

The medical interview

Good communication between doctor and patient forms the basis for excellent patient care and the clinical consultation lies at the heart of medical practice. Good communication skills encompass more than the personality traits of individual doctors – they form an essential core competence for medical practitioners. In essence, good communication skills produce more effective consultations and, together with medical knowledge and physical examination skills, lead to better diagnostic reasoning and therapeutic intervention. The term ‘communication skills’, when applied to medical practice, describes a set of specific skills that can be taught, learned and assessed. A large evidence base shows that health outcomes for patients and both patient and doctor satisfaction within the therapeutic relationship are enhanced by good communication skills.

In this chapter the medical interview as a whole will be considered and then the way in which communication skills should be approached in different types of assessment encountered by students and trainees is reviewed.

There are a number of different models for learning communication skills in use throughout the world. They are generally similar and all emphasise the importance of patient-centred interview methods. This chapter is based on the Calgary–Cambridge model (Fig. 1.1) which has been widely adopted in Europe and the USA and with which the authors are familiar as a means of teaching and learning and as a framework for assessment (Silverman et al. 2005). Like all clinical skills, communication skills can only be acquired by experiential learning. This may take the form of small group learning with role play, the use of actors in simulated learning environments or, for more experienced learners, in recorded real consultations with subsequent feedback.

Effective consultation

Effective consultations are patient-centred and efficient, taking place within the time and other practical constraints that exist in everyday medical practice. The use of specific communication skills together with a structured approach to the medical interview can enhance this process. Important communication skills can be considered in three categories: content, process and perceptual skills (see Table 1.1); these mirror the essential knowledge, skills and attitudes required for good medical practice. These skills are closely interrelated so that, for example, effective use of process skills can improve the accuracy of information gathered from the patient, thus enhancing the content skills used subsequently in the consultation.

Structure

Providing structure to the consultation is one of the most important features of effective consultation. Process skills should be used to develop a structure that is responsive to the patient and flexible for different consultations. Six groups of skills can be identified and each will be considered in the sections that follow.

Sequential in the consultation:

- initiating the session
- gathering information (including from physical examination)
- explanation and planning
- closing the session

Throughout the consultation:

- organisation
- relationship building

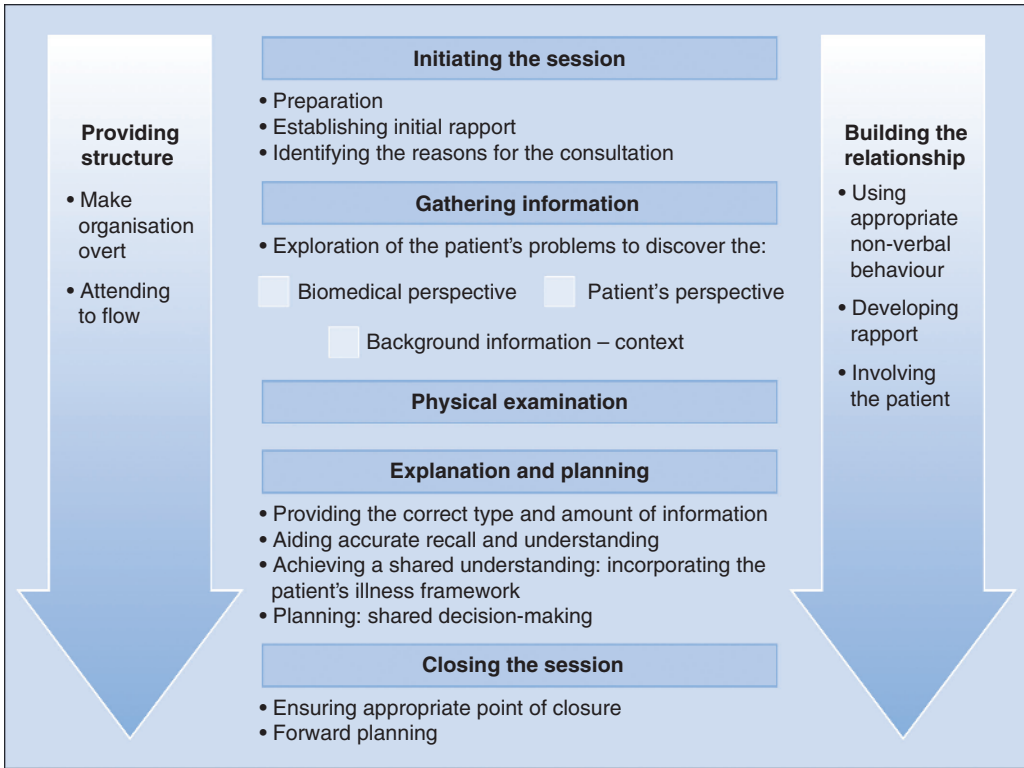


Figure 1.1 The Calgary–Cambridge Guide. Source: Kurtz, S. et al. (2005) *Teaching and Learning Communication Skills in Medicine*, 2nd edn. Oxford: Radcliffe Publishing.

Table 1.1 Categories of communication skills	
Skill	Examples
Content skills <i>What the doctor communicates</i>	Knowledge-based: appropriate questions and responses; accurate information gathering and explanation to patient; clear discussion of investigation and treatments based on knowledge
Process skills <i>How the doctor communicates</i>	Skills-based: verbal and non-verbal communication skills; relationship building; organising and structuring the interview
Perceptual skills <i>What the doctor is thinking</i>	Attitude-based: clinical reasoning and problem-solving skills; attitudes towards the patient; feelings and thoughts about the patient; awareness of internal biases

Initiating the session

The initial part of a consultation is essential to form the basis for relationship building and to set objectives for

the rest of the interview. Before meeting a patient, the doctor should prepare by focusing him- or herself, trying to avoid distractions and reviewing any available information such as previous notes or referral letters.

**Initiating the session**

Establish rapport: greet the patient, confirm their name, introduce yourself and explain your role, attend to the patient's comfort.

Identify the reason for the consultation: use an appropriate opening question, listen to the patient, confirm the problem and screen for any other issues that the patient may wish to discuss.

Confirm an agenda for the consultation.

Gathering information

An accurate clinical history provides about 80% of the information required to make a diagnosis. Traditionally, history-taking focused on questions related to the biomedical aspects of the patient's problems. Recent evidence suggests that better outcomes are obtained by including the patient's perspective of their illness and by taking this into account in subsequent parts of the consultation. The objectives for gathering information should therefore include exploring the history from both the biomedical and patient perspectives, checking that the information gathered is complete and ensuring that the patient feels that the doctor is listening to them.

Further information is gathered from the physical examination. Establishment of a good rapport during the first part of the consultation will facilitate communication during the examination. An appropriate chaperone should be present during the physical examination.

**Gathering information**

Ask the patient to tell their own story.

Listen attentively: do not interrupt; leave the patient time and space to think about what they are saying.

Use open and closed questions: clarify issues in the history; use clear, concise and easily understood questions; move from open to closed questions then back again.

Use verbal and non-verbal facilitation: silences, repetition, paraphrasing.

Pick up on patient's verbal and non-verbal clues: acknowledge them by checking.

Summarise at intervals: verify your understanding; allow the patient to correct or add to the history.

Encourage the patient to express their feelings: actively seek their ideas, concerns and expectations.

**Physical examination**

Ask permission: gain the patient's consent for examination.

Ensure that the patient is comfortable: position them adequately for the examination; if doing a full examination, cover parts of the body not being examined actively.

Be clear and precise: explain what you are going to do in advance.

Be aware: the patient may be embarrassed or in pain.

Explanation and planning

Explanation and planning is crucially important to the effective consultation. Establishment of a management plan jointly between the doctor and the patient has important positive effects on patient recall, understanding of their condition, adherence to treatment and overall satisfaction. Patient expectations have changed and many wish to be more

**Explanation and planning**

Avoid jargon: use clear concise language; explain any medical terminology.

Find out what the patient knows: establish prior knowledge; find out how much they wish to know at this stage.

'Chunk and check': provide information in small amounts and check understanding; use this to assess how to proceed.

Organise explanation: develop a logical sequence; categorise information; repeat and summarise; signpost what is coming next; use diagrams or charts, written information or instructions.

Relate the information to the patient's perspective.

Respond to patient's cues: verbal and non-verbal; allow patient to ask questions or clarify information.

Involve the patient: share thoughts; reveal rationale for opinions; offer your opinion of what is going on and name it where possible; explore management options; take the patient's lifestyle and cultural background into account in the discussion.

Negotiate a mutually agreeable action plan: check that this meets the patient's expectations and addresses their concerns.

involved in decision-making about investigation and treatment options. The goals of this part of the consultation are thus to gauge the amount and type of information required by each individual patient, to provide information in a way that the patient can remember and understand and which takes their perspectives into account, to arrive at a shared understanding of the problem and to engage the patient in planning the next moves.

Closing the session

Closing the interview allows the doctor to summarise and clarify the plans that have been made and what the next steps will be. It is also important to ensure that contingency plans are in place in case of unexpected

events and that the patient is clear about follow-up arrangements. Continuing to foster the doctor–patient relationship in this way has positive effects on adherence to treatment and health outcomes.

Two essential parts of effective consultation skills run throughout the interview – organisation and relationship building. The way in which these two are used is shown in Table 1.2.

Organisation allows a flexible but ordered and logical process to occur within an appropriate time-frame. It encourages patient participation and collaboration and facilitates accurate information gathering.

Building a relationship with the patient involves a number of communication skills that enable the doctor to establish rapport and trust between themselves and the patient. It maximises the chances of accurate information gathering, explanation and planning and can form part of the development of a continuing relationship over time. It is vital to patient and doctor satisfaction with the consultation process.



Closing the session

Summarise: review the consultation and clarify the plan of action; make a contract with the patient about the next steps.

Describe contingency plans: explain any possible unexpected outcomes; how and when to seek help.

Final check: ensure that the patient agrees and has no further questions.

Special circumstances

Certain circumstances demand a special approach to communication skills, such as breaking bad news, dealing with cultural diversity, using an interpreter,

Table 1.2 Skills for organising the consultation and building the relationship

Organising the consultation		Building the relationship	
Summarising	Summarise the end of a specific line of enquiry; confirm your understanding; allow patient to correct; order information; reflect on what to do next.	Non-verbal communication	Includes eye contact, facial expression, posture, proximity, body movement, touch; use of time, your appearance, manner; the environment.
Signposting	Structure the interview overtly; draw attention to what you are about to say; introduce summaries; help patient to understand where the interview is going; ask permission to move on through the interview.	Rapport	Accept patient's views; empathise to show understanding of patient's views and feelings; support by expressing concern, willingness to help, acknowledge efforts to cope; be sensitive towards embarrassing or difficult issues.
Sequencing	Maintain a logical sequence to the interview; use flexible but ordered organisation by signposting and summarising.	Involve the patient	Share your thoughts to encourage patient interaction; explain your rationale for doing things; explain your actions during the physical examination.
Timing	Pace the interview; use other skills to achieve good timing.		

Breaking bad news

Prepare: ensure you have all the clinical details and know the facts; set aside enough time; encourage the patient to bring a relative or friend.

Start the session: review what has happened so far; assess the patient's state of mind; find out what they know and what they are thinking.

Share the information: warn the patient that the news is not good; give the information clearly and in small amounts; relate to the patient's perspective; do not overwhelm with information in the first instance; check repeatedly that the patient understands.

Be sensitive: respond to the patient's emotions – tears, anger, denial; allow time for silences and questions and respond to them honestly; gauge the patient's wishes for information and respond accordingly; be empathic and concerned; check the patient's understanding of what you have said and elicit their concerns and understanding of the situation; do not be afraid to show your own emotions.

Make a plan: explain what will happen next; give hope but be realistic; confirm your role as a partner in care.

Closure: summarise and check the patient's understanding; respond to additional questions; check the patient's support systems and offer to speak to family if requested; make an early follow-up appointment.

and consultation with the elderly, with mentally ill patients or the parents of a sick child. In essence, the core communication skills described here form the basis for any of the more difficult communication skills scenarios. Complex situations require the doctor to use basic skills to a higher level. Preparation and planning, listening to the patient, delivering information in small amounts with regular checking and allowing time for information to be assimilated and for questioning are paramount. Closure is also important, ensuring the patient knows what is happening and is clear about the next steps.

Assessment of communication skills

Clinical competence is assessed at all levels of medical education. Communication skills are usually

Approach to communication skills assessment

Past papers: the format of the examination should be available for review; look at the communication skills stations; familiarise yourself with the format; are the process and content components weighted and, if so, how?

Be prepared: obtain as much information as possible in advance of the assessment; how long are the stations? Is the station simply an observed communication scenario or is a structured viva involved? In some examinations the clinical scenario is available in advance of the examination to allow preparation of content – if so, read it carefully and be certain of the medical facts.

Read the instructions: in most summative assessments the scenario is presented at the station with a few minutes' reading time. Read the scenario carefully. Think about the content as well as the process skills.

Be clear about the task: are you required to take a history, to give information, gain consent for a procedure, talk to a relative or colleague?

Make a plan: before you enter the station, have a clear plan as to how you will approach the consultation and what you wish to achieve.

Think about what you might encounter: communication skills assessments usually use simulated patients who may respond in a number of ways. For example, how will you deal with an emotional patient, a non-communicative patient or an angry response to breaking bad news?

Listen to the examiner: if you are asked to present and discuss the case, listen carefully to the examiner and present the salient features in a clear and logical manner.

assessed in undergraduate examinations by stations in Objective Structured Clinical Examinations (OSCEs). More varied assessments take place for postgraduates, including stations in the Royal College of Physicians MRCP Part 3 examination (Practical Assessment of Clinical Examination Skills; PACES) and mini-CEX assessments as part of ongoing workplace-based assessments for trainees. Students and trainees attempting these assessments should have been through appropriate communication skills

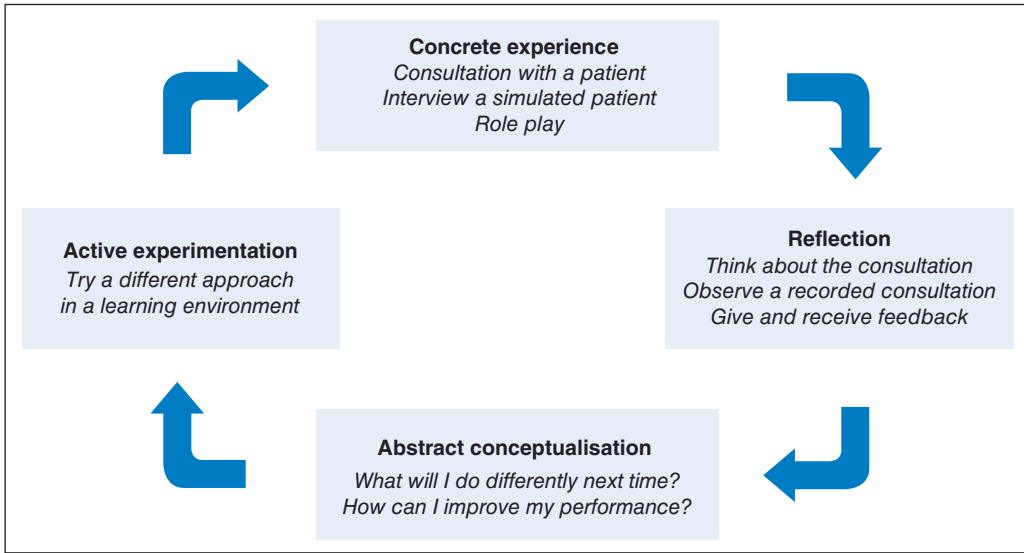


Figure 1.2 Application of the Experiential Learning Cycle to learning communication skills. The learning process may begin with any of the four types of experience. The cycle enables the learner to build on existing knowledge and skills, to take responsibility for their own progress and to use real-life clinical and simulated encounters to promote further learning. Source: Kolb, D.A. (1984) *Experiential Learning: Experience as the Source of Learning and Development*. Englewood Cliffs, NJ: Prentice Hall.

experiential learning programmes allowing them to develop skills in simulated environments and practise them in clinical settings (Fig. 1.2). Whatever the assessment format, a number of factors should be addressed.

 **REFERENCE**

Silverman, J., Kurtz, S. and Draper, J. (2005) *Skills for Communicating with Patients*, 2nd edn. Oxford: Radcliffe Publishing.