PSYCHOLOGICAL FEATURES OF THE FORMATION OF COMMUNICATION SKILLS AMONG STUDENTS OF MEDICAL UNIVERSITIES

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Abstract. At the same time, we note that the development of electronic means of communication allows us to talk about the tendency to reduce the role of direct interpersonal communication, as well as about the decrease of its component in the communicative competence of the individual, but, in our opinion, this applies to a lesser extent to the communicative competence of the doctor.

Key words: communication skills, psychological characteristics, medical students

One of the main competencies in the field of healthcare is the communicative competence of the individual. The profession of a doctor belongs to the activity of the subject-subject type (person-person), where interpersonal communication with patients and their relatives occupies a special place, therefore, speaking about the communicative competence of a doctor as a professionally significant quality, we primarily mean the effectiveness of direct interpersonal communication. [1]

The purpose of the study. Research of psychological aspects of the formation of communicative competence among graduates of medical universities.

Materials and methods. Approaches to the definition of a doctor's communicative competence are interesting, in which it is understood as "a multilevel integral quality of personality (a set of cognitive, emotional and behavioral characteristics), mediating medical professional activity aimed at establishing, maintaining and developing effective contacts with patients and other participants in the therapeutic and preventive process. [2] In the structure of a doctor's communicative competence, we distinguish three interrelated and relatively independent levels: the basic (value) level, the content level and the instrumental (operational, technical) level, which includes two sublevels: general and professional communication skills and abilities" [3].

At the same time, the basic level is considered the main one, since it provides motivation for communication and opportunities for the development of communicative competence, facilitating or complicating this process. Basic communicative characteristics largely determine the originality of cognitive schemes, on the basis of which communicative programs are developed (content level), and the originality of the development of communicative skills and abilities (instrumental level). The content level ensures the translation of professional (medical) tasks into communicative ones, as well as the construction of communication programs and plans. The instrumental level includes general (for example, listening skills) and professional communication skills and abilities (for example, techniques for joining a patient) [3]. In accordance with this approach, the formation of a doctor's communicative competence is carried out according to modular principles, each of which is aimed at developing appropriate levels of communicative competence. Along with the multilevel consideration of communicative competence, as well as its development

through the development of appropriate levels, multicomponent models of the formation of communicative competence of future specialists are currently being developed [4].

Results and discussion. Thus, it can be stated that at present the communicative competence of a specialist is considered as an integral, multilevel (multicomponent) concept, including socio-psychological, psychological-pedagogical and linguistic parameters (qualities). At the same time, it is necessary to note the following features of the doctor's communicative competence and its specifics: - firstly, the doctor, like no one else, very often has to work in situations of time shortage and increased responsibility for making a vital decision on the patient's treatment, as well as for the content of information transmitted to patients or their relatives. At the same time, we must not forget about the high cost of error, which is an essential feature of the professional activity of a doctor. In addition, any information transmitted, for example, to the patient's relatives and containing a threat to the health or life of the latter, in most cases generates a stressful situation, the consequences of which cannot always be predicted, especially when communication occurs with relatives of terminally ill; - secondly, the doctor has to communicate with so-called difficult patients.

Some authors refer to the second category as depressive patients with a high risk of suicidal behavior, people with anxiety-hypochondriac character accentuation, patients - doctors by profession, introverted patients, closed to their inner world, and elderly people with mental disorders against the background of progressive atherosclerosis with memory loss, impaired concentration, with intellectual decreased or with inadequate emotions that do not correspond to the physical condition [4]. Other authors consider hysteroid, anancastic (obsessive-compulsive), excitable, avoidant, dependent, passive-aggressive, paranoid, schizoid, narcissistic and antisocial personalities with different degrees of disorders to be "difficult" types [5]. According to our firm belief, firstly, training in communication of a

future doctor with such patients should take place only at departments where clinical psychology is studied; secondly, this should happen after the trainees receive the necessary knowledge and consolidate the appropriate skills in psychological and pedagogical disciplines. In addition, it is necessary to realize the optimal level of development of these qualities. For example, empathy is a very important quality of a doctor's personality, but emphasis on the emotive type will necessarily lead to professional burnout with all the ensuing consequences. 3) The use of verbal techniques and non-verbal signals that help improve communication. The ability to hear and understand what has been said is one of the main conditions for improving communication, therefore, the development of active listening techniques is an important link in the formation of interpersonal communication skills. The techniques of active listening include: repetition technique (verbalization, step A - quoting, verbatim repetition of the words of the interlocutor), paraphrasing technique (verbalization, step B - brief transmission of the meaning of the interlocutor's message in their own words or using the formulations of the interlocutor), interpretation technique (verbalization, step B - interpretation of what the partner said). Most psychologists attribute negative assessments, ignoring the interlocutor and egocentrism to verbal techniques that worsen understanding in communication (searching for answers only to problems that concern us). In addition, we must not forget that in the process of transmitting information, its loss, distortion and addition occur. Often, distortion and addition are caused by apperception, i.e. the dependence of perception on past life experience, on the orientation of the personality and some personal characteristics. 4) Demonstration of confident behavior, exclusion of insecure (passive-aggressive) and aggressive behavior. As a rule, patients trust a self-confident specialist more, so it is necessary to increase their own confidence, to understand which signs demonstrate confident behavior and which do not. At the behavioral level, the signs of confident behavior include a friendly look when establishing contact with the interlocutor, a calm facial

expression, an open pose, the appropriateness of actions and movements, etc. 5) Mastering the methods and skills of argumentation of one's point of view, decision, position. You can read about argumentation methods in a large number of sources, but you can master them only with the help of practical classes and trainings, and even then not from the first time. It is especially difficult to argue your point of view with a significant number of opinions, when everyone is 100% sure of the correctness of their opinion. 6) Knowledge of strategies (styles) of behavior in conflict situations and techniques for regulating tension in conflict resolution. In accordance with the generally accepted theory of K. Thomas, there are five strategies (styles) of behavior in a conflict situation: cooperation, rivalry (struggle, confrontation), compromise, adaptation, avoidance (withdrawal). Interpreting the results of the Thomas questionnaire, many psychologists claim that the optimal result is indicators from 5 to 7 points on each scale. This suggests the need to use all five strategies (styles) of behavior in conflict situations equally. In addition, for the successful resolution of the conflict, the indicators of active actions (cooperation and rivalry) should prevail over the indicators of passive actions (adaptation and avoidance), as well as the indicators of joint actions (cooperation and adaptation) should be greater than the indicators of individual actions (competition and avoidance). Agreeing with this approach, we emphasize that for a doctor, the main strategy of behavior in a conflict situation is cooperation, while rivalry can only be used for tactical purposes, and avoidance can only be used if the patient is transferred to another specialist for treatment. Choosing a particular strategy of behavior in a conflict situation, it is important to understand not only yourself, but also the patient (patients), especially if the patient has a pronounced accentuation of at least one of such types as excitable, stuck, hyperthymic, cycloid and demonstrative. But this is not the subject of this article. In line with the above approaches to the consideration of communicative competence, we analyzed the components

of the instrumental level, i.e. psychological techniques, skills and abilities of interpersonal communication.

Conclusions: 1. The communicative competence of a specialist is an integral, multilevel (multicomponent) concept, including socio-psychological, psychological-pedagogical and linguistic parameters (components). 2. The formation of the future doctor's communicative competence should be carried out during the entire period of training both at psychological and pedagogical and specialized departments. 3. The development of communication skills (techniques) as components of communicative competence requires a long time and is possible only during practical classes or trainings.

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