use easy to understand language without technical terms?</td>
<td>yes</td>
<td>(8)</td>
<td></td>
</tr>
</tbody>
</table>

Total points _______________________

replied “3”, and 6 replied “2” of diagnosis. For attitude toward the practice sessions, 41 replied “5” and 51 replied “4”, and thus the students seemed to have participated with enthusiasm. To the question, “Do you think this format is a useful method of learning?”, 74 replied “A” (yes) and 25 replied “B” (fairly). To the question, “Are you interested in this method of learning?”, 79 replied “A” (yes) and 20 replied “B” (moderately), the highest evaluation any of the training sessions has ever received.

2) Patients’ evaluation of the students: The objective structured clinical examination (OSCE) evaluation list was used for the patients’ evaluation. Eight patients participated, and the tabulations of the replies of the 8 patients are shown in Table 5.

A 4-grade rating from “4” (yes) to “1” (no) was used to evaluate items from 1 to 5. One patient did not answer question 4, and thus the results only represent the replies of 7 patients. All of the patients but one replied “4” (yes) to the question “Did you feel that the doctor’s attitude was sympathetic?”. The replies to “Did the doctor seem trustworthy?” were 1 replied “4” (yes), 5 replied “3”, and 2 replied “2”. To the question, “Were you able to say everything you wanted to say during the interview?”, 4 replied
“4” (yes), and 4 replied “3”, and to the question, “Did the doctor summarize your illness well?”, 3 replied “4” (yes), 3 replied “3”, and 1 replied “2”. To the question, “Did the doctor use easy to understand language without technical terms?”, 8 replied “4” (yes).

Based on these results, the patients evaluated the students as having a sympathetic attitude, speaking in a manner that was easy to understand, and listening to them sufficiently.

3) Summary of the comments of the teachers: Many of the teachers indicated that the students must improve their ability to process information and what they want to ask, that the questions were disorganized and did not follow any pattern, that knowledge about the diseases and thinking about patterns were inadequate, that they did not elicit background information, and that there was a lack of competence in relation to the interview, while at the same time stating that in general their attitude appeared to be good. They also claimed that there were too many students in each group and that just a few persons would be ideal. Another comment was that one hour was too short a period of time to ask questions and summarize the information.

4) Students’ written impressions: “I felt tension that I didn’t notice during role play.”, “I realized that I don’t know much and that I have to study more.”, “I thought it was much more instructive than slides and lectures.”, “We do diagnosis in tutorials too, but I was at a loss as to where to begin and what questions to ask in the interview.”, “I can’t ask questions in a systematic way.”, “Being able to listen to symptoms during an illness and to patients’ complaints was a meaningful experience for me.”, “The time was too short. I wanted to hear the patients talk more.”, “I would like to experience more classes like this”.

Discussion

The 3rd year practical training sessions with “simulated paper patients”, if they can be coordinated with the clinical lectures, and especially the tutorials, students should be able to engage in more active role play in the future. As seen in the students’ impressions as well, however, even when a student has acquired textbook knowledge, it is fairly difficult because role play interviews reconstruct it in three-dimensions, and experiential learning by the role play method seemed necessary to strengthen clinical diagnostic ability. Hori et al stated that the “simulated paper patients” have real patients’ clinical histories and are as effective as living patients, but in order for the students to allow their imaginations to range farther and expand on the content of the case, adequate knowledge of the disease is needed. If the students were allowed to prepare in advance as they requested, the “simulated paper patient” role playing would be even more effective. Since the diseases in the 3rd year are limited, and psychiatric lectures are not conducted at this time, consideration of the practical training time will be necessary.

Since it was possible to carry out the 4th year practical training this time by means of direct interviews with real patients instead of simulations by role playing, its seems to have had a rather powerful impact on the students. They were quite animated during the training sessions. This time there were nine groups of 15 or 16 students each, and if it were possible, groups with just a few students would be preferable. It seemed that it would have been better if the students had thought about the order and the manner of asking their questions in advance, and the one hour period was too short.

Uemura stated that simulation is indispensable to education in the emotional area, i.e., attitude toward patients and manners, but since this committee used role play as interview training at the Shirakawa orientation, and also conducted role play training in the 1st year, the students’ attitude toward the patients was generally good in both sets of practical training sessions this time, and the patients also sensed a sympathetic attitude. The method of evaluation is important in practical training by role
playing, and in evaluating interviewing methods evaluators check the manner in which the interview is advanced and the information obtained during it. However, because there was no check-list evaluation of the students role play in either year this time, such an evaluation should by all means be conducted next time. The 4th year students seemed most suitable for direct interviews with patients, but since this practical training will stop in the 4th year beginning next year, it will be necessary to consider where to insert it.

Communication skill training is based on a concept completely different from conventional education. It incorporates a variety of simulation techniques, and evaluates behavior in them, and teachers say that clinical experience alone up until now, has been inadequate and that special training is needed. It takes a great deal of work to prepare for practical training. It is an educational method that tests the ability of teachers. We would like to review each of the methods of training being conducted at the present time and seek out even more effective methods of teaching.

Among communiaiton skills, both the aspect of scientifically listening to the history of the patient’s illness (science) and the aspect of establishing a good doctor-patient relationship (art) are equally valued in the medical interview.

In conventional interviews, history taking is the main point and establishing a good doctor-patient relationship is not emphasized, but education in communication skills represents education in the art portion, and is all experiential learning.

The students become aware of a great many things through this experiential learning, and in the future, when they have become clinicians they will ask themselves, “What is a good doctor for the patient?”.

Education in communication skills is closest to psychiatric therapy. It is linked to the fostering of physicians who are capable of psychotherapy and psychological approach, and thus it seems meaningful for the department of psychiatry be given major responsibility for conducting it.

**Conclusion**

Through the efforts of its chairperson and the committee members the Human Relations Committee inaugurated in 1988, before the “Medical Education MD Program 90”, seems to have little by little, but definitely, achieved results by consistent experiential learning, from the 1st year to the 4th year. Practical training that extends over all departments and divisions is impossible without the cooperation of all faculty members. We think that discussion learning by small number of students or in groups by means of “tutorials” in this field of study should be applied as training for communication skills between “one person and many persons” as well, and would certainly like to seek this knowledge in tutors (teachers in the tutorial system) as well. In the future there will be great changes in medicine, and we will enter an age when physicians who are capable of providing psychological care will be more in demand. The role of interpersonal relations and attitude education will grow, and the involvement of the department of psychiatry is likely to become more important.

**Cooperators in practical training:** Masatake Ishikawa, Kyoichi Totsuka, Kohei Ota, Keiko Kojo, Kayoko Saito, Chisako Mitsuishi, Kei Nishikawa, Mari Suzuki, Choka Ko, Masashi Honda, Midori Takasaki

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ヒューマン・リレーションズ学習の試みとその成果

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医学教育 MD プログラム90]の発足に先立ち、発足した[ヒューマン・リレーションズ委員会]は、一貫してコミュニケーション技法教育（医師-患者関係）に取り組んできたが、教育内容は精神科との関わりが深く、中心を精神科に置いている。

今回、“simulated patient”を使用した3学年のクリニックインタビュー、直接患者にインタビューを試みた4学年のクリニックインタビューの実習を企画・実施したので、それについて報告し検討する。

(1) 3学年の“simulated patient”使用によるロールプレイ実習は既学習の疾患、特にチュートリアル課題と連携すれば、より効果的なロールプレイ学習となると思われた。
(2) ロールプレイによる学習は、教科書的な知識は頭に入っていても、それを立体化し再構築することとは困難で、臨床診断学の力をつけるためにも有用な勉強法であると思われる。
(3) 3学年の実習は、実習時期の検討も必要である。
(4) 4学年の直接患者にインタビューできた体験学習は、大変インパクトが強く、学生は生き生きと目を輝かしていた。シミュレーション学習が主な一連の学習の中に、ぜひ取入れたい学習方法であると思われた。
(5) ロールプレイ学習は、その評価が重要で、今後評価の検討も必要とされる。
今後医療は大きく変わり、ますます心の医療のできる医師が求められる時代となるが、その中でコミュニケーション技法教育の役割は大きく、更に精神科としての関わりも重要になるであろう。