PRIMARY CARE

MED437

Enhancing Consultation Competencies & Communication Skills

Objectives:

1. Show understanding of the three models of consultation; Stott and Davis, Pendleton and Calgary and their tasks.
2. Recognize different consultation styles.
3. Describe the verbal and nonverbal communication and signify the importance of each.
4. Perform video analysis assessment showing the tasks of consultation of the three different models by using videos and case scenarios.
5. Illustrate understanding of verbal, nonverbal clues, cues, gestures and certain techniques that will facilitate communication between Dr and patient through videos analysis and role play.

Done by:

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Study consultation skills and Doctor patient communication lectures before.
This FCR was only questions from the dr and video analysis.

References

- Doctor's slides and notes

Important *Notes* *Extra* *Golden*

Editing file link

Dr questions

- Housekeeping means to put everything in structure and according to time
- Calgary-Cambridge model is the best model since it has almost all the ideas in the other models and its structured very well.

Q1. What are the components of consultation models?

- Interviewing and history taking skills
- Physical examination skills
- Patient management skills
- Problem -solving skills
- Behavior /relationship with patient
- Anticipatory care
- Record keeping

Q2. Why do we have models of consultations?

Cause it describes will provide a range of approaches and makes the consultation easier.

Q3. Describe the triaxial models?

physical, psychological and social. consider the patient's emotional, family, social and environmental circumstances that have a profound effect on health.

Q4. Describe the health belief Model "I.C.E"?

It focuses on patients' thoughts what does he think the problem with him.

- I= ideas: what is the disease that affecting him why is it affecting him
- C=concerns: how is it going to affect his life, work
- E =expectation: what does the patient expect from the doctor

Q5. What are the areas of Stott and Davis and describe each one?

- Management of presenting problem: to know the reason why patient came to you and manage that problem.
- Management of continuing problems: management of chronic disease and risk factors that the patient has but is not the main complain.
- Modification of help seeking behavior: Some behavioral that started to show up in the patient or community due to media or previous doctor encounter like prescribing antibiotic to simple / viral sore throat. So, we educate the patient no need to come to the hospital it can resolve by itself at home.
- Opportunistic health promotion: we take the opportunity to promote health like smoking cessation, vaccination, screen for chronic diseases as HTN, etc.

Q6. How many tasks in present in Pendleton's Model? 7

Q7. What is the first task in Pendleton's Model?

- To define the reasons for the patient's attendance which includes:
- Nature and history of the problem
- Etiology
- Patient ideas,concerns and expectations
- The effect of the problem.

Q8. What does it mean "To choose with the patient an appropriate action for each problem"?

Provide an options/ solution to each problem and chose with the patient the most appropriate one.

Q9. What does it mean "To achieve a shared understanding of the problems with the patient"?

Make sure that the patient understands what you are telling him and why this is the situation and why you should do that.

Q10. "To involve the patient in the management and encourage him to accept appropriate responsibility." Why do we involve patient in the management?
To improve the outcome by increasing the compliance with management

Q11. What does patient agenda mean?
I.C.E with the effect of the problem on the patient

Q12. What is the patient perspective? Only I.C.E

Q13. What is the difference between doctor centered and patient centered?

- doctor centered: focuses more on the doctor rather than patient, asking close ended questions, etc.
- patient centered: focuses on the patient more, giving him more time to take and express by asking open ended questions, etc.

Q14. Pitfalls to avoid common barriers to satisfactory consultation?

- Poor eye contact
- Over reliance on notes
- Lack of clarification
- Misinterpretation
- Insensitivities to language /cultural differences
- Omitting to ask what the patient think of his illness

Q15. Factors interfering with patient satisfaction?

- Poor communication
- Physician insensitivity
- Office foul ups eg Appointment delay

Q16. What are the main factors in communication process?

- The doctor
- The patient
- The message
- The environment
- The rapport

Q17. What is the best position for patient and doctor in relation to the desk?

L shape

Q18. What factors in the waiting room could improve satisfaction of the patient?

- Short waiting time
- Present of enough and comfortable chairs
- Good ventilation
- Present of educational material

Q19. mention some positive doctor behavior at first contact?

- Introduce himself to the patient
- Make the patient feel comfortable
- Be unhurried and relaxed
- Focus firmly on the patient
- Use open ended questions.
- Make appropriate reassuring gestures.

Q20. Mention some positive doctor behavior?

- Caring
- Responsibility
- Empathy
- Trust Respect
- Sensitivity Interest
- Confidence Concern
- Competence

Q21. Examples of massages that could lead to negative communication?

- Language difficulties: different language between doctor and patient
- Complex problems: eg. patient has multiple comorbidities like drug abuse, cancer, etc.
- Emotional problems: when patient has depression or other psychiatric problem or when patient has someone recently passed
- Uncertainty and doubt

Q22. Communicating Strategies, you might use to improve communication?

- Modify language
- Avoid jargon
- Clear explanations
- Clear treatment instructions
- Evaluate pt's understanding
- Summarize and repeat
- Avoid uncertainty
- Avoid inappropriate reassurance

Q23. What do we mean by active listening?

- Checking facts: ask more about the information the patient gave you
- Checking feelings: we want the patient to talk about their feelings about the problem
- Encouragement: encourage patient to talk more about the presenting problem and shows interest in what patient says.
- Reflection: tell patient in summary what is going on

Video analysis

Video 1:

https://youtu.be/tWFVT-fUafQ

Comments:

- Doctor didn’t great patient
- There was no eye contact as he focuses on notes more than patient
- Body language of patient showed that she was uncomfortable and unsatisfied
- Doctor was interrupting her
- Closed ended questions
- Didn’t show any interest to the patient
- He was careless and insensitive to her problem
- Didn't respect to patient privacy
- Didn’t answer patient answer at the end and didn’t ask about I.C.E

Things to improve:

- Good explanation to the patient of why he changed the Abx
- check patient understanding
- It was a good opportunity for health promotion since the patient is smoker he could advise her to quit smoking.

Video 2:

https://youtu.be/tWFVT-fUafQ?t=214

Comments:

- Doctor greats patient
- He asked open ended questions
- There was an eye contact
- He asks about I.C.E
- Took consent before examining her and told her exactly what he was going to do
- He respect her privacy
- He shows interest to what she was saying
- Explain why he changes Abx and side effects
- Health promotion
    - ask her to stop smoking
    - measure blood pressure
- He asks about social history
- Body language:
    - Mirroring
    - Vocal pacing

Video 3: https://youtu.be/Cg4BbnkBavQ

Comments on the patient:

- Body language of patient:
  - Depressed shoulder
  - Avoid eye contact
- General appearance of patient:
- Clothes are not clean
- Her hair is messy

Comment on the doctor

- He showed empathy to the patient
- encourage her to talk more
- Active listening
- I.C.E
- Open ended question
- He was asking about who would help her and about her free time all of this is important to see the effect of the problem
- Ask about the effect of the problem “asking about who would help her and her free time”

Video 4:

"Use consultation assessment form"

1- Initiation the session:

- Doctor greets the patient
- He might seen the mother for the first time, so he should introduce himself
- The doctor was not sensitive to the mother fear and did not address her concern.

2- Gathering information:

- **Exploration of the problem:**
  - Doctor should give more information about the complications of smoking "eg. different types of malignancies " and how can it affect his health.

- **Understanding patient perspective:**
  - Doctor as we said before didn't address the mother fears
  - Before the examination the doctor explained what he was going to do and gave the patient detailed instruction on what to do

- **Providing structure to consultation:**
  - He did summarize to the patient however he used a medical terminology "leukemia" instead of explaining what it is.

3- Building relationship:

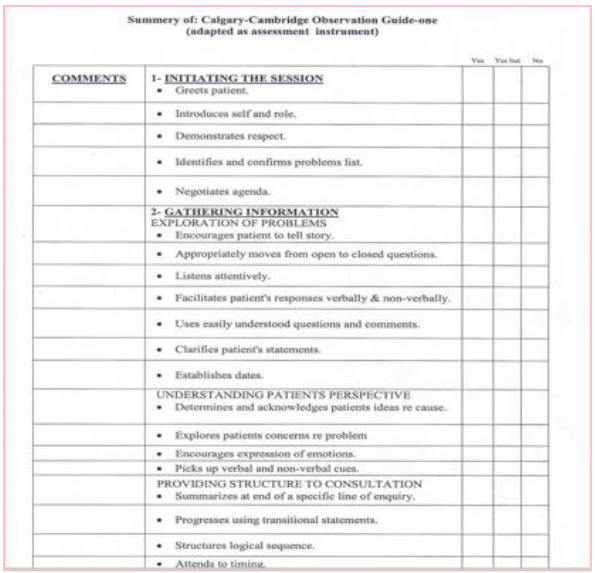
- The doctor was judgmental especially to the mother and didn't show empathy however he was supportive and confidante

4- Explanation and planning:

- He didn't give the patient plans or options to choose from
- Didn't involve patient in the management "like ask him to record his improvement in quitting"
- Didn't give a clear plan for patient to quit smoking.
- Motivating patient as said before is by elaborating more on the complications
- We can involve the mother by asking her to tell everyone not to smoke inside the house to create optimal environment for quitting.

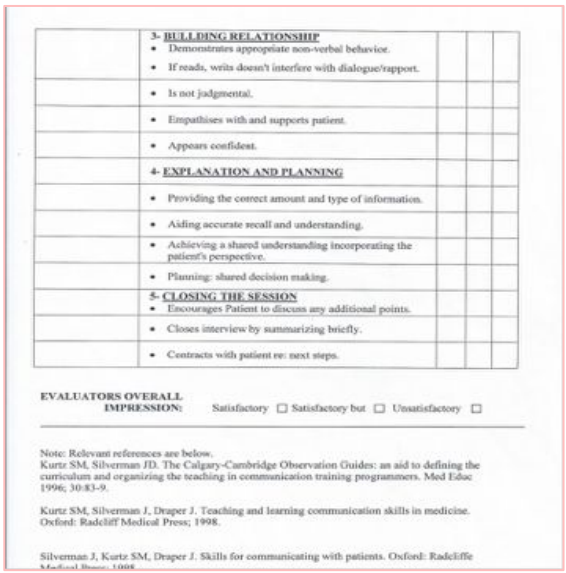
Examples of options could be given to patient:
first: is the patient said he want to quit by himself.
Second: give him medication and patches.

you should always ask the patient if he is motivated, did he try anything before to quit smoking.



Summery of: Calgary-Cambridge Observation Guide-one (adapted as assessment instrument)

COMMENTS		Yes	Yes but	No
	1- INITIATING THE SESSION			
	• Greets patient.			
	• Introduces self and role.			
	• Demonstrates respect.			
	• Identifies and confirms problems list.			
	• Negotiates agenda.			
	2- GATHERING INFORMATION			
	EXPLORATION OF PROBLEMS			
	• Encourages patient to tell story.			
	• Appropriately moves from open to closed questions.			
	• Listens attentively.			
	• Facilitates patient's responses verbally & non-verbally.			
	• Uses easily understood questions and comments.			
	• Clarifies patient's statements.			
	• Establishes dates.			
	UNDERSTANDING PATIENTS PERSPECTIVE			
	• Determines and acknowledges patients ideas re cause.			
	• Explores patients concerns re problem			
	• Encourages expression of emotions.			
	• Picks up verbal and non-verbal cues.			
	PROVIDING STRUCTURE TO CONSULTATION			
	• Summarizes at end of a specific line of enquiry.			
	• Progresses using transitional statements.			
	• Structures logical sequence.			
	• Attends to timing.			



	3- BUILDING RELATIONSHIP			
	• Demonstrates appropriate non-verbal behavior.			
	• If reads, writs doesn't interfere with dialogue/rapport.			
	• Is not judgmental.			
	• Empathises with and supports patient.			
	• Appears confident.			
	4- EXPLANATION AND PLANNING			
	• Providing the correct amount and type of information.			
	• Aiding accurate recall and understanding.			
	• Achieving a shared understanding incorporating the patient's perspective.			
	• Planning: shared decision making.			
	5- CLOSING THE SESSION			
	• Encourages Patient to discuss any additional points.			
	• Closes interview by summarizing briefly.			
	• Contracts with patient re: next steps.			

EVALUATORS OVERALL IMPRESSION: Satisfactory ☐ Satisfactory but ☐ Unsatisfactory ☐

Note: Relevant references are below.

Kurtz SM, Silverman JD. The Calgary-Cambridge Observation Guides: an aid to defining the curriculum and organizing the teaching in communication training programmers. Med Educ 1996; 30:83-9.

Kurtz SM, Silverman J, Draper J. Teaching and learning communication skills in medicine. Oxford: Radcliff Medical Press; 1998.

Silverman J, Kurtz SM, Draper J. Skills for communicating with patients. Oxford: Radcliffe