Dr Gill Pinner
Professor Gill Doody

Development of Communication Skills: Assessment & Training
Learning Objectives

By the end of the workshop, delegates will:

- Understand the core theoretical principles of teaching and learning communication skills
- Understand how to apply important principles of teaching and assessment including how to apply tools of analysis including the Calgary Cambridge model, the FACs and how to give effective feedback
- Apply these principles to enable the development of local training courses and develop their own clinical and supervisory practice
GUESS THIS...

How many medical interviews does a doctor conduct during a working lifetime?
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200,000 (Silverman et al, 2005)

Very important to get it right!
Political climate over last 20 years

- Neo-liberalism (Thatcherite doctrine)
  - The “Patients Charter” (DoH, 1991) - “rights” for NHS patients
  - “Market individualism” c.f. “greater good”
  - Public institutions streamlined / privatised
  - NHS internal markets based on USA models
  - Purchaser / provider split in NHS
  - NHS providers in a competitive market
HOW CLINICAL COMMUNICATION BECAME A CORE PART OF MEDICAL EDUCATION IN THE UK

Sociological influences

- NHS provides a service - patient becomes the “customer”
- Health care becomes a commodity
- Rise of the internet – patients access to information
- Society moves away from old respect for professions stance
- Emergence of a new individualism – “patient-centredness”
Patient-centred communication

- New skills required
  - Negotiation
  - Shared management planning

- New challenges to face
  - Litigation (70% poor communication)
  - Multi-professional healthcare team (extended roles)

- Explore both the disease and the illness experience
- Move away from the autocratic role stereotype of the doctor 1970s/1980s
- “Climbing down from the medical pedestal”
- Putting the ideas, concerns and expectations (ICE) of the patient at the core of the consultation
The Patient Centred Clinical Interview

Patient presents unwell

Parallel search of two content frameworks

**Content**
- Disease Framework ("Doctor’s Agenda")
- History
- Physical examination
- Investigations

**Process**
- Skills:
  - Attentive listening
  - Question style: open to closed
  - Clarification
  - Summarising
  - Rapport: verbal & non-verbal

**Content**
- Illness Framework ("Patient’s Agenda")
- Ideas
- Expectations
- Feelings

**Integration**
- Problem-Orientated Medical Record Management Plan

Understanding the patient

After McWhinney 1989
THE DISEASE – ILLNESS MODEL

EXPLANATION AND PLANNING

DOCTORS BIOMEDICAL MODEL

PATIENT ICE

PATIENT PROBLEMS
COMMUNICATION SKILLS THAT WE KNOW CAN BE TAUGHT

General “Techniques”
- Verbal and non-verbal communication (Lienard et al, 2010)
  - Focused and open questions, chunking and checking
  - Appropriate responses to patients’ cues
  - Mirroring/matching
  - Clustering, Helicopter, Summarising, Reflecting
- Expressions of empathy
  - Effect diminishes over time without continued training (Fallowfield et al, 2003)
  - Psychopaths
  - Using Tone, Expressing Empathy, Mirror and Matching

Guidance for “Special” Situations
- Delivering bad news
  - Oncology (Fallowfield et al, 2002)
- Motivational interviewing
HOW ARE THESE SKILLS BEST TAUGHT?

- Active small group or 1:1 learning
- Observation of learners
- Video or audio recording and review
- Well-intentioned feedback
- Rehearsal
HOW TO USE YOUR VIDEOS

- Look at use of specific techniques that have been taught
- Raise awareness of “missed opportunities” eg responding to the patients cues
- Raise awareness of NVC not otherwise accessible to the individual
- Run it all through using interview assessment guide
- Play the video with the sound off
- Freeze-frame key moments
ASSESSMENT AND FEEDBACK
Mostly designed for undergraduates

Purpose

- Research
  - Roter Interaction Analysis System (RIAS) (Roter et al, 1987)
  - Conversational Analysis (CA) – (Sacks, 1968)
  - Medical Interaction Process System (MIPS) (Ford et al, 2000)
    Audiotaped analysis utterance-by-utterance

- Medical Education
  - Formative - Teaching
  - Summative - OSCEs
  - Adapted for both
Calgary-Cambridge
  - Designed for undergraduate medics

The 3 +T (beginning middle and end +toolkit)
  - Generic
THE CALGARY-CAMBRIDGE APPROACH
(Suzanne Kurtz & Jonathan Silverman 1996)

(1) Initiating the Session
   a) establishing initial rapport
   b) identifying the reason(s) for the consultation

(2) Gathering Information
   a) exploration of problems
   b) understanding the patient’s perspective
   c) providing structure to the consultation

(3) Building the Relationship
   a) developing rapport
   b) involving the patient

(4) Providing structure to the interview
   a) summary
   b) signposting
   c) sequencing
   d) timing

(5) Explanation and Planning
   a) providing the correct amount and type of information
   b) aiding accurate recall and understanding
   c) achieving a shared understanding: incorporating the patient’s perspective
   d) planning: shared decision making

(6) Closing the Session
The 3 + T - BEGINNING, MIDDLE AND END + toolkit

THE BEGINNING
- Suss things out
  - First impressions
  - MDF or concrete picket fence?
- Build rapport
  - Opening gambits
  - Curtain raisers
  - Active process / Not the same as liking someone
- Establish ground rules

THE MIDDLE
- Eliciting
- Explaining and Planning
- Influencing / Negotiating

THE END
- Forward planning
- Appropriate ending
WHY ASSESS?

- What you decide to assess is the key driver for what learners decide to learn
- Subject becomes relevant to learners
- Fidelity of subject
- Assists funding
- Ensures continuity
ISSUES TO CONSIDER IN ASSESSMENT

- Formative versus summative?
- What are we trying to assess in communication?
- Who does the assessments
FORMATIVE VERSUS SUMMATIVE

Formative
– Informal, ongoing, integrated over time, non-threatening and non-judgemental.
  - Encourages honest and open self reflection.
  - Learners benefit best form well-motivated teachers who are able to offer support and boost confidence.
  - Main purpose is to provide feedback to the learner.
FORMATIVE VERSUS SUMMATIVE

Summative
- Preset times
- Pass / fail
- Based on information at the end of a learning experience
- Implies remediation available to rectify omissions
- Often number of attempts limited
AN ASSESSMENT INSTRUMENT FOR PSYCHIATRY

“FACS”

FORMATIVE ASSESSMENT OF COMMUNICATION SKILLS
Assessment tool key points
- Beginning, middle and end format
- Checklist left hand column
- Objectifiable, non judgemental behavioural descriptors
- Three constructs:
  - Empathy and Sensitivity
  - Verbal Communication
  - Non-verbal Communication
- Competency indicators right hand column
- Anchor descriptors
Communication skills training in Nottingham

- **CT1s** – 20 half day sessions, 2 tutors.
- Early – taught basic skills
- Middle – role play scenarios trainees have encountered, bring videos of patients on rota
- Later – use role play and simulated patients in set scenarios to test communication skills e.g. grief, communication with healthcare professionals, embarrassing subjects.
- **CT2s&3s** – rolling CASC preparation course
Feedback
Set of ground rules to ensure that feedback does not focus on weaknesses but also considers strengths.

- Clarify factual aspects
- Interviewer states what went well
- Observer states what was done well
- Learner states what could be done differently
- Observer states what could be done differently

- Begin with interviewers agenda, then the patient’s agenda and establish to what extent each has been attained.  
- Encourage self assessment and self problem solving first.  
- Involve the others in the group as solvers of the problems identified.  
- Value the interview as a gift of raw material for the group.  
- Opportunistically introduce concepts, research principles and wider discussion.  
- Structure and summarise.
Figure 6.1 How agenda-led outcome-based analysis works in practice.
GIVING EFFECTIVE FEEDBACK

Feedback has two components:
- Content
- Process

It should be:
- Clear
- Timely
- Interactive
- Face-to-face
- Well intentioned
- NON-JUDGEMENTAL e.g. Descriptive
NON-JUDGEMENTAL e.g. DESCRIPTIVE

“I THOUGHT THE BEGINNING OF THE INTERVIEW WAS AWFUL, YOU JUST IGNORED HER”

“AT THE BEGINNING OF THE INTERVIEW, I NOTICED THAT YOU WERE STARING OUT AT YOUR NOTES AND NOT MAKING EYE CONTACT WITH THE PATIENT”
FOCUS ON BEHAVIOUR RATHER THAN PERSONALITY

“I DIDN’T THINK YOU WERE VERY EMPATHIC”

“I COULDN’T TELL WHAT YOU WERE FEELING WHEN SHE TOLD YOU HOW UNHAPPY SHE WAS, YOUR FACIAL EXPRESSION DID NOT SEEM TO CHANGE”
GIVING EFFECTIVE FEEDBACK

ONLY GIVE FEEDBACK ABOUT THINGS THAT CAN BE CHANGED

“YOUR STUTTER MAKES EVERYTHING PAINFULLY SLOW”

“YOU HAVE OBVIOUSLY HAD THE STUTTER FOR MANY YEARS IS THERE ANYTHING WE CAN HELP WITH IN THAT REGARD, OR SHOULD WE JUST ACCEPT AND WORK AROUND IT?”
COMMON PROBLEMS

Unable to develop rapport
Does not cover patient agenda or ICE
Does not use enough open questions
Interruption of patient with closed question
Misses patient cues
Forgets to find out what patient already knows before giving explanation
Gives too much information / jargon at once
Poor / no follow up arrangements
WHAT ARE THE POTENTIALLY DIFFICULT SITUATIONS?

In the learner
Memories of personal experiences reactivated
Performance anxiety
Low self esteem
Fear of being wrong

In the group
Cultural value differences
Misunderstandings
Interpersonal baggage
Power struggles
The “supportive/accepting/acknowledging response”

- Accept (but not necessarily agree) non-judgementally what the learner says
- Acknowledge the legitimacy of the learner holding their own views and feelings
- Value the learner’s contribution

E.g. I can feel how anxious you are – feeling anxious is fair enough.
STRATEGIES FOR DEALING WITH POTENTIALLY DIFFICULT SITUATIONS

- Paraphrase (to check common understanding)
- Re-establish common ground
- Awareness of boundary between group facilitation and therapy important (hold up a mirror to the group)
- Improve self esteem (often low self esteem belies an arrogant persona)
- Work hard to develop a supportive climate through sharing your own strengths and weaknesses, open, relaxed NVC and a clear agenda
- Focus on the primary emotion behind any anger
HANDLING MISTAKES

- Explain that mistakes are OK and that if they do not happen learning will not occur

- Do not say something is wrong, refocus instead
  e.g. “You seem to think the menopausal is the problem, why do you think the LFTs are deranged”?

- If a learner says they do not know, ask others, if no-one knows ask them to guess and provide a few clues
DEALING WITH DISRUPTIVE GROUP MEMBERS

i.e.
Leadership challenge
Unsupportive or critical to colleagues
Refusal to participate
Competitive / over confident
Silence or sullenness
Sabotage
The “out of control group”
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