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Communication Skills Manual

February – July 2003

ACKNOWLEDGEMENT

The following manual is based on the experience gained by its author from being involved in the Cambridge Cascade programme for teaching communication skills at postgraduate level and teaching undergraduate students at Addenbrookes Hospital, Cambridge.

This manual is meant to be used alongside the book 'Skills for Communication with Patients' (Radcliffe Medical press). Its content is inspired and based on the book and teachings of two of its authors - Jonathan Silvermann and Julie Draper.

Dr. Andrew Chafer January 2003

Table of Contents

Introduction 1

The overall objectives of this course

- This course suggests a curriculum of 'core' communication skills, which will help you conduct a patient-centred style of consultation, based on the Disease-Illness model and principles that promote effective diagnostic reasoning.
- The problems you encounter in the consultation need to be evaluated within an overall structure or consultation model. The Cambridge-Calgary will suggest effective communication skills, supported by research, to help you resolve them.
- You will be encouraged to use specific methods to analyse consultation skills, which are designed to encourage you to reflect on your own personal outcomes in the consultation, and how they can be improved.
- The course will hopefully help you integrate and understand the interdependence between communication skills, knowledge and clinical reasoning (problem solving). This is important, not only help make you a better clinician, but to improve your chances of achieving other important outcomes in the consultation.

How and why are we proposing you learn communication skills?

There are approximately 200,000 consultations to get through during a professional lifetime, so there should be some incentive for you as a doctor to learn the skills that restore a sense of control and help you cope!

Doctors often complain that they frequently find consultations difficult and challenging. Over a third of them find a quarter of all their consultations frustrating and a eight percent say that over more than half are dysfunctional or difficult.[1]

This is often because they feel poorly equipped to deal with the demands placed on them, as well as the behaviour and personalities of certain patients.

Unfortunately, GP Registrars continue to fail the video component of Summative Assessment due to a lack of basic skills as well as inadequate knowledge.

There are now established ways to help you approach and solve many of these difficulties as well as improve several important consultation outcomes. Furthermore, contrary to popular belief, most of the outcomes within the consultation are largely under your control.

Common problems and their reasons are discussed at the end in Chapter 7.

The process of learning communication skills has changed

The conventional way to learn communication skills is still to attend a short but concentrated course on the consultation that 'fires-up' short-term enthusiasm and raises awareness about the principles and practice of communication. Sadly, these often rapidly dwindle away and become forgotten shortly afterwards. Furthermore, learning is not automatically translated into consulting behaviour - and knowing about skills is a long way from putting them into practice.

There is evidence that experience alone is a poor teacher when it comes to sustaining our personal habits and communication skills. If you leave them to their own devices, your skills and ability to communicate with patients will become worse not better [2].

A better way to approach learning communication skills is to spread it over the time you are a GP registrar. This will give you a chance to learn, absorb, reflect and re-visit the skills the course introduced to you.

This is a 'helical' approach to learning. It involves continual review and repetition of acquired knowledge and skills, which has probably been the main way you have mastered most of your professional expertise so far. Your knowledge and skills have not been retained through a single exposure - they have needed continual re-visiting in the same way a world class concert pianist periodically returns to practising scales to maintain their technique and fluency throughout their own professional career.

Things might even get worse before they get better!

There are well-defined stages that you are likely to go through when confronted with new knowledge or skills. Learning new effective communication skills will hopefully result in those skills becoming integrated into your natural consulting behaviour [3]. Unfortunately there is also a natural tendency in all of us to resist change, with loss of our original motivation and confidence.

This awkward and difficult stage of changing older and less effective habits for new and better ones occurs because after first starting to use them, you often recognize your performance tends to go 'downhill' for a while, until the new skills are mastered properly.

This is similar to how you feel after playing and enjoying tennis for many years – but then want to improve your game further by taking up lessons. When you are finally coached how to hold a tennis racquet properly it often feels wrong and awkward and as a result your game suffers. However if you persevere, eventually your game improves much more than could have been achieved by relying on your original grip – making the investment in change worthwhile.

It is important for you to understand that the same might be true when first starting to use new communication skills. Perseverance with support and feedback from your trainer will help improve your performance.

What this course involves

There are four structured seminars and two role-play sessions.

Each seminar will start by looking at the objectives and principles relating to communication within the relevant section of the consultation – illustrating these using a combination of didactic teaching, group exercises and watching prepared tapes that highlight the various problems that occur. It is also important to combine these by looking at and reflecting on some of your personal experiences of problems in these areas.

Date	Time	Session/Seminar	Place
Thursday, 20th February	13:00 – 14:30	Hook lecture: An introduction to consultation and some of its problems	Multi Skills Lab Post-grad centre
Thursday, 6th March	14:00 – 17:00	Initiating the consultation	Seminar Room 2: Post-grad centre
Thursday, 17th April	14:00 – 17:00	Gathering information and Building rapport within the consultation	Seminar Room 2; Post-grad centre
Thursday, 15th May	14:00 – 17:00	Role-play session 1: Initiating the consultation & Gathering information and Building rapport	Multi Skills Lab Post-grad centre
Thursday, 5th June	14:00 – 17:00	Explanation, Planning and Closing the consultation	Seminar Room 2: Post-grad centre
Thursday, 3rd July	14:00 – 17:00	Role-play session 2:: Explanation, Planning & Closing the consultation	Multi Skills Lab Post-grad centre

Role-play

Using role-play as a method for learning communication skills often brings out concerns that it is artificial or 'unreal' compared to the real thing. This is true. However, it does allow participants to experiment and practice different skills and approaches in safety rather than ending up harming or offending real patients. If eventually you are to succeed in changing your habits, you need to be able to fail safely first.

How this manual might be used within your GP Registrar year

To get the most out of this course, a certain amount of reading is necessary. Simply getting 'stuck in' and practising communication skills in isolation without some understanding for their use or rationale is like starting to use a new electronic gadget without referring to its instruction manual. You are likely to become discouraged and frustrated when things don't work and are unlikely to learn the full potential of what's available.

It is important that you spend time reading the relevant chapters before each session to help set the scene for each of the seminars. This demands spending no more than half an hour or so a month.

However, you are directed to spend a little more of your valuable time reading a few important extracts from the book 'Skills for Communication with Patients'. The other books suggested in the Bibliography are optional - but very worthwhile for the inquisitive.

The process or method of analysing consultations on video suggested in the next chapter also relies on the importance of recognising and placing the difficulties you encounter within the relevant section of the consultation. This is the key to unravelling and understanding the cause(s) of problems as well as possible solutions to them.

At the end of chapters three to five there are suggested topics for you and your trainer to discuss in relation to that part of the consultation - as well as ways of looking at your videos and evaluating the difficulties within them.

Finally, the manual should become a record of your learning and use of consultation skills, to combine the structured teaching on this course with your own opportunistic learning from seeing patients on a daily basis.

Probably most important of all, this manual has a timescale intended to encourage you to start videoing your surgeries as soon as possible after starting your GP Registrar year. There is no need to wait until you feel proficient in general practice – or none of us would probably ever start!

1 Byrne & Long: (1976) Doctors talking to patients. Her Majesty's Stationery office, London
2 Levinson et al:(1993) Physician frustration with communicating with patients. Med Care 31(4):285-95
3 Wackman et al (1976) Student Workbook: increasing awareness & communication skills. Interpersonal communication programmes, Minneapolis.

Consultation models 2

The objectives of this chapter

- Why learning a structure or consultation model is important
- Starting to think in terms of outcomes and skills - what you want to achieve and how you get there
- The Cambridge-Calgary consultation model used in this course
- How the underlying principles of effective communication relate to medical communication

Learning a structure or consultation model

If you were to visit the capitol of a country for the first time, it is useful to use a map to discover the main tourist attractions as well as navigate its transport system. The limited time you have available would be more likely to be effectively spent if you planned your journey using it, rather than starting off walking down the first street you come across. You would also probably need to learn a few new terms of that countries language to help make sense of directions and landmarks.

A consultation model or structure has similar functions. Simply learning a list of helpful skills doesn't work in itself without understanding where they are found to be most appropriate and helpful in the consultation.

During your training, there is a need to relate the problems and difficulties you meet during the consultation to a recognisable structure or consultation model. In this way, problems can be analysed and alternative and effective skills suggested and tried out.

How you might do this is discussed in Chapter 6: Watching Videos, as well as within the suggested exercises located at the end of each of Chapters 3 – 5 that look at each of the respective parts of the consultation.

A consultation model helps you to maintain control in the consultation

Doctors frequently complain they feel out of control when talking to patients. They can't finish or prevent new items being brought up or stop what appears to be often unnecessary and irrelevant information from being discussed.

Thinking in terms of a structure also helps to prevent aimless wandering between the various parts of the consultation by ordering your thinking and relating the interview to where you are now and where you want to go next. Reflecting on what you hope to achieve at different stages of the consultation will influence your choice of how to get there using the most appropriate skills.

It identifies which parts of the consultation have been completed and helps prevent missing out or 'skipping' the important parts that need covering because they are essential to diagnostic accuracy. It also helps prevent you becoming frustrated and from wasting time from becoming involved in a series of circular questioning and examining.

Questions you need to start asking yourself

During each consultation – and particularly when faced with difficulties - you need to train yourself to think in terms of three questions.

- Where am I within the consultation - and what I am trying to achieve in this section?
- What have I learnt so far and what (content) do I need to find out before I can move on?
- What skills can I use to help me get there?

Skills are a set of communication tools

It is often useful to use the analogy of learning communication skills like looking after tools in a toolbox. Imagine the skills of communication rather like a set of tools within a mechanics toolbox.[1]

Each tool is purpose made to achieve a particular task or job efficiently and effectively. Whilst you can remove a nut with hammer and chisel - it is much easier and more satisfying to remove the nut without damaging it by using a polished socket wrench, specially made for the job. Of course, a car mechanic needs training and practice to learn how to use each tool – and in addition - which jobs need which tool(s).

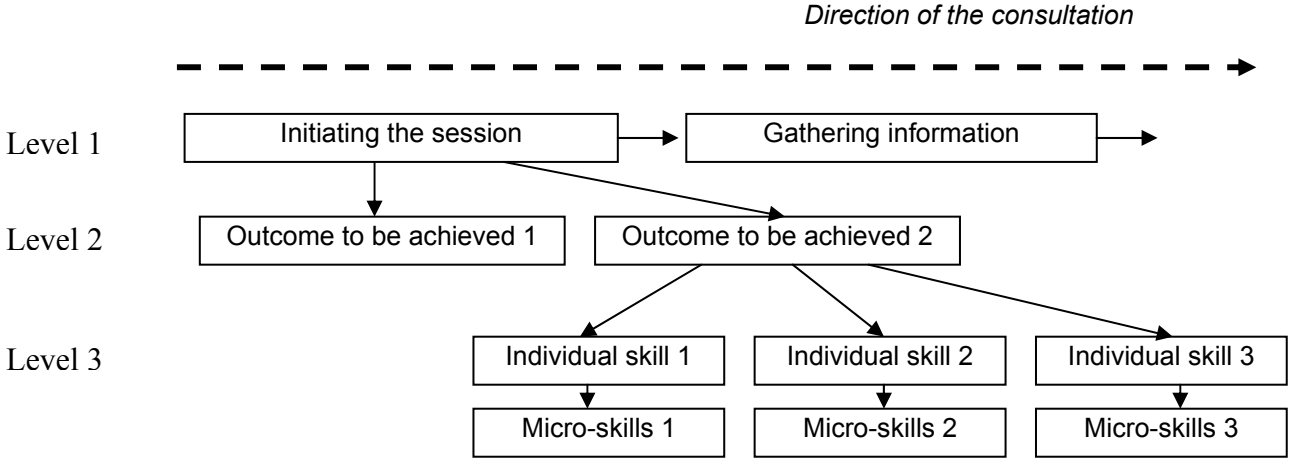
Similarly we need help using and identifying which communication skill(s) can be used at certain points in the consultation as well as what they can or cannot achieve. It's not just a question of knowing what tools or skills are available - but when and how to use them. Not all tools or skills are needed all the time - but we need to know where they are and be able to call for them when we need.

It also helps if the toolbox has compartments (analogous to the structure of the consultation). The sections in the toolbox help the mechanic to organise his tools so he knows where they are as well as reminding him which tools work well together. Using a consultation model or structure helps doctors relate certain skills to each other and to the right and appropriate part of the consultation.

The Cambridge-Calgary consultation model

Whilst there are many consultation models on offer this manual is based on the Cambridge-Calgary consultation model or observation guide described in the book Skills for Communicating with Patients. The model was developed by its authors to organise communication skills within a structure or consultation model that is comprised of several objectives or outcomes and supported by many different skills that help achieve them. Neither the objectives or skills are arbitrary – they are based on forty years or more of evidence-based research and on the basic established principles that govern all forms or effective communication.

The overall model appears as a three-layered construction - or framework that cascades from above downwards through the main sections of the consultation - to their relevant objectives and finally to each objectives individual skills.



Each section of the consultation is divided into objectives or outcomes that you are attempting to accomplish before moving on. (See next page - Level 2)

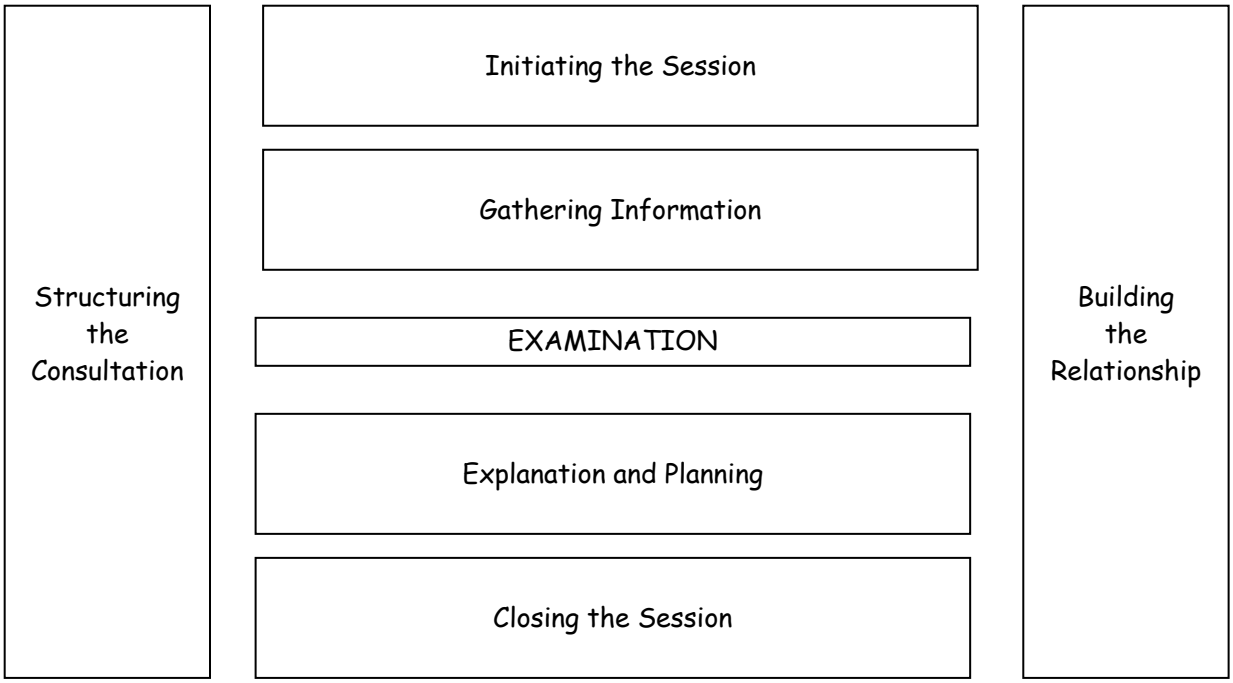
Underneath each objective or outcome - are a list of skills that help you achieve them – and below these - the 'micro-skills' that are the way each skill is delivered or phrased. (See below – and the relevant chapter that deals with each section for these)

The overall Cambridge-Calgary model consists of four main sections that run in a temporal sequence throughout the consultation with the examination of the patient situated in between the second and third sections.

Running parallel to these sections are two sections that relate to the tasks of 'Building the Relationship' and 'Structuring the consultation', which contain skills that are used continuously throughout the consultation - rather like mortar runs between bricks - cementing them together.

THE CAMBRIDGE CALGARY OBSERVATION GUIDE

After Silvermann, Kurtz and Draper Level 1



Micro-skills: It's not what you say - it's the way that you say it!

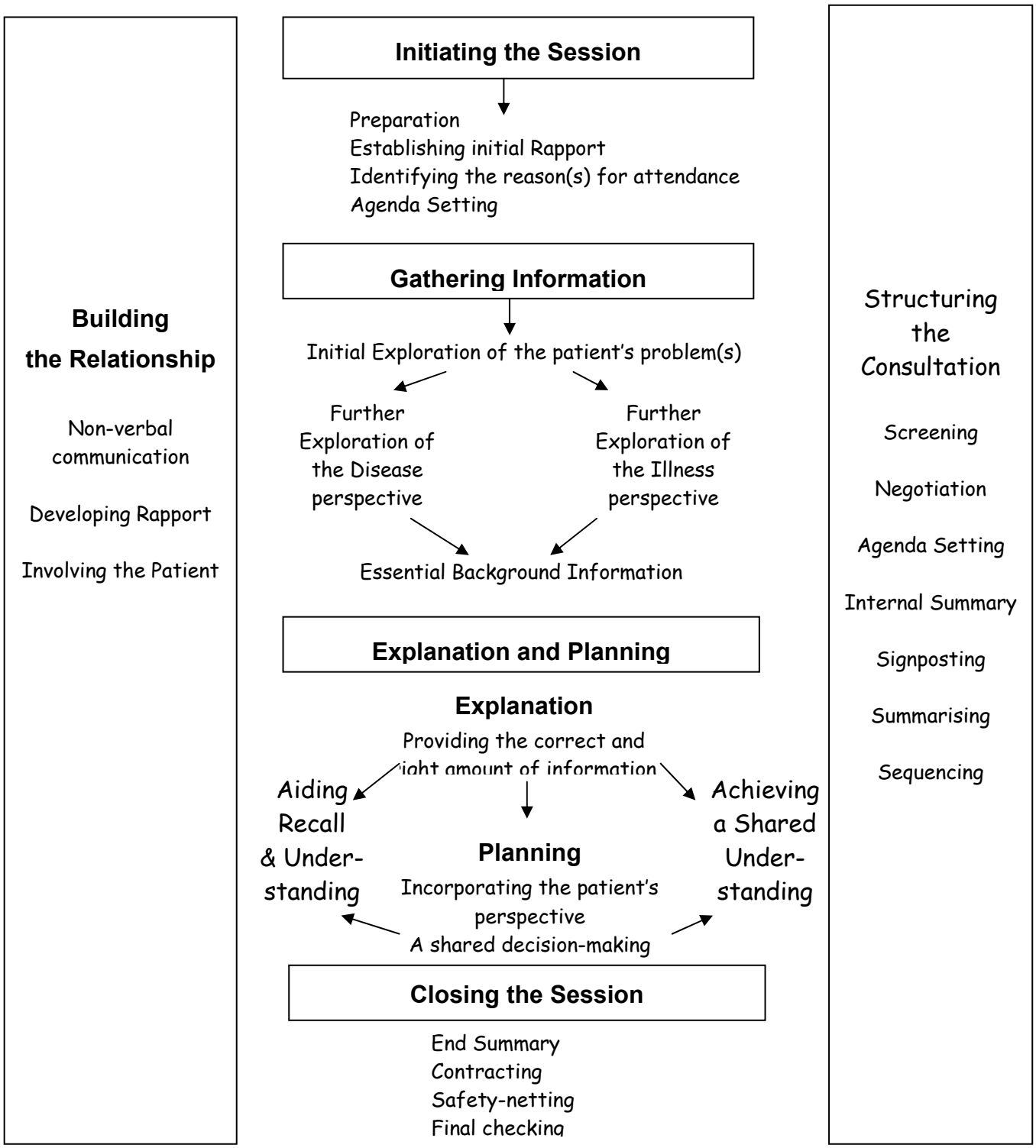
The effectiveness of each skill depends heavily on how exactly it is used and said. It is one thing to learn the individual skills of empathy but another to phrase them so that they seem natural and sensitive to the context of the consultation and patient concerned.

These are the so-called 'micro-skills'. Once specific skills are learnt, learners need to rehearse and practice them. So long as it achieves its desired effect, deciding the exact phraseology to deliver a skill is a matter of personal choice and should reflect the individual style and personality of the doctor using them.

It will soon become obvious, however, that certain words hold potentially emotive or threatening meanings to some patients. Later we will see that avoiding certain words maybe important.

For instance saying, *"what are you worried about"* in an attempt to gain insight into the personal perspective of an anxious or nervous patient may well receive a somewhat defensive and restrictive response of *"nothing, doctor..!…".* The word 'worried' maybe perceived by the patient as being judgemental by the doctor leading to feelings of vulnerability. Testing out alternatives using role-play and rephrasing this perhaps more sensitively and tentatively will often make a significant difference to patient's response.

Doctor: "Many patients might have underlying concerns in a situation like this – I wondered if this might be true for you...?"


Building the Relationship
Non-verbal communication
Developing Rapport
Involving the Patient
Initiating the Session
Preparation
Establishing initial Rapport
Identifying the reason(s) for attendance
Agenda Setting
Gathering Information
Initial Exploration of the patient's problem(s)
Further Exploration of the Disease perspective
Further Exploration of the Illness perspective
Essential Background Information
Explanation and Planning
Explanation
Providing the correct and
Aiding Recall & Under-standing
Achieving a Shared Under-standing
Planning
Incorporating the patient's perspective
A shared decision-making
Closing the Session
End Summary
Contracting
Safety-netting
Final checking
Structuring the Consultation
Screening
Negotiation
Agenda Setting
Internal Summary
Signposting
Summarising
Sequencing

The basic underlying principles associated with effective communication

Effective communication, in any setting, is based on six fundamental principles. They are linked to universal objectives of achieving effective communication in any situation – medical or otherwise – as well as to the specific skills needed to accomplish them.

1. Establishing 'mutual common ground' between people

The effectiveness of any communication ultimately depends on finding enough commonality between the parties concerned. Medical training tends to redefine the way doctors explain and understand health and illness – whereas most patient's beliefs remain culturally determined - based on a mixture of age, gender, social, and spiritual factors. There is therefore always a risk of conflict and disagreement between doctors and patients when it comes to areas that involve explanation and treatment. Unfortunately doctors rarely attempt to find out what patients think let alone try and negotiate agreement before making decisions within consultations.[2]

The first step is to identify the patient's ideas concerns and expectations – which make up their beliefs and perspective about what should be done.

Next there is a need to respond to these in an unconditional and non-judgemental way. Doctors need to accept their patient's views as legitimate – at least initially.

Finally, the differences between your own and the patient's understanding and explanations need to be compared openly - in a spirit of mutual respect - to find sufficient commonality to work together and solve the presenting problems.

The doctor's own explanations and recommendations will only be accepted if they are achievable and make sense in the patient's own life-world.

2. Communication should be an interactive process

For any communication to be effective it must be possible for it to be first remembered and understood and finally interpreted as intended. Whether messages are sent verbally or non-verbally, this may not always happen, unless communication is viewed as an interactive process with the sender checking with the receiver that each of these intentions has been accomplished.

There are lots of reasons why messages may get distorted or misinterpreted in the consultation. The patient may not hear you correctly either because they are anxious or deaf - or the computer printer makes too much noise. Even if patients hear you correctly, they may not be able to understand it because it is shrouded in medical terms or jargon that patients don't fully understand. Mixed messages may come across if verbal and non-verbal communications seem to conflict or even contradict each other. Non-verbals tend to win over verbal messages – particularly when you say, *"is there anything else?"* but at the same time look away and tidy up your notes. Patients don't always ask doctors to repeat or explain what they think they've heard – it is up to you to actively check this out.

Even when messages are heard and understood correctly, patients may receive it inappropriately because the meaning to them is ambiguous. Asking them *"are you stressed at the moment"* may be heard and understood as you intended, but the impact of this is for them to become defensive because they feel they may be judged as 'overanxious' and wasting the doctor's time.

Communication is consequently only complete if you the doctor receive feedback from the patient that it has been heard, understood and accepted as intended. If a response is not given spontaneously the doctor must make an active attempt to ensure that this has happened.

Doctor: "...perhaps you could repeat back to me what you have heard... and tell me whether you are happy and understand it?"

3. Reducing unnecessary uncertainty that 'blocks' communication

A common problem preventing effective communication is where poor concentration often due to levels of patient anxiety preventing things from being 'heard'. Patients may be anxious about what they fear they might hear, or what the doctor might think of them and end up suggesting.

A carefully planned story about their illness is one-way patients prepare themselves to overcome nervousness. If the doctor interrupts the patient early in the consultation, the flow of often well-rehearsed and relatively ordered information is halted. The result is that whatever was going to said next - is forgotten.

Even the apprehension of seeing a doctor they hadn't expected, as when the GP Registrar suddenly turns up on the doorstep instead of the trainer, may be enough to cause uncertainty and block further effective communication. Remembering to introduce yourself and explain your role and relationship to the practice at the beginning of the consultation - is an effective way of alleviating this.

Another common area where uncertainty occurs is where the patient does not understand the significance of a certain 'line of questioning' or the need for a type of examination. Asking a patient if they have noticed headaches when they present with 'flashing lights' may cause them to believe you think they have a brain tumour rather than migraine. Their anxiety is raised as the consultation proceeds but without an explanation of what you are thinking - their concentration begins to waver. Examining the groin of a patient presenting with an injured foot without explanation may have dire consequences especially if the doctor and patient are of a different sex!

Perhaps some of the most difficult areas doctors and patients have to grapple with is diagnostic uncertainty and the insecurity of medical outcomes. Whilst some uncertainty is inevitable there are ways that effective communication can be used to reduce this and develop trust and openness with the patient particularly where knowledge is lacking or where a completely safe course of action is unknown.

4. Thinking in terms outcomes

There are always a number of possible approaches when faced with a particular problem in the consultation. The type of skills you use will be determined by the outcome you want to achieve.

You may want to approach repeated unnecessary attendance by a patient, simply by being firm or angry, when your aim is to simply prevent them from doing this in the future. Alternatively, if your aim is to discover the underlying reasons for why they repeatedly behave in this way – using different types of skills to enable a more inquisitive and empathetic approach are likely to be used instead.

5. Demonstrating flexibility or dynamism

Different situations require different skills - and doctors need to be able to react appropriately and respond flexibly. The trembling patient who bursts into tears presenting the break-up of a relationship needs a totally different approach to one with the same problem who appears withdrawn, vague and 'distant'.

6. Communication follows a 'helical' course over time - not a direct line

Communication follows a 'helical' rather than a linear course during its transmission. What one person says influences what the other says next in return – and so on. In the same way mutual understanding changes between participants - and their meanings continually become refined as issues are repeated and reiterated during the course of a conversation.

[1] Kurtz, Silvermann & Draper (1988) Teaching & learning communication skills in medicine (3) p37

[2] Tuckett et al (1985) Meetings between experts: an approach to sharing ideas in medical consultations. Tavistock, London.

Initiating the Session

3

Introduction

The start the consultation is literally the 'shop front' of the interview and arguably the most critical and influential part of the medical interview. The success (or otherwise) of this part of the consultation often has decisive effects over the outcome of the consultation as a whole. Many of the problems found later in the consultation arise solely as a result of doctors getting off to a bad start.

Traditionally doctors have not been taught to identify the initial few minutes of the consultation as being a distinct part of the consultation and separate it from the main history taking part. Failure to appreciate this is rather like running to a place where you think a ball will land without keeping your eye on it. You're almost certain to drop or miss it altogether – and then waste time stopping and going back to collect it!

The core objectives of Initiating the Session

Initiating the session has unique and separate objectives that must be completed before moving on to the main history taking or information gathering section. It is broken up into four areas.

- Preparation
- Establishing an initial rapport
- Identifying the reasons(s) for the consultation
- Negotiating and Agenda setting

The first relates to the important period of a minute or two that occurs in-between patients or before we start a surgery. This means looking up previous information about the patient you are about to see - and attending to or acknowledging factors that might adversely influence your 'neutrality' in the forthcoming consultation.

Preparation

Putting aside feelings and emotions

Attending to self-comfort

Reading relevant information and material beforehand

Establishing an initial rapport

Greetings and introductions

Attending to patient comfort

Showing respect and interest in the patient by appropriate non-verbal & verbal behaviour

Identifying the reason(s) for attendance

Doctors Opening Question

Active Listening (during the Patient's Opening Statement)

Summarising and Screening for other symptoms and problems

Agenda Setting

Negotiation and prioritising

Agenda Setting for the rest of the consultation

The skills

Preparation – ensuring you are informed and in 'neutral'

Even before you start it is important to be aware of factors that might adversely affect your ability to perform effectively and impartially within the consultation. There is ample evidence that clinical errors arise because doctors fail to attend to this pre-consultation period, resulting in them starting in a hurried and distracted state of mind.[1]

Your clinical reasoning or perceptual skills are frequently affected by events or assumptions you carry into the consultation itself. Being distracted by issues relating to your personal as well as professional life will prevent you from focusing on the patient fairly. Assumptions as to why they are coming and what agenda will some up – as well as letting personal attitudes towards the patient govern our approach in the consultation - are common problems we must try and overcome.

Doctor: "He always comes worrying about nothing..."

Doctor: "I can't stand her continual fixation about allergies causing all of Jack's problems".

We also need to prepare ourselves adequately by returning to the notes and scanning for results or letters that have recently appeared. Like the pilot sitting in the cockpit of an aircraft about to take off a quick mental 'check-list' needs reviewing before take-off!

- Are there issues or problems that might interfere with the way I will conduct myself? – If so, attend to your own comfort and if necessary take a short break. Make sure you have completed tasks from the last consultation so they won't impinge on the next.
- Do I have feelings about the next patient that might get in the way of an objective approach? - If so, try and develop a 'Devils advocate' approach with yourself - that you just might be wrong this time – or at least try and give them benefit of doubt on this occasion.
- Have I checked their notes or records first? – Do you have a reasonable understanding about what was previously wrong with them - what regular treatments they were supposed to be taking - try and recall or read what might have been said to them previously? Are there tests or letters that you should be aware of?

Establishing an initial rapport

These first few seconds are about creating an atmosphere that encourages the patient to feel relaxed and welcome and that he is going to be listened to. It is also about removing any uncertainties or anxieties that he is going to be listened to and involves: -

- Greeting the patient by introducing yourself and clarifying your role
- Verifying the patient's identity and any possible connections or uncertainties
- Demonstrating you care and are intent on listening and giving your undivided attention

Confusion can arise here in many ways. Whilst you may remember the patient – the patient may not always remember who you are. You may feel uncomfortable because you yourself aren't able to remember where you've seen them before (you in fact visited six months ago

and admitted her husband who later died). Both scenarios will block communication and concentration.

Sometimes all types of useful information may come out that might colour how the consultation next proceeds.

Patient: "No doctor, we've not met before – but you are looking after my daughter who is seriously ill at the moment"...(different surname – mother registered with another doctor in the practice - and you have not met her before!).

It is important to greet the patient using appropriate non-verbal skills that involve smiling, eye contact and gestures to make them feel welcome such as offering a handshake and attending to their comfort such as by positioning their chair.

It is also necessary to position the doctor and patient within the room to achieve a balance between appearing over familiar and potentially threatening and generating unnecessary anxiety (people usually want easy eye contact but not so direct that they cannot readily 'escape'. [2]) such as positioning yourself behind a large desk to appear powerful and aloof. This tends to increase the gradient of power and control that governed the traditional doctor-patient relationship and which perpetuated barriers to communication in the past.

Identifying the reasons(s) for the consultation

Doctors frequently say they find it difficult to discover why the patient came to see them. Research shows that they may get this wrong in up to 75% of consultations as well as discovering less than half of all the issues including perhaps the most important one the patient hoped to discuss that consultation. The problem often lies with not using the right skills in this section.

The Doctors Opening Question

The section starts with the doctor's invitation to the patient to start telling them their problems using the doctors 'opening question'. It is important to realise how the phrase we use as the 'opening question' may affect the rest of the consultation. Not only can it subtly change the patient's response but it also can steer the whole consultation away from its intended course.

For instance, starting off by assuming the patient has come back to discuss their blood pressure treatment by using the opening statement*, "how did you get on with those tablets…?"* will skew the whole consultation to focus on this before finding they have something different and much more important that's cropped up.

Even when you're pretty sure - it is best to keep your options open…

Doctor: "So...is this a follow on to last time...or have you brought something new to talk about today?"

There isn't one single 'best' phrase to use as an opening question – but there is a need to be aware of how and what we say may influence things. Its rather like the initial setting of a boats rudder potentially having the greatest effect on the final direction it might go. The important principle is to try and use a phrase that starts the consultation as a totally blank sheet without assumptions or preconditions or restricting the patient's potential agenda. For example…

Doctor: "What have you come to see me about, today?"

Doctor: "How would you like me to help you?"

See chapter 2 of 'Skills for communicating with patients' to look at other examples of how the opening question may cause different reactions.

'Active' listening

This is perhaps the most important skill of all to learn. It involves a two-way transmission of verbal and non-verbal behaviour between doctor and patient with the aim of encouraging the patient to continue their opening statement as far as possible without interruption.

It entails the doctor listening and observing the patient's verbal and non-verbal behaviour whilst communicating back your own - showing that you are genuinely listening and interested in wanting them to continue.

Avoid fiddling with notes or computers. This is very 'off-putting' to patients and interferes with attempts to develop initial rapport at this stage. If these do have to be referred to - the following rules are suggested.

- Deliberately postpone using the records until the patient has completed his opening statement.
- Wait for an opportune moment before looking at the notes.
- Separate listening to their story from note reading - by telling them (sign-posting) of your intention to look at the records and when you have finished - so that the patient understands and is comfortable with the process

The key is to intentionally 'sit-back' and make yourself listen and observe. Try to determine their emotional state from their verbal and non-verbal behaviour as well as clues to their underlying agenda and concerns.

There are several other positive non-verbals that can be used to indicate we are listening supportively - often known under the mnemonic **S.O.L.E.R.**

Sitting **S**quare on to the patient with an **O**pen position, **L**eaning slightly forward with **E**ye contact in a **R**elaxed posture.

The most important is eye contact followed by facial expression and inflection of voice. Most patients appear to regard a concerned facial expression combined with a voice that indicates an 'anxious regard' for their symptoms to imply a more interested and caring attitude.

In other words patients prefer doctors who are able to communicate emotion using their faces and voices. [3] The reader is directed to pages 73 – 79 Chapter 4 of Skills for communicating with patients for further information about the use of non-verbal skills in the consultation.

Encouraging the patient to complete and expand their opening statement

Use non-verbal behaviour such as nodding - and verbal 'neutral' encouragers such as *…'go on'; 'uh-uh'…'Ok'…'yes'…*or *'I see'* - to help promote continuation of the patients opening statement.

Where necessary it means permitting and tolerating periods of silence - allowing patients to think and recall information at their own pace.

Unfortunately, doctors at the beginning of the consultation do not tolerate even brief periods of silence well and feel a sense of pressure to move things on and say something.

The reader is directed to pages 27 – 30 Chapter 2 of Skills for communicating with patients for further information about the facilitative response.

It is important to remember that any form of interruption or attempt to clarify or interpret what has been said at this stage often irrevocably risks breaking the flow of information. The whole course of the consultation will be altered by a premature 'foray' into exploring a small part of the patient's story rather than considering the total presentation a little later on.

Some patients are better than others when it comes to encouraging them to tell a story. Some dry up quickly whilst a few stray into potentially irrelevant areas of information. However, it is rare for the opening statement to carry on for much longer than two minutes – and even if it does - it usually carries a rich supply of important information, presented to you 'on a plate' rather than it needing to be discovered and taking up time later on if you're lucky!

Screening

To start off the important process of clinical reasoning, most doctors need to work on more than one symptom or piece of information alone. As well as encouraging the patient to go as far as possible to expand their opening statement they should be encouraged to generate a list of related co-symptoms or perceptions about the presenting problem by saying

Doctor: '…and is there anything else?'

This process is known as screening. It is a deliberate method of checking back with the patient for any other important co-symptoms or perceptions that they haven't already mentioned before you move on any further.

Doctor: "So you say you've been getting chest pains and breathless lately. Have you noticed anything else?"

This often prompts them to continue with the doctor listening further until the patient stops again. The screening process is repeated until the patient eventually says that they have finished.

Doctor: "So you've also been feeling very light-headed and irritable and were wondering if these symptoms might be anything to do with worrying about your son... ...anything else?"

At the end of this process when the patient says *"No, that's about it",* it's helpful to re-iterate what you've heard to ensure you have accurately understood and remembered their presenting list correctly.

Doctor: "So as I understand it, you've been getting chest pain and breathless but have also been feeling light headed, rather irritable and a bit low, and your concern was that the break-up of your son's marriage might have something to do with this. Have I got that right?"

If you haven't got it right the patient will correct or at least refine it, which has the benefit of improving accuracy and reinforcing recall of information by the doctor.

Most doctors find the deliberate process of screening difficult and consciously resist it at first. This is partly through fear of loosing control and inviting extra work and partly through anxiety to get on with the consultation because of pressure of time. However, a little more time spent at the beginning is likely to save you time later on.

Finally, where there is a discrepancy between patient expectations and time available to discuss them – these should be openly discussed.

Doctor: "That's quite a list for us to get through in ten minutes so... I'm not sure that we are going to have enough time to do it all justice; how about if we start with.....then we can see if we have enough time to look at your.... Otherwise we'll need another appointment?"

The doctor must also take responsibility for prioritising presenting symptoms. Breathlessness and chest pain should obviously take precedence over chilblains however distressing they are to the patient.

Additional skills that help manage other presentations

The emotional patient

Screening needs to done sensitively. What is appropriate for one situation is inappropriate for another. The patient who breaks down into tears because her husband has just left her needs your full-undivided attention. Continuing to listen takes priority over screening. It would be tactless to interrupt and say…

Doctor: "Ok, we'll come back to that in a minute... but first ... is there anything else that you would like to discuss today?!!"

The patient with a 'loaded gun'

Occasionally the patient presents a major demand or concern during their opening statement. They may insist on antibiotics or a referral or seek premature reassurance against a diagnosis they fear they may have.

Patient: "I have this terrible pain that's keeping me awake all night…You don't think I've got cancer, do you doctor…?"

It is important to 'disarm' the demand and not become drawn into an answer that immediately counters or reassures them. The best approach might be to respond to the emotion behind their demand and accept their concern as an important insight into their life-world and perspective of things.

Scene 1: Demand for antibiotics in a healthy looking two year old you don't know

Doctor: "I sense there is something that has made you very concerned about Jade's cough…?"

Mother: "Yes doctor, you see my husband is in hospital having just been diagnosed with leukaemia…and I'm petrified I'll pass on an infection if she doesn't have them…"

Scene 2: Concern over having cancer

Patient: "I've been getting a lot of belching and wind lately. You don't think I've got cancer do you, doctor?"

Doctor: "That sounds very worrying - I can imagine you would want me to answer that as soon as possible. Perhaps you can start by telling me a little more about this - and then perhaps we can explore this further by looking at your symptoms."

Patient: "well my mother died of bowel cancer when she was only forty – and like her mother before her – and I remember how she used to constantly burp and loose wind."

The patient with a shopping list

Most doctors' hearts sink when a patient produces a long pre-written-shopping list as they sit down. Alternatively this can be seen as an opportunity to screen the agenda and negotiate gently but firmly what is possible in the time you have today.

Most patients rehearse what they want to say and can often be seen running through it in the waiting room before entering the doctor's room. Some speeches can be long enough to make the doctor feel uncertain about where and when they might need to stop it.

However, most long opening statements are so full of the patient's own perceptions that they are too greater source for clues about their feelings, concerns and expectations and should be

tolerated. Surprisingly, they tend to save time later on and sharpen diagnostic reasoning at the beginning where it is most effective. Occasionally the over-anxious patient who cannot seem to stop wandering away from the point will need specific skills to temporarily break, redirect and re-focus the flow of information. This is discussed in the next chapter.

The 'Accepting response'

The Accepting response is important skill that allows doctors to acknowledge and respond to patients concerns and demands without finding themselves pushed into either a premature situation of confrontation or acquiescence.

It responds to the emotions or feelings behind statements or demands, rather than the content of the question.

The key is to initially accept the patient's viewpoint and feelings without passing judgement however alien it is to your own view and understanding. Otherwise you risk provoking a defensive reaction by the patient to block further communication and rapport. It is much easier to correct misapprehensions later on in the consultation and offer your own perspective once you have all the facts and their trust at your disposal.

Patients are more likely to be amenable and accept your viewpoint if you accept theirs first as a valued and legitimate alternative. The Accepting response does not mean you will end up agreeing with them - not does understanding their concerns and expectations - ultimately mean you will have to act on them.

The Accepting response has three parts

1: Acknowledging the patient's thoughts or feelings by restating, paraphrasing or summarising what's the patient has said

Doctor: "So, you're worried that the wind might be caused by cancer"

2: Make a 'valuing statement' about their right to hold this view

Doctor: "I can understand why you might be concerned about that....."

3: then…most important of all…a pause or silence

Doctor: "Yes, doctor, you see my mother died of bowel cancer when she was 40 and I remember she had a lot of wind"

It is very important to avoid the "Yes – but" response - which negates any acceptance and resist the temptation to 'jump' in and give premature reassurance in haste to please and help. It is ultimately more productive to encourage them to carry on and reveal more of their perceptions by asking

Doctor: "can you tell me more about this?"

The reader is directed to pages 79 – 82 Chapter 4 of Skills for communicating with patients for further examples about the use of the Accepting Response in the consultation.

1 Ely et all (1995) Perceived causes of family physician's errors Journal of Family Practice. 40 (4): 337-344
2 Somner (1971) Social parameters in naturalistic health research. In behaviour and environment – the use of space by animals and men (ed A Esser). Plenum press, new York.
3 DiMatteo et al. (1980) predicting patient satisfaction from physician's non-verbal communication skill. Med care 18: 376-87
3 DiMatteo et al. (1986) Relationship of physician's non-verbal communication to patient satisfaction, appointment non-compliance and physician workload. Health Psychology. 5: 581-94
4 Mehrabian and Ksionsky (1974) A theory of affiliation. Lexington Books, DC Health & co; Lexington, MA.

Suggested exercises: Initiating the consultation

Review the core communicating skills for this section

- Non-verbal skills that develop rapport
- Active Listening
- Facilitation
- Screening
- The Accepting Response

GP Registrar objectives

- Understanding the importance of adequate preparation
- Knowledge of the factors and assumptions that precede and influence a consultation. e.g. new and follow-up consultations, previous experience of the patient and their problems, 'heart-sinks' etc.
- Knowledge of the skills that promote (and discourage) rapport building – the importance of greetings & introductions, attending to patient comfort, appropriate verbal and non-verbal behaviour.
- Encouraging and facilitating the flow of information at the beginning of the consultation - and an understanding of the consequences of early interruptions on the outcome of the consultation as a whole.
- The components and skills of Active Listening.
- The importance of screening and setting an agenda for the consultation by negotiation.
- Understanding the factors that affect the balance between listening and screening at the beginning of the consultation.

Areas for discussion

- Setting up regular video sessions and looking at the relevant technical aspects
- Preparation
- Consider how much time should be spent on preparation for the next consultation and what minimum of information is necessary before consulting?
- Discuss when doctors should look at notes/computer records during the consultation?
- Think about how patients you don't like (or have found difficult before so-called 'Heart-sink' patients) can potentially affect the consultation.
- Consider which sort of patients are difficult – and why?
- Managing time when you are running very late.

Building rapport

- Discuss possible issues that an accompanying partner or person might raise when attending with a patient.
- Discuss how issues relating to age, gender, and cultural might affect the way a consultation might be approached?
- How do you manage interruptions in the consultation?

Discovering the reasons for the patient attending

- What phrase or opening question do you usually start the consultation, and how might this influence the consultation?
- How might age, gender, and cultural issues affect the opening question?
- When is silence uncomfortable – and why?
- What males us decide when to continue listening – and when to start screening for other problems.

Watching videos

Stopping the video after the first three minutes

- Label the skills you used to build rapport with the patient
- Are you able to identify the emotional state of the patient (even if neutral) and what clues did you use to assess this?
- Time how long it is before you ask the patient your first direct question – and what information were you trying to obtain?
- Summarise the information you have learnt from the first three minutes back to your trainer

Looking at the whole consultation

- Did you actively screen for other problems or did they spontaneously emerge during the consultation?
- How many problems did the patient present with and when did each one 'surface' during the consultation?

Role-play

- Role-play as badly as possible the beginning of the consultation - list and compare the negative skills you used with positive rapport building ones.
- Ask your trainer to start telling you about what they did during his/her last holiday.
- Use the skills of 'Active listening' and facilitation using neutral encouragement and summarising only. Stop when you need to start using either an open or closed question to gain more information.

Notes for the Trainer when watching videos

- Do they adequately prepare themselves for the consultation?
- Do they use appropriate skills to build a rapport with the patient?
- How long is it before they interrupt the flow of information?
- Are they aware of the patient's presenting emotional state?
- Do they encourage the patient to continue?
- Do they screen for other problems before moving on down the first line of enquiry?
- Have they discovered the reason(s) for the patient consulting them? (This may require seeing the whole of the consultation to pick up late arising agendas)

Gathering Information 4

Introduction

The traditional method of history taking was established in the nineteenth century and no longer fulfils the requirements of present day consultations. There is a need to conduct patient centred medicine that places emphasis on equal partnership between doctors and patients with consideration for the patients' perspective or context that includes their thoughts, feelings, ideas, concerns, and expectations.

Gathering information is based on the work of Professor Ian McWhinney at Ontario University who developed the disease-illness model as a new way of approaching the consultation based on current communication theory as well as changing patterns and demands of modern society.

It is also built on an understanding for the process of what is called 'diagnostic reasoning'. This is the often unconscious process doctors use to intellectually solve problems based on their knowledge and experience.

These two underlying principles in turn require that this part of the consultation is structured within an overall framework that relates both to the content that the doctor is trying to discover and the process or way that this information is collected. The skills that help to achieve these ends are based on the underlying aims of medical communication - accuracy, efficiency and supportiveness.

The core objectives of Gathering Information

The four main aims of this part are to: -

1. Take an accurate and complete 'bio-physical' or medical history in an attempt to recognise patterns associated with important disease
2. Exploration and understanding of the patient's perspective so as to understand the meaning of the symptoms and the illness for the patient
3. Structure the consultation to improve the process of diagnostic reasoning and ensure effective and efficient use of time
4. Involve the patient in an interactive process that promotes their participation and understanding - as well as developing rapport and responding supportively to their involvement.

A conceptual framework for Gathering Information

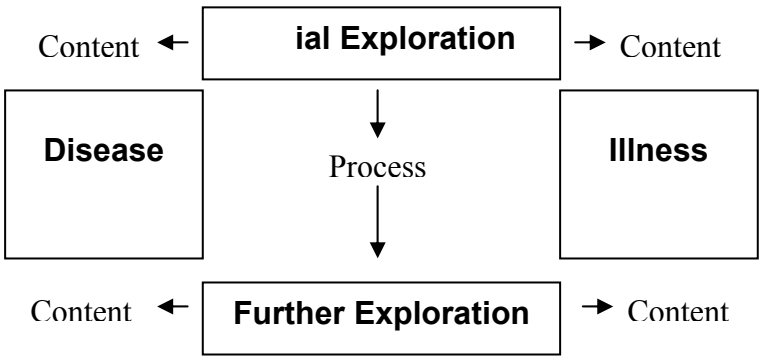
Even from the start, as the patient begins to tell their story, it will become clear that it's content is heavily laden with information about both disease and illness. Traditionally you have been trained as a doctor to selectively concentrate and listen for symptoms that indicate potential underlying disease. Doctors often disregard or relegate competing symptoms that describe the experience or meaning of symptoms to the patient as being a set of unhelpful emotional distractions - or miss them altogether.

Perhaps the most important challenge is to conceptually change the structure of your thinking - and mentally 'tune' yourself to listen for content contained within the two parallel aspects of disease and illness at the same time.

The framework also relates to the way you process or gather this content - and is based on the dual objectives of facilitating the patient's story and improving the doctor's process of diagnostic reasoning.

It is helpful to think of the gathering information part of the consultation being divided into two parts. An initial exploratory stage dominated by listening and responding to the patients story -

and a further exploratory stage that entails a more directive and interrogative approach that searches for further important or missing information and a seeks a deeper understanding of the patient's problems.



How clinical reasoning takes place

The single commonest reason for consultations going badly is the failure of doctors to discover the reason(s) for why patients see them.

As doctors become more experienced they increasingly use a 'stab in the dark' approach of reasoning based on 'pattern recognition' to make a diagnosis. They rely on their experience to help them guess what is going to happen next. As soon as think they have heard enough evidence - they interrupt to test out their hunch. The trouble is that they do this too soon and as a result get the diagnosis wrong first time more than they get it right. Frustratingly for the sake of a few seconds more, they would often hear additional information that would completely re-direct their clinical reasoning or problem solving processes.

This has two important effects on the consultation and patient.

1. It ends up making the consultation less efficient and longer because the doctor is forced to stop and re-start the consultation again – and any objective of 'jumping in' early to shorten the consultation is often reversed.
2. Secondly, and perhaps more seriously – the patient becomes passive and relatively 'mute' from that point onwards. They now defer to the doctor even if they sense that the line of questioning is irrelevant often assuming the doctor knows something that they don't. If they do bring up the information they had hoped - they tend to do this at the end when the doctor has had their say and time has been used up.

Only too frequently, the urge to interrupt and question the patient about their symptoms early on – becomes just too tempting - leading to premature and inaccurate assumptions and a 'dead-end' in terms of an understanding for what is going on.

The correct method of clinical reasoning

The key is to listen to the patient and continue thinking whilst collecting important information - instead of trying to make an early diagnosis by jumping ahead and making assumptions. This will automatically happen if doctors train themselves to use open-ended questions first - instead of instinctively resorting to a string of closed questions they learnt during their training that interrogate the patient's presenting symptoms or organ systems.

Open questions are not only more effective in gathering more information than closed questions - they force your thinking to focus on problem solving instead of thinking of what to ask next. The method of questioning that encourages this process clinical reasoning is often termed the 'open-to-closed' cone of questioning.

A more comprehensive transcript about the process of clinical reasoning and the way doctors think during whilst making a diagnosis - is discussed in chapter eight, Clinical Method: A Textbook of Family Medicine by Ian McWhinney. (Oxford University Press).

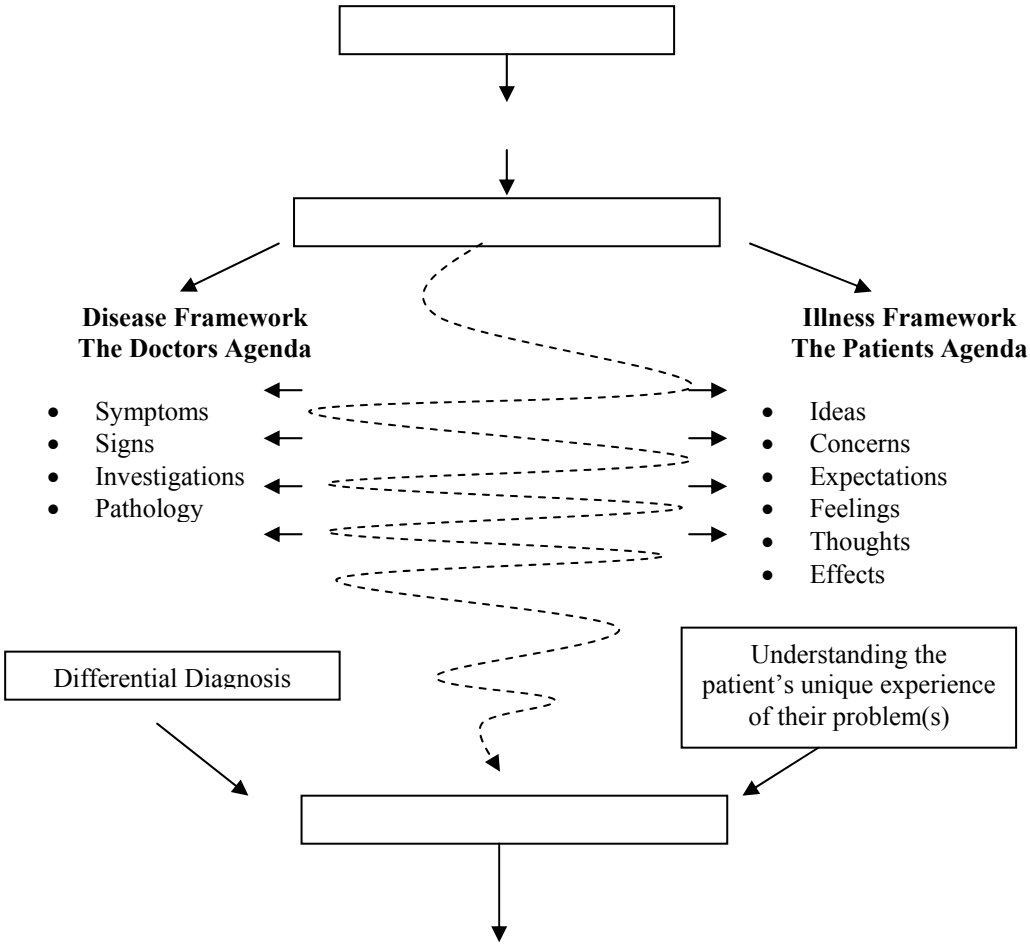
The Disease - Illness model

Integrating the clinical or biophysical content with an understanding for what symptoms mean to the patient within their own 'life-world' remains the ultimate goal for this part of the consultation. It helps to explain why, and when patients present - as well as how they subsequently behave.

This is known as the Disease-Illness model and is based on the work of Professor Ian McWhinney and colleagues at the Ontario University, Canada in 1990. Readers are strongly recommended to read a fuller account of the Disease-Illness model on pages 35 – 42: Chapter three of 'Skills for communicating with patients'.

In practice there is a gentle meandering between the disease and illness content throughout the information gathering section of the consultation. You are not only listening and probing openly for biophysical symptoms that might reveal evidence for underlying disease – but consciously using your awareness and senses to 'listen out' and discover clues for the patient's illness perspective that tends to 'leak out' at any time.

The skills that help uncover both these perspectives as well as the process by which both are integrated are discussed below.



For a variety of reasons, it is fundamental to discover the patient's perspective if we want to practise as effective clinicians

- We can't always make a diagnosis of disease (in fact we do so in rather less than 50% of patients problems)
- There is plenty of evidence that we never reach a diagnosis even after many consultations. Numerous presentations are eventually labelled in retrospect as 'functional' or 'non-organic'. Research shows this applies to common problems of chest pain, tiredness, abdominal pain, headache and many others.[1]
- Exploring the illness perspective early on will help to uncover a significant number of presentations where their roots lie more in the emotional or personal domain.
- Even if there is co-existent disease an understanding of why the patient has presented at this stage often after a long period of time will not be easily understood without exploring the factors that initiated it.
- Alternatively, a patient who repeatedly appears to 'make light' of their symptoms may in fact be concealing an underlying fear of a diagnosis that might affect their livelihood or ability to function within their family unit.
- Diabetes may stop them driving - and a diagnosis of cancer may be denied to protect a worried and dependant partner.

We are likely to use time and resources more efficiently

It may be easy to make a straightforward diagnosis of asthma in a child, but without an understanding of what this means to the mother (who may have totally different ideas about causation and management) constructing an effective management plan is likely to fail.

This not only wastes our own time - but taxpayer's money on expensive prescriptions too. Even when doctors are confident that the symptoms are functional repeated visits with the same problems usually result in us feeling forced into investigation or referral, unless the person's world is explored and symptoms related to it. Doctors who conduct patient centred consultations and spend time exploring patients concerns have fewer follow-up appointments, perform fewer investigations and refer patients less often.[2]

A large study that looked at the outcome of chronic headache and which factors were most closely related to resolution found that the most significant aspect that lead to it's resolution was the time given to explore the patient's concerns about their symptoms at the initial interview.

Resolution of the headaches did not seem to be related to the severity or type of the presenting symptoms, nor to the way it was managed including the type and complexity of any investigations, referral or treatment offered.

Uncovering the patient's perspective improves our chances of making a correct diagnosis

Asking for the patient's own ideas about causation may bring up all sorts of unlikely but helpful information which might otherwise have not been discovered. A recurrent vaginal discharge in a happily married woman may sound innocuous and common enough.

However when a patient's mentions that her mother had a similar discharge followed by a diagnosis of Crohn's disease and a bowel resection - suddenly puts previous vague bouts of diarrhoea and a prior assumption of 'irritable bowel' into a different diagnostic category.

It helps us plan the next stage of managing the problem

Frequently the acceptance of treatment by the patient depends on their personal beliefs. We are more likely to succeed by using appropriate negotiating skills to get across our preference for prescribing an antidepressant first if we are aware that this is likely to meet initial resistance beforehand. Discovering the patient's own beliefs that they think it is due to a hormonal imbalance will give us prior warning before blundering in first with our own agenda.

Discovering the patients own expectations about what they had hoped would result from the consultation can save a lot of time. Discovering a sick note is all they require instead of a presumed demand for tablets, physiotherapy or referral will make the management much clearer and efficient.

Equally discovering patient's expectations may sometimes help and even protect us during situations where uncertainty is normal. To discover that the person had hoped to be *"sent straight into hospital…"* with their mild abdominal pain - will not only give a clue as to their underlying level of concern and tolerance (as well as probably prompt us one extra last search for potentially serious features) it will allow us to incorporate this option objectively during our discussion of management and during the course of 'safety-netting' at the end.

Apart from engendering confidence in the patient and indicating that you are taking them seriously - if unexpected things do arise - it might help prevent criticism – even when an unexpected disastrous outcome could not have been reasonably.

Further exploration of symptoms relating to possible illness

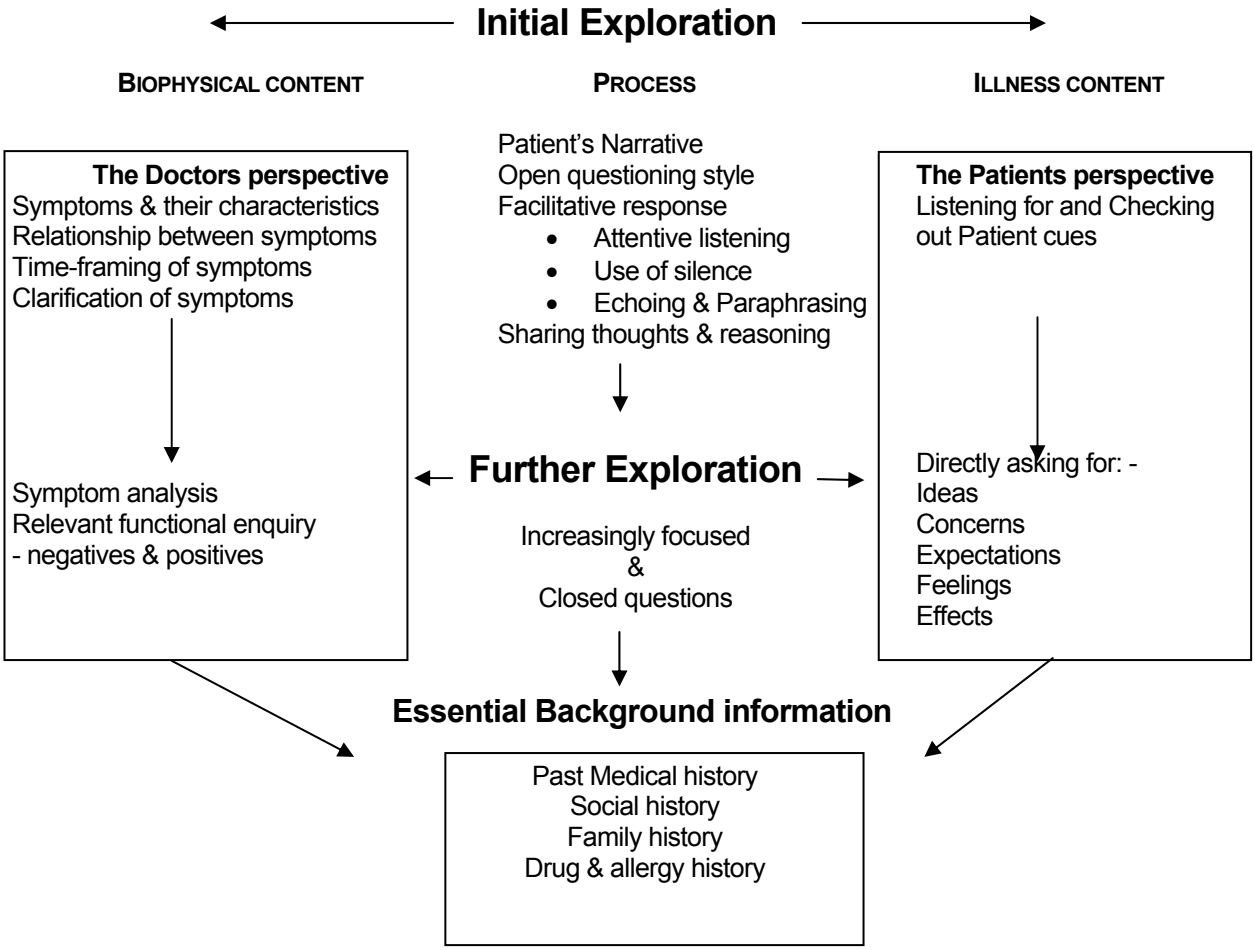
Most patients do not volunteer their concerns openly or at least not at first! Despite our best efforts as doctors to be patient-friendly and approachable there is still a natural power gradient that prevents equal discourse of ideas. There are many reasons for this that range between patients feeling unsure or being afraid of doctor's reactions to fear of the truth. This is more fully discussed on pages 109 –110 Chapter five of Skills for communicating with patients.

The Skills

Before the skills are individually discussed it is helpful to expand the framework of this part of the consultation into the different areas of content and process.

There are skills that discover the **disease** or **biophysical content** and those that help determine the **illness** or **patient perspective**.

The process skills help make the transition between the **initial** and **further** exploration of the patient's problems.



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During the initial exploration of the patient's problem the aim should be to cover four aspects of the biophysical content: -

1. The range of symptoms and their characteristics
2. The relationship between symptoms
3. Clarification of symptoms used by the patient
4. The timing of these (Time-framing) – their onset, duration, development over time, and where present – their pattern or variation.

It is often how we phrase our initial exploratory questions, to search for medical content, to cause most of the problems with clinical reasoning. Instead of moving straight into a traditional mode of inquiry - we need to rephrase the questions we use to facilitate the patient's story without interruption - and change our instinctive style for using closed questions - to an open-ended questioning approach instead.

The Narrative thread

This has the dual effect of discovering both content and starting the process of gathering information. It is a little like encouraging the patient to start telling their story from the beginning and often acts as a catalyst to encourage the patient to recount a more coherent and logical form of their story. This is something they may have rehearsed in some detail beforehand – yet it is liable to 'fall apart' as a result of anxiety during a confrontation with a doctor in the consultation.

Asking them to start at the beginning helps them to develop a better story or narrative that is less disjointed, fragmented or full of things that previously mystified them.

Doctor: "Perhaps you start at the beginning and tell me how this all began...?"

Interestingly, it allows the doctor a certain amount of interference without damaging the flow of information from the patient.

Doctor: "So the headaches came on first, then you started to feel faint...I see... go on..."...?"

However, the doctor must be careful to direct them exactly back to the point where they interrupted them so that the patient is able to continue telling their story without disturbing its flow or their concentration and end up deflecting the story 'off-course' onto something else.

This is reminiscent of the way a child asks for clarification during the process of reading a story at bedtime!

Doctor: "Go back to the headache again...."

Patient: "Oh Yes... that's right...the headaches...then my hands started shaking and the room went dim...?"

The narrative thread also has another important function. The doctor can use an adaptation of the 'Narrative thread' perhaps called 'Returning to the Narrative' as a powerful skill or technique to help regain structure and control of the consultation's direction and content. This is especially helpful when the patient wanders 'off course' and steers away from important lines of exploration or enquiry. This is discussed further below.

Using Open-ended questions first – within the open-to closed cone of questioning

The more open the type of question used at the start, the more it encourages patients to elaborate and widen their story.

Using open-ended questions at the beginning are also the best way of discovering the patient's perspective and interpretation of their story as well as being the most efficient and effective way of gathering information in general. (See below)

Open questions often start with the What, Why, How and When… format, but can also start by using directive statements that encourage the patient to 'tell their story'.

Doctor: "So tell me more about the dizziness...?"

Clarification

It is also important to encourage patients to clarify and describe their symptoms and perceptions accurately. What is meant by 'dizziness' or 'tummy upset'?

What do they mean when they say they are ‘a bit low’? How does a patient characterise their pain – what sort of quality do they ascribe to it? We need to be sure that what they are describing is close to what we think.

Time-framing

This is one of the most important characteristics often left out in haste that leads to poor diagnostic evaluation of symptoms. The timing and mode of onset for a severe headache can be crucial - as is the pattern and timing of abdominal pain in many circumstances. Failure to appreciate the development of pain over time may also leads to diagnostic and management errors.

Phrasing opening questions during the initial exploration of the patient’s problem

It is the way we instinctively start asking questions at the beginning that causes so much trouble. Frequently doctors start using closed types of questions they were trained with at the beginning - to start interrogating symptoms.

After perhaps using the ‘Narrative thread’ and one or two broad ‘open-ended’ questions to screen for the range of symptoms - it often falls to the doctor to direct the patient to each of the symptoms possible characteristics whilst continuing to use an open ended style.

The exact phrases below are only suggestions using a mnemonic to help remind you of one possible way of expressing these.

You need to develop an individual repertoire of phrases rather than use the same one each time that is comfortable and becomes part of our own personality and style.

Using Open style questions Mnem	Using traditional closed approach (Macleod 1964)
When did it first START?	Duration
HOW did it come ON?	Onset
WHAT were you doing at the time?	
Can you describe how it has VARIED over time? How has it developed over time?	Frequency & Course
How INTENSE has this become?	Severity
Have you noticed any PATTERN to it?	Periodicity
Can you DESCRIBE it in more DETAIL? (What does it feel like?)	Site, Radiation, Character
What ALTERS it?	Aggravating factors, Alleviating factors
Have you TRIED/TALKED to anyone else about it?	What have they tried or been influenced by
Have you noticed anything ELSE?	Associated Phenomena
How SERIOUS do you think this is?	Perhaps a good ‘lead into’ their personal perspective & concerns

Further exploration of the biophysical content or perspective

Using closed questions to fill in the 'gaps' and determine important physiological function

The objectives here include asking for remaining important and missing information that is vital to 'rule in' or 'rule-out' clinical disease.

Relevant areas of the functional enquiry need visiting as well as any characteristics for symptoms not already mentioned.

This is where closed questions are more helpful and designed to allow only a limited response when it is your intension is to seek specific important data.

It should therefore be realised that both open and closed questioning styles are essential – it is the order that is important.

Open questions should be used first since they are the best way of screening for information in general and picking up the early clues as to the patient's perspective discussed below.

Closed questions act as a precise and selective tool that serves the doctor's agenda. They can be used to 'fill in' the holes quickly and efficiently by directing the patient that this is about to happen – and why.

Doctor: "I'd just like to ask a few quick questions about this pain to make it clear to me whether you have an ulcer or gall-stones causing your symptoms ...then I'll ask you a few more questions on how the rest of your digestive system might be working...if that's Ok with you?"

This type of statement not only clearly 'signposts' your intent for the consultation to enter into a new and more interrogative style (and why) – it also shares your diagnostic reasoning with the patient.

The initial exploration of the patient's perspective

Most patients do not come out openly with their concerns and worries - and for various reasons hold back unless given encouragement or opportunity. However research shows that after consultations over three quarters of patients wanted to ask questions or express doubts of one sort or another.[3]

Most commonly this was to do with feeling hurried or uncertain about how to ask questions, or feeling that their view was unlikely to be unconsidered and unimportant - as well as remaining frightened of getting a negative reaction from the doctor. Less than 10% cited their fear of the truth as a reason.

Furthermore over 85% of patients do make some attempt to become involved and express themselves in the consultation though they tend to do this in covert or indirect ways by giving out various non-verbal 'cues' or by dropping hints and vague suggestions or expressing doubts. Even if they are picked up - 80% of doctors make no effort to listen or deliberately interrupt them; 13% of doctors listen passively but don't pursue their concerns – and only 7% becoming actively engaged.

The importance of developing and maintaining rapport

This underlines the importance of developing and maintaining an atmosphere of collaboration and trust between the doctor and patient in the consultation – allowing patients to feel confident about being involved in its process. The emphasis should be on partnership rather than patients being made to feel submissive and subservient within a traditional doctor-centred approach.

Some of the skills of developing rapport have already been covered in the first chapter and others that help maintain it - will be discussed further on below.

Using Open ended questions

The skills used during the process of Gathering information are important here. As already mentioned open-ended questions are more likely to gain access into the patient's perspective or illness framework than closed questions. Doctors are more likely to pick up the vital 'cues' that frequently leak out at this stage in the consultation. By 'handing over' control to the patient to tell their story – the doctor encourages a patient centred approach.

Picking up 'cues' that underline the patient's perspective

Clues to the patient's perspective frequently occur early on in the consultation either in their opening statement or during the opening stages of gathering information. They are often also the strongest clues to the patient's underlying concerns and expectations - but because they are often vague and covert - are easily missed or ignored by the doctor's selective concentration on clues that screen for disease.

Picking up cues is also the most natural way patients indicate their views. It is important to either check them out immediately or at least to acknowledge them and 'flag up' that you will return to them shortly.

The only way is for doctors to be constantly alert and actively think about picking up 'cues' that 'leak-out' during the consultation.

Doctor: "...you said you were very worried about that... can you tell me a bit more about your concerns...?" *or...*

Doctor: "...you said you were very worried about that... I can see that there is something here you are very concerned about...but can I come back to that in a moment to explore this with you?"

"First - can I just make sure I've finished understanding some of the other things you've been telling me...so I don't loose track?"

The patient's perspective may present from verbal or non-verbal behaviour.

Nonverbal behaviour

- Patient looks anxious or worried from expression, tone of voice, posture and body tone
- Persistent poor eye contact

Verbal behaviour

- The use of emotionally laden terms by the patient:

"Worried, upset, frightened, serious, dangerous, important..."

- Repeating words or continually returning to phrases are a patients attempt to give a 'wake-up' call to the doctor who misses their hints the first time round.
- Speech censoring - which indicates a person is holding back from saying soothing important or sensitive:
- Hesitating in mid-sentence
- Deletions – deliberately omitting information that allows understanding:

"It's no better" (what's no better?)

"Something will have to be done" (What and who should do this?)

As the patient's perspective is explored - there are three important rules to follow.

Sensitivity: Enquiring about people's inner feelings needs a certain amount of tact because many people recognise that their fears may be seen to be signs of neuroticism or personal weakness and if wrong will be made to look silly. The doctor needs to be empathetic (see below) or use the Accepting response when exploring patient cues.

Doctor: "When you said 'serious'...I wonder what was going through your mind when you said that...?"

Patient: "Well... you know...(embarrassed pause followed by silence)...."

Doctor: "I know that many patients might be thinking of something as grave as a Brain tumour...especially when they are so severe...I think that can only be both understandable and natural..."

In some situations where particular sensitive issues are being discussed or when the patient appears very nervous talking about a subject – the doctor may need to ask permission before being sure the patient is ready to reveal them.

Doctor: "...You look really upset when you said you had fears about going mad...can you bear to go on and tell me a little more... or do you want to just sit for a minute?"

Tentativeness: You need to give the patient chance to reject or at least defer owning a certain emotion or feeling – particularly if they are embarrassed to provoke a defensive reaction that blocks further exploration

Doctor: "...I may be wrong but you seemed to look upset when you talked about your mother just then..."

Accuracy: It is also very important to check that your interpretation is correct.

Doctor: "...When you said 'serious'...I know many patients might be thinking of something as grave as a Brain tumour... especially when they are so severe...I think that is only understandable and natural...would I be right in thinking this?"

Patient: "I hadn't specifically thought that...but you see my father complained of headaches just before he died of a brain haemorrhage... and I did wonder if my headaches meant I was at risk of having a stroke?"

Because someone simply looks anxious may not be the case out and misunderstanding will take place.

Doctor: "...you look worried...?"

Patient: "...Oh no... sorry doctor...I was just concentrating on what you had just said...I'm afraid I always tend look like that when I'm thinking!"

Further exploration of the patient's perspective

Asking directly for the patient's perspective

Even if early cues have been elicited previously - direct questions are often needed to explore the patient's perspective further to get a comprehensive picture of how the patient is feeling and what their expectations about this consultation are. This is the counterpart to filling in any essential medical content left out during the initial exploration.

The types of questions asked can be thought about under the headings of - Ideas, Concerns, Expectations, Feelings and Effects.

Ideas

What do you think is causing it?

Why do you think that might be happening?

Have you had any ideas about this yourself?

Have you got any clues or theories?

You've obviously given this some thought; it would help me to know what you might be thinking it might be?

Concerns

What are you concerned that it might be?

Is there anything particular or specific that you were uneasy about...?

What was your worse fear or thoughts about this?

In your darkest moments... what had been going through your mind?

Expectations

How were you hoping I might help you with this?

What were you hoping we might be able to do for this?

What do you think might be the best plan of action?

You've obviously given this some thought, what were you thinking might be the best way of tackling this?

Feelings

How has all of this made you feel?

How has this left you feeling?

How have things seemed to you?

Effects

How has this affected your life?

When should doctors attempt to discover the patient's perspective?

Using phrases that are sensitive is important. Asking what they thought was wrong can receive a curt reply.

Patient: "...You're the doctor... you tell me!" or

Doctor: "...What are you worried about?" ...is likely to be somewhat defensively replied with

Patient: silence... "... nothing.. or... I'm not worried!".

'Concern' might have be a better term than 'worried'.

GP Registrars need to try out and practice various phrases that are sensitive and sound natural when eliciting such areas. There are several examples from Skills for communicating with patients Chapter three; page 63.

The use of direct questions designed to explore the patient's perspective further has to be timed carefully and sensitively.

Asking too early on in the part of the consultation can give the impression that you are possibly evading making a diagnosis – leading to the patient 'closing down' and becoming reluctant to contribute further.

On the other hand, too late an attempt to ask patients directly for their perspective risks wasting time on issues unimportant to the interview. Suggestions may have been made that have to be retracted. It is better to leave this towards the end of the information-gathering phase unless a 'cue' comes up.

Just like we fill in missing medical facts by asking a series of more direct closed questions an attempt to find their thoughts and feelings can be signposted as follows.

Doctor: "Before I ask some questions about your past medical history... it often helps to know how all of this has seemed to you..."
pause...
"I wonder if there had been any particular areas that had concerned you..." pause...

"Had you had any thoughts as to what might be the best way forward here?"

Getting essential background information

Traditionally the medical interview started off with the doctor interrogating the patient about personal details concerning things like age, social status and occupation before taking a presenting history.

This had the effect of being unsupportive to the patient and promoting a doctor-centred start to the consultation.

Much of the patient's past medical, family, social, drug and sometimes even their allergies may come out spontaneously during their story. These essential areas that haven't can be filled in later on.

Again, signposting your intent helps focus the patient to an area of the consultation that hasn't previously been discussed.

Doctor: "Perhaps I could fill in on a few more details about your about your...(past medical, family history, social history, allergies etc...) as well as make sure I have a list of all the drugs you are taking at present... is that Ok?

The Narrative Thread and 'open-to-closed cone' of questioning

The most important skills that facilitate the process of gathering information have already been discussed – the Narrative thread and open-to-closed cone of questioning.

They have dual properties that act as the 'cornerstone' for exploring both the content of disease and illness and starting the process of gathering them.

There are other important skills that are based on encouraging the patient to expand their story further.

Facilitation

Facilitation contains skills that are similar in some respect to the Active listening phase proposed during initiating the session. It consists of encouragement, use (and tolerance) of silence, repetition (or echoing), and paraphrasing.

However, there are some important additional differences.

Facilitation may involve tolerating longer periods of silence when the patient is having difficulty in describing themselves or reflecting upon painful emotional areas. Whilst there is a balance between comfortable and uncomfortable silence - it probably only needs to be broken when there are signs from the patient (rather than the doctor) that they feel uncomfortable.

The continuing use of appropriate non-verbal behaviour from the doctor is often enough. Occasionally there is a need to give reassurance that you are comfortable and respect their need for a pause in communication. Permission can be verbalised for them to carry on using silence for thought, or to gather 'strength'.

Repetition (or echoing) the last few words or sentence is a powerful way of encouraging patients to both carry on and elaborate further.

Patient: "I'm not sure I will cope very well if things get much worse..."

Doctor: "...if things get worse...?"

Patient: "It keeps reminding me of what happened when my mother had breast cancer – the pain and all that..."

Paraphrasing

This goes one stage further by the reflecting back both what has been said and also the interpretation and meaning of what was said. It is a useful way of detecting if there are hidden feelings or emotions behind what the patient has said.

Patient: "I have always said I would stand by him how ever much he drinks - because of my religion...and there's the children – but I really don't know how this will affect our marriage this time"

Doctor: "You mean you are not sure whether you can live with John anymore?"

Patient: "I don't even mind his awful language – but the children are now growing older and asking questions and I don't know what effect it' having on them"

Doctor: "Am I right in thinking things have changed...and you now feel you are letting the children down more than your beliefs by staying with John?"

Sharing clinical reasoning with the patient

One of the most powerful ways of combining patient collaboration with the doctors own problem solving is for the doctor to openly feed back to the patient what they are thinking and how they are forming their opinions.

This enables various ideas to be 'floated' or theories tested out with the patient - without making any assumptions or decisions. It is a particularly good method to bring up sensitive issues that may not be initially accepted by some patients such as symptoms that are likely to have psychological rather than physical origins.

The key again is to raise your thoughts sensitively and retain a certain amount of tentativeness before checking for accuracy and acceptance by the patient.

A useful ploy is to de-personalise symptoms from being personally owned by the patient until they accept and acknowledge them as possibilities. Equally, generalising symptoms or experiences away to others as being common and normal maybe helpful.

Doctor: "One of the ways tiredness can come about is through sheer exhaustion over worry and pressure at work and home. Whilst this might not apply to you...I just wondered if this could be a factor in all of this... what do you think?"

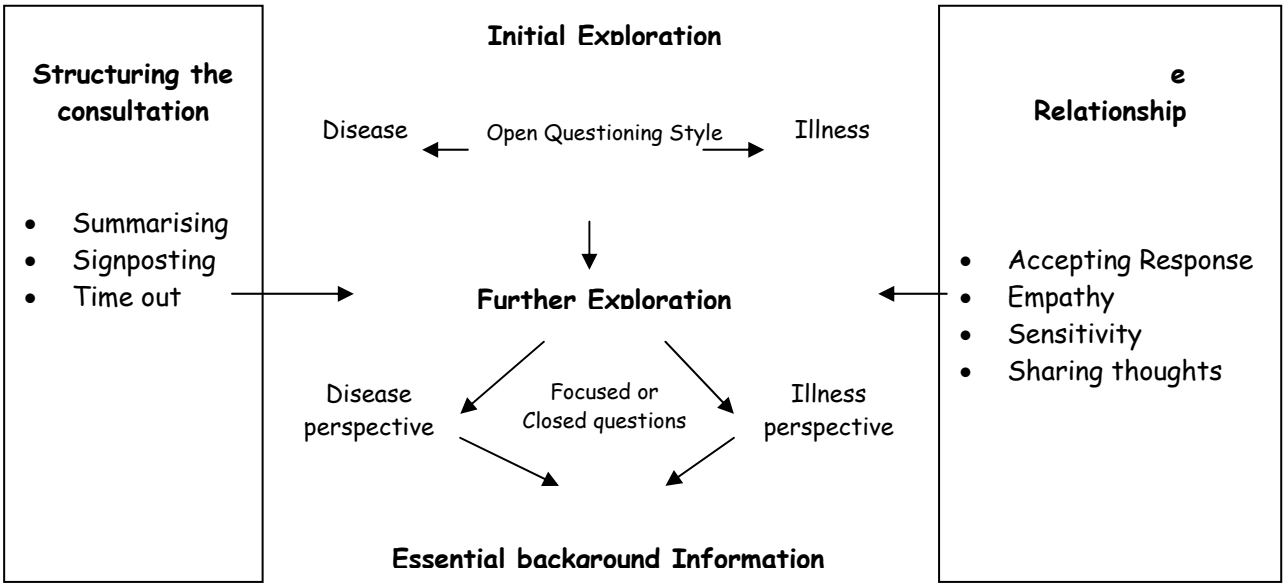
Doctor: "Whilst we still may need to consider whether tests are needed...on occasions I've known abdominal pain like this to be brought on by stress...?"

Doctor: "Although indigestion like this is certainly very real and severe - the cause may lie with how many of us constantly live with worry and nervous tension in our lives...do you think this might possibly explain why - after all the tests - you still have such bad pain?"

Structuring the consultation

Finally the framework for this part of the consultation is expanded one further step. Whilst the content and process of exploring the patients are going on – there is also a need to maintain some sort of order and control between the various sections to be covered – rather than allow the consultation to wander aimlessly on.

At the same time there is a need to respond to the patients views and contribution without reacting to give premature reassurance or judgement. Conceptually the framework must include parallel sections that contain skills that 'Structure the consultation' and 'Develop the relationship'.



Maintaining control and structuring the consultation

One of the repeated concerns voiced by doctors is controlling patient-centred consultations and doctors allowing of patients control over the direction of the consultation.

These are partly to do with concerns about being potentially swamped by demands and partly because of the way information tends to come out in a less organised and memorable form during patient-centred interviews.

The three key skills that help control organise and manage the information we here are Summarising, Signposting and 'Returning to the Narrative'.

Summarising

This skill is a statement or summary that feeds back to the patient what the doctor has heard and understood so far. It acts not only as a structuring skill – similar to the way punctuation is used to structure an essay - but also as an enabling or facilitating skill that encourages the patient to go further into their problem.

The process of summarising allows doctors to check both the accuracy of what they've just heard and to organise and make information more memorable by the process of repetition. Far from causing interference, summarising facilitates story telling by promoting the flow of information and concentration of the patient. By constantly checking back with the patient - it allows uncertainties and misinterpretations to be clarified and put right before carrying on.

It also allows a breathing space for the doctor to think and review what's been covered as well as clarify what aspects of the story need further exploration as well as being helpful when we are uncertain where to go next.

Summarising will often naturally restore the consultation either by it encouraging new information to come forward or by the next step becoming more obvious. It clarifies where you are and where you want to go next. It's likely that the patient will not only embellish further the information that was originally offered - but will hone it into a more comprehensible and accurate form.

Summarising can be used repeatedly throughout the first phase of gathering information to maintain control and structure and again right at the end to ensure both the biomedical and illness perspectives have been included.

Signposting

This is a directive statement to the patient that explains where you are going in the consultation and why. The end result is to structure what is going on to the patient so they can concentrate and contribute more effectively. It is particularly useful to use signposting when intending to move between the different sections and between parts within each section of the consultation.

Signposting satisfies another of the five underlying principle of communication – reducing patient uncertainty.

- From the introduction into the gathering information stage
- From open to closed questions
- Into specific questions about the patient's ideas, concerns or expectations
- Into the functional enquiry about symptoms and organ systems
- Into the examination
- Into explanation and planning

Returning to the Narrative

Patients tend to communicate their problems as part of a story or narrative.

Patient: "First this happened... and then that happened. Then I felt something....just here ...then there...which then moved over here...followed by something else. Then it started to make me think... but then someone said...then I remembered... and I can't help worrying that...after talking to a few people...it might mean...sort of thing"

Despite the story often being well rehearsed – it is still often disjointed and poorly linked up.

Doctors not only need to listen - they need to use skills that help the patient tell their story more effectively and efficiently – and make connections later on in the Explanation and Planning part of the consultation.

This helps both the doctor and patient make more sense and gain clarity for their presenting problems. If necessary, it is important to gently steer their story within limits of significant information and retain its focus without restricting the patient's imagination and recall.

The easiest way - is to ask the patient to return to their story or 'narrative' whenever we sense it is becoming unrelated or detached from our developing understanding of the problem.

Doctor: " ...I'm really sorry to hear about the difficulties your friend has had... ... ...but I wonder if we might go back to the point when you said your breathing had started to get worse...particularly the part when you said you had noticed going up hills seemed to restrict you...and you had to stop to draw breath for a few minutes...?"

This is like putting the needle of a gramophone record back to where you want it. Doing this a few times – is a gentle but effective way of re-focusing the patient's train of thought on the problems at hand - rather than wandering off down thoughts and reflections that randomly distract them.

However, sometimes it is worth asking a patient why they digressed in the way they did – in case there has been an even greater leap or unexplained 'knights move' in thought processes – that at first cannot be easily connected - yet can - after explanation.

Doctor: "I'm interested to check out why you said that...I'm not sure why the news about gas attacks in Iraq fits in with problems to do with your vision?"

Patient: " I'm sorry doctor ...it started to remind me of how I was treated as prisoner of war and how we had several infections affecting our eyes over the years that weren't treated. I still can't help wondering if some sort of infection was left behind?"

How to deal with really over-talkative patients

When you watch two people talk there is often a natural rhythm of taking turns. A conversation is governing by unstated rules using both verbal and non-verbal behaviour. Eye contact is often refocused in the distance away from direct eye-to-eye contact when speaking only for it to be regained when speaking is coming to a close. Equally the voice drops and there maybe subtle changes in posture and position that are automatically picked up by the other person as a signal to take their turn in replying. Over-talkativeness may occasionally occur from misperceptions about 'turn-taking' in conversation.

The natural rules of 'turn-taking' also become lost and overridden when there is over-riding anxiety or preoccupation with internal or external issues by the patient.

It may in some cases represent a conscious or unconscious attempt to avoid certain difficult issues.

When patients have difficulty focusing on one issue at a time or are easily distracted towards unhelpful information, doctors need to refocus the patient onto the problem in hand.

Responding to their anxiety may also help them to control their talkativeness.

Doctor: "I can sense that what you are trying to tell me is making you very nervous ... am I right...would it help to tell me more about this first before going on?"

Doctor: "What you say sounds interesting – but can I just repeat what I think is really important that I have heard so far – if that is alright with you?" or

Doctor: "That sounds important – though I'm not sure how that fits in with how your arthritis has changed?"

Some doctors unnecessarily worry that this appears rude as it might during normal social conversation – yet most patients usually welcome it - since it signals your interest in their problem and its resolution - and they see it the duty of the doctor to steer them back onto course. Enquiring about a possible cause for their over-talkativeness sometimes helps.

Rarely it is also necessary for doctors to resort to restoring the basic rhythm between participants in a conversation by first maintaining eye contact – drawing closer and putting their hand up to indicate that the patient should stop. If this doesn't work repeating the patients name in a low but increasingly louder voice – does!

Maintaining rapport and supporting the patient

Sometimes rapport building skills become an aim in themselves. These skills are the mainstay of consultations that focus on supportive counselling to patients with emotional needs.

Some of the rapport building skills have already been covered. These include the appropriate use of non-verbal behaviour and picking up patient cues that represent their personal perspective of their symptoms, the Accepting response and sharing thoughts and rationale behind the clinical reasoning process used by the doctor.

Empathy

Empathy is perhaps the key skill used to build the doctor-patient relationship. The aim is to develop an emotional bond or understanding that demonstrates we are not only interested in them as patients but we want to put ourselves directly into their shoes to understand them further – often termed 'emotional resonance'.

Despite this we don't have to either personally experience or share their feelings to be empathetic - nor do we need to agree with them.

There are two essential parts.

1. The need to show that you understand how the patient is feeling or affected
2. An ability to communicate this back in a supportive way and demonstrate this understanding

The simplest form of empathy is for the doctor to make a straightforward supportive statement starting with I… (the doctor) and include …a you ...(the patient).

Doctor: "I can see how difficult it is for you to talk about this today..."

As social beings most adults have other highly developed skills to help them sense and interpret the emotional processes of others. These come from four different modalities.

1. From what we **hear** – from what and how patients say things

> *Doctor: "You sound as though you are very low at he moment?"*

2. From what we **see** – frequently from our observations of a patients non-verbals

> *Doctor: "You look as though this worries you?"*

3. From what we **feel** – what we pick up as emotional contagion or the ability to sense the feelings of others by paying attention to the effect on our own feelings

> *Doctor: "Somehow I sense you feel overwhelmed by your problems at present?"*

This is often similar to us as doctors disclosing how what we have heard has made us feel or 'self-disclosure'

> *Doctor: "It makes me feel sad to hear that – does it you?"*

4. From what we **imagine** – Particularly when we have little in common with patient

> *Doctor: "I can imagine that must have been very difficult for you to carry on at that stage?"*

As well as the straightforward 'I - you' statements – empathetic statements can be based on observing patients experiences or behaviour in certain situations.

Observations on experience

> *Doctor: "It seems to me that you've really been through a lot this time"*
>
> *Doctor: "You must have felt very frightened when that happened*

Observations on behaviour

> *Doctor: "You must have been feeling very angry to have said that"*
>
> *Doctor: "That must have been very difficult to do"*

Frequently empathetic statements are linked to other supportive themes. These usually revolve around ideas that convey concern, understanding, willingness to help, partnership and acknowledging coping efforts.

Concern:

> *"I'm concerned that you have no one to talk to when you go home to an empty house tonight "*

Understanding:

"I can totally understand how the result of your operation has left you feeling angry"

Willingness to help:

"Although as I say we can't cure the cancer, I'd like to try to help you with any symptoms that it might cause so please tell me straight away if anything happens"

Partnership:

"We'll have to work together to get on top of this illness so let's look at the options that we can choose from"

Acknowledging coping efforts and appropriate self-care:

"You've really done exactly the right things in trying to get his temperature down"

However, there are a few dangers of being empathetic particularly if it is used too early without permission before trust has developed.

Again the rules of sensitivity, tentativeness and checking out the accuracy or interpretation with the patient help prevent this. It is also safer to use observation of patient behaviour or the experiences they have given you rather than try and interpret their feelings, which to some patients represent private and intimate views.

Some forms of empathy can also be irritating or even threatening to some patients.

Saying "I know how you must be feeling" might receive an angry response of "nobody knows how I'm feeling*!"*

1 Blacklock (1977)
2 Stewart et al (1997)

Suggested exercises: Gathering information

Review the core communicating skills for this section

- The narrative thread and the open-to-closed questioning cone of enquiry
- Clarification & Time-framing
- Exploring the patients perspective through
- Picking up patient cues – and checking them out
- Direct questioning to discover the patients perspective
- Summarising & Signposting

GP Registrar objectives

- Develop an understanding for the Disease – Illness model
- Knowledge of the cultural and sociological factors that determine the patient's perspective
- Awareness of how different types of questioning styles affects the interview at various stages.
- Importance of using the Open-to-closed questioning style in taking a history to improve accuracy and efficiency of information gathering and the process of clinical reasoning.
- Using open-ended phraseology when initially exploring patient's problems instead of relying on a series of closed doctor-centred questions.
- The importance of using focused and closed questioning style in eliciting the functional enquiry and background information.
- Discovering the meaning of illness from the patient's perspective
- By recognising the cues that occur during the interview
- By direct enquiry using sensitive and appropriate phraseology and timing during the interview
- Importance of reacting to the patient's perspective using a combination of the Accepting, supporting and empathetic response.
- The use of summarising to facilitate improving accuracy and further exploration of the patient's problems
- Using Summarising and Signposting as twin skills to structure and facilitate patient's involvement in the interview

Areas for discussion

Exploring the patient's problem

- List five common terms or descriptions used by patients for each organ system (e.g. constipation, feeling light-headed, dizziness, shaky, palpitations… etc.) that need clarifying to be understood accurately by a doctor.

- List six common causes of headache that need to be considered in a fifty year old man. Characterise each in terms of their timing. Use variables such as mode of onset, pattern and variation over time.
- List the basic areas of information or data you need to cover medically - to make an accurate assessment of the following common presentations met in primary care.
    - Exacerbation of asthma
    - Depression
    - Headache
    - Tiredness & lethargy
    - Low back pain
    - Prostatism
    - Skin rash
    - Rectal bleeding
    - Dyspepsia… etc…

Discuss the difference between Disease and Illness.

- What defines a disease – think of five examples of disease without illness
- What are the components that constitute illness – think of five examples of illnesses without disease
- How (and why) does the contribution of disease and illness vary in
    - Hypertension
    - Cancer
    - Bereavement
    - Degenerative spinal disease
    - Epilepsy

…and how does this influence management?

Exploring the patient's perspective

- Think of how you might phrase questions that ask patients directly for their
    - Ideas
    - Concerns
    - Expectations
    - Feelings
- Discuss the difficulties of patients who somatise. Think of how you might phrase questions that explore possible links between symptoms and emotions or feelings.
- E.g.: Chronic fatigue, IBS, non-cardiac chest pain etc

Consider how you might respond to the following patient concerns

"I been getting a stiff neck at work this week and now I'm frightened I might be getting meningitis!"

"I think my child is dyslexic – and I would like him allergy tested doctor."

"I don't seem to have any sex drive anymore and I don't feel I can cope with the children either – do you think it is caused by my hormones"

"I think I've got dementia – my memory's so poor these days and now I've started leaking urine – I'm sure this means I'm not going to live much longer now"

"Everything I do seems to go wrong, I'm a hopeless mother, I've fallen out with my best friend and I can't even find a part-time job – don't you think that makes me sound useless?"

"I wonder if you could prescribe some antibiotics for Harry – he has such a bad cough!"

"I wonder if you could give me a full check-up Dr. – being 40 and all that"

"I find it very difficult to walk these days – do you think I'll need a wheel chair soon?"

"I don't want to take any medicine for my diabetes or else it will stop me driving my lorry"

"I think Dr. Smith was awful to me on the telephone last night – he didn't seem to care at all that I'd just brought John back from having a serious operation – I feel like making a complaint"

Watching videos

Stop the video before the examination or explanation begins

- Picking up patient cues. Let the tape run – but stop each time you suspect a significant verbal or non-verbal cue. Describe what made you stop there and discuss what the patient might have been thinking or feeling at that stage - and what might they have been trying to say? Discuss how you would check out your interpretation back with the patient.
- Are both disease and illness perspectives covered in the consultation? Stop the tape before the examination or explanation begins. Summarise separately what you have discovered about each area.
- Look to see if there is evidence of an open-to-closed cone of enquiry. Stop the tape after each question that is asked by the doctor and label it on a scale between being an open or closed questioning style.

Looking at the whole consultation

- Look at the consultation from a clinical reasoning perspective. Stop the tape every minute or so and discuss the reasoning behind the line of questioning. Discuss in terms of what information do you know at that point and what still do you need in order to get an accurate picture of the problems. Where relevant - consider alternatives to the questions asked on the video.

- Look at whether there has been clarity and understanding between doctor and patient. Record any terms or phrases used by the patient that were vague or ambiguous e.g. 'dizziness' as well as any medical terms or 'jargon' used by the doctor. Were these clarified or explained during the course of the consultation?

Role-play

- Practice using the Narrative thread. Role-play a scenario with your trainer presenting as a patient with a simple URTI. Make a determined attempt to phrase questions using an open-ended line of enquiry first.
- Role-play a scenario with your trainer presenting as a patient with rectal bleeding and a family history of bowel cancer. Try out the various phrases to directly discover their ideas, concerns, expectations and feelings.
- Role-play a scenario with your trainer presenting as a very anxious person with headaches. Try out questions that attempt to explore possible links between their symptoms and their emotions and feelings. Discuss the non-verbal cues your trainer was using.

Notes for trainers when watching videos

- Do they finish or complete taking a history before they examine or start planning care or giving advice?
- Does the medical history explore enough information to consider important and serious conditions?
- Do they explore the patient's problem by using an open to closed cone of questioning that encourages accurate clinical reasoning?
- Does the medical history explore enough information to consider important and serious conditions? Does he demonstrate that hey have considered important variables such as the mode of onset, length and development of symptoms (time-framing)? An accurate description of symptoms including its severity & effects on the patient and where relevant? Any pattern, altering factors and associated features as well as clarification of any ambiguous statements or descriptions the patient may use.
- Do they structure and check the accuracy and interpretation of the information they hear by Summarising?
- Do they use appropriate closed questions to complete important information about the relevant function of body systems, past medical, family & social history
- Do they discover the patient's perspective sufficiently enough to understand the meaning of their symptoms to them as well as help you plan management?
- Do they respond to patient ideas and concerns in an empathetic and non-judgmental way?

- Do they discover the patient's perspective by asking direct but sensitive questions about their ideas concerns, expectations and feelings?
- Do they respond to patient ideas and concerns in an empathetic and non-judgmental way?
- Do they maintain order and structure within the consultation by using summarising and signposting - so that it flows in a reasonably ordered sequence?
- Do they involve the patient by sharing their thoughts, providing rationale and signposting changes of direction within the

Explanation and Planning 5

Introduction

Traditionally this part of the consultation involves discussion about diagnoses and/or medical information followed by instruction by the doctor about appropriate management.

However, the importance of both the process and the content of this part of the consultation has undergone a fundamental change in direction over the last decade. This is partly because of demands made by patients themselves to become involved in decisions relating to their care and by society in general - to make doctors more accountable.

Despite their own perceptions, research shows that doctors do not devote enough time to this part of the consultation.

There are problems with giving both the right amount and type of information that patients need and want. Patients often find it difficult to remember and make sense of what they hear and frequently feel frustrated by their unsuccessful attempts to become involved in the decision-making processes of their care.

Furthermore there are major medical and economic issues that relate to poor compliance and ineffective use of medical resources as a result.

There is increasing evidence that the skills used in this part of the consultation have direct effects on not only economic issues but to improving medical and health outcomes. Using the appropriate skills not only improves compliance and leads to more efficient use of medical time and resources; it also achieves better physiological outcomes.

There is now a real need for doctors to respect and incorporate patient views into the decision making process rather than being content to inform them of what is going to be done.

The core objectives of Explanation & Planning

Although Explanation & Planning may serve many different purposes that range from the common function of giving an opinion and planning management to discussing risk management, motivational counselling or supportive counselling - the overall approach (including the skills used) involves four core objectives that need completing - and are common to all consultations.

1. Providing the appropriate amount and type of information.
2. Delivering information in a form that facilitates recall and understanding
3. Reaching a shared understanding about what is discussed.
4. Encouraging the patient to become involved collaboratively in making decisions about their care.

1 Providing the appropriate amount and type of information

a) This entails actively finding the patient's 'starting point' in terms of how much they want to know - and what they already know and have experience of – followed by what more they want to know.

b) It also involves what they need to know from a medical perspective - so they can become involved at an appropriate level of informed understanding for personal decision-making.

c) Sometimes – it involves finding out the patient's 'starting point' in terms of their awareness and understanding for the level of potential seriousness. This is especially important where there is the likelihood of breaking bad news. It is not just limited to situations that are potentially life threatening such as cancer – but where any diagnosis might have a major impact of their life such as being told they have Parkinson's disease or diabetes.

2 Delivering information in a form that facilitates recall and understanding.

a) This involves giving information in a clear and unambiguous form that is free of unexplained medical jargon.

b) Important areas of information should be given in an organised or categorised form – and broken down into logical sections that can be reinforced to increase recall.

c) Information should be given at a pace governed by the patient's ability to absorb and assimilate it.

d) The patient's own understanding of the information needs to be actively checked throughout.

3 Reaching a shared understanding about what is discussed.

a) This means actively seeking the patient's reaction as well as responding to patient's verbal views or non-verbal 'cues' given out during the process of giving information or planning management.

b) The doctor should relate back to previously held views expressed earlier in the consultation - from any aspect of the patient's perspective

c) The doctor needs to negotiate any differences of viewpoint in terms of

- The nature or causes of the problem
- The aims and expectations of the consultation and any subsequent plan of action
- The underlining beliefs held by the doctor and patient about their respective roles and abilities – being able to explore and define what they expect from each other in terms of decision making and responsibility.

4 Encouraging the patient to become involved collaboratively in making dec

a) Again this entails actively finding the patient's 'starting point' in terms of how much they want to become involved in planning – as well as what sort of areas they might find unacceptable. This 'starting point' is not necessarily governed by the initial decision they made to seek or avoid information.

b) It means providing clear and relevant information about the various approaches and options

c) It involves offering options or choices and making suggestions rather than directives

d) It entails haring the reasoning and rationale behind them.

e) Actively seeking and encouraging their reactions and views about what is discussed – particularly any concerns or obstacles they foresee.

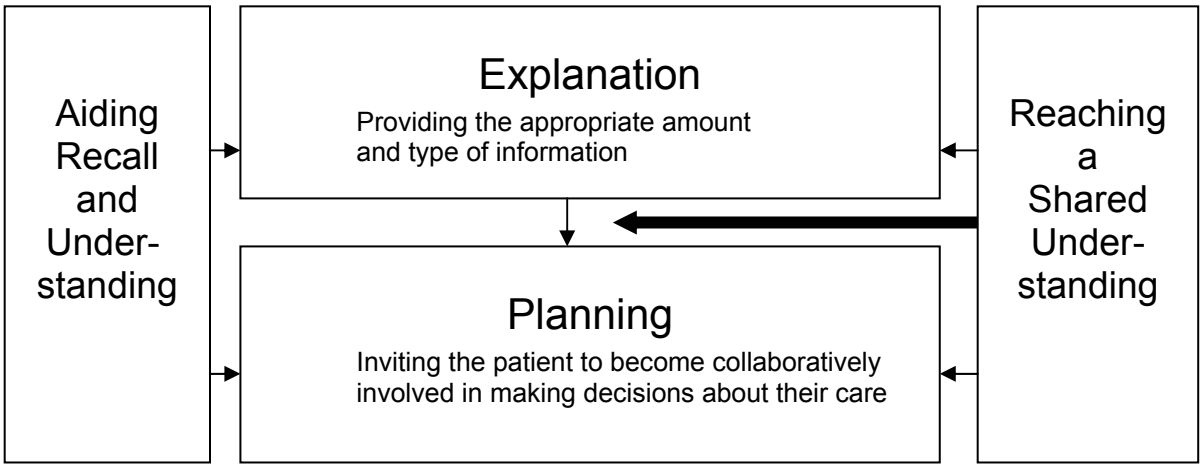
A conceptual framework for Explanation & Planning

It is useful to hold mentally a conceptual structure or framework of how the four sections (that represent its objectives) relate with each other during 'live' consultations.

As within other parts of the overall consultation model - each section holds the respective skills that help achieve or realise them – as discussed below.

During the consultation there is a logical sequence of moving from explanation (where doctors provide the appropriate amount and type of information) to planning (where doctors invite the patient to become collaboratively involved in making decisions about their care).

There are two parallel sections that represent the skills that relate to giving information in a form that facilitates recall and understanding - and skills that continually seek to reach or maintain a shared understanding with the patient throughout this part of the consultation.



The Skills

Providing the appropriate amount and type of information

Finding the patient's starting point

The first aim is to give information that is tailored to needs of the individual patient.

Despite the general criticisms about the amount of information doctors give not all patients want more information.

Roughly 80% of patients are so-called 'seekers' whilst the remaining 20% aren't - and are known as so-called 'avoiders'. They do less well if over-burdened by doctors rhetoric and with knowledge they never asked for. This means doctors have a duty to first discover a patient's personal 'starting point' before launching into giving information.

Furthermore, it not always easy to predict which are 'seekers' and which are 'avoiders'. There is no clear relationship between intelligence or social class.

It is also important to realise that individual patient's need for information often changes over time as well as between different situations - particularly within serious or chronic illness. Even if you know the patient well – you may need to check their 'starting point' each time.

Having established that the patient wants to hear more about their problem – explore what they know and want to know. This allows you to think rather than immediately launch off into an often 'long-winded' and poorly structured homily that you have had little time to think about.

Many patients often already have a lot of information and practical experience of health and illness that comes from contact with families or friends or sources within the media.

Their knowledge may or may not be accurate. Knowing what the patient knows first helps the doctor plan out what they need to cover - what gaps to fill in - and what they can leave. This might save time, since not all the information the doctor expected he needed to cover is necessary.

Even if patients don't have a major understanding of their situation it is useful to discover if there are any misunderstandings or distortions that should be identified first before committing your viewpoint.

Doctor: "The type of back pain you have described along with what I have discovered from examining you - makes me think that it is likely that you have a slipped or prolapsed disc to cause your symptoms..." Pause...

Doctor: "There's a lot of information I could give you about a prolapsed disc disease - would you like me to go on?"

Scenario 1:

Patient: "No...doc thankyou – just get me back on my feet and tell me what I need to do"

Scenario 2:

Patient: "Yes...please go on."

Doctor: "Before I do - it's often helpful to find out what you already know about this – so I can help fill in the gaps"

Patient: "My father had a bad back...it ended his profession... and he was never the same man again. We had to move house and he became very depressed"

Doctor: "Ok...I'll try and put this in perspective in terms of how it effects most people in a minute...but first are there any other specific areas you would like me to cover – or do you want think about this as I go along?"...

If the patient wants to hear more about their problem but does not know what they want to ask - then the areas described by Helman help to define which areas are most important as well as what patients want later on. Helman discovered that patients ask themselves five questions each time they try to make sense of health changes

- What has happened?
- Why now? Why me?
- What … if I don't do something about it? What… if I do something about it?

It is a universal human characteristic to try and explain personal experiences in order to give people a sense of having some control labelling their experiences. [1]

If possible, name the condition(s) or diagnosis being considered - though sometimes it is only possible to describe the presentation descriptively. Where there is a list of potential diagnoses list them including important possibilities you can safely rule out.

- Give the reasons or rationale for this and your level of certainty
- Outline possible causes
- Indicate the importance or seriousness of this diagnosis (es)
- Give an expected outlook or a range of possibilities (or prognosis) for the future
- Explain how they can personally become involved in their care – either to prevent it recurring in the future or from it getting worse/complications

A useful mnemonic to remember (that also rhymes) is d – c – e – p – t

(**D**iagnosis – **C**ause– **E**xpected course – **P**rognosis & Seriousness –**T**reatment [later on])

The patient's own request for the type of information they want should be addressed first, with the doctor aiming to fill in the important gaps of information that is considered medically important to give a balanced understanding and help make an informed decision later on.

It is also a good idea to round off your explanation by asking the patient to remind you if there has been anything important left out or that has surfaced in his or her mind during your discussion.

Doctor: "Ok…so that's covered what I think is causing your symptoms and why this might be happening…and what it could mean for you in the future… is there anything you think I've left out?"

Patient: "Yes… will this be something my children could inherit… and can you advise me what I can do myself to help or prevent problems in the future?"

Once answered checking once more that all the topics have been covered will allow you to move safely on without finding you are covering them later on.

Doctor: "Ok…anything else you feel might be important..?"

Patient: "No that's about it for the moment…perhaps you could tell what I should do next?"

Breaking Bad news

It is not always possible to know what constitutes bad news. It is obvious when there is potentially life-threatening illness such as cancer but less so with less serious illnesses such as angina or asthma. Even mundane conditions such as eczema or glaucoma can incite devastating reactions where the meaning of theses conditions goes much further than normal everyday medical perceptions.

Although there maybe clues from the patient's ideas and concerns discovered earlier in the consultation – it is safer treat any diagnosis as potentially important to the patient and avoid any flippant description that might be construed as insensitive and cause embarrassment and loss of confidence later on.

Where there is a potentially serious diagnosis to impart – it is important to find out whether they are aware of this and what they have been told or discussed with others.

Many patients are very aware and expectant of receiving such news and it is a question then of confirming their worst fears rather than going on into 'breaking bad news'. Nothing can help soften this blow – other to say it in the most sensitive and compassionate way possible and follow it up as you would after breaking bad news.

Doctor: During the last few weeks - have you had any particular thoughts about what might be a causing them?

Patient: "Yes…I 'm afraid they all appear like those I remember my father had before he had bowel cancer diagnosed…"

Pause…Doctor leans slightly forward with steady eye contact and offers a steadying hand to their shoulder

Doctor: "I am so sorry to have to tell you this at this time… I'm afraid your fears are right… the tests do indeed indicate that there is likely to be tumour affecting your bowel…"

Where there is no apparent awareness, it is first necessary to warn the person that bad news is about to be delivered – to give them the chance to avoid overwhelming pain that a serious diagnosis means to them. This allows them to 'shelter' within denial.

It is important to know that forcing an unpleasant diagnosis on them has been shown to often cause irreparable harm and seriously affect the health of patients for the remainder of their illness.

Doctor: During the last few weeks - have you had any particular thoughts about what might be causing them?

Patient: "I thought it might be due to an infection I'd picked when I was in the army in Burma"

You should then fire a 'warning shot' that the problem is more serious than they realised.

Doctor: I'm afraid we have not found an infection…. It looks as though it is more serious that that"

The patient then either indicates that they want you to proceed further and tell them more - or that they do not want to hear what is coming next

You should then proceed through a series of euphemisms until you are sure that they want to hear the full extent of the bad news. This gives the patient time to make the transition from believing their situation is non-threatening to understanding that it is potentially fatal. [2]

Patient: "What do you mean…. more serious?

Doctor: "I have received the results of your x-ray…and it shows that there is a blockage that is causing your symptoms?

Patient: "What sort of blockage…?"

Doctor: "It looks as though there is something abnormal growing inside the bowel to cause your pain and bleeding"

Patient: "What sort of growth…?"
Doctor: "I'm afraid it looks like a bowel tumour…"

Patient: "Do you mean its cancer?"

Doctor: "I'm afraid that is most likely explanation given by the specialist who has reported your x-rays"

In converse about 10% of patients will deny the gravity of the impending news and block further progress

Patient: "Oh dear… I'm sure it will pass …I'm sure you will know what to do next?

You should now check to see how solid their denial is either by going over any inconsistencies in their story

Doctor: "I remember last time that you were very worried when you had discovered you had lost nearly two stone in weight ...and that the pains were getting worse...I wondered if this still worried you as much...?"

…or by giving them a second chance by confronting them with an opportunity to face what is going on by looking for a 'window' in their denial.

Doctor: "...I wonder, if at any time, you have had thoughts that there might be something else more serious causing your symptoms...rather than an infection caught during your war years...?"

If the denial remains solid – then it should be respected – with you proceeding to managing practical issues and planning the next steps. If there is hesitance or non-verbal cues that indicate that your challenge has breached their initial facade you can gently probe further.

Doctor: "I wonder if you can bear to talk a little further about this?"

It is vitally important to pause – if necessary for a long period after first breaking bad news - to allow first 'shut down' by the patient and time to allow them to rally after absorbing what they have heard.

The consultation should then proceed slowly through four well-defined phases as below.

1) Acknowledge and ask for the patient's first feelings and thoughts
    - Respond by giving 'hope tempered with realism'
2) Elicit all of the patients concerns – and address them
    - Ensure you elicit all their main concerns before you offer advice or reassurance
    - Use repetitive screening if necessary
3) Give appropriate advice at the right level needed/wanted by the patient
    - Remember to chunk and check (described below) and allow time and spaces for thinking
4) Plan and negotiate the next steps in their management
    - Including continuing support and follow up

Delivering information in a form that facilitates recall and understanding

If any information is to be remembered and understood - it must be given in a clear and unambiguous form, which is intelligible to the patient.

Research shows that patients often recall a lot about what they were told by doctors during consultations - but what they recollect is often muddled, disjointed and fragmented. Information is often given too hurriedly for them to assimilate properly and shrouded further in medical terminology they don't fully understand nor ask about. Consequently they have difficulty in making sense of it.

‘Chunking and Checking’

The most important skill a doctor needs to use is ‘chunking and checking’. This has the dual function of pacing information at a rate the patient can absorb information whilst checking for their reaction to what’s said. Many doctors give too much information all at once with the patient often left thinking about the first sentence when doctor is already on the fifth!

The aim is to give small amounts or chunks of information followed by stopping to check whether they appear to being keeping up with you - before moving on!

It is important to monitor the patient’s non-verbal reactions, which often give the most reliable clue as to whether they have really taken it in, understood it - and agreed with what’s been said.

It is important to practice ‘chunking and checking’ to see you are doing this in practice by videoing this section of the consultation or role-playing with your trainer. Make sure you pace things correctly – and (usually) take it more slowly than you usually do!

Categorising and signposting

It is important to try and divide up the topic that is being discussed into discrete ‘packets’ of information that are distinct and more likely to be memorable to the patient.

A good way is for you to first outline the areas to be covered and then discusses each in turn - preparing you and the patient to think in a logical sequence under identifiable headings.

Mentally using the mnemonic **d – c – e – p – t** might help. (Diagnosis – Cause– Expected course – Prognosis & Seriousness –Treatment [later on])

Doctor: “There are a number of important things you might need to know about hypertension. Let me start first by explaining what hypertension is - and a little of what we know about its causes. Then, perhaps I could tell you about how this might effect you in the future, and why hypertension is important to manage properly as well as the dangers of not treating it… is that Ok?”

Patient: “Yes… please go on….”

Clarity and Jargon

It is important to use concise, easily understood language. If Jargon is used – explain it. Patients rarely interrupt for fear of looking stupid or difficult and prefer to remain ignorant.

Many doctors use diagrams or visual aids that increase understanding and supplement the consultation with leaflets for the patient to take away and read later.

Repetition and Restatement

Repetition by the doctor to summarise key areas is an important skill that increases patient recall. Even more powerful is asking the patient to repeat back what they have heard. This allows you to check not only their powers of recall, but also their understanding and interpretation as well as agreeing with it. Remember restatement increases patient recall by up to 30 per cent!

Doctor: “So to summarise – there are some important ways you can help to control your blood pressure - and which are also beneficial for your heart and circulation as a whole. Losing weight, cutting down your alcohol intake and start exercising more… Perhaps you could go through how I suggested you might go about doing these – so I can check that this is acceptable?”

Developing a shared understanding and finding mutual common ground

Giving a diagnosis the patient may not readily agree with

Sometimes, it is possible to sense early on in the consultation that there may be problems or even conflict ahead when the diagnosis eventually needs to be discussed. The patient may present with a complex of symptoms that strongly suggest an underlying psychosomatic cause to the doctor, yet they present in a way that suggests they firmly believe them to originate from a physical basis.

During the first half of the consultation the best way of reacting to these is by responding to the underlying emotion or using the Accepting Response discussed in earlier chapters, rather than give premature reassurance or rejection or that frequently causes the consultation to come 'unstuck'.

Sensing a possible disagreement - doctors often end up investigating or deferring confrontation - by using a number of labels such as a 'viral infection' that might seem more acceptable and less antagonistic.

The diagnostic label

However, eventually, the doctor has to face the 'crunch' of introducing a potentially unacceptable explanation or interpretation. This is where the intended diagnostic 'label' used by the doctor has to be compared with the definition held by the patient – to try and develop a shared understanding about each other's beliefs and interpretations.

If a diagnostic label is going to be used early on – then it needs to be given in a way that opens up the possibility for negotiation. There is little point in moving on and telling the patient they are suffering from stress and anxiety and proceeding to explain the causes of stress and how it effects people to cause tiredness and chest pains - if the patient doesn't agree. Furthermore it is hard to plan their management on this basis. They may seem to listen but may seek help elsewhere or tear up the prescription once they have left - never to return as planned.

Achieving a shared understanding as a goal throughout explanation & planning

Achieving a shared understanding may therefore start at the beginning of explanation and planning - with its respective skills employed throughout – ensuring that you maintain understanding and agreement first about the possible underlying nature or causes for the problem – and secondly, as to what should be done about it - the aims and expectations of the consultation and any subsequent plan of action.

The basic skills are constantly seeking the patient's reaction throughout as well as responding to their verbal or non-verbal 'cues'.

The first objective is to express any 'label' in a way that gives the patient a chance to accept it later on after negotiation.

Placing a potentially unacceptable 'label' within a list of other possibilities and being willing to discuss and check out a few reasonable alternatives is one way.

It is important to suggest a diagnosis tentatively and perhaps phrase it using the third person allowing you to retract if necessary preventing you from appearing judgemental and inflexible and the patient from feeling stigmatised and labelled early on.

It shows that you are willing to bargain and negotiate with the patient.

Doctor: "There are number of possible causes that could be the reason for why you are feeling so tired. One is that you could be anaemic as you mentioned or that your body is reacting in some way to a recent infection - possibly a blood test might help here?

I may be wrong…but occasionally, I find that the pressure our bodies often go through when we are juggling a responsible job, coping with getting over two recent infections and worrying about our relationships… might also be a possibility…what do you think?"

Or…

Doctor: "There are number of possible causes that could be the reason for why you are feeling so tired. Although there is a chance that anaemia might cause your symptoms – I have been faced with similar situations to this where it turns out that the tiredness and chest pains are due to the body being distressed on account of the person being 'run down' and constantly under strain as a result of things going on in their lives… do you think this might be a possible reason for you?"

Another way is to use a little **'PR'** or 'public relations'. P - R helps remember how to couch a statement that links physical symptoms with a possible underlying psychosocial cause – **P**roduced in **R**esponse to.

Doctor: Sometimes I am left wondering whether what might be happening is how the body produces symptoms in response to constant strain and tension (emotion, distress, unhappiness, depression etc)"

Patient: silence…

Doctor: "Would you like me to go on and tell how I think this might be happening…or would you like me to go through some of the other possible causes first."

Patient: "no go on…"

When things get really tough

Sometimes there is profound disagreement over the underlying cause for symptoms and it may be impossible for doctor and patient to agree at all. It is pointless to argue about whose diagnosis is correct - nor is it essential for the doctor to agree or acquiesce to the patient's unscientific explanation so long as sufficient common ground can be developed to make a management plan acceptable to both. The patient's beliefs are often deeply rooted and originate from influences derived from their age, gender, family, culture and socio-economic status. [3]

The most important step is to ask what the 'label' means to the patient.

Doctor: "You sound very unhappy when I suggesting some of your symptoms might be due to depression… I wonder what depression means to you?"

Patient: "It makes me feel that you don't believe me and that you are just fobbing me off…that's always happened in my life…. and I'm really fed up with it!"

Doctor: "Can you tell me more about where that comes from…?"

When patients and doctors explore the meaning of their 'labels', they narrow the gap in understanding which otherwise separates them. The 'label' often holds many potential conscious or unconscious meanings for the patient. [4]

A physical cause has a less threatening basis for both treatment and acceptance. It allows continuing denial from feelings or of facing intractable problems or expressing distress without embarrassment. Physical problems are less likely to be stigmatised or to activate subconscious feelings of inadequacy, fear or guilt about issues.

Rarely there is continuing disagreement over both the nature and the priorities of treatment. It is necessary to go to the lowest common denominator between the doctor and patient - and examine the relationship between them.

Here it is important to look at the underlining beliefs held by the doctor and patient about their respective roles and abilities – being able to explore and define what they expect from each other in terms of both decision-making and responsibility.

What sort of doctor does the patient see them needing? What sorts of decisions are wanted? How should these be made? Who should be responsible for what? What realistic control does either have over symptoms and their causes?

When things are more straightforward

Even if the diagnostic label used by the doctor is relatively straightforward and uncontroversial – it still may not be certain that all things will automatically be acceptable by the time you have finished discussing the various areas related to it during the explanatory phase.

The patient may be able to remember the main details of what's been said and fully understand it yet they may not agree with it's interpretation or impact on their lives. As a result they will not be committed to your plan or suggestions.

Before you able to move on and plan the management of care with the patient there is a crucial phase of ensuring that you both have the same understanding and share mutually common ground so far.

Even if there has no suggestion or clues that there is any disagreement – it is vital at the end of the explanatory phase that you actively seek out reactions and feelings from the patient as to what's said so far. Hence the large arrow on the diagram above - that implies that even in the context of a normal functional consultation there is always a need to check briefly that everything has been accepted and you can move on and start planning management.

You need to actively pursue the patient's belief's, reactions and feelings

Doctor: "I'm not sure how that has left you feeling?" Or...

Doctor: "Do you have any concerns or reservations about what I have said?"

Doctor: "Does that leave you with any questions... or things that you are unclear about?"

Pick up on any verbal and non-verbal cues

Doctor: "You didn't look particularly comfortable when I mentioned we may need to consider medication?"

You also need to relate back to any explanations to previous concerns uncovering from the patient's perspective

Doctor: "I remember you mentioned that you thought your BP might be caused solely through stress - and we may need to look at ways of helping you with this - but I am still concerned about the level of BP that might be occurring in those situations...what do you think?"

Looking at the skills of Planning – as a shared decision making

For the majority of patients decisions about management should be drawn up collaboratively – at least to impart some measure of 'ownership' and responsibility during the forthcoming process of care.

Before you can proceed, it is necessary first to consider a 'starting point' in terms of how much the patient wants to become involved in actual decision-making. It is important to realise this starting point is not necessarily governed by the initial decision they made to seek or avoid information.

It is possible for patients who have not wanted much in the way about the details of a condition – yet they are keen to become involved in deciding which of the possible options is best for them. Equally there are others who are interested to know a lot about what is causing their symptoms but completely happy for a professional to make decisions about what's best in terms of management for them.

Doctor: "Would you like me to go through some of the options we have... or would you like me to tell you what I think is the best course of action..."

Patient: "No, that's fine ...you're the expert!" Or...

Patient: "Yes I would like to look at some of the options...if that's alright"

Doctor: "I remember you mentioned you were keen to continue just using your inhalers more regularly to sort your chest out...but I think that we also need to look at how we might relieve some of your symptoms by allowing your inhalers to work more effectively by adding in a course of steroids tablets"

1) First it is a good idea to start with encouraging the **patient to contribute their thoughts** first and it's useful to be forewarned about potentially strong feelings against a course of action, before rather than after, it has been suggested.

Doctor: "Before I suggest a way... I'd like to hear what you had in mind – or anything you wouldn't be keen to consider?"

Patient: "I've heard a lot about the dangers of surgery and I'm not too keen on being reliant on drugs for the rest of my life. Is there a homeopathic remedy you can recommend?"

2) Next you should **share your own thoughts** about management - this allows patients to understand your own reasoning as well as your difficulties and dilemmas

Doctor: "I can well understand your concerns about medication – but having a Bp of this level makes me think it is unlikely that you will be able to control it by diet and exercise alone. There might be a risk involved if you exercise vigorously in the meantime ...I think the best ways is to.... What do you think?"

Next, you need to provide clear and relevant information about the various approaches and options

3) Continue by **involving the patient by offering choices and making suggestions**…not directives

Doctor: "There are clearly pros and cons to each of these options … what preferences do you have?"

Patient: "Yes I agree – I'm really not sure now"

Doctor: "My suggestion is that we get an expert opinion about your gallstones…and see what this

4) Finally - **actively seek and encourage their reactions, views and acceptability about what is proposed** – and negotiate a mutually acceptable plan

Doctor: "Perhaps we can start with something mild and check to see if there are any problems before going on… Is this acceptable or do you have any other ideas"

In particularly you need to openly explore any concerns or obstacles they foresee in carrying it out. Plans have to built on reality and based within the patient's own life world – not the doctors.

It is necessary to take into account their abilities, beliefs, cultural background, lifestyle, and available support if things are going to work.

It some circumstances it is necessary to look at issues of motivation – and special approaches using skills within motivational counselling are necessary to help change deeply ingrained behaviour.

A suggested minimum is to ask about any foreseeable barriers in completing what has been agreed.

Doctor: "Ok…so we are agreed that the best way forward at this point is for you to keep a diary of your headaches and see if there is any pattern that might help us…rather than take anything on a regular basis…can I check that you are happy with this…or do you see any problems that might prevent this from happening…?"

Closing the session

There are three important functions to complete before finally ending the consultation.

Contracting

This involves agreeing the next steps and responsibilities for both doctor and patient. It might include asking them to phone back after two hours or letting them know you will visit them the next day.

Doctor: "I'll ask the x-ray department to send you and appointment that should be sent by post in next two weeks or so. Can you make an appointment through the receptionist to have blood taken and an ECG performed by the nurse in the next week or so? Will you let me know by telephone if there are any delays or problems?"

Safety-netting

This sets out contingency plans in the eventuality that something goes wrong or unexpected developments occur. No one can guarantee all outcomes and the level of uncertainty needs to be openly discussed earlier in the consultation. Important areas should include: -

- Re-iterate what to expect if things go as expected
- How to recognise when things are not going to plan – either through persistence or recurrence of symptoms or their duration or timing
- Who or how they should seek further help
- Any change this might mean to the original assessment or plan if this happens

Doctor: "Jack should continue to improve over the next 24 hours or so. However, if he starts vomiting again or develops a fever – contact the surgery on the usual number and if necessary you will be transferred to the out-of-hours service. This might mean he has to go to hospital because of the risk of dehydration. Is that Ok?"

Final checking

There should be one final check that the patient is happy not only with the intended plan of management and responsibilities and procedures to follow - but also but with what to do if it things go wrong.

Patient: "That's fine doctor – I'm happy about what you've said and understand what to do"

Suggested Exercises: Explanation and Planning

Review the core communicating skills for this section

- Discovering the patient's starting point
- Maximising recall and understanding by the patient
- Reaching a shared understanding of problems
- Negotiating mutual common ground
- Shared decision-making
- Safety netting & contracting

GP Registrar objectives

- Importance of discovering the patient's starting point
- How much they want to know
- What they already know and want to know
- Avoiding premature explanations and reassurance
- Using skills that that maximises recall and understanding by the patient
- Chunking & checking
- Using clarity and avoiding Jargon
- Using repetition
- Being able to communicate the level of certainty, rationale and risks to patient
- Importance of developing a shared understanding of their problems before planning management through
- Picking up patient's reactions through verbal & non-verbal responses
- Actively asking for reactions
- Reaching mutually common ground where differences exist
- The importance of exploring differences between the doctors and patients 'explanatory frameworks' - and negotiating a mutually acceptable plan and reaching mutually common ground through negotiation.
- The principle of involving and sharing decisions with the patient about management - and negotiating a mutually acceptable plan by
- Discovering the level of desired involvement wanted by the patient
- Offering choices and making suggestions
- Actively asking for contribution
- Closing the interview safely by using appropriate safety-netting and contracting.

Areas for discussion

Giving information

Consider the traditional and modern sources of information and influences on medial topics. How much is a patient's determination to consult an isolated decision?

List the essential information you consider as a doctor you should attempt to get across to the patient who present with a new diagnosis of

- Hypertension
- Diabetes
- Epilepsy
- Osteoarthritis

…or requesting a prescription for

- HRT
- The oral contraceptive pill
- Temazepam

…or requesting a

- PSA test
- Cholesterol level
- Back x-ray

What types of information might involve breaking bad news to patients?

Planning management

- What are the origins of uncertainty in the consultation – and how can doctors minimise risk?
- Discuss the misunderstandings that often occur about the reliability of investigations and screening.
- Brainstorm phrases for making suggestions and offering management options with the aim of involving patients.
- Look at cases from memory of patients that have not complied or adhered to taking treatment or of a management plan. What were the possible reasons?

Difficulties between doctors & patients

Discuss consultations where there have been disagreements about management or where the patient failed to take their treatment or return as directed. What might have been the causes for them?

Watching videos

Look at the video starting from the point of discussing a plan of management

Review the tape bearing in mind the following six aims: -

1) Was an attempt made to discover the patient's need for information as well as their prior knowledge and understanding?
2) Was the information given in chunks that were clear and manageable
3) Was there an attempt to check to see they had understood what was said – and how did you know?
4) Was there any evidence of uncertainty or doubt in the patient – if so – how did they exhibit this?
5) Was there negotiation of differences where they occurred?
6) Was the patient offered involvement in planning final management?
7) Where there was an element of uncertainty – was safety netting and contracting used at the end?

Looking at the whole consultation

1) Was the patient's expectations explored at any stage?
2) Did the management incorporate any earlier views volunteered by the patient about what should be done?

Role-play

1) Role-play the scenario of giving a diagnosis of childhood asthma with a parent and starting them off on a steroid inhaler
2) Role-play a giving a patient the news that there is an abnormality on their CXR that needs referral to a specialist.
3) Role-play a visit to a febrile child with anxious parents the diagnosis of a viral illness, which involves discussing potential diagnostic uncertainty as well as you the doctor using a strategy to minimise risk.
4) Look at the notes of a patient who has recently failed to take treatment or adhere to an expected plan of action. Role-play the explanation and planning part of the consultation to see if the origins of failure can be identified and explained.

Notes for the Trainer when watching videos

1) Do they give information/advice prematurely?
2) Do they try to discover the patient's starting point and tailor information to the needs of the patient?

3) Can they give information clearly at a pace the patient can understand?

4) Do they involve the patient during the process of giving information?

5) Do they involve the patient in possible management by making suggestions and offering options?

6) Is there an attempt to get reactions and feelings to what is discussed?

7) Is there an attempt to discuss and manage uncertainty? (Where relevant)

8) Is the plan or management logical and reasonable in light of evidence-based care?

Watching Videos 6

The objectives of this chapter

- Learning a list of skills and relating them within a structure is not enough
- The suggested guidelines or set of 'rules' when watching videos with your trainer
- The different ways videos can be used to increase learning
- How to analyse problems on your videos
- Common problems that crop up in the consultation

Learning skills using experiential methods

It is not enough to simply learn skills and place them within a structure or model to help you remember them. To transfer skills and make them an enduring part of your future consulting behaviour requires a further additional step that involves the method you use whilst learning them.

New knowledge and skills become incorporated into behaviour only when you use experiential learning methods.[1] This comes from an understanding of Adult Learning theory which emphasises the need for you to try out the things you learn. This is different to previous learning methods you probably experienced during most of your school and medical student years. In short, as mature students, you respond and retain much more when presented with opportunities to get your hands 'dirty'!

The three essential ingredients are

1) The learner needs to be seen consulting (usually on videotape)
2) The learner needs to receive constructive and where necessary corrective feedback from their trainer acting as 'coach'
3) The learner needs to get opportunities to try out alternative skills and solutions, ideally in safety using role-play first and trying them out 'live' and seeing them succeed in future consultations.

Similarly, educational research confirms that new consulting skills and behaviour will only be learnt and retained if you get into regular habits of looking at video consultations and getting constructive feedback. [2]

It is important for you and your trainer to be aware that there are some possible difficulties and dangers whenever this type of experiential learning is used.

Problems watching videos

Because personal communication is closely related to your own individual concept of clinical competence as well as identity and personality, it is all too easy for you to become threatened and defensive when your communication skills come under scrutiny.

Not only are you supposed to have done this right for several years of your professional life, the longer you have been a doctor the further you 'feel you have to fall'.

Most of us have experienced the negative and often unsupportive observations that characterised hospital ward rounds, which leaves you with both unpleasant memories and a natural reluctance to expose yourself once more.

Because of these experiences and perceptions – it is important to watch consultations using a strict set of guidelines that incorporates a code of behaviour between anyone who shows a video and those that watch them. The aim is to prevent awkwardness and defensiveness that gets in the way of learning and change.

The basic guidelines suggested for watching videos with your trainer

This is a suggested method for looking at video consultations on a one-to-one basis.

Agree first whether you are going to look at the whole consultation, a specific part, or use a stop-start approach that are linked to specific aims. (see below)

Before starting the video allow your trainer watching the consultation to 'sink' themselves into your shoes by briefly outlining any important matters of fact. Any relevant information and circumstances should be divulged. This might include previously known information or contact with the patient or factors that might influence how the consultation might be affected (such as surgery being 45 minutes overdue you appearing unsettled because you had only just returned from an emergency visit etc.)

Whilst watching the video it is helpful to write down your observations using a consultation guide that helps to prompt you to consider the objectives and outcomes you are trying to achieve as you go along (a copy is included the end of this manual).

After watching the video - you should start by identifying any difficulties or problems (or successes!) you had noticed in the consultation and try and make an assessment of these. A list can be made at the top of the Consultation Analysis Log including any suggestions added by the trainer. (Again a copy is included at the end of this manual)

Break down each problem into a logical sequence to assess it objectively

Identifying where you were in the consultation when difficulties started to arise on the tape. Rewind and review this part on of the tape if necessary.

Discussing what happened descriptively in the form of a commentary WITHOUT making any judgements or evaluations about how effective it was. (see SET-GO below)

Attempt to identify what you were trying to achieve at this point and compare these with the objectives suggested in the relevant section of the consultation model.

Making suggestions as to how the problem might be approached differently along with which skills might be used to try and achieve this.

Try them out in role-play and focus particularly on the new skills used. Your trainer can offer his own observations and feedback including alternative suggestions for you to try.

Reflect on why the difficulties or problems occurred. Use the Consultation Analysis Log to record where the problem possibly originated in terms of the three broad types of

communication skills – Knowledge, Skills or Attitudes (see below - Content, Process or Perceptual difficulties)

Write down which areas need addressing and identify which skills might work better in similar situations in the future.

What other issues are important when looking at videos?

It is important to develop a trusting and supportive relationship between yourself and your trainer from the beginning. The table below outlines areas of behaviour and feedback that should to be considered.

Supportive climate	Defensive Climate
• Descriptive	• Evaluative
• Direct Observations	• Passing Judgement
• Non-judgemental assessment	• Evaluating as Good or Bad
• Reflecting opinions	• Questioning motives & standards
• Collaborative	• Control
• Mutually defining & solving problems	• Telling them what to do
• Spontaneity	• Strategy
• Straightforwardness	• Control and rigidity
• Flexible response to situations	• Manipulation through tricks or hidden plans
• Empathetic	• Neutrality
• Respect & Understanding	• Indifference
• Accepting	• Detachment
• Becoming involved with learner	• Viewing the learner as an object of study
• Equality	• Superiority
• Recognising worth & contribution of others	• Arousing feelings of inadequacy
• Work mutually together	• Communicating that one is better than the other
• Provisionalism	• Certainty
• Tentativeness	• Dogmatism
• Open-mindedness	• Resists alternatives
• Willingness to explore alternatives	• Proving a point rather than solving a problem

The importance of describing what happens descriptively

The way in which a problem is described is important. Problems need to be described objectively, specifically and accurately rather than reflecting a gut reaction or subjective feeling.

The 'SET-GO' method is a useful and descriptive way of analysing the consultation, which helps prevent unnecessary defensiveness and evaluative responses.

(After Silvermann, Kurtz & Draper)

- What did you **S**ee?
- What **E**lse did you see? (What happened next?)
- What do you **T**hink?
- What **G**oal(s) were you trying to achieve at that point in the consultation?
- Any **O**ffers how where and how to go next?

Different ways of looking at videos

There are three different ways of looking at video consultations depending on the stage and context of the training - or the objectives of the session.

1 Watching complete consultations

Sometimes it is useful to look at the whole of a video consultation – from beginning to end to get a complete feel for how things have gone. This is particularly useful when you are beginning to watch videos at the start of your GP Registrar year.

Strengths: It allows problems to be seen most easily and fully in the context of the whole consultation. Sometimes the source or origin of the problem may not be seen easily by restricting observation only to the part where the difficulties arose. (e.g. difficulty ending a consultation may at first not be seen as being due to a bad start). It is also more likely that you will become aware of additional areas in the consultation that went well to balance up areas that caused difficulties. It is especially important at the beginning of the GP Registrar year, when confidence is only just developing, for your trainer to give balanced feedback about what went well - as well as what didn't.

Weaknesses. Watching videos all the way through takes time with the result that fewer examples of consultation skills will be seen. It is also difficult to remember an accurate description of what was said or what actually occurred within a long consultation. Unless written down verbatim we rely on memory and subjective impressions that risk an evaluative rather than an objective assessment.

2 Looking at specific parts of the consultation

This is a powerful way of focussing attention on the objectives and skills of a particular part of the consultation.

Strengths: Many consultations can be seen relatively quickly and it allows you to focus on the specific aims and skills of each section. It is easier to observe descriptively what happens and to assess difficulties objectively. Role-play is less threatening and more fun since rapid short sections can be looked at and several alternative skills and micro-skills can be tried out quickly as alternatives.

Weaknesses. Focusing on a selected area of the consultation can provoke defensiveness in some of us. If the same difficulties occur repeatedly in many videos there is a danger of the deficiencies becoming 'rubbed in'. It is important to balance problems equally with success within each section if possible. Alternatively the use of 'prepared' tapes that highlight specific problems or using your trainer's own consultations as good or bad examples can help lessen the effect of continually focusing on the weaknesses of the GP Registrar.

Finally, sometimes the source or origin of the problem may not be easily seen without seeing the whole consultation. (See watching complete consultations above).

3 Stop - Start methods of looking at the consultation

This is a good way of looking at the whole or perhaps large parts of the consultation without some of its weaknesses. Either an agreement is made to stop the tape after two or three minutes – irrespective of where it has got to – or you can hold and control the pause button and stop it where you see something interesting and worth looking at.

Strengths: The whole consultation can be seen if needed. Breaking it up into time intervals is a good way of looking at problems that may arise. Again it allows you to focus on the specific skills of each section whilst observing them descriptively and objectively. Again, role-play is less threatening and fun since rapid short sections can be looked at and several alternative skills and their associated micro-skills can be tried out quickly as alternatives.

Weaknesses. Watching the whole video like this can take a very long time. It can also provoke defensiveness if only problems and difficulties are focussed on. This is partly prevented if you have overall control over the stop-start sequence.

Analysing your video using the three types of communication skills

There are three broad types of communication skills, which run in parallel during the consultation. The success of the consultation depends on all three being addressed adequately.[3]

Content Skills

This is the clinical knowledge learnt and used by doctors. It is the information they gather when taking a history and the knowledge they give during treatment and giving explanations to patients.

Process Skills

This is how knowledge is communicated with patients as well as how doctors go about discovering information from the patient. It involves both the verbal and non-verbal skills they use to do this including rapport-building skills to develop relationships with patients. It is also how well doctors organise and structure communication. Traditionally, process skills are thought of as 'communication skills' proper - which is the main focus for a course such as this.

Perceptual Skills

This constitutes what doctors think and the emotions felt by them during the process of problem solving and clinical reasoning. Perceptual skills are influenced by feelings and thoughts about the patient and about how doctors view the illnesses they see. It also involves issues about doctors' own self-confidence, biases, and attitudes - and their day-to-day stresses and personal distractions. Perceptual skills therefore are often referred to as being 'Attitudinal'.

How they relate to each other

Consultations will go wrong when there are one or more weaknesses within each of these three broad types of communication. They are interrelated and reliant on each other.

There is little point you having first class knowledge (content skills) if you can't find out why patients come to see you. Equally, if you can't communicate a plan of action that can be clearly understood by the patient (communication or process skills) then all your hard work and knowledge will be wasted.
Irritation with a patient's personality (attitudinal or perceptual skills) will make you blind as a doctor to important non-verbal cues (communication or process skills) just as physical attraction to a patient (attitudinal or perceptual skills) might prevent you from asking sensitive questions about sexual matters (knowledge or content skills) that are vital in making a diagnosis.
It is therefore useful when looking at videos to try and categorise whether a problem is related to one or more areas of clinical knowledge, communication skills or attitudinal origins.

Common consultation Problems

It is useful at this stage to mention a number of common recurring problems that appear repeatedly in consultations.

Content

1) The doctor does not take an accurate clinical history
2) The doctor does no elicit the patient's illness framework and takes a doctor-centred approach throughout the consultation

Process

1) The doctor doesn't listen and interrupts with early closed questions
2) The doctor doesn't discover why the patient has come or feels he hasn't understood his agenda
3) Problems of structuring information and controlling the consultation; the patient talks all the time; the doctor has difficulty bringing the consultation to an end
4) The consultation appears aimless, long-winded and the doctor appears to get lost

Perceptual

1) The doctor does not like the patient
2) The doctor shows little empathetic skills or rapport building skills
3) The doctor makes erroneous assumptions about or during the consultation
4) There is conflict (usually about management) during the interview
5) You and your trainer may find this list useful to refer to when problems arise without clear explanations. Hopefully they may direct you to cause(s) and skills that resolve them.

[1] Knowles MS: (1984) The Adult Learner – a neglected species. Gulf, Houston, Texas.
[2] Maguire et al (1978) The value of feedback in teaching interviewing skills to medical students. Psychological med. (8) 695-704.
[3] Kurtz, Silvermann & Draper (1988) Teaching & learning communication skills in medicine (1) 18-19

Common problems

7

We only have to ask doctors and patients about the problems they experience - if proof is required that we need to learn consultation skills.

Doctors often say they have difficulty in controlling the consultation

If you ask doctors which part of the consultation gives them most problems – they most often complain they are unable to close or resolve complaints. Patients seem to keep bringing up new problems – and worse still…. after ten minutes or so dealing with their arthritis they come out with...

"...by the way Dr...I've got a breast lump"

The evidence is that in fact the problem is at the beginning and the reason is that doctors get off to a bad start and don't find out what's on the patient's agenda first.

One of the main reasons is that doctors tend to interrupt the flow of information very early on in the consultation. It has been shown that on average a doctor interrupts the patient after only twenty-three seconds. Only twenty-three per cent of patients complete their opening statement, which if left alone would mostly last only sixty seconds or so. Once the doctor 'takes the floor' only four per cent of patients are allowed to continue and finish their opening statement.

Even if we do get off to a good start, doctors can be seen to commonly make other serious assumptions early on in the consultation.

Frequently the doctor assumes the first complaint is the most important and only complaint, when in fact the patient wants to discuss between two to four issues. Furthermore there is no relation between order of presentation and order of importance. Therefore the doctor cannot make assumptions and needs to ask.

When doctors are following up patients after recent interval or with a recurring or chronic complaint, they often assume the current consultation will be a continuation of last one. Often the doctor can be seen omitting any of the usual greetings or opening question - and go straight into the last week's problems *"…and how are you getting on with those pills?"*

Later on after spending a lot of time on this – the patient informs them that they had in fact brought another new problem and hadn't intended taking time with the previous consultation's topic.

The solution is to screen for other problems after the patient's opening statement at the beginning of the consultation rather than wait for things to come up later on. Revealing an agenda at the beginning allows the doctor to negotiate what can and can't be addressed and allocate time more efficiently and appropriately.

Large percentages of doctors say consultations are difficult.

Over a third of doctors label a quarter of consultations - and ten per cent of doctors label half or more of consultations difficult to deal with - or dysfunctional.

The single most important cause of dysfunctional consultations is the failure of doctors to discover the reason(s) for why patients see them. Berne & Long.

If you interview doctors and patients after consultations - there are considerable differences in their perceptions over what occurred.

- On average doctors and patients disagreed over half the time as to which of the problems was the main complaint. This was better at six per cent when physical complaints were presented – but a lot worse at seventy-six per cent when psychosocial issues were presented.
- On average only fifty per cent of the total number of problems were discovered by doctors.

It is important to look at the reasons for this.

Once again it is partly due to the doctor interrupting the patient early on in the consultation. Frustratingly for the sake of a few seconds more, they would then hear information that would completely re-direct their clinical reasoning or problem solving processes.

There are perhaps two main reasons why early interruptions occur.

1) Some of it is to do with the constraint of time – and with it the relentless pressure to diagnose, treat and move on.
2) More fundamentally it is probably more to do with the way that doctors make a diagnosis. As doctors become more experienced they use a process often described as a 'stab in the dark' approach. This where doctors start to increasingly rely on a 'pattern of recognition' of what they see to make a diagnosis. As soon as feel they have enough evidence - they interrupt to test out their hunch. The trouble is that they do this too soon and as a result get the diagnosis wrong first time more than they get it right.

This has two important effects on the consultation and patient. It ends up making the consultation less efficient and longer because the doctor is forced to stop and re-start the consultation again. The idea that jumping in early might shorten the consultation is thwarted and in fact reversed.

Secondly, and perhaps more seriously – the patient then becomes passive from that point onwards. They now defer to the doctor even if they sense that the line of questioning is irrelevant often assuming the doctor knows something that they don't. If they do bring up the information they had hoped - they tend to do this at the end when the doctor has had their say.

Another important reason why doctors face dysfunctional consultations is because they automatically use a disease or doctor-centred approach to the consultation. They are trained to selectively explore symptoms of disease.

Yet research shows that in many situations this is not the case. Over fifty per cent of patients with chest pain do not have a clinical diagnosis after six months of investigation and review - (missed diagnoses would have come to light in this time) which is similar for many other presentations that include abdominal pain, headache and tiredness.

Doctors are trained to either 'rule-in disease - or rule-out' disease. Making a diagnosis traditionally rests on using a string of closed questions that interrogate the patient's presenting symptoms or organ systems - otherwise known as the functional enquiry. All of us have been trained to use Macleod's system of assessing a pain for instance. When presented with a pain we instinctively feel forced to enquire along disease orientated lines with "…is it sharp or is it dull, does it hurt on breathing or walking etc, etc …"

In short we impulsively use closed questioning techniques at the expense of open type of questions to pursue objective facts. However open questions are a much more efficient and effective way to gain information. You wouldn't ask a person who has just been on holiday to answer a long list of pursuits they might possibly have done. Instead you ask them to tell you in their own words what they did - and in a few minutes you have a clear and accurate picture of their experience.

Relying on closed questions automatically puts doctors in control - but puts patients in a position to which they are only able to passively answer back.

The question of poor compliance

All of us are aware that compliance is poor after patients are given advice. On average fifty per cent of patients do not take medicine properly – with as much as much as £700 million lost to NHS each year. Research shows that only twenty to thirty per cent follow advice with medication that is given for acute illness; thirty to forty per cent for medication for prevention (think of cost from waste when prescribing Statins!); and fifty per cent with medication that is given for chronic conditions. The best is seventy-two per cent for diet.

When compliance is looked at in more detail there is in fact a much bigger variation (between ten and ninety per cent) between doctors. Compliance appears to depend on the consulting style and techniques used by the doctor. Doctors that use certain communication skills have much higher compliance rates.

First, they can be seen to be giving more information in a more ordered and clearer form. They use simple communication giving techniques – that reinforce information and improve recall by the patient.

Perhaps the one important factor is clarity - giving information in a clear and unambiguous way – allowing the patient to understand what's said. They either omit or explain medical terms or jargon.

They can be seen to summarise and repeat important information. Simply asking a patient to restate what they have understood in their own words increases recall by up to thirty per cent.

Chunking & checking is a powerful technique for delivering information. The aim is to give information in repeated small chunks with intervening periods of silence. This allows the patient to absorb information at their pace as well as acknowledge through their no-verbals they understand and agree with it. The problem is the doctor is often on the fourth sentence – whilst patient is still trying to make sense of the first!

Another problem is that most of us have been taught that there is little point in giving patients much information because they can't remember it.

"Pts don't remember much of what is said..." .....furthermore

"The more you tell them the less they remember"

More recent research suggests that patient do in fact recall much more of what is said than we first thought. Patients probably forget less than ten per cent of information.

Understanding low compliance rates is more to do with understanding the difference between recall, understanding and interpretation. Recall and compliance are not the same thing.

It's one thing to remember and even understand what's said but another if they don't agree with it - they tend not to carry out your advice.

It is therefore vital to explore the patient's own viewpoint – or explanatory framework - first and then try to reach mutually understood ground through negotiation.

This is known as reaching a **Shared understanding.**

Research shows that the patients who automatically comply with doctor's advice - tend to have similar ideas and expectations as the doctor before seeing them. They therefore hear the information or advice they wanted and expected.

Consultations go wrong where there is a prior difference between doctors and patient's explanatory frameworks or their explanation, understanding and expectations about a problem. The trouble is that doctors rarely explore the patient's views beforehand – which is despite patients giving them the chance to do so.

Over eight five per cent of patients try to become actively involved in the consultation. However this is often done in covert or indirect ways. Often this leaks out by patients seeking

clarification, expressing doubts or rationale for doctor's opinions or through their non-verbal behaviour.

Sadly of those that do attempt involvement – only seven per cent of doctors take up their concerns and become actively engaged in conversation, thirteen per cent of doctors listen passively with no comment or exchange of views and the majority - eighty per cent - make no effort to listen or even deliberately interrupt the patient to stop them.

Patients often say they are unhappy with the way doctors communicate with them.

Traditionally the main aim of doctors is to interpret and classify the patient's symptoms in terms of disease and pathology, whereas the patient is hoping their symptoms will be seen as part of their life-world - along with the way this personally affects them.

All surveys show that patients prefer a patient-centred approach. The more patient-centred the consultation – the more they are satisfied. However, doctors persist in pursuing a doctor-centred approach partly through a fear of loosing control and possibly encouraging patients to make even more demands.

However, research consistently shows that patient satisfaction is linked directly to major positive outcomes within the consultation that include compliance, disclosure and even reduced litigation.

At the same time the same research shows that patients do not in fact need to get what they wanted to remain satisfied. They simply need to feel have their ideas, concerns and expectations explored and their opinions considered – and therefore the doctor doesn't have to give in to their demands to keep them happy and satisfied.

Patients complain that they don't receive enough or the right type of information

Doctors are criticised in no less than 4 areas: -

1) The amount of information
2) The type of information
3) The timing and appropriateness
4) The use of medical terms or Jargon

The amount

Doctors often underestimate the amount of time they spend giving information by a large factor. Most doctors only devote ten percent of consultation time to giving information when they personally believe they use fifty percent or more of total time.

Whilst most patients want more information and time devoted to it - twenty percent don't and do less well if overloaded. It is therefore important to pitch information at the right level for each individual. The problem is that it is difficult to know beforehand which patients want more information and which don't. They need to be asked for their own each individual starting point.

The type

Again there is a difference in perception between doctors and patients as to what type of information is most useful. Doctors tend to feel that treatment and management issues are paramount. Patients – on the other hand – are equally if not more interested in causes of symptoms, their seriousness, the immediate and long-term effects on them and their prognosis. Yet these are the areas that are often left out by doctor even when seeing patients over a period of time.

Patients have been shown to ask a stereotyped list of questions each time they try to make sense of what is happening to them when changes in health occur.

What has happened?

Why now?

Why me?

What ... if I don something about it?

What... if I do something about it?

Doctors also make assumptions based on prejudices and perceptions about the detail and type of information needed by individuals.

At first sight, explaining the diagnosis of diabetes to a university lecturer and a manual labourer would be approached in a different way according to intellect.

However the lecturer may know very little about practical things – whilst understanding some of the metabolic effects excess sugar has. The labourer, on the other hand, may have practical experience because his father had diabetes and ultimately an amputation, and his sister has recently gone blind with it.

Good communicators pitch information at the right level finding the individual's starting point. This means asking them - not only how much they want to know - but what they know and want to know. It also helps doctors to use the limited time they have available by allowing them to concentrate on filling in the gaps.

Even when patients don't possess factual knowledge or practical experience - it is useful to know and 'iron out' any misunderstandings or distortions about illnesses early on.

Timing

Doctors tend to give premature information and reassurance. Sometimes when faced with the scenario of being asked *"Do you think little Jenny needs antibiotics for her cough…doctor?"* most of us will immediately react to decline - especially when Jenny appears to look reasonably well. However shortly afterwards - when we find a temperature and associated localised chest signs – we are forced into an embarrassing and humiliating retreat.

We are also often found 'guilty' of giving reassurance too soon about diagnoses and outcomes especially when dealing with serious or terminal illnesses - leading to us eventually being found out and loosing the patient's trust and respect.

Jargon

Doctors use medical terms or jargon in half of consultations. This tends to confuse and frustrate patients - leading to reduced understanding and compliance. Amazingly they appear to tolerate it - possibly for fear of looking stupid or ungrateful. Yet their understanding of medical terms can sometimes lead to disastrous results. In one study fifty two per cent of patients thought medication for oedema caused water retention and stopped them.

Sadly, using jargon is often used as a device by doctors to control information and end consultations.

Doctors are facing increasing levels of Medico-legal problems

The medical defence unions cite two main causes for litigation - poor communication skills and clinical errors.

Contrary to what might be expected the majority of these – forty five per cent - are due to problem with communication whist only twenty per cent of litigation involves purely clinical errors. More than eighty per cent of cases involve difficulties with communication in some form or another.

In the USA there is now a seven per cent reduction in defence fees for those who attend a consultation course. Perhaps the same will happen in Britain!

Summative Assessment and the MRCGP

8

Introduction

Passing Summative assessment is mandatory if you want to carry on practice as an independent practitioner at the end of your GP Registrar year. For many, passing the MRCGP is a logical extension for all the effort put into the training year and is seen by many as the best opportunity to take and pass at least some of its current modules - before getting 'bogged' down with professional life and its various pressures.

Although videoing ourselves consulting in the future will hopefully become part of continuing professional development (if not part of our assessment) – the effort required and the time for support and critical analysis will never be better than during the GP Registrar year. So do it if you can.

There is now a single pathway for marking videos. If your video is submitted for the MRCGP examination and passes – it will automatically qualify you as passing at the Summative Assessment level of marking. No more assessment.

However, if it is not successful, your video will then be forwarded on for a second inspection by different assessors, looking to mark your video at the Summative Assessment level.

Marking schedules

The standards and marking schedules are naturally different for Summative assessment and the MRCGP.

Summative assessment

Summative assessment uses a system of first and second level assessors. After passing a simple quality check for sound and video quality (see below) - your video is submitted to two 'first level' examiners who see your tape independently of each other.

They have to mark a minimum of six videos each using the marking schedule at the end of this manual. By the end - they have to decide whether your tape has passed the criteria acceptably - or gives either of them sufficient doubt for it to be 'referred' on to two more experienced 'second level' examiners.

The second level assessors sit together and decide whether the standard seen on the referred consultations represent acceptable and safe practice - or should be referred onto a national panel of experts, who are the last and final stage and ultimately make the decision about whether you pass or fail this part of Summative Assessment.

Between 20-30% of tapes are referred from first to second level assessors - whereas only 1-2 % are finally referred on from the second level assessors to the national panel. However, most referred on from the second to the final stage - will fail overall.

Sound and visual quality

Unfortunately, some videos are sent back even before they can be assessed - usually because they fail basic sound and visual quality tests.

A directional microphone attached to the camcorder is rarely satisfactory. Make sure you use a desk microphone and it is placed away from printers, air vents and other interfering noise. If you cannot hear both yourself and the patient at normal sound volumes at playback - than sound quality is not likely to be adequate. Even more common – make sure your microphone is switched on!

Your camcorder must possess a time and date counter - fuzzy clocks in the distance are no longer acceptable. Make sure both you and the patient can be seen in the picture – with ideally both faces being visible at least from one side.

All intimate or potentially embarrassing examinations should take place away from direct view. This doesn't mean undressing children or hiding male chests but it does mean revealing most females below the neckline and males below the beltline – other than perhaps bare legs. Any discussion must be audible and taped whilst examination is taking place out of view.

What contributes to failing candidates at Summative Assessment?

1. The problem is not discovered or defined well enough
2. Taking an inadequate (or unsafe) clinical history
    - The candidate makes early assumptions and a wrong diagnosis
    - Important symptom characteristics such as onset, severity or duration are not assessed or considered
    - Important 'negatives' are not asked or considered
    - The candidate shows they consistently have difficulty recognising common general practice problems and presentations
3. Examination is inadequate
    - A basic minimum of examination necessary to rule our serious disease is omitted or not mentioned
    - The log fails to indicate and explain what and why certain examinations have taken place
4. The candidate consistently appears insensitive or blind to the patient's feelings and wishes
5. The candidate consistently show they have poor problem solving skills – showing they are unable to formulate simple and safe manageable plans
6. The range of conditions seen on the tape is neither deep nor wide enough.
    - The tape needs to show at least one child and both sexes as well as show consultations of at least moderate difficulty for the assessors to be confident you can handle both a wide range of patients and problems
7. The log is nothing other than a commentary and fails to show any understanding or reasoning behind the patient's presentation, the candidates actions and behaviour nor any important and likely consequences for the doctor or patient in the future.

The MRCGP

There are now many good books that help candidates pass the MRCGP video module so this manual will therefore not spend too much time reviewing these or their tips here.

The emphasis is different from Summative assessment – with very much more weight placed on the quality of the doctor-patient relationship – with most candidates failing as a result of not involving the patient and using patient centeredness throughout both the information gathering and explanation and planning stages. The marking schedule is also included at the end of the manual.

The framework used in the Membership examination to evaluate competence in consulting skills - consist of five broad areas:

- Discover the reason for the patient's attendance
- Define the clinical problem(s)
- Explain the problem(s) to the patient
- Address the patient's problem(s)
- Make effective use of the consultation

1. Discover the reasons for a patient's attendance

ELICIT THE PATIENT'S ACCOUNT OF SYMPTOM(S) WHICH MADE THEM PRESENT TO THE DOCTOR

- The doctor encourages the patient's contribution at appropriate points in the consultation
- The doctor responds to cues

OBTAIN RELEVANT ITEMS OF SOCIAL AND OCCUPATIONAL CIRCUMSTANCES

- The doctor elicits appropriate details to place the complaint(s) in a social and psychological context

EXPLORE THE PATIENT'S HEALTH UNDERSTANDING

- The doctor takes the patient's health understanding into account

2. Define the clinical problem(s)

OBTAIN ADDITIONAL INFORMATION ABOUT SYMPTOMS AND DETAILS OF MEDICAL HISTORY

- The doctor obtains sufficient information for no serious condition to be missed

ASSESS THE CONDITION OF THE PATIENT BY APPROPRIATE PHYSICAL OR MENTAL EXAMINATION

- The doctor chooses an examination, which is likely to confirm or disprove hypotheses

MAKE A WORKING DIAGNOSIS

- The doctor appears to make a clinically appropriate working diagnosis

3. Explain the problem(s) to the patient

SHARE THE FINDINGS WITH THE PATIENT

- The doctor explains the diagnosis, management and effects of treatment

TAILOR THE EXPLANATION TO THE PATIENT

- The doctor explains in language appropriate to the patient
- The doctor's explanation takes account of some or all of the patient's elicited beliefs

ENSURE THAT THE EXPLANATION IS UNDERSTOOD AND ACCEPTED BY THE PATIENT

- The doctor seeks to confirm the patient's understanding

4. Address the patient's problem(s)

CHOOSE AN APPROPRIATE FORM OF MANAGEMENT

- The doctor's management plan is appropriate for the working diagnosis, reflecting a good understanding of modern accepted medical practice

INVOLVE THE PATIENT IN THE MANAGEMENT PLAN TO THE APPROPRIATE EXTENT

- The doctor shares management options with the patient

5. **Make effective use of the consultation**

MAKE EFFICIENT USE OF RESOURCES

- The doctor's prescribing behaviour is appropriate

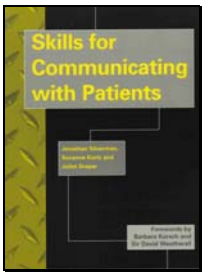
ESTABLISH A RELATIONSHIP WITH THE PATIENT

- The patient and doctor appear to have established a rapport

Bibliography

9

ESSENTIAL READING



Skills for Communicating with Patients
Silvermann, Kurtz & Draper Radcliffe Medical Press
ISBN 1 85775 189 2

RECOMMENDED

Thinking about patients
David Misselbrook Petroc Press ISBN 1 900603 49 7

Challenges & Solutions in patient-Centered care
Brown, Stewart Weston Radcliffe Medical Press ISBN 1 8577 598 69

Narrative-based Primary Care – a practical guide
John Launer Radcliffe Medical Press ISBN 1 85775 539 1

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What are you feeling, Doctor
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Roger Neighbour Petroc Press ISBN 1 900603 95 0

Family Medicine
Ian McWhinney Oxford University Press ISBN 0 19 505986 7

The Medical Interview: The Three-Function Approach
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