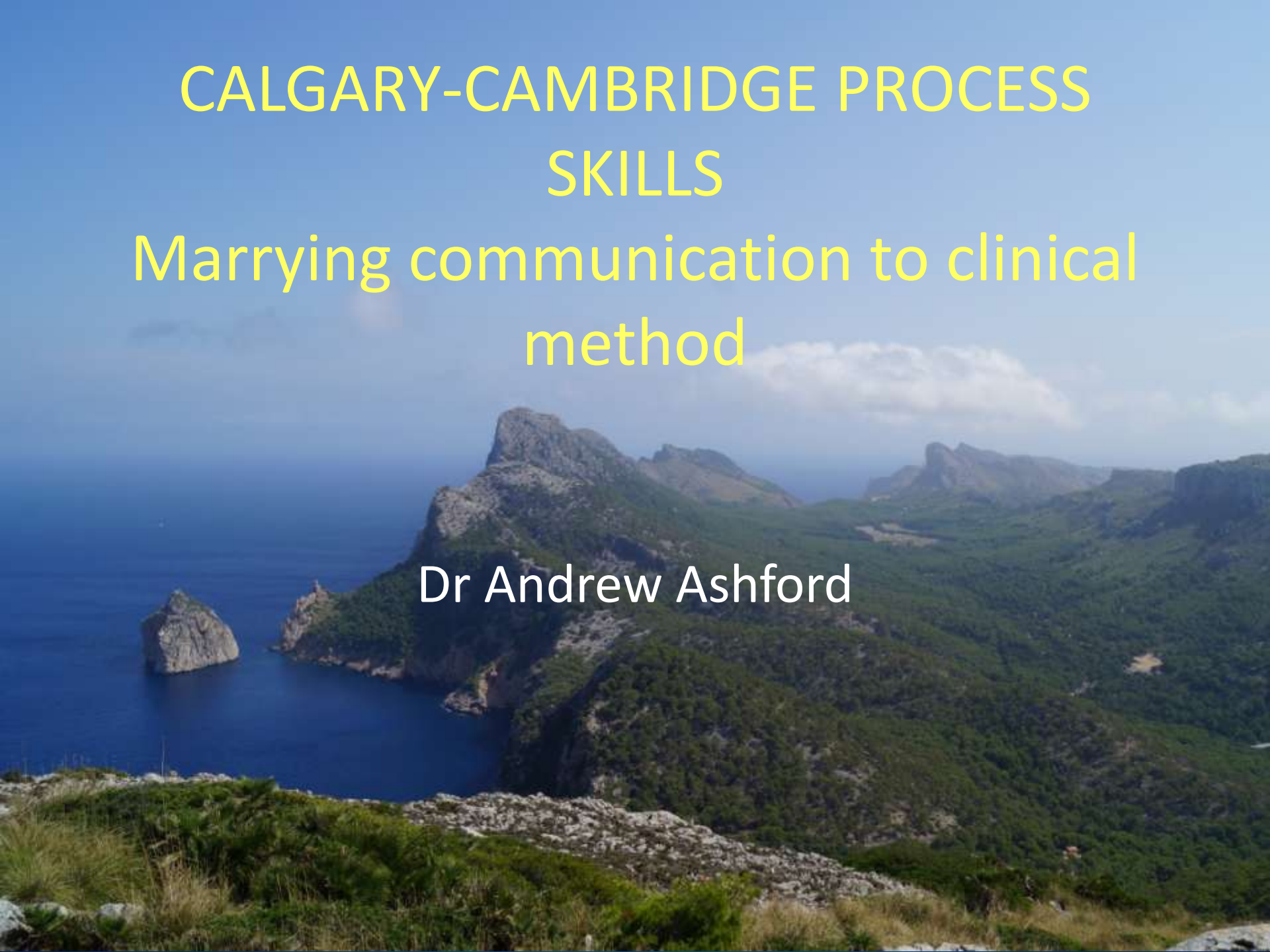
CALGARY-CAMBRIDGE PROCESS SKILLS
Marrying communication to clinical method



Dr Andrew Ashford

Aims of session

- Consider WHY teach communication skills
- Clarify the relationship between CONTENT and PROCESS
- Clear up misconceptions about how communication skills fit with “trad” medical approach
- Provide clear overall structure
- Have some fun!
- Take a closer look at – and practice! – core skills for the beginning of the consultation

What should we teach and why?

BACKGROUND

Why teach / learn communication skills?

- Because the RCGP says so!
- To get through my exams

Health Services Ombudsman

Two commonest reasons for NHS complaint:

- Clinical care and treatment
- Poor communication

Complaints to GMC

The three most prevalent were:

- Concerns with investigations or treatment, such as the failure to diagnose or inappropriate prescribing
- Problems with communication, such as not responding to people's concerns
- Perceived lack of respect, such as being rude.

But isn't this all about experience?

- No! – not for communication skills
- Experience is an excellent reinforcer of habits – but does not differentiate well between good and bad ones!
- Without specific communication skills training medical students entered medical school with better skills than when they left! (Helfer 1970)
  - ?? Preoccupied with medical model
  - Desire to obtain factual information

But can it be taught?

- YES – research literature evidences this beyond doubt
- Demonstrates increased utilisation of skills
- Later studies have found improvement in interviewing skills during progress through medical school

Why teach communication skills?

Does it make a difference? – YES!

- **Improves clinical performance**
- Fine line between teachers and learners
- YOU are the communIcation skills teachers of the next generation!
  - Formally or informally
  - As role models
- "NO DOCTOR CAN ESCAPE THIS RESPONSIBILITY" (Silverman, Kurtz & Draper 2004)

Improves clinical performance

- Produces a more effective consultation for both patient and doctor
- Improves
  - Accuracy, efficiency, supportiveness
  - Health outcomes
  - Satisfaction for both patient and doctor
  - Therapeutic relationship
- Bridges gap between evidence-based medicine and working with individual patients

Doctor-patient relationship

Paternalistic

- Doctor centred
- Authority unchallenged
- Parent / child
- Patient passive

Collaborative

- Patient- or relationship-
- Mutuality
- More equal
- Patient free to influence process

Consumerist

- Do whatever the patient wants
- Regardless of cost or effectiveness

Medical student difficulties

- Discovering the main problem
- Clarifying ambiguity
- Eliciting personal, psychological, social aspects
- Picking up non-verbal cues or leads
- Establishing the impact of the problem on daily life

Types of communication skills

1. CONTENT SKILLS
   - *What we communicate*
2. PROCESS SKILLS
   - *How we do it*
3. PERCEPTUAL SKILLS
   - *What we are thinking and feeling*

In clinical practice these are all going on at the same time! – inextricably linked


EXAMPLES

- Questioning styles (PROCESS)
  - Focussing on just one area? (CONTENT)
  - Are you getting the full picture?
- Hypothesis generation (PERCEPTUAL)
  - Inappropriate questions may lead to poor differentials

Process and Content in Medical Education

Historically separated when teaching medical interview / consulting, into

- Traditional medical history
- Communication models

Traditional medical history

- Main complaint
- History of the present complaint
- PMH
- FH
- Personal & social history
- Drug & allergy history
- Functional enquiry / systems review

This is all CONTENT!

Communication models

Alternative framework / list of skills detailing how

- The consultation is conducted
- Rapport is developed
- The information in the traditional model is obtained
- To discuss findings and management

This is all PROCESS!

Confusions

- The traditional medical history is NOT a guide to process!
- Communication models have introduced new CONTENT – the patient's perspective
  - Missed out of traditional medical history
  - Required to understand individual needs / concerns
  - Validated by studies of patient satisfaction, adherence, recall & physiological outcomes

Either – or?

These confusions can create the danger that learners may think they need to

- EITHER discover patient ideas, concerns etc
- OR take a full and accurate biomedical history

In fact they need to do BOTH!

Disease and Illness

- Disease – the biochemical cause of sickness in terms of pathophysiology

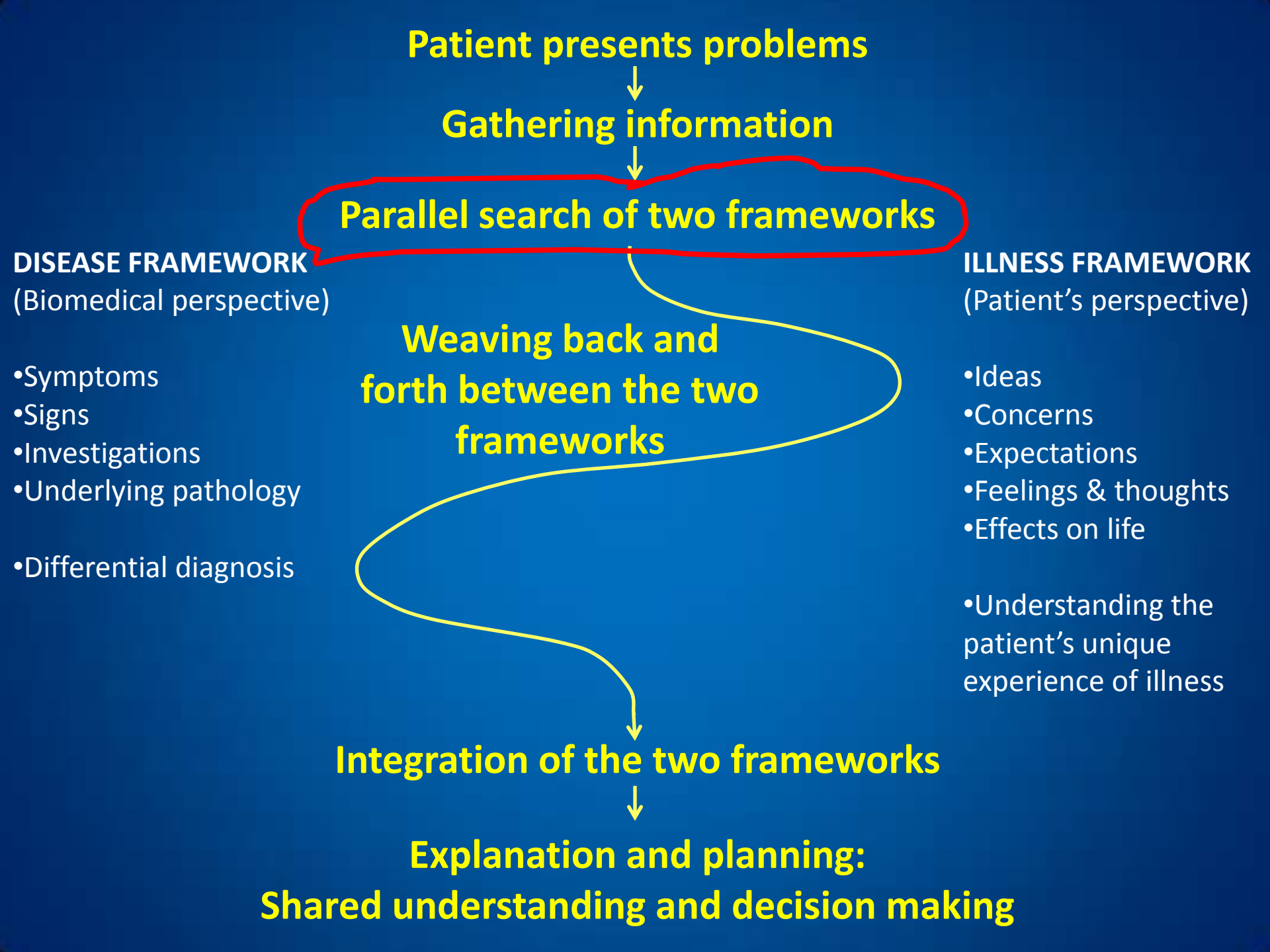
- Illness – the individual patient's unique experience of sickness
  - How they perceive, experience and cope
  - Includes feelings, thoughts, concerns, effect on life
  - Represents patient's response to events, their understanding of what is happening to them, and their expectations of help

Disease and / or Illness

Although disease and illness usually co-exist,

- Patients can be ill but have no disease
- Patients can have a disease but be well
- The same disease can cause remarkably different illness experiences in different patients

To understand this we have a “unique responsibility” to explore both


Patient presents problems
Gathering information
Parallel search of two frameworks
DISEASE FRAMEWORK
(Biomedical perspective)
•Symptoms
•Signs
•Investigations
•Underlying pathology
•Differential diagnosis
Weaving back and forth between the two frameworks
ILLNESS FRAMEWORK
(Patient's perspective)
•Ideas
•Concerns
•Expectations
•Feelings & thoughts
•Effects on life
•Understanding the patient's unique experience of illness
Integration of the two frameworks
Explanation and planning:
Shared understanding and decision making

Patient perspective / illness framework

- Important to both process and content
- Culturally determined – BUT…
- Wide variation even within the same culture
- Prevailing culture may give clues, but still a need to establish individual's perspective
- Understanding this allows explanation and planning IN TERMS THE PATIENT CAN UNDERSTAND AND ACCEPT

Communication Process Skills

THE CALGARY CAMBRIDGE GUIDES

The need for structure

- Guide delineates 71 skills!
- (Don't worry… no consultation uses all of them)
- Helps to place within overarching structure
- Allows facilitators / teachers to ask
  - "where are you in the consultation?"
  - "what are you trying to achieve?"
- Followed by…
  - "How might you get there?" – skill SELECTION

The skills list

- The skills do not provide exact phrases or wordings – you have to work these out for yourself!
- Watching / discussing with peers / trainers / facilitators will give you a range of ideas
- The list of skills is ONLY A START – to become adept using them requires
  - Ongoing practice
  - Feedback
  - Adaptation

THE BASIC FRAMEWORK

Providing structure

Initiating the session

Gathering information

Physical examination

Explanation and planning

Closing the session

Building the relationship

Initiating the session

- Preparation
- Establishing initial rapport
- Identifying the reasons for the consultation

Gathering information

- Exploration of the patient's problems to discover the:-
  - BIOMEDICAL perspective
  - PATIENT'S perspective
  - BACKGROUND INFORMATION - context

Physical examination

- Content informed by:-
  - Biomedical perspective (hypothesis testing)
  - Patient perspective (valuing ideas, reassurance)
- Communication process continues throughout this!

Explanation and planning

- Providing the correct amount & type of information
- Aiding accurate recall & understanding
- Achieving a shared understanding: incorporating the patient's illness framework
- Planning: shared decision making

Closing the session

- Ensuring appropriate point of closure
- Forward planning

Providing structure:

Objectives

- Enabling a FLEXIBLE but ORDERED consultation
- Helping the patient to understand and be overtly involved in where the interview is going and why
- Encouraging the patient to be part of the structuring process
- Encouraging patient participation and collaboration
- Enabling accurate information gathering and giving
- Using time efficiently

Providing structure:

Skills

From “Initiating the session” –

- Problem identification
- Screening
- Agenda setting

+

Making organisation overt

- Internal summarising
- Signposting

Attending to flow

- Sequencing
- Signposting

- Using appropriate non-verbal behaviour
- Developing rapport
- Involving the patient

Providing structure

- Making organisation overt
- Attending to flow

Initiating the session

- Preparation
- Establishing initial rapport
- Identifying the reasons for the consultation

Gathering information

- Exploration of the patient's problem to discover:
  - ☐ Biomedical perspective
  - ☐ Patient's perspective
  - ☐ Background information - context

Physical examination

Explanation and planning

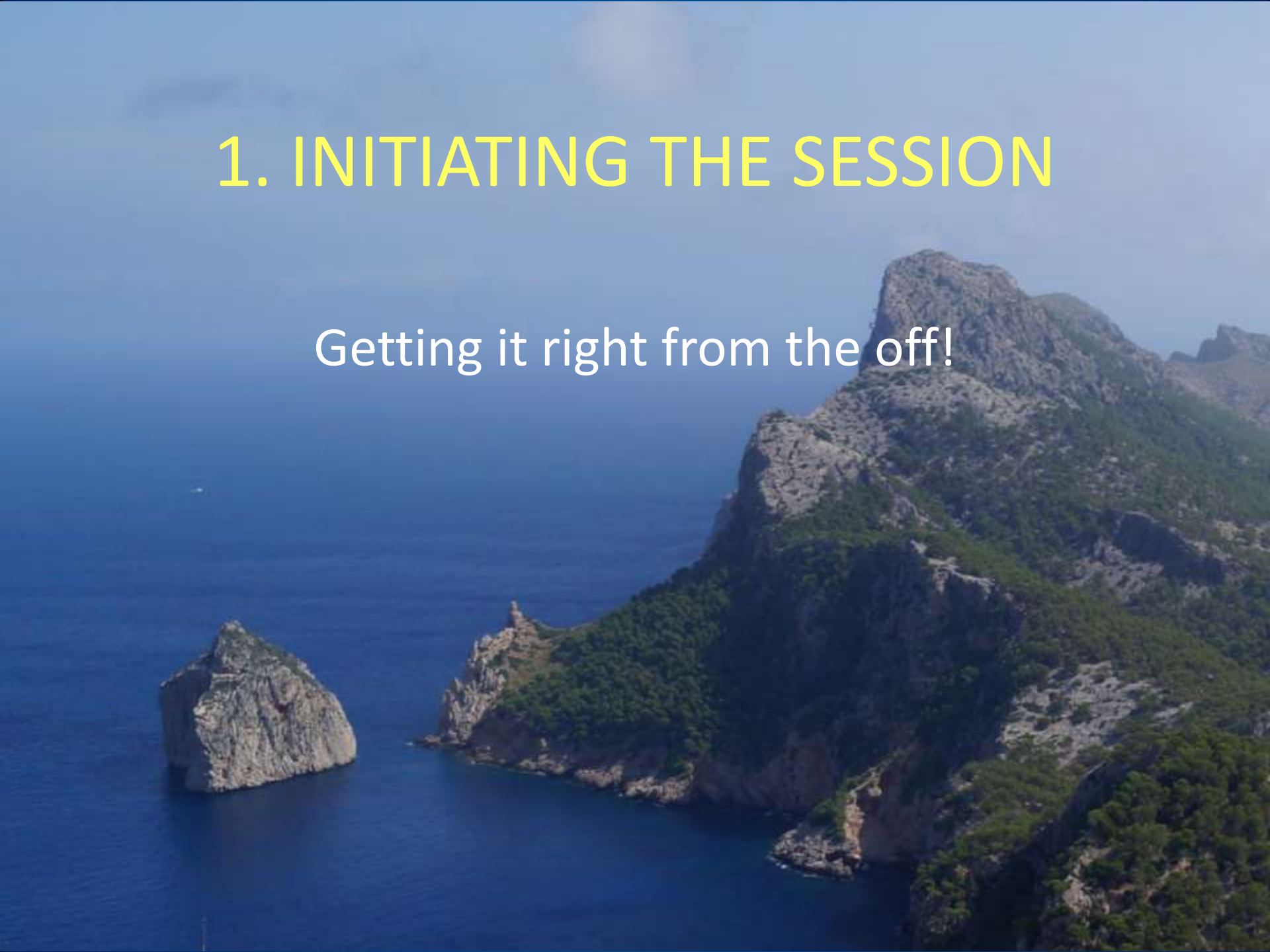
- Providing correct amount & type of information
- Aiding accurate recall & understanding
- Achieving a shared understanding: incorporating the patient's illness framework
- Planning: shared decision making

Closing the session

- Ensuring appropriate point of closure
- Forward planning

Building the relationship

- Using appropriate non-verbal behaviour
- Developing rapport
- Involving the patient



1. INITIATING THE SESSION

Getting it right from the off!

EXERCISE ONE

- Get into threes –
  - Patient
  - Doctor
  - Observer & Timekeeper
- Instructions for each person – DON'T SHARE THESE
- Allow patient 3-4 mins to absorb role
- Off you go!


A CLOSER LOOK…
The actual skills

Establishing initial rapport

1. **Greets** patient and obtains patient's name
2. **Introduces** self, role and nature of interview; obtains consent if necessary
3. **Demonstrates respect** and interest; attends to patient's physical comfort

Greeting and introductions

"Hello – my name is Dr Archer – I'm one of the junior doctors on Dr Aldridge's team"

"Can I just check? – it's Mr Nigel Pargeter isn't it?"

"I really wasn't too fussed about who they said they were as long as there was a nice smile and a bit of eye contact"

(Quote from inpatient)

Interest and respect, comfort

General demeanour

Arrangement of room / furniture contributes

“Are you OK there? – would you like to sit up a bit before we start?”

“Can I get you / your partner a chair?”

Little things … but they can make a big difference

Identifying the reason(s) for the consultation

4. **Identifies** the patient's problems / issues they wish to address with appropriate **opening question**

5. **Listens** attentively to opening statement, without interrupting or directing the patient response

The opening question

- This will vary with different settings and situations
- What works well in one setting may cause difficulties in another
- We all develop our favourite opener! – so tend to lose flexibility if not careful / aware

Common 1ary care openers

- *"How can I help?"*
- *"Fire away!"*
- *"What seems to be the problem?"*
- *"How are things?"*
- *"Tell me the trouble"*
- *"What's happened?"*
- *"What can I do for you today?"*
- *"So what's brought you in?"*
- *"What's up?"*
- *"How are you doing?"*
- *"Tell me what you've come to see me about"*
- *"What's the agenda today?"*

OR…

Nothing said (all implied in body language)

Beware ambiguity!

“How are things?”

“Oh – not so bad – business is a pain as usual, and the house is still in a mess what with the builders…”

[but I’ve actually come about a rash…]

Beware the patient you know

“What can I do for you today?”

“Er … well, you asked me to come back!”

“Hi there. Now, how are you getting on?”

“Oh fine, doc, the new pills are a lot better – although they do give me a bit of indigestion”

[but I’ve actually come about something else!]

EXERCISE 2

- Think of a problem or dilemma you currently have in your life
- Pair up
- Go for a walk together
- Take turns in sharing your problem or dilemma
- Back in 15 mins

Listening

“You’re just not listening to what I’m saying!”

“Yes I am! – I can repeat everything you’ve said!”

Attentive listening

- An active, high level skill
- Needs conscious effort!
- 4 components:
  - Wait time
  - Facilitative response
  - Non-verbal skills
  - Picking up verbal and non-verbal cues

Wait time

= How long you wait for a reply to your question

- Increasing from one second to 3 – 5 seconds brings changes - students
  - Contribute more often
  - Spoke for longer
  - Asked more questions
  - Provided more evidence for their thinking
- Difficult or “invisible” students started to contribute

(Rowe 1986)

Facilitative responses

These work better at beginning!

Divided into –

- "Neutral" facilitative phrases ("go on", "OK", "uh-huh", "I see", "Mmm" etc)

And the rest –

- Repetition (echoing)
- Paraphrasing
- Interpretation

Potential interrupters to opening statement!

Non-verbal facilitative skills

- Mirroring and matching
- Nodding
- Eye contact (not the computer)
- Eye contact (not the notes)
- Eye contact (not the BNF)
- Eye contact (not the Ferrari in the car park!)

All these: not too little, not too much! (culture)

Picking up cues

- Big subject! – brief overview only today
- Cues to many of the patient's thoughts and feelings often occur EARLY in the opening statement

The main dangers are –

- Missing them completely!
- Assuming we know what they mean without checking out with patient

Why are cues important?

- Usually a short cut to important areas that need our attention!
- The dilemma is WHEN! –
  - Too early and you interrupt
  - Too late and you discover stuff that changes hypotheses well into the consultation… or you forget completely!
- Useful to jot down so you can return at an appropriate point

Identifying the reason(s) for the consultation (2)

6. **Confirms list and screens** for further problems

7. **Negotiates agenda** taking both patient's and physician's needs into account

EXERCISE 3(a)

- Pair up! – you will take turns being doctor or patient

- Doctors – TURN ROUND!

PATIENTS

You have come with 3 problems – you have

1. a mole on your back which bled when you caught it
2. “Oh… the other thing is…” you need a repeat script for your blood pressure pills, and
3. since making the appointment you have noticed you sometimes get a tight feeling in your chest if you walk quickly

You present these one at a time *unless* specifically prompted

Turn round everyone!

DOCTORS

Your next patient you don’t know well, but are aware he/she is being treated for hypertension. You don’t know the reason for today’s visit.

GO!

EXERCISE 3(b)

- Swap over
- Doctors turn away!

PATIENTS

You have made a routine appointment for your annual medication review (T4, migraine meds). Since then you have been burgled (you and your partner were in the house but heard nothing), all the jewellery went + £1,500 in cash you had just taken out for a holiday. Nothing has been recovered.

You are shaky and upset, and cannot sleep. You blurt out the above story as soon as you come in to the consultation.

Turn round everyone!

DOCTORS

Your next patient you know quite well – they are booked in for an annual medication review (hypothyroidism, migraine)

GO!

Screening

- *"OK, so before we look at that in more detail was there anything else you wanted to discuss today?" (repeat as necessary)*

- *"So that's the mole, your repeat prescription, and the chest pains – anything else?"*

Research shows that patients CANNOT be relied on to present multiple agendas in order of importance!

Screening

- There is a balance between listening and screening! – depends on sensitivity of opening statements
- Screen at a natural pause – avoid making it an interruption!
- Screening may have to wait quite a time – but if you forget it, it will often come back to bite you at (what you thought was) the “end”!

Agenda setting

- Inviting patient to participate in making an agreed plan
- Particularly necessary in primary care when patients present with “lists”
- Lists may be –
  - trivial problems only, often quick to deal with
  - a mix of trivial and (potentially) more serious
  - (nightmare!) multiple serious problems

Agreeing an agenda

- *“OK, so we’re agreed we’ll look at your moles first, then your knee and back, and depending on how we get on we may have to rebook you for the medication review”*

- *“That’s quite a list to get through, and I don’t think we’ll have enough time to do it anywhere near justice. Can I suggest…? How does that sound…?” etc*

Agenda setting – final thoughts

- Much of the time, this is relatively painless, and reduces stress for both patient and doctor
- We do however meet patients who
  - are extraordinarily unrealistic about what can be achieved in the time available
  - become aggressive or abusive if all demands / agendas are not met
- Very stressful, no easy answers!
- Persistent offenders: educate letter, warning letter, final warning, remove from list is my suggestion

Initiating the session - summary

- Establishing the reason(s) for the patient's attendance, and agreeing an agenda, is the foundation upon which the rest of the consultation is built
- If you get it wrong, everything falls down later on!
- If you get it right, everyone is happier!
- SO PRACTICE WITH YOUR TRAINERS IN THOSE TEACHING SURGERIES!


THE END