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DOCTOR-PATIENT
INTERACTION AND COMMUNICATION

Effective doctor-patient interaction and communication is central to doctor and patient satisfaction, to the clinical competence of doctors, and to the health outcomes of their patients. There are indications that many doctors do not communicate effectively in medical practice, and that training in interactional and relationship skills deserves to be included as an important part of medical training. The introduction of training in interactional and communication skills represents a relatively low cost investment considering the high rewards that can be gained for doctors, patients, medical schools and health care.

This document is for the attention of deans of medical schools and chairpersons of medical school curriculum review committees and others concerned with improving the teaching of interactional, relationship and communication skills in medical schools and other institutions for the training of health workers.

The document examines both basic and advanced skills and looks particularly at teaching methods that are learner-centred and experiential in nature. Although this may involve the introduction of new teaching methods into medical schools it usually requires little additional curriculum time and resources.

DIVISION OF MENTAL HEALTH

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DOCTOR-PATIENT INTERACTION AND COMMUNICATION

CONTENTS

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DOCTOR-PATIENT COMMUNICATION: THE CORNERSTONE OF GOOD MEDICAL PRACTICE

There has been much recognition in recent years of the need to include communication and other interactional skills training in medical school curricula[1]. In a consensus statement on communication skills teaching in Canadian medical schools, doctor-patient communication is described as an integral component of quality medical care (see Appendix 6). Holte (1990) described communication as the most important method for primary health care practitioners.

Good doctor-patient communication has been described as the cornerstone of good medical practice (Doherty *et al.* 1990). This may well be the case considering the research findings that 60-80% of medical diagnosis are made on the basis of information arising from the medical interview alone, as are a similar proportion of treatment decisions (Hampton *et al.* 1975, Sandler 1980). The basis of the medical interview is communication and the medical interview is itself the basis of medical practice.

Effective communication is an integral part of diagnosis

Evans *et al.* (1991) found that after taking part in a communication skills course, medical students were more adept at detecting and responding appropriately to patients verbal and non-verbal cues, and were able to elicit more relevant information from patients. In this study, Evans *et al.* demonstrated that students that took part in communication skills training were diagnostically more efficient in that they were significantly better at eliciting full, relevant data from patients, even though they took no longer to elicit the information than their control group counterparts.

Effective diagnosis depends not only upon identifying physical symptoms of illness, but also in being able to identify physical symptoms that may have psychological or social origins requiring different treatment plans.

Better communication enhances patient compliance to treatment plans

Effectiveness of treatment depends not only on accurate diagnosis but also on patient compliance with treatment plans. Research has shown that communication skills training has a positive influence on patient compliance with prescribed medication (Cockburn *et al.* 1987). Non-adherence to prescribed treatment has been described as the most serious health problem in medicine (Ley 1983).

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[1] The term communication skills is used primarily in this document, although it is taken to include the broader concept of interactional skills.

Considering that more and more health problems have been found to be lifestyle and behaviour related, doctors will need to approach medical interviews in a more patient-centred way to encourage motivation and compliance with treatment regimes. Effective communication enables doctors to pass on relevant health information, and to motivate patients to pursue healthier lifestyles, thus enhancing the doctors' role in health promotion and disease prevention.

There are indications that good doctor-patient communication can have an impact on the health outcomes, in terms of the patient's functional status and subjective evaluation of health, as well as psychological outcome measures (Kaplan *et al.*, 1989).

Effective communication contributes to doctor clinical competence and self assurance

Fallowfield (1992) found that better doctor-patient communication can give rise to more rewarding consultations for the doctor both professionally and personally. The Edinburgh Declaration of the World Federation for Medical Education (1988) states that the individual patient should be able to expect a doctor trained as an attentive listener, a careful observer, a sensitive communicator and an effective clinician.

The clinical competence of doctors is in fact, often judged in terms of communication skills, even though communication skills are not usually taught as a formal part of medical training. In a study of surgery students oral examination scores, it was found that there was a significant relationship between scores on communication skills and the overall scores on examinations, suggesting that evaluators are strongly influenced by how well a student communicates (Rowland-Morin *et al.* 1991). In another study, when consultants were asked what they considered were the key attributes of a high quality senior house officer or registrar, communication skills was consistently found to be the most significant factor (Jones *et al.* 1992).

Effective communication contributes to patient satisfaction

Studies have shown that there are significant associations among many aspects of the clinicians' interpersonal skills and aspects of the patients' motivation and satisfaction (Thomson *et al.* 1990). It has been well documented that poor communication on the part of the doctor is a major factor leading to patients' and relatives' dissatisfaction with care. Patients were found to be less satisfied when physicians dominated the interview by talking more or when the emotional tone was characterized by physician dominance (Bertakis *et al.* 1991). This may well be related to changes in patient expectations of the doctors' role, as people see themselves more as active participants in their own health care.

Training in communication skills helps doctors to deal more effectively with sensitive aspects of doctor-patient interaction that are common in practice, but which are usually not included in medical training, for example having to tell a patient that he or she is terminally ill, telling a patient's relative that he/she has died or other instances of giving bad news.

Effective communication may contribute to cost and resource effectiveness

The gains from the introduction of communication skills training contribute to cost and resource effectiveness in health care, given the potential for more accurate diagnosis and better patient compliance with treatment plans. Such improvements could help to prevent unnecessary prescriptions for medication that are either wrongly prescribed or not properly used by patients (Kaplan, 1989; Sandler, 1980). Poor communication leads to accidents and subsequent litigation (Vincent, 1992).

Effective communication is particularly important in conditions of extreme time constraints on medical consultations. The kinds of skills taught in communication skills training can help the doctor to deal more effectively with the need to make a diagnosis and arrive at an appropriate treatment plan and convey this to the patient within the available period of time. In a very busy practice or outpatient department the issue of effective communication needs to be given very serious consideration and strategies devised to facilitate this.

Communication skills training can give rise to institutional gains

Communication skills training can give rise to certain institutional adjustments which may be of value to the medical school. It represents a small investment, and if it is integrated will require little extra curriculum time, whilst providing many benefits.

1. The introduction of communication skills training can result in different disciplines working together to develop and implement the programme and training. This can have positive implications for the medical school as a whole and may even have far reaching implications for the structure of health care systems if it gives rise to more interdisciplinary work.

2. The introduction of communication skills training can be integrated into the structure of the medical school curriculum and in so doing might improve the style of teaching in the medical school. If it is thus integrated into existing parts of the curriculum, with tutors drawn from different disciplines, the teaching of other subjects, using similar methods may follow.

3. The teaching of communication skills allows the introduction of learner-centred teaching methods. This offers optimal conditions for learning and teaching which can have a positive effect on the teaching of other parts of the medical curriculum.

4. Communication skills training for medical students can give rise to improvements in medical school staff performance. As the staff learn effective communication as part of their role as trainers of students, they can become more effective in their own medical practice, as well as becoming better role models for their students.

5. The introduction of this teaching may give rise to new research possibilities in a domain that is increasingly recognised as central to medical training and practice.

6. Communication skills training is a good prerequisite for the introduction of training in areas which require good communication skills, such as training in counselling skills and behaviour change methods.

DO DOCTORS COMMUNICATE EFFECTIVELY?

Simpson *et al.* (1991) have suggested that studies in many countries confirm that serious communication problems are common in clinical practice.

The traditional hypothetico-deductive problem solving routine of medical doctors has been criticized for depending on too many closed questions and not responding to cues from patients (Evans *et al.* 1991). Meuleman & Harward (1992) found that structured evaluation of medical history taking revealed frequent interviewing problems. Similar results were reported by Maguire and Rutter (1976) following a videotape analysis of the history taking of senior medical students, which revealed serious deficiencies in history taking skills. Physicians themselves seem to be aware that communication skills are of great importance and there are indications that they would like additional help with this (Calman & Donaldson 1991; Shea *et al.* 1990).

Such findings are significant considering that poor communication skills have been reported to have adverse consequences on physical, psychosocial and economic aspects of health care (Fallowfield 1992).

As medicine becomes dominated by advanced technology, there is the danger of doctors becoming more distanced from patients. Medical training may actually encourage the process of desensitization to patients' feelings, and have a detrimental influence on the doctors' capacity to communicate effectively with patients. Helfer (1970) found that senior medical students were much more likely than inexperienced students to ask leading questions, avoid emotional aspects of cases, use medical jargon, and ignore important cues.

WHY INVEST IN COMMUNICATION SKILLS TRAINING?

Communication skills training: a small investment with great potential gains

As already discussed, communication skills is a relatively small investment in time and resources in comparison with the considerable potential benefits for patients, doctors, medical schools and health care systems.

The feasibility of communication skills training has been widely demonstrated

The ability to communicate is a basic human skill. As with any other skill, some people show more natural aptitude than others. However, skills can and should be improved. Appropriate training in communication skills has been shown to improve the communication of the trainees (Bird *et al.*, 1993; Kahn *et al.*, 1979; Sanson-Fisher *et al.*, 1991).

The teaching of communication skills has become one of the most emphasized and rapidly growing sectors of medical education in recent years. There are courses for undergraduate medical students, which are usually taught before the students move from pre-clinical to clinical training. In such courses communication skills are taught as a part of learning about history taking and conducting a medical interview. There are examples of communication skills being taught in this way in medical schools in Britain (Bird *et al.* 1993, Joesbury 1990), in Ireland (Doherty *et al.* 1990), the US (Kahn *et al.* 1979), and in Australia (Sanson-Fisher *et al.* 1991). Communication skills training courses being implemented in Australia and Lithuania are outlined in appendices 4 and 5 of this report.

Other courses have been developed to respond to the more specific needs of interns and of students during clinical training. In such courses, communication skills are taught in the context of specific aspects of doctor-patient interaction. Effective communication has been taught as a way to encourage adherence to treatment regimes, and for the giving of bad news (Sanson-Fisher *et al.* 1991). Communication skills have also been taught as a part of the curriculum of a freshman emergency medicine course (Burdick & Escovitz 1992); to strengthen medical school training in STD prevention (Steinberg *et al.* 1991); as a part of a curriculum in the care of the terminally ill (Bulkin & Lukashok 1991); to strengthen medical school training for working with deaf patients (Smith & Hasnip 1991), and mentally retarded adults (Harper & Wadsworth 1992). In one department of paediatrics in the US, it was found that 24% of all medical care contacts are made on the telephone. Because of this, interpersonal telephone communication training was included as part of residency training (Kosower *et al.* 1991).

Communication skills training has been shown to improve doctors' communication skills

A review of communication skills training for medical students and general practitioners found many reports of success of communication skills training worldwide (Moorhead 1992). Tamburrino *et al.* (1990) showed that even a brief small group interviewing course can effect a positive change in student's communication skills. Roter *et al.* (1990) found that residents trained in communication skills asked more open-ended questions and fewer leading questions, summarized main points more frequently, did more psychosocial counselling, and were rated as having better communication skills by a simulated patient.

There are indications that communication skills training is not being given its rightful place as an important part of medical training. In a review of communication skills training in British medical schools (Frederikson & Bull 1992), it was found that although all survey respondents provided some form of communication skills training, relatively few are committed to formal instruction, assessment, and evaluation of the subject within the medical curriculum. There is much evidence to suggest that medical school curricula should include the teaching of communication skills as a core component of medical training.

THE CONTENT OF COMMUNICATION SKILLS TRAINING

What should be taught in communication skills training?

The following section outlines the aspects of communication that are most often looked for in effective doctor-patient communication. Although this is likely to vary across cultures and settings, these points could help to identify criteria for effective doctor-patient communication, and therefore what should be taught in communication skills training in medical schools. The rating scales provided as appendices to this report can also help to illustrate those aspects of communication that are considered to be important. Within any cultural setting, it would be advisable for a group of physicians, together with other relevant professionals, to identify particular behaviours that constitute good practice with regard to the core communication skills for that particular culture. For some of these, particularly interpersonal skills, it would also be appropriate to convene a group of people representing the consumers of health services, who could identify aspects of a consultation that they consider desirable. The information generated by such groups could be used to help develop (a) specific learning objectives with regard to the various components of good communication skills (b) rating scales which could be used to assess student performance in this field, both for providing feedback to students during training and for more formal assessments of competence.

Students need to acquire certain core and advanced communication skills. For training purposes it can be useful to group these as follows.

Core communication skills

- Doctor-patient interpersonal skills
- Information gathering skills
- Information giving skills and patient education

Advanced communication skills

- Skills for motivating patient adherence to treatment plans
- Other applications of core communication skills in specific situations

CORE COMMUNICATION SKILLS

Doctor-patient interpersonal skills

Doctor-patient interpersonal skills refer to the basic skills which help create effective helping relationships.

A training in doctor-patient interpersonal skills should aim to produce a basic level of competence in the following areas:

Appropriate physical environment

The need to establish an appropriate physical environment to enhance privacy, comfort and attentiveness. Small things like arranging seating in a manner which is neither threatening nor distant, or having a curtain to create a sense of privacy will improve the outcome of the interview.

Greeting patients

Greeting patients in a manner acceptable within the cultural norms relating to age, sex, etc. will help maintain their dignity and encourage their participation. Using patient's name as appropriate where the patient is known to the doctor, offering an appropriate signal of recognition ("How are the family?" "How was your holiday?" "You're looking better today" etc).

Active listening

This involves using both verbal and non-verbal communication techniques. The doctor should clearly signal that the patient has his/her full attention by look, by offering acceptance and continuation signals such as nods, phrases such as "right"/"I see" etc. A willingness to listen actively is however best signalled by use of open questions to promote fuller answers.

Empathy, respect, interest, warmth and support

These issues are at the heart of interpersonal skills. They cannot easily be faked, and if doctors do not have them, they cannot easily be taught things to *do* by way of improving them. Success in this area is not a matter of skills but of attitude. However, doctors should clearly signal their interest in how the patient's problem is perceived by the, how it affects their life, whether it concerns them, what their hopes and expectations are. Doctors can confirm their patient-centredness with phrases like "That must be nuisance for you", and should ask questions to discover patient perception "Does the thought of the operation worry you?". The doctor should also learn to show respect, interest, warmth and support. this will also involve being non-judgemental in attitude.

Language

Doctors should monitor the level of jargon they use rather than abandoning it ("You've got appendicitis" is appropriate for most adults but not young children etc), should monitor the difficulty of any explanatory language they use, particularly in explaining diagnosis and the reasoning behind it and suggestions for management and the reasons behind them.

It is also important for doctors to monitor their use of potentially frightening words "Cancer"/"lump" etc. even a negative use ("We can rule out cancer") might sometimes raise

more fears than it allays, if the possibility had never occurred to the patient. And they should also monitor the certainty with which they offer opinions, so that patients are not misled by spurious certainty, nor left uneasy by apparent doubt in the doctor's mind.

Non-verbal communication

Skills in non-verbal communication like eye contact, physical proximity, and facial expression need to be monitored with feedback to the students to help them improve their interactions. This should convey to the patient that the doctor is attentive and interested.

Collaborative relationship

It is important that patients should feel that the doctor clearly understand their needs, and is prepared to work with a patient to achieve them. This will occur where the management plan clearly arises from careful explanation of options and a full understanding of needs, which lead to informed negotiation.

Closing the interview

In addition to the skills of setting up, beginning and continuing an interview, the way of closing the interview is also important. The doctor should clearly signal that the interview is drawing to a close, usually by summarising what has been said and what has been negotiated.

In the teaching of interpersonal skills it is important to address issues that will affect the way we communicate with others, for example gender, cultural and socio-economic factors which affect perceptions of norms and standards of appropriate communication.

It is also essential for students to realize that what is needed is not only to know how to recognize a disease, but also how to recognize and to respond to a patient's emotional response to their disease. In their interactions with patients, it is important for the students to be aware of patients' emotional responses to their situation and at the same time to be aware of their own emotional reactions toward the patients.

Information gathering skills

A critical part of all doctor-patient interactions involves eliciting information from the patient. The core skills which are needed to facilitate the process of information gathering are skills which help to facilitate the patients' involvement in the medical interview in a way that enables the doctor to arrive at an accurate diagnosis of a patient's problem or symptoms.

Using an appropriate balance of open to closed questions

Open questions invite an extended answer, not a "Yes/No" response. Generally open questions such as "Please tell me about your pain" are better at eliciting information than are closed questions such as "Is it a stabbing pain?". Open questions are particularly useful when patients are being asked to describe their problem; which they should be allowed to do with minimal interruption early on in the consultation.

Silence

Students need to learn to use silence appropriately as a way to encourage patients to express themselves more fully, raise difficult topics and remember important information.

Clarifying patient expectations about the consultation

Students need to clarify with the patient what their expectations are about the consultation, and should avoid making premature conclusions about the reason for the person's visit to the doctor. This may helps to reveal cases where the symptom presented by the patient is not in fact the patient's main concern. The latter may be called a "hidden agenda", which if not identified could result in inaccurate diagnosis of the patient's problem.

Clarifying the information given by the patient

Students need to clarify the meaning of what the patient is saying and the signals that the doctor perceives from the patient's non-verbal communication in order to ensure that he/she understands the patient fully.

Sequencing of events

After eliciting a broad description of the patient's situation, students need to learn how to help the patient to sequence events and experiences in order to develop a logical picture of the patients situation.

Directing the flow of information

While it is important that patients be allowed the opportunity to communicate freely, at the same time the student needs to learn to maintain control of the interview, by tactfully guiding the interview content towards a diagnosis of the problem.

Summarizing

Since a lot of information can be exchanged in consultations, the student should learn to summarize the main issues raised during the consultation and should ensure that there is a shared understanding of these.

Information giving skills and patient education

The medical interview usually involves the doctor in providing information to the patient about their illness or problem, and when appropriate the doctor will give information and advise about the proposed treatment plan or treatment options.

Providing clear and simple information by monitoring jargon, difficulty and certainty as above, and by checking the patient's understanding before ("What do you know about asthma?") and during ("Have I made myself clear?") the explanation process.

Using specific advice with concrete examples. Abstract or general advice/ information should be exemplified and contextualized in terms that make sense to the patient "Don't eat acidic foods for example steer clear of fried things".

Putting important things first. Research suggests that what is said first is best remembered. A doctor should say first what it is most important for the patient to recall.

Using repetition. Repetition should be used carefully,a t a level appropriate to the patient. Often it is best to recycle information using slightly different words, in case the first formulation has been only partly understood.

Summarising. This is an important interview-closing skill (see above). Summaries should be brief, and repeat the main points agreed in language which is unambiguous and clear. Patients may also be invited to repeat the doctor's instructions to ensure that there is shared understanding.

Categorising information to reduce complexity and aid recall. Where the information to be conveyed is complex,. or where there is a lot to be said, it should be clearly broken down into manageable units which are clearly signalled to the patient, using markers such as "there are three things we need to think about ... firstly/secondly/thirdly etc".

Using tools. Where the information is complex, or is simply best given in this way - for example explaining and locating the site of an ulcer - diagrams can be very helpful. Complex information could well be accompanied by a series of heading jotted on a piece of paper as an aide-memoire and or followed up by a letter. Some doctors offer tape recordings of their consultations to patients where the information has been intellectual demanding or psychologically distressing.

Checking patient understanding of what has been said. Repeating important instructions, using diagrams, written instructions, and sometimes technical aids to explain difficult concepts are useful. The student must be competent in summarising the information given and in checking patient understanding by asking the patient to repeat what they have heard and understood.

ADVANCED COMMUNICATION SKILLS

Skills for motivating patient adherence to treatment plans

Information giving skills, described earlier, will contribute to patient adherence to treatment plans by making sure that the patient has understood the relevant information about the diagnosis and proposed treatment. Additional ways to promote patient compliance are described below. This list includes skills for the promotion of behaviour change, since realistic compliance with treatment plans may require patients to make significant changes to their diet, lifestyle or daily routine on a short term or long term basis.

Providing a rationale for behaviour change
Tailoring the treatment to suit the patient's lifestyle
Countering barriers to change
Providing examples of role models
Allowing opportunities for verbal rehearsal of the details of the treatment regime
Feedback (positive reinforcement of constructive behaviour changes already achieved since earlier consultations)
Understanding how the patient explains the illness and phrasing communication with the patient to take account of this.

Other applications of communication skills in specific situations

Core communication skills can be taught as a way to improve doctor-patient communication in medical interviews that are complicated by factors that affect the way in which the patient communicates, as described below. For such situations the doctor may require higher levels of competence in core communication skills, for which additional training sessions may be required. Advanced level training programmes could be developed for further training at the undergraduate or postgraduate level. In addition, the WHO Division of Mental Health has prepared a number of modules dealing with specific situations and problems which require advanced communication skills. These are listed in Appendix 7 of this document. At the very least, medical students should be made aware of the problems that require more advanced communication skills, as well as the potential scope of effective communication.

1. Special groups of population:

   - with language and cultural differences
   - with families or couples

2. Special groups of disorders:

- disabled (blind, deaf, paraplegic, etc.)
- mentally retarded
- chronically ill
- terminally ill
- depressive and/or suicidal patients
- AIDS
- STD's
- chronic pain
- speech impediments
- problems of addiction
- somatoform disorders
- neurotic disorders

3. Special personality problems:

- non-cooperative patients
- hostile patients
- overdependent patients
- inhibited patients
- overdefensive patients

4. Special clinical situations:

- giving bad news
- dealing with sensitive issues (sexual, etc.)
- telephone contact
- preparation for threatening diagnostic and/or treatment procedures (e.g. vaginal examination, surgery, etc.)
- when speaking to others (eg. relatives) about a patient
- the very short contact*

* *The very short contact.* It is recognized that in some countries the amount of time a patient and doctor have in contact with each other is extremely limited. Constraints may also include lack of space and lack of privacy, with tens of patients crowding a room or crowding around the doctor's table. Doctor-patient communication skills can help a clinician be more efficient and effective particularly when such constraints exist. Using communication skills and being innovative can enhance the outcome of the consultation e.g. using a curtain/screen, or a specific chair to single out the patient currently being seen, focusing full attention on that patient, using appropriate non-verbal communication, and clarifying comments. One may have to prioritise patients for additional interviewing and call them back at a more convenient time. More effective use of paraprofessional staff may promote better communication.

Experience in training those involved in such short contacts has been that most clinicians start by doubting the relevance of doctor-patient communication skills to such a situation, but then perceive the advantages of using such skills as training progresses.

METHODS OF TEACHING COMMUNICATION SKILLS

The characteristics of effective teaching and learning procedures have been summarised using the acronym ASPIRE, as below (Harrison and McIntosh, 1989).

A (Activity) The more goal-related activity each learner engages in, the more they are likely to learn.

S (Support) A supportive atmosphere allows risk taking and mistakes which are integral to learning.

P (Partnership) Learning is enhanced when tutors and learners have an active partnership, learning from and with each other.

I (Integration) Learning is facilitated by links between new material and the experience and interests of the learners.

R (Reflection) Learning is consolidated when learners review and reflect on the meaning of new material.

E (Explicitness) Clear agreement about goals and methods promotes effective learning.

The fundamental principle of the teaching of communication skills is that the methods used should be congruent with the subject matter. As the subject matter chiefly consists of practical skills, the teaching should be practical. In the case of skills teaching, this means that the teaching methods should be primarily experiential. This emphasis on experiential learning is the most distinguishing feature of communication skills training . In experiential learning, students are actively engaged in the learning process, working in partnership with other learners and/or teachers. The core aspects of the communication process should be taught and practised in a supportive learning environment.

It is important to ensure adequate time for feedback and reflection on the performance of students during experiential learning activities. Much practice, repetition and feedback is required to ensure adequate learning of the skills.

It is also important to set clearly defined objectives for the skills learning and that clear criteria are established against which performance can be measured.

The key methods used in communication skills training are described below, other methods include lectures, written materials and small group discussions.

Student-patient interactions

Most medical schools provide clinical teaching opportunities for students to work with real patients at some point in their training. These clinical teaching sessions allow the opportunity to teach, practise and assess students' communication skills in conjunction with learning, practising and assessing other clinical skills. This will help integrate communication skills into everyday professional behaviour.

Modelling

Tutor models

Tutors can demonstrate appropriate communication skills in classroom settings, with real or simulated patients.

Clinician models

Clinicians in medical settings usually serve as role models for medical students. It is thus highly desirable that clinicians' own communication skills reflect those which students are being taught.

Video film models

Professionally produced videotape films can be shown to students to demonstrate appropriate communication skills. And likewise, video films can be used to demonstrate and discuss inappropriate, undesirable doctor-patient communication.

Modelling needs to be combined with practice of and feedback about, the skills that have been demonstrated.

Role play

Student role plays with other students are very effective and a relatively inexpensive method of providing opportunities for practise and feedback about skills. Students can work in threes and each take turns in role playing the doctor and patient and being the observer for a number of medical scenarios. This approach allows students to experience the patient role: helping them to become more sensitive to patient needs, and giving them an insight into the patient's impression of the medical scenario that is being role played, allowing the opportunity for immediate feedback from the "patient" that they have interviewed.

Simulated patients can also be used to provide opportunities for students to practise their communication skills. Simulated patients are people who are trained to play the role of

a particular patient. They are given a brief script and they role play the type of patient described e.g. a patient who has been undergoing tests for cancer. The student is also given a brief script such as to play the role of a doctor who has to advise the patient in an informal and non-threatening way.

Because simulated patients are usually paid to do this work, this may be an expensive teaching method, but it allows the opportunity to standardize the patient presentation. It is thus particularly useful for assessment situations.

Feedback

Role plays can be even more effective if videotaped and then used for providing structured feedback in small group sessions with a trained tutor. The videotape process allows the student the opportunity to see their own communication patterns as others see them. This is potentially a very powerful form of feedback and care should be taken to ensure that appropriate guidelines are followed for delivering feedback to the student. (see last section on Formative Assessment.)

Appropriate feedback techniques are crucial for effective teaching. In order that feedback be accepted by, and useful to the student, the following guidelines can be followed (based on rules for giving feedback, Pendleton *et al.* 1984).

a. Feedback should be given as immediately as possible after the learner's contribution.
b. The learner should be assisted in giving feedback on his/her own performance before the assessor provides feedback.
c. Successful aspects of the person's communication should be mentioned first.
d. Less successful aspects of the person's communication should not be referred to in critical or judgemental terms, but rather as, for example, "things which might be worth doing differently" and specific recommendations should be suggested.
e. Feedback should be as specific and concrete as possible, referring to actual examples of the student's behaviour, rather than giving broad generalizations or comments on the student's personality characteristics.

Sources of feedback can include: the patient/simulated patient; clinicians, tutors, other staff, other students, and even feedback by self-assessment (via personal videotaping of consultations and assessment against written criteria).

Dealing with students' personal problems which may emerge in training

During communication skills training personal issues may arise which are sensitive or painful for the student. Support needs to be provided throughout the teaching process. The tutor however must keep in mind the difference between support and therapy. The latter should be made available through separate therapeutic facilities, and preferably, by other specialists. It should not be attempted as part of the teaching.

When to teach communication skills

Communication skills training should begin when the students are most receptive, i.e. early in medical training. Some medical schools might prefer to start communication training by giving an introductory course in basic communication and then move on to medical communication. Other schools may prefer to begin training immediately with a medically oriented communication skills course. Because the effects of communication skills training tend to decline during medical training, there should be reinforcement and opportunities for further development of such skills throughout medical training at both undergraduate, postgraduate and continuing education levels.

TRAINING OF TRAINERS

Training in communication skills requires special input from the medical faculty. For most medical schools, communication skills will be a new aspect to training, for which faculty staff will need specific teaching skills. A major recommendation of the Wold Summit on Medical Education (World Federation for Medical Education, 1994) on communication with patients states within it that teaching staff should be appointed who are competent to ensure the promotion of communication skills.

It is suggested that 2 levels of training are desirable. The first level comprises teachers with competence in communication skills and teaching techniques who can become core trainers for communication training for a broad range of teachers in the medical school. The second level comprises a larger number of teachers from various disciplines/specialities who can support the actual training of the students in communication skills, and ensure that the lessons learnt in the training programme are applied and reinforced throughout the curriculum. Unfortunately, most teachers in medical schools will not have had the opportunity themselves for formal communication skills or teaching skills training. Training in these areas may therefore improve their efficiency and efficacy both as teachers and as clinicians.

It is thus desirable to identify a core team of teachers within the faculty of each medical school. Teachers trained in communication skills are sometimes already available within some medical schools. However, it is recognized that many medical schools may not have such staff and it may be necessary to create such a resource by providing training from outside. Interested faculty members who are known to be good communicators and good teachers could be trained to form this core group of trainers.

Medical school faculty should consider whether training in communication and teaching skills should be a requirement for all its members. If it is not possible to offer all staff the training, then it is at least desirable that a number of key faculty members be involved in the communication skills training. It is recommended that all new junior clinical appointees should receive communication skills training.

The training

The training of trainers should be done in such a way that the process models the style and methods of training that they would be expected to use with students. This is indeed the best way to illustrate the methods that are being taught.

It is recommended that the training takes the form of experiential workshops run by facilitators who are known to have relevant skills. These workshops usually need to be of several days duration.

The goals of these workshops can be to impart core communication skills (as already defined) and core teaching skills, e.g. feedback techniques, use of audiovisual aids, understanding and managing small groups, and using models of different teacher-student interactions.

The training workshops would probably involve a variety of group learning formats (e.g. whole group lecture, small group discussion, work in pairs). The content of training would be designed to include the following:

1. Initial *orientation* giving the outline of the aims and methods of the training.
2. *Demonstration* of particular communication and teaching skills.
3. *Practice* of both communication and teaching skills by all participants with constructive feedback in a supportive learning environment.
4. *Discussion* of personal factors which may inhibit or distort communication and teaching.
5. Opportunity of access to relevant reading materials for the necessary *background knowledge.*

It is recommended that the training be evaluated with some structured assessment. The communication and teaching skills of participants could be assessed before and after the course, and the course content and training could itself be assessed.

ASSESSMENT OF COMMUNICATION SKILLS TEACHING

Student assessment

As with all other clinical skills, assessment of communication skills has the dual function of educational feedback for the student (formative assessment), and the rating of competence of performance as a part of student evaluation (summative assessment). Assessment therefore forms an integral part of the teaching of communication skills by both supporting the learning process, and formally testing whether the students have met the learning objectives that were set. Formal assessment can contribute both to the course development, and the students' own perceptions of the importance of the subject. Inclusion of assessment should therefore drive both the teachers and the students to perform better.

Any assessment of students must depend upon the agreed objectives of the teaching. Assessment of communication skills should therefore be developed for each institution, since the total amount and specific components of teaching will differ between institutions.

Formative Assessment

Informal feedback on performance

As a minimum assessment of the communication skills of medical students, feedback of performance can be provided by student peers. To ensure that informal feedback is as meaningful as possible, guidelines on how the feedback is to be given, and criteria which specify the style and content of a good student-patient interactions could be made available to students.

Standardized assessment

This would be formal assessment of communication skills using a variety of objective, standardized evaluation methods. Structured assessment should primarily test the performance skills. Ideally, standardized assessment should involve testing actual, rather than potential, performance. To test performance, objective assessment must involve direct observation of the student, as is the case in assessment of other clinical skills (such as examining the patient's abdomen).

The assessment could be of individual components that are considered to make up communication skills, for example general issues (e.g. manner of consulting) or specific interview skills (e.g. introductions, information gathering, information giving). Knowledge base and attitudes related to communication skills can also be evaluated in written examinations, although, ideally, this should be considered only as an addition to performance-based evaluation.

Methods of objective structured assessment can include observation of student consultations or assessment with patients or simulated patients. Performance should be assessed according to stated criteria of competence (informed by the medical school objectives for communication skills). Where there are relatively few teachers skilled in communication skills or there are other logistic problems preventing direct observation, then faculty staff might consider using students' performances on videotape (or audiotape as a second-best) for assessment reviews at a later date. When assessing communication performance with either real or simulated patients, the use of rating scales and checklists is important to increase objectivity. Examples of such scales are included as appendices to this report (see Appendices 1-3).

Another method of standardized assessment can be provided by using the Objective Structured Clinical Examination (OSCE), which has been used in some medical schools as a way of testing students' clinical skills. OSCE involves the use of various different "test stations" with a different task set for the student at each testing point or 'station'. At each "station" students will typically be allowed five minutes to perform a single defined task often set out as case descriptions or vignettes. For example, a student may be asked to encourage a simulated patient to consent to an invasive medical procedure. During an OSCE, students may be assessed by student peers, by the simulated patient, or by direct observation by an examiner, and assessment is made in terms of previously determined criteria on a marking

schedule/rating scale. This method of assessment can have the advantage of presenting a standard task for each student which should have the same degree of difficulty for all.

Another source of evaluation is from patients themselves. However, research findings suggests that patients are poor discriminators in evaluating medical students, because they tend to rate all students favourably (Henkin *et al.* 1990, Feletti & Carney, 1984). It seems that feedback from patients may be falsely reassuring.

Summative/End Point Assessment

In setting criteria by which students are rated in communication skills, the medical school can require that all students obtain a minimum standard of competence in communication skills. The medical faculty may stipulate this as a barrier exam, so requiring competence in communication skills as one of the minimum requirements for progressing through medical training and ultimately qualifying.

Schools where there is an assessment of student performance at the end of clerkship should be asked to specifically include communication skills in any clinical assessment. Any evaluation of clinical skills should also include an assessment of communication skills in that particular field. Where the school evaluates students using a structured or semi-structured evaluation it should include communication skills as an item.

Ideally, demonstrated competence in communication skills should become an essential component of all assessed clinical examinations. This should therefore become a part of the assessment of all long or short clinical cases taken on by students. Formal assessment of communication skills would then become integrated within the teaching or assessment of other clinical skills.

In institutions that develop the OSCE method as described above, this can provide a method of end point assessment. Such objective examinations help to standardize the assessment of students, and it becomes possible to provide the same examination for all of the students.

EVALUATION OF THE COMMUNICATION SKILLS TRAINING PROGRAMME AND TEACHING

Assessment of communication skills training should evaluate the success of the training programme in meeting predetermined educational objectives. Monitoring of student performance is one way of evaluating a training programme, since inadequate performance in communication skills by students could well indicate that there is inadequate teaching of communication skills. However, assessment of the training programme should also include the assessment of the teaching skills of the tutors that run the training sessions, and assessment of the actual content of the training. As with student assessment, evaluation of the training programme and teaching requires that explicit objectives are agreed for the communication skills training programme and teaching prior to the assessment.

Ideally, there would be some assessment of teacher training skills prior to their involvement in the teaching of students. Although this might not always be feasible in the early stages of running training sessions, evaluation of the tutors' teaching skills should be treated as an important aspect of ensuring a successful communication skills training programme. New junior clinical appointees could be asked to take a communication course, possibly including teaching skills in addition to skills necessary for interaction with colleagues as well as patients. This can improve their skills and also widen the range of future teachers in communication skills.

Such assessment will usually include some form of student feedback (questionnaire survey or rating scale) and feedback from other colleagues.

SUMMARY OF RECOMMENDATIONS

1. Criteria for effective doctor-patient communication should be established and this would determine the learning objectives for communication skills training.

2. The learning of communication skills should be largely experiential. The core learning process should include demonstration and practice of communication skills with feedback on performance in a supportive learning environment.

3. Every medical school should have a communication skills programme, with some form of appropriate interdepartmental committee to oversee its application, with clear terms of reference and responsibilities.

4. Communication skills courses should be introduced when the students are most receptive, i.e. early in medical training. Because the effects of communication skills training tend to decline during medical training, there should be reinforcement and further development of communication skills throughout training at both undergraduate, postgraduate and continuing education levels.

5. The communication skills teaching should be linked with appropriate assessment, for example, with the use of rating scales/questionnaires (see appendices 1-3). An assessment of their communication skills should ideally be carried out and fed back to the students throughout their time in medical school. It should be included as a component of any assessment of their clinical skills. It is also desirable that an objective practical assessment of communication competence should be a requirement for registration as a medical practitioner.

6. This document should be made available to all chairpersons of medical school curriculum review committees.

7. Selected medical schools in each region should be designated as teacher training centres for communication skills training.

8. Each Dean of a medical school should identify a small team of potential core trainers in communication skills, drawn from diverse disciplines.

9. Regional workshops should be organised for training at least one of the core trainers from each medical school.

10. Core trainers in each school should identify a group of support trainers from diverse disciplines, whose function would be to take the lead in training the students.

For further recommendations, see Appendix 6, the Consensus Statement of the Workshop on the Teaching and Assessment of Communication Skills in Canadian Medical Schools, 22-24 March 1992. This paper outlines further recommendations and requirements for communication skills teaching, that may be aspired to, although they are not necessarily relevant in the early stages of communication skills training programme development.

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APPENDICES

Rating scales/questionnaires are included to illustrate the kinds of points that could be evaluated in the assessment of the communication skills of medical students (appendices 1-3). Appendices 1 and 2 were developed for the evaluation of students that took part in communication skills training programmes in the UK and Australia, respectively. Appendix 3 has been adapted from a rating scale that was originally developed for the assessment of video recordings of general practitioners in the UK.

These examples may serve as a useful starting point from which to develop culturally relevant and appropriate rating scales to assess the communication skills of students in medical schools where communication skills training programmes are being developed and implemented.

Appendices 4 and 5 describe two quite different approaches to the teaching of communication skills to undergraduate medical students.

Appendix 6, the Consensus Statement of the Workshop on the Teaching and Assessment of Communication Skills in Canadian Medical Schools, 22-24 March 1992, outlines further recommendations and requirements for communication training programmes that may be aspired to. The list of references for this statement have not been included, but most appear in the main list of references for this document (page 22).

APPENDIX 1

Communication skills score sheet

INTERVIEWER ..... RATER ..... DATE .....

FUNCTION	SKILLS	YES				NO	NOT APPL	COMMENTS
Starting the interview	Greets and seats warmly	5	4	3	2	1	NA	
	Intro comments (purpose, constraints, etc)	5	4	3	2	1		
	Other	5	4	3	2	1	NA	
DATA GATHERING	Enough open questions	5	4	3	2	1	NA	
	Avoids leading or multiple questions	5	4	3	2	1	NA	
	Facilitation as needed	5	4	3	2	1	NA	
	Clarification as needed	5	4	3	2	1	NA	
	Non verbal attention	5	4	3	2	1	NA	
	Other	5	4	3	2	1	NA	
Guiding the interview	Interrupts if needed	5	4	3	2	1	NA	
	Praises helpfulness	5	4	3	2	1	NA	
	Directs if needed	5	4	3	2	1	NA	
	Other	5	4	3	2	1	NA	
EMOTIONAL SUPPORT	Helps ventilation	5	4	3	2	1	NA	
	Right quality & quantity of:							
	- empathic statements	5	4	3	2	1	NA	
	- respect statements	5	4	3	2	1	NA	
	- reassurance statements	5	4	3	2	1	NA	
	Non-verbal responsiveness	5	4	3	2	1	NA	
	Other	5	4	3	2	1	NA	
MANAGEMENT	Clear explanations	5	4	3	2	1	NA	
	Clear instructions	5	4	3	2	1	NA	
	Checks understanding	5	4	3	2	1	NA	
	Explores compliance	5	4	3	2	1	NA	
	Praises coping	5	4	3	2	1	NA	
	Fosters partnership	5	4	3	2	1	NA	
	Positive attributions	5	4	3	2	1	NA	
	Other	5	4	3	2	1	NA	
Closing the interview	Warns of ending	5	4	3	2	1	NA	
	Summarises well	5	4	3	2	1	NA	
	Invites comment	5	4	3	2	1	NA	
	Checks next step	5	4	3	2	1	NA	
	Ends punctually	5	4	3	2	1	NA	

APPENDIX 2

The University of Newcastle
Faculty of Medicine
Bachelor of Medicine

Year 1 (rev 92)

Professional skills - medical interview assessment form

STUDENT: ..... DATE: .....

ASSESSOR: .....

		TICK OR COMMENT SATISFACTORY OR NOT SATISFACTORY
1.	**Greeting**	
-	introduces self (name and role)	.....
-	elicits patient's name preferred form of address	.....
-	states purpose of interaction	.....
2.	**Setting the Scene**	
-	optimises the environment (seating arrangements, physical barriers, distractions)	.....
-	puts patient at ease (physical comfort, emotional distress)	.....
-	introduction enquiry re current state (e.g. "How are you feeling?" or other appropriate comment)	.....
-	conveys interest and concern (eye contact, posture, actions, responds appropriately to result of introductory enquiry)	.....
3.	**Opening Survey of Problem(s)**	
-	invitation to state problem(s)	.....
-	appropriate use of silence	.....
-	balance of open-ended vs closed questions	.....
-	use of facilitation, clarification, other subsidiary techniques	.....
-	balance of patient spontaneity vs interviewer control	.....

4. Delineating the Present Illness

- organises the flow of the interview around a narrative thread .....
- elicits details of symptoms (bodily location; quality; quantity; chronology; context; aggravating or relieving factors; associated manifestations) .....
- develops the life context of the patient .....
- pursues hypotheses .....
- uses appropriate methods of enquiry (see 3 above) .....

5. Interaction Skills

- student presentation (appearance and behaviour, including self-assurance, confidence, professionalism) .....
- speech and use of language (especially clarity) .....
- quality of rapport (warmth; sensitivity; attentiveness; concern; empathy; attitude to patient, e.g. respectful, non-judgemental, etc) .....
- management of sensitive/personal issues .....
- handling of time constrains .....

6. Closing the Interview

- review as necessary .....
- asks if there is anything the patient has not mentioned which may be important .....
- asks if patient has any questions .....
- use of explanation, reassurance .....
- attends to future arrangements as necessary .....
- taking leave .....

OVERALL RATING: NOT SATISFACTORY SATISFACTORY

ASSESSOR'S SIGNATURE: .....

APPENDIX 3

Adapted from a scale presented in Cox, J. and Mulholland, H. (1993) An instrument for the assessment of videotapes of general practitioners' performance. British Medical Journal. 306, 1043-1046

Tick the box in each scale that most closely describes the extent of agreement with the statements at each end of the scale. If they have insufficient information to give a mark they write X in the box.

	Insufficient information	Extent of agreement	
The student concentrates on records, computer or elsewhere than the patient, avoids eye contact.	☐	☐ ☐ ☐ ☐ ☐	There is eye contact between student and patient most of the time
The student is relaxed and tolerant	☐	☐ ☐ ☐ ☐ ☐	The student is tense / uncomfortable / impatient irritated /rude /loses temper / has irritating habits
The student is cold / distant / frightening / unfriendly / abrupt / sarcastic	☐	☐ ☐ ☐ ☐ ☐	The student smiles / is warm / friendly / pleasant / touches patient when appropriate
The student is authoritarian / patronising / judgemental / moralising / pompous / condescending	☐	☐ ☐ ☐ ☐ ☐	The student is humble / approachable / flexible / treats the patient as an equal
The student wastes time	☐	☐ ☐ ☐ ☐ ☐	The student uses time efficiently
The student answers questions	☐	☐ ☐ ☐ ☐ ☐	The student ignores or evades questions
The student considers patient and family history / background	☐	☐ ☐ ☐ ☐ ☐	The student makes incorrect assumptions / jumps to conclusions
The student is not courteous	☐	☐ ☐ ☐ ☐ ☐	The student is courteous

The student allows patient opportunity to discuss their problems	☐	␣ ␣ ␣ ␣ ␣	There is no opportunity for the patient to discuss other problems with the student
The student is reassuring / encouraging /decisive / inspires confidence	☐	␣ ␣ ␣ ␣ ␣	The student fails to reassure the patient or inspire confidence / indecisive / overconfident
The student ends the consultation well	☐	␣ ␣ ␣ ␣ ␣	The end of the consultation is rude / prolonged / abrupt
The student explores patient's ideas / concerns / expectations	☐	␣ ␣ ␣ ␣ ␣	The student ignores the patient's ideas / concerns / expectations / fails to recognize reason for consultation
The student is empathetic	☐	␣ ␣ ␣ ␣ ␣	The student disregards / dismisses /trivialises patient's views / feelings
The student uses inappropriate language / medical jargon / swamps patient with information	☐	␣ ␣ ␣ ␣ ␣	The patient understands the student
The student listens to the patient / looks interested	☐	␣ ␣ ␣ ␣ ␣	The student ignores the patient / talks too much / is offhand / aloof / uninterested / bored
The student allows time for the patient	☐	␣ ␣ ␣ ␣ ␣	The consultation is hurried / rushed
Allowing for the nature of the consultation the patient appears to be as relaxed / at ease as possible	☐	␣ ␣ ␣ ␣ ␣	The patient appears unnecessarily uncomfortable / confused / dissatisfied during the consultation
The student is confused / contradictory / disorganized /dithers / fumbles	☐	␣ ␣ ␣ ␣ ␣	The consultation is logical / well organized
The student interrupts the patient unnecessarily	☐	␣ ␣ ␣ ␣ ␣	The student does not interrupt the patient inappropriately

APPENDIX 4

The University of Newcastle
Faculty of Medicine
Bachelor of Medicine

Year 1 (rev 92) 93

Medical interview skills

Course Outline (Year 1)

Medical interview skills are taught in 20 hours of small group tutorials.

Objectives

By the completion of the Medical Interviewing programme, students should have developed skills in the following areas:

1. Optimising the physical environment: obtaining nursing staff permission and cooperation, attending to seating arrangements, attending to physical barriers, attending to privacy.

2. Opening the interview: observation, preparing oneself to listen.

3. Greeting the patient

4. Introducing oneself, conveying interest.

5. Surveying problems, developing hypotheses: using narrative thread, Balance of open-ended versus closed questions, facilitation, clarification; developing life context of the patient and the problem; pursuing symptoms and testing hypotheses.

6. Closing: ensuring agendas have been covered, attending to future arrangements.

7. Developing a therapeutic alliance.

8. Dealing with affect in the patient, e.g. sadness, anxiety, hostility. Dealing with affect in the interviewer.

9. Introducing sensitive topics such as alcohol abuse, sexual problems, and relationship problems.

10. Other skills: style of questions, non-verbal communication, calibration of the interview, facilitation, use of silence, responding to hard questions such as "am I going to die, doctor?", empathic statements.

Types of learning experiences

1. Brief patient interviews on the ward and in the tutorial setting.

2. Extended patient interviews on the ward and in the tutorial setting.

3. Interactional exercises such as experimenting with non-verbal communication.

4. Role plays of interviews with peers, tutor, and simulated patients.

5. Feedback and replay with peers, tutor, and simulated patients.

6. Audio or audio visual recording and playback of patient or role play interviews.

7. Discussion and evaluation of references provided.

This course, in the first year of medicine, lays the foundation for further training courses in interactional skills training, including:

- How to break bad news
- How to help your patients follow treatment instructions
- Preparing patients for potentially threatening clinical procedures
- How to encourage your patients to quit smoking
- How to encourage your patients to adopt responsible levels of alcohol consumption

APPENDIX 5

Vilnius University
Faculty of Medicine
Department of Psychiatry
Vilnius Clinical Psychotherapeutic Centre

Doctor-patient communication skills

Doctor-Patient Communication Skills are taught in the third year of medical school, which his the first clinical training year of the medical curriculum. This course is the continuation of the course "Medical Psychology" (total amount 64 hours, taught in the 2nd year). It consists of 16 hours of lectures and 16 hours of training in small groups.

Objectives

By the completion of the Doctor-patient Communication course students are expected: 1) to have acquired information concerning the processes going on inside every contact between professional and patient (consultation process), 2) to have acquired the skills for controlling the content and process of consultation.

Topics of lectures

1. Motivation of learning and acquiring new skills. Learning as a process of self-awareness and change. Standards, values and habits which affect performance. Resistance to learning.

2. Four basic skills in general practice: Systemic approach, Managing the relationship, Somatic examination and Psychosomatic investigation.

3. Orientation stage in the consultation process: goals, methods, problems.

4. Clarification stage in the consultation process.

5. Definition stage in the consultation process.

6. Discussing and formulating the plan. Evaluation of the consultation.

7. Nonverbal behaviour of both parts in the consultation process.

8. Professionals' emotional responses and its value as a diagnostic tool. Transference and counter transference.

Goals of the training in the small groups

1. Training in organization and optimization of the setting of the consultation.

2. Creating the cooperative and collaborative atmosphere of the consultation.

3. Keeping the order of the consultation's stages.

4. Keeping the balance between the somatic and psychosocial sides of the information gathering ("circular process").

5. Staying "close to the patient's world".

6. Dividing the responsibility for the diagnostic and therapeutic activities between the two parts of the consultation.

7. Training and using empathy as a basic therapeutic tool.

8. Keeping the balance between open and closed questions.

9. Dealing with difficulties, affects, resistance, uncooperativeness, non-motivation, acting-out, etc.

10. Collecting information for diagnosis and as a therapeutic activity.

While role playing, tutors should remember that these are training groups and should resist allowing them to turn into a therapeutic type of group.

This course is used as a background for training in the courses "Basic Psychosomatics", taught in the 4th year, "Basic Psychotherapy Skills", taught in the 5th year, and "Contemporary Medical Ethics", taught in the 6th year at the undergraduate level at the Faculty of Medicine of Vilnius University.

APPENDIX 6

Workshop on the Teaching and Assessment
of Communication Skills in Canadian Schools
22-24 March 1992, Toronto, Canada

Sponsored by: Canadian Cancer Society, National Cancer Institute of Canada, Lederle Laboratories, Associated Medical Services, Inc.

Consensus statement on the teaching and assessment of communication skills in Canadian medical schools

The interaction between doctors and patient involves the forming of a relationship and the gathering and giving of information. Its purpose is to promote the physical, emotional and social well-being of patients and their families. Communication skills are fundamental to the interaction and involve verbal, nonverbal and written methods of communication.

The importance of communication skills and the concern that they were not always being taught adequately in medical schools led to the organization of a national conference, held on March 22 to 24 1992. It was sponsored by the Canadian Cancer Society, the National Cancer Institute of Canada, Lederle Laboratories and Associated Medical Services, Inc. Participants included expert panellists from Australia, the United States, Britain and Canada, representatives from the undergraduate teaching programmes of all 16 Canadian medical schools and representatives from medical school postgraduate programmes, undergraduate medical student organizations, licensing and accrediting bodies, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, patient and ethnic groups, and schools of nursing and social work.

Through presentations, panel discussions and small workshops, the participants reviewed research evidence, discussed existing approaches to the teaching and assessment of communication skills in medical schools and affirmed the importance of doctor-patient communication. The participants developed and agreed to the following consensus statement.

General principles

1. Doctor-patient communication is an integral component of quality medical care. It has an important and demonstrable influence on a number of significant patient outcomes.

2. Rigorous research has revealed major deficits in communication between doctors and patients. This highlights the need for formal training programmes at the undergraduate, postgraduate and continuing education levels.

3. Controlled trials have shown that defined teaching strategies can produce significant changes in students' communication knowledge, skills and attitudes.

Recommendations

Canadian facilities of medicine should collaborate in initiatives to facilitate the teaching and assessment of communication skills. These would include:

1. Identification and further development of the necessary knowledge, skills and attitudes fundamental to establishing an effective doctor-patient relationship.

2. Establishment of national objectives for the teaching and assessment of knowledge, skills and attitudes of communication at all levels of medical education - undergraduate, postgraduate and continuing.

3. Setting of minimal standards of competence.

4. Further development of sensitive, reliable and valid methods for evaluating students' competence and performance, as well as for evaluating programmes.

5. Establishment of collaborative faculty development projects in communication.

Requirements for Implementation

1. Strong faculty support for a programme in doctor-patient communication.

2. Involvement of a significant number of faculty role models, with appropriate academic recognition. They should be trained in defined communication skills and should represent as many disciplines as possible: they should not be exclusively from the disciplines of general practice, psychiatry and social sciences but should also be fromal specialities and subspecialities.

3. Early introduction of an integrated programme in communication skills in the undergraduate curriculum, with continuation through all years of undergraduate training and into postgraduate and continuing education programmes.

4. Educational programmes in communication that are grounded in the research literature whenever possible.

5. Learning strategies and methods that are largely experiential and involve all the disciplines of medicine.

6. Educational settings that are clinically relevant (for example, information gathering and giving could be taught in the context of interviews with real or simulated patients, and aspects of how to break bad news could be taught during teaching in oncology).

7. Development of students' skills in assessing their own and their peers' performance.

8. Assessment of student performance in communication that is as rigorous and relevant as assessment of performance in other components of the medical curriculum and as important in determining student progress.

9. Learning programmes that reflect the needs of all patients, including those of differing ethnic, cultural and socioeconomic backgrounds.

10. Inclusion of competence in communication skills as an important requirement for licensure of physicians.

11. Inclusion of teaching and assessment of communication skills as important components of medical school accreditation.

12. Support from funding agencies and medical schools for research and development in the field of communication skills.

APPENDIX 7

List of Behavioural Science Learning Modules on Specific Situations and Problems

Adding behavioural and cognitive interventions in preparing patients for invasive medical and surgical procedures (D.J. De Horne)

Adherence to dietary regimens (K.D. Brownell)

Implementing and stimulating continued compliance with a low salt diet (J.H. DiMarco)

Improving adherence behaviour with treatment regimens (N.C. Mann)

Communicating bad news to patients (J.N. Premi)
Breaking bad news (K. Donovan)
Introducing parents to their abnormal baby (R.G. Pearse)

Teaching mothers about oral rehydration therapy: lessons from the social and behavioural sciences (J. Coreil)

Guidance to health workers and parents where child abuse is suspected
Part I: Physical abuse, emotional abuse, and child neglect (M. Kerfoot)
Part II: Sexual abuse (B. Minty)

A smoking cessation manual: helping health providers make smoking interventions (L. Hewitt)

Coping with distressing life changes (T. Theorell)

Dealing with depression and other troubled feelings in a cultural context: a convergence of approaches (C.W. Branch)

Increasing screening behaviour for female cancers in developing countries (G. Rodriguez)

Techniques to overcome sleep disturbance (F.J. de Riba)

Self-management of recurrent headache (K.A. Holroyd and D.B. Penzien)

Adding psychological interventions to physiotherapy for patients with chronic back pain (S.J. Linton)

Promoting nonpharmacologic interventions to treat elevated blood pressure (E.M. Stuart, R. Friedman and H. Benson)

For further information please write to the WHO Division of Mental Health, 1211 Geneva 27, Switzerland

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