

Developing Communication Skills for the General Practice Consultation Process

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تطوير مهارات التواصل في عملية الاستشارة بالطب العام

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المخلص: نتج عن تنقيح المناهج الطبية في مختلف مناطق العالم خلال العشرين عاما الأخيرة زيادة في الساعات المخصصة لمهارات التواصل، تصف هذه المقالة برنامج تعليم مهارات التواصل الفعلي الموجه للممارسة الطبية العامة. حضر أكثر من 2000 طبيبا منذ ربيع 1992 من الدنمارك والسويد وفنلندا مساقات ضمن هذا البرنامج في كاليمينوس باليونان. تم التدريب في مجاميع من ثمانية أطباء مع مشرف واحد. كان التدريب مبنيا على التغذية الراجعة بأفلام الفيديو باستخدام طريقة إشراف النافذة الموصوفة هنا. استطعنا تحديد عدة مشاكل مخفية معهودة للطبيب والتي كانت من صلب اهتمام البرنامج. كذلك شخصنا تسع خطوات لكي تكون عملية الاستشارة فعالة، والتي أعطيت الكلمة المركبة (عملي) باللغة الانجليزية. القضية الرئيسية هي التمييز بين عملية التواصل التي تخص المريض وتلك التي تخص الطبيب، وما هو مشترك بينهما. من خلال خبرتنا وجدنا أن هذا النموذج يقلل وقت الاستشارة إلى 15 دقيقة فقط عندما يتعاون الأطباء مع المرضى والتي يتم من خلالها تبني جدول متفق عليه من أجل التعامل بفعالية مع المشاكل الرئيسية للمرضى.

مفتاح الكلمات: طب عام، تواصل، مهارات.

ABSTRACT: Medical curriculum revisions all over the world in the last 20 years have increased the number of teaching hours in communication skills. This article describes a concrete communication skills teaching programme focused on general practice. Since the spring of 1992, more than 2,000 physicians from Denmark, Sweden and Finland have attended courses within this programme in Kalymnos, Greece. The training mainly takes place in groups of 8 doctors and 1 supervisor. The skills training is based on video feedback using the Window Supervision Method described here. We have identified several classical pitfalls for the doctor which this training programme seeks to address. We have also defined the 9 steps in an effective consultation process, which are given the acronym PRACTICAL. The major issue is to discriminate between the patient's, the doctor's and the shared part of the communication process. In our experience, this model shortens the consultation time to c. 15 minutes as doctors collaborate with their patients and build up an agreed agenda in order to deal effectively with the main problems of the patients.

Keywords: General practice; Communication; Skills

Communication Skills – Why?

Being clinically active in general practice and psychiatry in the 1970s and 80s, we noticed, as did many colleagues, that conditions were changing for physicians. A new wave of patient expectations and complaints began, and there were fewer manpower hours, but more patients. Physicians began to complain about too much work (increasingly many doctors lost their motivation and basic curiosity). Many were at risk of burning out.

A lot of the patient complaints were due to insufficient communication skills in the health care system.

On the positive side, patients defended their right to become collaborators with their doctor rather than just subordinate customers. Health care information had become readily available in newspapers and magazines and on the Internet leading to doctors being challenged by well informed patients.

A growing awareness of compliance and life style issues arose. The need for a patient focused health care culture and rehabilitation outcomes became apparent. This was supported by research and development on consultation models.^{1,2} We participated in some of this research

and developed a new model for conducting consultation in general practice.^{3,4,5} With this model, we wanted to offer general practitioners a set of tools and skills to become more efficient communicators and more satisfied doctors. We launched the consultation training courses in Kalymnos, Greece, in the spring of 1992 with, so far, close to 2,000 physicians from Denmark, Sweden and Finland having attended them.

Communication in the Medical Curriculum

Curriculum revisions all over the world in the last 20 years have increased the number of teaching hours in communication. The importance of communication is emphasised in lectures and small group teaching as well as in skills laboratories with simulated patients. This all has the purpose of improving the doctor-patient collaboration and relationship which is not an option, but a necessity.⁶ A well-known international programme of teaching communication skills in the medical curriculum is published by Juliet Draper and co-workers.^{7,8} Doctor Ong and partners have written a review of the literature on doctor-patient communication.⁹

In addition to the factors mentioned above, there are some classical reasons for making sure that future doctors do have sufficient competence as communicators. First, history taking is a crucial task for any physician and an essential part of it is building up a trusting relationship with the patient without which collaboration and compliance with the patient is not attainable. Special communication skills are required to deliver so-called 'bad news' – poor prognosis! – but even sound instructions, explanations and reassurance require skillful communication. Stressful working loads or single exhausting experiences require debriefing or supervision implying new communication challenges. Medical education must be life-long and communication skills should be continuously trained and refined.

Specific Challenges in the Consultation

Based on our courses we can delineate several classical pitfalls for the doctor:

1. Patients with a long list of complaints. Requires

skills to prioritise and collaborate with the patient.

2. The worried patient. Requires skills to phrase the worries and to console or inform rationally.
3. New problems on the way out of the consultation room. Need to start all over. The agenda for the consultation has not been set.
4. The angry patient. Requires acceptance and containing functions.
5. The patient with low self esteem. Requires praise and respect, focus on resources.
6. The patient seeking prolonged sickness certificate. May be promised some prolongation before discussion of alternatives and long term solutions.
7. The patient asking for superfluous expensive investigations (magnetic resonance (MR) or positron emission tomography (PET) scans, etc.). The motives for the wishes must be thoroughly understood before any decision is taken.
8. The patient in need of life style changes. How much information is needed at the outset?
9. The doctor feeling hurt by the patient. Analyse the counter transference feelings.
10. Patient asking for more drugs. Check the consumption well before deciding on continued prescription.
11. Gifts – expensive or clearly personalised gifts must not be accepted. Gifts from the doctor should be exceptional.

The Kalymnos Courses

The Kalymnos courses have been run spring and autumn since 1992. They have been conducted in Danish, Swedish, and English. The setting is 3-hour scheduled learning in the morning and 3-hour scheduled learning in the evening. The afternoon, from 12 noon to 5 pm is free for recreation – an important dimension of the course. The general practitioners participating in the courses have been of different types from the very experienced needing new inspiration to very young doctors needing basic skills. In groups of 8, the learning process is built on mutual respect and eagerness to

learn from each other.¹⁰

The exercises concerning social networks and life scripts aim to develop personal resources within the individual doctor enabling him or her to integrate personal challenges into the professional role as a physician.¹¹ The outcome of the course can easily be detected in terms of a high degree of self confidence and personal enlightenment by the end of the week.

THE LEARNING FRAMEWORK IS:

- Limited plenary sessions
- Small group sessions with videotaped role plays
- Small group sessions with videotaped real consultations (brought from home)
- Video replay with supervision
- Training in supervision with various techniques
- Exercise in uncovering own social network
- Life script exercise

The Phases of Effective Consultations

The core of the communication skills training is based on the 9 steps shown in Table 1.⁵

THE PATIENT'S PART

1. PRIOR

Patients usually prepare themselves before seeking a doctor. Although many patients and doctors like to start the consultation with the present complaints, it pays off to start more openly tracing the events more generally prior to the consultation. This also includes self treatment, information from the Internet, advices from family and friends and it may even include consultations with other doctors. In any case, the patient will have a history before visiting the present doctor. The patient should have the opportunity to reveal his history. Information from this phase can help the doctor to avoid suggesting remedies already tried by the patient. The patients' preparation also includes questions to themselves like: What is happening? Why this? Why me? Why

now? What can I do? Who might be able to help me?¹²

2. RELATIONSHIP

When the doctor asks the patient to tell his story, the relationship is beginning to develop. This phase includes more than "Hello! How do you do?" and it stretches throughout the consultation process. A positive relationship is fundamental for trust and confidence in the doctor, and necessary for constructive collaboration and compliance. The most important technique for obtaining a positive relationship with the patient is reassurance and attentive listening by the doctor. Another important technique is to give permission to the patient for having his or her complaints, and to be the person they are. Many patients fear that they are not interesting for the doctor. They might even feel shame.

3. ANXIETIES (CONCERNS AND EXPECTATIONS)

Through our courses we have learned that the key to managing the consultation is embedded in the phase we call anxieties: clarifying ideas, concerns and expectations on behalf of the patient, and revealing the reflections of the patient.¹ If this part of the consultation is not fully completed, it is not possible to work out a valid and prioritised agenda for the consultation. This might result in the classical remark from the patient with his hand on the door handle on his way out: "Oh, what I really came to see you for was...!" The patient, like the doctor, has his or her model of the world which includes a model of the illness. Examples of such models are: destiny, biological, environmental, and psychological. It is very useful for the doctor to know which model the patient is employing most in the present situation.¹³ Asking for the patient's concerns reinforces the respectful relationship and may give the patient a deep sense of relief that the doctor is interested in such feelings. The patients often have their very concrete expectations about the consultation varying from reassurance, explanation of symptoms to expensive laboratory investigations, extended sick leave or prescription of addictive drugs. Instead of waiting for or maybe fearing these

Table 1: PRACTICAL model for doctor-patient communication (9 steps)

P rior to the consultation (feelings, thoughts and actions)	The patient's part
R elationship (permission)	
A nxiety (ideas, concerns, and expectations - both affective and cognitive)	
C ommon understanding (summarise, check of health beliefs)	The doctor's part
T ranslating (verbal, physical examination into a diagnosis)	
I nteraction (common understanding, change of frame of reference, doctor's or patient's choice)	
C onverting insight into action (impede, promote)	The common part
A greement check (safety netting, prolonging)	
L et's try it (OK feelings on both sides, housekeeping)	

demands, the doctor should encourage these expectations to be put into words early in the consultation in order to plan and make the right decision later on in the consultation. To summarise this phase, a Norwegian doctor has suggested five key questions.¹⁴

1. Why do you want to see me today?
2. What are your own thoughts on the situation?
3. What are your own thoughts on the reason for the problem?
4. What are you particularly worried about?
5. What do you want me to help you with?

So far, the consultation has focused on the premises of the patient. We call this phase the patient's part of the consultation. This distinction between the patient's and the doctor's part is crucial to learn and practice because if the doctor interrupts the patient, he or she will eventually distract the patient. This can make the patient forget what s/he needs to tell the doctor, leading to confusion and waste of time for both of them.

THE DOCTOR'S PART

4. COMMON UNDERSTANDING

First the agenda of the consultation should be settled. This should be initiated by the doctor through testing their common understanding. The doctor summarises what he or she has heard, and how different complaints and wishes should be prioritised in the present

consultation. The summary should be phrased as the doctor's temporary understanding and preferably contain both emotional (affective) and factual (cognitive) statements. The doctor is seeking the informed consent of the patient.

5. TRANSLATION

The doctor now continues with traditional physician communication. He asks questions to circumscribe the symptoms. When did it all start? Where is the pain most severe? Is there any fever? Etc. In this phase, the doctor will conduct a physical examination and he may order some laboratory investigations. In this way, the doctor translates the verbal and physical findings, giving an explanation to the patient and maybe a diagnosis, prescription, referral, treatment etc.

THE COMMON PART

6. INTERACTION

The doctor's suggestions might be challenged by the patient, requiring further interaction with negotiations in respect of aetiology, treatment modalities, and further investigations. The doctor may try to change the terms of reference of the patient or present a choice of possibilities. The more the patient agrees to the plan, the more compliance is likely.

7. CONVERTING INSIGHT

In order to strengthen compliance further the doctor might invite a discussion on the obstacles and facilitators to solving the

problem. This also can be named converting insight into action.

8. AGREEMENT CHECK

In order to finish the consultation an agreement check is advisable. Can we conclude, that we agree so and so? Do we need a safety net in terms of a follow-up consultation? This can be necessary also for the doctor to verify his judgment or simply to quality assure his or her work.

9. LET'S TRY IT

Bye,bye... Before starting the next consultation, housekeeping is necessary for the doctor. It might be some fresh air, a cup of tea or coffee – or a brief interaction with another staff member in the workplace. The doctor's screen should be erased before the next patient comes in.

The important lesson is to remember the three main phases: the Patient's part, the Doctor's part, and the Common part. All nine phases might seem for some doctors to be too structured. Some will even think that they will not have sufficient time in a normal consultation. Our experience, which has been shared with numerous colleagues, is that on the contrary this model shortens the consultation time through collaboration with the patient and building up an agreed agenda (avoiding superfluous questions on the doctor's part and a list of patient complaints that the doctor should deal with successively). It is our goal to be able to conduct most consultations within 15 minutes and in that time to be able to deal effectively with the main problems of the patient.

The Window Supervision Method

Lectures and texts are not enough to master the 9 phases of the consultation. It requires various skills to manage the different phases. So the main focus in the course is learning these skills through role play, video feedback of role play and video recordings of real life situations brought from the doctor's home consultations. The video feedback must be supervised. We prefer a supervision method invented by Coles and modified by Larsen, Risør, and Nystrup.^{15,16,17} This supervision has a rigid, structured schedule, which must be followed

sequentially. For this reason, we call the method the Window Supervision Method, since one window (schedule) must be dealt with before the next one should be opened [Table 2].

The method thus defines a set of rules which make the participants secure, and it conveys a supervision culture that prevents self-criticism which is a common defense. Supervision amongst peers easily creates competition and arguments, both scientific and attitudinal. Such arguments will very often hurt someone in the group, and such arguments will most often create a barrier for learning. For this reason no free discussion is allowed. By building up trust and confidence, the supervision reaches a stage where brainstorming is allowed. The objective of the supervision is to enhance the doctor's skills in communicating and dealing with their patients. The supervision takes place in groups with 8 doctors and 1 supervisor. The next section describes how the model works.

THE CONTRACT

In order to emphasise ownership of the process on the part of the supervisee, we first of all ask the supervisee to state what s/he wants from the colleagues. This is called a contract. Sometimes it is difficult for the supervisee doctor to formulate this in advance. It can facilitate the process to view the videotape first. In this way, the doctor might present his case and provide more information than contained on the videotape.

FEELINGS ON THE PART OF THE SUPERVISEE

Many different – and often contradictory – feelings arise in the doctor during a consultation. In this window, the supervisor is particularly interested in the feelings towards the patient. Such counter transference feelings are often the reason why the doctor may feel poisoned after the consultation. A successful supervision should be able to detoxify the supervisee. Typical negative counter transference feelings are: helplessness, meaninglessness, pain, loneliness, anger, grief and fear of illness or death. Positive counter transference feelings can be sympathy, pity, compassion, engagement to help. Some of the feelings are real feelings created by the situation (the personality and the illness); however, surprisingly, many are countertransference feelings originating from something that happened in the

Table 2: Window Supervision process

What do I want the colleagues help with?	
Physician	Colleagues
<p>1. Feelings of the supervisee</p> <p>Which feelings does the patient evoke in me?</p>	<p>2. Feelings of the colleagues</p> <p>If I place myself in the physician's situation which feelings does the patient evoke in me?</p>
<p>3. Praise to myself</p> <p>I think ... worked well</p>	<p>4. Praise from my colleagues</p> <p>It worked well when you</p>
<p>5. Constructive criticism</p> <p>I wish I had done ... in that way</p>	<p>6. Brainstorm</p> <p>If it had been me, I might have done</p>
<p>7. Take home messages for the supervisee</p> <p>What I take home is</p>	<p>8. Take home messages for the colleagues</p> <p>As for me, I take home</p>
<p>9. Feelings of supervisee</p> <p>Now I am feeling</p>	<p>10. Feelings of the colleagues</p> <p>Now I am feeling</p>

doctor's past. It is not constructive in the supervision process to spend time on the real origination. This might be relevant in psychotherapy. What interests us is how different kinds of feelings will influence the consultation and how the feelings of the patient are transmitted and reflected in the doctor. In this way, the feelings of the doctor can become a diagnostic tool for how the patient feels.

In many instances, when starting to learn this new method, the supervisee will begin by being self-critical. The supervisor might clarify the nature of these feelings as originating from the doctor him or herself, and in this way guide the detection of feelings towards the patient. Also the supervisor might need to emphasise that supervision is not a type of competition. The aim is not to find the right solution to the problem, but rather to find different and alternative solutions. First of all the aim is to be open for learning.

FEELINGS ON THE PART OF COLLEAGUES

Now the colleagues are invited to open their window. What are their feelings if they have identified with the supervisee? This often runs quite smoothly. Additional feelings arise – often unexpected ones. This illustrates for the group and for the supervisee that no single feeling is sought for, and different – even negative – feelings toward the patient can be a reality in a consultation. This often creates an atmosphere of permission and a group dynamic of understanding, sharing and respecting differences in attitudes and personalities. The supervisor might

join the process by sharing his or her own feelings towards the patient.

PRAISE TO MYSELF

Many colleagues wonder about the relevance of all the positive comments. They are ready for constructive criticism, they often say. Our experience tells us, that this is not so. The supervisee first needs to be assured of his or her competence. Something must be put in the bank account before it is meaningful to draw from it. So this window encourages the supervisee to describe what he or she managed well in the consultation giving as many concrete instances as possible. The group is not allowed to argue or dispute the descriptions.

PRAISE FROM MY COLLEAGUES

Now the colleagues are asked to point out what they detected (through the videotape) as working well in the consultation. The supervisor might join in this session. And the supervisor might summarise the content of these two windows making sure that the supervisee accepts the positive points.

CONSTRUCTIVE CRITICISM

In this window, the supervisee is asked (after viewing the videotape) what he or she thinks could have been done differently, and maybe what s/he would want to do differently another time. No discussion or arguments is allowed from the group.

BRAINSTORM

In order to avoid the tendency for the supervisee

to defend him or herself, the supervisor might instruct the supervisee to turn his back to the group – and just listen and reflect on what ideas from the brainstorming process could be useful for the kind of doctor the supervisee is. Now the group starts brainstorming:

“If I had been in the same situation, may be - I would have tried this or that. And maybe I also would have been able to.... If I had had a real lucky day, then.....”

The supervisor does not need to summarise this. He might join the session. And he might encourage creativity. Also he might permit discussion amongst the colleagues at this point. It is, however, important to underline that one right solution, in terms of a group consensus, is not what is being sought. On the contrary, a variety of different constructive approaches are welcomed.

TAKE HOME MESSAGES FOR THE SUPERVISEE

This window serves the purpose that the supervisee might reflect on alternative ways of conducting the consultation. What of the many suggestions would be relevant for him or her – and what should be given priority? The supervisor gives permission to neglect or discard what has been said by the group. But it is all right to ask if something was interesting for the supervisee and draw attention to the helpful resources.

TAKE HOME MESSAGES FOR THE COLLEAGUES

Now it is time to elucidate the learning in the group in a wider context. This is done, by asking each individual member, what he or she has learned and would like to implement at home.

FEELINGS OF THE SUPERVISEE

In order to check the process, the supervisor asks about the feelings of the supervisee at this point. This is both about the feelings of having gone through the supervision process, and if the feelings towards the patient, as stated in the first window, have changed - particularly whether the negative countertransference feelings have diminished or vanished. If not, it might be necessary to start the supervision all over again.

FEELINGS OF THE COLLEAGUES

Exactly the same two questions are put to each of the colleagues. It is important to check whether somebody has been hurt by the group process. This very rarely occurs if the rigid structured schedule is adhered to. Another safety measure is time. Don't rush through this exercise. It normally requires 1–1 ½ hours.

Conclusion

Some patients are experienced as a burden by their doctor who experiences heartbeat, sweat and anxiety before consultations. This is often the case with psychosomatic patients waiting to tell their doctor that their symptoms have worsened since the last consultation. With empathy and consultation skill tools, the doctors are encouraged to meet the patients on a deeper emotional and psychosocial level. Our experience from these supervision courses is that, after the course, doctors no longer feel burdened by their patients. The patients have been taken seriously and therefore have received the help they sought.

CONFLICT OF INTEREST

The authors reported no conflict of interest.

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