CLINICAL COMMUNICATION SKILLS THEME

STAGE/LEVEL 2: 20011-2012

NEUROSCIENCES: EXPLANATION & PLANNING NEUROSCIENCES, RHEUMATOLOGY & ORTHOPAEDICS)

FACILITATORS' PACK V.15 (03/05/2011)

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Format of the explanation and planning course:

The Explanation and Planning Course occurs within the NRO (Neurosciences, Rheumatology & Orthopaedics) module in Stage/Level 2. The course is jointly facilitated by communication facilitators from the Clinical Communication Skills office and members of the Neurology department.

There is an introductory lecture on the first Monday of the attachment delivered by a member of the CCS team. This is then followed by two sessions, one week apart working with a simulated patient. Sessions are either on Mondays or Thursdays.

The attachment group will be divided into six smaller groups:

On Monday mornings (week 2 & 3)
(first session 09.00-12.30, second session 09.00-12.00)

On Monday afternoons (week 2 & 3)
(first session 14.00-17.30, second session 14.00-17.00)

On Thursday mornings (week 2 & 3)
(first session 09.00-12.30, second session 09.00-12.00)

On Thursday afternoons (week 2 & 3)
(first session 14.00-17.30, second session 14.00-17.00)

On Thursday morning (week 4 & 5)
(first session 09.00-12.30, second session 09.00-12.00)

On Thursday afternoon (week 4 & 5)
(first session 14.00-17.30, second session 14.00-17.00)

Please note that student packs now contain the following information:
Please note that facilitators have been asked to adhere to strict timekeeping for all CCS sessions. Therefore, you can expect this session to start and finish on time. Please ensure that you arrive at least 5 minutes before the start of the session as students arriving after the initial group introductions may not be allowed to join the group.

Verbal feedback is provided to individual students throughout the session. Students wanting to discuss/request further feedback may wish to speak to the facilitator privately. Similarly, if the facilitator has additional feedback for individuals they may request a meeting at the end of the session. Facilitators will aim to finish ten minutes before the end of the timetabled session to allow time for this and student evaluation/feedback.

Students' written feedback on the sessions will be made using the CCS system

Recording equipment will be used in all sessions

1. **<u>An interactive lecture for one hour on the first morning of the NRO attachment given to all students about the principles of E&P</u>**

- **How does E&P fit into the medical interview and CCS as a whole**
- **Objectives of the E&P phase of the interview**
- **Four divisions of E&P - theory and research:**
  - **providing the correct amount and type of information**
  - **aiding accurate recall and understanding**
  - **achieving a shared understanding: incorporating the patient's illness framework**
  - **planning: shared decision making**
- **Introduction to the core skills of E&P**
- **Preparation for next session**: **hand out sheet with information about patient with focal migraine:**
  - you are a medical SHO and have been asked by the ward sister to see a patient in the medical ward who has been in hospital for a few days for investigation of a joint pains - rheumatoid arthritis?
  - the patient had a bone densitometry test this morning and you have been asked to see her as she has developed a headache several hours ago initially associated with numbness in her right face and arm
  - you talk to her and discover a classical story of focal migraine – examination is normal – she tells you of episodes of headache, once a month or so for a year or two, which aren't too much bother - sound like common migraine – one episode last month like this which went off fairly quickly – now feeling better with less headache and no residual numbness
  - patient does not mention the term migraine
  - your task is to explain the diagnosis – please look up all about focal migraine and think what you will need to cover in your explanation
  - we want you to concentrate on the first two sections of the E&P guide and in particular work out how to assess what information the patient needs and how to give it in such a way that maximises the chances of her remembering and understanding what you have said - please think about this first
  - *students comment to me on the excellent skills of communication of consultants in neuro outpatients and we ask you to think about this as you go and observe good practice before you start your experiential sessions which will let you practice and perfect your skills – you could observe in out-patients with our sheets*

2. The first small group session

9:00 or 14:00: brief intro, names, signpost session

It is important to establish the group process right at the beginning and let the students be involved rather than just 'talked to' during the introductions:

- rounds of names
- remind them how the two sessions will work with the PowerPoint provided
- tie in to the task we have set them to watch others E&P during their NRO attachment *('students comment to me on the excellent skills of communication of consultants in Neuro')* - ask them what they have seen so far

9:10 or 14:10: go straight into coached session re basic E&P with the simulated patient

- remind them of what this first component is about: to concentrate on the first two sections of the E&P guide and in particular work out how to **assess what information the patient needs** and how to give it in such a way that **maximises the chances of her remembering and understanding** what you have said
- ask them what they remember of the skills and the research from the lecture
- show first two sections on the PowerPoint's provided (already described in lecture) and remind of the skills
- explain in this first scenario of the course, they are certain clinically re the diagnosis and there is not much emotional response from the patient to worry about – the task for them is straightforward information giving to a patient. In the 2nd case, we move onto more complex less certain more difficult situations
- describe the scenario in enough detail to orientate the group (setting, information already known) - specifically explain who the learners are and what their role is in the scenario
- do not spend any time on the facts of migraine – they should come fully prepared re this – minimal discussion only
- done without recording in a circle as quick-fire coaching exercise with specific reference to the skills particularly of assessing starting point, chunking and checking, what other information patient needs, how to organise explanation, language, summarising, categorisation, patient summary etc. Ask each student before their role-play which of the skills they are going to employ and practice
- note that they soon realise that section 1 takes preference over section 2 – too much categorisation and organisation may prevent flexibility of responding to patient's individual needs
- this is a chance to practice a selection of key skills from first two sections - patient can vary role from;
  - someone who knows little about migraine and needs explanation from no starting point
  - someone whose mother has migraine, has already looked it up in the migraine association newsletter and has worked out she has focal migraine
  - someone who has looked it up on the web and has some specific questions to ask (see actor role)

Explain limitations of not knowing patient and the effect of the illness on their life and concerns, especially if you have to explain something complex, an element of bad news or choice – hence gathering info session next re a different patient and E&P next week. Good E&P involves understanding the patient's perspective and also struggling with making the diagnosis – only then are you fully able to explain your rationale – an essential element of E&P

10:10 or 15:10: at the latest – coffee

10:30 or 15:30: 1 ¼ hrs straight communication teaching re funny turns case (same simulated patient)

Quickly get on to the interview. Explain that starting an interview in out-patients is different as you have a letter. Read letter and discuss how to incorporate best into the start of the interview. Divide into three sections:

- **initiation** (including screening for other symptoms or problems – push this as basic skill they may have forgotten)
- **gathering disease and illness information:** effective ways of gathering information about both disease and illness
- **essential background information**

Brief brainstorm of objectives before each section, then allow one student to do each section while other students watch **with the guide** – discover student's feelings, then one piece of feedback each, then personal coaching from facilitator with suggestions

Explain that the interviewer can stop and start and break for help whenever they would like

Before the initial interview starts, get another student to volunteer to write up the information obtained as the interview proceeds on the flipchart. Make sure that the person writing up the information that comes out writes up what info they hear, not their interpretation. Ask them to be complete. Pin up three blank separate flipcharts for disease, illness and essential background info for them to use

Stop each person at a pre-determined point. Check with the group where you are in the interview plan now and analyse what has happened so far - rehearse and then get someone else to take over the interviewing - make them see where they are going in the structure. Try to bring out skills early. You may need to do some clinical reasoning as you go to see what questions to ask and why.

Remember to:

- do the basics - especially getting the individual learner to state his learning agenda up-front (what he wants to explore, improve or get help with - see general experiential instructions) and making the other learners record descriptively
- when the student rejoins the group, provide communication skills feedback on the interview so far
- look at the micro-skills of communication and the exact words used
- practise and rehearse new techniques after suggestions from the group
- use the recording equipment
- make sure to balance positive and negative feedback
- bring out patient centred skills (both direct questions and picking up cues) as well as discovering facts
- utilise actor feedback

Give examination results – all normal

11:45 or 16:45: The clinical reasoning aspects of the doctor-patient encounter

- thirty minutes on refining the diagnosis with a specialist present and coming to a definite diagnostic conclusion by the end

If for any reason the specialist from the NRO department does not attend the session, please report this to the CCS office by recording it on the facilitator feedback form. If this does happen a DVD is available for the facilitator to use with the NRO specialists input recorded.

- tell the specialist how long they have and where you need to get to by the end **(see specialist information sheet for information they have been given prior to the session)**
- students to give the history (both disease and illness) to the registrar
- Brainstorm their 5 possible diagnoses - very fast? SpR to do separately

- SpR to take the lead in working through the clinical reasoning process and guiding them to likely diagnoses and what tests they would order
- **Facilitator (not neurologist) gives this preliminary information to patient – impossible to say whether faint or fit etc – no further on from before – will do tests and speak to witness on phone - patient responds without questions or emotion - patient has already been told by GP not to drive and agrees – patient says partner will ring in to speak to doctor next week - patient leaves room – <u>if short of time do not role-play this part</u>**
- results given plus witness statement and diagnosis made with specialist and level of certainty discussed
- the students brainstorm the issues that the patient might ask them or want answering when they next meet (reiterate importance of diagnosis, rationale, aetiology, prognosis and only then treatment; why me, why now; inheritance, driving, teratogenicity) and all the students look up complex partial epilepsy and the answers to the questions over the coming week - not separate learning issues but all of them putting themselves in a position to give info - do they know enough about the diagnosis or are there more knowledge gaps that need filling first? If they know about the condition, do they know about the treatment options sufficiently to make a management plan or understand the prognosis enough to explain to the patient? Also how to explain to the patient, what local resources and societies, groups, materials, information leaflets etc. are available. Point again towards the internet
- handout sheet from a specialist giving their possible diagnoses and level of certainty before tests, what they think it is likely or not to be and their rationale, what things help as pointers, what tests they would order, when they would see the patient next and what they felt they would need to say to the patient at this stage about driving etc. And then test results, witness statement, what the specialist thinks it is now, their level of uncertainty, what diagnosis they would give to the patient at the next appointment, how essential it is to treat and what medication would best suit the condition

By the beginning of the next session, the students should have put themselves in a position to provide definitive explanation and planning with the patient.
Aide-memoire

What are the key features that would support this diagnosis?
Are their any discriminating symptoms or signs that would point towards this condition?
Are their any discriminating symptoms or signs that would tend to rule out this condition?
What do you still need to know that you don't know already?
How likely is this as a diagnosis?
If it is unlikely, is it still possible?
How common is this condition?
Is this condition so uncommon as to be extremely unlikely?

12:20 or 17:20: Individual student feedback where appropriate

3 The second small group session

9:00 or 14:00: Reform group

- introductions
- what they have seen and reflected on since we last met
- ask them to summarise what they have got out of the last session
- show PowerPoint's of section 1 and 2 very briefly – explain quite cognitive approach
- objectives for this session: focusing on adding in the third and fourth part of the guides – show overheads and discuss – section 3 more feelings and emotional, section 4 about planning and collaboration
- mention here looking specifically, in this scenario at issues of uncertainty and choice

9:10 or 14:10: 2 ½ hours of E&P

- all having a go
- detailed exploration of techniques, especially sections three and four
- simulated patient will change behaviour with normal reticence, questioning and stunned patient behaviour if you want – simulated patient has been asked initially to not come forward with too many questions spontaneously but to do so if asked what questions they have or given gaps
- hand out guides and ask to make notes on as we go
- summarise with the guides

Brief discussion of what they have discovered about the condition – clarify what they want to say and explore any necessary medical facts briefly before each role-play so that they know what to say. Anything that needs clarifying from the handout

Discuss specifically here about how certain the diagnosis is, what they can say to the patient that they have now ruled out, how to relate to the patient's ideas and concerns and how to explain that the diagnosis is a clinical one and by far the most likely but not absolutely proven.

Mention that they are restarting a consultation – a month on – how are they going to do that? e.g.

- what has happened in the last month
- give results of tests, describe effect of witness statement from partner on diagnosis
- diagnosis, level of certainty
- explore how quickly to get to the diagnosis and how long to spend on the results

Either do it as chunks with each student continuing where the last left off or allow each student to have a go for as long as they want and the next person to restart from the beginning. Ask group and each participant what they would prefer.

Encourage one of the student's to start the process:

- what would be the particular issues for you here (try to get the participant to hone them down)
- what would you like to practice and refine and get feedback on
- how can the group help you best

Emphasise to the "doctor" that OK to stop and start whenever. Take time out or start again, as required. Re-play a section or re-play the whole lot, or just stop when help is needed.

Feedback

- Start with the learner –
    - how do you feel?
    - how do you feel in general about the role-play in relation to your objectives?
    - tell us what went well, specifically in relation to the objectives that you defined?
    - what went less well in relation to your specific objectives?
    - or "you obviously have a clear idea of what you would like to try"
    - would you like to have another go?
    - what do you want feedback on?

- Then get descriptive feedback from the group
- Use the recordings
- If participants make suggestions, ask prime learner if they would like to try this out or if they would like the other group member to have a go. Try to get someone else to role-play a section if they make a suggestion for doing it differently. "Would anyone else like to practice?"
- Bring in the simulated patient for insights and further rehearsal: ask the simulated patient in role questions that the group has honed down

Make the point that you are not just asking the simulated patient for insights, but these questions are exactly the ones that you should ask a patient in order to clarify whether the patient has understood what you have said, "have I made myself clear", and that you are in agreement about any proposed plan, "have I understood you correctly.....you would like to wait a bit before taking an antibiotic.....".

As the session proceeds cover section 3 and then move on to section 4. You are likely to need to explore how to explain what epilepsy is to someone (not easy). Also how to give the diagnosis and what words to use e.g. seizures, fits, epilepsy, a type of epilepsy and does it help to use warning shots and euphemisms first. Also to discuss what choice the patient has about treatment and whether the students are happy to go along with her views or whether they feel it is essential to recommend a definite plan. Also how to explain the issue of tetatogenicity (they must mention this, how to put across the level of risk etc). Best to explore these issues before relevant role-plays and then to try things out.

They should also explore how to offer different options first and explain the pros and cons of each, how to discover the patients views, how to make a suggestion to the patient, how to negotiate, how to discover if the patient wants the doctor to decide or to be involved.

11.:40 or 16:40: The end of session two
A round: students identifying areas at the end of each case that they have learnt about explanation and planning
Summarise what learnt about explanation and planning, relate to the guide and research
Fill in feedback form
Make sure to have covered key points e.g.

1. assessing patient's starting point
2. chunking and checking
3. taking patient with re ICE
4. sharing your thoughts
5. involving patients
6. offering choice where available

Summarize with the following handout:

HANDOUT I

- **Have I put myself in a position to give information?**
  Do I understand the disease and the illness?
- **Do I know what information I want to give?**
- **Does it relate to the patient's framework?**
- **Can I phrase and deliver it in a way the patient can understand?**
- **How can I make sure that I'm giving the information that the patient needs and wants?**
- **How do I check how the patient is reacting to what I am saying?**
- **How do I involve the patient in the process and encourage a collaborative approach to decision-making**
- **How can I check the patients' understanding?**

Remind re OSCE style assessment of their E&P skills as part of their neurosciences **attachment assessment - 15 minutes of info giving to a patient in week 9**

11.50 Student evaluations and individual student feedback where appropriate.

Your evaluation of the session
There is a feedback form provided for your comments on the session as a whole and to feedback on any student who is struggling and requires extra help in any way. If a student has been referred for help on more than 2 occasions in any one stage/level of their clinical studies, they will be contacted by the Senior Tutor in Clinical Communication and offered an appropriate programme of remedial support.

Please inform the student that you are being referred for support but that they will only be contacted on receiving the third referral. If they have any concerns about this they should be advised to contact Mandy Williams (mw480@medschl.cam.ac.uk), Senior Tutor in Clinical Communication.

It is important that you state why you are highlighting a student for help and what you have observed. This will assist the team in ensuring appropriate and timely support is provided.

We would also like you to identify any student who is clearly performing at a high level and you would like to nominate for the CCS prize

PROBLEMS IN COMMUNICATION IN THE EXPLANATION AND PLANNING SECTION OF THE INTERVIEW

Are there problems with the amount of information that doctors give?

- in general, physicians give sparse information to their patients, with most patients wanting their doctors to provide more information than they do **(Waitzkin 1984, Pinder 1990, Beisecker and Beisecker 1990)**
- many studies have shown that patients can be divided into seekers (80%) and avoiders (20%) concerning information, with seekers coping better with more information and avoiders with less **(Miller and Mangan 1983, Deber 1994, Jenkins et al 2001)**
- **Steptoe et al (1991)** showed that information avoiders report a better understanding and satisfaction with doctor-patient communication than seekers but paradoxically have a worse understanding: seekers on the other hand are less satisfied with communication and would like even more information despite having already gained a better understanding.
- **Waitzkin (1984)** has demonstrated that American internists devoted little more than one minute on average to the task of information giving in interviews lasting 20 minutes and overestimated the amount of time that they spent on this task by a factor of nine
- **Makoul et al (1995)** found that doctors in British general practice overestimated the extent to which they accomplished the following key tasks in explanation and planning: discussing the risks of medication, discussing the patient's ability to follow the treatment plan and eliciting the patient's opinion about medication prescribed.
- **Boreham and Gibson (1978)** in a study in Australian general practice showed that despite a lack of basic knowledge prior to the consultation and a strongly expressed desire to gain information concerning their illness, the majority of patients did not obtain even basic information concerning the diagnosis, prognosis, causation or treatment of their condition.
- **Richard and Lussier (2003)** studied the discussion of medications in Canadian general practice. In instances of the prescription of new medications, instructions were discussed in 75.9% of cases, warnings and side effects were rarely discussed and reasons to re-consult were discussed in only 35.4% of cases. Discussion of compliance issues regarding new prescriptions occurred in only 5% of cases.

Are there problems with the type of information that doctors give?

We also know that patients and doctors disagree over the relative importance of different types of medical information:

- **Kindelan and Kent (1987)** in a study in British general practice showed that patients placed the highest value on information about diagnosis, prognosis and causation of their condition. Doctors however greatly underestimated their patients' desire for information about prognosis and causation and overestimated their desire for information concerning treatment and drug therapy. Patients' individual information needs were not elicited.

Can patients understand the language that doctors use?

Many studies have shown that doctors not only use language that patients do not understand but also appear to use it to control their patients' involvement in the interview:

- **Korsch et al (1968)** found that paediatricians' use of technical language (e.g. "oedema") and medical shorthand (e.g. "history") was a barrier to communication in more than half of the 800 visits studied. Mothers were confused by the terms used by doctors yet rarely asked for clarification of unfamiliar terms.
- **Svarstad (1974)** suggested that doctors and patients engage in a "communication conspiracy". In only 15% of visits where unfamiliar terms were used did the patient admit that they did not understand. Doctors in turn seemed to speak as if their patients understood all that they said. Physicians deliberately used highly technical language to control communication and to limit patient questions - such behaviour occurred twice as often when doctors were under pressure of time.

- **McKinlay (1975)** in a study of British obstetricians and gynaecologists showed that physicians were well aware of the difficulties patients had in understanding doctors in general. Despite this, in their interviews with patients physicians continued to use terms which they had previously identified were the very ones that they would not expect their patients to understand

Do patients recall and understand the information that we give?

There are significant problems with patients' recall and understand of the information that doctors impart **(Tuckett et al 1985).** It is clear that patients do not recall all that we impart nor do they make sense of difficult messages. Original studies showed that only 50 to 60% of information given is recalled. Later studies have suggested that in fact much more is remembered and that the real difficulty is that patients do not always understand the meaning of key messages nor are they necessarily committed to the doctor's view. Tuckett explained some of the causes of this by showing that:

- in only a small percentage of occasions were doctors' views presented clearly
- in only 50% of occasions were rationales included to substantiate doctors' views
- even when rationales were given, they were mostly parsimonious in content and lacking in clarity
- in only 7% of consultations did doctors in any way check their patient's understanding of what had been said.
- there was almost no relation of doctors' explanations to patient's view or beliefs - in only 12 out of 405 consultations were doctors' explanations related to their patients beliefs at all
- in only 6% of consultations were patients' ideas and explanatory beliefs elicited in the first place
- even when patients volunteered their ideas either as hinted cues or as spontaneous outright statements, doctors still only asked patients to elaborate on their ideas in 7% of consultations
- 76% of the patients said afterwards that they had specific doubts or questions during the interview that they did not mention to the doctor
- 85% of patients utilised hints and vague questions to express their doubts or concerns rather than overtly with clear statements or questions
- In certain circumstances though, recall is poor: **Dunn et al (1993)** found that cancer patients in their first interview with an oncologist remembered only 45% of 'key points' as determined by the oncologist

Are patients involved in decision making to the level that they would wish?

Degner et al (1997) studied women with a confirmed diagnosis of breast cancer attending hospital oncology clinics, 22% wanted to select their own cancer treatment, 44% wanted to select their treatment collaboratively with their doctors, and 34% wanted to delegate this decision making to their doctors. Only 42% of women believed they had achieved their preferred level of control in decision making.

Do patients adhere to the plans that we make?

- Studies have consistently shown that between 10 and 90% of patients prescribed drugs by their doctors (with an average of 50%) do not take their medicine at all or take it incorrectly (**Haynes et al 1996)**
- Many studies show that patients do not follow their doctors' recommendations, with 20-30% non-adherence in medications for acute illness, 30-40% in medications for illness prevention, 50% for long-term medications and 72% for diet.
- Yet surprisingly, doctors have a tendency to ignore non-adherence as a possible cause of poor outcome
- Non-adherence is enormously expensive. The cost of wasted funds spent on prescription medications used inappropriately or not used in Canada amounts to 5 billion a year, based on an annual expenditure of 10.3 billion and data indicating that 50% of prescription medications are not used as prescribed. Estimates of the further costs of non-adherence (including extra visits to physicians, laboratory tests, additional medications, hospital and nursing home admissions, lost productivity and premature

death) were CAN$ 7-9 billion in Canada **(Coambs et al 1995)** and US$ 100 billion plus in the US (**Berg et al 1993**).

EVIDENCE SHOWS THAT COMMUNICATION SKILLS CAN OVERCOME THESE PROBLEMS AND MAKE A DIFFERENCE TO OUTCOMES OF CARE

Process of the interview

- the more questions patients are allowed to ask of the doctor, the more information they obtain but with increased negative affect from doctor! **(Tuckett et al 1985)**

Patient satisfaction

- patient satisfaction is directly related to the amount of information that patients perceive they have been given by their doctors **(Hall et al 1988): a** highly consistent finding
- the overt expression of uncertainty by physicians in the consultation has been shown to be associated with greater patient satisfaction **(Gordon et al 2000)**

Patient recall and understanding

- patient recall is increased by categorisation, signposting, summarising, repetition, clarity and use of diagrams **(Ley 1988)**
- asking patients to repeat in their own words what they understand of the information they have just been given increases their retention of that information by 30% (61 to 83% of info retained) **(Bertakis 1977)**
- **Tattersall et al (1997)**, **McConnell et al (1999), Sowden et al (2001) and Scott et al (2001)** show that the provision of audio or video tapes of the actual interview and writing to patients after their consultation increase patient satisfaction, recall and understanding and patient activity. In contrast, general audiotapes about a condition do not increase and may actually decrease patient recall and satisfaction with a specific interview.

Concordance

- patients who are viewed as partners, informed of treatment rationales and helped in understanding their disease are more adherent to plans made **(Schulman 1979)**
- **Stewart et al 1999** found that the following aspects of communication about management plans significantly influenced health outcomes:
  - patient encouraged to ask questions
  - provision of clear information
  - willingness of doctor to share decision making
  - agreement between patient and doctor about the problem and the plan

Outcome

- decreased need for analgesia after myocardial infarction and surgery is related to information giving and discussion with the patient **(Mumford et al 1982)**
- providing an atmosphere in which the patient can be involved in choices if they are available leads to less anxiety and depression after breast cancer surgery **(Fallowfield et al 1990)**
- hypertension, diabetic and rheumatoid patients of doctors with a more participatory and less controlling style developed better physiological outcomes: furthermore, in RCTs, patients who are coached in asking questions of and negotiating with their doctor not only obtain more information and report better health but actually achieve better BP control in hypertension and improved blood sugar control in diabetes **(Kaplan et al 1989, Rost et al 1991)**
- **Stewart et al (1997)** have shown that interviews where patients perceived that the doctor and patient found common ground in the decision-making process (involving a mutual discussion of treatment options and goals and roles in management, checking for feedback etc.) were associated with significantly less referrals and investigations

over the following two months. This suggests that a collaborative approach can reduce demands on the health care system.

Explanation and planning - migraine

You are a medical SHO and have been asked by the ward sister of the medical ward to see a 35 year old patient, Lorna Jones, who has been in hospital for a few days for investigation of a three month history of joint pains, possibly rheumatoid arthritis.

The patient had a bone densitometry test this morning and you have been asked to see her as the sister is worried that she developed a headache following the test several hours ago, associated with numbness in her right face and arm.

You talk to the patient and discover a classical story of focal migraine. She tells you of episodes of headache, once a month or so for a year or two, which are not to much of a bother to her and sound like migraine:

- throbbing headache, often on one side of the head only
- nausea
- increased sensitivity to light (photophobia)

One episode last month however was just like this one although it went off fairly quickly. In these episodes

- around 45 minutes before the headache begins, there is tingling or numbness on the right side (face and arm) with an inability to concentrate properly

She is now feeling better with less headaches and no residual numbness. The patient does not mention the term migraine during the discussion. Examination is normal.

Your task is to explain the diagnosis to the patient – please look up all you can about focal migraine and think what you will need to cover in your explanation – the first five or six hits on a Google search for migraine give high quality information from both the doctor's and patient's perspective.

We want you to concentrate on the first two sections of the explanation and planning guide and in particular to work out how to assess what information this particular patient needs and how to give it in such a way that maximises the chances of her remembering and understanding what you have said - please think about this first in some detail.

Explanation and Planning Course – simulated patient role 1

You are a 35 year old patient, Lorna Jones, who has been in hospital for a few days for investigation of a three month history of joint pains, possibly rheumatoid arthritis. You are quite OK about this and keen to discover what the problem is and get some help for your joint pains.

The medical SHO (a junior ward doctor) has been asked by the ward sister to see you: you had a bone densitometry test this morning (a long x-ray to assess your bone density) and following the test, you developed one of your headaches about three hours ago now. However on this occasion, the headache was preceeded by a really odd sensation of numbness in your right face and arm which made it feel weak although you don't think it was really. You found it difficult to concentrate. After 45 minutes you developed your headache as usual and the numbness got less. You are now feeling better with less headaches and no residual numbness.

You have had episodes of headache, once a month or so for about a year, lasting several hours, which are not too much of a bother to you and for which you take paracetamol:

- throbbing headache, often on one side of the head only
- nausea
- increased sensitivity to light

One episode last month however was just like this one although it went off fairly quickly. In both these episodes

- around 45 minutes before the headache began, there is tingling or numbness on the right side (face and arm) with an inability to concentrate properly

The doctor has just interviewed you about this headache and has examined you and is going straight on to explain the problem to you now. In this exercise, you will stay in the group setting and several students will try out the same task repeatedly, being coached by the facilitator on their skills of giving information to you. You will be asked at certain points by the facilitator to change the role slightly.

In this role, we want to exclude the patient having major concerns or worries and focus on the students' ability to give you the information that you need and in a way that you can understand. Start by being a patient who doesn't know much about migraine except that it is a bad headache - you don't really know anyone with it and you certainly haven't heard of numbness occurring with headaches – you were worried the first time that it was a stroke, although the fact that it went away reassured you. So the diagnosis is the key thing for you. Be hesitant to ask questions of the doctor unless asked (you feel ill at ease talking to doctors) - if asked, ask about whether it is related to your arthritis, or what might have caused it, or what else might happen, is it dangerous at all. One question at a time and then follow the doctor's lead again.

If asked by the facilitator, change role to be the same patient but whose mother has migraine: you have already discussed with your mother that this sounds like migraine too. You have read her recent migraine association newsletter and know that there are drugs that you can take either all the time to stop it happening or just when the symptoms occur. You have heard about flashing lights but not numbness although your mum says that can occur. Your main interest is to avoid long term medication if possible, but you are not sure if the numbness means you should take something.

If asked, change again: same patient, but you have looked up migraine on the internet and have read about migraine with aura (or focal migraine) and know all about it. You know that you should not take the oral contraceptive pill in the future but not why and you would like to know why. You wonder if there is more likelihood of a stroke and if you should take an aspirin a day. You have some articles in your handbag from the internet which you would like to show the doctor. Please read the articles below and underline something that you would like to discuss with the doctor.

Background information:

- please make up your own social background
- on Voltarol retard one daily for your arthritis pain
- not on the pill
- no allergies

Explanation and Planning Course – simulated patient role 2

Name Rowena Peto **Age:** 35

SETTING

You are waiting in the neurology out-patient clinic waiting room at Addenbrooke's Hospital to see a doctor. You have been waiting for about twenty minutes and you are by yourself. This is your first out-patient appointment at the hospital.

You were referred by your own GP six weeks ago. You had seen your GP, Dr. Rogers, a female doctor, twice. She had at first reassured you but then said we ought to investigate your attacks and suggested that you see a neurologist. Your doctor talked about excluding irregularities of your heart-beat and about epilepsy

You have already been told by the clinic nurse that you are going to see Dr…… who is the specialist registrar.

CLINICAL DETAILS

You have been having these 'attacks' over the last four months. They occur once a week at the most but sometimes you go a few weeks in between. They have not become more frequent.

They are always very similar - they start with a gradual loss of vision, you feel a bit light-headed and a little disorientated over several minutes. Your vision just seems to fade away. You feel distant but can hear people talking around you and can talk back although you are not sure what you have said or whether it made sense. You do not think that you have ever actually lost consciousness in these attacks. You recover after about a minute but feel tired and sick. They seem to occur possibly if you have not eaten for a long time, but you are not sure. They occur when sitting or standing but have never happened when lying down.

These episodes occur at work and at home – at work, you try to cover up but you assume people must have begun to notice and in one or two meetings, it must have looked as if you were just not concentrating or interested. Nobody has actually commented about them at work.

PAST MEDICAL HISTORY

Any previous operations: no

Any previous illnesses:

1. glandular fever when 15
2. mild irritable bowel syndrome, not investigated – gives you a lot of wind, abdominal pain and distension from time to time. You have learnt to live with it: you try to avoid certain foods and coffee

MEDICATION

Currently taking the Pill – Microgynon 30

Took Mefloquine, one tablet weekly to prevent malaria for holiday to the Gambia six months ago (took for two weeks before travel, for the two week holiday and four weeks afterwards as advised – no side effects from the tablets)

FAMILY HISTORY:

HEART DISEASE:	Mother has mild angina
SERIOUS ILLNESSES:	Father died 5 years ago from cancer of the colon, he had nocturnal fits for many years, well controlled with tablets which you never witnessed – they always occurred in bed

	There is a history of diabetes mellitus in maternal aunt
SMOKING:	No
ALCOHOL:	Very little

SOCIAL HISTORY
You have lived with your partner (not married) for the last two years. He works as a salesman for British Telecom and drives over the East of England on Business. He couldn't be here today as he is away at a meeting in Scarborough for 2 nights.
Children – No, but keen to start a family soon. You were thinking of coming off the pill shortly
Occupation – You work as a personal assistant to the Managing Director of a publishing company in Cambridge. This is a job with responsibility and you have to make a good impression with visitors and clients. If you had children, you would return to work which you enjoy
Where do you live – In Cherry Hinton
Type of housing – Own house which you've owned for a year with your partner
Background – Left school with good GCSE's and worked as a secretary before getting several promotions

TEMPERAMENT
Pleasant, reasonably forthcoming, straightforward and bright. Likes to understand what is going on: keen on information but wouldn't look things up medically on the internet etc. She is an 'organiser' and would be frustrated by NHS delays but would not be angry.

PATIENTS FRAMEWORK

- **Ideas and thoughts**

What do you think might have caused your problem: at first you thought they were just faints – you wondered if you were anaemic as you used to have heavy periods although not since you started the pill. You wonder about diabetes as there is a family history and you perhaps might be getting low blood sugar – you tend to skip meals. Could it be due to the 'pill'?
What have they told you so far: your doctor talked about excluding irregularities of your heart-beat and about epilepsy – she poo-poo'd the idea about diabetes but you weren't sure why. She asked you a lot about stress but you don't feel more stressed than everyone is these days: her question made you wonder if the doctors might think it was psychological though

- **Concerns**

Your main concern is that your job may be at risk because of these attacks. You don't feel your boss would understand and guess that if he felt your illness was interfering with the clients, he would get rid of you: you have been deliberately keeping it to yourself.
You haven't thought about this yet but if the doctor suggests long term tablets for whatever they diagnose, you would be then most concerned about your wish to have a child – would they harm the baby? See below for how you would react

- **Have you any underlying fears**

Is this epilepsy like your father had? It doesn't seem the same

- **Any practical problems**

As above

- **Expectations**

What are you hoping for: to be told that it is nothing and will go away, that it is because you are run down! You hope for a doctor who will be thorough and competent but be willing to explain carefully what is going on and answer all your questions:
What is it? What caused it? Is it inherited? Can it be treated? Can I continue working? Will it get worse? Should I tell them at work or try to hide it up?

- **Feelings**

How are you feeling about all this: really quite concerned although your partner is very supportive and you have been able to talk things through and that helps a lot. So you are composed today

- **Presenting symptoms or problems**

As above although you don't quite know what happens to you and can only say what you feel in an attack. Only bring up your concern re having children and medication towards the end of the case when the doctors are describing treatment options: focus on the job problem initially.

At the end of the first session, the facilitator himself will give the preliminary information to you – he will tell you that he is still not sure what is going on and that he will need to order tests - you take this without a lot of questions or anxiety at this point (you will think of your questions in the time waiting for the next appointment), just agree with the plan – he will tell you not to drive at the moment - this is OK as you have already been told by your GP not to drive and you understand even though it is inconvenient – he asks if he can speak to your partner and you say your partner could ring in to speak to the doctor next week.

- **Behaviour**

Pleasant and professional, has thought of questions but doesn't tend to ask them overtly unless prompted by the doctor by 'did you have anything you wanted to ask?' or by the doctor leaving a long pause. She would not ask questions otherwise as she perceives the doctor as having control of the interview and she should follow his lead (as most patients do).

- **Choice**

Towards the end of these two sessions, the doctors will explain the diagnosis and may suggest medication long-term. That is very difficult for you – when push comes to shove, your desire for a child would always outweigh your wish to keep your job or to drive. If you are just told that you must take anti-epileptic tablets whatever, you will agree to it but look a little uncertain non-verbally – in your mind you are already confused and thinking that you might not take whatever is prescribed but feel that you couldn't say that right now. If asked directly for your views about the plan or asked if you have any concerns or comments, then you bring up your real concern.

HANDOUT II

CALGARY - CAMBRIDGE GUIDE TWO – EXPLANATION AND PLANNING

PROVIDING THE CORRECT AMOUNT AND TYPE OF INFORMATION

Aims: to give comprehensive and appropriate information
to assess each individual patient's information needs
to neither restrict or overload

1. **Chunks and checks:** gives information in manageable chunks, checks for understanding, uses patient's response as a guide to how to proceed 2. **Assesses patient's starting point:** asks for patient's prior knowledge early on when giving information, discovers extent of patient's wish for information 3. **Asks patients what other information would be helpful** e.g. aetiology, prognosis 4. **Gives explanation at appropriate times:** avoids giving advice, information or reassurance prematurely	

AIDING ACCURATE RECALL AND UNDERSTANDING

Aims: to make information easier for the patient to remember and understand

5. **Organises explanation:** divides into discrete sections, develops a logical sequence 6. **Uses explicit categorisation or signposting** (e.g. "There are three important things that I would like to discuss. 1st..." "Now, shall we move on to.") 7**. Uses repetition and summarising** to reinforce information 8. **Uses** concise, **easily understood language**, avoids or explains jargon 9. **Uses visual methods of conveying information:** diagrams, models, written information and instructions 10. **Checks patient's understanding** of information given (or plans made): e.g. by asking patient to restate in own words; clarifies as necessary	

ACHIEVING A SHARED UNDERSTANDING: INCORPORATING THE PATIENT'S PERSPECTIVE

Aims: to provide explanations and plans that relate to the patient's perspective
to discover the patient's thoughts and feelings about information given
to encourage an interaction rather than one-way transmission

11. **Relates explanations to patient's perspective:** to previously elicited ideas, concerns and expectations 12. **Provides opportunities and encourages patient to contribute:** to ask questions, seek clarification or express doubts; responds appropriately 13. **Picks up and responds to verbal and non-verbal cues** e.g. patient's need to contribute information or ask questions, information overload, distress 14. **Elicits patient's beliefs, reactions and feelings** re information given, terms used; acknowledges and addresses where necessary	

PLANNING: SHARED DECISION MAKING

Aims: to allow patients to understand the decision making process
to involve patients in decision making to the level they wish
to increase patients' commitment to plans made

15. **Shares own thinking as appropriate:** ideas, thought processes, dilemmas 16. **Involves patient:** - offers suggestions and choices rather than directives - encourages patient to contribute their own ideas, suggestions 17. **Explores management options** 18. **Ascertains level of involvement patient wishes** in making the decision at hand 19. **Negotiates a mutually acceptable plan** - signposts own position of equipoise or preference regarding available options - determines patient's preferences 20. **Checks with patient** - if accepts plans, - if concerns have been addressed	

CLOSING THE SESSION

Forward planning 21. **Contracts** with patient re next steps for patient and physician 22. **Safety nets**, explaining possible unexpected outcomes, what to do if plan is not working, when and how to seek help **Ensuring appropriate point of closure** 23. **Summarises session** briefly and clarifies plan of care 24. **Final check** that patient agrees and is comfortable with plan and asks if any corrections, questions or other issues	

Additional Comments:

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HANDOUT III

Referring GP:
Dr. Alison Rogers
Cherry Hinton Health Centre,
Cambs

To:
Dr. John Chisholm
Consultant Neurologist
Addenbrooke's Hospital

Date: six weeks ago

Re Miss Rowena Peto 27 Woodland Grove, Cherry Hinton, Cambridge

Age 35

Hospital number 374910

Category: soon

Dear Doctor Chisholm,

Thank you very much indeed for seeing this 29 year old woman with a three month history of short-lived funny turns which seem to have been occurring several times a month. She feels odd during the episodes but does not think she loses consciousness at any point and recovers fairly quickly.

Her past medical history is unremarkable and she is not on any medication apart from the contraceptive pill.

On examination, I really can't find much to account for her symptoms and in particular neurological and cardiovascular examination is normal.

Obviously there are a number of possible diagnosis here including arrhythmias so I'm not sure whether this will turn out to be neurological - if not, could you kindly refer her on.

I would be very grateful for your help an advice.

Thank you very much,

Best wishes

Yours sincerely

Dr. Alison Rogers

HANDOUT IV

NEUROLOGIST'S COMMENTARY ON ROWENA PETO

This young woman presents with episodes of altered function, which are brief and stereotyped. This suggests an organic disturbance, although in the back of my mind is always the possibility of psychogenic disorders presenting with neurological symptoms, a common finding in neurology clinics.

Transient organic neurological disturbances are due to three main causes. They can be due to:

- migraine.
- transient cerebral ischaemia
- epileptic fits

Migrainous symptoms usually evolve over minutes and last 20-60 minutes and are associated with headache etc in most cases. This doesn't fit the bill.

Transient ischaemia can be due to:

- global loss of blood supply
- focal loss of blood supply

Is this focal? Many episodes of loss of blood just to one part of the brain (e.g. TIAs) giving stereotyped symptoms is highly unlikely, so if this is ischaemic it is more likely to be global. Amnesia is also not a feature of TIA's

Global ischaemia can either be:

- simple faints
- cardiogenic faints.

Most of us have had the warning symptoms of a ***simple faint*** and recognize the symptoms: blurred vision, light-headedness, remoteness, tinnitus and disorientation, sometimes with sweating and a feeling of being hot or cold. These symptoms certainly overlap those of a faint. A benign faint often occurs in specific situations – on changing posture, at the sight of needles, in response to nausea etc. An ordinary faint gets better when you lie down. Has she ever done this? ***Anaemia*** could make simple faints more likely.

A ***cardiogenic faint*** may come on whilst lying down – has that ever happened? That would make me worry about serious cardiac causes such as arrhythmia – long Q-T syndrome, HOCM or other rarer conditions manifesting in the young. She says in fact they never come on lying down.

Epileptic fits usually present with positive symptoms: jerking or hallucination rather than loss of a sense, but vision is an exception and seizures can manifest with loss of vision. This is not a generalised tonic-clonic seizure nor does it fit with absence seizures (petit-mal) – are you sure why? These could well be partial seizures though – do you know the difference between simple and complex partial epilepsy?

From her own history it is impossible to be sure if this is a fit or a faint. **A witnessed account** may be crucial.

The most difficult diagnosis to differentiate from epilepsy is of **psychogenic non-epileptic attacks**, which can mimic almost any kind of attack. They are very common and about 20% of patients with a label of uncontrolled epilepsy do not have epilepsy at all and have this disorder. Although clinically these may look like epilepsy, there is no abnormal electrical activity in the brain during the attack, unlike in epilepsy. The psychological mechanism and associations of this disorder vary. Patients are not always obviously distressed but there is an increased incidence of associated psychiatric disorders and other medically unexplained symptoms. The attacks themselves are often less stereotyped than epileptic seizures and they never arise out of sleep, although an EEG may be needed to prove if a patient is asleep at onset.

Note ***hyoglycaemia*** is possible but vanishingly rare except in the lay imagination and causes much more protracted episodes.

What I can tell the patient now before they go for investigations:

- Level of certainty: not clear before witness statement and investigations – several possibilities including cardiac and epilepsy.
- See after tests in one month
- Tests as below
- Should not drive

Initial investigations showed:

- fasting blood sugar of 3.5
- ECG normal
- U and E normal
- FBC/ESR normal
- ANF weak positive (homogeneous pattern)
- other auto-antibodies normal
- 24 hour tape normal
- routine EEG normal (waiting list one month)
- CT brain normal (waiting list one month) – *not optimal test – picks up tumour only*

The witnessed account suggests a blank spell during which she says things in a stereotyped fashion that she does not recall. Then she seems OK but is amnesic for a relatively long period, given the brevity of the clinical episode itself.

She just goes blank with the attacks and says "I'll be all right in a minute", before recovering altogether. It's always the same comment, almost word for word. Then she seems to have no memory at all for the few minutes previous to the episode. She does not go pale or sweaty and it does not look like a faint to you. She is not stressed particularly.

This suggests a highly focal disturbance of cerebral function and points very strongly toward this being a fit rather than a faint, after which patients may be dazed but would have such disproportionate amnesia. A faint with amnesia but no fall would also be very odd. To be absolutely sure I would have liked to hear about some abnormal movement such as mouth or swallowing movements or her head turning to one side. These are common seizure symptoms. Clinically, this sounds like complex partial epilepsy.

WHAT YOU MIGHT TELL ROWENA AT HER NEXT APPOINTMENT AND WHY

Diagnosis
Focal epilepsy

Note:
1) Witnessed history is crucial – epilepsy is a clinical diagnosis
2) EEG has a low sensitivity except during attacks.
3) Video and EEG recording may be needed to be sure of the attacks
4) Failure of treatment can occur even if the diagnosis is correct although it should lead one to question diagnosis

To treat or not to treat?
Are these episodes causing altered function with loss of awareness that could put her at risk? This is the key question. If not, do you treat someone with non-life-threatening seizures if say they do not want to take drugs long term or if they want children? What about work – how will they react there when they know she has epilepsy? How do you involve the patient in the decision? Unless there is a pressing reason not to treat them from the patient's perspective, I would overall recommend treatment here.

Offering and negotiating choice
Patient choice is very important: the patient may need to balance the possibility of say teratogenicity and weight increase (reasons not to take medication) versus problems re driving and labelling at work (reasons to take medication).

Why might she not want treatment?
1) Fear of adverse effects – usually can be minimised although you may need to change drugs
2) Fear of teratogenicity: this is a major issue – with single drug therapy it can be kept to low levels (about 1%) but we know of no drug that we are certain is free of this effect. Some drugs are worse than others; valproate has a 5% risk, and carbamazepine about 1%.
3) Fear of taking drugs long-term
4) Resentment of diagnosis and the label of epilepsy for which drugs are a continuing reminder – may cause surreptitious non-compliance.
5) Believes that alternative medicine can cure her – there is no real evidence for efficacy of alternative medicine in epilepsy

Other issues to discuss
1) Driving – not until seizure-free 1 year
2) Hazardous activities – no definite restrictions but seek advice of those running e.g. warn the attendant at the swimming baths.
3) Showers rather than baths or at least don't overfill the bath
4) Consider a hard pillow rather than a soft and asphyxiating one

What drug?

1) The choice is between carbamazepine and lamotrigine. The SANAD study (Lancet, May 20007), showed that Lamotrigine has slightly but significantly fewer side effects and similar perhaps marginally less efficacy that carbamazepine
2) Carbamazepine is efficacious in complex partial epilepsy and has the lowest teratogenicity. It can cause some sedation as you start it and may cause an allergic rash. It requires a high dose OCP. Even then the efficacy of the OCP is slightly reduced. Remember odd kinetics of the drug with auto-induction.
3) Lamotrigine has a good side-effect profile, doesn't interfere with OCP, although OCP reduces lamotrigine levels and teratogenicity in humans is similar, perhaps a little worse than carbamazepine.
4) She needs to be warned and if she wants to become pregnant to seek advice and if she comes off the pill to start folic acid to prevent spina bifida.

INVESTIGATIONS <u>OVER THE NEXT SEVERAL YEARS</u> IN THE REAL CASE SHOWED:

- MRI brain: normal (waiting list one month) – *best imaging test – picks up tumours, small vascular malformations, developmental abnormalities, hippocampal disease*
- sleep deprived EEG: normal (one month waiting list)
- ambulatory EEG recorded 3 attacks: in the first two there was no abnormality and in the third, the tracing was obscured by movement artefact.
- repeat EEG's and a tilt test that was normal.
- further ambulatory EEG showed some slow activity over one hemisphere during an attack that was of uncertain significance
- video-EEG recording in London with drug reduction and clear epileptic seizures were caught on video and on EEG.

Investigations in epilepsy

50% of patients with epilepsy have a normal routine EEG. I would not be put off the diagnosis but I would get a sleep-deprived EEG.

20% of patients with epilepsy have a normal sleep-deprived EEG. I would not be put off the diagnosis and would recommend treatment. If the treatment didn't work, I would try to catch one of the attacks with an ambulatory EEG. Most attacks where there is altered consciousness show up on ambulatory EEG if the attack itself is recorded. But these recordings use many fewer electrodes than a standard EEG and have a lower sensitivity than an ictal recording on an inpatient EEG. The normality of the ambulatory EEG is a little unnerving but if there were a good treatment response, I would rely on the clinical diagnosis.

In this lady treatment response was poor and she was getting in desperate straits over her work. We needed to know for certain whether we were barking up the wrong tree. She was sent for full video-EEG-telemetry. The EEG was typically epileptic and the seizure looked like a typical complex partial seizure – she did have mouth movements as well. Know the limitations of the EEG test you are using. Some seizures don't show up even with this sort of EEG, hence the corroborative video recording.

In true life, the course of this woman's illness was:
Despite all the normal EEG's, a clinical diagnosis of focal epilepsy was made. Over the years she was treated with a wide variety of anti-epileptic drugs, including ethosuximide, phenytoin, sodium valproate and carbamazepine with no impact on her attacks and with many of them she developed side effects at low doses so they had to be withdrawn. She was eventually referred for video-EEG-telemetry of her attacks. She underwent video-EEG recording in London with drug reduction and clear epileptic seizures were caught on video and on EEG. She is now on lamotrigine. This tablet seems to help.

In the intervening years it transpired that a number of other members of her family suffer from a disease affecting the brain in which there are seizures and major changes in the white matter on MRI (leukodystrophy). This particular pattern has not been described before and is being evaluated in the family. The inheritance appears to be autosomal dominant. She turned out not have the syndrome exhibited by others in her family.

HANDOUT V

CALGARY - CAMBRIDGE GUIDE ONE – INTERVEWING THE PATIENT

INITIATING THE SESSION	
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 **Identifying the reason(s) for the consultation** 4. **Identifies** the patient's problems or the issues that the patient wishes to address with appropriate **opening question** (e.g. "What problems brought you to the hospital?" or "What would you like to discuss today?") 5. **Listens** attentively to the patient's opening statement, without interrupting or directing patient's response 6. **Confirms list and screens** for further problems (e.g. "so that's headaches and tiredness; anything else……?") 7. **Negotiates agenda** taking both patient's and physician's needs into account	

GATHERING INFORMATION	
Exploration of patient's problems 8. **Encourages patient to tell the story** of the problem(s) from when first started to the present in own words (clarifying reason for presenting now) 9. **Uses open and closed questioning technique**, appropriately moving from open to closed 10. **Listens** attentively, allowing patient to complete statements without interruption and leaving space for patient to think before answering or go on after pausing 11. **Facilitates** patient's responses verbally and non–verbally e.g. use of encouragement, silence, repetition, paraphrasing, interpretation 12. **Picks up** verbal and non–verbal **cues** (body language, speech, facial expression, affect); **checks out and acknowledges** as appropriate 13. **Clarifies** patient's statements that are unclear or need amplification (e.g. "Could you explain what you mean by light headed") 14. **Periodically summarises** to verify own understanding of what the patient has said; invites patient to correct interpretation or provide further information. 15. **Uses** concise, **easily understood questions and comments**, avoids or adequately explains jargon 16. **Establishes dates and sequence** of events **Additional skills for understanding the patient's perspective** 17. Actively **determines and appropriately explores**: • patient's **ideas** (i.e. beliefs re cause) • patient's **concerns** (i.e. worries) regarding each problem • patient's **expectations** (i.e., goals, what help the patient had expected for each problem) • effects: how each problem **affects** the patient's life 18. **Encourages patient to express feelings**	

BUILDING RELATIONSHIP	
Using appropriate non-verbal behaviour 23. **Demonstrates appropriate non–verbal behaviour** • eye contact, facial expression • posture, position & movement • vocal cues e.g. rate, volume, tone 24. If reads, writes **notes** or uses computer, does **in a manner that does not interfere with dialogue or rapport** 25. **Demonstrates** appropriate **confidence** **Developing rapport** 26. **Accepts** legitimacy of patient's views and feelings; is not judgmental 27. **Uses empathy** to communicate understanding and appreciation of the patient's feelings or predicament; overtly **acknowledges patient's views** and feelings 28. **Provides support**: expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self care; offers partnership 29. **Deals sensitively** with embarrassing and disturbing topics and physical pain, including when associated with physical examination **Involving the patient** 30. **Shares thinking** with patient to encourage patient's involvement (e.g. "What I'm thinking now is....") 31. **Explains rationale** for questions or parts of physical examination that could appear to be non-sequiturs 32. During **physical examination**, explains process, asks permission	

CLOSING THE SESSION (PRELIMINARY EXPLANATION & PLANNING)	
33. **Gives any preliminary information** in clear well organised manner, avoids or explains jargon 34. **Checks patient understanding** and acceptance of explanation and plans; ensures that concerns have been addressed 35. **Encourages patient to discuss** any additional points and provides opportunity to do so (eg. "Are there any questions you'd like to ask or anything at all you'd like to discuss further?") 36. **Summarises session** briefly 37. **Contracts** with patient re next steps for patient and physician	

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