School of Medicine

Year 2 – 2012/13

## Foundations of Clinical Practice

**Autumn and Spring term course guide**

## woman listeningdoctor sitting listeningnon verbal communication

## Clinical Communication

## Student Guide

Course Leaders:

**Dr Ged M Murtagh Dr Athina Belsi**

Tel: 020 3312 7761 020 3312 1100

email: [g.murtagh@imperial.ac.uk](mailto:g.murtagh@imperial.ac.uk) [a.belsi@imperial.ac.uk](mailto:a.belsi@imperial.ac.uk)

<https://education.med.imperial.ac.uk>

Year 2 – Autumn and Spring term

CONTENTS

Page

SOLE iii-ix

INTRODUCTION 1

COURSE STRUCTURE AND LEARNING OBJECTIVES 1

GUIDELINES FOR FEEDBACK 3

READING LIST 6

E-LEARNING 7

ASSESSMENT DETAILS 8

ATTENDANCE 8

CONTACT DETAILS 9

SESSIONS 11

Session 1: History Taking (i): Content and process 11

Session 2: History Taking (ii) with a Simulated Patient 31

Session 3: History Taking (iii): Social History 43

Session 4: Cross Cultural Communication 59

Session 5: Revision workshop 69

<https://education.med.imperial.ac.uk>

**SOLE FEEDBACK – Clinical Communication**

The following pages provide you with templates on which you can record your thoughts as the course proceeds. At the end of the course you can enter your views onto SOLE.

**Please answer all questions by selecting the response which best reflects your view.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Very Good | Good | Satisfactory | Poor | No Response |
| The support materials available for this module (e.g. handouts, web pages, problem sheets and/or notes on the board). |  |  |  |  |  |
| The organisation of the module. |  |  |  |  |  |
|  | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| Feedback on my work has been prompt (this refers to your work being commented upon within a specified time). |  |  |  |  |  |
| Feedback on my work has helped me clarify things I did not understand. |  |  |  |  |  |

Please use this box for constructive feedback and suggestions for improvement.

|  |
| --- |
|  |

**SOLE FEEDBACK - INDIVIDUAL TUTORS**

This template gives you the opportunity to record your comments about your tutor.

**On the following section, you have an opportunity to record any comments and constructive feedback you have for each tutor.**

|  | **The tutorial was well structured** | | | | | **The tutor explains concepts clearly.** | | | | | **The tutor engages well with the students.** | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Tutor** | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
| <Prof. Karim Meeran> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Please use the space below for additional constructive feedback on each tutor.

|  |  |
| --- | --- |
| **Tutor** | **Comments** |
|  |  |
|  |  |
|  |  |
|  |  |

**SOLE FEEDBACK - INDIVIDUAL LECTURERS**

Please note that for SOLE, a Lecturer’s name will only appear once. This template gives you the opportunity to record your comments about each lecture in the order of delivery.

**On the following section, you have an opportunity to record any comments and constructive feedback you have for each lecturer.**

|  | **The structure and delivery of the lectures.** | | | | | **The explanation of concepts given by the lecturer.** | | | | | **The approachability of the lecturer.** | | | | | **The interest and enthusiasm generated by the lecturer.** | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Lecturer and Lecture Title** | Very Good | Good | Satisfactory | Poor | Very Poor | Very Good | Good | Satisfactory | Poor | Very Poor | Very Good | Good | Satisfactory | Poor | Very Poor | Very Good | Good | Satisfactory | Poor | Very Poor |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

| **Lecturer and Lecture Title** | **Please use this box for additional constructive feedback.** |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

# Session reflection and evaluation

In order for the course to continue to evolve, we rely on student and tutor feedback. They will only take a couple of minutes to complete but are invaluable. SOLE templates are in the front of the guide. Please complete them at the end of each session. Please pay extra attention to recording the name of your tutor for each session as we utilize a large pool of tutors.

In addition we may also use additional forms in the sessions designed to support your development as a reflective practitioner and to provide us with additional feedback on specific aspects of the course.

**VERY IMPORTANT!**

**I**

**t is critical that you approach your feedback carefully and seriously. The ultimate purpose of SOLE feedback is to improve the course, so do not waste this feedback opportunity with throw away comments (e.g. ‘the lecture was a waste of time’, ‘I cannot see the relevance of this session’). The course leaders cannot do anything with comments like this as they lack any specificity or explication. If you do decide to comment on the course think about providing a rationale for your evaluation and do so with the view of how to improve the course in a reasonable way. SOLE feedback is taken very seriously by the College, so please treat it with the same level of seriousness.**

Introduction

The “Clinical Communication” course is taught during the Autumn and Spring terms of Year 2. By the end of the second year, you should be able to describe and demonstrate a range of basic communication skills (verbal and non-verbal) relevant for working with patients, peers and clinicians. You will be able to identify a patient-centred consultation and will have developed relevant skills for opening, gathering information and closing medical interviews that explore patients’ experiences as well as incorporating some basic history-taking skills. You will be able to “repackage” information into other forms to present either in verbal form or in writing. You will also be aware of your strengths and weaknesses in communicating within some health care contexts and have clear strategies for the maintenance of your effective skills and improvement of your developing skills. You will also be aware of difficulties that some patients have in communicating within health care settings (e.g. patients whose language is different to the clinician). Throughout the second year of “Clinical Communication”, you will need to refer to the background information provided in the Year 1 guide.

Course structure and learning objectives

The 5 sessions are shown below with a summary of their learning objectives

Session 1: History Taking (i)

* Identify the key content features of a medical history
* Identify the skills necessary to establish the patient’s presenting complaint, the history of the presenting complaint and past medical history
* Interview and receive feedback from a simulated patient
* Practise using and integrating the skills associated with patient-centred interviewing while taking a medical history

Session 2: Interviewing a simulated patient

* Receive feedback on communication skills from a simulated patient
* Receive feedback on communication and history-taking skills from a tutor
* Receive feedback on communication and history-taking skills from peers
* Identify skills that you effectively used in simulated patient-centred interviews associated with history-taking
* Identify your skills that require development
* Identify ways in which your communication and history-taking strengths will be maintained
* Identify ways in which your communication and history-taking weaknesses will be improved

Session 3: History taking (ii)

* Give examples of the range of problems to which diet contributes
* Discuss some of the problems in establishing a patient’s dietary habits
* Give examples of the key screening questions to ask every patient when taking a nutrition history
* Identify the skills necessary for an effective assessment of drug, alcohol and tobacco use
* Use a range of other questions to explore each area more deeply

Session 4: Cross Cultural Communication

* Reflect on your own cultural background
* Differentiate the cultural groups to which people belong and explain why these may not always be obvious
* Identify how cultural issues may affect communication
* Identify a range of solutions for managing problems arising from cross-cultural communication
* Outline the difficulties that may arise if family or relatives are used as interpreters
* Describe the skills required by health professionals when working with interpreters

Session 5: Revision Workshop

Structure of sessions

For each session there is:

* An introduction stating aims, learning objectives, methods, activities and recommended readings
* An activity description with aim/s and prompts
* An outline of closure including a review of the learning objectives, summary of issues, instructions for evaluation and a lead into the next session

## Educational methods

Group sizes vary from groups of 3 to whole cohort sessions.

A range of methods are used in the delivery of the programme: brainstorming, role-play, student presentations, trigger videos, and instructional DVDs.

All the sessions are interactive, with several opportunities for students to give and receive feedback on their performance.

Guidelines for giving feedback

There will be several opportunities for you to give and receive feedback during this (and other) courses (e.g. role-play interviews, SP interviews, presentations). Please review the guidelines for giving and receiving feedback below. These are the same as the guidelines used in our tutor and simulated patient training.

* Remind yourself of the purpose of feedback in this situation – to support student learning in patient-centred communication
* Think about what you want to say and how you want to say it
* Try to address the learning needs/goals the student identifies - Time will preclude much further discussion
* You might like to use a structural approach to interviewing – that is, the interview has a beginning, middle and end. Then think about something from each phase that you observed as working well or something to do differently
* It is important to stick with the following sequence for giving feedback
* Focus FIRST on what the student interviewer did well and then proceed to things that can be done differently
* Always identify strengths that the student has demonstrated
* Give your own experience of the communication For example:

*“It was very helpful when you entered the room to make eye contact and introduce yourself with your name, role and a clear statement of the purpose of the interview. I think you said that you would like to spend about 5 minutes talking with the patient about why they had come to hospital. This was clear, honest and focused. Well done.”*

*“When you said that you wanted to have a little chat, I thought you were trivialising your task. In some ways you were also being dishonest. What you are doing is asking several questions about why the patient has come into hospital. That is quite different to a little chat.”*

*“When you smiled at the patient right at the beginning of the interview, I thought you conveyed a sincere interest in the patient.”*

*“When you asked the patient about her smoking, alcohol and other drug use, I thought that your tone seemed judgmental. You also used multiple questions which are not very helpful for getting specific information.”*

*“I could not easily hear your name at the beginning of the interview. Even though you have a long name, it is important that you use your whole name right at the beginning. It is also important that you say this when the patient can hear you – not when you are in the process of sitting down and closing the door.”*

You might consider that when identifying weaknesses or areas for development, you can ask questions to help the student develop alternatives

*“Can you think of different ways of…?”*

*“Sometimes I find it helpful…What do you think about that?”*

*“When you did… I was wondering what would have happened if you’d done…Do you have any thoughts on this”*

*“I was interested in your questions about the impact of the symptoms on the patient’s work. It seemed to me that you really wanted to know about this but your patient was reluctant to share anything further. How else might you have managed this?”*

“Do you know why the patient was so anxious? … How might you have explored the reasons for his anxiety? It seemed to me that you assumed why he was anxious.”

* Always confine “negative” feedback to things that can be changed.
* Be honest – If you did not think that the student was patient-centred, try to specify what it was they did that led you to think this way.

“I didn’t think it was helpful when you spoke over the patient. Were you aware of doing this?”

*“I thought you distanced yourself from the patient when you used terms that the patient did not understand, your tone of voice was quite pompous and you did not make much eye contact.”*

*“I think you need to think about the way you present yourself – even in this simulated environment. The body position you adopted suggested you had little respect for the patient. Let’s have a look at the videotape and let me know what you think.”*

* Be accurate
* Limit the use of generalisations

*“That was good.” (State why it was “good” – You looked at the patient, you sat up, your tone of voice and the pace of your speech was friendly and engaging. You didn’t fidget and it seemed to me like you really listened…”*

Support Challenge Model of Feedback

This model can help you think about the way you give feedback. Statements given as feedback can be graded in terms of support and challenge. The most effective feedback falls in the high support/high challenge quadrant.

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
| Support | “That was obviously great – you are trying very hard” | “A good effort. I could see how you were drawing the feelings out. I wonder if you got to the crux of the matter?” |
| “Good, carry on, seems to be working” | “Well that could have been done better. Why didn’t you focus more earlier on?” |
| Challenge | | | |

Reading List

Books (practical insights)

There are many texts on basic medical interviewing skills. Although we do not recommend any particular reference, students have found the following books valuable.

Cole SA & Bird J. The Medical Interview: The Three Function Approach. 2000. 2nd edition. Mosby: Missouri

Lloyd M & Bor R. Communication Skills for Medicine. 2004. 2nd edition Churchill: London

Silverman J, Kurtz S, Draper J. Skills for Communicating with Patients. 2005. 2nd edition. Radcliffe Medical Press: Oxford

Smith RC. Patient-Centred Interviewing: An Evidence-Based Method. 2002. 2nd edition. Lippincott William and Wilkins: Philadelphia

Washer P. Clinical Communication Skills. 2009. Oxford University Press: Oxford.

Books (analytical insights)

The following books are for those of you who want to extend your knowledge of doctor-patient communication. Effectively, they provide useful analytical foundations to support the skills you will be learning. They are by no means required reading but have been included as an extra layer of materials and resources you can utilize to galvanise your understanding of communication skills.

Heritage J. and Maynard D. (eds.) Communication in Medical Care: Interaction between primary care physicians and patients 2006. Cambridge University Press: Cambridge. (See Chapters 1, 5, 6, and 8)

Roter D. and Hall J. Doctors Talking with Patients/Patients Talking with Doctors: Improving communication in medical visits 2006. Auburn House, Westport, CT.(See Chapters 1, 2, 3 and 9)

Websites

Foundation Programme

<http://www.foundationprogramme.nhs.uk/pages/home>

Tomorrow’s Doctors

<http://www.gmc-uk.org/education/undergraduate/tomorrows_doctors_2009.asp>

E-Learning



The UK Council of Clinical Communication in Undergraduate Medical Education is an organisation made up of the Clinical Communication course leaders from all 33 UK Medical Schools, including Imperial. The UK Council have created a new e-learning package which has been made available all UK medical schools to support the development of your clinical communication. You will find it on Blackboard.

The package is made up of 7 modules, each of which focuses on a key task defined in the Calgary-Cambridge consultation model;

* Initiating the consultation
* Information gathering and history taking
* Communicating during the physical examination
* Explaining and planning
* Closing the consultation
* Structuring the consultation
* Building the relationship

In addition, there is an introductory module which outlines the purpose of the package and gives some background on how it was made and why as well as ideas about how to best use it;

* Essential Clinical Communication

These modules are available for you to access at any time, but we will be signposting in Clinical Communication teaching sessions and in the guide when they may be most appropriate. Most of them are relevant for year 2 whilst others (explaining and planning & communicating during the physical examination) are suggested year 3 material.

There is also benefit to revisiting a module at different time points in the course as you will benefit at different levels depending on your level of experience (for instance you may focus on the basic information gathering skills in Year 1, but me more interested in the clinical reasoning elements of history taking in Year 3, both of which are covered in “Information gathering and history taking”.

As you progress through the course, the clinical situations you will face will become increasingly challenging and in these circumstances, effective communication is vital. In your PACES exams in years 5 and 6 the mark sheet is also divided into domains that run throughout the exam (Clinical skills, Formulation of clinical issues, Discussion of management, Professionalism and patient centred approach). In addition to being marked per station, you must also pass each domain to pass the exam, thus communication with patients and colleagues is a key factor in the exam.

## Assessment

Summative assessment of the course will be in the format of “modified essay questions” in a written paper with ‘Ethics and Law’ and ‘Personal and Professional Development’. This paper is sat in Jan of Year 3 when you will have had more chance to practise using the skills taught, with patients, whilst on clinical attachments. The paper is designed to assess your understanding of how communication, ethics and law and professional development interrelate with one another in a way which will advance your professional knowledge and practice. A case story will be released in advance to enable you to prepare. From the point of view of the communication element, the content will be based around the stated aims and learning objectives of the CC course and how those aims blend with ethical, professional and legal relevancies. This will be covered more specifically in Y3. Please refer to the Medical Ethics and Law and PPD course guides for further information.

In Year 3 you will also be directly assessed on your ability to communicate. This is the first time you have high stakes assessments on your skills (rather than your knowledge of communication). These Objective Structured Clinical Examinations (OSCEs) draw on all aspects of Years 1 and especially Year 2. In preparation for this you will be required to sit a formative assessment in which you will have to conduct a simulated patient interview. This interview will be identical in format to your previous in course encounters and the assessment criteria will be based entirely on what has been covered in the course. The interview itself will last 10 minutes and as this is a formative assessment you will receive feedback. This will take place in April/May but further information with specific details will be posted on the intranet later in the year

Attendance

An attendance sheet will be completed at every session. You must sign in for each small group session. Signing in for absent colleagues is unacceptable and is considered cheating. Students who do this will be asked to leave the session. Additional penalties may be applied.

Please refer to attendance policies relevant to your undergraduate medical studies.

If you are unable to attend a session, please email Dr Murtagh ([g.murtagh@imperial.ac.uk](mailto:g.murtagh@imperial.ac.uk)) or Dr Belsi (a.belsi@imperial.ac.uk) prior to the session or within 24 hours. If there is an opportunity, we will try to offer you a rescheduled session provided your absence is for a legitimate reason.

Contact details

The core communication faculty are based in the Division of Surgery and Cancer 2nd Floor, Paterson Wing, St Mary’s.

If you have any questions relating to this programme, please contact:

Dr Ged M Murtagh (Senior Lecturer) g.murtagh@imperial.ac.uk

Dr Athina Belsi (Lecturer) a.belsi@imperial.ac.uk

Dr Ged M Murtagh

Dr Murtagh is a social scientist whose research involves the application of conversation analysis to the medical encounter. He received his Postgraduate Certificate in Learning and Teaching in 2005. He has contributed to clinical communication skills teaching for Undergraduate medical students in his previous position at the University of Leicester. With colleagues at Leicester he has developed a consultation aid for Oncologists and cancer patients soon to be tested in an intervention study at the Leicester Royal Infirmary. With colleagues at Imperial and the University of Bristol he is extending this work into surgical training examining communication skills practices in surgical practice.

<http://www1.imperial.ac.uk/medicine/people/g.murtagh/>

Dr Athina Belsi

Dr Belsi is a social scientist with a background in public health. Her research focuses on the motivation to study and the impact of personality on clinical career pathways. She is currently developing research on communication within healthcare teams. She has previously taught at the Dental Institute and the School of Medicine in her previous position at King’s College London where she worked on developing communication stations for the OSCE. Recently, in the Department of Public Health and Primary Care here at Imperial, Dr Belsi has led work into understanding patient perceptions of integrated care pathways. She has also been involved in the Pilot Registry for the Investigation and Prevention of Alzheimer’s disease (RIPA).

Session 1

History Taking (i) Content and Process

Introduction

This is the first session for the second year of the “Clinical Communication” course (CC) and it builds on your experiences from last year. By the end of first-year you were expected to be able to describe and demonstrate a range of basic communication skills (verbal and non-verbal) relevant for working with patients, peers and clinicians. You should be able to identify the central features of a patient-centred consultation and will have developed basic relevant skills for opening, gathering information and closing interviews that explore patients’ experiences. You will have developed awareness of your strengths and weaknesses in communicating within some health care contexts and have clear strategies to maintain your more effective skills and to improve those that are less developed. The introductory section of this manual provides detailed information on aims of the second year of CC.

This session aims to prepare you for establishing a patient’s chief complaint and past medical history. It is the first part of history taking skills with part 2 covering useful skills for taking a social history.

Learning objectives

After this session, you should be able to:

* Identify the key content features of a medical history
* Identify the skills necessary for an effective assessment of the patient’s chief complaint and past medical history
* Discuss the reasons why if doctors and patients have different or unshared expectations or agendas within a consultation the consultation may be unsatisfactory for both
* Have practised using and integrating the skills associated with patient-centred interviewing while taking a medical history

Activities

* What information do I need from patients?
* Role-play

Content and process

In year 1 you have learned the *process* of taking a medical history using consultation models (e.g. Calgary-Cambridge). This gives you a framework in which to put the content. In your forthcoming clinical attachments, you will soon be inundated with questions you need to ask patients while taking their medical history. The challenge today is to help you integrate the *content* (information you need from the patient) with the *process* (effective patient-centred communication). i.e. history taking and patient-centred communication are not two different things!

Content skills

Firstly, there are content skills, i.e. the substantive character of questions and responses, information being sought and delivered, discussion of treatment options, management plans etc. Most texts dealing with consultation skills will suggest that the content of a medical history should include:

Presenting complaint

History of the Presenting Complaint

Past Medical History

Social History

Family History

Lifestyle

Functional enquiry/systems review

Whilst these are relevant and important lines of inquiry, this still begs the question, **HOW** do you cover these topics in a way that will ensure you gathering information effectively and efficiently in a way that does not alienate the patient. This is where process skills come in

Process Skills

Process skills allow you to answer the HOW question. Content and Process CANNOT be viewed as mutually exclusive. The relation between the two will be developed more extensively in Year 2.

The following information sets out a framework which incorporates, structure as well as fundamental process skills to assist you in communicating effectively with patients. It is designed to reflect the needs of medical students learning to communicate in medical interviews for the first time but is also relevant for interacting with patients during physical examination and while conducting procedures.

You will gain different experiences in history-taking depending on the firms to which you are assigned. Consultants have slightly different emphasis and style regarding the content of a medical history which reflects their personal preferences. We aim to help you understand the broad aims and provide a general checklist of types of information and questions that can contribute to the effectiveness of information gathering.

Remember that checklists of questions can interfere with the flow of communication in medical interviews. Following a checklist can steer the exchange into a doctor-centred interrogation which is unhelpful, not only to the patient but also, to the doctor as important information can be missed. Unless there is a medical emergency, early questions in the medical interview should focus on the patient’s experience of illness. This conveys a powerful message to the patient that you as doctor/ medical student respect and care about what is happening for this patient. Listening to the patient’s experience and subtly guiding them to address the issues you want explored is a very effective way to establish a supportive relationship with your patient while still obtaining more detailed information. It is likely that the patient will feel heard and your own information needs will have been met.

Once the patient has been encouraged to provide their own narrative it can be more appropriate to formulate closed questions that enable you to complete your ‘doctor-centred’ questions which can be formulated in relation to your mental checklist. Robert Smith, in his book “patient-centred interviewing” describes this process as “integrated medical interviewing”. He stresses the importance of returning to patient-centred skills in response to verbal and non-verbal cues from the patient (Smith, 2002).

Sequential Organisation

**The key is to ensuring effective integration of content and process is to pay close attention to the sequential organization of the interaction.** The following example is only suggestive and is designed to give you a feel of how to think about how to sequence and structure your interview. The different subtle ways in which you ask a question can influence how the patient responds. Sometimes the distinction between ‘open’ and ‘closed’ questions is not sufficient to capture these differences. On occasion patients can provide very ‘closed’ answers to ‘open’ questions. To ensure this doesn’t impact negatively on your information gathering - always

READ THE PATIENT!

**Listen carefully to the information the patient provides. Observe carefully how the patient responds to each question. For example, minimal responses or sudden changes in body language provide you with important clues as to how to shape the form and content of the questions you want to ask and how you should ask them. Observing the sequence of the interaction in this way will also enable you to effectively conduct the sequential tasks of the consultation itself.**

Use of language

In sociology you will have learned that different social groups can use language differently and that meanings are often bound up with the activities and practices of different social groups. Doctors and patients are two social groups whose use of language (in referring to a particular problem) may be quite different. Consequently, communication difficulties can easily arise. Therefore, you will need to be able to carefully clarify what patients mean when they use certain terms. On the other hand, patients are becoming increasingly more health literate and more assertive in their encounters with health care professionals. Different categories of patients will present their problems in different ways and to handle this effectively you will have to learn how to adjust your communication style accordingly. In this respect clinical communication presents you with an opportunity to critically engage with different theories of the doctor-patient relationship you have learned about in sociology.

Activity 1: What information do I need from patients?

*Aim: To encourage you to explore the range of* topics *relevant to history-taking*

Discuss in 2s or 3s for 2 minutes:

a) What do I need to know about “all” my patients?

Your tutor will then collect the thoughts of the group to create a template of a medical history

b. What do I need to know about patients presenting with…?

Discuss in groups of about 5 for 5 minutes (one patient per group). Each group will then present their thoughts to the room.

b) What topics you might explore with the following patients? How would you word your questions? Remember to consider the language you use and the use of open/closed questions. Refer to the “patient-centred interviewing skills” summary on the next page when considering how you may phrase your questions.

* Mr. Dale Gallagher, aged 48, an abattoir worker, has gone to the Emergency Department with acute abdominal pain.
* Mr. Stephen Bowers, aged 63, recently retired from taxi driving, has been experiencing acute chest pain and has been brought to the GP clinic by his wife.
* Ms. Sara Lieberman, aged 78, an author has made an appointment to see her GP because she has been having episodes of dizziness.
* Mr. Jean-Paul Sarkozy, aged 37, has made an appointment to see his GP because he is concerned about the stiffness in his hip joint.
* Miss Valerie Pecresse, aged 26, a buyer for a large retail store, is in the outpatient department for investigation of haematuria (blood in urine).

Activity 2: How do I establish the presenting complaint, the history of the presenting complaint and past medical history?

Establishing the patient’s presenting complaint is a standard in medical history taking. This is not always as straightforward as it seems. Patients can respond in vague or general terms or may focus too specifically on particular symptoms. Try to focus on information the patient provides about episodes which caused a change in the patient’s health status to determine the diagnosis given to those episodes. The key is to try to discern which ‘news items’ are relevant to the presenting problem. This will come with repeated opportunities to practice history taking.

How do you establish the patient’s PC, HPC and PMH?

What kinds of questions might you use to establish the patient’s PC?

What kinds of questions might you use to establish the HPC?

What kinds of questions might you use to establish the patient’s PMH?

Activity 3: Role-play

*Aims:*

* *To practise taking a medical history using a patient-centred approach to interviewing*
* *To practise meeting the agenda of patients and of interviewers*

6 students will be randomly selected to conduct an 8 min interview with a patient exactly as you did in the simulated patient sessions in Y1. The students will work in groups of 2 (an interviewer and an observer). The purpose of this exercise is to provide an opportunity to practice your skills in establishing the PC, HPC and PMH. Those not selected for this exercise will be asked (using the course guidelines) to give and feedback in a way that promotes learning and professional development.

Factors important for successful role-play include:

* Clear aims and objectives about task and roles
* Roles that reflect real experiences and appropriate level challenges
* Acknowledging potential difficulties in role-play
* Opportunities to try out different strategies
* “Safety” for participants because it is simulated
* Following feedback guidelines
* Relating role-play to the broader contexts in which you are learning and working
* Writing reflections on the experience
* Opportunities for debriefing for some students
* Summarising experiences

Review the communication skills list before you get started. Do any skills require clarification? The background information section in your Year 1 guide might be a useful reference.

Before the first role-play

Think about how to meet both the patient’s and interviewer’s agendas in a consultation. The following tips might be helpful.

* Clearly state your intentions at the commencement of the interview
* Try to identify the patient’s presenting complaint as well as their, worries and concerns at the beginning of the interview
* Work with your patient to prioritise these symptoms, worries and concerns
* Check you understand what your patient is saying
* Summarise
* Invite your patient to ask questions or clarify anything you say

Consider the strategies that can be used to help patients express their emotions and then deal with the patient’s response. That is, identify the feeling you think the patient is experiencing and let the patient know your thoughts on this. If the interviewer is correct, patients will usually tell you so. Rapport can be established as the interview proceeds.

Many students report the value of using SOCRATES to assess pain. Although we would not recommend that you use it directly – translating the terms into lay language may help ensure that you make an accurate assessment of pain. Remember to ask what patients have done about their pain. This might include taking medicine or resting etc

Site where exactly is the pain?

Onset when did the pain start, did it start suddenly or gradually?

Character describe the pain- sharp? knife-like? gripping? vice-like? burning? crushing?

Radiation does the pain spread anywhere? To the arm, jaw, groin, etc?

Associations is the pain accompanied by any other features?

Timing does the pain vary in intensity during the day?

Exacerbating or relieving factors - does anything make the pain better or worse?

Severity does the pain interfere with daily activities or with sleep?

Before the second role-play

Again

* Clearly state your intentions at the commencement of the interview
* Try to identify the patient’s presenting complaint as well as their, worries and concerns at the beginning of the interview
* Work with your patient to prioritise these symptoms, worries and concerns
* Check you understand what your patient is saying
* Summarise
* Invite your patient to ask questions or clarify anything you say

You may want to refer to your systems review in this role play

1) Cardiorespiratory symptoms

* + chest pain
  + exertional dyspnoea (quantify exercise tolerance: how many stairs)
  + paroxysmal nocturnal dyspnoea
  + orthopnoea (i.e. Breathless on lying flat – a symptom of left ventricular failure)
  + oedema
  + palpitations (awareness of heart beats)
  + cough
  + sputum
  + haemoptysis (coughing up blood)
  + wheeze

Take time after the session to reflect on your experience of the role-play. There will also be forms available in the session for observers and patients to record their experiences. These should be given to the interviewer when s/he has finished.

Remember although you may be thinking of a structure to your interview, this may not be the same structure the patient has in mind. For example, when asking about the presenting complaint, patients may respond by giving you information that relates to the history of the presenting complaint.

Before the third role-play

Again

* Clearly state your intentions at the commencement of the interview
* Try to identify the patient’s presenting complaint as well as their, worries and concerns at the beginning of the interview
* Work with your patient to establish the problem and how it relates to the past medical history
* Work with your patient to establish the details of the pain
* Summarise
* Invite your patient to ask questions or clarify anything you say

Again you may want to refer to SOCRATES

Site where exactly is the pain?

Onset when did the pain start, did it start suddenly or gradually?

Character describe the pain- sharp? knife-like? gripping? vice-like? burning? crushing?

Radiation does the pain spread anywhere? To the arm, jaw, groin, etc?

Associations is the pain accompanied by any other features?

Timing does the pain vary in intensity during the day?

Exacerbating or relieving factors - does anything make the pain better or worse?

Severity does the pain interfere with daily activities or with sleep?

Take time after the session to reflect on your experience of the role-play. There will also be forms available in the session for observers and patients to record their experiences. These should be given to the interviewer when s/he has finished.

Remember although you may be thinking of a structure to your interview, this may not be the same structure the patient has in mind. For example, when asking about the presenting complaint, patients may respond by giving you information that relates to the history of the presenting complaint.

Process of reflection and feedback

Each of you will be the observer once. Your role is to guide the interviewer through reflection and to give them some feedback on their performance.

* Use the checklist to identify which skills the interviewer used
* For providing feedback remember the guidelines from last year (see below)
* The following questions may be helpful in staying focused on your task and ensuring a balance
  + - **“What emotions were you feeling during the interview?”** [The purpose of this question is to raise your awareness of the link between feelings and behaviour]
    - **“And now describe two aspects of the interview that worked well?”**
* Observer asks the role-play patient:
  + - **“Can you please identify two communication skills that the interviewer used that were effective?”**
  + Observer provides specific feedback on two skills that s/he observed worked well
  + Observer asks the interviewer:
    - **“Now outline two aspects of the interview that you would do differently if you could repeat the interview?”**
  + Observer asks the role-play patient:
    - **“Can you identify two communication skills that the student could have used to improve the interview?”**
* Observer provides feedback on two skills that could have improved the interview
* Observer summarises the feedback on things that worked well and things to improve

The interviewing student will also receive written feedback

* The patient should complete the “simulated patient rating form”
* The observer should identify skills used well and those requiring development on the “patient-centred interviewing skills” list

Role-play 1

Medical student

You are working with a general practitioner (GP) who has asked you to practise taking a medical history. One of the patients in the surgery has come to see a doctor because s/he has been feeling unwell for several months. You have a private interview room in which to talk with your patient. Remember to look at the patient and respond to how you think they are feeling.

Observer

Use the checklist to think about the skills the interviewer uses, particularly in the opening and setting the agenda. Consider the content issues in relation to checklist. Use the guidelines on giving feedback to help you give constructive support to your colleague with respect to his/her patient-centred interviewing skills and content aspects of the history. Specifically, does the interviewer note the emotional state of the patient? If so, how does s/he deal with this? What is the patient’s response?

Role-play 2

Medical student

You are working with a general practitioner (GP) who has asked you to practise taking a medical history. One of the patients in the surgery has come to see a doctor about chest pain. The GP has asked you to practice your history taking and to report back before he sees the patient. You have 8 mins to talk to the patient.Try to focus on establishing the specifics of the presenting complaint try also to elicit the patient’s concerns about the complaint (chest pain)

Observer

Use the checklist to think about the skills the interviewer uses, particularly in the opening and setting the agenda. Consider the content issues in relation to checklist. Use the guidelines on giving feedback to help you give constructive support to your colleague with respect to his/her patient-centred interviewing skills and content aspects of the history.

Role-play 3

Medical student

You are a medical student in a vascular surgery clinic. You have been asked to take practice your history taking with a patient who has been referred to the clinic with a pain in the left leg on walking. Please elicit a focused history on the presenting complaints. You are not required to present your findings.

Observer

Concentrate on how well Use the guidelines on giving feedback to help you give constructive support to your colleague with respect to his/her patient-centred interviewing skills and content aspects of the history.

Patient-centred interviewing skills

|  |  |  |
| --- | --- | --- |
| Preparing for interaction  Attend to self-comfort  Minimise distraction  Focus attention on next interaction |  | Giving information  Skills to be covered later in CC |
| Commencing the interaction  Greet the patient  State your full name  Clarify your role  Obtain patient’s name  Attend to patient’s comfort  Obtain the patient’s consent  State purpose of the interaction  Mention note taking  Clarify time available  Assess patient’s ability to communicate  Demonstrate interest and respect  Empower patient to ask questions or seek clarification of anything that is unclear |  | Closing the interaction  Provide an end summary  Discuss an action plan  Check for further information  Ask for questions  Check if the patient has any worries or concerns |
| Gathering information  Use open questions initially  Allow patient to complete first sentence/s  Identify the patient’s ideas, concerns and expectations  Use active listening   * verbal (staying with patient’s topic; using patient’s words; reflection) * non-verbal (eye contact; nodding)   Use other non-verbal behaviours (body posture; gestures; facial expressions; nodding)  Use open to closed-cone questions  Pick up verbal cues  Pick up non-verbal cues  Probe sensitively  Survey for other problems  Set agenda  Clarify patient’s terms  Make interim summaries  Signpost or transition statements  Use silence appropriately  Avoid multiple questions  Avoid leading questions  Avoid unexplained jargon |  | Relationship building skills  Throughout each stage, it is important to use relationship-building skills in order to establish and maintain your relationship with the patient  Use active listening  Make empathic statements  Show warmth  Pick up verbal and non-verbal cues  Use non-verbal behaviours (posture, gestures, facial expressions)  Identify patient’s ideas, concerns and expectations  Avoid being judgmental  Not all the skills listed here will be used in every interaction.  The skills are not necessarily in a specific order although some skills obviously precede others. |

This page has been left blank for student notes

Simulated patient rating form

Student’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate your satisfaction with the student for each of the following:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Not at all satisfied |  |  |  |  | Completely satisfied | Unable to rate |
| 1 | Beginning the interview | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2 | Asking questions | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3 | Listening to you | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4 | Warmth towards you | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5 | Asking about your feelings | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6 | Choice of words | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7 | Topics covered | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | Ending the interview | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9 | Student’s appearance | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10 | Overall satisfaction | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|  |  | Highly anxious |  |  |  |  | Not at all anxious |  |
| 11 | How anxious do you think student was? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Please add any other comments that you would like to make below:

This page has been left blank for student notes

Summary

By the end of this session, you should be able to

* Identify the key content features of a medical history
* Identify the skills necessary for an effective assessment of the patient’s, presenting complaint, the history of the presenting complaint and their past medical history
* Have practised using and integrating the skills associated with patient-centred interviewing while taking a medical history

E-learning



The most relevant module for the material we have covered in this session is “information gathering and history taking”. This module is the longest of the 7 (about 2 hours if you complete it fully) so we would advise that you either leave plenty of time or complete it in two sittings. Some of the more complex concepts (such as clinical reasoning in history taking) may be more appropriate in Year 3, so please try to re-visit the module next year as well.

You may want to spend some time looking at “initiating the session”, Structuring the session”, “building the relationship” and “closing the session” prior to your simulated patient interview or during your clinical attachment when you will be focusing on history taking in a clinical setting.

References and recommended readings

CLARK, W. (1995) Effective interviewing and intervention for alcohol problems (pp 284-293). IN LIPKIN, M., PUTNAM, S. M. & LAZARE, A. (Eds.) *The Medical Interview: Clinical Care, Education and Research.* Ann-Arbour, New York, Springer-Verlag.

FISHMAN, J. & FISHMAN, L. (2005) *History Taking in Medicine and Surgery,* Cheshire, PasTest Ltd.

- a useful source of relevant questions, but many will need adapting to more patient-centred style of interviewing

HEARNE, R., CONNOLLY, A. & SHEEHAN, J. (2002-Feb) Alcohol abuse: prevalence and detection in a general hospital. *J R Soc Med,* 95**,** 84-87.

HOCKING, G., KALYANARAMAN, R. & DEMELLO, W. F. (1998) Better drug history taking: an assessment of the DRUGS mnemonic. *J R Soc Med,* 91**,** 305-6.

KNEEBONE, R. L. & NESTEL, D. (2005) Learning clinical skills - the place of simulation. *The Clinical Teacher,* 2**,** (2) 86-90.

LEWIS, T. (2004) Using the NO TEARS tool for medication review. BMJ 329**,** 434.

LIPKIN, M., FRANKEL, R., BECKMAN, H., CHARON, R. & FEIN, O. (1995) Performing the interview (ch 5, pp 65-82 : see pp 73). In LIPKIN, M., PUTNAM, S. M. & LAZARE, A. (Eds.) *The Medical Interview: Clinical Care, Education and Research.* Ann-Arbour, New York, Springer-Verlag.

LLOYD, M. & BOR, R. (2004) *Communication Skills for Medicine (2nd ed),* London, Churchill.

LONGMORE, M. WILKINSON, I. TURMEZEI, T. CHEUNG, C.K. (ed). (2007) *Oxford Handbook of Clinical Medicine (7th ed),* Oxford, UK, OUP.

SILVERMAN, J., KURTZ, S. & DRAPER, J. (2004) *Skills for Communicating with Patients (2nd ed) (pp 57-105),* Oxford, Radcliffe Medical Press.

SMITH, R. C. (2002) *Patient-Centred Interviewing: An Evidence-Based Method (2nd ed),* Philadelphia, Lippincott William and Wilkins.

SNADDON, D., LAING, R., MASTERTON, G. & COLEDGE, N. (2005) History taking (pp 1-37). IN DOUGLAS, G., NICOL, F. & ROBERTSON, C. (Eds.) *MacLeod's Clinical Examination.* 11th ed. London, UK, Elseiver Churchill Livingstone.

WASHER, P. (2009) How to take a medical history (Ch 3, pp18-25). In WASHER, P. *Clinical Communication skills.* Oxford, OUP.

Complete your SOLE pages before you leave the session

In your next session you will be interviewing a simulated patient.

Please check the intranet to find out the time and place of your simulated patient interview session.

Appendix: Content of a medical history (Longmore et al, 2007)

Presenting complaint (PC)

“What has been the trouble recently?”

ICE – Ideas, concerns, expectations about presenting complaint and/or the patients health in general

How is the PC impacting their life? How has it affected their daily living?

History of presenting complaint (HPC)

When did it start? What was the first thing you noticed? Progression since then. Ever had it before?

Assess the patient’s knowledge of investigations (have they had previous investigations? Do they have an expectation regarding investigations?)

Assess the patient’s knowledge of treatment (have they received treatment? Do they have an expectation regarding treatment?)

Try to characterise pain and symptoms roughly as:

* Site; radiation; intensity; duration; onset (gradual or sudden)
* Character (sharp, dull, knife-like, colicky)
* Associated features (nausea, vomiting etc)
* Exacerbating and alleviating factors (What, if anything, makes it worse? What, if anything, takes it away or makes it better?)

Direct questioning

Specific questions about the diagnosis you have in mind (and risk factors e.g. travel) and a review of the relevant system

Past medical history (PMH)

Serious illnesses beginning in childhood

Hospitalisations

Surgical Procedures

Accidents or Injuries

Current Medications

Immunisations

Screening Procedures

Medications/allergies

* Any tablets, injections?
* Any ‘off the shelf’ drugs?
* Herbal remedies?
* Ask the features of allergies; it may not have been one.

Social and family history (SH/FH)

* Probe without prying.
* “Who else is at home with you?”
* Job
* Marital status
* Spouse/partner’s job and health
* Housing
* Who visits? – relatives, neighbours, GP, nurse
* Who does the cooking and shopping?
* What can the patient not do because of the illness?
* Age, health, and cause of death, if known, of parents, siblings, children; ask about TB, diabetes mellitus, and other relevant disease.
* Areas of the family history may need detailed questioning e.g. to determine if there is a significant family history of heart disease you need to ask about grandfathers’ and male siblings’ health, smoking, and tendency to hypertension, hyperlipaedemia, and claudication before they were 60 years old, as well as ascertaining the cause of death.

Lifestyle

* General questions regarding:
* Diet (what types of food do they typically eat?)
* Exercise
* Sexual history
* Recent travel
* Any significant life events

Alcohol, ‘recreational’ drugs, tobacco

* How much? How long?

Functional enquiry/Systems review

To uncover undeclared symptoms. Some of this may already have been incorporated into the history.

General questions may be the most significant, e.g. in TB or cancer:

* weight loss
* night sweats
* any lumps
* fatigue
* appetite
* fevers
* itch
* recent trauma

1. Cardiorespiratory symptoms

* chest pain
* exertional dyspnoea (quantify exercise tolerance: how many stairs)
* paroxysmal nocturnal dyspnoea
* orthopnoea (i.e. Breathless on lying flat – a symptom of left ventricular failure)
* oedema
* palpitations (awareness of heart beats)
* cough
* sputum
* haemoptysis (coughing up blood)
* wheeze

1. Gut symptoms

## abdominal pain (constant or colicky, sharp or dull; site; radiation; duration; onset; severity; relationship to eating and bowel action; alleviating/exacerbating or associated features)

## indigestion; nausea/vomiting

## stool – colour, consistency, blood, colour of blood, slime, difficulty flushing away

## tenesmus (feeling that there is something in the rectum that cannot be passed e.g. due to a tumour)

## maleana is altered (black) blood passed PR

## haematemesis (vomiting blood)

## 3) Genitourinary symptoms

## incontinence (stress or urge)

## dysuria (painful micturition)

## haematuria (blood in urine)

## nocturia (needing to pass urine at night)

## frequency

## polyuria

## hesitancy

## terminal dribbling

## vaginal discharge

* menses: frequency, regularity, heavy or light, duration, painful, first day of last menstrual period (LMP)
* number of pregnancies
* menarche
* menopause
* chance of current pregnancy?

## 4) Neurological symptoms

## Sight

## Hearing

## Smell / taste

## Seizures, faints, funny turns

## Headache

## Pins and needles (paraesthesiae)

## Weakness “Do your arms and legs work?” poor balance

## Speech problems

## Sphincter disturbance

## Higher mental function and psychiatric symptoms

## Differences between right and left

The important thing is to assess function: what the patient can and cannot do at home, work etc.

## 5) Musculoskeletal symptoms

## Pain, stiffness, swelling of joints

## Diurnal variation in symptoms (i.e. With time of day)

## Functional deficit

## Muscle wasting

## Trauma

## 6) Thyroid symptoms

## Hyperthyropidism: Prefers cold weather, sweaty, diarrhoea, oligomenorrhoea, weight loss, tremor, visual problems

## Hypothyroidism: depressed, slow, tired, thin hair, croaky voice, heavy periods, constipation, and dry skin

Session 2

History taking (ii) with a simulated patient

Introduction

In this session you will have an opportunity to practise the interviewing skills you were developing throughout last year and blending in the core skill of history taking. Effective use of your communication skills will enable you to obtain clinical information important for making a diagnosis.

Instructions

Please arrive 5 minutes before you are scheduled to start. You are expected to participate throughout the entire session (80 mins).

Please bring your guide and supplement to the session and complete the learning goals form **before** the session.

Aim

To give you the opportunity to practise integrating history taking with the patient-centred communication skills you have developed in year 1. There is an opportunity to for you to give and receive feedback on the use of your skills in the context of history taking. Please revisit the principles of and models of feedback outlined in year 1 handbook.

Learning objectives

By the end of this session, you should be able to:

* Receive feedback on your communication skills from a simulated patient
* Receive feedback on communication integrated with history-taking skills from a tutor and from peers
* Identify those history-taking skills that you used effectively in the simulated interviews
* Identify those skills that require further development
* Identify ways in which your communication and history-taking strengths will be maintained
* Identify ways in which your communication and history-taking weaknesses will be improved

After the session, you will be expected to:

* Continue the development of self-awareness in relation to your strengths and weaknesses in communicating with patients.
* Think about how you might improve your communication skills
* Link your learning experiences to other courses in year 2 Foundations of Clinical practice.

Methods

You will work in groups of 3 with a tutor and a simulated patient.

Activity 1: Interviewing a simulated patient

*Aim: To provide you with an opportunity to practise your interviewing skills while obtaining information important for making a diagnosis*

You will be assigned a start time of 1000, 1135, 1400 or 1535.

Please arrive 5 minutes before you are scheduled to start. You must attend the entire session (80 mins)

Morning Afternoon

Session 1

Introduction 1000 - 1010 1400 - 1410

Interview 1 1010 - 1030 1410 - 1430

Interview 2 1030 - 1050 1430 - 1450

Interview 3 1050 - 1110 1450 - 1510

Summary 1110 – 1120 1510 - 1520

BREAK 1120 - 1135 1520 - 1535

Session 2

Introduction 1135 – 1145 1535 - 1545

Interview 1 1145 - 1205 1545 - 1605

Interview 2 1205 - 1225 1605 - 1625

Interview 3 1225 - 1245 1625 - 1645

Summary 1245 – 1255 1645 - 1655

Patient-Centred interviewing skills

Skills to be targeted draw on your 1st and 2nd Year programmes. You will find it helpful to read the background section of your Year 1 guide on patient-centred interviewing skills again before attending this session. Not all these skills will be discussed before the interviews commence so try to re-familiarise yourself with them. If you have any questions about any of the skills, then ask your tutor at the beginning of the session.

Different approaches to interviewing are needed for different patients. A gentle approach may suit one patient, while another might prefer a more assertive manner. It is important to recognise that doctors also differ in their personalities and abilities. There is no one correct approach. You will find your own style and manner of practising in patient centred ways.

Student task in the interview

Your task is to gather information relevant to a medical history in a way that is efficient and orderly, and demonstrate sensitivity to the patient’s needs and concerns. You will aim to achieve some understanding of the simulated patient’s emotional state, and their view of the illness. The patient’s perception of their illness may or may not be accurate from a biomedical perspective, but it is always important – the patient is the expert about the way they are feeling. Also you might find it possible to cover the following areas: obtaining consent, setting the agenda, and assessing alcohol, tobacco and other drug use.

When asking questions consider:

* Will the words you are using be understood by the patient?
* Does the question contain abbreviations, unconventional phrases or jargon?
* Is it vague?
* Is it too precise?
* Is it biased?
* Is it threatening?
* Does it contain more than one concept?
* Does it contain a double negative?
* Are the answers mutually exclusive?
* Does it assume too much about the patient’s behaviour?
* Is an unambiguous time reference provided?
* Is the question cryptic? (Summerton, 2007)

Integrating content and process

To effectively integrate content and process, you may need to think more carefully about the sequential structure of your interview. In some instances this may require some oscillation (back and forth movements) between open and closed questions rather than simply moving from a more open to a closed directional focus (**see Content and Process and Sequential Organisation under session 1**). This technique can also be used to build a clearer picture of the patient’s ideas and to gather the specific clinical information you need thereby effectively integrating content and process.

ePortfolio Task



This eportfolio task asks you to reflect on your communication skills and history taking. In addition it encourages team-work and feedback skills as you will be gatewaying the forms to peers and giving/receiving feedback.

Please complete the form entitled: Y1-CC-Session 2: Simulated Patient History

Remember to incorporate your feelings, feelings of other (tutors, patients, peers) and viewpoint of experts (e.g. literature) in your reflections.

Please gateway/email this form to the **other students who were in your session** (usually two others). You should receive completed forms form the other students as well.

When you receive a completed form, please give feedback and return it to the author. The guidelines for grading reflective writing are on the next page.

This task is entirely student-focused and the forms are not gatewayed to staff. If you do not receive a completed form from a colleague in your group or do not receive feedback on your own reflections, we encourage you to ask for it. Ensuring that others support you within a team is an important part of professional behaviour.

**This task should be completed within 2 weeks of your session. Remember there are 2 stages so allow one week for each.**

Written reflections on interview

|  |  |  |  |
| --- | --- | --- | --- |
| Skill | Feelings | Rationale | Patient Response |
| Opening  Describe a skill you used to open the consultation | Identify feelings not thoughts ”I felt the patient was withholding information” is a thought not a feeling.  “I felt nervous at the beginning” is a feeling. | You should include your own reasoning backed up by evidence from the literature | Patient’s responses could include verbal or non-verbal behaviours in response to the skills used by the student |
| Establish Rapport  Describe a skill you used to establish rapport |  |  |  |
| Information Gathering  Describe a skill you used to gather information |  |  |  |
| Closure  Describe a skill you used to close the consultaiton |  |  |  |
| Maintain Strengths  Say **how** you will maintain strengths | | Improve Weaknesses  Say **how** you will improve weaknesses | |

Summary

When you have all conducted an interview and received feedback the session will be brought to a close.

Review the learning objectives:

By the end of this session, you should be able to:

* Receive feedback on your communication skills from a simulated patient
* Receive feedback on communication and history-taking skills from a tutor and from peers
* Identify those history-taking skills that you used effectively in the simulated interviews
* Identify those skills that require development
* Identify ways in which your communication and history-taking strengths will be maintained
* Identify ways in which your communication and history-taking weaknesses will be improved

After the session, you should:

* Continue the development of self-awareness in relation to your strengths and weaknesses in communicating
* Think about how you might improve your communication skills
* Link your learning experiences to other courses in Year 2 Foundations of Clinical Practice.

References

COLE, S. A. & BIRD, J. (2000) Chief complaint and survey of problems (ch 8, pp 68-77). *The Medical Interview: Three Function Approach.* 2nd ed. Missouri, Mosby.

COLE, S. A. & BIRD, J. (2000) Patient profile and social history (ch 12, pp 95-100). *The Medical Interview: The Three Function Approach.* 2nd ed. Missouri, Mosby.

LLOYD, M. & BOR, R. (2004) Basic communication skills (ch 2, pp 9-25). *Communication Skills for Medicine.* 2nd ed. London, Churchill.

PENDLETON, D., SCHOFIELD, T., TATE, P. & HAVELOCK, P. (1984) An approach to learning and teaching (ch 6, pp 61-72). *The Consultation: An Approach to Learning and Teaching.* Oxford, Oxford University Press.

SILVERMAN, J., KURTZ, S. & DRAPER, J. (2004) *Skills for Communicating with Patients (2nd ed),* Oxford, Radcliffe Medical Press.

SMITH, R. C. (2002) Interviewing [ch1, 1-16]. *Patient-Centred Interviewing: An Evidence-Based Method.* 2nd ed. Philadelphia, Lippincott William and Wilkins.

SMITH, R. C. (2002) Facilitating skills (ch 2, pp 17-33) (patient-centred comm). *Patient-Centred Interviewing: An Evidence-Based Method.* 2nd ed. Philadelphia, Lippincott William and Wilkins.

SMITH, R. C. (2004) Patient-Centred Interviewing (ch 3, pp 35-71). *Patient-Centred Interviewing: An Evidence-Based Method.* 2nd ed. Philadelphia, Lippincott William and Wilkins.

SUMMERTON, N. (2007) Patient's story: symptoms (ch 4, pp 36-56). *Patient centred diagnosis.* Oxford, Radcliffe.

WASHER, P. (2009) How to take a medical history (Ch 3, pp18-25). In WASHER, P. *Clinical Communication skills.* Oxford, OUP.

Complete your SOLE pages before you leave the session

Learning goals

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you feel about your interview with the simulated patient?

What skills do you want to focus on in your interview?

1.

2.

3.

Is there anything specific you would like the tutor to observe and give you feedback on?

Briefly outline.

Patient centred interviewing skills

|  |  |  |  |
| --- | --- | --- | --- |
| Preparing for interaction  Attend to self-comfort  Minimise distraction  Focus attention on next interaction |  | | Giving information  Skills to be covered later in the CP |
| Commencing the interaction  Greet the patient  State your full name  Clarify your role  Obtain patient’s name  Attend to patient’s comfort  Obtain the patient’s consent  State purpose of the interaction  Mention note taking  Clarify time available  Assess patient’s ability to communicate  Demonstrate interest and respect  Empower patient to ask questions or seek clarification of anything that is unclear | |  | Closing the interaction  Provide an end summary  Discuss an action plan  Check for further information  Ask for questions  Check if the patient has any worries or concerns |
| Gathering information Use open questions initially  Allow patient to complete first sentence/s  Identify the patient’s ideas, concerns and expectations  Use active listening   * verbal (staying with patient’s topic; using patient’s words; reflection) * non-verbal (eye contact; nodding)   Use other non-verbal behaviours (body posture; gestures; facial expressions, nodding)  Use open to closed-cone questions  Pick up verbal cues  Pick up non-verbal cues  Probe sensitively  Survey for other problems  Set agenda  Clarify patient’s terms  Make interim summaries  Signpost or transition statements  Use silence appropriately  Avoid multiple questions  Avoid leading questions  Avoid unexplained jargon |  | | Relationship building skills  Throughout each stage, it is important to use relationship-building skills in order to establish and maintain your relationship with the patient  Use active listening  Make empathic statements  Show warmth  Pick up verbal and non-verbal cues  Use non-verbal behaviours (posture, gestures, facial expressions)  Identify patient’s ideas, concerns and expectations  Avoid being judgmental  Not all the skills listed here will be used in every interaction.  The skills are not necessarily in a specific order although some skills obviously precede others. |

Content of medical history

|  |  |  |
| --- | --- | --- |
| Presenting complaint (PC)   * Patient’s IDEAS about the cause of PC * Patient’s CONCERNS about the PC * Patient’s EXPECTATIONS of what will happen * Effect of the PC on patient’s life (home & work) |  | Social history   * Age * Who lives in household * Quality of relationships * Work - nature & satisfaction * Housing - location & type |
| History of PC   * When did it start * First things noticed * What has happened * What has the patient done about it * Medication for PC * Ever had it before * If so, what happened last time * Characterise pain/symptoms * Site, radiation, intensity, duration, on-set, associated features * Patient’s knowledge of treatment * Patient’s knowledge of investigation |  | Lifestyle   * Smoking/tobacco * Alcohol * Recreational drugs * Exercise * Diet * Sleep * Sexual history * Recent travel * Significant life events |
| Past medical history   * Previous illnesses * Previous operations * Previous hospitalisations * Screening questions: diabetes, asthma, tuberculosis, jaundice, rheumatic fever, high blood pressure, heart disease, stroke, epilepsy, anaesthetic problems |  | Functional Enquiry/Systems Review   * General (fever, weight loss, night sweats, lumps, fatigue, appetite, itch, recent trauma) * Cardio-respiratory * Gut * Genito-urinary * Neurological * Musculo-skeletal * Thyroid |
| Medication/Allergies   * Medication * Over-the-counter medicine * Alternative medicine * Allergies * Consider DRUGS mnemonic |  | Initially, it is VERY important to stay with the patient’s narrative. Skilful communicators guide the patient in these directions while ACTIVELY listening to the patient |
| Family history  Parents, siblings, children - alive, well, if not, what happened |  | This is not an exclusive list. There is overlap between boxes. The list is not sequential but groups together aspects of a patient’s history about which you need to enquire |

Simulated patient rating form

Student’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate your satisfaction with the student for each of the following:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Not at all satisfied |  |  |  |  | Completely satisfied | Unable to rate |
| 1 | Beginning the interview | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2 | Asking questions | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3 | Listening to you | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4 | Warmth towards you | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5 | Asking about your feelings | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6 | Choice of words | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7 | Topics covered | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | Ending the interview | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9 | Student’s appearance | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10 | Overall satisfaction | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|  |  | Highly anxious |  |  |  |  | Not at all anxious |  |
| 11 | How anxious do you think student was? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Please add any other comments that you would like to make below:

Session 3

History Taking (iii): Social History (Diet, alcohol, drug and tobacco use)

Introduction

This session is an expansion on session 1 and aims to prepare you for tackling topics relating to a \*social history including a patient’s dietary habits, alcohol and tobacco consumption. It also addresses the issue of cross cultural communication. Your patient’s eating habits and lifestyle patterns can be the cause of other more serious health problems and if not clearly identified can result in ineffective treatments and exacerbating symptoms. For example, Obesity has also been linked to key health problems, such as type 2 diabetes and heart disease and overall can have a significant impact on life expectancy. Cultural beliefs and practices too, can impact on a patient’s health.

In addition to providing some practical guidance, this session will consider these issues from the point of view of the communication process with patients. One of the difficulties is that patients can have strong beliefs about what they eat and drink and may not recognise the connections with their health. Moreover, in asking about diet and alcohol consumption etc patients can become defensive and give vague responses which can present a barrier to effective information gathering. It is important then that should the occasion arise where you feel you have to inquire into a patient’s dietary habits and lifestyle, that you are equipped with the basics to do so.

Diet and lifestyle

Food allergies are becoming increasingly more common and can in some instances be difficult to diagnose which can be problematic particularly when the occur in children and young people. NICE has set out guidelines for consultation on the diagnosis and assessment of food allergies in children and young people.

<http://guidance.nice.org.uk/CC116>

The problem of obesity has exploded in the past 10 years. A person is considered obese if they have a body mass index (BMI) of 30 or greater. Over time, eating excess calories leads to weight gain. Without lifestyle changes to increase the amount of physical activity done on a daily basis, or reduce the amount of calories consumed, people can become obese. In 2008, the latest year with available figures, nearly a quarter of adults (over 16 years of age) in England were obese (had a BMI over 30). Just under a third of women, 32%, were overweight (a BMI of 25-30), and 42% of men were overweight. <http://www.nhs.uk/conditions/obesity/pages/introduction.aspx>

**\*NB** We do not advocate that you should necessarily think about the structure and sequence of the medical history in this way. We have divided it in this way for instructive purposes. Often times information pertaining to the patient’s social history may come in very early on when asking about the presenting complaint etc.

Learning objectives

* Give examples of the range of problems to which diet contributes
* Discuss some of the problems in establishing a patient’s dietary habits
* Give examples of the key screening questions to ask every patient when taking a nutrition history
* Identify the skills necessary for an effective assessment of drug, alcohol and tobacco use
* Use a range of other questions to explore each area more deeply

Activities

1. What information do I need about patients dietary habits?

2. Assessing diet and lifestyle

3. Assessing alcohol, drug and tobacco use

Activity 1: What information do I need about a patient’s dietary habits?

Discuss in 2s or 3s for 5 minutes and then report back to the group:

Activity 2: Assessing a patient’s nutrition history

Take a Dietary History

Many diseases have dietary components and this has been increasingly recognised in recent years. Exploration of your patient’s diet is a crucial part of your understanding of their health and wellbeing

What do you think are the key questions that would allow you to begin to assess a patient’s nutrition history?

What do you think you need to know about a patient’s typical day’s food and drink?

What if the patient is on a special diet? What do you need to know and why?

What about the patient’s height, weight and BMI?

NB when you come to Paediatrics in year 5 you will explore this area with particular relevance to children

Activity 3: Assessing alcohol, drug & tobacco use

*Aim: To provide you with an opportunity to focus on specific elements of medical histories*

There are many subjects that patients may find it difficult to talk openly about if you do not create the appropriate atmosphere and enquire in appropriate ways. Among these areas are alcohol, tobacco and drug use.

a) Alcohol use

Would it be easy for you to answer questions about your own alcohol consumption? How might you feel about being asked such questions? How honestly / accurately might you answer? Many individuals are unaware of how much alcohol they drink and its potential impact on their health. Whilst it is important to obtain information about alcohol intake from all patients as part of a medical history this needs to be done sensitively.

There are a number of ways in which information can be gathered about alcohol consumption. Most people, who drink alcohol in our society, do so sensibly without leading to health problems. Ascertaining that their drinking habits are in the region of the recommended ranges may be all you need to do at this early stage. However patients can underestimate their alcohol intake and tobacco usage and you may feel it is worth asking about alcohol in an additional way e.g. “so what would your usual pattern of drinking be over a working week?”

Alcohol consumption is usually expressed in terms of units. One unit of alcohol comprises 10 g, equivalent to half a pint of beer, one glass of wine or one measure of spirit.

Recommended maximum units:

Women: <14 u/week

Men: <21 u/week (higher levels are controversial)

This equates to: no more than 2-3 units per day for women

no more than 3-4 units per day for men

Should be taken regularly with food and not in binges.

Consumption over these levels confers a significant risk of an alcohol-related disorder (chronic liver disease; peripheral neuropathy; cerebral atrophy; pancreatitis; and alcoholic cardiomyopathy). Hospital-based surveys report that up to one-third of men admitted to medical and surgical wards have alcohol-related problems. In accident and emergency departments, as many as 40% of male patients may have alcohol-related problems. (Hearne et al, 2002)

The amount of alcohol contained in any alcoholic drink is measured in units. A unit is equivalent 10ml of pure alcohol.

### How to measure units

Any drink that you buy will contain a measurement of its alcohol by volume (ABV). ABV is a measurement of how much of that drink is made up of pure alcohol.

The easiest way to work out how many units of alcohol a drink provides is:

* find out what the drink’s ABV is
* then multiply that by how many milli-litres of liquid are in the drink
* then divide that by 1,000

So for a standard pint of strong lager:

* its ABV would be 5%
* a pint contains 568ml
* 5 times 568 equals 2,840
* divide that by 100, to give a measurement of 2.8 units

The units found in some standard drink sizes are listed below:

* a can of standard lager, beer, bitter – 1.8 units
* a can of strong lager, beer, bitter – 2.2 units
* a pint of standard lager, beer, bitter – 2.3 units
* a pint of strong lager, beer, bitter – 2.8 units
* a small glass of wine (125ml) – 1.5 units
* a large glass of wine (250ml) – 3 units
* a bottle of alcopops – 1.4 units
* a glass of spirits (25ml) – 1 unit
* a bottle of wine – 9 units
* a one litre bottle of standard cider – 4 units
* a one litre bottle of strong cider – 9 units
* a 700ml bottle of spirits – 27-28 units

If a patient tells you they are drinking above the recommended level or you have reasons to suspect they may be at risk (e.g. examination or blood tests suggest alcohol-related problem) then you may want to consider using one of the screening tool such as those outlined below.

Individuals whose repeated drinking may harm their work or social life may be alcoholic. Denial is a leading feature of alcoholism. The level of alcohol related illness encountered by doctors has led to the development of a number of screening tools. Many of them are known by a mnemonic, you do not need to learn all of these but they are useful to explore specific alcohol related concerns.

Mnemonics are often used in order to help you remember to ask about certain conditions etc. They are a form of checklist and need to be used wisely to support your information gathering rather than driving it – this could reduce the flow and relationship building stage of the interview. You may find it helpful to experiment with each and find what works for you (and for your patients).

CONTROL

CO Can you always COntrol your drinking?

N Has alcohol ever led you to Neglect your family or your work?

T What Time do you start drinking? Do you sometimes start before this?

R Do friends comment on how much you drink or ask you to Reduce intake?

O Do you ever drink in the mornings to Overcome a hangover?

L Go through an average day’s alcohol, Leaving nothing out.

This can be used if you suspect that your patient may have problems with drinking.

Clearly not relevant to ALL patients. (Hope *et al*, 1998)

The following information should also be obtained if alcohol abuse is suspected:

* the nature and quantity of alcohol presently consumed per week
* the amount of money spent on alcohol per week, as sometimes this reveals a striking discrepancy
* the age of onset of drinking
* previous drinking habit, including maximum weekly intake and presence or absence of bout drinking
* previous episodes of the shakes, delirium, tremors and admission to hospital
* time of taking the first drink in the day (regular morning drinking is strongly suggestive of dependence)
* with whom and where drinking occurs, at home or in a pub

A recent comparison of alcohol assessment tools identified FAST as the most efficient screening questionnaire for primary care and emergency settings. (Parker et al, 2008 Diagnosis and management of alcohol disorders BMJ, Vol. 336)

Fast Alcohol Screening Test (FAST)

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

1 MEN: How often do you have EIGHT or more drinks on one occasion?

WOMEN: How often do you have SIX or more drinks on one occasion?

Never Less than monthly Monthly Weekly Daily or almost daily

2 How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never Less than monthly Monthly Weekly Daily or almost daily

3 How often during the last year have you failed to do what was normally expected of you because of drinking?

Never Less than monthly Monthly Weekly Daily or almost daily

4 In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No Yes on one occasion Yes on more than one occasion

If the response to question 1 is Never then the patient is not misusing alcohol. If the response to question 1 is Weekly or Daily or almost daily then the patient is a hazardous, harmful or dependent drinker.

*Over 50% of people will be classified using just this one question.*

Only consider questions 2, 3 and 4 if the response to question 1 is Less than monthly or Monthly.

If the response to question 1 is Less than monthly or Monthly then each of the four questions is scored 0 to4. These are then added together, resulting in a total score between 0 and 16. The person is misusing alcohol if the total score for all four questions is 3 or more.

In summary:

Score questions 1 to 3: 0, 1, 2, 3, 4

Score question 4: 0, 2, 4

The minimum score is 0

The maximum score is 16

The score for hazardous drinking is 3 or more.

For more information see:

<http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/manual_for_the_fast_alcohol_screen_test_fast_fast_screening_for_alcohol_problems.jsp>

b) Drug use

Use of illegal drugs is widespread in all Western societies, and many young people experiment with so-called recreational drugs such as cannabis or ecstasy. For most people, there’ll be no long term mental or physical health consequences. Other people are not so fortunate, and you’ll encounter people who have mental health problems related to their drug use (such as cannabis psychosis), or who are addicted to stimulants, particularly cocaine and its derivate ‘crack’, or to opiates such as diamorphine (heroin). At the extreme end of the spectrum, some chaotic drug users may use a variety of drugs (poly-drug use). As with alcohol, any enquiries around drug use you make should be sensitive and non-judgemental.

Enquiries into drug use can be made as part of a medication history. This DRUGS mnemonic was developed for use in taking a history prior to anaesthesia. Its use identified a range of drug sensitivities not elicited by “general” history taking. Broad questions like, “Are you taking any medications?” may not lead patients to volunteer information that may be important in any management plan (e.g. paracetamol or non-steroidal anti-inflammatory drugs). Hospital staff need to be sure they are not giving toxic doses by adding to existing treatment. Be aware that an “allergy” may often be interpreted as a side-effect by patients (e.g. sleepiness after morphine). Failure to apply your basic communications skills to question more closely may lead to a patient being denied an effective medication. (Hocking et al, 1998)

Doctor Any medications prescribed by a registered medical or dental practitioner

Recreational Tobacco, alcohol, illicit drugs, anabolic steroids etc obtained for non-medicinal use

User Over-the-counter purchases from a pharmacy, alternative medicines/homeopathy

Gynaecological Oral contraceptives, hormone replacement therapy

Sensitivities Response to anaesthetics, including the exact nature of the response

The NO TEARS acronym was reported (Lewis, 2004) in the BMJ. It aims to improve assessment of patient’s current medication use. It is useful for patients on long-term medication or those taking multiple medications – to identify if they are all needed still, if doses need reviewing, if there are newer alternatives etc.

Need and indication Are they still needed? Does the patient know why they are taking them? Is the dose appropriate?

Open questions “Do you have any problems with your medication?” “Can I check we both agree what you are taking regularly” “Do you think your tablets are working?”

Tests and monitoring Assess disease control – is anything untreated? Does any condition require monitoring?

Evidence and guidelines Has the evidence base changed since the prescription was initiated? Is the dose appropriate?

Adverse events “Are there any side effects?” remember the prescribing cascade – often side-effects are misinterpreted for a new condition. Is the patient taking any over the counter or alternative medication that may interact?

Risk reduction or prevention What are the risks to this patient? Are the drugs optimised to reduce the risks?

Simplification and switches Can treatment be simplified? Replace several low dose agents with a single full dose. Consider cost effectiveness as well as convenience.

c) Tobacco use

What information do you need from patients in order to assess their tobacco use?

How do you raise these topics with patients?

After you have heard the patient’s story, signpost the structure of the interview, e.g. ‘I need to ask you some questions about your, past medical history, family history, social history’ and so on.

Normalise the content, “We ask this of all patients…I need to know about whether you drink alcohol, whether you smoke, or if you use drugs’

Since smoking is implicated in so many illnesses and diseases it is essential that a smoking history is recorded for all patients. Remembering how being judgemental can have an impact on the relationship-building process and try to convey a non-judgemental attitude whilst gathering information. (There may be opportunities at a later stage to mention support to stop smoking etc) There is evidence that merely raising the issue of smoking, in this neutral way during a consultation can be sufficient to help some patients consider changing their behaviours.

Activity 4: Consultation demonstrations

You will observe and then discuss role-plays acted out at the front of the lecture theatre. The demonstrations portray different interview approaches to introducing lifestyle topics such as diet and alcohol. You are encouraged to identify the skills used and why they are used. You are also encouraged to identify how best to approach these potentially sensitive topics.

Summary and review

* Understand the range of problems to which diet contributes
* Recognise some of the problems in establishing a patient’s dietary habits
* Learn the key screening questions to ask every patient when taking a nutrition history
* Identify the skills necessary for an effective assessment of drug, alcohol and tobacco use
* Use a range of other questions to explore each area more deeply
* Identify how cultural issues may affect communication
* Identify a range of solutions for managing cross-cultural communication

Complete your SOLE pages before you leave the session

#### References

Diet

<http://guidance.nice.org.uk/CC116>

<http://www.nhs.uk/conditions/obesity/pages/introduction.aspx>

Alcohol

CLARK, W. (1995) Effective interviewing and intervention for alcohol problems (pp 284-293). IN LIPKIN, M., PUTNAM, S. M. & LAZARE, A. (Eds.) *The Medical Interview: Clinical Care, Education and Research.* Ann-Arbour, New York, Springer-Verlag.

HEARNE, R., CONNOLLY, A. & SHEEHAN, J. (2002-Feb) Alcohol abuse: prevalence and detection in a general hospital. *J R Soc Med,* 95**,** 84-87.

HOCKING, G., KALYANARAMAN, R. & DEMELLO, W. F. (1998) Better drug history taking: an assessment of the DRUGS mnemonic. *J R Soc Med,* 91**,** 305-6.

LEWIS, T. (2004) Using the NO TEARS tool for medication review. BMJ 329**,** 434.

LIPKIN, M., FRANKEL, R., BECKMAN, H., CHARON, R. & FEIN, O. (1995) Performing the interview (ch 5, pp 65-82 : see pp 73). In LIPKIN, M., PUTNAM, S. M. & LAZARE, A. (Eds.) *The Medical Interview: Clinical Care, Education and Research.* Ann-Arbour, New York, Springer-Verlag.

LLOYD, M. & BOR, R. (2004) *Communication Skills for Medicine (2nd ed),* London, Churchill.

LONGMORE, M. WILKINSON, I. TURMEZEI, T. CHEUNG, C.K. (ed). (2007) *Oxford Handbook of Clinical Medicine (7th ed),* Oxford, UK, OUP.

PARKER, A., MARSHALL EJ., & BALL D. (2008) Diagnosis and management of alcohol use disorders. *BMJ* Vol. 336 No. 7642.

SILVERMAN, J., KURTZ, S. & DRAPER, J. (2004) *Skills for Communicating with Patients (2nd ed) (pp 57-105),* Oxford, Radcliffe Medical Press.

SMITH, R. C. (2002) *Patient-Centred Interviewing: An Evidence-Based Method (2nd ed),* Philadelphia, Lippincott William and Wilkins.

SNADDON, D., LAING, R., MASTERTON, G. & COLEDGE, N. (2005) History taking (pp 1-37). IN DOUGLAS, G., NICOL, F. & ROBERTSON, C. (Eds.) *MacLeod's Clinical Examination.* 11th ed. London, UK, Elseiver Churchill Livingstone.

WASHER, P. (2009) How to take a medical history (Ch 3, pp18-25). In WASHER, P. *Clinical Communication skills.* Oxford, OUP.

<http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/manual_for_the_fast_alcohol_screen_test_fast_fast_screening_for_alcohol_problems.jsp>

*Appendix: Take a Dietary History*

Many diseases have dietary components and this has been increasingly recognised in recent years. Exploration of your patient’s diet is a crucial part of your understanding of their health and wellbeing

**Key questions**

* Can I ask you about your Weight?
* Do you have any concerns over your weight?
* Can you take me thorough a typical day’s food and drink?
* Do you eat a special diet?

You need to cover each of these questions, perhaps quite briefly if there is little evidence of problems, but use the discussion below to explore in greater depth as the need arises.

**NB Language:** for many patients “diet” means a weight reducing diet. “Can I ask about your diet?” gets the reply “I’m not on a diet” ask about “eating habits”.

**What is your Weight?**

* Do you know how much you weigh? (NB it is still important to weigh your patient – see below under “examination”)
* Is it increasing/decreasing?
* Are your clothes tighter/looser?

**Do you have any concerns over your weight?**

* losing wt unintentionally (eg malignancy, thyrotoxicosis, inflamm. bowel disease, diabetes),
* unexpected wt gain (myxoedema, diabetes)
* “How do you feel about your weight?” (anorexia/bulimia/ body image disorders)

**Can you take me thorough a typical day’s food and drink?**

Go through the day finding out what the patient eats from the time they wake up, throughout the day, until bedtime. Those whose diets are of most concern, may not have proper meals and may have very chaotic eating patterns, living on snacks, bingeing and starving, eating sweets, microwaved frozen food in front of the telly etc, etc. shift/night workers may have unusual (although perfectly satisfactory) eating arrangements. So avoid asking (at least initially) about breakfast, lunch, dinner, etc .

* Look for evidence of good diet:
  + most of energy as carbohydrates especially unrefined/wholegrain,
  + adequate protein intake (remember)
  + modest amount of fats (unsaturated –from vegetable oils, mono-unsaturated – olive oil) in diet. “Good” fats: oily fish with omega 3 fatty acids protective against heart disease
  + plenty of fruit and vegetables, provides fibre, vitamins. NHS Promotion of “five a day” (but benefits disputed)
* Evidence of bad diet:
  + lots of refined carbohydrates (sugary fizzy drinks, cakes, biscuits, sweets, “sweet tooth”),
  + excess fats eg; fried food, “bad” animal fats (butter, fatty meats eg burgers, chicken nuggets)   
    (NB palm oil, used in many prepared foods is a largely saturated fat despite vegetable origin)
  + Ready meals often contain more fat, salt, sugar (to add flavour at low cost)
* Junk food: “McDonalds diet” – high fat, sugar, salt
* Snacks
  + Large numbers extra calories assoc with small but frequent eating of biscuits etc
  + Do you snack in between meals?
  + Do you snack at bedtime or during the night?
* Drinks eg
  + large amounts of fizzy drinks – associated with obesity,
  + large amounts of coffee, tea or chocolate (containing caffeine or caffeine like substances )– assoc with anxiety, arrhythmias, irritable bowel syndrome)
  + alcohol – calories+++ , alcoholics may get energy needs from alcohol and omit other foods becoming vitamin deficient (particularly B group), non-alcoholic “social drinkers” often underestimate calories due to alcohol.
* Vegetarian (vegetable diet ± dairy/eggs ±fish) & Vegan diets (nothing derived from animals)
  + Vegetarian diet may be healthy diet, but extremists may be vitamin (particularly B12) deficient,
  + Some vegetarian diets lack balance so not healthy.
  + Plenty of vegetarian junk food available full of salt, sugar & fat, so not necessarily healthy

**“Do you have to eat a special diet?” If so why?**

* + Differentiate **medically** necessary diets (eg gluten free for coeliac disease)
  + From “**popular**” (ie mainly scientific sounding, but nonsensical) diets, eg detox regimes, candida diet, Gillian MacKeith: “Internationally Acclaimed Holistic Nutritionist ”
  + Weight loss / Slimming diets: some sound, some wacky. A well thought out, nutritionally sound one from the BHF is <http://www.bhf.org.uk/publications/view-publication.aspx?ps=1000807>
  + Food allergies. *Genuine* food allergies are common and increasing: eg Peanuts (causing anaphylaxis particularly), gluten enteropathy. (NICE review at <http://guidance.nice.org.uk/CG116> is helpful). Also lots of *bogus* ones from quack nutritionists. Finding out who made the diagnosis often helps sort out which is which.
  + Food intolerance. Non-allergic reactions to foods. Hereditary Fructose intolerance and Lactose intolerance (NB not same as cow’s milk *allergy*) are examples. Salicylate intolerance (producing rhinitis, nasal polyps asthma etc) is another.

There is a substantial industry devoted to diagnosing food intolerances (eg wheat) for which there is little strong evidence

* + “Orthorexia” a term coined in 1997 to describe people fixated on what they consider to be healthy eating, which can be so severe as to result in malnutrition

**Examination: Measure height and weight**

* Measure both weight and height (patients may often creatively under/overestimate!)
* **Calculate BMI** (online tools: <http://www.bhf.org.uk/bmi/BMI_Calc.html>, <http://www.bdaweightwise.com/lose/lose_bmi.html> ) or manually:

|  |  |
| --- | --- |
| BMI = (kg/m²) | weight in kilograms |
| height in meters² |

* **Waist measurement** is a useful indicator of central obesity (and likelihood of developing “metabolic syndrome”

NB when you come to Paediatrics in year 5 you will explore this area with particular relevance to children

Session 4

Cross Cultural Communication

Introduction

This session aims to develop your understanding of problems that can occur in cross-cultural communication, their causes and how to improve skills in this area. We examine how doctors and patients relate when they are from different ethnic backgrounds and/or do not share a common language or cultural beliefs. We also identify how health care professionals can work effectively with interpreters by identifying the skills needed by the doctor and what guidance the interpreter may need.

Learning objectives

After this session, you should be able to:

* Reflect on your own cultural background
* Differentiate the cultural groups to which people belong and explain why these may not always be obvious
* Identify how cultural issues may affect communication
* Identify a range of solutions for managing problems arising from cross-cultural communication
* Outline the difficulties that may arise if family or relatives are used as interpreters
* Describe the skills required by health professionals when working with interpreters

Aims

To develop an understanding of problems that can be encountered in cross-cultural communication, their causes and how to improve communication in this area.

Activities

1. Cultural - what is it?
2. Cultural issues in health care
3. Video Clips: Working with patients whose language is different to your own

Activity 1: Cross cultural communication

Culture

Learning about, and respecting the diverse perspectives of others is the essence of patient-centredness, and can help health-care professionals develop supportive, co-operative and more effective relationships with patients. Patients and their doctors approach health care encounters with their own unique communication characteristics, health beliefs, and customs based on their individual backgrounds. These can dramatically influence health care needs, health behaviours, and the necessary sharing of information which will enable an effective outcome from a consultation. Cross cultural communication is a complex subject we will not be able to address all of the issues. We aim to raise your awareness of the need to use effective communication skills to gain an understanding of the patient’s perception of illness, elicit the patient’s expectation of treatment, and educate patients about their illness in a culturally appropriate manner.

What is Culture?

*Aim: To explore sociological notions of culture in terms of our own and others’ perceptions of ourselves*

We all belong to cultures and sub-cultures. Our membership enables us to interact with others in ways which usually means that we share some understanding.

What does culture mean to you on a personal level?

The iceberg model of cultural influences on communication

One way of explaining how differences in nationalities and languages can be experienced as cultural barriers to effective communication is the “iceberg” model. This identifies how some cultural influences may be readily apparent whilst other major influences are hidden and may not be recognised by the health-care professional.

The model suggests that some characteristics are above sea level – age, gender, ethnicity, nationality while others are below sea level – socioeconomic status, occupation, health, previous health experiences, religion, education, social groupings, sexual orientation, political orientation, cultural beliefs, expectations and behaviours etc (Kai, 1999). Even with those characteristics that are above sea level it is difficult to tell which are predominant characteristics in a particular setting at a particular time.

Activity 2: Cultural issues in health care

*Aim: To highlight examples of cultural issues in the consultation*

The following questions are designed to develop your cultural self-awareness by prompting you to reflect on your thoughts and feelings. Take some time to think about your answers to these questions

1. Have I made assumptions about this person? If so, are these helpful?
2. Have I dealt with this person as my equal?
3. Have I made an effort to understand their way of thinking about their problem? Did I really hear what they were telling me?
4. Have I made an effort to explain what I intend to do and how I see their problem?
5. Have I sought permission or consent for their co-operation?
6. In what ways have I ensured that the approach to dealing with the patient is compatible with their personal and professional life?

Common issues and barriers in cross-cultural communication (Silverman et al, 2005)

Use of language

* Use of foreign language (i.e. patient and clinician must communicate in a language they are not fluent in)
* Use of slang
* Accent/dialect
* Giving offence through over-familiarity

Use and interpretation of non-verbal communication

* Physical touch
* Body language
* Proximity – closeness/distance
* Eye contact
* Expression of affect/emotion

Cultural beliefs and healthcare

* Interpretation of symptoms – what is considered normal and abnormal
* Beliefs about causation
* Beliefs about efficacy of treatment alternatives
* Attitudes toward illness and disease
* Use of complementary or alternative sources of healthcare
* Gender and age expectations about roles and relationships
* Role of doctor and social interactions related to power and ways of showing respect
* Perceived responsibilities regarding adherence to medical recommendations
* Family life events (e.g. rituals and beliefs with regard to arranged marriages, pregnancy and childbirth, older adult caregiving, treatment of elders, death)
* Psychosocial issues (identifying common stressors, awareness of diversity in family/community supports)
* Role of clinician in mental health

Sensitive issues

* Sexuality – including sexual orientation, sexual practices and birth control
* Uneasiness about some physical examinations
* Use and abuse of alcohol and other substances
* Domestic violence and abuse
* Sharing bad news

Health care practice issues/barriers

* Extent of clinician-patient partnership, extent of family involvement, personal and family responsibility for healthcare and treatment
* Ethical issues in care
* Doctor’s assumptions, stereotyping or prejudices
* Concurrent consulting with a practitioner of complementary or alternative medicine

###### Before turning over take a moment to consider questions you could ask patients who are culturally different to you?

Examples of particular cultural practices that may impact on individual health care

Islam and Ramadan

Islam is the second largest religion in Britain, after Christianity (roughly 2.5 million Muslims in Britain). Ramadan lasts for 29 or 30 days, depending on the sighting of the moon. This is just one of many examples of how a patient’s cultural and religious beliefs could affect their treatment and justifies the importance of communicating and understanding patient’s own beliefs.

Customs in Ramadan

* Fasting from dawn to dusk
* Prayer and meditation
* Iftari, evening feast celebrated with family and friends
* Spiritual activities (Taraveeh- night prayer) (Queshi, 2002)

Fasting Muslims abstain from food, liquids, tobacco, sexual activity and medication (which includes oral, inhalers, or injection) from sunrise to sunset. The sick, pregnant & nursing mothers and children are exempt. If a fasting person becomes ill, they are allowed to end the fast.

Ramadan directly influences the control of diabetes because of the month long changes in meal times, types of foods, use of medication, and daily lifestyle. Doctors who encounter Muslim patients need to understand the practicalities. What might you need to consider?

* A Muslim may be devoted, liberal or secular - How does your patient fit these descriptions?
* Ramadan fasting improves diabetes by lowering blood glucose & HbA1c - Does insulin need to be adjusted?
* Meditation and prayers tend to lower blood pressure – Do other medications need to be adjusted? (e,g, anti-hypertensives)
* Pork-based synthetic insulins and beef insulins are not acceptable to devoted Muslims (Queshi, 2002)

What other examples have you observed where a patient’s cultural beliefs clashed with the medical care that was proposed or provided?

The next activity uses a videotape and was developed by Kai (1995) for training general practitioners and other health care professionals in cross-cultural communications. The video clips we use are designed to get you to appreciate how misunderstanding cultural norms, and inappropriate interpretation of patient’s behaviours collectively lead to poorer health outcomes, and less satisfying doctor-patient communication.

Activity 3: Video clips and discusion

Video 1: “Red faces all around”

What difficulties do you think may be arising for the doctor, the patient and the relative acting as interpreter?

What do you think the doctor could have done differently to improve the ultimate outcome?

Video 2: “Red faces all around” (with English subtitles)

After watching this consultation again, this time with the subtitles, answer the following question:

What sort of difficulties may arise in a situation where a family member acts as an interpreter

Video 2: “Shall I explain?” (interpreter in a hospital setting)

The following information is from Kai’s (1995) manual.

Ways of reducing stress in situations where there is no or little shared common language (Mares et al, 1985)

* Allow more time than you would for an English-speaking patient
* Give plenty of verbal reassurance
* Try to communicate some information about what’s going to happen next, even at a very simple level
* Get the patient’s name right
* Try to pronounce the patient’s name correctly
* Keep fuller case notes (this avoids subjecting the patient to repeated unnecessary or complicated questioning)
* Try to ensure that the patient always sees the same staff as far as possible
* Try to find out whether the patient has any specific fears or worries
* Write down any important points clearly and simply on a piece of paper for the patient to take away

Simplifying your English

To avoid confusing, patronising or offending patients it is important to adapt the following advice to individual’s needs (Mares et al, 1985)

* Speak clearly but do not raise your voice
* Speak slowly throughout (but not too slowly)
* Repeat when you have not been understood
* Use the words the patient is likely to know
* Be careful of idioms
* Simplify the form of each sentence
* Don’t speak pidgin English
* Give instructions in a clear, logical sequence
* Simplify the total structure of what you want to say in your mind before you begin
* Stick to one topic at a time
* Be careful when you use examples
* Use pictures or clear mime to help get the meaning across
* Judge how much people are likely to remember
* Be aware of your language (both verbal and non-verbal) all the time

Checking

Checking back should be done throughout the interaction (Mares et al, 1985)

* Try not to ask “Do you understand?” or “Is that alright?” You are almost bound to get “yes” for an answer
* Try also to avoid questions to which the hopeful/desired answer is “yes” – Phrase the question differently
* Ask the patient to explain back to you what he is going to do
* Do not take nods and other gestures or expressions at face value

Working with interpreters

This information is based on Kai & Briddon (1995) and their training manual for health care professionals working with interpreters and advocates.

*Before getting started the interpreter is asked to obtain the following:*

* The name and role of the health-care professional
* Date and time and probable duration of the consultation/interaction
* The name, age and sex of the client
* The context in which the consultation will take place e.g. to obtain informed consent
* The exact language and dialect spoken by the patient
* Whether any reading or written information is required to be translated
* Whether the relative or carer or advocate will be present

When interpreting, the interpreter is asked to:

* Observe confidentiality at all times
* Conduct himself/herself professionally
* Respect the values and practices of the health professional’s organisation
* Be attentive to the needs and wishes of the patient at all times, although the patient does not have the right to misuse the interpreter
* Respect the right of the patient to object to him or her as the interpreter. If this occurs the interpreter must inform the health-care professional
* Be aware that a female patient may be reluctant to share information with a male interpreter and vice versa but may not say this openly. An awareness of this possibility should prompt the interpreter to explore this appropriately
* Respect the rights of parents of children to be involved in care and decisions about the child as patient, but understand the rights of the child as paramount
* Interpret accurately and competently with sensitivity to the circumstances of the interaction
* Be competent in both languages, aware of emotional content, strength and force of words, the double meanings of specific words and be consistent in translation of common words
* Be aware of, and sensitive to, factors which vary among individuals and groups which may be relevant to health care, for example:
  + Health beliefs and attitudes to illness
  + Negative experience or fear of health services
  + Stigma attached to particular problems (e.g. mental health)
  + Fear of death
  + Particular problems encountered by refugees and recent immigrants
  + Socio-economic problems
  + Fear of attack, harassment and victimization and other stressful situations
* Remain neutral, non-judgmental and not be biased by the class, gender, sexuality, political beliefs, religious beliefs or disabilities of the patient

Practical things to do when working effectively with interpreters (Kai & Briddon, 1995)

* Check the interpreter and the patient speak the same language and the same dialect
* Allow time for pre-interview discussion with interpreter in order to talk about the contents of the interview and the way in which you will work together
* Ask the interpreter to teach you how to pronounce the patient’s name correctly
* Allow time for the interpreter to:
  + Introduce him/herself to the patient and explain his/her role
  + Explain that the interview will be kept confidential
  + Check whether he/she as an interpreter is acceptable to the patient
  + Introduce you and your role to the patient
* Encourage the interpreter to interrupt and intervene during the consultation as necessary
* Use straightforward language and avoid jargon
* Actively listen to the interpreter and patient
* Allow enough time for the consultation
* At the end of the interaction check that the patient has understood everything and whether he/she wants to add anything
* Have a post-interaction discussion with the interpreter if appropriate

Things to remember

* The pressure on the interpreter
* The responsibility for the interaction is yours as the health-care professional
* Your power as a health-care professional – as perceived by the interpreter and the patient
* To show patience and compassion in a demanding situation
* To be aware of your own attitudes towards those who are different from you – including awareness of racism
* To be aware of your own shortcomings, for example not being able to speak the same language as the patient
* To show respect to the interpreter and his/her skills

Points to check if things seem wrong (Kai & Briddon, 1995)

* Does the interpreter speak English and the patient’s language fluently?
* Is the interpreter acceptable to the patient?
* Is the patient prevented from telling you things because of his/her relationship with the interpreter?
* Are you creating as good a relationship as possible with the patient?
* Is the interpreter translating exactly what you and your patient are saying or is he/she advancing his/her own views and opinion?
* Does the interpreter understand the purpose of the interview and his/her role?
* Have you given the interpreter time to meet the patient and explain what is going on?
* Does the interpreter feel free to interrupt you as necessary to indicate problems or seek clarification?
* Are you using simple jargon-free English?
* Is the interpreter ashamed or embarrassed by the patient or the subject of the consultation?
* Are you allowing the interpreter enough time?
* Are you maintaining as good a relationship with the interpreter as you can?

#### References

Hardt E. The bilingual interview and medical interpretation. In: Lipkin M, Putnam SM, Lazare A. eds. The Medical Interview: Clinical Care, Education and Research. NY: Springer-Verlag, 1995; 14 172-177.

Helman CG. Culture, health and illness.2007, 5th edition.London: Wright.

Kai J. Valuing Diversity: A Resource for Effective Health Care of Ethically Diverse Communities. 1999, Royal College of General Practitioners, London.

Kai J & Briddon D. Working with interpreters and advocates. In, Kai J. Valuing Diversity: A Resource for Effective Health Care of Ethically Diverse Communities. 1999, Royal College of General Practitioners, London.

Mares P, Henley A & Baxter C. Health care in multi-racial Britain. *Health Education Council / National Extension College:* 1985 Cambridge.

Queshi B. (2002) Diabetes in Ramadan. *Journal of the Royal Society of Medicine*. **95**(10):489-490.

Rosen J, Spatz ES, Gaaserun AMJ, Abramovitch H, Weinreb B, Wenger NS, & Margolis CZ. (2004) A new approach to developing cross-cultural communication skills. *Medical Teacher* **26**(2):126-132.

Silverman J, Kurtz S & Draper J. *Skills for Communicating with Patients.*  2005, 2nd edition, Radcliffe Medical Press Ltd; Oxon. pp 216-217.

Skelton JR, Kai J & Loudon RF. (2001) Cross cultural communication in medicine: questions for educators. *Medical Education* 35:257-261.

WASHER, P. (2009) Talking with people from other cultures (Ch 8, pp59-66). In WASHER, P. *Clinical Communication skills.* Oxford, OUP.

Zabar S, Hanley K, Kachur E, Stevens D, Schwartz MD, Pearlman E, Adams J, Felix K, Lipkin M, Jr., Kalet A. *“Oh! She Doesn’t Speak English!” Assessing Resident Competence in Managing Linguistic and Cultural Barriers.* Journal of General Internal Medicine. 2006; 21:510–513.

Complete your SOLE pages before you leave the session

Session 5

Revision Workshop

* Key learning points from the course will be covered
* There will be opportunities to observe and practice communication skills
* The exam format will be explained and there will be opportunities to ask questions