Teaching Tool description.	
Title	The medical interview – building the relationship
For whom? (pregrad, postgrad, residents,…)	Clinical students
Goals/ Educational objectives	• to continue initiation and gathering information • to focus particularly on **building the relationship** by looking at slightly more difficult situations that the students may already have experienced or might find themselves in at some time in the future, situations in which the patient displays emotion or asks difficult questions. • to start to explore closure – to explore what students can offer the patient, especially if they discover significant previously un-revealed patient information e.g. patient's ICE
Methods (small group, lecture,…)	Small group work, actors (simulated patients) video recording and play back
Short description	Experiential work on building the relationship, for **skills of developing rapport** - acceptance, empathy, support and sensitivity
Practical Implementation advice	2 sessions (75 min each) 1 actor (2 roles)
Tips for success Pitfalls	• need for experiential - practice, observation, feedback, rehearsal • chance to do and redo and gain confidence • not judgmental, simply practicing skills • shared group learning – all benefit together if there are not respected the conditions listed above
Contact (name and email)	Jonathan Silverman

INTRODUCTORY COURSE FOR CLINICAL STUDENTS IN CLINICAL COMMUNICATION SKILLS, SEPTEMBER 2010

Relationship Building:	**Tues 28 – Thurs 30 Sept 2010**	**10.30– 13.00 or 14.00 - 16.30**

Title: The medical interview – building the relationship

Format: In groups of 6-7, four groups per session – please note shorter than first two sessions - only 2 ½ hours

Actors
There will be two prepared simulated patient roles specifically for this session: each actor can play both roles. In this session, you work with the same actor for the whole session

Video use
We shall use video recording and play back throughout.. This year the Clinical School has moved to a system of digital recording which provides students with their interviews in a form that they can watch on any computer via Windows Media Player. Recordings will be made as digital files straight onto computer hard disk in these files will be uploaded to students' own secure password-protected individual portfolio area of the ER Web. Students therefore will not have a VHS tape. It is important for all facilitators to learn how to use the new recording and playback equipment before these introductory course sessions start.

Aims

- to continue initiation and gathering information
- to focus particularly on **building the relationship** by looking at slightly more difficult situations that the students may already have experienced or might find themselves in at some time in the future, situations in which the patient displays emotion or asks difficult questions. Please note that we return to building the relationship later in the course – this is an introduction only
- to start to explore closure – to explore what students can offer the patient, especially if they discover significant previously un-revealed patient information e.g. patient's ICE

Plan of day
There are two components to the session. Firstly, a brief discussion of any problems they have experienced so far and secondly, two actor roles concerning crying and anger. The students will probably need a short break at some point in the session which can be determined by yourself at a convenient moment. There is no need to swap actors in this session

Introduction
Self – you will probably already know the group; if not please introduce yourself and say that you have discussed what the group has covered in past sessions with their previous facilitator in order to maintain continuity
Actor - your wish to help the students in any way that you can; a resource - on the learners' side
Aims of session and plan of day

Round of names and how they are getting on so far in the clinical course – e.g. what they have done since you last met, what they have enjoyed, what they have found difficult so far, how are they feeling etc

Troubleshooting - for half an hour only

The aim of this section is to **discuss** the students' experiences with real patients so far. In their course, they will already have experienced the following:

- **seeing a patient in the first week as part of the CCS course**
- **going to Arthur Rank House**
- **shadowing a FY1**
- **several sessions practicing interviewing and examination on the wards in pairs**
- **working with their clinical supervisor and associate clinical supervisor**
- **going to general practice**

In these sessions, they may have had direct experience of talking to patients and will certainly have watched patients being cared for by other doctors and nurses. We would like to discuss their experiences and in particular see what questions have arisen for them since we last met with regard to how they relate to and interview patients.

Sit and think for a minute first.

Then as a round to encourage all to contribute.

- **what experience have you had now of talking to patients themselves or of watching others do so?**
- **what was it like in both cases?**
- **what difficulties have already come up for you that need addressing to enable you to feel more confident working with and interviewing patients?**
- **what did you feel about how other people that you have watched related to and interviewed patients – how do you think the patients felt?**

Flipchart responses ? turned round to their needs

The following areas may come up from the students:

- **that what they have seen other doctors and health professionals do is not what we are teaching!**
- **that they have experienced difficulties themselves in their interviews with patients – either about the areas they have already covered, initiation and gathering information, or about other components of the interview**
- **that they have thought of further communication needs that they had not expressed so far**
- **that the role of a medical student has some inherent difficulties**

Possibly explore if relevant the enclosed '**ten common concerns'** from "The Medical Interview" by Steven Cohen-Cole – will be provided as handout

Make sure to relate to: **the stages of the Calgary-Cambridge guide**

Explain that we cannot cover all of these today but they will be opportunities throughout the CCS course to help them with these problems

Experiential work on building the relationship
Please get to here within half an hour of start

Facilitator: please note that this afternoon we are particularly concerned to attend to the skills of developing rapport as listed in the skills list below **- acceptance, empathy, support and sensitivity**

Developing rapport
- Acceptance: accepts legitimacy of patient's views and feelings; is not judgmental
- Empathy: uses empathy to communicate understanding and appreciation of the patient's feelings or predicament; overtly acknowledges patient's views and feelings
- Support: expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self care; offers partnership
- Sensitivity: deals sensitively with embarrassing and disturbing topics and physical pain, including when associated with physical examination

Non-verbal behaviour
- Demonstrates appropriate non–verbal behaviour
  eye contact, facial expression
  posture, position & movement
  vocal cues e.g. rate, volume, tone
- Use of notes: if reads, writes notes or uses computer, does in a manner that does not interfere with dialogue or rapport

Involving the patient
- Sharing of thoughts: shares thinking with patient to encourage patient's involvement (e.g. "What I'm thinking now is.....")
- Provides rationale: explains rationale for questions or parts of physical examination that could appear to be non-sequiturs
- Examination: during physical examination, explains process, asks permission

Now use the following two actor roles:
- **a prepared actor role** on loss of vision in which the patient breaks down and cries; desperately worried about the future and what will happen. If the student acknowledges and empathises, the patient asks the student questions about their disease that the student is unable to answer
- **a prepared actor role** on loss of consciousness in which the patient offers some pretty big non-verbal cues that they do not want to be interviewed by the student but do not say so overtly. If the cues are not picked up, the patient remains sulky and unresponsive throughout; if picked up, the patient overtly expresses anger but not about being interviewed by the student, about the lack of information from and contact with the doctors – they are angry with not knowing what is going on.

Recap why not just didactic and discussion:
- need for experiential - practice, observation, feedback, rehearsal
- chance to do and redo and gain confidence
- not judgmental, simply practicing skills
- shared group learning – all benefit together

PLEASE REFER TO "GENERAL INSTRUCTIONS RE ACTOR SESSIONS" ON SEPARATE SHEET

We would like you particularly to ensure that the following areas have been discussed by the end of the afternoon:
- **Picking up cues to the patient's feelings and emotions** (see pp 61-64 in the first edition and 95-96 in the new edition of the Skills book)

- **Responding to patient's cues and feelings** (see pp 61-64 in the first edition and 95-96 in the new edition of the Skills book)
- **Acceptance and acknowledgement as a key skill in diffusing doctor-patient conflict or unease** (pp 79-82 in the first edition and 129-133 in the second edition)
- **Using the empathic response** (pp 83-85 in the first edition and 133-136 in the second edition)
- **Expressing concern and support** (pp 83-85 in the first edition and 136 in the second edition)

This is of course an introduction to these areas only – we are not expecting mastery! **We suggest that in this session, experiential work predominates but may be mixed with teaching exercises and brief didactic inputs.** We suggest the following possibilities that you could mug up before the session:

- **didactic teaching input on acceptance**
- **didactic teaching input on empathy**
- **exercises as on p139 of first edition and p196 of second edition of Teaching book on empathy – definitions, non-verbal and verbal communication of empathy, importance of explicit verbal empathy** (better than non-verbal by itself as not only conveys that you have heard and that you empathise but also checks out your understanding and acts as a facilitative opening), **brainstorming phrases**

Hints re teaching re anger: in the anger role-play, the following solutions arise normally –

- **stay calm**
- **not directed at you**
- **do not fight anger with anger**
- **careful with body language**
- **get down physically to the patient's level**
- **empathy**
- **apologise (that they feel upset, not necessarily that your colleague was at fault)**
- **get to calmer waters**
- **offer realistic and achievable help**
- **move on with the patient**
- **if necessary give up student task - patient's needs might be much more important**

Could you also as the session continues ensure that you cover what the student should do if he/she discovers important as yet **UN-REVEALED CLINICAL INFORMATION OR UN-REVEALED PATIENT CONCERNS**. It is important that they discuss with the patient how this information will be passed on. They can encourage the patient to tell their doctor at the next opportunity but should also offer to pass the information on themselves to the key doctor or to the sister in charge of the ward (see ten common concerns)

Finishing session

Round of one thing learnt or still thinking about
Facilitator to summarise content and process of the day, answer questions, check understanding
Please remember to praise and give plenty of positive feedback
Definitely bring in content and clinical reasoning at the end of each role - discuss what their findings might mean very briefly so that they get the buzz of seeing how their histories are helpful clinically
At the end of each patient role this year, we have added a brief description of the clinical reasoning appertaining to the case and directions to the students to the web for brief further reading. Please point them in this direction so they can follow-up the work here

Handout 10 concerns list

Student homework

read chapter on relationship building in the Skills for Communicating with Patients book

Feedback to and from actor

Please make sure to spend ten minutes after each section with the actor to give and receive feedback re the session

MEETING THE PATIENT: TEN COMMON CONCERNS

From: The Medical Interview - The Three Function Approach *
Steven Cole and Julian Bird - Mosby 2000

Most medical students eagerly anticipate their first contacts with patients. Many students spend a year and sometimes longer in classroom settings before they ever get a chance to talk with a patient. Courses on clinical methods, physical diagnosis or the doctor-patient relationship therefore usually come as a great relief to students because they may be finally getting a taste of what 'real' medicine will be like for them. Most physicians remember their first interviews with patients very well because these early encounters mark in a real as well as symbolic way the true beginnings of their careers. These first contacts with patients are some of the most exciting and moving aspects of medical education.

Along with this reasonable and expected excitement, however, comes anxiety. Medical students are almost always anxious before they meet their first patients. The sources of this anxiety are numerous and quite understandable. Students may feel worried about how the patient will react to them. They are usually concerned that the patient will feel intruded upon. They imagine that the patient's privacy and dignity will be invaded by their interview.

Even worse, when students are learning the basic elements of the physical examination, they must impose upon the patient to be exposed physically and sometimes to undergo painful examination. To some students, this seems to be yet another indignity and humiliation to the patient. Students often ask themselves 'Why must the patient go through this, just for my education?" If the patient is very seriously ill or dying, all these concerns become even more intense.

The student who feels very anxious about interviewing patients should be assured that he or she is in good company. Learning to interview involves learning not only a new set of difficult and complex skills but also learning to assume a new and dramatically different social role. The student, in putting on the white coat for the first time, automatically attains the social status of 'physician.' This simple symbolic dressing change marks a momentous interpersonal change. Suddenly, the student is required to ask intimate questions of other people and to tell them to undress and be examined. Even more strange to some students, these other people ("patients") usually do what they are told and treat the student with enormous respect.

Learning to function in this new and powerful social role understandably makes most medical students quite anxious. There are many questions students ask themselves and their instructors as they begin this part of their training. Ten very common concerns will be discussed here:

1. **Why should patients want to talk or be examined by a student?**
2. **Isn't this a humiliation and indignity to patients?**
3. **How should I dress? Should I wear a white coat? ***
4. **Should I introduce myself as doctor. If I do that, am I not deceiving the patient?**
5. **If the patient is in pain or emotional distress, should I continue with the interview?**
6. **Should I shake the patient's hand? Under what circumstances is it alright to touch a patient?**
7. **If the patient asks me questions, should I answer them if I know the answer? What should I do if I do not know the answer?**
8. **What do I do if the patient starts crying or if the patient gets angry at me?**
9. **What should I do if the patient tells me things his or her doctor does not know? For example, what if the patient tells me that he or she is depressed or suicidal?**
10. **What should I do if the patient promises to tell me some important secrets if I promise to maintain his or her confidence ?**

** We have removed a brief discussion about what student doctors should wear as this related mainly to white coats and is therefore no longer relevant to the UK*

WHY SHOULD PATIENTS WANT TO TALK TO OR BE EXAMINED BY A STUDENT?

Students usually find it difficult to understand why a patient should want to be interviewed by a student or, even worse, be examined by a student. What could the patient possibly gain from this encounter?

In fact, most patients are quite willing to be interviewed and examined by students. They usually understand that students need to learn about illness with real patients, and they often derive altruistic satisfaction in allowing themselves to be such subjects. Patients rarely feel like 'guinea-pigs' More commonly, such patients feel that they are making a genuine and active contribution by assisting in the training of a physician. In fact, participating in such educational activities often plays a profound and critical role in the psychological adaptation of the severely ill or incapacitated. The feelings of uselessness that are associated with illness can be meaningfully counteracted in some patients by their sense of contribution to the education of future physicians.

Thus, even if the student does absolutely 'nothing" positive for the patient, the patient may actually benefit from the interview and physical examination by simply being allowed to 'give" something to a physician in training.

Most students do in fact, give the patient something quite important. The concern, interest, and attention provided by the student can offer significant emotional comfort to the patient. Although sometimes intangible and difficult to measure, this emotional dimension to the student-patient interaction can be dramatic. Even the physical examination is often interpreted by patients as an emotional gift.

Thus, students would do well to realize that most patients are quite willing and often eager to be interviewed and examined. It provides an opportunity for patients to give something to someone else as well as another opportunity to receive emotional comfort and support.

Of course, there are some patients who do not want to be inter-viewed or examined. Students need to ask their patients, before beginning if they are willing to be interviewed. If the patient indicates that he or she does not want to be interviewed, this wish must be respected. The student should politely thank the patient and leave. The student should then check with his or her supervisor for guidance in how to proceed further.

ISN'T THIS A HUMILIATION OR INDIGNITY TO THE PATIENI?

Some students feel awkward because they think that patients will feel humiliated to have to subject themselves to an interview by a student. This fear, on the student's part, has to do with the implied power of the role of the physician. Students feel uncomfortable assuming this power when they 'do not deserve it" because they are nor able to offer true medical assistance. As pointed out above, very few patients feel this embarrassment or humiliation

SHOULD I INTRODUCE MYSELF AS "DOCTOR"? IF I DO, AM I NOT DECEIVING THE PATIENT?

Most beginning students are uncomfortable with introducing themselves as 'doctor.' This discomfort is understandable because many patients do not understand the difference between students, interns, residents, or attending physicians. It is generally preferable for students to make their status and level of training clear. The following examples illustrate ways this can be achieved:

Student: Hello. My name is John Smith. I am a medical student taking a course on how to interview patients. I was given your name as someone who might be willing to talk with me about your illness. Would that be all right with you?

Another alternative, for students in a clerkship situation, could be:

Student: Hello. My name is Bill Stevens, and I am a student doctor working with Dr. Jones. Do you mind if I ask you a few questions about your problems before you see Dr. Jones?

In practice, this type of introduction works easily and well for most students and their patients.

IF THE PATIENT IS IN PAIN OR EMOTIONAL DISTRESS, SHOULD I CONTINUE WITH THE INTERVIEW?

If the patient is in pain or emotional distress, the wishes of the patient must be respected. First of all, the pain or distress must be acknowledged by the student. Comments like:

Student: You seem to be in distress. or You seem to be in a lot of pain right now.

are quite appropriate and will let the patient know that his or her suffering has been noticed. Students can and should directly ask whether there is anything that can be done to help. Often patients will appreciate a glass of water, a change of the position of the bed, or some other small intervention.

After the discomfort has been acknowledged and offers of assistance have been made, the student should ask the patient whether the interview can be conducted or should be postponed. If the patient wants the student to go away, this desire should be respected. Most often and to the surprise of most students, the patients will want to continue the interview or examination. Once pain or distress has been acknowledged, the patients will usually feel comforted by the concern and attention of the student and will usually prefer to continue.

SHOULD I SHAKE THE PATIENT'S HAND? WHEN IS IT ALL RIGHT TO TOUCH THE PATIENT?

Many physicians offer a patient their hand in greeting when they introduce themselves. In general, this practice works well for beginning students.

Some male students, however, express discomfort with this practice because they have been told that it is 'rude' to offer a hand to a woman, even for a social or professional greeting. They have been taught that respectful behaviour requires a gentleman to wait for a woman to offer him her hand before he attempts to shake hands. Students who are uncomfortable with shaking hands in greeting will do better to wait for patients to offer a hand to them. Students who are un-comfortable about touching a patient in any way will be better advised to avoid touch rather than forcing themselves into physical contact out of a belief that it may be 'good for the patient.'

Touch is a very powerful and supportive technique in medicine. In situations of great distress, it is common and appropriate for physicians to hold a patient's hand or put an arm around a patient's shoulders. Experienced physicians routinely use measured physical contact to re-assure their patients and enhance rapport. Most patients like to be touched appropriately.

However, some patients do not want to be touched, and some physicians find any type of touch other than the physical examination anxiety provoking. It is generally best for students and physicians to adhere to the following rule:

If a student feels uncomfortable in touching a patient, this should not be done.

This discomfort will communicate itself to patients through nonverbal channels, and such a touch will itself become an anxiety-producing intervention for the patient rather than a support.

Also, some students and physicians can be overly familiar with their patients and touch them too much. It is critical for physicians to observe their patients. A patient who is uncomfortable with being touched will give some signal, usually nonverbal, that the touch is not appreciated. He or she will back away, stiffen up, become quiet, etc. The doctor must be vigilant to watch for these signs and respond to them appropriately, in general by backing away respectfully.

Also, it is important to remember that touch can be emotionally and/or sexually seductive. Physicians should be aware of the tremendous power they wield over their patients. Illness causes psychological and physical regression in patients and thus elevates the role of the physician in patients' minds. The resulting emotional dependency on the physician is often overwhelming. Patients often are not able to utilise their most rational thought processes and often relate to their physicians as children relate to their parents. Inappropriate touch can be part of an emotionally seductive doctor-patient relationship that can harm patients by fostering dependency rather than adaptive coping.

Sexual seductiveness can also be communicated by touching patients. This can tragically lead to sexual relationships between physicians and patients. Because of the grossly unequal power in the doctor-patient relationship and the psychological dependency of the illness situation, patients may not be able to make mature decisions about sexuality with their physicians. It is important for students and physicians to remember the following ethical principle:

A sexual relationship between a doctor and his or her patient is always an abuse of the power in the doctor-patient relationship. This is unethical behaviour and exploitative.

IF A PATIENT ASKS ME QUESTIONS, SHOULD I ANSWER THEM IF I KNOW THE ANSWERS? WHAT SHOULD I DO IF I DO NOT KNOW THE ANSWERS?

A medical student practicing an interview or physical examination with someone else's patient should, in general, avoid answering specific questions about a patient's individual condition. At times, in the heady moments of finally being regarded as an 'expert," students might be tempted to answer some medical question that they think they under-stand well. It is important to resist this temptation. Students may have an incomplete understanding of the medical issue and also may not understand the personal meaning of the question to the patient they are interviewing or examining. Since the student will breeze into and out of this patient's life in a few hours, the student will also not be able to observe the impact of whatever information he or she gives the patient. Some seemingly innocuous question might have great import for the patient. For medical students practicing an interview all medical questions should be referred back to the patient's primary physician.

This rule does not necessarily hold for patients of medical students' senior clinical clerkships. Such students often become the patients' primary source of information. When students assume the role of educator however, they should be confident of the information they give to their patients and be sensitive to the emotional impact of the information they transmit. Any uncertainty should be raised carefully with supervisors

WHAT DO I DO IF THE PATIENT STARTS CRYING? WHAT DO I DO IF THE PATIENT BECOMES ANGRY WITH ME?:

Nothing makes some students (and sometimes physicians) more comfortable than the expression of emotion by the patient. What should the student do when the patient starts-crying? This will be a common occurrence and students need to start learning how to re-act in a way that is helpful and supportive to patients.

In general, an attitude of interest and respect will almost always be comforting to patients. no matter what the student does or says. This respect and caring can be communicated nonverbally without any conscious effort by the student. Most patients feel supported and reassured by physicians who can accept and respond appropriately to the limited ventilation of feelings.

Some students and physicians are so uncomfortable with sadness they communicate their own anxiety to patients. This discomfort is usually interpreted by patients to mean that the doctor does not want the patient to show any more emotion. Patients usually honour this perception and 'cooperate' with their physician by suppressing the expression of further emotion.

When students have some verbal strategy in mind to deal with these situations, their own anxiety will be less, and they will be able to help patients more. The following general rule has proven useful:

When in doubt about how to respond to a patient's emotions, use reflection and legitimation.

Comments like:

Student: I can see that you are very upset by this situation, or I understand this is very troubling.

are very appropriate. In general, such reflective comments will encourage the patient to discuss some details of the troubling situation. This information can usually be followed by legitimating comments

Student: I can certainly understand why this has taken such a toll on you. or Anyone would have trouble dealing with this.

But what about when a patient gets angry? This is even more difficult to manage. The natural response to anger is either to withdraw or attack. Both responses are not particularly helpful in developing rapport with an angry medical patient. Of more help is reflection, even of an angry emotion. For example, the student can say

Student: This conversation seems to irritate you.

Again, this type of reflective comment will usually lead to the patient discussing more of the particular details of his or her situation. Subsequent to this discussion, a legitimating comment may be appropriate:

Student: I can certainly understand why this situation has made you so frustrated.

WHAT SHOULD I DO IF THE PATIENT TELLS ME SOMEIHING HIS OR HER DOCTOR DOES NOT KNOW? FOR EXAMPLE, WHAT IF THE PATIENT TELLS ME OF SUICIDAL FEELINGS?

Because medical students are often deeply interested in their patients and often have more listening time than do the patients' doctors, it is not uncommon for patients to confide levels of psychic distress to students that they have not been able to confide in their own

This information must always be communicated to the patients' physicians by the students themselves.

Students can advise patients to tell their physicians directly. But this is not sufficient. If the patients have not already told their physicians, they cannot be relied on to tell their physicians the problems they have discussed with the student doctor. The only way the student can be sure that the physician will become aware of the problem will be if the student tells the physician himself or herself

WHAT SHOULD I DO IF THE PATIENT TELLS ME SOME SECRET IF I AGREE TO MAINTAIN HIS OR HER CONFIDENCE?

Since most students demonstrate a high degree of emotional interest in their patients, an occasional patient will want to share some secret that he or she may not want to be shared with the rest of the medical team.

Students should never promise a patient absolute confidentiality.

If a patient asks for confidentiality, the student should indicate that his or her student status makes it impossible to give an absolute promise of confidentiality. The student may have to share this information with a superior or the patient's treatment team. The student can guarantee to use his or her best judgment about whether or not any information the patient provides might have relevance to the medical situation. If the student feels the information is relevant to the medical care, he or she must receive supervision from some superior to make sure the information is utilized appropriately by the medical team.

In general, such requests for complete confidentiality represent opportunities for students to enhance the care a patient receives as long as the patient is told the limits of a student's confidentiality and the information is appropriately handled after it has been received.

(NB We have removed a brief discussion about what student doctors should wear as this related mainly to white coats and is therefore no longer relevant to the UK)