3 Relationship: Communication and consultation skills

This area of performance is about communication with patients and the use of recognised consultation techniques.

Needs Further Development	Competent for licensing	Excellent	
Develops a working relationship with the patient, but one in which the problem rather than the person is the focus.	Explores the patient's agenda, health beliefs and preferences. Elicits psychological and social information to place the patient's problem in context.	Incorporates the patient's perspective and context when negotiating the management plan.	**1**

This first progression illustrates how we move from:

A problem-centred consulting approach, through

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Regular efforts to understand the patient's perspective and the impact of the patient's problem on their lives

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Developing management plans that reflect this understanding

Joined up?
See p14

Looking at each of the word pictures in turn:

Develops a working relationship with the patient, but one in which the problem rather than the person is the focus.

Doctors who demonstrate this level of competence develop a working (or functional) relationship with the patient that can achieve results but does not necessarily reflect any depth of relationship between doctor and patient. Because the relationship element is not well-developed, it is unlikely that the patient's problems are understood by the doctor in the context of the patient's life or that management plans are particularly sophisticated.

Question

If we think about patient factors rather than our own communication skills, in what situations might it be difficult to establish rapport with the patient?

Normally, rapport is fairly straightforward to establish with most patients. However, in some situations it can be tricky. For example, there may be patients who have permanent communication difficulties such as those who have had a stroke or who have learning disabilities. The challenge here is for us to maintain a patient-centred approach even when communication involves carers and other intermediaries.

Sometimes, there may be a combination of factors that impede communication. For example, patients with drug & alcohol misuse problems could have communication problems because of their condition, and might be met with negative emotions (through our prejudice, fear etc) that make rapport even more difficult to achieve. Similarly, patients with mental health problems, learning difficulties and those from other cultures may be more challenging to establish rapport with.

Why is this word picture labelled NFD (needs further development)? This is because to achieve the next step (competent), we have to focus on the patient rather than simply the problem. In most circumstances, this should be possible although sometimes, such as when the patient has an acute or emergency problem, this may not be possible or even appropriate. Arguably, in these circumstances we could demonstrate patient-centredness by trying to understand the patient's thoughts and preferences through the relatives.

Assessor's corner: being patient-centred

Does the trainee take an interest in the patient and recognise that they are dealing with a person rather than a problem?

Sometimes, trainees may misunderstand patient-centredness, believing this to mean that they should simply accede to the patient's wishes. Once again, the patient, as a person, has not really being taken account of and the doctor is simply being *reactive* rather than responsive.

Explores the patient's agenda, health beliefs and preferences.

This behaviour is felt by educators to be particularly important.

The key skill here is to 'explore', in other words not to passively accept what is offered by the patient, but probe further until we are happy that we have a good understanding of the patient's ideas concerns and expectations about the problem. All patients have thoughts, but many need help with expressing and clarifying these. For example, men may be less articulate about their health compared with women and some may be apologetic ('I didn't want to come, but my partner made me'). Don't let this fool you as such patients are usually no less concerned about their health than the average person, sometimes more so!

Exploring the patient's thoughts requires us to put patients at their ease, particularly if, as with sexual health or bowel conditions, the patient might find such discussion embarrassing. Sometimes, 'exploring' may mean that we have to challenge a patient's thoughts, for example whether or not they are ready to quit smoking.

Patients and their families not only have thoughts about the problems, but also about what they expect from the practice and the health service more generally. Exploring these thoughts (e.g. 'what did you hope that we might do about this problem?') is not only good consulting practice, but can help us to tailor the management plan more appropriately to the patient's needs and thereby reduce dissatisfaction with the service.

Elicits psychological and social information to place the patient's problem in context.

The object here is to understand whether, how and to what degree a problem is having an impact on the life of the patient. We might explore to see if a psychological problem is present as this often coexists with more significant physical problems and may not be recognised or admitted by the patient. The fact that psychological problems can lead to physical disease is often overlooked, particularly in those with enduring mental illness. What does 'social impact' mean? It may involve relationships, the workplace and especially for younger patients, education.

Every problem has the capacity to have a wider impact both in the patient and in those associated with him or her. Sometimes, such an impact might be anticipated, for example with patients who have visual difficulties or patients with skin problems that cause disfigurement. Sometimes, the impact may not be obvious or may not be mentioned to us, as a result of which it may not be considered. For example, domestic violence in women and physical abuse of the elderly are prevalent but are easily overlooked.

Incorporates the patient's perspective and context when negotiating the management plan.

Having elicited the information above, at the 'excellent' end of the scale this competence is achieved when the management plan is discussed and developed by explicitly incorporating the patient's perspective and context. The classification of 'excellent' is because negotiation can involve challenge and conflict and is therefore a difficult area of communication.

What do the words perspective and context mean in practice? For example, the patient's perspective may determine whether a drug or non-drug approach is chosen or whether (when appropriate) they wish to live with a problem rather than be referred and so on.

The patient's context may include the nature of their illness and its interaction with other conditions from which they suffer, the employer's attitude to sickness absence, whether the patient has dependents, the availability of help and so on. Any of these could have an impact upon a proposed management plan.

There is considerable overlap between this section and 'practising holistically'. The difference is that this section is concerned with the communication skills used to achieve a holistic objective, whereas 'practising holistically' concentrates on the use made of holistic information.

Computers and communication

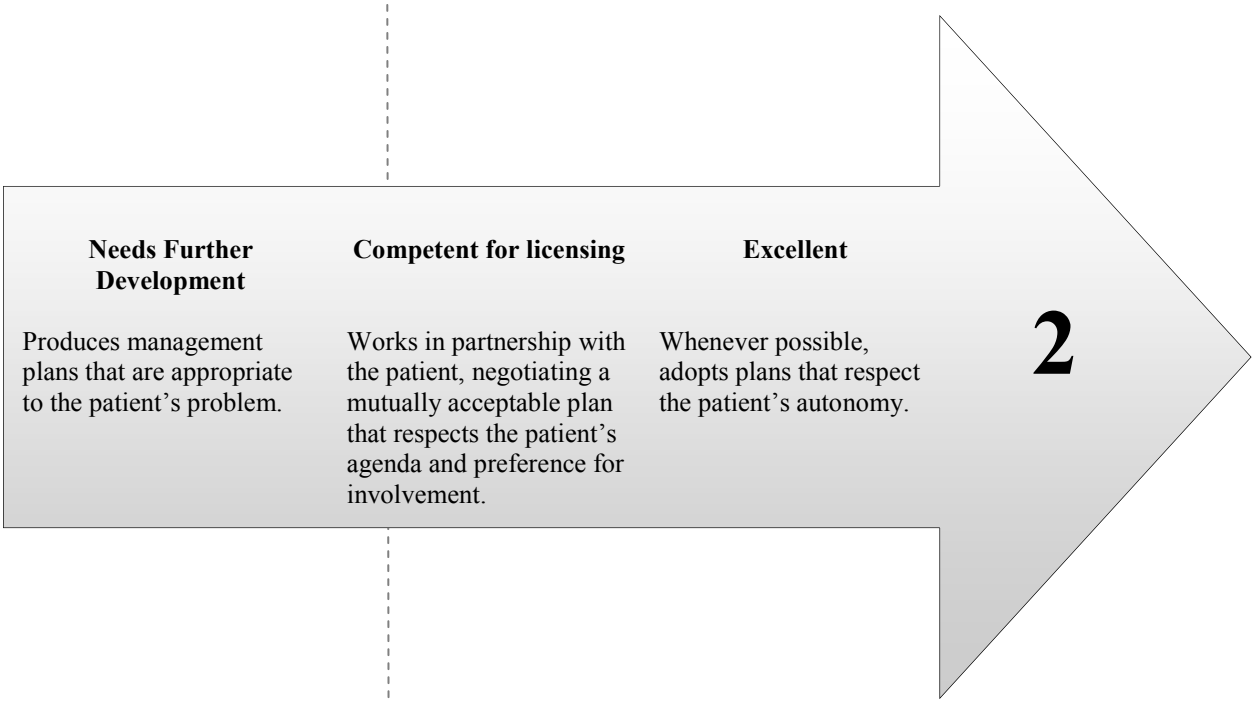
The consulting room computer is a relatively recent but significant threat to establishing and maintaining a relationship with the patient. Look at yourself on video and ask yourself if you are becoming too *'computer-centred'*.

Sometimes, repositioning the computer can help to reduce the time spent looking away or even worse, turning away, from the patient. Involving the patient in the use of the computer is another way of keeping attention focused on the patient and their problem.

Assessor's corner: putting the problem in context

Does the trainee elicit psychosocial information when history taking? Look for a disparity between what the trainee says that they would do (e.g. in CbD) and what they actually do in COT.

In case-discussion, try to discuss psychosocial issues. If they haven't been asked about by the trainee, no meaningful discussion can take place.



This second progression illustrates how we move from:

Producing a plan that seems appropriate to the problem, but doing so without significant patient involvement

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Engaging in dialogue that results in a negotiated plan

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Ensuring that plans are, wherever possible, patient-centred

Looking at each of the word pictures in turn:

Produces management plans that are appropriate to the patient's problem.

This behaviour is usually straightforward, although we need to remember that 'problems' are not always diseases. The major emphasis, however, is on clinical care.

Sometimes, an appropriate management plan may not be immediately obvious. This may mean that we have to wait and review the patient within a specified time frame to see how the condition evolves. Occasionally it may mean that we have to admit that no more intervention can be offered, for example when curative options are exhausted. However, this should not be seen as being a bleak or hopeless outcome as there are always other options. As has been said, doctors should 'cure sometimes, palliate often and comfort always'.

Incorporating the patient's perspective: what is the evidence?

This competence centres on negotiation and the doctor's willingness to modify management plans. Watch a consultation: are the patient's preferences discussed?

Are initial ideas about the plan changed or tailored in the light of the patient's preferences.

What we need to remember is that this behaviour lies in the *communication* domain rather than pure clinical management which means that to demonstrate it, we have to show that we have developed a sufficiently good relationship to recommend an appropriate management plan, particularly through the desire to engage and the ability to listen attentively. At this level of achievement, we are not yet 'competent' because we are not yet working in partnership.

Works in partnership with the patient, negotiating a mutually acceptable plan that respects the patient's agenda and preference for involvement.

This competence is felt by many educators to be the most important in the communication skills domain.

The key competence here is our ability to adopt a partnership mindset, characterised by the desire to work as joint experts in which we contribute medical expertise and the patient contributes expertise about themselves to the management plan. Put another way, doctors bring medical evidence and patients bring the 'evidence' of their values and preferences . Additionally, doctors need to have the skills to negotiate a plan that respects the patient's viewpoint but also exemplifies good clinical management.

Sometimes, perhaps for personal or cultural reasons or because of physical frailty, patients may prefer not to be involved in developing the plan and may then abdicate responsibility to ourselves. As long as we have genuinely tried to involve the patient, rather than assumed that they are reluctant to engage, we will have demonstrated the communication skill that this competency requires.

Of course, a plan may *appear* to be negotiated, but may not be followed by the patient. If this happens more frequently than we would anticipate, we might ask ourselves whether we are truly negotiating and whether we really elicit the patient's preferences before making our own preferences known.

Whenever possible, adopts plans that respect the patient's autonomy.

The opportunity for this may sometimes be limited, for example if the patient has insufficient mental capacity either through acute illness or long-term problems such as learning disability. We may need to involve other people who can speak on the patient's behalf and sometimes this can cause a conflict of views between parties who each believe that they are acting in the patient's best interest. Autonomy may be tailored as the patient develops. For example, young children may have little autonomy but older children and adolescents are capable of giving informed consent within certain parameters, as laid out in guidelines such as Gillick or Fraser competence.

Ask yourself: How often do you try talking to children directly, rather than through adults?

Question: How might empowering the patient be helpful when negotiating a management plan?

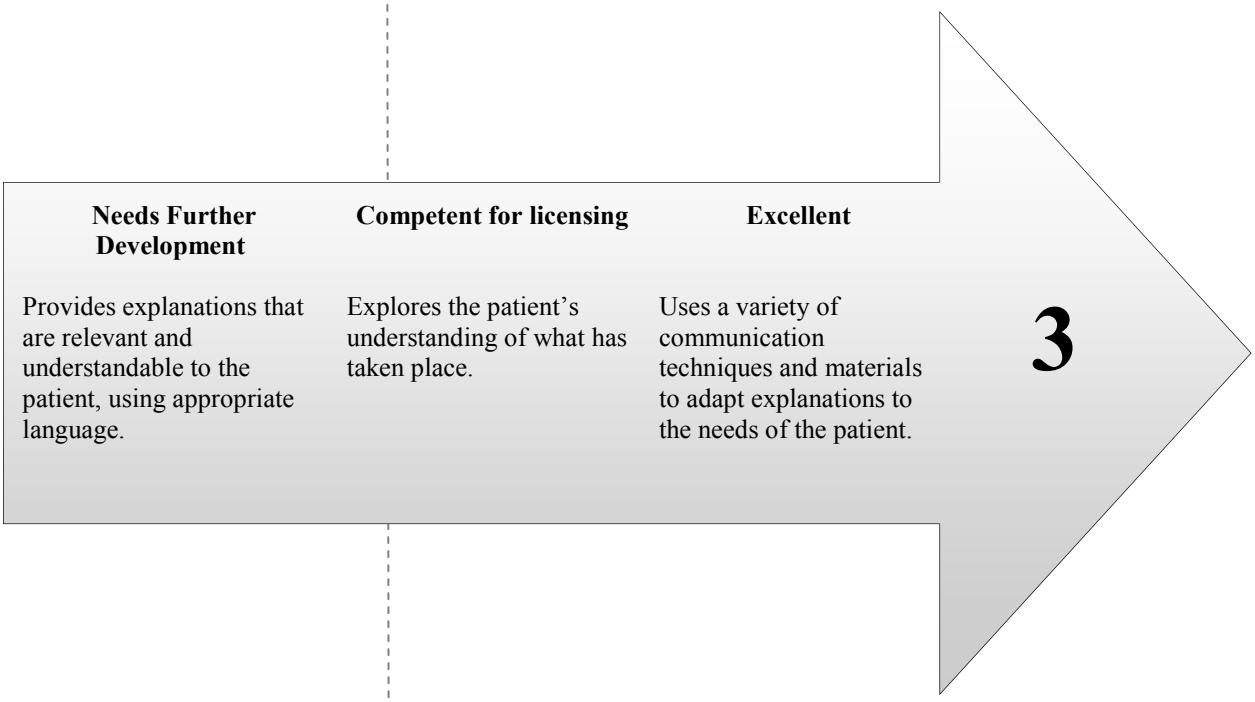
Other management approaches require doctors to empower their patients, for example to adopt self-treatment and coping strategies for relatively minor conditions like hay fever, but more importantly for significant / chronic conditions like asthma where the day-to-day management is best when under the patient's control.

Assessor's corner: negotiating a plan

Look closely at COT. Does the doctor provide a legitimate range of management options, explaining the pros and cons of each approach? Does the doctor avoid well-meaning dictatorship, in which they simply choose on behalf of the patient?

Assessor's corner: respecting the patient's autonomy

Does the trainee facilitate autonomy by explaining well and providing information about the implications of the available choices? Does the trainee override the patient or criticise their preference?



This third progression illustrates how we move from:

Providing explanations that are capable of being understood by the patient

Checking what the patient has understood and whether this understanding is correct

When communication is more challenging, using techniques to make sure that the messages are understood

Looking at each of the word pictures in turn:

Provides explanations that are relevant and understandable to the patient, using appropriate language

Good explanations rarely, unless talking to other health professionals, use technical language. The ability to phrase in plain English, using colloquial language when appropriate and (even better) use the patient's preferred phrases, not only helps us to make good explanations but greatly increases the chance that the explanation will be properly understood - and believed. All patients deserve explanations, even when their capacity to understand is poor, for example in

children and those with intellectual impairments. Good GPs will do their best to involve the patient and tailor explanations so that what they say is useful and does not cause avoidable distress. Sometimes this can simply be to inform patients that a full explanation is being given to someone they trust such as a parent or carer.

Explanations help patients to make choices. One of the most challenging areas is when we are required to explain risk, for example the risk of cardiovascular events or the risk of complications from obesity and diabetes. Here, language may not be enough on its own and pictorial illustrations of risk may be needed to clarify and reinforce the message.

Good explanation is not just part of good communicating. By explaining well, better choices can be made, concordance can be improved and the risk to patient safety that might result from misunderstandings can be reduced. Also, a careful choice of words can help patients to have a more positive approach to improvement. For example, patients with rheumatic disorders may respond better to being told about 'wear and repair' than about 'disintegrating joints'.

Assessor's corner: exploring the patient's understanding

It may be obvious from COT whether or not the trainee asks what the patient has understood. More subtly, does the trainee follow-up on non-verbal cues that indicate that the patient may be confused, unsure or disbelieving?

Explores the patient's understanding of what has taken place.

Explanations may seem to be going well, especially when the patient gives non-verbal cues such as smiling and nodding at us when we speak. However, they may simply be being polite! Studies show that patients recall little of what is said and therefore it is not surprising that they may misunderstand some of the detail, for example how often tablets are to be taken or when their condition should be reviewed. Sometimes, they may have entirely misunderstood the *substance* of the explanation. For instance, despite our best efforts at explaining, patients may believe themselves to be diabetic when they have glycosuria but a normal fasting sugar.

Assessor's corner: adapting explanations

Look closely at COT. Does the trainee use a 'one size fits all' approach? Does s/he vary explanations, for example tailoring them to the needs of different types of patients (age, gender, ethnic groups etc)?

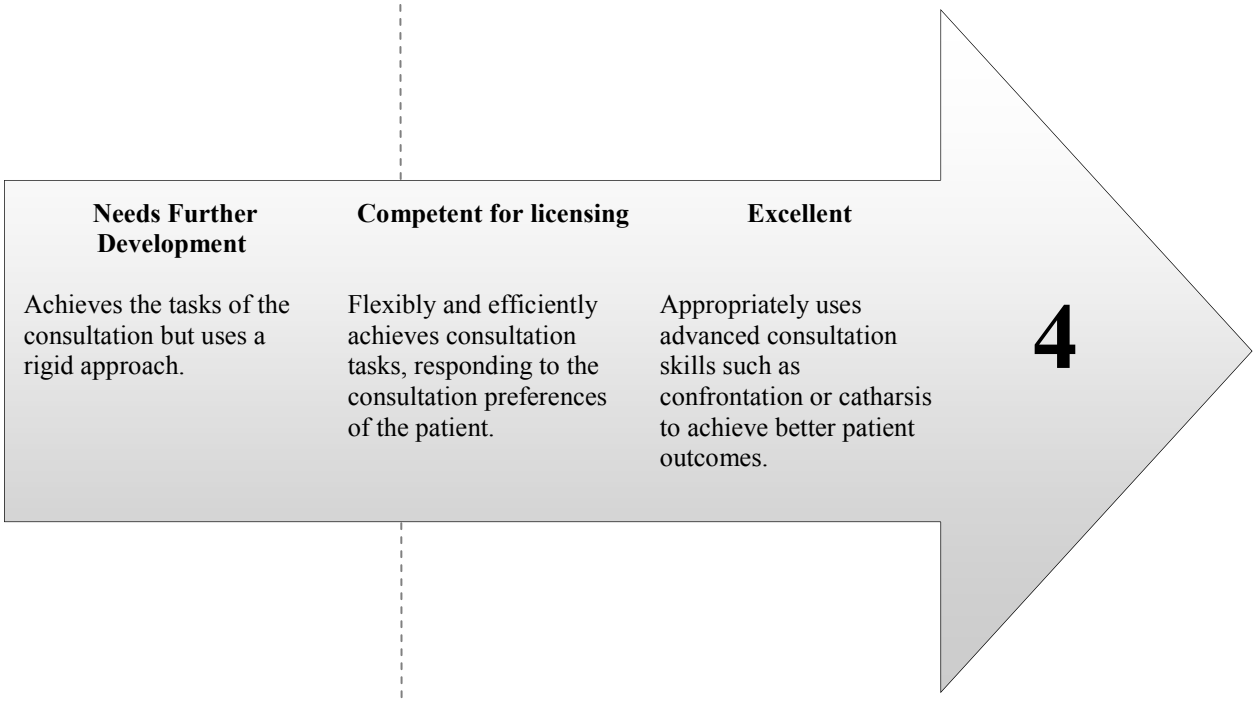
Rather than adapt the explanation, does the trainee appear frustrated or angry if the patient appears not to understand?

Uses a variety of communication techniques and materials to adapt explanations to the needs of the patient.

This is a higher level competence because the ability to adapt in a variety of ways comes from experience of patient needs and from proficiency with consulting skills. Examples include commonplace activities such as communicating effectively with patients who have hearing impairment, for example by remembering to face the patient and speak clearly to let them lip-read. Sometimes, diagrams and drawings may be needed and Internet-based information is increasingly useful either during the consultation or as homework. Depending on the nature of the local population, patients may require interpreters. Here, part of the communication challenge for us is to remain patient-focused by looking at and talking to the patient rather than to the third party.

We mentioned autonomy in the previous section and the heart of respecting the patient's autonomy is to provide sufficient information and explanation in a form that the patient understands. To do this, we will need to tailor our language, speak clearly and so on, but we may also need to back this up with communication aids like diagrams and leaflets as described in this section.

Providing explanations is not the sole responsibility of the GP. We should encourage questioning by the patient and encourage the patient, their carer and family to access further information and use patient support groups when appropriate.



This fourth progression illustrates how we move from:

An inexpert approach to consulting, which at this basic level can look like a process of consulting 'by numbers'. For example, we may go through every consultation in a formulaic manner, irrespective of the nature of the problem or the personality of the patient.

A competent and fluid approach in which consultation tasks may be performed in a variety of sequences according to the circumstances rather than in a predetermined order. For example, we may listen, take some history, explore some management options and then come back to further history taking, doing so without disturbing the flow of the dialogue.

We not only have a fluid technique but, when the situation demands, may use special communication skills. For example when we have hit an impasse in dealing with the problem we may use interventions such as helping the patient to release emotional tension (catharsis) and encouraging the patient to problem-solve through reflection and self-discovery (catalysis).

Looking at each of the word pictures in turn:

Achieves the tasks of the consultation but uses a rigid approach.

Doctors who perform at this level are conversant with basic skills. They 'tick the boxes' but lack flexibility and fluency. If consulting *skills* are basic, then the

consultation *outcomes* are likely to reflect this. It is therefore less likely that difficult situations such as dealing with multiple problems and hidden agendas will be tackled well.

Flexibly and efficiently achieves consultation tasks, responding to the consultation preferences of the patient.

Different patients require different approaches. This may be obvious when there is a language barrier. Less obviously, we may have to tailor our consultation approach to the needs of groups such as children, pregnant women, the elderly or the housebound. Culture also makes a difference. For example, in some cultures there is less willingness to accept the Western model of shared decision-making and patients may prefer what we would call a 'doctor-centred' consultation model. However, we should take care not to *assume* that this is the case as it is increasingly rare for patients from any culture to unquestioningly accept our advice in the way they did a generation ago.

Appropriately uses advanced consultation skills such as confrontation or catharsis to achieve better patient outcomes.

At the excellent end of the scale, we help patients to become better-able to share in decision-making by encouraging them to question more, understand the issues better, become more aware of their motivating factors and to be more accountable for keeping their side of the management-plan bargain. This not only requires the patient's trust, usually built upon the bedrock of an existing relationship, but also requires advanced communication skills that include the abilities to challenge, question, inform and negotiate.

The skills involved in consulting with patients can help greatly with other aspects of medical practice. As we will see later, they can assist us to communicate with teams, groups and organisations in order to improve services and achieve change.

Looking to the future, when all doctors will have some role in teaching, there are striking similarities between consulting skills and the skills required for effective teaching, in particular active listening, questioning and summarising to help reach a shared understanding of the problem or issue that needs to be addressed. Maybe this should make us think of our consultations as being *learning* opportunities and voyages of discovery? Not always easy last thing on a Friday afternoon!

Learning more advanced consulting skills

Watch more experienced doctors consult and look to see how they jump about with consultation tasks rather than pursue them in a linear fashion. In particular, look out for patient cues (e.g. remarks that are dropped or facial expressions).

These are often significant and good consulters will pick up on them and come back to them, weaving them in to the consultation later on.

Try to make notes when you sit in on consultations, perhaps using the COT schedule so that you can learn to recognise these more advanced skills and see what they can achieve.

What are the deeper features that underpin communication?

This is a good time to go back to the deeper features. Look closely at those listed under empathy & sensitivity and communication skills.

Ask someone more experienced to give you some feedback on these. Are there any that you feel are weaknesses for you? How would you work on them?