Integration of Attitude, Ethics, and Communication Competencies into Competency-based UG Curriculum

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Abstract
The new MBBS curriculum has a course called Attitudes, Ethics, and Communication (AETCOM) which will run across years. Students will be assessed for how they communicate with patients, how they counsel people for organ donation or other challenging procedures, how sensitively they offer care and obtain informed consent? All these elements will count along with competencies. The new regulations mandate the development of AETCOM competencies through 27 modules with emphasis on self-directed learning. Ultimately it is expected that these modules are integrated into the basic curriculum of Indian Medical Graduates. Each module is a comprehensive self-contained unit. It describes learning objectives of competencies addressed, level of learning, contents of learning, professional year of study, hours of study, methods of learning and their formative and summative assessment along with accessible resource material.

Keywords: Attitude, communication, ethics, integration

Critical Analysis of Attitudes, Ethics and Communication Competencies
Overall, it is a comprehensive program which addresses specific competencies covering global attitude, ethics, and communication competencies in the role of an Indian Medical Graduate (IMG). The package of competencies is enunciated in 27 modules to be transacted in four professional years of study-spanning over different phases of teaching-Preclinical, Paraclinical, and Clinical phases. The total number of competencies addressed in various modules is 44; however, the list expands to overlapping 54 competencies. Of these 39 are core and the remaining 15 are noncore (desirable) competencies that are assessed formatively. As many as 26 competencies are knowledge based (knows and knows how) while 18 are skill based (shows and shows how). Total time mandated for transacting these modules amounts to 140 h spread over to different phases of learning.¹,²

The program recommends a hybrid problem-oriented approach (problem-based learning) for students to explore the various facets of “real-life issues” that will confront them in their careers, is the most effective way of learning Attitudes, Ethics, and Communication (AETCOM). As many as sixteen case studies have been incorporated in these modules, with 80 h devoted to problem-based learning. However, these case studies primarily focus on “profile” of patients presenting at the level of tertiary hospital, much different from cases presenting at the primary health care facility. Hence, they do not address the health needs of society. Community health-based case studies on Community diagnosis, Community therapy are considered more relevant in the Indian context than hospital-based case studies. The whole focus is on Students. There should be equal concern for Teachers/Faculty who are the role models for the students. Regular sensitization of the learned faculty is essential on core competencies of AETCOM, one-time training at nodal and regional centers of Medical Council of India (MCI) is not enough. AETCOM competencies have repeatedly used the words “patient encounters” in several modules. How one can demonstrate empathy in patient encounters? Encounter

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means a kind of confrontation or unpleasant struggle. This must be deleted from the vocabulary of AETCOM competencies. Meeting or contacts with patients/family/community are more dignified words showing respect, empathy, and addressing the concern of the patient/community. The vital component of communication need assessment of patient/community is missing altogether in these modules. This must be explicitly incorporated in all the modules on communication.

Integration of AETCOM Competencies into UG Curriculum

Until now there was no formal training of IMG in AETCOM competencies. The students during their formative years learned silently by observing their role models and dreamed to emulate them in their later life. The traditional way of learning – Experiential learning by trial and error was in vogue for decades. Now the MCI has rolled out a competency-based curriculum as well as formal AETCOM course in modular form. The challenge for medical colleges and their faculties is to integrate these modules into their competency-based curriculum which itself is a great challenging task because of shortages of trained faculty, large number of students, and poor logistics. MCI has facilitated the task to a great degree by rolling out 27 modules and resource material for framing the institutional curriculum. The framework provided by MCI can be used and implemented by respective institutions. Integration means combine to form the whole. Integration is a learning experience that allows the learner to perceive the relationship from blocks of knowledge and develop a unified view of its basis and its application. Teaching and learning of AETCOM competencies permeate the entire MBBS course longitudinally and progressively in various phases. Each phase builds on the success of the previous phase of learning in the continuum of medical education and generates a virtuous cycle.

Integration of AETCOM competencies into the existing program for the department of Community Medicine are analyzed and illustrated in detail as an example, other departments can take a lead from this example. The Department of Community Medicine is responsible for teaching and training of wide-ranging competencies directly or indirectly related to AETCOM competencies. The department can dovetail AETCOM competencies with the existing curriculum.

The AETCOM module 2.3 – “Health care as a Right” can be integrated into the existing competencies under topic CM 1.“Concept of Health and Disease” and CM 17.“Health Care of the Community.” The objective of module 2.3 is to introduce students to health-care systems, their access, equity, and the role of doctor in the health-care systems. The WHO constitution affirms that it is one of the fundamental rights of every human being to enjoy the highest attainable standards of health. The National Health Policy 2017 has not resolved so far on this issue. The policy question is whether we have reached the level of economic and health systems development to make this a justifiable right-implying that denial is an offense.

Right to health care covers a wide canvas encompassing issues of preventive, curative, rehabilitative and palliative health care across rural and urban areas, infrastructure availability, and human resources. It has also issues extending beyond the health sector into the domain of poverty, equity, literacy, sanitation, and drinking water availability. Right to health cannot be perceived unless a basic health infrastructure like doctor–patient ratio, patient bed ratio, nurses patient ratio, etc., are near or about threshold levels and uniformly spread over the geographical frontiers of the country.[5]

Expected learning outcome

The students should be able to describe and discuss the barriers to health as a fundamental right in the present health care systems.

AETCOM course modules 1.4, 2.1, 3.1, 3.3, and 4.1 on “The Foundations of Communication” can be integrated into existing competencies CM 1.9-“Role of Effective Communication in Health” and the topic CM 4-“Principles of Health Promotion and Education” which addresses three competencies. In community medicine patient is “Community or population subgroup.” Besides communicating with patients students must learn to communicate with the community, its leaders and organized groups to elicit community participation in health care need assessment. The students interact with the community and allotted families by frequent and recurrent contacts to build rapport with people. Direct observations of life processes in the community and allotted families make them wiser about features of geographical area, size of the population, demographic profile, and social determinants of health. Active listening to the community helps assessing their felt health needs. Talking with people, elected and nonformal leaders in the community validates felt health needs. Looking at the available health records in the community provides information on health problems. Thus, by walking (transact walk), listening, talking, and looking at available records and by frequent contacts the students are able to assess health service needs of the community to arrive at community diagnosis. After having assessed the health service needs the students to gather information on knowledge, attitude, beliefs, and health practices of a most prevalent and serious public health problem concerning people, this leads on to communication needs assessment. Once the communication needs of the community and family are assessed the student identifies the target audience, prepares specific health messages, uses appropriate channels to communicate with the community. This way they learn how to communicate and what behaviors to be changed over a specified time frame as also barriers to communication.[6] Finally, they assess the effect of communication on behavior change resulting in improved health practices leading to improved health status. Behavior change is a long-term process which requires sustained contact with the community and family. It is worthwhile to give live case studies or a project on communication to first professional year students to be pursued through 4 years to study the effect of communication, its success and failure.
Expected learning outcomes

He/she should be able to assess the communication need of the patient/community. Core skills on communication (listening, interpreting, body language, writing, reading, and reasoning) get inculcated and the learner is able to communicate effectively with patients and the community and colleagues in respectful non-threatening, non-judgmental, and empathetic manner.

The AETCOM competency modules- 1.2, 1.3, and 4.4 on “Doctor-Patient Relationship” can be integrated into existing competency CM 1.10 “Doctor-Patient Relationship.” The households, families, and community are connected with dynamic health care system through community-based volunteers such as ASHAs, AWWs, and health workers. Sustained contacts with community occur by regular home visits, outreach sessions, regular digital contacts of ANMOL (ANM Online) on daily basis, Village Health Sanitation and Nutrition Committee meetings once a month and Village health and nutrition day, Swasth Nagrik Abhiyan, during health days and health themes, mass campaigns and household surveys and their updation on regular basis provides a platform for regular contacts. Household surveys ensure not only contact between families and community taking place but is sustained long enough through a lifelong tracking system built under the integrated reproductive, maternal, and child health system. This transforms the attitude of providers to listening to the community to assess their health needs, inform and advise and become accountable to the community.

Expected outcomes

Students attend village health sanitation and nutrition committee meeting and VHSN day to understand the bonding between community and health-care providers to learn the nature and frequency of their contacts with the community to establish durable relationships. The students interact frequently with rural/urban community and health team members at the grass root level.

The AETCOM module 4.1-“Patient Diagnosis therapy and prognosis” can be integrated into existing competencies – CM 17.1 and CM 17.2-“Concept of Health care of Community and Community Diagnosis.” Patient in community medicine is “the Community” and not an individual. Community diagnosis, therapy, community compliance, and prognosis or outcomes are assessed and measured by different parameters such as utilization and coverage of health services, improved health status, reduction of morbidity, mortality, fertility, and improvement in nutrition. Steps in community diagnosis primarily focus on the assessment of “Community health needs” and the resources to meet these needs. The health intervention (therapy) is directed to the whole population such as promoting healthy behaviors, healthy environments and organizing and providing primary health-care services to the entire community (Universal Health Coverage). The students in small groups can be given annual household and facility survey data of a village/census ward in urban area gathered by ASHAs and AWWs to assess community health needs. Alternatively, the faculty members prepare hybrid problem-based learning case study for students based on household and facility survey data.

Expected outcomes

UGs at the end of training are able to assess community health needs (community diagnosis) and identify interventions and resource gaps those need to be addressed.

The AETCOM module 1.1-“Role of Physician in Health care system and responsibility to society and community”, Module 1.2 on – “Empathy” in patient contacts and Module 1.3-“Doctor-patient/Community relationship” can be integrated into the topic CM2 – “Relationship of social and behavioral sciences to health and disease.” Medicine is a social science, and its responsibility is to ensure health for all. Under the competency-based medical education curriculum, the department of community medicine holds the responsibility of the teaching of five inter-related competencies under the topic of – “Relationship of Social and Behavioral sciences to health and disease.” The learning objectives of these competencies (CM 2.1 to CM 2.5) are that the student regularly interacts with rural/urban/tribal community and allotted families in these communities to illustrate community size, community structure, its organization, leadership pattern, local self-government, its resources, its role and participation in health and development activities. Students regularly follow-up allotted families in these locations to elicit demographic profile, socio-cultural, behavioral, and environmental factors in health and disease. They follow these families longitudinally and their formative and summative assessment is carried out in the community setting.

Expected learning outcomes

The students are able to narrate their experiences and interaction with the community, their contribution in health activities and support provided to health workers and health volunteers. Based on their interaction with community and allotted families they can describe the role and responsibilities of the physician in the community health care system and beyond the health sector, the relationship of doctor with community, empathy in community contacts, healthy and unhealthy lifestyles, various risk factors and barriers to good health and health-seeking behavior.

The AETCOM competency module 2.4-“Working in a Health care team as a leader and member of health team” can be integrated into the existing topic CM 16-“Health Planning and Management.” This module aims at introducing students to health care systems and their functions. In the Indian Health care system, Doctor/Medical officer is first and foremost a manager as he is in charge of extensive resources both manpower and materials which must be major means of reaching 30,000 population of PHC and 1,20,000 population of CHC. He is the leader of the health team at PHC/CHC. Most of the functions of primary health care have been delegated to health workers. The outcomes of health care largely depend
on the performance of health teams. Whose role is to motivate health teams, provide continued education and training to progressively upgrade their technical skills, monitor and supervision of their work performance through regular monthly performance reports. Who provides written job descriptions to all members of the health team to reinforce as to what is expected of them, thus a Medical Doctor is the key facilitating figure in the National strategy of “Health for All.”

**Expected learning outcomes**
The students interact with health workers (health team), observe their work, have conversation with them and able to write a narrative based on their interactions. They develop respect for paramedicals, understand and learn jobs of the health team, their workload, their ways of working in the community, their workplan, available resources, community relationship and accountability to the community.

The AETCOM 4.3 on “Organ Donation” can be integrated into CM 20.4- “Laws pertaining to practice of Medicine such as Clinical Establishment Act and Human Organs Transplantation and Tissues Act.” The Government of India is implementing National Organ Transplant Program for the promotion of organ donation from deceased persons. A large gap exists between patients who require organ transplants and organ donors that are available. After brain stem death a person can donate many vital organs like kidneys, liver, heart, lungs, intestine and tissues like corneas, skin, bones, and heart valves. One organ donor can save up to eight lives and improve the quality of life of many others. Eye donation fortnight is observed every year. The students can visit Eye Bank and interact with people to elicit their views on the organ donation program.

**Expected learning outcomes**
The student should be able to develop counseling skills to promote organ donation.

**Assessment of Skills related to attitudes, ethics, and communication**
It is necessary that expected outcomes of each competency are defined explicitly beforehand by the teachers to enable them to assess the performance. The NMC considers the assessment as vital component of competency-based medical education. In addition to making to pass and fail decision a very important role of assessment is to provide feedback to the learner and help him/her to improve learning. The assessment of AETCOM module is designed with this purpose. The teacher should use this opportunity to observe the performance and provide feedback based on their observations. In case a student has demonstrated a performance which is considered below expectation, corrective action including counseling should be initiated. The assessor needs to be sensitized and trained on subjective assessment of soft skills of attitude, ethics, and communication.\(^5\) In fact, it is an assessment of the faculty and students alike. If the student has not acquired the AETCOM competencies we must look back to the system of medical education.

**Conclusion**
Medical Education Department/Units/Skill lab units and/or Curriculum and Ethical committees in medical colleges can coordinate learning and integration of AETCOM competencies into the existing competency-based curriculum spanning over 4 years. It requires little extra time. Department of Community Medicine holds a unique position as it maintains regular contact with students throughout the MBBS course. It can oversee effectively and coordinate the implementation of multidisciplinary AETCOM courses. All the necessary additional inputs to be invested in AETCOM course must be given to the Department of Community Medicine to strengthen the capacities. Community medicine department holds the responsibility for building 107 core competencies under the new MBBS curriculum. The critical analysis shows that out of these at least 20 competencies are related and relevant to AETCOM competencies and can be easily integrated into the existing curriculum of UGs. Hence it plays much bigger role. These 20 competencies address the concerns of “Patient/Community” in the areas of Medical Sociology, applied psychology, behavioral sciences, demography and population sciences, management sciences, medical ethics in research, communication skills, community diagnosis, public health legislation including appropriate behavior during national disasters and pandemic. Other departments of medical colleges can take a lead from this communication to integrate the AETCOM competencies into existing competency-based teaching and training programs. Integration of AETCOM into UG existing curriculum enriches the contents and quality of medical education.

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There are no conflicts of interest.

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