UNIVERSITY OF DUNDEE
College of Medicine, Dentistry and Nursing

Consultation and Communication Skills (CCS)

Year 3
2011-12
Semester 1

Tutor Guide

Contents

Clinical Communication in Year 3

Introduction

The Consultation and Communication Skills Course runs across five years of the undergraduate curriculum. The core aim is to help students communicate effectively in clinical environments. A qualified doctor's clinical communication is:

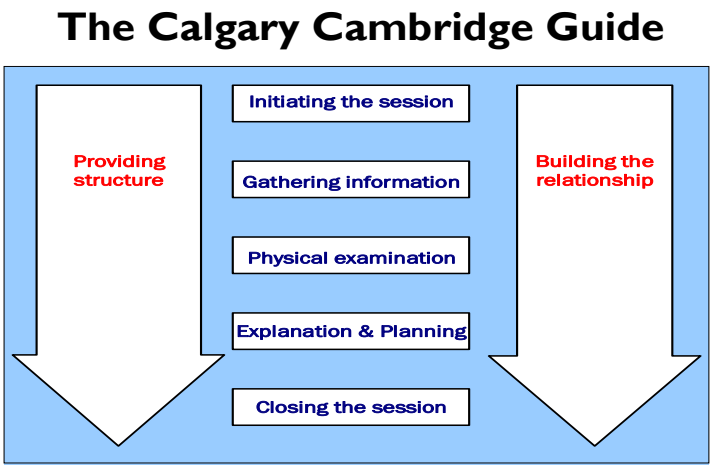
- Accurate
- Skilful
- Supportive
- Efficient, and
- Safe.

Progress so Far

In years one and two students have concentrated on the basic tasks of the consultation. This approach divides the communication skills needed into seven key tasks. The skills have to be practised together, however for ease of explanation the tasks are divided up into the seven;

These are;

1. ***Initiating the interview***
2. ***Gathering information***
3. ***The physical examination***
4. ***Explanation and planning***
5. ***Closing the session***
6. ***Building the relationship***
7. ***Structuring the consultation***



Remember too that the course acknowledges three types of core skills. Again they are interlinked and cannot be taught independently of each other.

1. **Content skills**
   These include what doctors communicate; the substance of their questions and responses; the information they gather and give; the treatments they discuss.

2. **Process skills**
   How doctors do each of the key tasks of the consultation.

3. **Perceptual skills**
   What doctors are thinking and feeling – their internal decision making, clinical reasoning and problem solving; their awareness of feelings and thought about the patient their illness and other issues that may be concerning them; awareness of their own self-concept and confidence in their own biases, attitudes, intentions and distractions.

Year 3 CCS

This year is an introduction to more complex, contextual communication skills training and will allow students to consolidate their learning from years one and two. By focusing on giving information and creating management plans around serious illness, students will have to be clear about the purpose of the consultation with these patients and the intended outcomes. You will be able to develop your skills in psychiatric history taking and communicating with people who have mental health problems that may, by their very nature, make communication challenging.

The scenarios are designed to fit in with your system based teaching. If you are asked to carry out an interview around a topic you have not yet covered in detail you will not be expected to have extensive knowledge – these roles are designed to allow you to discuss the issues in a more general manner with the patient.

You will be covering the following topics in semester 1

Nervous system block

- Breaking bad news around the topic of multiple sclerosis
- A patient with possible early dementia

Psychiatry system block

- A patient behaving strangely
- Assessment of suicide risk for a patient with self-harm

CCS year 3: Nervous System Block
Breaking Bad News - a new diagnosis of Multiple Sclerosis

Tutor Notes

The student is a junior doctor in Neurology outpatient clinic. This patient is coming for the results of an MRI scan.

This role is about Breaking Bad News. Patients at this time usually do not take in too much information and so students do not need to prepare in great detail to discuss the medical aspects of Multiple Sclerosis. However, it is very important that they offer patients some hope and some sort of reassurance, and this might be around the possible progression of the disease, and what kind of support you are able to offer etc.

The student should:

- Give information on the result of the investigations in terms the patient can understand
- Allow time for the patient to respond to the information
- Listen and enable the patient to express concerns, and respond to them appropriately
- Demonstrate empathy

Learning objectives

- Strategies for breaking bad news (see appendix 2)
- Strategies for dealing with an emotional response
- Reflecting on own feelings during the interview, such as the feeling of helplessness.

Students and tutors may find the following useful in preparation –

Appendix 2 – Breaking Bad News
Appendix 3 – Diagnosing Multiple Sclerosis
(please remember that this session shouldn't go too far into clinical detail)

CCS year 3: Nervous System Block
Breaking Bad News - a new diagnosis of Multiple Sclerosis

Script

Penny/Paul Gallagher (age 20-50)

You have attended the outpatient clinic today for a follow up visit. You attended your GP off and on over the last 6 months with various problems which at first you (and your GP) thought were stress related. You have a high profile job as a Press Officer for a large international marketing company. You fly between Scotland, London and the New York office a lot (often only to attend one meeting or one event before you have to fly home again).

The problems ranged from weakness of your left leg, even once a numbness of your lower leg which lasted two days (you thought you had squashed a nerve on one of you double flights), a tendency to trip going up stairs (again usually when you are rushing), a bad episode of travel sickness with nausea which lasted for several days even after you got home (it was a very bumpy windy flight that time) and the worse thing of all, a facial twitch or tic which went on for hours, just before you had a press launch and speech to make. This is what made you ask for a second opinion.

Your GP eventually referred you privately to a consultant neurologist who was very uncommunicative about what he thought might be wrong with you and simply sent you for the MRI scan, after he had checked if your insurance covered it, which it did, thank goodness!

You are worried you have a brain tumour, although you know that they are rare. You are just too busy to be ill though and have not thought at all about what else might be wrong.

When given the "Bad News" of the diagnosis you are completely shocked. You cannot think straight at all for a few minutes, and then you can only think of Jacqueline DuPre or Richard Pryor, and they are both dead!

You just want to get out of the clinic and back into your car to drive away. You want to cry your eyes out (if female) or punch someone (if male) but you never cry in public and you are never violent! You need to tell your sister who is the only person you could ever tell about something so awful. She is your older sister and since your mum died you have always shared troubles.

You are divorced, (10 years ago – a short disastrous marriage) and you have no kids. You are financially secure as long as you are working. You also love your job and can't imagine ever not doing it.

The student should:

- Give information on the result of the investigations in terms you can understand
- Allow time for you to respond to the information
- Listen so you can express your concerns
- Demonstrate empathy and be supportive.

CCS year 3: Nervous System Block
Breaking Bad News - a new diagnosis of Multiple Sclerosis

Scene setting for student

Penny/Paul Gallagher (age 20-50)

You are a FY2 doctor doing an outreach follow up clinic in Pitlochry Cottage Hospital for the consultant neurologist.

He has seen this patient at his private clinic and she/he attended the department at NInewells for an MRI scan. There is an arrangement for that to happen.

The patient was then sent a return clinic appointment through the NHS, which is a mix up in this case, but happens sometimes. You see from the result that the MRI scan was highly suggestive of a diagnosis of Multiple Sclerosis.

Think about what you would do – one option is to give the patient this information and then try and arrange follow-up by the consultant, either at the private clinic again if the patent wants that or through the NHS, as he/she will clearly be needing long term follow up and that may be best done through the NHS.

Text of MRI report

The imaging of this brain is abnormal. There are seven dense lesions within the white matter, one infratentorial, three juxtacortical and four periventricular, each measuring between 1 and 2.5cm. The appearance is highly suggestive of a diagnosis of multiple sclerosis.

You should:

- Give information on the result of the investigations in terms the patient can understand
- Allow time for the patient to respond to the information
- Listen to the patient so that they can express concerns and then respond to them
- Demonstrate empathy.

Learning objectives

- Strategies for breaking bad news **(see appendix 2)**
- Strategies for dealing with emotional response
- Reflecting on own feelings during the interview

CCS year 3: Nervous System Block
A patient with early dementia?

Tutor notes

Richard/Ruthie Douglas (age 45+)

The student is playing the role of a GP trainee in a university town: St Andrews. They have been told that they know this patient's son – who is concerned about their parent.

This patient possibly has early dementia and is aware there is something wrong with his/her memory but is not yet unduly concerned about it. He/she has always been academic and scholarly and so day to day things seem trivial. People seem to be commenting however, and are clearly watching and waiting for some sort of slip up. Things are more complicated by the fact that the patient's husband/wife died six months ago from a stroke.

A diagnosis of dementia is one laden with stigma, uncertainty and often fear. In this case it is unclear whether this patient has dementia or whether they may have a combination of eccentric personality, bereavement and/or depression.

The student should

- Think about how much to tell the patient about what they know already
- Uncover the extent of possible short term memory loss and other symptoms linked to dementia, depression or bereavement.
- Agree a shared agenda and management plan that is achievable within the patient's current mental capacity
- Agree a management plan that will allow information sharing and involvement of the patient's son

Learning objectives

- Consider the differential diagnosis of memory loss
- Consider patient's abilities when developing a management plan
- Ensure both support and safety are in the management plan

Appendix 4 has some notes on diagnosing dementia.

As a trainee GP it may be reasonable to make a plan for a review appointment after the trainee has discussed the case with a senior, or for referral to a neurologist. There may be a few initial investigations that a GP can do to help clarify things at this stage – such as a Mini Mental State Examination and/or some blood tests. These may be included in the plan.

You may of course wish to consider whether the patient may require any supportive measures through the diagnostic process.

CCS year 3: Nervous System Block
A patient with early dementia?

Script

Richard/Ruthie Douglas (45-60)

You have noticed that you are becoming increasingly "forgetful" and people are beginning to comment on this. You are puzzled why as you have always being a little vague about minor and boring details about day to day living. You are a Professor of English Literature and specialise in Shakespearean sonnets. You can recite many of them easily still.

You have recently lost your wife/husband (she/he died of a stroke suddenly, six months ago) and she/he used to do all the day to day things, running the house, the bank accounts etc. She/he started doing all this when the children came along as your career was more important. It paid more and she/he was only too happy to give up working to be a house wife/husband.

As far as you're concerned your absent mindedness is only a little bit worse and is not a problem, but your son has insisted you come along to see the doctor today. Your son plays golf with this doctor and has spoken to him/her about you to make sure he/she knows you are becoming forgetful. He cannot come today however as he is away on business and, anyway, you would not have allowed him to come with you. After all you're not senile!

You are not sleeping well and know you are very tired a lot of the time. You have just gone back to work after compassionate leave, and your head of department is very understanding and has allowed you to continue in an administrative capacity with very few lectures and no tutorials.

Last week you were lecturing and did seem to lose your place a little, but it was alright as you decided to end the lecture early and the students were mostly pleased, although one did complaint to your head of department.

You expect that the doctor will understand that there is nothing wrong with you other than understandable stress at losing your wife/husband, and will tell your son that when he/she next sees him at golf.

If asked – you are not weepy, you eat OK, you wake at about 6am after your disturbed nights – but always have done. You admit that you are not happy, but you would deny being depressed. You do look forward to seeing your son and his family. You have never thought about harming yourself.

Note to actors;

- *if asked to be specific about recent events be as vague as possible as you can't really remember any details about recent events*
- *try and deflect the doctor from finding out too much though by going back to older memories, which are quite clear. You can even recite a bit of a sonnet about grief, if it seems a good way of showing how good your memory really is and making the point that you are grieving right now!*

The student should

- Use time to allow you to tell your story
- Develop a rapport and trust to allow you to be open and less defensive

- Clarify your memory loss and explore other symptoms which may be linked with dementia or depression
- Agree a shared agenda and management plan that is achievable within your current mental capacity, possibly to include your son.

"No longer mourn for me when I am dead
Than you shall hear the surly sullen bell
Give warning to the world that I am fled
From this vile world, with vilest worms to dwell:
Nay, if you read this line , remember not
The hand that writ it; for I love you so,
That I in your sweet thoughts would be forgot,
If thinking on me then should make you woe.
O, if (I say) you look upon this verse,
When I perhaps compounded am with clay,
Do not so much as my poor name rehearse;
But let your love even with my live decay:
Lest the wise world should look into your moan,
And mock you with me after I am gone."

CCS year 3: Nervous System Block
A patient with early dementia?

Scene setting for student

Richard/Ruthie Douglas (age 45-60)

You are a trainee GP in practice in St Andrews. You are on your own in the surgery today. You have never met Mr/s Douglas before. The patient has very brief medical notes: remarkably little medical history, no medications, do not smoke and drink minimal alcohol.

This patient's son (William) spoke to you recently as you play golf together most weekends. His other parent died six months ago, suddenly, of a stroke and Richard/Ruthie is very upset still. However the remaining parent seems to be coping with the grief, whilst not coping with the day to day things at all well. He/she has lost three sets of house keys, has reversed the car into the gate posts and never seems to have any proper food in the house.

He/she works at the University and is regarded as a UK authority on Shakespearean sonnets. His/her head of department was at the funeral and did say then to William that he was concerned about how Richard/Ruthie would cope on his/her own as he/she did seem to be increasingly forgetful at work.

You are pleased Richard/Ruthie has now made an appointment, and you hope to be able to reassure yourself that this is only a grief reaction in someone who has not had to be very "worldly practical" in the past.

Introduce yourself as Dr……..

You should;

- Think about how much you are going to tell the patient you know already
- Work out what might be going on with the patient
- Work out a management plan with the patient

There are some notes on diagnosing dementia in appendix 4.

CCS year 3: Nervous System Block
A patient behaving strangely.

Tutor notes

Steve/Susan Wallace (age 25-45)

This is a difficult scenario involving a frightened, suspicious patient who has come to A&E reluctantly. The patient has a history of mental health problems and is already involved with the psychiatric services – although the student does not know this at the start of the interview.

The patient is displaying overt symptoms of a psychotic nature. They do have a little insight into their difficulties – hence their presentation in A&E. They have engaged with psychiatry services before, so with skilful and patient encouragement they may well do so again.

Issues

- Putting the patient at ease
- Making a provisional diagnosis
- Empathy and understanding to enable the patient to talk about fears and suspicions
- Supportive approach accepting the patient's real fears about the voices
- Reassurance of the need to gain information in order to help the patient

Learning objectives

- Communicating with patients who have psychosis
- Gaining trust
- Recognising the problem at hand (a general diagnosis rather than a specific one)
- Strategies for dealing with patients who are reluctant to give information
- Reflecting on how own feelings may influence the communication process

Appendix 5 has some useful notes on communicating with patients with psychiatric problems.

CCS year 3: Nervous System Block
A patient behaving strangely

Script

Steve/Susan Wallace (age 25-45)

Your friend, Jimmy, insisted you go to hospital today, as he thought you were taking your medication incorrectly. You have been seen by the triage nurse in A&E and you told her you had "headaches" but when she asked further about you she seemed less interested in your headaches and went to find a doctor.

You are a 'mature' university student reading Politics and Economics. You have not been attending lectures for several weeks and have been spending most of your time in your room. You live in a hall of residence. You smoke a bit of dope and drink tins of lager most evenings.

You are a bit of a loner and have few friends. You have been neglecting yourself recently and have not been taking care of your appearance. Your friend, Jimmy, persuaded you to go out last night with some other students to the local pub. You ended up in an argument with a stranger on the street who you accused of saying something obscene as you passed by. Jimmy managed to diffuse the situation and avoided the police being involved. He is very concerned about you, although you do not see what all the fuss is about.

You have been on medication for several years for "agitation" but you do not like taking it as it makes you tired. You do however take it most days. If asked be vague, say the name of the tablets is clozapine, if pushed about the dose you are taking say 3 or 4 each day but you are not sure what strength of tablet you are on and that people keep changing the dose, so you get mixed up. You can't, or won't, name the doctors who treat you, nor can you recall when or where you were last seen. You are happy to talk about 'Liff' hospital (old psychiatric hospital – not that you were ever a patient there) – and the meaning of Liff…

During the interview with the doctor you are very suspicious, avoiding eye contact and answering in monosyllables. Initially you volunteer no information, denying there is a problem. You feel angry with Jimmy for sending you, however Jimmy did persuade you to talk to the doctor so you will do that because you know he is the only person that looks out for you, and you trust him.

Eventually, you tell the doctor there is a plot by "fascists and politicians" directed at you because of your left wing views. You are being spied on and followed in the street. You hear voices calling you names and threatening to harm you. These come from people in the street when you go out. As a result you are becoming afraid to leave your room. You do not trust anyone!

Your parents live in England and they do not know anything about this. In fact you do not want to involve them, as they may be in danger.

Before, when things were upsetting you ended up in hospital and was given strong drugs by way of injections. You do not want that to happen again. You eventually realise you need help and are willing to accept a referral so long as they don't make you stay in hospital again.

Note to the actors;

- *This is a difficult role as it is easy to see that if the student is not particularly skilled the patient might become agitated and even try and leave.*
- *Please do not go so far as to actually leave if that happens, if it gets to that stage simply threaten to leave*
- *It would be quite acceptable that a patient like this could suddenly change to being more frightened than agitated and have enough insight to know they really need help and so have to stay*

The student should

- Introduce him/herself and put you at ease
- Explore the nature of your problems
- Let you talk about your fears and suspicions
- Reassure you about the need to gain information in order to help
- With you, work out what to do next.

CCS year 3: Nervous System Block
A patient behaving strangely

Setting the scene for students

Steve/Susan Wallace (aged 25 – 45)

You are a FY2 doctor working a shift in A&E. Introduce yourself as Dr……..

Initially this patient presented complaining of a "fuzzy head" but the triage nurse has come to find you as she suspects a psychiatric problem.

Issues

- Try to gain the patient's trust
- Find out what is wrong
- Work out a management plan

A&E departments often ask doctors from the psychiatry team or senior psychiatry nurses to come to assess patients that they suspect have a mental health issue.

Appendix 5 has some useful information about talking with patients with significant psychiatric problems.

CCS year 3: Nervous System Block
Assessment of suicide risk

Tutor notes

Susan/James Gilbert (age 25-50)

This patient is being seen in A&E by the student who is playing the role of a FY2 in psychiatry.

Although the patient is depressed there is a more immediate problem to be dealt with: the risk of further self-harm. Although the two are interlinked managing the depression is not the focus for this role play, only acknowledging its seriousness and its effect on the patient's life. The over-riding concern is one of safety for the patient and therefore the need to engage her in a focused management plan.

The student should

- Encourage the patient to tell their story
- Determine a level of suicide risk in this patient
- Acknowledge the patients views and feelings and accept the legitimacy of these views and feelings
- Offer an opinion about what might need to happen and give a rationale for that in a supportive manner
- Engage patient in shared management plan

Learning objectives

- Developing interviewing strategies to cope with difficult and emotionally challenging patients
- Recognise the primary problem – here *suicide risk*, above *depression*,
- How to assess suicide risk

Appendix 5 has some useful tips on talking with patients with psychiatric problems.

CCS year 3: Nervous System Block
Assessment of suicide risk

Script

Susan/James Gilbert (age 20-50)

You are sitting in the A & E department of the local hospital feeling very down. You took an overdose of forty paracetamol tablets washed down with half a bottle of vodka twelve hours ago. On the previous night you waited until your partner had gone to sleep and went, unobserved, to the kitchen to take the tablets. After taking the tablets and the alcohol you were found by your partner, some hours later, semi-conscious.

In A&E you were treated with something they made you swallow and put on a drip. You remember being examined by a taciturn doctor in the middle of the night who said that you were lucky to be alive. This made you feel more guilty and ashamed than you already were. You regret being found before the tablets had a chance to work.

Life had been tolerably good till twelve months ago. You were enjoying working as a computer technician in a small software company. You were getting on reasonably well with your partner but didn't communicate all that well with each other. Your mother then died unexpectedly after a routine operation and your world gradually caved in. You had never got on well with her; in fact you had hardly spoken to her for ten years. She had always been bitter, cold and unloving after your father left, and you had eventually left home at an early age. You felt guilty about the relationship and especially the fact that you didn't patch things up before she died.

Since her death you gradually became more unsociable and withdrew into yourself. You no longer enjoyed going out for meals with your partner and stopped enjoying television or reading. You felt down and irritable most of the time and people at work started commenting that you had become very serious. Work has always been enjoyable, but over the last six months your concentration has been poor and you had been making more mistakes than usual. Things took much longer to do and you lost confidence in your abilities.

You started to ruminate incessantly about your relationship with your partner and your mother and became convinced that these problems have been your fault. You have had numerous arguments with your partner, as he/she does not understand that you are too tired to socialise and consequently, you have no interest in sex. Recently he/she has talked about counseling or separating and you feel like a millstone around his/her neck. You have never talked a lot, but things have been really distant lately.

You have lost interest in food and have lost more than half a stone in weight in the last few months. Over the past month you have lain awake at night trying to solve your problems and wake exhausted at 5 am every morning, but can't get back to sleep. You don't look forward to anything.

Over the past month you have started to think about death as a way out of this mess. Initially this came on only fleetingly but over the past week you have been thinking about ending it all, and made active plans to overdose.

You didn't leave a note. You do regret that it didn't work. This is the first time you have tried to harm yourself ever. You've never seen a psychiatrist or had any formal mental health diagnoses in the past.

Past medical history and Medications

- None

Family history

- Mother was always down, bad tempered and irritable. You think she was probably depressed, especially when your parents separated when you were eleven
- Parents were always rowing when you were a child
- No contact with father since he emigrated to the United States when you were thirteen
- Only child

Personal/Social history

- You had an unhappy childhood with family rows and friction at home.
- Your father was unemployed with consequent financial problems.
- You found it difficult to settle at school, always shy, a loner and school refusal intermittently during childhood
- Academically bright but didn't do well in exams, always froze.
- You met your partner at work. First major relationship. Very different people, partner outgoing.

Personality

- Serious
- Dedicated
- tend to internalize your problems

Cigarettes

- none

Alcohol

- 3-4 glasses of wine per week
- recently drinking more than ½ bottle of wine a night to cheer you up but with no improvement

Patient's ideas and thoughts

- Guilty about difficult relationships you have with other people and tearful when talking about significant relationships
- You blame yourself for what has happened in recent times
- You see no way things will ever improve and have thought about other means of killing yourself. You feel you will take a bigger overdose next time
- You feel a total failure and that you have never achieved anything in your life
- You are apathetic and reluctant to talk at first
- Apologize for wasting their time as there is nothing they can do for you, it's all your fault for messing up your life
- Become more expansive if empathy shown and open-ended questions asked
- Respond by elaborating more on your history if reassurance given
- Causes of depression only revealed if asked for.

Patient's feelings

- You feel very down
- You see no hope for the future and would prefer to be dead
- You feel initially apprehensive towards the interviewer
- You feel that nothing can help you now

Effect on life

- Everything around you is falling asunder
- You can't enjoy yourself or work and the relationship is almost over
- Death is the easiest possible solution

Behaviour

It is important that this role starts in misery and withdrawn but reasonably quickly picks up speed if sensitively handled by the student. Too slow and we get nowhere in the hour and the student is not rewarded, too fast and there is no challenge.

You are feeling hopeless, you are a waste of time to everyone. It is you who is guilty, not your family or the doctors or nurses. You look distressed and haunted but cannot engage with the person who is approaching you, it is all too much effort. Everything is internal for you. You sit huddled in a chair with your legs crossed away from the interviewer. Avoid eye contact and look away at first.

You don't see the point of talking to a psychiatrist but are not angry or difficult. You respond at first with:

'Sorry……' and look away,
then, after a silence:
'I feel…….': leave the sentence incomplete, but shoot a glance of eye contact with desperation in it.

Then gradually come out with:

'I shouldn't be here'
or
'I feel so guilty'
or
'I feel awful'

Become more animated if the interviewer is empathic and reassurance given or gives you time, start to respond to their questions about what happened or why you feel like you do. You begin to feel that at last someone is listening, it is a relief, you start to give some eye contact.

Outcome of interview

You see little point in coming into hospital and become fearful at the thought of admission to a psychiatric unit. Nevertheless you still think suicide is an option to consider.

- Ask what can they do for you there? You can't see how talking or tablets will improve things
- Agree to admission if a persuasive case is made for treatment. Maybe there is light at the end of the tunnel

The student should

- Encourage you to tell your story
- Acknowledge your views and feelings and accept them
- Offer an opinion about what might need to happen and give a rationale for that in a supportive manner
- Develop a plan with you.

CCS year 3: Nervous System Block
Assessment of suicide risk

Scene setting for student

Susan/James Gilbert (age 25-50)

You are a Foundation Year 2 doctor working in psychiatry in Dundee.

There is a rota for FY2 doctors to visit the A/E department to do the initial assessment of all patients who have been seen with self-harm. You are expected to arrange for any patients who you consider may be at risk to themselves to be transferred over to be seen by a senior psychiatry trainee (registrar) and/or liaison nurse. You are not expected to initiate any treatment yourself.

You know from the A&E staff that Mr/s Gilbert has had an overdose of paracetamol and alcohol last night. She had a paracetamol level that required treatment with parvolex (antidote) through a drip, which has been completed.

You have read that she has had recent relationship difficulties, a family bereavement and took an OD as a reaction. She drinks well over the recommended limit but denies illicit drugs or smoking. She has no PMH of note, including no psychiatric history. She "appears depressed" to the doctor who admitted her to A&E.

You should

- Clarify the story with this patient
- Assess whether she is a risk to herself
- Determine her needs in terms of follow up by the psychiatry team
- Agree a management plan with her

Appendix 5 has some useful tips on talking with patients with psychiatric problems.

Appendix 1

Calgary Cambridge Guide to the Medical Interview

INITIATING THE SESSION

Establishing initial rapport

1. **Greets** patient and obtains patient's name
2. **Introduces** self, role and nature of interview; obtains consent
3. Demonstrates interest, concern and **respect**, 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. Checks and **screens** for further problems (e.g. "So that's headaches and tiredness, what other problems have you noticed?" or "Is there anything else you'd like to discuss today as well?")
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 questions,** 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** statements which are vague 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 **language**, avoids or explains jargon

Understanding the patient's perspective

16. **Determines and acknowledges**
    - Patient's **ideas** (i.e. beliefs re cause) and **concerns** (i.e. worries) regarding each problem
    - Patient's **expectations**: goals, what help the patient had expected for each problem
    - Effects: how each problem **affects** the patient's life
17. **Encourages expression** of the patient's **feelings** and **thoughts**

Providing structure to the consultation

18. **Summarises** at the end of a specific line of inquiry to confirm understanding before moving on to the next section
19. Progresses from one section to another using **signposting**; includes rationale for next section
20. Structures interview in logical **sequence**
21. Attends to **timing** and keeping interview on task

BUILDING THE RELATIONSHIP

Developing rapport

22. Demonstrates appropriate **non-verbal behaviour** (e.g. eye contact, posture & position, movement, facial expression, use of voice)
23. If reads, writes **notes**, or uses computer, does in a manner that does not interfere with dialogue or rapport
24. **Acknowledges** patient's views and feelings; **accepts** legitimacy; is not judgmental
25. Uses **empathy** to communicate understanding and appreciation of the patient's feelings or predicament
26. Provides **support**: expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self care; offers partnership
27. Deals **sensitively** with embarrassing and disturbing topics and physical pain, including when associated with physical examination

Involving the patient

28. **Shares thinking** with patient to encourage patient's involvement (e.g. "What I'm thinking now is…")
29. **Explains rationale** for questions or parts of physical examination that could appear to be non-sequiturs
30. During **physical examination**, explains process, asks permission.

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*

31. **Chunks and checks:** gives information in assimilated chunks, checks for understanding, uses patient's response as a guide to how to proceed
32. **Assesses patient's starting point:** asks for patient's prior knowledge early on when giving information, discovers extent of patient's wish for information
33. **Asks patients what other information would be helpful** e.g. aetiology, prognosis
34. **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*

35. **Organises explanation:** divides into discrete sections, develops a logical sequence
36. 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…")
37. Uses **repetition and summarizing** to reinforce information
38. Uses concise, easily understood **language**, avoids or explains jargon
39. Uses **visual methods of conveying information:** diagrams, models, written information and instructions
40. **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*

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

Planning: shared decision making

Aims

- *to allow the patient to understand the decision-making process*
- *to involve the patient in decision-making to the level they wish*
- *to increase the patient's commitment to plans made*

45**. Shares own thoughts:** ideas, thought processes, and dilemmas

46**. Involves patient** by making suggestions rather than directives

47**. Encourages patient to contribute their thoughts:** ideas, suggestions and preferences

48**. Negotiates** a mutually acceptable plan

49**. Offers choices:** encourages patient to make choices and decisions to the level that they wish

50. **Checks with patient** if plans are acceptable, if concerns have been addressed

CLOSING THE SESSION

51**. Summarizes** session briefly and clarifies plan of care

52. **Contracts** with patient re next steps for patient and physician

53**. Safety nets,** explaining possible unexpected outcomes, what to do if plan is not working, when and how to seek help

54**. Final check** that patient agrees and is comfortable with plan and asks if any corrections, questions or other items to discuss

OPTIONS IN EXPLANATION AND PLANNING

If discussing options and significance of problems

56. Offers **opinion** of what is going on and names if possible

57. Reveals **rationale** for opinion

58. **Explains** causation, seriousness, expected outcome, short long term consequences

59. **Elicits patient's beliefs, reactions and concerns**, e.g. if opinion matches patients thoughts, acceptability, feelings

If negotiating mutual plan of action

60. **Discusses options** e.g. no action, investigation, medication or surgery, non-drug treatments, preventative methods

61. Provides **information on action or treatment** offered, e.g. name, steps involved, how it works, benefits and advantages, possible side-effects

62. **Obtains patient's views**, advocates alternative viewpoint as necessary

63. **Accepts** patients yews, advocates alternative viewpoint as necessary

64. **Elicits patients reactions**, concerns about plans and treatment, including acceptability

65. **Takes patients lifestyles, beliefs, cultural background and abilities into consideration**

66. **Encourages patient to be involved** in implementing plans, to take responsibility and be self-reliant

67. Asks about **patient support systems**, discussed other support available

If discussing investigations and procedures

68. **Provides clear information** on procedures, including what patient might experience and how patient will be informed of results

69. **Relates procedures to treatment plan**; value and purpose

70. **Encourage questions about, and discussion** of, potential anxieties or negative outcomes

Silverman J, Kurtz S, Draper J. Skills for communicating with patients (2nd edition) Oxford Radcliffe Medical Press, 2004

Appendix 2

Breaking Bad News

Aim

- To give students the opportunity to explore and try out the principles of breaking bad news in a variety of challenging settings

Objectives

By the end of the session on breaking bad news the student will be able to;

- Determine how much information to give
- Break news using warning shots and appropriate choice of words
- Elicit the patients concerns and feelings
- Respond to the patients concerns and feelings
- Understand the principles of coping with distressing situations
- Develop a shared plan/way forward with patients in these situations

What is bad news?

Bad news is any information that is likely to alter drastically a patient's future.

Why is it so difficult for doctors to break bad news?[1]

- Doctors worry that the patient will blame them personally for the bad news.
- Doctors have no training and confidence in this area. They, therefore, avoid it.
- Doctors fear that they may unleash a reaction in the patient with which they will have difficulty coping e.g. a crying or angry patient.
- Doctors are afraid to express emotion and sympathy. They fear that if they say they are "sorry" the patient will interpret this as the doctor apologising for some error that has been made.
- Doctors have a fear of not knowing the answers to the questions that the patients will ask, e.g. why has it happened?
- Doctors have personal fears about illness and death. This is often a result of society's taboo about death, or a personal denial of illness or death by the doctor. They distance themselves from someone who is in this situation.

Why is it important for patients to be told bad news well?

- Not being told what is wrong is the most common complaint that patients make about doctors.[2]
- In a number of studies patients have shown extreme anger towards doctors who do not tell bad news.
- If bad news is not dealt with openly, the patients may have many needless fears about their illness and are not given the opportunity to discuss them—e.g. that cancer is infectious, inherited or leads to a painful and prolonged death.
- There is evidence that if breaking bad news is badly handled, it impedes patients' and relatives' long term adjustment to the news.

There is no magic formula but here are some points to consider:

Preparation

- Make preparations as fully as possible, e.g. checking notes, test results and arrangements for further investigations and treatment.
- Think about what you are going to say and how you are going to say it.
- Think about whom else might be present, e.g. nurse or relative.
- Arrange for a room with privacy, and arrange the furniture appropriately.
- Ensure that you will not be disturbed.
- Allow enough time.
- It is helpful if you have an understanding of the background of the patient and their family.

The consultation

- Make sure the patient/relatives know who you are and the purpose of the consultation.
- Do not assume that someone else has handled important parts of the information-giving. **Check what the patient knows and understands first, and then what they want to know**.
- **Listen to the patient** and show you are listening.
- Sit close enough to the patient for physical contact and at the same level as the patient.
- **Break news sensitively** – use warning shot if required, take it in steps from patient's starting point, select words carefully.
- Ensure that the patient/relative has enough time to let news sink in, react and ask questions.
- **Ask patients about how they are feeling**, allow patients to express their emotions, whether it be by crying or by anger. Be ready to cope with emotion without embarrassment or guilt.
- **Check that the patient has understood what you have said and invite questions** (what you think is important is not necessarily the same as what the patient feels is important).
- Give as much positive **practical support and information** as possible, but avoid giving false or premature reassurance.
- Be prepared for a variety of reactions from patients, including numbness, disbelief, anger, guilt or acceptance.
- It is important to tell patient's families if possible, otherwise there may be barriers between family members, a conspiracy of silence, which can reduce communication at a time when families should be at their closest. However, you must be sensitive to patient confidentiality and ensure that you have patients' consent to discuss their medical problems with family members. Sometimes patients are grateful if you offer to tell their family for them, others will want to do it themselves, but may appreciate an offer from you to answer questions or talk to relatives later.
- **Offer follow-up** appointment, as well as a number to ring, etc. and addresses of other helpful agencies.
- Check your own state of mind before seeing another patient.

Six Step Protocol

Buckman[1] has defined a six-step protocol for breaking bad news which gives a useful framework for thinking about how to break bad news:

Step 1 Getting Started

- Getting the physical context right
- Where?
- Who should be there?
- Starting off

Step 2 Finding out how much the patient knows

Step 3 Finding out how much the patient wants to know

- Depends on context. In many circumstances patients will express a wish to know certain aspects - especially with complicated information.

Step 4 Sharing the information

- Decide on your agenda (diagnosis/treatment plan/prognosis/support)
- Start from the patient's starting point
- Give information in small chunks
    - The warning shot
- Use simple English, not jargon
- Check frequently that the patient has understood and clarify any points
- Listen for your patient's agenda, concerns and anxieties
- Try to blend your agenda with the patient's

Step 5 Responding to patient's feelings

- Identify and acknowledge the patient's reaction

Step 6 Planning and follow through

- Organising and planning
- Making a contract and following through

Further reading

Buckman, R. (1994). *How to break bad news, A guide for health-care professionals*. MacMillan: London. ISBN: 033034040

Maguire, P. (2000). *Communication Skills for Doctors: A guide to effective communication with patients and families*. London: Arnold. Chapter 6:55–66. ISBN: 34066309.

Appendix 3

Diagnosing multiple sclerosis

Taken from http://www.nhs.uk/Conditions/Multiple-sclerosis/Pages/Diagnosis.aspx

If you have unexplained symptoms that are similar to those of multiple sclerosis (MS), see your GP. If your GP suspects MS, they will ask you for a detailed medical history, including past signs and symptoms as well as the current state of your health.

Your GP can refer you to a neurologist (a specialist in conditions of the central nervous system). If your GP suspects that you have MS, you should see a neurologist within six weeks.

Want to know more?

- Multiple Sclerosis Society: Just diagnosed with MS.
- Multiple Sclerosis Trust: Diagnosis.

Diagnostic tests

Diagnosing MS is complicated because no single laboratory test can positively diagnose it. Several conditions have symptoms that are similar to those of MS, so your neurologist may rule them out first.

To confirm a diagnosis of MS, your neurologist may carry out a number of tests.

Neurological examination

Your neurologist will look for changes or weakness in your eye movements, leg or hand co-ordination, balance, speech and reflexes. This will show whether any of your nerve pathways are damaged.

Magnetic resonance imaging (MRI) scan

A magnetic resonance imaging (MRI) scan creates a detailed image of your brain and spinal cord. The procedure is painless and usually takes between 10 and 30 minutes. A standard MRI scanner is like a giant tube or tunnel. You may feel claustrophobic when going into the tunnel and the machine is noisy. Tell your neurologist if you have any concerns about this experience.

MRI scans can show whether there is any damage or scarring of the myelin in your central nervous system. Over 90% of people with MS are diagnosed using an MRI scan.

Evoked potentials test

An evoked potentials test involves placing small electrodes on your head. These monitor how your brain waves respond to what you see and hear. It is painless and can show whether it takes your brain longer than normal to receive messages.

Lumbar puncture

A lumbar puncture is also sometimes called a spinal tap. A sample of your cerebrospinal fluid (the fluid that surrounds your brain and spinal cord) is taken using a needle inserted into the area around your spinal cord.

This is done under local anaesthetic, which means that you will be awake but the area that the needle goes into will be numbed. The sample is tested for antibodies, the presence of which means that your immune system has been fighting a disease in your central nervous system.

A lumbar puncture is usually only needed if other tests for MS are inconclusive, or for a diagnosis of primary progressive MS.

Blood tests

Blood tests are usually performed to rule out other causes of your symptoms, such as vitamin deficiencies. In addition, antibody tests may be required, for example to rule out a special type of MS called Devic's disease.

Want to know more?

- Multiple Sclerosis Society: How is MS diagnosed?
- Genetic and Rare Diseases Information Center: Devic's disease.

Diagnosing the different types of multiple sclerosis

Once a diagnosis of MS has been made, your neurologist may be able to identify which type of MS you have.

However, this often only becomes clear over time as the symptoms of MS are so varied and unpredictable. This is particularly true of benign MS (BMS), which can only be diagnosed once you have been free of symptoms for 10-15 years.

A diagnosis of relapsing remitting multiple sclerosis (RRMS) may be made if:

- you have two relapses of your symptoms more than 30 days apart, or
- you have one relapse and an MRI scan shows new myelin damage or scarring three months later

A diagnosis of secondary progressive multiple sclerosis (SPMS) may be made if:

- you have had relapses of your symptoms in the past, and
- you have become steadily more disabled for at least six months, with or without relapses

A diagnosis of primary progressive multiple sclerosis (PPMS) may be made if you have had no previous relapses of your symptoms, and:

- you have become steadily more disabled for at least one year
- an MRI scan shows damage and scarring to myelin

- a lumbar puncture shows that there are antibodies in the fluid surrounding your brain and spinal cord

Uncertain diagnosis

In some cases, your neurologist may not be able to say for certain whether you have MS. This can happen when the test results are unclear, for example if your symptoms and lumbar puncture results point towards MS but there is no sign of myelin damage on the MRI scan.

If this is the case, your neurologist may tell you that you have possible MS. You may have to wait for your symptoms to relapse before a definite diagnosis can be made.

Appendix 4

Diagnosing dementia

Taken fromhttp://www.nhs.uk/Conditions/Dementia/Pages/Diagnosis.aspx

Confirming a diagnosis of dementia can be difficult, particularly when the condition is in its early stages. This is because many of the symptoms of dementia can be caused by other conditions.

It can be helpful if you and a close relative are seen together, as they can help you remember what is happening.

In order for dementia to be diagnosed correctly, you will have a number of different tests and assessments including:

- a review of your personal history including education and employment
- a review of your medical history
- a full assessment of your mental abilities
- a range of tests, including blood tests to rule out other possible causes of your symptoms, such as a vitamin B deficiency
- imaging scans, such as a CT scan or magnetic resonance imaging (MRI) scan, which can provide information about the physical state and structure of your brain
- a review of any medication you may be taking, in case these are contributing to your symptoms

Some of these tests can be carried out by your GP. Others will be carried out by other specialists, such as a neurologist (an expert in treating conditions that affect the brain and nervous system) or a psychiatrist with experience in treating dementia.

Assessing your mental abilities

There are some questionnaires that can be used to help test your mental abilities and how severe your symptoms are. One widely used questionnaire is the Mini Mental State Examination (MMSE).

The MMSE can be used to assess a number of different mental abilities including:

- short- and long-term memory
- attention span
- concentration
- language and communication skills
- ability to plan
- ability to understand instructions

The MMSE is a series of questions, each carrying a score that can give a maximum result of 30 points. Example questions include:

- memorising a short list of objects and then repeat the list back
- writing a short sentence that is grammatically correct, such as 'the dog sat on the floor'
- correctly identifying the current day of the week, followed by the date, the month, the season and the year

The MMSE cannot diagnose dementia by itself but it is useful for assessing the level of mental impairment that a person with dementia may have.

- a score of 25 or above is considered normal
- a score of 18 to 24 indicates mild to moderate impairment
- a score of 17 or below indicates serious impairment

These scores are affected by education. Some people who cannot read or write well may always score less than 25, but they may not have dementia. Other people with a higher level of education, may have a higher score but still have dementia.

Want to know more?

- Dementia UK: How should we get an assessment/find out if this is dementia?
- Alzheimer's Society: The Mini Mental State Examination.

Further tests

There are blood tests that can be used to rule out other conditions that may be responsible for the patient's symptoms.

A full blood count

A full blood count can be used to assess your general health and check for a range of disorders, including anaemia and infection. A blood sample will usually be taken from a vein in your arm using a needle and syringe. The test will also check for other illnesses.

Blood glucose test

A blood glucose test can be used to find out whether your blood glucose level is normal, and can also determine whether you have diabetes. A blood sample is taken to rule out whether your symptoms might be caused by undiagnosed diabetes.

Urine analysis

Urine analysis is used to diagnose diabetes or problems with your kidneys. During the test, you will be asked to pass a small sample of urine into a sterile container.

Measurement of thyroid hormones

A measurement of your thyroid hormones may be taken in order to screen for thyroid disorders, including an underactive thyroid (hypothyroidism) and an overactive thyroid (hyperthyroidism).

Measurement of vitamin B_{12} levels

You may also have a test to check whether your symptoms are caused by a lack of vitamin B_{12}. However, if you do have a B_{12} deficiency, it is still possible that you may also have dementia.

Imaging scans

Imaging scans can check if there are any underlying problems with your brain, such as a brain tumour, that could help explain your symptoms.

Imaging scans can also identify changes in the appearance of the brain that may indicate dementia. Several types of imaging scans can be used in the diagnosis of dementia.

Computerised tomography

A computerised tomography (CT) scan can take a series of X-ray images of your brain. The images are fed into a computer to build up a detailed 3D image of the inside of your brain.

Magnetic resonance imaging

A magnetic resonance imaging (MRI) scan may be used as an alternatve to a CT scan.

MRI scans help doctors determine whether:

- there is any shrinkage to the outer layer of the brain
- there is any evidence of changes to the blood vessels
- there are any blood clots that might have resulted in vascular dementia

The test will also show whether other conditions, such as a brain tumour, are causing your symptoms.

Single photon-emission computed tomography

A single photon-emission computed tomography (SPECT) scan may be recommended if doctors are unsure whether you have Alzheimer's disease, frontot-emporal dementia or vascular dementia.

A SPECT scan is similar to a CT scan, but the scanner used for a SPECT scan is able to take moving pictures of the blood flow in your brain. The results show if the blood flow in your brain is abnormal, which can often be used to help diagnose the type of dementia

Appendix 5

Interviewing the Psychiatric Patient

Dr Jonathan Silverman
Addenbrooke's Hospital
Cambridge

1. Assessing suicidal risk and depression following an overdose

Key objectives are

- *to engage with a patient who has taken an overdose*
- *to assess suicidal risk*

Key core skills include:

initiating the session

- introduction of yourself and role, consent
- demonstrating interest, concern and respect
- opening question: re feelings

gathering information

- listening, use of silence
- proceeding at the patient's pace
- gauging the patient's emotional state
- discovering and responding to patient's feelings
- picking up, reflecting and checking out non-verbal and verbal cues
- eliciting the patient's ideas and concerns and the effects of the illness on their life
- facilitation through repetition, interpretation and paraphrase and use of silence
- using open questions
- clarifying
- asking directive questions re suicidal risk and depression
- signposting

building the relationship

- non verbal communication
- empathy
- acceptance
- lack of premature reassurance
- support

Key information required to assess suicidal risk:

- how does the patient feel now
- why did the patient take the overdose, what was going through their head
- does the patient regret the suicide attempt - is the patient glad to be alive
- how does the patient view the future
- what method did the patient use to harm themselves
- did the patient plan the suicide attempt or was it an impulsive action (note this is key to the assessment of a depressed patient prior to a suicide attempt – have you thought how you would kill or hurt yourself – have you made any plans or preparations – what is the closest you have come to actually doing it)
- how did the patient plan it (i.e. final acts, avoid being found, what methods used to avoid detection by other people? violent method? alcohol?)
- did the patient leave a suicide note
- does the patient think they might harm themselves in the future
- is there anything that would stop them doing it
- social and personal circumstances of the patient particularly with regard to social isolation and unemployment
- has the patient tried to harm themselves before - details of methods and seriousness of attempts.
- were drugs or alcohol involved at the time of the attempt
- symptoms of clinical depression:
    - disturbance of mood
    - hopelessness/helplessness
    - feelings of worthlessness, low self-esteem
    - poor concentration
    - loss of interest or pleasure
    - guilt/self-blame
    - alterations in appetite
    - alterations in weight
    - difficulty in sleeping - sleep pattern
    - agitation or retardation
- does the patient think he could be helped with the right treatment
- would they consider that?

Commentary

Depression is a very frequently occurring psychiatric disorder which is all too easily missed in medical practice. Accurate recognition and diagnosis depends very much on the skill of the doctor. There are distinct skills needed both to uncover covert depression and also to assess the severity and in particular the risk of suicide once depression has been recognised.

In this session, we are concentrating on someone who has taken an overdose, who may or may not be depressed. We are not looking at the patient who you think is depressed in other circumstances and has not attempted self-harm.

Yet all possibly depressed patients are at risk of suicide and must be asked specifically about thoughts of hopelessness, self harm, death or suicide. Do not fall into the trap of avoiding these questions – be reassured that you will not plant suicidal ideas into someone's thoughts who have not already thought of them.

It is often possible to ask a direct question, or it may be appropriate to ask in a more oblique fashion, "testing the water" first. For example:

"I'm wondering how low you really are....can you bear to tell me?"

"You look depressed today.....would you like to tell me about how you are feeling?"

"You are wondering if you are depressed. I'd like to ask you some specific questions about your mood, concentration, appetite and sleeping patterns which will help us..."

"Do you ever feel that there's a light at the end of the tunnel?"

"You've told me how difficult it is to sleep...what is going through your mind when you are lying tossing and turning.....?"

"Have you ever felt that you might want to harm yourself?"

"Some people feel that they can't go on when they are depressed....have you had thoughts like that?.....that you'd like to end it all?"

2. Interviewing and assessing the patient with delusions and hallucinations

Patients with delusions and hallucinations present considerable communication challenges. The patient is in some way out of touch with reality; this may be quite a subtle state or the patient may be acutely ill and out of control. Not only may the patient be unable to function normally but their communication skills are often impaired and they may be frightened, bewildered and untrusting. In fact, it may be impossible to make a relationship with the patient; attempts to get close to the patient may be misinterpreted and feel threatening. On the other hand patients with mental illness greatly value being understood.

The challenge for the doctor is to overcome the barriers to communication while simultaneously gathering information, often from diverse cues, of the presence and extent of a psychotic disorder. Gathering information in a sensitive and empathic manner when the doctor himself is ill at ease requires communication skills of a high order. Do not underestimate the effect of anxiety, fear and discomfort on both doctor and patient.

Key objectives for students

The main purpose of this exercise is to give you the opportunity to work through a potentially difficult situation before it happens to you in real life. Please remember that psychosis is as difficult, important, and devastating a diagnosis as AIDS

We hope that you develop some key skills that enable you to feel more prepared to face similar situations in the future.

Our key objectives are therefore for you to practice:

- engaging a disturbed patient in interview, teasing out information
- attempting to make an assessment of psychotic symptoms
- feeling comfortable discussing psychotic symptoms and identifying some appropriate responses
- assessing what you see and picking up on aspects of appearance and behaviour to cue questions, e.g. "You seem to be bothered at times while we talk by something else, you look away. Is there something you are hearing or think you hear?"
- empathising (without colluding) with a patient (and their family) struggling to make sense of events around them and of strange internal and external stimuli
- dealing with the emotional impact on the patient, making contact with the patients' experiences

Key issues to be assessed by the end of an interview include:

- abnormal behaviour, dress or manner of the patient
- the emotional state of the patient
- the predominant mood of the patient during the interview
- speech and thought flow, content and form
- whether the patient has delusional beliefs
- whether the patient has a systematized delusional system or many different types of delusions
- whether the patient feels that their thoughts or actions are being controlled by an outside agency
- whether the patient is hallucinating in any modality
- nature of hallucinations: whether persecutory in nature, whether as commands, whether thought broadcasting
- whether the patient has insight into their illness
- apathy and loss of interest in family, occupational or social life
- whether alcohol or illicit drugs were involved in presentation
- risk to patient of self harm/neglect/inattention to normal daily risks
- risk to others from patient, e.g. threat to individuals that the patient has delusional beliefs about specifically, or to the public at large if delusions incorporate many people/everyone

Commentary

There are a number of presentations of psychosis that we see which influence the communication skills that we need to employ. In this scenario, we are looking at the second of the three presentations below although elements of the first situation still apply:

1. **The florid psychotic patient with obvious thought disorder, pressure of speech, agitation, paranoia and hallucinations and delusions.**

Here the key core skills from the Calgary Cambridge guide which may be helpful are:

- Preparation
- introducing yourself and explaining why you are there (but see below)
- checking that the patient is not in any physical discomfort
- sitting still, keeping calm, confident, relaxed pose, keeping in neutral
- open posture, facing the patient, non threatening body language
- eye contact, but not staring
- starting with very directed simple non-threatening questions – name, where they live, age etc
- building rapport by exploring patient's 'external' rather than 'internal' problems first
- attentive, quiet listening, slowing the pace down
- accurate observation of the patients nonverbal behavior
- picking up verbal and non-verbal cues and deciding when to pursue
- use of patient's own language
- lack of surprise, non-judgmental acceptance
- gauging the patients emotional state
- flexibility
- appreciating and making allowances for the possible effect of poor concentration and pre-occupation with internal thoughts on ordered communication
- respect
- support – offer to help with their problems as best as you can

Skills which <u>may be unhelpful</u>, which may make the patient more agitated and liable to misinterpret you include:

- introducing yourself if you are a psychiatrist and explaining why you are there: the patient has not sought this interview - on one hand there is a need for a clear explanation of who the doctor is and why they have been asked to see the patient – on the other, if the patient is thought disordered, full explanation of your psychiatric role can immediately increase suspicion and impair rapport
- either too early open-ended questioning or very directed questions about psychosis can increase anxiety
- reflecting back verbal and non-verbal cues immediately: may increase suspicion
- eye contact for too long
- sharing your thinking
- silence
- touch

Attempts to assess the extent of the patient's thoughts, beliefs and thinking processes can be difficult and need judicial use of open and closed questions. "Following" with closed questions rather than open ones will clarify how thought disordered the patient is without confrontation:

Patient: "I can see people at the window" Doctor: "what are they wearing?" (rather than, "tell me all about them?" this may upset and agitate the patient).

The patient may then follow on your line of questioning, clarifying that he has a major thought disorder. Some psychiatrists describe this technique as analogous to fishing.

Alternatively, open questions can be used:

"I'm wondering what you were thinking when you said.....?" "You said that people were controlling you through the television...can you tell me a bit more about that?"

or the more direct

"Do you have thoughts that you hear out loud in your head?" or "Do you feel you have special powers?"

It is important not to confront delusions as false beliefs – empathise with the patient's situation and legitimise their experience without necessarily agreeing or colluding with their interpretation of reality. Do not rebuff but remain interested in their view and offer empathy and help with their problems:

I can certainly understand that you would feel so upset because you think you are being poisoned

In response to "Don't you believe me?"

"You ask if I believe you about whether you are being poisoned. I can tell you for sure that I am not poisoning you. I can't tell for sure right now whether anyone else my be poisoning you, but I'd like to listen to you and help in any way that I can"

Later in the interview, being the advocate of the patient at the same time as challenging and confronting the patient with his illness is a real skill. Offering explanations that accept the patient's experiences as valid and show empathy but provides an alternative view is a difficult balancing act with a psychotic patient. It is helpful for the doctor to find phrases that work well in different circumstances and to practice them.

"I know that you feel that you are not ill at the moment, but I am concerned about you today.....I think that you need some treatment and would like to help."

It is often very important to get accurate information from others who know the patient well. This can be perceived as threatening and unsupportive to a paranoid person with disordered thinking and it is important to have the patient's permission if the doctor is aiming to achieve a collaborative relationship. Of course, their relatives and friends are often anxious and sometimes angry and this may also complicate the interviewing process.

2. The less florid psychotic patient

Many of the above issues still apply but helpful core skills in this less dramatic situation include:

- Initial open questions about the patient's situation
- Attentive listening
- Eliciting the patient's concerns - staying initially with the patient's world view and problems rather than attempting too fast too explore thought disorders will help build rapport; use of patient's own language
- The effects of the patient's problems on their life**:** the patient may not think they are "ill" and the doctor needs to reflect back the patient's experiences and develop a shared understanding of how these experiences are affecting the patient's life.
- Structuring the interview with signposting and sequencing to help a patient with thought disorder: signposting is vital as the patient may not be concentrating and misunderstand reasons for focused questions.
- Being non judgmental and being able to accept the patient's beliefs and the fact they are valid for them while not necessarily agreeing.
- Empathy without collusion
- Support – offers to help sort out their problems as best as you can
- Assessing the patient's <u>insight</u> into his illness with signposting and sensitive phrasing of specific questions, for example

"You've told me that you are hearing voices again.....I remember last time you were ill, and the same thing was happening....what do you think?"

3. The suspicious patient who shows few overt signs of psychosis.

Here the key core skills for building the relationship with the patient are all important as long as you don't "invade" the patient's space too much. Empathy and support are vital (e.g. attempting to understand why psychotic patients so dislike taking medication as they perceive that it alters their persona etc.)

In this situation you may need to ask directive questions re disordered thinking, paranoid ideas and the presence of auditory and visual hallucinations, ideas of reference etc. How to do this without making the patient increasingly suspicious and paranoid can be difficult. If you know the patient you can signpost quite nicely:

"I remember when you were last ill, you were concerned that the neighbours were thinking ill of you/you thought you had special powers…..is that how you are thinking now?

If you don't know the patient and listening initially doesn't elicit any psychotic thinking then asking a general question sensitively about paranoia

" do you feel people are a bit against you at the moment?" may open the patient up a bit. Once you gain their confidence it's easier to follow with more direct questions about psychosis. Asking right out "are you hearing people talking to you in your head?" can provoke anger and threatening behaviour.

Further Reading

Washer, P. Ed. Clinical Communication Skills. Oxford University Press. 2009.

Silverman JD Kurtz SM Draper J. Skills for Communicating with Patients – second edition. Oxford Radcliffe Medical Press. 2005.

Tate, P. The Doctors Communication Handbook (fourth edition) Oxford Radcliffe Medical Press. 2001.

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