

RESEARCH PAPER

Challenges facing the introduction of communication skills into medical education in Iraq

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Abstract

Background: Communication skills have no clear curriculum in most Iraqi medical colleges. This shortcoming of education is reflected on doctor centered approach practice.

Objectives: To identify challenges facing the introduction of communication skills into medical education.

Methods: A questionnaire-based study was conducted to explore the opinion of healthcare professionals regarding challenges facing the introduction of communication skills in their institutions.

Results: One hundred forty-four participants responded. The frequency of challenges related to medical practice, education, and patients was 36%, 44%, and 20% respectively. Forty-four participants (30.5%) mentioned that challenges related to the medical colleges' adoption of the traditional subject-based curriculum, and biomedical approach, with nearly the same frequency of the participants, related challenges to the lack of a clearly defined curriculum, and (23%) due to scarcity of human, financial, and logistical resources.

Medical practice-related challenges include doctor-centred approach and neglect of patients' psychosocial aspects in the frequency of 44% and 28% respectively. Twelve respondents (8%) believe that doctors' use of medical jargon hinders the patient's contribution to the medical interview.

Low health literacy, language, and cultural metaphors constituted 71%, and 15% respectively.

There is no significant statistical difference in challenges in relation to specialty, workplace, sex, and years of practice.

Conclusion: Multiple levels of challenges need systematic review in educational curricula, medical practice, and social determinants.

Keywords: Communication skills, challenges, Iraqi medical education, College of Medicine, Iraqi medical practice.

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Introduction

Iraq responded to WHO recommendation in 1978 on Primary Health care (PHC) and the goal of Health for all by 2000. So, the Iraqi Ministry of Health (MOH) adopted the PHC system as a strategic approach to the practice of medicine with other levels of care. PHC is based on the biopsychosocial perspective that proposed

the adoption of community-oriented and patient-center care. However, Iraq failed to achieve the goal of health for all in 2000 because it suffered from political and social turmoil due to wars and the international embargo that was imposed at the time.^{1,2} On the other hand, most of the teaching in Iraqi medical and other health professions education colleges is based on the biomedical approach, which mainly focuses on training the students in hospitals. Such training doesn't let graduated doctors to acquire the knowledge and skills needed to practice community-oriented, patient-centred care.³⁻⁵ The National Council for

Accreditation of Medical Colleges in Iraq adopted national standards and graduate outcomes for accreditation of Iraqi medical colleges, these standards and outcomes included several Communication Skills (CS) requirements: "The graduate will be able to communicate effectively with patients, families, communities, and colleagues in a medical context."⁶ Also, the demand from participants in CS courses conducted in several medical colleges has become crucial,⁷ faculty presented their needs in questions; why we didn't study this subject in medical colleges? Why we didn't enter such courses at the beginning of our medical practice?

With all the above reasons, number of questions can be raised: Why medical practice and educational institutions had ignored CS before and how the late introduction of CS training activities can be made possible to be incorporated within their curricula now? This study aims to identify the challenges facing the adoption and inclusion of CS into medical education in Iraq.

Methods

A questionnaire-based study was conducted on healthcare professionals (HCP) who had participated in CS training courses all over Iraq. The training program started in 2016 at MoH; each health directorate from fifteen governorates nominated two interested HCP to participate in a five-day intensive course with home assignments at the National Training Center every three months. On the other hand, intensive courses were also introduced at Basrah Medical College in 2016, followed by Kufa Medical College in 2017 and Hawler Medical College in 2018. Finally, Kurdistan MoH participated in the project in 2020. We used an experiential learning approach; observation, feedback, and rehearsal were the main tools for training. The assessment

was based on descriptive feedback using agenda-led outcome-based analysis.^{8,9} Around one-third of the invited HCPs participated in the study. Participants' inputs regarding challenges facing them in the introduction of CS in their institutions were collected and collated. The questionnaire form was distributed online from April to October 2021, and it consisted of three sections; the first section covered personal data; gender, age, specialization, place of work, and years of practice. The second section included four questions: the first question was about the most important single challenge that hinders the introduction of CS in the Iraqi profession, the second question deals with challenges facing the introduction of CS in medical practice, and the third question focused on factors related to medical education, the fourth question concentrated on factors related to patient and society. Finally, the third section was an open-ended question about the participant's reasons for choosing the challenges mentioned in each field. Data were analyzed to quantify the participants' views and opinions on specific points using the Statistical Package for Social Sciences (SPSS).

Results

Figure-1, shows the most important challenge that the participants believe impeding the introduction of CS in the Iraqi medical profession. Sixty-four participants "44%" identified problems in medical practice as the main challenge to the introduction of CS in the medical profession, and fifty-two participants "36%" indicated that the main barrier is the fixed nature of the curricula of the educational institutions, and twenty-eight participants "20%" identified that the reason for not introducing CS is due to problems related to the patients and social culture.

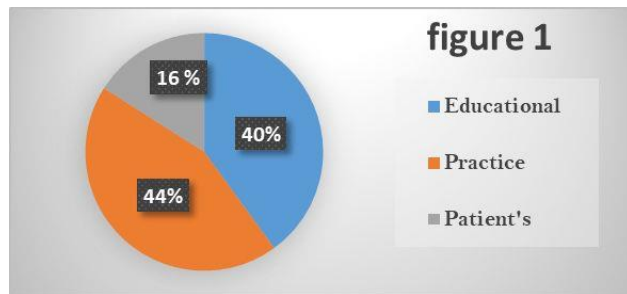


Fig 1. The distribution of communication skill challenges

Supplement Student's opinion

In practice, we rely on traditional history taking, and it is impossible to apply these skills in clinical training because of the large number of patients and the lack of time, in addition to some faculty members insist to take history in the old method as strict and "scientific" as possible and purely scientific means we shouldn't care about patient's suffering "physical aspect" only, so in order to apply these skills, there must be high-level coordination between departments in clinical training, and CS should be seriously taken. Otherwise, they are useless if they are not applied.

Table-1, shows that Sixty-four participants (44%) indicated that the difficulty of introducing CS into medical practice is due to the adoption of doctor-centred approach during medical encounters where patients play negative roles. Forty participants (28%) believe that the main reason is the neglect of the psychosocial aspect that enables the patient to express his predicament during the encounter. Twenty-eight participants (20%) believe that the main reason is the cultural disparity between doctors' approach and Iraqi culture. Finally, twelve respondents (8%) believe that doctors' use of medical jargon and difficult-to-understand terms hinder the patient's contribution to the medical interview.

Table 1. Frequency of challenges related to medical practice

Variables	No.	%
Doctors centered approach	64	44
Neglecting psychosocial aspects	40	28
Culture disparity	28	20
Language embarrassment	12	8

Table-2, shows a breakdown of the challenges that hinder the introduction of CS in the educational curricula: 44 participants (30.5%) mentioned that the main reason for the challenges is the medical colleges' adoption of the traditional subject-based curriculum, biomedical, and teacher centred approach, with nearly the same percentage of participants stating that there is no clearly defined curriculum with lack of teaching/learning aids including local textbooks. Thirty-three participants (23%) confirm that the reason for not introducing CS is the scarcity of human, financial, and logistical resources. Finally, twenty-four participants (16%) indicated that the main reason was the excessive increase in the number of medical colleges at the present time.

Table 2. Frequency of challenges related to medical education

Variables	No.	%
subject-based curriculum	44	30.5
No defined curriculum for Communication and behavioral skills	43	30.5
scarcity of resources	33	23
Increase number of medical colleges	24	16

Table-3, shows a breakdown of the challenges that hinder the introduction of CS related to patients and society: Sixty-seven participants (71%) indicate that low health literacy and health-seeking behavior is the most important obstacle to the use of CS in medical practice.

Patients visit several resources in a vicious circle before seeking appropriate medical advice: starting with folk and/or faith healers to paramedics, a pharmacist before and after consulting the doctor. Twenty-two participants (15%) indicated that the main reason is the patient's language and cultural metaphors. Twenty participants (14%) referred to family or triadic interviews; the nature of Iraqi society and collective behavior often leads the doctor to confront with more than one companion at the same time and the dialogue will be with three or four persons at the same time.

Table 3. Frequency of challenges related to patients and society

Variables	No.	%
Health literacy	102	71
Patients' language	22	15
Family interview	20	14

Discussion

1. Medical practice challenges

The practice-related challenges represent the biggest barriers (44%) to the introduction of CS in the medical profession in Iraq, this is compatible with other findings.^{10,11} Iraq responded to the recommendations of the World Health Organization Alma Ata conference in 1978, which called for health for all as a global goal to achieve by the year 2000.¹ In accordance, the Iraqi Ministry of Health adopted the primary healthcare system, which is based on the biopsychosocial perspective in medical practice and needs to prepare the doctors capable of improving the health of the individual and society to the extent that they can treat disease, provide patient-centred care, and healthcare for all members of society in partnership with other levels of healthcare. This is consistent with the

modern orientation of the concept of health: Health is a dynamic state of well-being characterized by a physical, mental and social potential, which satisfies the demands of life commensurate with age, culture, and personal responsibility.¹² But Iraq couldn't achieve the goal of health for all by 2000 because it suffered from political and social turmoil due to wars and the international embargo that was imposed on it. The escalating deterioration in the performance of the health system and its infrastructure has led to a serious decline in health security and healthcare indicators, causing citizens to lose confidence in the health system. The deterioration of healthcare in Iraq continued after the American occupation in 2003 followed by successive waves of terrorism that hit Iraq, in addition to the fact that successive governments didn't give health a strategic priority and adequate funding.² The reasons for medical profession sticks to doctors-centred approach (44%) are health system suffers from a shortage of medical and nursing staff, poor distribution and insufficient training, as well as inappropriate working conditions. It is worth noting that one of the weaknesses in primary healthcare is the absence of family medicine and its practice in most primary healthcare centers,² and the reliance on hospitals remains the main provider of healthcare in Iraq, with a biomedical perspective that corresponds to the approach of medical colleges teaching.^{5,13} Therefore, the number of patients visiting hospitals increased, and the medical procedures required by the doctor to diagnose the medical condition from his/her biological perspective were raised. The doctor spent less time with the patient, the number of complaints increased, and the doctor felt frustrated. This approach is suitable only for hospital care where the situation necessitates doctor centred approach, diagnosis oriented, and often related to the acute intervention.¹⁴ While in

primary health care centers biomedical approach fails to respond to the needs of patients with chronic diseases. The doctor needs a biopsychosocial perspective that s/he hasn't trained on to build a patient-centred medical interview. The Iraqi society needs this approach because people suffer from the spread of chronic diseases, including cardiovascular diseases, diabetes, respiratory diseases, and cancer, which constitute 55% of deaths in Iraq, as well as preventive programs such as maternal and child health and combating smoking, and addiction.^{15,16} The Culture disparity was identified by 20% and language embarrassment by 12% where participants stated that they believe that as medical practice depends on inappropriate Western individualistic culture, the symptoms were derived from western textbooks, which reflect how the patients expressed their problems and used termed information expression. Whereas, in a collective culture like Iraq, patients present their suffering in an emotional expression.^{11,16} To overcome language embarrassment, the doctor first needs to understand the patient's slang language, and popular terms that describe his/her suffering, then convert them into standard Arabic and then translate them into English to enable the doctor to understand the true meaning. In return, we need to translate our advice from foreign and Latin into Arabic and then into popular vocabulary. When the doctor doesn't find the appropriate word in Arabic, he will be communicating the meaning to the patient in a way that results in creating an ambiguity of understanding.¹⁸ These phenomena of linguistic embarrassment and cultural disparities are one of the challenges that hinder the introduction of CS in medical practice if we don't take them into consideration during the teaching and training of CS.

2. Challenges in medical education

In Iraq, there is no specific module/course devoted to teaching and learning of CS which is adopted yet by medical colleges. This may be attributed to the adoption of old traditional subject-based curricula (SBC) by most Iraqi medical colleges which is by itself a rigid and fixed lecture-based curriculum^{4,5,13} The SBC is based on biomedical and teacher-centred approaches, through lectures, and traditional medical history taking concentrating on disease perspective. Thus, the patient's role is negative in the medical interview, so the need to use CS and the biopsychosocial approach is weakened and the patient's perspective is lost.¹⁴ Furthermore, attempts to systematically integrate CS within current clinical training face considerable difficulties.¹⁹ The reasons behind these challenges hide behind a poor awareness of decision-makers in higher education in regard to the importance of CS for medical graduates. This is rooted in the practice as doctors belong to the old patriarchal school that believes in the doctor's control over the medical interview, and that communication is learned by imitation and grows with the accumulation of the doctor's experience and does not need a special curriculum. Until now, there is no national strategic vision to adopt this subject into medical education in Iraq. In the meantime, the introduction of CS is not curricular but taken from personal initiatives by some Professors who have a clear vision and experience in this field and are enthusiastic to introduce this subject in their colleges. These professors have succeeded in establishing the curriculum in their institutions, but their number is still small compared to 33 medical colleges, and they face many challenges.¹³ Before the adoption of CS curriculum, some questions need to be answered: Is the medical college ready for this change? Does it take into account the needs of the faculty

members? How can we overcome the behavioral apathy of some faculty members? How can you prepare a curriculum that suits Iraqi society and is not imported from abroad? How do we manage the lack of human, financial, and logistical resources that lead to the success of the change? Finally, we should take into consideration how to motivate students' participation in this change.²⁵ Many Faculty members in Iraqi medical colleges are unaware of the role of effective CS in efficient healthcare,^{18,20} as studies confirm that effective communication is necessary to ensure efficient healthcare, to raise the degree of patient satisfaction, conviction, remembrance, understanding, adherence, and to improve outcomes. And the quality of communication is essential to clinical competence.⁹ Many faculty members are not familiar with CS research that identified the latent and potential communicative problems and the reliable learning methods that have proven their success with research evidence in this field. They need training sessions which is time consuming intensive program to build their knowledge of the methods of teaching and evaluating the subject that is dependent on their motivations which might be a problem. It is a new specialization that differs from their clinical disciplines. Communication is a modern science and art; it possesses a set of clinical skills that can be learned and maintained in practice. It is based on special teaching methods; experiential small-group training, observation of students during training, role-playing, the use of a simulated patient, recording and reviewing interviews with CS experts, and rehearsal over and over again to acquire the necessary skills that improve clinical practice.^{8,9,20} The explosive technological development in clinical diagnostic and management tools such as catheterization and endoscopes, intervention radiology, molecular biology study, and so on has complicated healthcare and reduced the time doctor spent at

the bedside of patients. A large number of students, an overloaded curriculum, and the introduction of e-learning, led to the difficulty of introducing a new subject that needs face-to-face training with small-group learning. Lack of resources: lack of experts and CS lab, we couldn't introduce the simulated patient program, which is very essential in teaching and assessing students because of the scarcity of financial support. So, the current training on CS depends on role play using personal mobile phones to record interviews.^{21,22} The increase in the number of students admitted to medical colleges relative to the number of faculty members with a scarcity of CS experts led to the reliance on teacher-centred, large group teaching instead of small-group training. We need a clear vision on how to prepare students as future doctors. The students should be armed with skills that enable them to perform the required roles in the future. They are not accustomed to learner-centred learning and suffer from low motivation and a lack of active participation in small-group training. We need to establish a learner-centred approach to be reflected in the future and adopt patient-centred care.²⁰⁻²² Incorporating CS into the educational curriculum can be successful if the Deanship supports the program and establishes an appropriate learning environment. The college needs two parallel curricula running together: a communication curriculum for students and Capacity building for teaching staff with intensive teaching, learning, and assessment courses for students.⁸ The college should establish a CS committee to implement, monitor, and assess the curriculum from the first year to the sixth year. The curriculum should be integrated with the other clinical subjects. And ensure rigorous training like physical examination training. Some medical colleges have succeeded in establishing this curriculum; College of Medicine in Basra, Kufa, and Erbil,

and work is continuing to introduce the rest of the colleges with doubled efforts⁷

3. Challenges related to the patient and society

Twenty percent of participants believe that patient related factors are the first barrier to introduction of CS to medical practice. Seventy one percent of them believe that low health literacy is the biggest barrier in this group. Patients usually have popular beliefs with different health perspective that is not related to modern medicine. Their beliefs are derived from customs and traditions that are deeply rooted in Sumerian civilization, tinged with religious attitude to increase the conviction of simple people to agree to folk diagnoses and therapy: The envious look, magic, Satan, bad luck, gini, and teething are still prevalent as major causes of diseases, and there are popular ways to treat them, such as cupping, beads, spells, and many others. This health behavior led to delays in seeking medical advice and patients' lack of commitment to treatment.^{23,24} The health belief model of the patient becomes a barrier to proper interrogation, establishing common ground, mutual understanding, and management plan. Patient-centred care is difficult to implant in such a community. Instead, we need a tender paternalistic approach giving patients the possibilities and trying to motivate them to take your advice.²⁵ Iraqi medical interview contains a lot of cultural metaphors. The patient uses local psychosocial terms to describe his/her predicament. Usually, with emotionally charged complaints, such a slang language is difficult to understand unless the doctor asks for clarification many times.¹⁸ Also, the usual practice allows the Iraqi patient to come for consultation with one or more than one companion to show strong family support. This behavior usually disturbs the interview. So, we

need to derive our skills from local studies rather than imported from dyadic interviews, and textbooks of CS that we translated.¹⁸

In Conclusion, there are multiple levels of challenges, and they need to be systematically reviewed in medical practice, education and patient's related factors. We need a CS curriculum that is internationally accepted and locally harmonizes Iraqi society, adopting the biopsychosocial model, learner-centered education to be reflected in practice to patient-centred approach. At the level of society, we need to raise health awareness and improve health literacy through extensive educational social programs to alleviate health literacy status. To achieve such goals World Health Organization has put colossal emphasis on the competencies of Communication Skills as one of five roles that a doctor should be able to perform side-to-side with being a care provider, decision maker, community leader and manager²⁶

Ethics approval and consent to participate

Participation was voluntary and the consent to participate was included in the questionnaire, thus informed consent was obtained from all participants. The study was approved by the Scientific and Ethics Committee of Basrah University College of Medicine (ethics code: 030411- 035 -2022). All methods were carried out in accordance with the relevant Declaration of Helsinki guidelines and regulations.

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Conflict of interest

The authors declare that they have no competing interests.

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التحديات التي تواجه إدخال مهارات التواصل في التعليم الطبي في العراق

المقدمة: ليس لمهارات التواصل منهج واضح في معظم كليات الطب العراقية. وينعكس هذا القصور على عدم إمكانية إدخال منهج الرعاية الصحية التي محورها المريض في التعليم الطبي.

الأهداف: التعرف على التحديات التي تواجه إدخال مهارات التواصل في التعليم الطبي.

طرق البحث: أجريت دراسة قائمة على الاستبيان لاستكشاف رأي المتخصصين في الرعاية الصحية فيما يتعلق بالتحديات التي تواجه إدخال مهارات التواصل في مؤسساتهم.

النتائج: استجاب مائة وأربعة وأربعون مشاركاً. وبلغ معدل تكرار التحديات المتعلقة بالممارسة الطبية والتعليم الطبي والمعوقات التي تتعلق بالمرضى ٣٦٪ و ٤٤٪ و ٢٠٪ على التوالي. وذكر أربعة وأربعون مشاركاً (٣٠,٥٪) أن التحديات المتعلقة لعدم تبني كليات الطب لمهارات التواصل هو التمسك بالمنهج التقليدي القائم على الموضوع، "النهج الطبي الحيوي"، وبنفس تكرار المشاركين تقريباً ذكر المشاركون المشكلات التي تتعلق بعدم وجود منهج محدد واضح لمهارات التواصل، وأفاد (٢٣٪) أن سبب عدم إدخال مهارات التواصل هو ندرة الموارد البشرية والمالية واللوجستية.

وتشمل التحديات المتعلقة بالممارسة الطبية: نهج التعليم الذي محوره الطبيب وإهمال الجوانب النفسية والاجتماعية للمرضى في المقابلة الطبية بنسبة ٤٤٪ و ٢٨٪ على التوالي. ويعتقد اثنا عشر مستجيباً (٨٪) أن استخدام الأطباء للمصطلحات الطبية يعيق مساهمة المريض في المقابلة الطبية.

وذكر المستجيبون العوامل التي تتعلق بالمرضى والمجتمع عوامل أهمها انخفاض الثقافة الصحية لدى المرضى والحرص اللغوي الثقافي بين الطبيب والمريض في أثناء الحوار الطبي ٧١٪ و ١٥٪ على التوالي.

وبين الاستبيان أن لا توجد فروق ذات دلالة إحصائية في التحديات فيما يتعلق بتخصص الملاكات الصحية المشاركة في الاستبيان ومكان العمل والجنس وسنوات الممارسة.

الخاتمة: تحتاج التحديات المتعددة إلى مراجعة جميع المستويات المؤثرة على إدخال مهارات التواصل في المناهج التعليمية والممارسة الطبية والمحددات الاجتماعية.

الكلمات المفتاحية: مهارات الاتصال ، التحديات ، التعليم الطبي العراقي ، كلية الطب ، الممارسة الطبية العراقية.