Communication Skills and Medical Interviewing (W1)

Communication Skills and Medical Interviewing Part 1 (L1)

Communication in medicine is very important

- The Australian commission on safety and quality in healthcare
- Communication is integral to all aspects of patient care.
- Communication is a core clinical skill that can be **developed and improved** with practice, experience, continuous learning, mentorship and support.
- Effective communication has a significant positive influence on patient experience and satisfaction.
- Poor communication contributes to teamwork failures, errors, misdiagnosis and inappropriate treatment.
- It is important to tailor your communication and consider the health literacy needs of patients, families and carers. This includes providing an opportunity to clarify the information received and to check understanding.
- Communicating with kindness and empathy improves interactions with patients and their families, and your colleagues

What is communication

- Communication is the means or methods through which information is shared between other people
- Communication refers to 'the imparting or exchanging of information by speaking, writing or using some other medium'
- Can be Verbal (7%) or Non-verbal (55%) (other 38% is paralanguage - tone, pitch, pace)

What is communication?

- **Verbal communication** involves a **speaker, a listener and a message**
- **Non-verbal communication** involves a range of **unspoken actions** and **behaviours** that carry a meaning.
- The **message delivered** by the speaker needs to be the **same** as the **message** that is **received** by the listener.
- Communication is a skill that can be **learned** (and taught), not necessarily an innate ability.
- Poor communication is the most common cause of patient dissatisfaction

For a **doctor**, communication skills are likely to include (among other things):

- The ability to **listen carefully** to what a patient tells you
- **Explain** your diagnosis, treatment, next steps, preventive advice clearly using **plain, easily understood language** (i.e not jargon or clinical terms)
- Provide **reassurance** to anxious or upset patients

Communication

- '**Patients** consider **communication** with their physicians to be a **precious component** of the medical encounter. Enhanced doctor-patient communication has been correlated with higher patient satisfaction, self management of chronic diseases, more accurate prescribing of medications, and superior health outcomes'. (Matusitz and Spear, 2014)

Patient perspective

- Dr X was excellent! From the moment I stepped into her consulting room she gave me **great comfort** and was very thorough on her assessment and very knowledgeable on my condition. Her professionalism, **compassion and genuine interest and care for me** as a patient was outstanding. I'd most definitely see her again. HIGHLY RECOMMENDED!
- Dr X was amazing. He is extremely knowledgeable, **caring and easy to talk to**. I can't thank him enough for **listening to me** when no one else would.
- Anytime I had a concern with my pregnancy, I was **reassured** straight away. His **kind, caring and gentle nature** really stood out to my husband and I.
- Dr X is a **great listener** and very attuned to **patients needs and concerns**.
- Dr. X is great, **takes time to talk, ask questions, and listen to concerns**.
- Dr. X genuinely **cares about her patients** and every aspect of their lives.

- Dr X is spot on and worth every cent! He knows exactly what he is talking about and **is kind and empathetic**

How can communication skills help you become a good doctor?
- More easily **determine the patient's main problems** and **improve diagnostic accuracy**.
- Determine how the patient's health status **impacts on emotional**, **occupational** and **social** areas of their life.
- Make **appropriate referrals** for test and specialist appointments.
- Improve **treatment compliance** and **patient satisfaction**.
- Enhance professional and work satisfaction and **fulfilment**, reduce work related stress and burnout.
- Perform well in clinical teams.
- Develop **good relationships** with colleagues

Communication skills are important
- A systematic review of 36 studies identified that for patients, the **quality of communication** was the main indicator of receiving a **high health care quality**.
- This included:
  - The doctor's ability to **listen**
  - Taking the **patient seriously** and demonstrating **respect and courtesy**
  - Clearly **explaining a condition and treatment**
  - Having a **good relationship** with doctor
  - Spending **more time talking** to patients
  - Having a **good rapport** between doctors and patients

Categories of communication skills
- **Content skills** – **what is said**, e.g the substance of what the doctor says; ability to gather information; practicing **evidence based medicine**.
- **Process skills** – **how it is said**, overall **communication** e.g how questions are asked; demonstration of listening skills; explanation and planning with patient; relationship building with patient.
- **Perceptual skills** – what the doctor is thinking and feeling, e.g **awareness** of **own decision** making and other thought processes; awareness and response to **attitudes** and emotions during an interview; **biases** and prejudices; whether you like or dislike the patient.

Communication skill progression
- Communication skills and medical interviewing
- **Theory and basic information** (lectures)
- **Practise** (clinical skills, workshops, role play, simulated patients)
- **Implementation** (placements, hospital wards, and clinics)

Patient centred care
- Patient centred care is the practice of caring for patients (and their families) in ways that are meaningful and valuable to the individual patient. It includes **listening to, informing and involving patients in their care**
- The US Institute of Medicine defines patient centred care as: "Providing care that is **respectful of, and responsive to, individual patient preferences**, **needs and values**, and ensuring that **patient values guide all clinical decisions**."
- Core principle is that an **individual is central and integral to the provision of care** and should be consulted before any decisions are made about treatment
- This gives a greater focus on **patient autonomy** and **self-determination** – patients are more involved in their medical care and active participants in the decision making process.
- They make choices about medical care that **suit their needs, lifestyle, family situation** etc.
- This supports the development of a therapeutic alliance based on respect for each persons competencies, decision making abilities, personal values and preferences.

Picker's Eight Principles of Patient-Centred Care
1. Respect for patients' preferences

2. Coordination and integration of care
3. Information and education
4. Physical comfort
5. Emotional support
6. Involvement of family and friends
7. Continuity and transition
8. Access to care

Patient centred care
- Patient **familiarity** with, and **confidence** in the doctor.
- Feeling **emotionally supported**.
- Doctor **knowledge** of the patient – includes their family and social circumstances and knowledge of patient's medical history.
- **Trust** in the doctor. Patients assume that doctors are trustworthy. Patients like to feel **confident** with the doctor, feel that the doctor is **competent** and feel **secure** with the doctor. Feel that the information they provide to the doctor will be **confidential**.
- Feeling that **care is coordinated** – increases feelings of **safety** and provides **reassurance**.

Patient centred care
- **Autonomy** – The doctor treats patients as an individual and respects their autonomy.
- **Empathy** – important for the doctor to understand the patients' feelings – physically and emotionally.
- **Humane** – the doctor is caring, compassionate and kind.
- **Respect** – the doctor takes the patients input seriously and works together with the patient to elicit their concerns and determine their preferences for treatment and management.
- **Regard** – the notion of feeling comfortable with the doctor and of liking the doctor. Having an easy and comfortable relationship with the doctor.

Shared decision making – No decision about me without me
- Shared decision-making is a process in which **clinicians and patients work together to select tests, treatments, management strategies**, screening tests based on **clinical evidence and the patient's preferences**.
- It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients' informed preferences.
- **Both parties share information** – the **clinician offers options** for the presenting problems and describes the associated risks and benefits, and the **patient expresses their preferences** and **values**.

Shared decision making
- Benefits include:
  - Gives patients an **active role** in the decision making process.
  - Improved **compliance**.
  - Enhanced patient **engagement** and involvement in **long term treatment** and management.
  - **Improved clinical outcomes** for patients who share decision making compared with being passive recipients of care.
  - Each participant (doctor and patient) has a better understanding of the relevant factors and **shares responsibility in clinical decision making**.
  - Makes it easier to implement evidence based decisions regarding treatment

Illness behaviour
- **Illness behaviour** describes the **patient's reaction to the experience of being unwell** – defined in the late 50's by David Mechanic.
- It refers to the 'varying ways **individuals respond to bodily indications**, how they **monitor internal states**, define and **interpret symptoms**, make attributions, take remedial actions and utilize various sources of informal and formal care' (Mechanic, 1995)

- The concept of illness behaviour aims to define i) the **large variability in reactions to symptoms** and **illness at an individual patient level**; and ii) to identify **socio-cultural, environmental and psychological factors** that affect such reactions.

Illness behaviour - main determinants and consequences of illness behaviour
- Illness-related variables
- Patient-related variables
- Doctor-related variables
- Use of health care services
- Adherence to medical regimens
- Response to preventive screenings

Patient experience of illness
- **Restrictions** to lifestyle and activities.
- Impact on **friendships** and peer groups – feeling different; disclosure, especially in a younger patient.
- The need to take **regular medication**.
- **Financial** problems.
- Increased access to, and **dependence** on health services.
- Changes in roles in relationships, e.g with partners, and situations where adult children become carers.
- **Loss of independence** and increasing frailty and **isolation** in older patients.
- **Fear** for the future – progression of the disease, death and dying.
- **Depression/anxiety** and other psychological issues.

Communication Skills and Medical Interviewing Part 2 (L2)

Communication skills for conducting a medical interview
- Asking questions
- Active listening
- Facilitation
- Clarification
- Summarising silence and reflection
- Empathy

Establishing rapport
- **Rapport**: a friendly, harmonious relationship; a relationship **characterised by agreement**, mutual understanding, and empathy that makes communication possible or easy

Asking questions
- Open, closed, probing, questions to avoid

Activate listening
1. **Pay attention** and **connect with the speaker**
   - Give the speaker your **full attention**
   - Maintain **eye contact**
   - **Avoid distractions** - phones, other conversations around you etc.
2. **Demonstrate** that you are listening
   - Facilitate the conversion by asking **follow-up questions**
   - **Periodically summarise** to demonstrate that you are listening.
   - Be aware of your **body language** and **gestures** and what these may convey to the listener.
   - Use non-verbal facial expressions, such as **nodding, smiles**.
   - Encourage the speaker to continue with **small verbal encouragers** like ‘go on’, and ‘uh huh’.
   - Make sure that your **posture is open and inviting**.
   - Avoid interruptions – demonstrates impatience and disinterest.
3. Ask **open questions**
   - Enables patient to guide the discussion in the direction they want
4. Provide feedback

- Use **reflective paraphrasing**, e.g ‘What I’m hearing is…’ and ‘It sounds like you’re saying…’
- Ask **appropriate questions to clarify certain points**. "What do you mean when you say..." "Is this what you mean?"
- **Do not interrupt** or cut the person off – wait for an appropriate pause in the conversation

5. Defer judgement
   - **Avoid being judgemental** about what is being discussed – this will **destroy trust** and may result in **important information being withheld**.
   - Do **not** become **argumentative or negative**.
   - Do **not humiliate** or **embarrass** the person.
   - Be prepared to **put your own views regarding ethical and moral judgements to one side** if these are different to the person you are talking to.
6. Respond **appropriately**
   - **Active and constructive responding** – e.g, if someone tells you some **good news**, respond appropriately.
   - On the other hand, if you are told that a family member has recently been diagnosed with **cancer**, express **concern** and demonstrate **empathy appropriately**.
   - Be **respectful, open and honest** in your response.

<u>Active listening - patient perspective</u>
- A qualitative study found that, for patients, active listening was a main characteristic of a good doctor.
- Enables patient to **feel comfortable in disclosing information**, particularly sensitive and emotional issues.
- Patient feels that **doctor cares** about them and their well-being.
- Essential skill for **gathering relevant clinical information** for **diagnosis and treatment**.
- Can be a **healing and therapeutic agent**.
- Can foster and **strengthen the doctor-patient relationship**.

<u>Facilitation</u>
- Facilitation means to **make something easier**.
- Facilitation gives the patient the **chance to talk in as much detail as they feel is necessary** in order to **fully describe their problems**.
- Doctors can facilitate an interview by **encouraging and guiding the patient to continue talking**, especially after pauses.
- Non-verbally, doctors can facilitate the interview by **maintaining eye contact**, and **providing encouragers** such as **head nodding or hand gestures**.

<u>Clarification</u>
- Clarification can be used at any point in the interview to:
  - Enable the doctor to **check on particular details** of what the patient has said during the interview
  - Enable the patient to **make corrections or add additional information** if needed

<u>Summarising</u>
- Benefits to the **doctor**
  1. Gives the doctor a chance to **communicate back to the patient** his/her understanding of what the patient has said and **check for accuracy**
  2. Gives the doctor a chance to put his/her thoughts in order, and begin the process of **clinical reasoning**
- Benefits to the **patient**
  3. Allows the patient some **space to think**.
  4. Shows the patient that the **doctor has listened** to what has been said.
  5. Gives the patient the chance to **correct any inaccuracies**, raise **other concerns**, add in **forgotten information** or **ask questions**.
  6. Promotes **trust** and **collaboration** in the doctor-patient relationship

Summarising
- As well as summarising the main points of a history to the patient, students will also need to summarise a patient interview
  - To an **examiner** during an assessment
  - To a **consultant/registrar** on the ward during a clinical placement

Silence and reflection
- In medical interviewing, **silence** can be valuable:
  - Provides the patient with time to **pause and gather their thoughts** – particularly important in **emotionally difficult situations**.
  - Provides an opportunity for the **doctor** to **observe the patient**.
  - Provides an opportunity for the **doctor** to **reflect and start the process of clinical reasoning** and formulation.
  - Provides an opportunity for the doctor to plan for the **next stage** of the interview

Empathy
- Empathy is the ability to **understand and share the feelings of others**.
- Being empathetic enables someone to **recognize another person's emotional state**, **understand** their emotional state, show **concern** and respond appropriately and effectively.
- Empathy is different to **sympathy**, which is **simply feeling sorry for someone due to their circumstances** or something that has happened to them.
- The ability to demonstrate empathy to patients can help build **rapport**, improve **outcomes** and increase **patient satisfaction**.

Non-verbal communication
- Non-verbal communication can:
  - **Reveal additional information** about ourselves and how we are feeling.
  - **Reinforce or modify** what is said verbally, e.g. vigorously nodding may emphasise agreement, shrugging shoulders and a sad expression when saying 'I'm fine thanks,' may imply that things are not really fine.
  - Convey information about an **emotional state**.
  - Provide **feedback** to the other person.
  - Regulate the **flow of communication**, for example by signalling to others that they have **finished speaking or wish to say something**.

Components of non-verbal communication
- **Facial expression**: Can convey many **emotions** – happy, sad, pensive, fearful, e.g by smiling, frowning, staring.
- **Eye contact**: Indicates that you are **listening**; can communicate level of emotion -when you dislike someone you avoid eye contact; indicates to the other person when it is their turn to speak; lack of eye contact can indicate a sign of respect in some cultures.
- **Mirroring**: Copying gestures, positioning etc

Components of non-verbal communication
- **Fine movements**: includes **gestures**; **head** and **hand movements**; can reinforce or emphasise what a person is saying.
- **Proximity**: refers to the **physical distance** that we maintain from another person. Depends on our relationship with that person, if we know them and the social setting.
- **Artefacts**: e.g. **looking at watch may communicate 'hurry up'**; **fidgeting** with rings or pen tapping may indicate **anxiety/tension**, boredom, impatience, disinterest.

Paralanguage
- Paralanguage is the area of communication that **accompanies speech and emphasises body language** and voice nuances as a means of expressing thoughts and feelings. Includes:
  - All aspects of the **voice**
  - **Tone** and **pitch** of the voice
  - **Speed** and **volume**

- **Pauses and hesitations** between words
- **Intonations** and **inflections**
- **Gestures** and facial expressions
- **Expression** of emotion

Posture
- An **open posture** can be used to **communicate openness or interest** in someone and a readiness to listen, whereas **closed posture** might imply **discomfort** or **disinterest** with that person.
- **Open** – face the other person with **hands apart** on the **arms of the chair**, **lean forward slightly**; **avoid barriers** such as a desk, maintain **eye contact**.
- **Closed** – **arms folded**, **legs crossed**, **behind a desk**.

Position and posture - SOLER
- Face the patient **Squarely**. It is important that you position yourself so that you convey that you wish to be **physically present** and available to the patient."I am here with you".
- Adopt an **Open** posture. Crossed arms and legs may place a barrier between you and your patient. Instead arms should be **loosely at your side when standing**, or **resting on the arms of the chair or in your lap when sitting**.
- **Lean** slightly forward. This communicates to the other person "**I am interested** in what you are saying". Be aware that leaning forward too far or before you establish a person's trust might be interpreted as threatening.
- Maintain good **Eye** contact without staring.
- Try to be **Relaxed** and natural in these behaviours. This helps to put the patient at **ease** and enables you to be **comfortable** with the use of your body as a vehicle of contact and expression.

Touch
- Can **comfort** an upset patient, but may not be helpful for someone who is angry or upset.
- Have regard for patient sensitivities and professional codes of conduct.
- Use touch in conjunction with verbal communication.
- Tell the patient **when, where and how** they will be touched during an examination.
- Be careful that touch is **not interpreted as intimacy**. Male doctors may request a female colleague to be present when examining female patients.
- Be aware of coming across as being **patronising** by patting a patient on the back or shoulder.
- Be aware of **cultural appropriateness** regarding touch.
- Be aware of the patient's **response** to touch e.g. if they pull away, look startled or frightened.

Other things to be aware of
- **Physiological reactions**: Blushing; sweaty palms.
- **Dress**: Choice of dress can communicate your level of **professionalism** and shows that you **respect** those around you; make sure that you are appropriately dressed at all times as a medical student especially on clinical placements, when working with colleagues and interacting with simulated patients.
- **Personal hygiene**: Be aware of **body odours**; use of makeup, perfume etc.

Patient non-verbal behaviours
- **Difficulty** in **maintaining eye-contact** may indicate that the patient feels **depressed**, **embarrassed** about what they are saying, is in **pain** or is **distracted** from the interview.
- Conversely, **excessive eye contact** may indicate **anger, aggression**.
- **Posture-confident** people usually sit **upright**, while **depressed** people may **sit slouched** with **head bent forward**. Posture may also give clues about **level of pain**.
- **Gestures** - angry patients may **clench fists**; anxious patients may **wring hands or tap feet**.

Medical interviewing: history of the presenting complaint (preview)
- The aims are to:

- Obtain a **complete, accurate and relevant history** of the presenting complaint – the **reason** that the patient has **come** to see you today.
- Find out from the patient's perspective **what they think the problem might be** and what **might be causing it**.
- Determine what **impact** the problem is having on their day to day life, level of **functioning**, work, **social** life, family life and relationships.
- Lead into **clinical reasoning and formulation**.

<u>Presenting complaint history</u>

- Over the next few days think of the information that you need to ask a patient who comes to see you about a sporting injury that has resulted in a painful ankle

Introduction to Clinical Skills (W2)

Overview (L1)

Tutors

- Throughout the clinical skills sessions you will have different tutors and PAL tutors and may be shown varying ways to interview or examine and in clinical practice you will also notice slight variation from clinician to clinician.
- The most important part is **understanding what questions to ask** (or **what to examine**), **why you are asking/examining it** in the way that you are and whether that is an **effective method** to elicit a **symptom or sign** if it is present

Simulated patients

- In some sessions community members volunteer to play the role of patients
- They will have medical scenarios provided to them and you will engage with them to take histories and examinations
- These sessions are extremely important for your learning
- Things to consider:
  - Your bag/chai placement in the room to ensure easy movement for the volunteers
  - Ensuring you arrive on time so as not to impact other students practice
  - Professional dress requirements

Professional dress

- The MD Dress Code document guidance available on the MD Community LMS site is a co-creation go MD academics and students
- It outlines what to wear - and what not to wear - to placement, and infection control aspects of dressing and grooming in placement and in clinical assessments
- Clothing: personal items of clothing (that are not scrubs or uniforms). These include **button-up shirts**, blouses, long pants, skirts, etc
- Clothing should be:
  - Neat and modest (e.g. no cleavage, midriff or upper thigh exposed)
  - In good condition and well fitting
  - Permit physical examination without being revealing e.g. bending forward from the waist, crouching down on the floor
  - Footwear design should include a closed toe, non-slip sole, and be well fastened or fitted

Professional dress

- Bare Belows the Elbows
- All medical students must adopt “Bare Below the Elbows” practices relating to jewellery and nail care
- In brief these principles are:
  - Bracelets, health monitoring devices, watches and rings with stones or ridges are not worn on hands or lower forearm areas. A single flat ring/band may be worn but should not interfere with effective hand hygiene practices
  - A medical alert necklace is preferred to a medical alert bracelet
  - Short sleeves should be worn (or long sleeves rolled securely to above the blow) to allow for appropriate hand hygiene techniques to be practise
  - Fingernails should be kept short, clean and free of nail polish.. artificial nails are not to be worn in the clinical settings.
  - Lanyards, ties, necklaces, scarves, glasses on chains etc. must be secured when providing clinical care to ensure the items do not have contact with the patient or the patient environment

Professional dress

- Badges
  - Should be worn during these sessions (and all the other mandatory classes) and your name must be visible
  - If you forget your badge, then you can use a sticker. This is a temporary option only

Policies and procedures