

NAME:



UNIVERSITY OF BRISTOL

**MEDICAL SCHOOL**

CENTRE FOR ACADEMIC PRIMARY CARE

## **MB ChB Consultation Skills**



**Teachers' and Students' Handbook for  
Consultation Skills Teaching**

**2013-14**

## Acknowledgements

We are grateful to Professor Suzanne Kurtz, University of Calgary for permission to use the Calgary-Cambridge Guide<sup>2</sup> and to Paul Kinnersley and colleagues at Cardiff University for sharing ideas, handbooks and materials. We have drawn on the texts associated with the Calgary-Cambridge Guide in writing these course notes. These can be referred to for further reading.<sup>1 3</sup>

## About the course organisers

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## Professional Behaviour

Students should adhere to the professional code of practice at all times which can be found at:

<http://www.bristol.ac.uk/medical-school/hippocrates/medicine-surgery-assess/component-a/>

This includes:

- At all times preserving patient confidentiality
- Treating all patients, staff, teachers and colleagues with respect
- Actively contributing to learning sessions contributions
- Managing own learning including recording progress and reflections in the eportfolio
- Attending all teaching on time and adhering to the clinical dress code
- Being honest and handing in all required paperwork/assessments to deadlines
- Taking care of your health and seeking help if your health may impact on patient care

## **About this handbook**

This document has been written to help both students and teachers get the most out of communication skills teaching. This teaching sits within the Consultation and Procedural Skills (CaPS) vertical theme. The handbook summarises the evidence for the use of communication skills and how they can be taught, and offers guidance on how the small group sessions in years two to five can be run.

From 2013, students should record their consultation skills teaching in the “CaPS logbook”. Over the five years, students need to have consultations observed and documented. The minimum requirement for classroom-based consultation with actors is one consultation in year two; one in year three; and one in years four or five. The minimum requirement for community or ward-based consultations with patients is five consultations between years two to five.

**Students are required to bring their CaPS logbook and this handbook to all consultation skills sessions (in Years 2, 3, 4 and 5) and should be ready to produce their CaPS logbook at any stage of the undergraduate curriculum as evidence of their communication skills learning plan.**

### **Contributors**

This Handbook is edited by Matthew Ridd. The first version was written by Alastair Hay in 2003. It has subsequently been updated with contributions from Louise Younie, Sian Goodson, Wendy Peek, Marion Steiner, Sunita Procter, Jessica Buchan, Barbara Laue, Lucy Jenkins, David Memel and Emma Anderson.

This edition was produced in August 2013.

# When Someone Deeply Listens to You

By John Fox

When someone deeply listens to you  
It is like holding a dented cup  
you've had since childhood  
And watching it fill up with  
cold, fresh water.  
When it balances on top of the brim,  
you are understood.  
When it overflows and touches your skin,  
you are loved.

When someone deeply listens to you  
the room where you stay  
starts a new life  
and the place where you wrote  
your first poem  
begins to glow in your mind's eye.  
It is as if gold has been discovered!

When someone deeply listens to you  
your bare feet are on the earth  
and a beloved land that seemed distant  
Is now at home within you

# Table of contents

<b>Acknowledgements</b> .....	<b>1</b>
<b>About the course organisers</b> .....	<b>1</b>
<b>Professional Behaviour</b> .....	<b>3</b>
<b>When Someone Deeply Listens to You</b> .....	<b>5</b>
<b>Table of contents</b> .....	<b>6</b>
<b>1. Introduction</b> .....	<b>8</b>
1.1. <i>Background</i> .....	8
1.2. <i>Course aim</i> .....	9
1.3. <i>Course objectives</i> .....	9
1.4. <i>Course feedback</i> .....	9
<b>2. What is the point of good communication skills?</b> .....	<b>11</b>
2.1. <i>Safe, efficient and effective healthcare</i> .....	11
2.2. <i>Understanding patients' problems</i> .....	11
2.3. <i>Improving communication leads to better patient outcomes</i> .....	13
<b>3. How can communication skills be improved?</b> .....	<b>14</b>
3.1. <i>The Calgary-Cambridge Observation Guide</i> .....	14
<b>4. Consultation skills teaching in the classroom</b> .....	<b>21</b>
4.1. <i>Attendance</i> .....	21
4.2. <i>Simulated consultations</i> .....	21
4.2.1. <i>What role is the student taking?</i> .....	21
4.2.2. <i>What is the student's aim?</i> .....	21
4.3. <i>Running the sessions</i> .....	22
4.3.1. <i>Rationale for teaching methods</i> .....	22
4.3.2. <i>Tutors – Ground rules and facilitating the group work</i> .....	23
4.3.3. <i>Giving constructive feedback</i> .....	23
4.3.4. <i>Recording feedback</i> .....	25
4.3.5. <i>Teaching resources</i> .....	25
<b>5. Consultation skills teaching in the community and on the ward</b> .....	<b>26</b>
5.1. <i>Students observing clinician consultations</i> .....	26
5.2. <i>Clinicians observing student consultations</i> .....	27
<b>6. Self-study and other resources</b> .....	<b>28</b>
6.1. <i>Essential Clinical Communication eLearning Package</i> .....	28
6.2. <i>Recommended reading</i> .....	28
<b>7. Year specific teaching</b> .....	<b>29</b>
7.1. <i>Year one</i> .....	29
7.2. <i>Year two</i> .....	29
7.3. <i>Year three</i> .....	29
7.3.1. <i>Classroom based teaching</i> .....	29
7.3.2. <i>GP attachment</i> .....	30

7.4. Year four.....	30
7.4.1. Lecture and classroom based teaching.....	30
7.4.2. GP attachment.....	31
7.5. Year five .....	31
7.5.1. Classroom-based teaching (based in academies) .....	31
7.5.2. GP attachment.....	31
7.6. Other communication skills teaching.....	32
<b>8. References.....</b>	<b>34</b>



# 1. Introduction

*"It is more important to know what sort of person has a disease than to know what sort of disease a person has."* Hippocrates (circa 400 BC).

## 1.1. Background

The consultation is the bedrock of all medical practice, and during the course of a professional lifetime, most doctors will conduct between 160,000 – 300,000 interviews<sup>4</sup> Doctor-patient communication is a key ingredient to establishing a patient's diagnosis and successfully managing the patient's problem. Being a good doctor also demands good interpersonal and communication skills for working in clinical teams. Even doctors without direct responsibility for patient care need to be able communicate effectively and accurately with clinical colleagues.

Within the consultation,<sup>1</sup> doctors can employ sophisticated communication skills to facilitate the patient's storytelling, interpret the information gathered and assist the patient's understanding and treatment of the problem. Unfortunately, when these skills are not used successfully, the results are patient dissatisfaction leading to complaints and worse; errors in diagnosis and treatment, jeopardising safety. Patients' complaints about doctors' performance rose fifteen fold in the ten years to 2003,<sup>5</sup> and a frequent source of complaint relates to poor communication. Indeed, poor communication skills performance in national licensing examinations has been shown to be predictive of increased patient complaints in Canada the US.<sup>6</sup>

It is not surprising then that the importance of good communication skills is recognised by the General Medical Council (GMC),<sup>3</sup> the British Medical Association (BMA)<sup>5</sup> and the Royal Colleges of General Practitioners (RCGP), Physicians (RCP) and Surgeons (RCS). The GMC has indicated that for revalidation, doctors will have to produce evidence of patient satisfaction with their performance and the RCGP have mooted that GPs will all have to attend at least one half day of communication skills training every five years in order to be revalidated.<sup>7</sup> All the Royal Colleges now assess communication skills within their membership examinations, and candidates with inadequate skills are prevented from progressing. Indeed, the most recent (2005) GP contract now remunerates GPs on a number of clinical and non-clinical indicators, including GPs interpersonal skills.

All medical schools in the United Kingdom must teach communication skills and the GMC has offered guidance on aims and objectives in its document, Tomorrow's Doctors.<sup>3</sup> At the University of Bristol, the importance of communication skills has been recognised by its position in the curriculum within the '**Consultation and Procedural Skills**' (CaPs) vertical theme, meaning it is taught in all five years. Clearly some students enter medical school with innate communication skills, but abilities vary and medical consultations demand skills different to that

required for social interaction. It takes time to learn how new *process* skills can be employed to obtain the necessary information (or *content*) required for good consultations. The acquisition and maintenance of good communication skills should be seen as a life-long learning task. Five facets of effective training in communication skills have been described.<sup>8</sup> First, teachers should provide evidence of deficiencies in communication, second, offer an evidence base for the skills needed to overcome deficiencies, third demonstrate the skills to be learned and elicit reactions to these, fourth provide an opportunity to practise skills and fifth give constructive feedback.

This document has two purposes. First, it reviews the evidence base for teaching communication and consultation skills. Second, it describes the core communication skills teaching sessions provided by the Centre for Academic Primary Care in Years one to five. These represent unique opportunities within the overall vertical theme in which to practice and develop this key professional skill. The Course has been singled out by internal (the Faculty Quality Assurance Team) and external (GMC) assessment bodies as being a stimulating, useful and successful course.

## **1.2. Course aim**

By graduation, students should be able to communicate clearly, sensitively and effectively with patients.<sup>3</sup>

## **1.3. Course objectives**

Students should:

- Be able to communicate effectively with individuals regardless of their social, cultural or ethnic backgrounds, or their disabilities.<sup>3</sup>
- Know the evidence base for the skills used by good communicators.
- Be able to use the abridged Calgary-Cambridge observation guide to assess their own and each other's communication skills.
- Understand that communication skills are acquired as part of lifelong learning and should be part of every clinician's continuing professional development plan.

## **1.4. Course feedback**

We welcome feedback from anyone who is involved on this course – students, tutors and actors. Whilst there is always room for improvement, teaching on this course is highly rated. Here are some example quotes from previous students:

*It was highly constructive to find out how I deal with patients, what was good and what can be improved during a consultation. I definitely recommend sessions like these.*

*I invariably dread these sessions but I felt this was incredibly valuable learning experience – and a chance to practice and observe difficult consultation skills with really useful feedback.*

*Loved going through the specifics of how to break news. i.e. Role play is good, teaching is good too. The two together are excellent.*

*Really invaluable! Fantastic tutors, please don't stop this!*

As the above examples illustrate, some students are initially worried about attending these sessions or sceptical about their value. Overwhelming, they complete the course having had a positive experience and asking for more.

## 2. What is the point of good communication skills?

### 2.1. Safe, efficient and effective healthcare

Clinicians have differing armamentaria of therapeutic interventions available to help patients; physiotherapy, drugs, radiotherapy, surgical procedures, cognitive behavioural therapy and so on. But for each, a careful assessment has to be made regarding the effectiveness and risks of the intervention to the individual patient. For example, a surgeon may have excellent technical skill, but s/he still needs to decide when and if to operate on a four year-old boy with suspected appendicitis. In general, more diagnostic information is available from the history than any other part of the clinical assessment, examination or investigations.<sup>9</sup> As much as 28% of medical error is diagnostic, of which half are potentially serious.<sup>10</sup> Sometimes this is due to the use of a 'closed' approach to information gathering in the early stages of the consultation. Here, the clinician fails to allow the patient to give the history with his/her own emphases. This can lead to narrow hypothesis generation and so inaccurate differential diagnosis. While good communication skills with patients and their carers are paramount, so is communication between professionals; verbal, written and electronic. Inter-professional communication breakdown has been central to several high profile systems failure. The Victoria Climbié report states that 'improvements are needed in the exchange of both written and verbal information between professionals if repeat tragedies are to be avoided'.<sup>11</sup>

Adherence to medication is a major problem with as many as 50% of people not taking prescribed medicines as recommended. This is estimated to cost the UK £300 million each year is wasted or unused drugs. Patients whose doctors fail to elicit their ideas and expectations of their illness and treatment are less likely to understand their illness, adhere to medication or feel satisfied with the consultation.<sup>12 13</sup> Patients' expectations are a powerful determinant of, for example, antibiotic prescribing,<sup>14</sup> yet without explicitly asking, doctors are poor at guessing which patients actually expect them.<sup>15</sup> Improving adherence requires greater concordance in the consultation. That is, one in which the patient's beliefs and wishes are respected, the patient is recognised as an equal partner and a therapeutic plan is determined through negotiation.

### 2.2. Understanding patients' problems

There is good evidence demonstrating deficiencies in doctor–patient communication. Doctors fail to identify the reason for the patient's attendance in up to 50% of consultations, and if asked separately after the consultation, doctors and patients disagree on the presenting problem in around 50%.<sup>2</sup> If patients and doctors disagree on an explanation, the patient remembers less of what the doctor has said. Doctors frequently interrupt patients, particularly at the start of the consultation and assume the first complaint is the only or most important complaint. One study showed that, on average, doctors wait 23 seconds before interrupting the patient's opening statement.<sup>16</sup> Only six extra seconds would allow the patient to finish. Starting the consultation

with open-ended questions may produce longer problem presentation (27 seconds vs. 11 seconds) that contain significantly more discrete symptoms,<sup>17</sup> but it will prevent frustration with patients who at the end of consultations ask “Oh, by the way doctor” type questions. In one primary care study, patients introduced new problems not previously discussed at the close of the interview in 21% of consultations.<sup>18</sup> Although clinicians tend to blame patients for this, in fact it is frequently the result of defective interview technique; failure to elicit the patient’s entire agenda early in the visit.<sup>19</sup>

Many patients seen in general medical settings are concerned that their symptoms represent a serious illness. Identifying these concerns and providing a plausible explanation for symptoms is therefore an important goal. Patients frequently construct explanatory models as an aid to understanding their symptoms. Physicians who take the time to elicit and understand patients’ models are in a better position to develop a negotiated approach to diagnosis and therapy.<sup>20</sup>

While patients usually want more information than doctors routinely give, doctors use jargon that patients don’t understand. It is not surprising then that patients frequently cannot remember what doctors have told them. Doctors generally give more information about treatment options whereas patients are more interested in information about the diagnosis and prognosis without intervention – that is, the natural history of the condition.<sup>21</sup> Patients frequently complain they have not been treated as human beings, with respect, understanding or empathy. When communication breaks down, patients are more likely to use lawyers to express their concerns. For this reason, some medical defence companies reduce premiums in doctors who attend communication skills courses.

There are many potential barriers to effective communication, including a patient’s cultural background. Whilst age, gender, language and ethnicity may be obvious, it is worth remembering that there are multiple factors – some hidden – that comprise an individual’s ‘culture’. These include socioeconomic status, occupation, health, previous health experiences, religion, education, social grouping, sexual or political orientation.<sup>22</sup> With this in mind, it is worth screening an individual for their personal health beliefs, so that they can be incorporated into diagnostic reasoning and management planning. Questions that might be helpful include: what do you think caused the problem and what do you most fear about the problem?<sup>23</sup>

Patients can also assume some responsibility for improving communication in the consultation. There are initiatives to encourage patients to be clearer in what they want from a consultation and to empower them to be ‘Expert Patients’.<sup>24</sup>

### **2.3. Improving communication leads to better patient outcomes**

Evidence suggests that improving communication leads to better patient outcomes.<sup>2</sup> For example, the longer a doctor waits before interrupting the patient the more likely s/he is to discover the full reason for attendance. The use of open rather than closed questions leads to greater patient disclosure. The more questions patients are allowed to ask, the more information they obtain. Asking patients to repeat what they have been told improves information retention, and discovering patient expectations improves adherence. Good communication is closely related to being patient centred. This is care which explores the patient's main reason for the consultation, seeks an integrated understanding of the patient's world (whole person care) including their cultural background and beliefs,<sup>25</sup> finds common ground on what the problem is and mutual agreement on its management. This type of care enhances disease prevention and health promotion and promotes the continuing doctor-patient relationship.<sup>26 27</sup> Patient centeredness and effective communication are associated with improved health outcomes in patients with headaches,<sup>27</sup> sore throat<sup>28</sup> and also; hypertension, diabetes control, pain after myocardial infarct and anxiety after breast cancer surgery.<sup>29</sup> Communication skills may also be used to dissuade patients of the need for inappropriate treatment, for example antibiotics.<sup>30 31</sup> Finally, there are benefits for doctors too. Doctors with good communication skills have greater job satisfaction and less work stress.<sup>8</sup>

### 3. How can communication skills be improved?

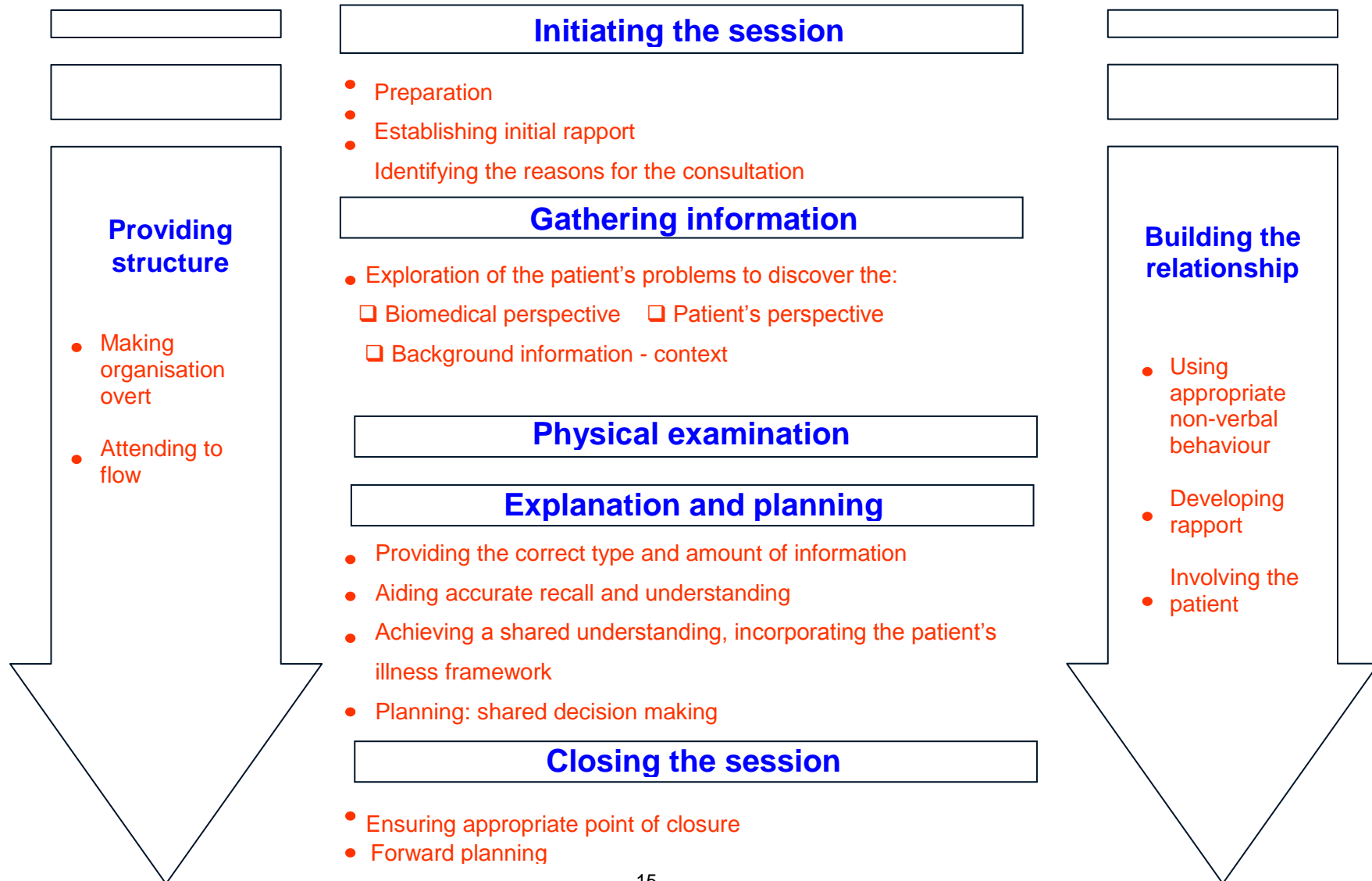
Communication in the consultation is complicated. The key to improvement is to learn and practice its constituent components.<sup>2</sup> It is not sufficient to state a student has a 'good patient manner' or is 'confident with patients'. The aim of the Calgary-Cambridge Guide is to identify the component skills of good communication. This assists teachers and learners to conceptualise and structure learning. The evidence suggests that observation of performance, assessment of strengths and weaknesses followed by detailed, descriptive feedback effects change in learners' skills and that these are retained.<sup>2</sup> While recognising the importance of skills, the importance of the *attitudes underlying these skills* should not be forgotten.<sup>32</sup>

#### 3.1. The Calgary-Cambridge Observation Guide

Whilst there are other tasks associated with the consultation, the Guide is based on six communication skills tasks. These are:

1. Initiating the consultation
2. Gathering information
3. Providing structure to the consultation
4. Building the relationship
5. Explanation and planning
6. Closing the consultation.

While these tasks tend to be sequential, 'building the relationship' and 'providing structure' continue throughout the consultation.<sup>1</sup> They are represented diagrammatically in the Figure on page 13 which highlights that the tasks are part of a **process** which, when combined with the history taking questions – the **content** – form a **consultation**.<sup>1</sup> Within the six tasks, the Guide itemises 77 communication skills. For completeness, we have included a copy of the whole Guide in this handbook. While this is a comprehensive list and it should be noted that students should be aiming to have mastered all skills by graduation, they will be learned incrementally. Following the whole Guide, an abridged version is shown on page 19, which is a suitable starting point. Although the Guide was originally developed for adult-doctor consultations, it has been adapted, and found to be feasible and valid, for use with children in 'triadic' consultations.<sup>33</sup>





## The Calgary-Cambridge Guide

### **TASK ONE: INITIATING THE CONSULTATION**

#### **Establishing Initial Rapport**

1. GREETES patient and obtains patient's name
2. INTRODUCES self, role and nature of interview; obtains consent if necessary
3. DEMONSTRATES RESPECT and interest, attends to patient's physical comfort

#### **Identifying the Reason(s) for the Consultation**

4. IDENTIFIES PROBLEMS LIST or issues patient wishes to discuss (e.g., "What would you like to discuss?; "What questions did you hope to get answered today?")
5. LISTENS attentively to the patient's opening statement without interrupting or directing patient's response
6. CONFIRMS LIST AND SCREENS for further problems (e.g., "so that's headaches and tiredness; anything else?")
7. NEGOTIATES AGENDA taking both patient's & doctor's perspectives into account

### **TASK TWO: GATHERING INFORMATION**

#### **Exploration of Patient's Problem**

8. ENCOURAGES PATIENT TO TELL STORY of problem(s) from when first started to the present in own words (clarifies reason for presenting now)
9. USES OPEN-ENDED AND CLOSED QUESTIONS, appropriately moving from open-ended to closed
10. LISTENS ATTENTIVELY, allows patient to complete statements without interruption, leaves space for patient to think before answering, go on after pausing
11. FACILITATES PATIENTS RESPONSES VERBALLY & NON-VERBALLY (e.g., uses encouragement, silence, repetition, paraphrasing)
12. PICKS UP VERBAL AND NON-VERBAL CLUES (i.e., body language, speech, facial expression, affect); CHECKS OUT & ACKNOWLEDGES as appropriate
13. CLARIFIES PATIENT'S STATEMENTS that are unclear or need amplification (e.g. "Could you explain what you mean by light headed")
14. USES concise, EASILY UNDERSTOOD QUESTIONS AND COMMENTS, avoids or adequately explains jargon
15. ESTABLISHES DATES AND SEQUENCE of events

#### **Additional Skills for Understanding the Patient's Perspective**

16. Actively DETERMINES AND APPROPRIATELY EXPLORES:
  - PATIENT'S IDEAS (i.e., beliefs re cause)
  - PATIENT'S CONCERNS (i.e.; worries) regarding each problem
  - PATIENT'S EXPECTATIONS (i.e.; goals, help patient expects re each problem)
  - EFFECTS ON PATIENT: how each problem affects the patient's life
17. ENCOURAGES PATIENT TO EXPRESS FEELINGS

### **TASK THREE: PROVIDING STRUCTURE TO THE CONSULTATION**

#### **Making Organization Overt**

18. SUMMARIZES AT END OF A SPECIFIC LINE OF INQUIRY (e.g., HPI) to confirm understanding & ensure no important data was missed; invites patient to correct
19. PROGRESSES from one section to another USING SIGNPOSTING, TRANSITIONAL STATEMENTS; includes rationale for next section

#### **Attending to Flow**

20. STRUCTURES interview in LOGICAL SEQUENCE
21. ATTENDS TO TIMING and keeping interview on task

### **TASK FOUR: BUILDING THE RELATIONSHIP - Facilitating Patient's Involvement**

#### **Using Appropriate Non-Verbal Behaviour**

22. DEMONSTRATES APPROPRIATE NON-VERBAL BEHAVIOUR
  - eye contact, facial expressions
  - posture, position, gestures & other movement
  - vocal cues, e.g., rate, volume, tone, pitch
23. If READS, WRITES NOTES or uses computer, does IN A MANNER THAT DOES NOT INTERFERE WITH DIALOGUE OR RAPPORT
24. DEMONSTRATES appropriate CONFIDENCE

#### **Developing Rapport**

25. ACCEPTS LEGITIMACY OF PATIENT'S VIEWS and feelings; is not judgmental
26. USES EMPATHY to communicate understanding and appreciation of patient's feelings or situation; overtly ACKNOWLEDGES PATIENT'S VIEWS & feelings
27. PROVIDES SUPPORT: expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self care; offers partnership
28. DEALS SENSITIVELY with embarrassing or disturbing topics and physical pain, including when associated with physical examination

#### **Involving The Patient**

29. SHARES THINKING with patient to encourage patient's involvement (e.g., "What I am thinking now is.....")
30. EXPLAINS RATIONAL for questions or parts of physical examination that could appear to be non-sequiturs
31. When doing PHYSICAL EXAMINATION, explains process, asks permission

### **TASK FIVE: CLOSING THE CONSULTATION (Preliminary Explanation & Planning)**

32. GIVES EXPLANATION AT APPROPRIATE TIMES (avoids giving advice, information, opinions prematurely)
33. GIVES INFORMATION IN CLEAR, WELL-ORGANIZED FASHION without overloading patient, avoids or explains jargon
34. CONTRACTS WITH PATIENT RE: NEXT STEPS for patient and physician
35. CHECKS PATIENT'S UNDERSTANDING AND ACCEPTANCE of explanation and plans; ensures that concerns have been addressed
36. SUMMARIZES SESSION briefly
37. ENCOURAGES PATIENT TO DISCUSS ANY ADDITIONAL POINTS and provides opportunity to do so (e.g. "Are there any questions you'd like to ask or anything at all you'd like to discuss further?")

References: Kurtz S, Silverman J, and Draper J (1998) **Teaching and Learning Communication Skills in Medicine**. Oxford, UK: Radcliffe Medical Press  
Silverman J, Kurtz S, and Draper J (1998) **Skills for Communicating with Patients**. Oxford, UK: Radcliffe Medical Press  
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## **TASK SIX: EXPLANATION AND PLANNING**

### **Providing the Correct Amount and Type of Information**

1. INITIATES: summarizes to date, determines expectations, sets agenda
2. ASSESSES PATIENT'S STARTING POINT: ask for patient's prior knowledge early, discovers extent of patient's wish for information
3. CHUNKS AND CHECKS: gives information in chunks, checks for understanding, uses patient's response as a guide on how to proceed
4. ASKS patient WHAT OTHER INFORMATION WOULD BE HELPFUL: e.g. aetiology, prognosis
5. GIVES EXPLANATION AT APPROPRIATE TIMES: avoids giving advice, information or reassurance prematurely

### **Aiding Accurate Recall and Understanding**

6. ORGANIZES EXPLANATION: divides into discrete sections, develops logical sequence
7. USES EXPLICIT CATEGORIZATION OR SIGNPOSTING: (e.g. "There are three important things that I would like to discuss. 1st...Now we shall move on to...")
8. USES REPTITION AND SUMMARIZING: to reinforce information
9. LANGUAGE: uses concise, easily understood statements, avoids or explains jargon
10. USES VISUAL METHODS OF CONVEYING INFORMATION: diagrams, models, written information and instructions
11. CHECKS PATIENT'S UNDERSTANDING OF INFORMATION GIVEN (or plans made): e.g. by asking patient to restate in own words; clarifies as necessary

### **Incorporating the Patient's Perspective - Achieving Shared Understanding**

12. RELATES EXPLANATIONS TO PATIENT'S ILLNESS FRAMEWORK: to previously elicited beliefs, concerns, and expectations
13. PROVIDES OPPORTUNITIES/ENCOURAGES PATIENT TO CONTRIBUTE: to ask questions, seek clarification or express doubts, responds appropriately
14. PICKS UP VERBAL AND NONVERBAL CUES: e.g. patient's need to contribute information or ask questions, information overload, distress
15. ELICITS PATIENT'S BELIEFS, REACTIONS AND FEELING: re information given, decisions, terms used, acknowledges and addresses where necessary

### **Planning: Shared Decision Making**

16. SHARES OWN THOUGHTS: ideas, thought processes and dilemmas
17. INVOLVES PATIENT by making suggestions rather than directives
18. ENCOURAGES PATIENT TO CONTRIBUTE their IDEAS, suggestions, preferences, beliefs
19. NEGOTIATES a MUTUALLY ACCEPTABLE PLAN
20. OFFERS CHOICES: encourages patient to make choices/decisions to level they wish
21. CHECKS WITH PATIENT: if accepts plans, if concerns have been addressed

## **TASK SIX (continued): OPTIONS IN EXPLANATION & PLANNING**

### ***IF Discussion Opinion And Significance of Problem***

22. OFFERS OPINION of what is going on and names if possible
23. REVEALS RATIONALE for opinion
24. EXPLAINS causation, seriousness, expected outcome, short & long term consequences
25. CHECKS PATIENT'S UNDERSTANDING of what has been said
26. ELICITS PATIENT'S BELIEFS, REACTIONS AND CONCERNS e.g. if opinion matches patient's thoughts, acceptability, feelings

### ***IF Negotiating Mutual Plan Of Action***

27. DISCUSSES OPTIONS e.g. no action, investigation, medication or surgery, non-drug treatments (physiotherapy, walking aids, fluids, counselling), preventative measures
28. PROVIDES INFORMATION on action or treatment offered
  - a) name
  - b) steps involved, how it works
  - c) benefits and advantages
  - d) possible side effects
29. ELICITS PATIENT'S UNDERSTANDING REACTIONS AND CONCERNS about plans and treatments, including acceptability
30. OBTAINS PATIENT'S VIEW of NEED for action, BENEFITS, BARRIERS, MOTIVATION; accepts and advocates alternative viewpoint as needed
31. TAKES PATIENT'S LIFESTYLE, BELIEFS, cultural BACKGROUND and ABILITIES INTO CONSIDERATION
32. ENCOURAGES PATIENT to be involved in implementing plans, TO TAKE RESPONSIBILITY and be self reliant
33. ASKS ABOUT PATIENT SUPPORT SYSTEMS, discusses other

### ***IF Discussing Investigations and Procedures***

34. PROVIDES CLEAR INFORMATION ON PROCEDURES including what patient might experience and how patient will be informed of results
35. RELATES PROCEDURE TO TREATMENT PLAN: value and purpose
36. ENCOURAGES QUESTIONS AND EXPRESSION OF THOUGHTS re potential anxieties or negative outcome

## **TASK FIVE (continued): CLOSING THE CONSULTATION**

### ***Forward Planning***

37. CONTRACTS WITH PATIENT re steps for patient and physician
38. SAFETY NETS, explaining possible unexpected outcomes, what to do if plan is not working, when and how to seek help

### ***Ensuring Appropriate Point of Closure***

39. SUMMARIZES SESSION briefly and clarifies plan of care
40. FINAL CHECK that patient agrees and is comfortable with plan and asks if any correction, questions or other items to discuss

References: Kurtz S, Silverman J, and Draper J (1998) **Teaching and Learning Communication Skills in Medicine**. Oxford, UK: Radcliffe Medical Press  
Silverman J, Kurtz S, and Draper J (1998) **Skills for Communicating with Patients**. Oxford, UK: Radcliffe Medical Press, Reproduced with permission of Professor Kurtz

## **Abridged Calgary-Cambridge Guide** *(With thanks to Drs Peek and Younie)*

### **TASK 1: INITIATING THE SESSION**

#### **Establishing initial rapport**

1. **Greets** patient and obtains patient's name
2. **Introduces** self, role and nature of interview; obtains consent if necessary

#### **Identifying the reason(s) for the consultation**

3. **Identifies** the patient's problems or the issues that the patient wishes to address (e.g. "What problems brought you to the hospital?" or "What would you like to discuss today?" or "What questions did you hope to get answered today?")

### **TASK 2: GATHERING INFORMATION**

#### **Exploration of patient's problems**

*Discover the biomedical perspective, patient's perspective and the background information*

4. **Uses open and closed questioning technique**, moving from open to closed
5. **Listens** attentively, allowing patient to complete statements without interruption and leaving space for patient to think before answering or go on after pausing
6. **Facilitates** patient's responses verbally and non-verbally e.g. use of encouragement, silence, repetition, paraphrasing, interpretation

### **TASK 3: PROVIDING STRUCTURE**

7. **Summarises** at the end of a specific line of enquiry
8. Attends to **timing** and keeping interview on task

### **TASK 4: BUILDING RELATIONSHIP**

#### **Using appropriate non-verbal behaviour**

9. Demonstrates appropriate **non-verbal** behaviour
  - Eye contact, facial expression, posture, vocal cues e.g. rate, volume, tone

#### **Developing rapport**

10. Uses **empathy** to communicate understanding and appreciation of the patient's feelings or predicament; **overtly acknowledges patient's views** and feelings

### **TASK 5: CLOSING THE SESSION**

#### **Forward planning**

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

#### **Ensuring appropriate point of closure**

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

### **TASK 6: EXPLANATION AND PLANNING**

#### **Providing the correct amount and type of information**

13. **Chunks and checks**: gives information in manageable chunks, checks for understanding, uses patient's response as a guide to how to proceed

#### **Aiding accurate recall and understanding**

14. **Organises explanation**: divides into sections, develops a logical sequence

#### **Achieving a shared understanding: incorporating the patient's perspective**

15. **Provides opportunities and encourages patient to contribute**

#### **Planning: shared decision making**

16. **Involves patient** by making suggestions and checks if patient accepts plans.

## **4. Consultation skills teaching in the classroom**

The format of classroom-based communication skills teaching is similar across all. In groups of six to eight students, facilitated by a tutor, students rehearse consultations with simulated patients (trained actors). Learning is achieved by conducting consultations, observing others consult, and through constructive feedback on one's own performance and those of others.

### **4.1. Attendance**

Student attendance should be 100% for all teaching. Attendance is recorded and monitored by means of registers and the student CaPS logbook. If students are unable to attend a session for any reason, it is their responsibility to contact the teaching office and give a reason why; and to arrange to attend an alternative session on another day.

### **4.2. Simulated consultations**

#### **4.2.1. What role is the student taking?**

Students early on in the MBChB programme can sometimes struggle with these sessions due to a fear about lack of knowledge in the topic area. The focus of the sessions across the course should always be on the *communication skills*. Expectations about student medical knowledge grows appropriately across the years so that in later years there is the increased expectation that students will combine skills and knowledge to become able to conduct a "complete" consultation.

Scenarios specify the capacity in which the student is consulting – either as a medical student or junior doctor. Students should come to the sessions prepared to consult on any one of the given scenarios.

#### **4.2.2. What is the student's aim?**

The emphasis in the classroom-based sessions during the earlier years (two and three) is not on making the correct diagnosis but instead:

- Initiating the consultation appropriately
- Gathering information - Eliciting accurate details of the patients' problem
- Understanding the reasons for the patient's attendance
- Establishing the patient's ideas, concerns and expectations (ICE) regarding their illness and its treatment. This may include what they think is wrong, what effects the illness has

had on them, their family, friends and work, what they are anxious about what the illness may mean for the future and what they have already tried to alleviate symptoms.

- Agreeing agendas
- Noticing and responding to cues and patient's emotions appropriately

### **4.3. Running the sessions**

#### **4.3.1. Rationale for teaching methods**

While educational theory offers a number of different teaching and learning models, the application of adult learning principles to undergraduate medical education involves a series of phases: activation of prior knowledge, offering a structure for new knowledge and then connecting the new with prior experiences.<sup>36</sup> The teaching style should support these phases. We encourage group discussion and 'brainstorming' to access students' previous experience of communication skills; rehearsing and observing performance consolidates new knowledge.

Tutors can support this process by:<sup>38</sup>

- Orientating the students for teaching, setting the scene and explaining clearly the aims of the session
- Motivating the students, showing enthusiasm for the subject, telling a personal anecdote, showing respect for and encouraging the students and emphasising the practical applications.
- Introducing new knowledge in a clear, logical manner, encouraging discussion and highlighting important learning points.
- Clarifying points of uncertainty or confusion.
- Elaborating and exploring deeper knowledge by asking questions to stimulate thinking and encouraging students with divergent opinions.
- Assessing adequacy of new knowledge by asking students to summarise learning points and obtaining student feedback.
- Ensuring that their feedback to students is specific, so that students who would particularly benefit from extra practise and skills development are aware they may be invited by the communication skills tutor to an extra follow-up communication skills session.

#### 4.3.2. Tutors – Ground rules and facilitating the group work

Consulting with simulated patients is a complex task that can be intimidating for students. It is therefore worth spending some time getting the students in each group to agree some **ground rules**. These might include:

- Respect for the individual. Everything that takes place in the sessions is confidential and should not be discussed outside of the classroom.
- When ‘consulting’, students need a safe environment. The student should feel in control and can stop and start the consultation when they want.
- Students can try again if they get stuck, rather like a film can be replayed. Different students can try to progress from a given point in their own way.
- Likewise, tutors should be able to stop the consultation at any point, for example to draw out an important learning point or to get some ideas from the group on how to tackle a difficulty.
- The group should respect the concentration of the consulting student by not talking or distracting them.
- Students are expected to bring their CaPS logbook to each session and note their personal key learning points in them.

Everyone should be clear that these sessions are formative, so ‘mistakes’ are expected and often represent valuable learning opportunities. Students should be encouraged to ‘give it a go’ as it does not matter if they “get it wrong”. Now is the time to learn from mistakes, not when real patients might suffer. More than one student can consult with any given patient.

#### 4.3.3. Giving constructive feedback

Tutors, actors and students should use the Calgary-Cambridge Guide to identify and record strengths and weaknesses. This serves several purposes:

- Students, tutors and actors become familiar with the Guide
- Students learn to assess their own and each other’s performance
- Students learn to give useful feedback.

Where possible, feedback should be ‘SMART’:

S: specific, significant, stretching

M: measurable, meaningful, motivational

A: agreed upon, attainable, achievable, acceptable, action-oriented



R: realistic, relevant, reasonable, rewarding, results-oriented

T: time-based, timely, tangible, trackable

In terms of the process of how this information is given and received, there are two broad approaches (Pendleton's rules and ALOBA, see below). Whichever approach is used (and tutors may choose to mix & match), before beginning feedback ensure the consulting student has a chance to "recover" and clarify any matters of fact first. Likewise, always remember to ask the actor for their opinion. We are lucky in Bristol to have an experienced group of simulated patients, who can uniquely offer the patient.

### *Pendleton's rules*

So-called "Pendleton's rules" provide a safe, if formulaic, way of delivering and discussing feedback:

- Ask the student to discuss strengths first. Even good students want to quickly move to discussing weaknesses. This should be restrained until later.
- Ask the group for their comments on strengths. What phrases worked, for example?
- Ask the student what they struggled with, or would like suggestions on how do have done something differently/better
- Ask for the group for suggestions on how to the encounter could have be improved.

However, there are some acknowledged limitations to this approach and in later years, students and tutors are being encouraged to adopt an Agenda-Led Outcome Based Analysis (ALOBA) approach.

### *Agenda-Led Outcome Based Analysis (ALOBA)*

ALOBA is a 'maturer' approach,<sup>39</sup> whereby:

- The student is asked before the scenario what problems they have experienced before and what help they would like from the group
- After the consultation, the learner gets to comment first, which may lead them to review or refine their "learning agenda", and may focus immediately on problem areas rather than strengths
- To assist this process, the group describes what they saw (not provide solutions) so the student can reflect on what happened.

- The whole group is involved in problem solving, allowing the “doctor” to go first, so that group members are working to help themselves in the future as well as the learner.
- Rehearse suggestions: this takes the analysis and feedback to a deeper level of understanding by practising specific skills

#### **4.3.4. Recording feedback**

In the CaPS logbook there is space on which strengths, weaknesses and strategies for improvement must be recorded, from the perspectives of the tutor, actor and student. It can be helpful to get another student to do this. There are several advantages in recording comments:

- It can be difficult for the student to remember multiple learning points, so tutors may wish to summarise and prioritise one or two main learning points.
- Different students can be asked to watch for the use of different skills e.g. use of open questions
- Multiple perspectives (tutor, student and actor) can be recorded
- The student and tutor can refer to comments from previous role-plays to focus attention on the student’s specific learning needs, providing some ‘continuity of education’.

#### **4.3.5. Teaching resources**

- Pens and dry marker boards or flip charts (will be available in the teaching rooms)
- Student register (please take at the start of each session) and return to the lead tutor, course facilitator, or the Primary Health Care teaching office at the end of each session.

## **5. Consultation skills teaching in the community and on the ward**

Students observe doctors and other clinicians consulting, and consult with patients themselves, throughout their training, and both students and clinicians should take every opportunity to reflect on the skills employed in doing this, as well as the outcome (be it diagnosis, treatment, etc.) of the consultation itself. During their clinical attachments, students are expected to consolidate and extend their consultation skills. They should be learning 'how to put it all together', i.e. they should be making a diagnosis and developing a management plan based on a thorough history and examination. Diagnostic reasoning and hypothetico-deductive thinking is introduced elsewhere in the course during years two and three.

The two week GP attachment in the fifth year gives students lots of opportunities to carry out full consultations, observed by the GP tutor and a fellow final year student, as well as observing GPs and nurses. In addition, once a week there should be a Medical Student Surgery, to which patients are pre-booked at 20-25 minute intervals. These surgeries will concentrate on consultation skills, and allow enough time for discussion with GP and fellow student after each consultation.

The principles of feedback are the same as those described in the classroom setting.

### **5.1. Students observing clinician consultations**

The doctor setting the example of being open to reflect on, and improve upon, their own skills in all observed consultations, is very powerful. Allowing enough time to do this and drawing on the Calgary Cambridge Guide reinforces the value of this consultation models to this process:

- Before consulting with patients ask the student to focus on specific aspects of the consultation, such the use of open and closed questioning; identification of verbal and non-verbal cues for example.
- Where possible, arrange for senior students to observe/consult with a number of different GPs to enable them to see and reflect on different consulting styles
- Maximise different consultation situations (for example seeing a known as opposed to an unknown patient; conducting the consultation by telephone or in the patient's home) to explore their influence of these factors on the consultation

## **5.2. Clinicians observing student consultations**

Agree when and how long you are going to let the student consult and how and when you will give feedback:

- Following the “ALOPA” principles (page 23), find out beforehand if there is anything the student specifically would like feedback on, referring to the feedback comments from their classroom-based sessions in their CaPS logbook.
- Where possible prepare the student in advance by discussing the condition/history as this may make it easier for the student to focus on the process of the consultation, rather than the content, and increase their confidence
- With students in years four and five practice timed/focused history taking
- If the patient is present during the feedback, invite them to contribute in a constructive and supportive way. If this may be difficult, ask the patient a more generic question e.g. “What have you found doctors who communicate well do? What tips do you have for us listening and talking with patients?”

## **6. Self-study and other resources**

There is no substitution for observing, practicing and reflecting on consultations with simulated and real life patients, but learning can be supported and reinforced with eLearning and traditional books.

### **6.1. Essential Clinical Communication eLearning Package**

This package has been developed and provided by the UK Clinical Communication in Undergraduate Medical Education. It is available to students through the Hippocrates ([www.bristol.ac.uk/medical-school/hippocrates/generalpractice](http://www.bristol.ac.uk/medical-school/hippocrates/generalpractice)) and Blackboard websites, and comprises the following interactive modules:

- Essential clinical communication
- Initiating the consultation
- Structuring the consultation
- Gathering information & history taking
- Communicating through the physical examination
- Building the relationship
- Explaining & planning
- Closing the consultation

### **6.2. Recommended reading**

The below reading list is not exhaustive, but an excellent place from which to continue one's learning about the importance of, and the research that underpins, clinical communication skills:

- Tate P. The Doctor's Communication Handbook. Radcliffe Medical Press 2007
- Silverman J, Kurtz S, Draper J. Skills for Communicating with Patients. Radcliffe Medical Press 2005.
- Kurtz S, Silverman J, Draper J. Teaching and Learning Communication Skills in Medicine. Radcliffe Medical Press 2005.
- Jackson C. Shut up and listen - a brief guide to clinical communication skills. Dundee University Press 2006.

## **7. Year specific teaching**

### **7.1. Year one**

In the first term of year 1 the Introduction to primary care lecture includes an introduction to communication skills. This is followed by a small group session, facilitated by an appropriately trained actor. This initial session generates the principles behind initiating a consultation, demonstrates the role of open and closed questions and allows the students to experience the importance of active listening. There is also a role play of a home visit allowing the students to practice and develop listening and communication skills in a safe environment before their first patient encounter. The GP attachment consists of 8 half-day sessions in a GP surgery. The aim is for students to become proficient at listening to patients and reflect on what they have heard with understanding and respect for different views and beliefs. During the attachment the students observe the GP consultation in action, exposing them to a variety of tasks of clinical communication; they also go in pairs to meet and interview a patient in depth and are encouraged to reflect on the patient's narrative through a creative piece with a written reflection, or reflective essay. This often reaches beyond the patient, involving communication with relatives, carers and the GP (intra-professional).

### **7.2. Year two**

The two classroom-based sessions provide the foundation of communication skills teaching at the University of Bristol. The overall aims of the two sessions is for students to appreciate that in order to collect all the information required from patients (the “content” of the consultation) in an effective and patient-centered manner, they need to pay attention to the means by which they do this (the “process” aspect of any consultation). Specifically, they move from initiating the consultation the gathering information (session one), through to relationship building and structuring the consultation (session two).

### **7.3. Year three**

#### **7.3.1. Classroom based teaching**

Year 3 consultation skills training involves simulated patient role-plays similar to Year 2 year but the scenarios are more complex and the actors may be more challenging. The aim of Year 3 teaching is to reinforce the skills developed in year 2 and to extend these skills to consultations requiring a change in patient's behaviour. We also expect more analytical feedback from the group observing the role play compared to Year 2.

The session is run as a single half-day in groups of 6-8 students with a GP tutor facilitating.

### **7.3.2. GP attachment**

Specific learning objectives for consultation skills in Year 3 are:

- Solid grasp of the ‘tasks of the consultation’ as described in the Calgary Cambridge Guide
- Understand the relationship between medical history taking and consultation skills– i.e. content and process of the medical encounter
- Move from “check-listing” to “problem solving” and whole person care.
  - a. The student should demonstrate that they can gather information in a patient centred way. This means the student can adapt the sequence of information gathering to what the patient is offering, grasp the importance of information and use follow up questions to clarify what the patient is saying.
  - b. The student should be formulating and reformulating problems and differential diagnoses throughout the information gathering process and this should be evident from the questioning.
- Student actively explore ideas, concerns and expectations
- Formulate a problem or diagnosis and a management plan and share this with the patient
- Demonstrate sensible safety netting
- Participated in self-assessment and reflection on their consultation skills
- Provide specific feedback to peers on their consultation skills

## **7.4. Year four**

### **7.4.1. Lecture and classroom based teaching**

During the Community Orientated Medical Practice II (COMP 2) course students have a teaching session that examines different aspects of consultation and communication skills. The sessions build upon the principles laid out in the Calgary-Cambridge guide and offer students the opportunity of practising their communication skills with actors.

The session concentrates on students completing a primary care based consultation. This emphasises moving beyond history and examination and forming a differential diagnosis; to sharing thinking and involving patients in making treatment decisions. The students are encouraged to be aware of the wide range of management options available to the GP. The scenarios are based on the core clinical topics of the COMP2 primary care curriculum. The session also covers the skills of imparting difficult news to patients.

#### **7.4.2. GP attachment**

Year 4 students spend 4 weeks in practice consolidating their consultation skills.

The aims are:

- To observe and reflect on GP consultations, being able to identify the stages of the consultation and the skills used to:
  - Set the agenda for the consultation
  - Actively listen and use questioning skills to understand the nature of the problem
  - Elicit patient ideas concerns and expectations
  - Form a “triple diagnosis” being aware of the psychological social and medical aspects at the root of patients’ problems
  - Explain the doctors thinking and put into context for the patient
  - Negotiate a shared management plan being aware of the variety of options open to the GP from reassurance to referral.
- To practice consultations while being observed and being able to reflect on the consultation taking account of observer feedback.

#### **7.5. Year five**

##### **7.5.1. Classroom-based teaching (based in academies)**

During the Preparing for Professional Practice (PPP) course students have a half day session on Consultation Skills at their local Academy organised by Primary Health Care, involving role play with actors working through four scenarios (each scenario can be role played twice, ensuring each student has the opportunity to practice their consultation skills) . This concentrates on Advanced Communication Skills relevant to those about to be qualified doctors. Topics cover other ways of consulting including: the use of telephones and interpreters, consent and capacity, consultation with patient and relative, multiple medical problems and dealing with an angry patient and handling complaint.

##### **7.5.2. GP attachment**

Particular advanced consultation skills to concentrate on are:

- Consultations where a relative/carer is also present
- Consulting with people with poor English and use of interpreters





The article in which this figure is published,<sup>43</sup> reviews the elements that medical schools should be including in their curricula. It shows the increasing complexity of tasks as learners move from the centre of the wheel to its edges. Our curriculum follows this progression with: Year 1 students are learning respect for others, the theory and evidence; Year 2 students the clinical communication tasks (as summarised in the Calgary-Cambridge guide); and Year 3 & 4 students learn about taking a sexual history, communication with deaf and visually impaired people, handling emotions such as anger and behaviour change. In Year 5 students learn about the outer rings of the wheel including telephone consultations, written communication (e.g. clinical computer medical records providing continuity of information) and use of interpreters. During SSCs, students conduct presentations to their peers and assessors.

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