UNIVERSITY OF CAMBRIDGE SCHOOL OF CLINICAL MEDICINE

INTRODUCTORY COURSE FOR CLINICAL STUDENTS IN CLINICAL COMMUNICATION SKILLS, SEPTEMBER 2011

Initiating the Medical Interview: Thurs 15 - Mon 19 September 2011 9.00-12.30 or 14.00-17.30

Title: Initiating the medical interview (and gathering information)

Format: in groups of 6-7, four groups per half-day

Actors

There are two $1^{1/2}$ hour sessions with a coffee break between. One actor will be present per group and will move groups at the end of the first session, so you will see two actors during the half day. Each actor will have two roles which will be different from those of the other actor you will see, so there are four possible roles in all per half-day. It is unlikely but possible that you will get through all 4 roles today. Each actor will have one role that is based at the hospital bedside and one that is situated elsewhere such as hospital outpatients or general practice - start off with the hospital role.

The actors stay in the group at all times and act as a friendly resource for the students

Video use

We shall use video recording and play back throughout.. **The Clinical School has moved to a system of digital recording which provides students with their interviews in a form that they can watch on any computer via Windows Media Player. Recordings are made as digital files straight onto computer hard disk in these files will be uploaded to students' own secure password-protected individual portfolio area of the ER Web. It is important for all facilitators to learn how to use the recording and playback equipment before the introductory course sessions start.**

Aims

- students to be able to **interact with patients with confidence** in their forthcoming clinical course
- to begin to explore **the skills of medical interviewing** experientially - **students to understand the map, learn to navigate and start to develop competence in basic skills**
- **to focus on initiation (and move into gathering information if the group is working well – this is increasingly likely to happen as students come better prepared from PfP)**
- **to introduce evidence** re the use of appropriate communication skills opportunistically

Notes for facilitators about working with undergraduates

Please remember with these undergraduate students, at the beginning of their course, that we need to be quite "upfront", to give a little more direction to learning. Please use plenty of signposting to learners so that they understand the point of each part of the session and where the session is heading. Our aim is to provide safety through structure, shared objectives and handouts rather than through labouring safety per se. Very important to try to generate a supportive environment right from the beginning with an upbeat feel: **a constant irritation for students is when the pace of the session is too slow or we are too laboured - enthuse not bore is our motto!**

These sessions should help students to feel more confident in their forthcoming interactions with patients. We need therefore to think from the students' perspective, of the problems that they will encounter in their specific role as medical students. But we would also like to demonstrate the problems that real doctors face and talk about the differences that the physician role plays in each stage of the interview.

The roleplays will almost certainly be much brief stabs rather than protracted interviews - encourage this and for everyone to have multiple goes. **Remember they are just starting so plenty of balance in our feedback please! But remember too that students say that we are too nice and never give them negative feedback. I have my doubts whether they really mean this - I do not think they would really like destructive criticism! But certainly we do want to give each person specific suggestions to help them improve rather than only praise them - make sure that each person feels they have something to go and work on between sessions.** Bite off small chunks of teaching, then draw the threads together and provide some cognitive input; **get down to specifics and summarise with the guide.**

The Calgary-Cambridge guide: the skills

Please familiarise yourself with the format of the guide. The structure and framework we use link process and content together carefully to produce a **comprehensive clinical method**. **Please use the guide, especially in the form of the cards, throughout the sessions. The frameworks are on the walls of all the teaching rooms and the students also now have pocket cards to remind them.** Here are some examples of skills for students that might be worth thinking through:

The opening question as a medical student is perhaps different from that of a doctor, particularly when 'clerking' a patient on the ward: the student may be discovering "what problems brought you to the hospital" from someone who was admitted some time ago (and is therefore already in the system) while the real doctor may be discovering from a new patient "how can I help you" or "tell me what problems you have been having". This style of student opening question may lead to a **less distinct initiation phase** of the consultation as the patient more quickly enters the narrative thread ("well, it all started two months ago...."). Or conversely, the patient may give a brief summary ("they say I've had an embolus" or "I've come in for investigations"), which may force the student to immediately signpost what they would like the patient to do ("right, I see - I'd be very interested to hear what problems you were experiencing that brought you here right at the beginning"). The student must be flexible.

Either way, it is still important to **summarise** at the end of the patient's opening statement and to screen. **Screening** is subtly different for students than in some doctor interviews: the learner when 'clerking' is not always seeking 'what else would you like to discuss today' as the interview may be entirely for the student's benefit and be the umpteenth clerk for the patient! But screening for **"what other problems have you noticed"** before exploring each symptom in turn is always relevant in all situations: this enables a broad overview to be taken, greatly enhancing clinical reasoning. Remember, in review interviews where the student is seeing how their patient is getting on on the ward, screening for the patient's concerns and agenda is very important.

Please note that it is releasing for students to realise that they can do things twice in the real interview and that they may well need to in order to get hold of the patient's story in their head. If the patient starts with their narrative right at the beginning of the interview, it is quite OK (after listening, summary, screening and agenda setting) to start the gathering information phase by returning to the beginning of the narrative thread and going through it again.

ICE is different too: it may be a two phase component – what were you concerned about before you came into hospital and what are you concerned about now.

Note taking

Students are encouraged not to write reams as the patient speaks but only to jot down important points that they might not remember. They should not appear to be policemen at the scene of a crime. They need to ensure attentive listening with a minimum of note taking and appropriate permission seeking. Students are often expected to start presentations or write-ups with " this is Mrs. Jones, a 63 year old domestic cleaner from Chipping Norton". This does not mean that they should start their 'clerking' by obtaining this

information. In fact, they should be encouraged to ask for this later on when the relationship has been established i.e. in the social history section of background information.

Plan of day

One and a half hours	**First session: initiation**
Half an hour	**Coffee**
One and a half hours	**Second session: initiation (plus or minus gathering)**

First session

Introduction

Self – your role, how you will relate to the participants over this course, how you will handover to other facilitator in later sessions (if appropriate)
Actor - your wish to help the students in any way that you can; a resource - on the learners' side: that you will join group right from the beginning
Aims of session and plan of day

Round of names and how they are getting on so far – e.g. something like what they have done recently (some groups will have done little, some lots, depending on the rotation), what they have enjoyed, what they have found difficult so far as new clinical students, how are they feeling

Orientation to the medical interview – be brief – just a mention of these areas!!

- now we are moving on from overall principles of communication and skills explored in the previous two sessions to practicing elements of the medical interview per se
- remind them that the interview has important aims for both patient and doctor and that we need to consider both all the time
- relate what we are doing today to the structure: the stages of the guide

Group task re initiating the session – definitely do this –important

Let's start thinking in terms of models and objectives for the beginning of the interview. Work together as two small groups. Preferably on the floor

Use a single piece of flipchart paper to construct a model for the initiation phase of the consultation, that part of the consultation that occurs prior to the doctor starting to explore any one problem in depth. Place it on the floor

What are you trying to achieve at the beginning of the consultation?
What do you need to accomplish as a doctor?
What is the patient trying to achieve in this part of the consultation? What does the patient need?

Try to work out a framework so that you can organise your thoughts about this part of the interview
What areas do you need to consider to accomplish your needs as a student doctor and also to help the patient achieve their needs in this section?
Try and work out a plan together in diagrammatic form on a piece of flipchart

This will hopefully produce a mix of objectives and skills - point this out and order their work with them
Look at our objectives and C-C skills lists (they will be available as handouts): stress the importance of having a structure to follow to make them as learners feel safe
Compare with theirs

Start experiential work on initiating the session – important to get going with this early

Focus down onto first small chunk – e.g. start with establishing initial rapport:

Get them to have a go experientially at this small area (remember that in these role-plays today, restart at the beginning each time)

In this first session before coffee, start with the actor role situated at the hospital bedside

Introduction to experiential work
Recap very fast how to learn interviewing and communication skills:

- need for experiential - practice, observation, feedback, rehearsal
- use of actors
- chance to do and redo and gain confidence
- not judgmental, simply practicing skills
- **introduce video work:** explain the point of self-observation and the evidence that it makes all the difference in communication skills learning.

Please just mention at this point re feedback - especially descriptive feedback
Explain learner is in control, rest of the group's job to help
The person who goes first is at a disadvantage - others will learn for those who put themselves on the line first - but it is not a competition - they are all helping each other.

- **PLEASE REFER AT THIS POINT TO "GENERAL INSTRUCTIONS RE EXPERIENTIAL ACTOR SESSIONS" ON SEPARATE SHEET – this tells you how to run the experiential components**
- **DO USE THE VIDEO PLAYBACK AND UTILISE THE ACTOR FOR FEEDBACK – DO NOT FORGET!!**
- **REMEMBER IT IS ESSENTIAL TO ENSURE A BALANCE OF FEEDBACK BY THE END OF EACH LEARNER'S ATTEMPT - IT IS VITAL THAT WE ENCOURAGE THE PARTICIPANTS - THEY ARE ONLY JUST STARTING!! BUT GIVE EACH PERSON SPECIFIC SUGGESTIONS TO HELP THEM IMPROVE RATHER THAN ONLY PRAISE THEM-MAKE SURE THAT EACH PERSON FEELS THEY HAVE SOMETHING TO GO AND WORK ON BETWEEN SESSIONS.**
- **GET ONE LEARNER TO CONCENTRATE ON THE CONTENT OF THE INTERVIEW WHILE WATCHING¶**

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Continuing
Others to practice what they would like: lots of role-plays
Short role-plays at first, then perhaps getting longer – short role-plays allow us to involve as many students as possible and allow discrete take home messages
Move on through the morning to next components of initiation:

- **opening question and listening**
- **then screening and agenda-setting**

There is plenty of time in the second session for this - no need to rush

Brief didactic inputs - initiating the interview: do one or two only opportunistically as the experiential work proceeds
The beginning of the interview is a particularly rich area of the interview: it sets the scene for all that occurs in the rest of the consultation. In these opening minutes, we make our first impressions, begin to establish rapport, attempt to identify the reason(s) for the patient's attendance and start to plan a course for the interview. Yet we know from research that many problems in doctor-patient communication occur in this initial phase of the interview. The research evidence reveals some particularly salutary lessons:

1. **how many problems do people bring:**
   in a variety of settings including primary care, paediatrics and internal medicine, the mean number of concerns ranged from 1.2 to 3.9 in both new and return visits

2. **how many discovered:**
   50% see below
3. **which is the most important, which one do doctors assume to be the most important:**
   order unrelated to importance yet doctors very often assume erroneously that the first complaint mentioned is the only one that the patient has brought (Beckman and Frankel 1984 in internal medicine residents and physicians in primary care)
4. **when do doctors interrupt:**
   Beckman and Frankel 1984 18 secs
   Marvel et al 1999 23secs
   the earlier the interruption the less likely hear more than one complaint and the more likely to have late arising complaints and to miss important complaints to
   only 23% of patients completed their opening statement
   in only 1 out of 51 interrupted statements was the patient allowed to complete their opening statement later
   94% of all interruptions concluded with the doctor obtaining the floor
   the longer the doctor waited before interruption, the more complaints were elicited
   allowing the patient to complete the opening statement led to a significant reduction in late arising problems
   in 34 out of 51 visits, the doctor interrupted the patient after the initial concern, apparently assuming that the first complaint was the chief one
   patients who were allowed to complete their opening statement without interruption mostly took less than 60 seconds and none took longer than 150 seconds even when encouraged to
5. **how important is rapport building at the beginning of the interview:**
   an important indicator of satisfaction with the interview as a whole

Finishing session

Brief round re what learnt

Facilitator to summarise content and process with the guides, answer questions, check understanding and signpost next session

Please ensure that you constantly reinforce structure

Relate the process skills used to the content discovered.

Work with the group briefly on clinical reasoning and what the differential diagnoses are even if not much has been covered.

At the end of each patient role this year, we have added a brief description of the clinical reasoning appertaining to the case and directions to the students to the web for brief further reading. Please point them in this direction so they can follow-up the work here

Feedback to and from actor

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

Coffee

Second session

Notes to facilitators

In this session, we continue with beginnings. We normally start with the actor role which is situated "elsewhere" from the bedside. This will enable the students to see how the beginning of the interview differs depending on setting and circumstance. Please feel free to use both of the actors roles if you wish in this session: if you move onto the "hospital bedside role", it will not be the same role as that used in your first session. The aim of this session is to continue and complete the exploration of the initiation phase. We are not sure how much time this will all take. Two things may possibly occur

You may move rather quicker than expected into gathering information (please see notes at beginning of this document which explains why this might happen). That's OK and bound to happen to some extent but resist moving onto what we are going to cover in the next half day until you are happy that they have done initiation properly. But if the group wishes to move into gathering information, you can be flexible here. They will have the specific disease questions on their cards to refer to at any point

You can if you want mix experiential work with teaching exercises and brief didactic inputs. This will provide variation for the students. We suggest the following that you could mug up before the session!

- **? start with students roleplaying 'the bad beginning'** against the actor, see who can do it worse - use this to summarise the first session and start in a light-hearted manner - also talk about the fact that they will see poor practice in reality and why that might happen
- **continue the teaching from The Transition to Clinical Medicine session on the difference between non-verbal and verbal communication** and the fact that non-verbal wins out if there are mixed messages - the importance of non-verbal communication at the beginning of the interview.
- **opening questions brainstormed as a round** including how this would differ in different places such as bedside, outpatients, general practice and why. Also what is the difference between what doctors and medical students might say and why.
- **refresh the components of attentive listening from The Transition to Clinical Medicine**- wait-time, facilitative response, non-verbal skills, picking up verbal and non-verbal cues
- **cues** - what you can see and hear when listening - what said and not said - what cues might you be looking out for - emotional state, calibrating the patient's emotional state at the beginning
- **review versus new appointments** - how to balance your agenda for the interview with discovering the patient's - here screening and agenda setting become more important. What happens when the student visits Mrs. Jones again on the ward: how to discover her current agenda and concerns
- **provide evidence of value of screening and agenda setting** - relate back to the principles of communication that they did in their earlier session in large groups

By the end of the morning, possibly do a demo yourself to show a 'good' interview initiation
Increasingly I feel it is important to do this so that the students see a good interview - but do late

Again, relate the process skills used to the content discovered.
Work with the group briefly on clinical reasoning and what the differential diagnoses are even if not much has been covered.

Finishing session

Round of one thing learnt or still thinking about
Facilitator to summarise content and process of the half-day with the guides, answer questions and check understanding.
Briefly summarise clinical reasoning and signpost next session.
Please ensure that you constantly reinforce structure
Please remember to praise and give plenty of positive feedback

Student homework before next session

- **read chapters on initiating and gathering from Skills for Communicating with Patients – they will be on the ERWeb, so do not have to buy!! On the ER Web there will be two versions of the chapters - a cut-down version just of the skills without the evidence if they want to read quickly and the more detailed chapters from the second editions of the books themselves.**
- **this year, we have programmed in specific time for practice between sessions - ensure students each ask their associate supervisor for two patients who they can practice interviewing on. Then before the next session on information gathering, could they pair up and visit patients to try out particular skills that they have learnt in your session that they feel they would like and need to practice further. Near the back of their pack are self-directed learning sheets for this purpose. They should discuss with their partner what small area they would like to practice and get feedback on and then use the sheet to guide their interview, observation and feedback.**

Feedback to and from actor

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