MODELS OF THE CONSULTATION

A summary of models that have been proposed over the last 40 years: Jonathan Silverman

There have been a number of helpful models of the consultation which have been produced over the last 30 years. Some are task-orientated, process or outcome-based; some are skills-based, some incorporate a temporal framework, and some are based on the doctor-patient relationship, or the patient’s perspective of illness. Many incorporate more than one of the above.

Models of the consultation give a framework for learning and teaching the consultation. Models enable the clinician to think where in the consultation they are experiencing the problem, and what they and the patient aiming towards. This is helpful in then identifying the skills that are needed to achieve the desired outcome.

1. ‘Physical, Psychological and Social’ (1972)
   The RCGP model encourages the doctor to extend his thinking practice beyond the purely organic approach to patients, i.e. to include the patient’s emotional, family, social and environmental circumstances.

2. Stott and Davis (1979)
   “The exceptional potential in each primary care consultation” suggests that four areas can be systematically explored each time a patient consults.
   
   (a) Management of presenting problems
   (b) Modification of help-seeking behaviours
   (c) Management of continuing problems
   (d) Opportunistic health promotion

   “Doctors talking to patients”. Six phases which form a logical structure to the consultation:

   Phase I  The doctor establishes a relationship with the patient
   Phase II The doctor either attempts to discover or actually discovers the reason for the patient’s attendance
   Phase III The doctor conducts a verbal or physical examination or both
   Phase IV The doctor, or the doctor and the patient, or the patient (in that order of probability) consider the condition
   Phase V  The doctor, and occasionally the patient, detail further treatment or further investigation
   Phase VI  The consultation is terminated usually by the doctor.

Byrne and Long’s study also analysed the range of verbal behaviours doctors used when talking to their patients. They described a spectrum ranging from a heavily doctor-dominated consultation, with any contribution from the patient as good as excluded, to a virtual
monologue by the patient untrammelled by any input from the doctor. Between these extremes, they described a graduation of styles from closed information-gathering to non-directive counselling, depending on whether the doctor was more interested in developing his own line of thought or the patient’s.

4. **Six Category Intervention Analysis (1975)**
   In the mid-1970’s the humanist Psychologist John Heron developed a simple but comprehensive model of the array of interventions a doctor (counsellor or therapist) could use with the patient (client). Within an overall setting of concern for the patient’s best interests, the doctor’s interventions fall into one of six categories:

   (1) **Prescriptive** - giving advice or instructions, being critical or directive
   (2) **Informative** - imparting new knowledge, instructing or interpreting
   (3) **Confronting** - challenging a restrictive attitude or behaviour, giving direct feedback within a caring context
   (4) **Cathartic** - seeking to release emotion in the form of weeping, laughter, trembling or anger
   (5) **Catalytic** - encouraging the patient to discover and explore his own latent thoughts and feelings
   (6) **Supportive** - offering comfort and approval, affirming the patient’s intrinsic value.

   Each category has a clear function within the total consultation.

5. **Helman’s ‘Folk Model’ (1981)**
   Cecil Helman is a Medical Anthropologist, with constantly enlightening insights into the cultural factors in health and illness. He suggests that a patient with a problem comes to a doctor seeing answers to six questions:

   (1) What has happened?
   (2) Why has it happened?
   (3) Why to me?
   (4) Why now?
   (5) What would happen if nothing was done about it?
   (6) What should I do about it or whom should I consult for further help?

6. **Transactional Analysis (1964)**
   Many doctors will be familiar with Eric Berne’s model of the human psyche as consisting of three ‘ego-states’ - Parent, Adult and Child. At any given moment each of us is in a state of mind when we think, feel, behave, react and have attitudes as if we were either a critical or caring Parent, a logical Adult, or a spontaneous or dependent Child. Many general practice consultations are conducted between a Parental doctor and a Child-like patient. This transaction is not always in the best interests of either party, and a familiarity with TA introduces a welcome flexibility into the doctor’s repertoire which can break out of the repetitious cycles of behaviour (‘games’) into which some consultations can degenerate.
7. **Pendleton, Schofield, Tate and Havelock (1984, 2003)**

‘The Consultation - An Approach to Learning and Teaching’ describe seven tasks which taken together form comprehensive and coherent aims for any consultation.

1. **To define the reason for the patient’s attendance, including:**
   i) the nature and history of the problems
   ii) their aetiology
   iii) the patient’s ideas, concerns and expectations
   iv) the effects of the problems

2. **To consider other problems:**
   i) continuing problems
   ii) at-risk factors

3. **With the patient, to choose an appropriate action for each problem**

4. **To achieve a shared understanding of the problems with the patient**

5. **To involve the patient in the management and encourage him to accept appropriate responsibility**

6. **To use time and resources appropriately:**
   i) in the consultation
   ii) in the long term

7. **To establish or maintain a relationship with the patient which helps to achieve the other tasks.**

8. **Neighbour (1987)**

Five check points: ‘where shall we make for next and how shall we get there?’

1. **Connecting** - establishing rapport with the patient

2. **Summarising** - getting to the point of why the patient has come using eliciting skills to discover their ideas, concerns, expectations and summarising back to the patient.

3. **Handing over** - doctors’ and patients’ agendas are agreed. Negotiating, influencing and gift wrapping.

4. **Safety net** - “What if?": consider what the doctor might do in each case.

5. **Housekeeping** - ‘Am I in good enough shape for the next patient?’

McWhinney and his colleagues at the University of Western Ontario proposed a “transformed clinical method”. Their approach has also been called “patient-centred clinical interviewing” to differentiate it from the more traditional “doctor-centred” method that attempts to interpret the patient’s illness only from the doctor’s perspective of disease and pathology.

The disease-illness model below attempts to provide a practical way of using these ideas in our everyday clinical practice. The doctor has the unique responsibility to elicit two sets of “content” of the patient’s story: the traditional biomedical history, and the patient’s experience of their illness.

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<table>
<thead>
<tr>
<th>Patient presents problem</th>
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<tbody>
<tr>
<td>Gathering information</td>
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<tr>
<td>Parallel search of two frameworks</td>
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</tbody>
</table>

- **Disease framework**
  - The biomedical perspective
  - Symptoms
  - Signs
  - Investigations
  - Underlying pathology

- **Illness framework**
  - The patient’s perspective
  - Ideas
  - Concerns
  - Expectations
  - Feelings and thoughts
  - Effects on life

- **Weaving back and forth between the two frameworks**

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**Integration of the two frameworks**

- Explanation and planning
- Shared understanding and decision-making

10. **AACH - The Three Function Approach to the Medical Interview** (1989)

Cohen-Cole and Bird have developed a model of the consultation that has been adopted by The American Academy on Communication in Healthcare as their model for teaching the Medical Interview.

(1) Gathering data to understand the patient’s problems
(2) Developing rapport and responding to patient’s emotion
(3) Patient education and motivation

<table>
<thead>
<tr>
<th>Functions</th>
<th>Skills</th>
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<tbody>
<tr>
<td>1. Gathering data</td>
<td>a) Open-ended questions</td>
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<td></td>
<td>b) Open to closed cone</td>
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<td>c) Facilitation</td>
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<td>d) Checking</td>
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<td>e) Survey of problems</td>
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<td></td>
<td>f) Negotiate priorities</td>
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<td></td>
<td>g) Clarification and direction</td>
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<td></td>
<td>h) Summarising</td>
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<tr>
<td></td>
<td>i) Elicit patient’s expectations</td>
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<td></td>
<td>j) Elicit patient’s ideas about aetiology</td>
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<tr>
<td></td>
<td>k) Elicit impact of illness on patient’s quality of life</td>
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<tr>
<td>2 Developing rapport</td>
<td>a) Reflection</td>
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<td>b) Legitimation</td>
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<td>c) Support</td>
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<td>d) Partnership</td>
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<td></td>
<td>e) Respect</td>
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<tr>
<td>3. Education and motivation</td>
<td>a) Education about illness</td>
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<tr>
<td></td>
<td>b) Negotiation and maintenance of a treatment plan</td>
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<td></td>
<td>c) Motivation of non-adherent patients</td>
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</table>

In 2000, the authors published a second edition, where they altered the order of the three functions of effective interviewing, putting “Building the relationship” in front of “Assessing the patient’s problems”, and “Managing the patient’s problems”.


Suzanne Kurtz & Jonathan Silverman have developed a model of the consultation, encapsulated within a practical teaching tool, the Calgary Cambridge Observation Guides. The Guides define the content of a communication skills curriculum by delineating and structuring the skills that have been shown by research and theory to aid doctor-patient communication. The guides also make accessible a concise and accessible summary for facilitators and learners alike which can be used as an aide-memoire during teaching sessions.

The following is the structure of the consultation proposed by the guides:

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

(2) **Gathering Information**
   exploration of the patient’s problems to discover the:
   a) biomedical perspective
   b) the patient’s perspective
   c) background information - context

(3) **Building the Relationship**
   a) using appropriate non-verbal behaviour
   b) developing rapport
   c) involving the patient

(4) **Providing structure**
   a) making organisation overt
   b) attending to flow

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

(6) **Closing the Session**
   a) ensuring appropriate point of closure
   b) forward planning

This new iteration of the guides combines the traditional method of taking a clinical history including the systems review, past medical history, social and family history, and drug history, with the process skills of effective communication. It places the disease-illness model at the centre of gathering information. It combines process with content in a logical schema; it is comprehensive and applicable to all medical interviews with patients, whatever the context *(see appendix for the full guide in detail)*
13. **The SEGUE Framework for teaching and assessing communication skills (Makoul 2001)**

   Greg Makoul in 2001 developed the SEGUE framework, a research-based checklist of medical communication tasks that has gained wide acceptance throughout North America. The framework consists of the following areas:

   1. Set the stage
   2. Elicit information
   3. Give information
   4. Understand the patient's perspective
   5. End the encounter
   6. If suggesting a new or modified treatment/prevention plan

   See appendix for the full version of the framework


   The MAAS-Global is an instrument to rate communication and clinical skills of doctors in their consultations. These ratings can be used as an objective measure for feedback and judgement, for education and assessment and the instrument is widely used in communication research. The guide is divided into the following areas:

   Section 1: Communication skills for each separate phase
   1. introduction
   2. follow-up consultation
   3. request for help
   4. physical examination
   5. diagnosis
   6. management
   7. evaluation of consultation

   Section 2: General communication skills
   8. exploration
   9. emotions
   10. information giving
   11. summarisations
   12. structuring
   13. empathy

   Section 3: Medical aspects
   14. history taking
   15. physical examination
   16. diagnosis
   17. management

   See appendix for the full version of the instrument
The four habits model is the centrepiece of an approach taken by one large healthcare organization in the USA, Kaiser Permanente, to enhance the clinical communication and relationship skills of their clinicians. The Model has served as the foundation for a diverse array of communication programmes. The goals of the Four Habits are to establish rapport and build trust rapidly, facilitate the effective exchange of information, demonstrate caring and concern, and improve the likelihood of adherence and positive health outcomes.

The Four Habits are:

1. Invest in the Beginning,
2. Elicit the Patient’s Perspective
3. Demonstrate Empathy
4. Invest in the End

See appendix for the full version of the approach

Bayer Institute for Health Care Communication E4 Model (Keller and Carroll 1994)

The Bayer Institute for health care communication conducts extensive programs designed to enhance the quality of health care by improving the communication between clinician and patients. At its centrepiece is the E4 model:

1. Engage
2. Empathize
3. Educate
4. Enlist
17. **Essential Elements of Communication in Medical Encounters: Kalamazoo Consensus Statement** (Participants in the Bayer-Fetzer Conference on Physician-Patient Communication in Medical Education 2001)

In May 1999, 21 leaders and representatives from major medical education and professional organizations attended an invitational conference to focus on a consensus statement delineating a coherent set of essential elements in physician-patient communication. The group included architects and representatives of five currently used models of doctor-patient communication:

- Bayer Institute for Health Care Communication E4 Model
- Three Function Model/Brown Interview Checklist
- The Calgary-Cambridge Observation Guide
- Patient-centered clinical method
- SEGUE Framework for teaching and assessing communication skills

**Build a Relationship: The Fundamental Communication Task**
A strong, therapeutic, and effective relationship is the sine qua non of physician-patient communication. The group endorses a patient-centered, or relationship-centered, approach to care, which emphasizes both the patient’s disease and his or her illness experience. This requires eliciting the patient’s story of illness while guiding the interview through a process of diagnostic reasoning. It also requires an awareness that the ideas, feelings, and values of both the patient and the physician influence the relationship. Further, this approach regards the physician-patient relationship as a partnership, and respects patients’ active participation in decision making. In essence, building a relationship is an ongoing task within and across encounters: it undergirds the more sequentially ordered sets of tasks identified below.

**Open the Discussion**
* Allow the patient to complete his or her opening statement
* Elicit the patient’s full set of concerns
* Establish/maintain a personal connection

**Gather Information**
* Use open-ended and closed-ended questions appropriately
* Structure, clarify, and summarize information
* Actively listen using nonverbal (e.g., eye contact) and verbal (e.g., words of encouragement) techniques

**Understand the Patient’s Perspective**
* Explore contextual factors (e.g., family, culture, gender, age, socioeconomic status, spirituality)
* Explore beliefs, concerns, and expectations about health and illness
* Acknowledge and respond to the patient’s ideas, feelings, and values

**Share Information**
* Use language the patient can understand
* Check for understanding
* Encourage questions

**Reach Agreement on Problems and Plans**
* Encourage the patient to participate in decisions to the extent he or she desires
* Check the patient’s willingness and ability to follow the plan
* Identify and enlist resources and supports

**Provide Closure**
* Ask whether the patient has other issues or concerns
* Summarize and affirm agreement with the plan of action
* Discuss follow-up (e.g., next visit, plan for unexpected outcomes)

18.  **PRACTICAL**  (J H Larsen, O Risør and S Putnam 1995)

Jan-Helge Larsen described a model for which the mnemonic, P-R-A-C-T-I-C-A-L, helps the practitioner to remember its nine steps. The model uses a chronological succession of strategies during the consultation that balances the voices of medicine and the life-world. In overview, the GP takes the patient, step by step, first through an exploration and clarification of his views of the illness, then expands the problem by further examination (e.g. the physical examination), a negotiation about the final model of the illness that includes both diagnosis and management, a discussion of the treatment plan, and finally a moment of reflection to prepare for the next visit.

**The Patient’s part**

<p>| | |</p>
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<tr>
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<tbody>
<tr>
<td>1. <strong>Prior</strong></td>
<td>to the consultation – Thoughts, feelings and actions</td>
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<tr>
<td>2. <strong>Relationship</strong></td>
<td>Hello, let the patient talk! Show that you see, believe and want to help</td>
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<td>3. <strong>Anxieties</strong></td>
<td>ideas, concerns and expectations</td>
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<td>4. <strong>Common language</strong></td>
<td>a summary of the problems presented</td>
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**The Doctor’s part**

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<td>5. <strong>Translating</strong></td>
<td>enquiry into history, clinical examination and finally explanation, suggesting a plan</td>
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**The Common part**

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<td>6. <strong>Interaction</strong></td>
<td>negotiation re solutions, possibly change of frame of reference, contract, e.g. a shared understanding</td>
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<td>7. <strong>Converting insight into action</strong></td>
<td>what can impede or promote. From insight to action</td>
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<td>8. <strong>Agreement check</strong></td>
<td>Follow up – safety net</td>
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<td>9. <strong>Let’s try it</strong></td>
<td>Anything else? Goodbye and housekeeping</td>
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<td>Working Party of the Royal College of General Practitioners (1972)</td>
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<td>Stott N C H &amp; Davis R H (1979) The Exceptional Potential in each Primary Care Consultation:</td>
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<td>Byrne P S &amp; Long B E L (1976) Doctors talking to Patients: London HMSO</td>
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<td>Helman C G (1981)</td>
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<td>Oxford: OUP</td>
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<td>Neighbour R (1987)</td>
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<td>The Inner Consultation</td>
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<td>MTO Press; Lancaster</td>
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<td>Patient Centred Medicine</td>
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<td>Sage Publications</td>
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<td>The Medical Interview, The Three Function Approach Mosby-Year Book</td>
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<td></td>
<td>The Calgary-Cambridge Observation Guides: an aid to defining the curriculum and organising the teaching in Communication Training Programmes.</td>
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<td>Med Education 30, 83-9</td>
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14  Jacques van Thiel, Paul Ram, Jan van Dalen (2000) MAAS-Global 2000 Maastricht University, Netherlands


APPENDIX
ENHANCED CALGARY-CAMBRIDGE GUIDE TO THE MEDICAL INTERVIEW

THE BASIC FRAMEWORK

- Initiating the Session
- Gathering information
- Physical Examination
- Explanation and planning
- Closing the Session

- Providing Structure
- Building the relationship
THE EXPANDED FRAMEWORK

Initiating the Session
- preparation
- establishing initial rapport
- identifying the reason(s) for the consultation

Gathering information
- exploration of the patient’s problems to discover the:
  - biomedical perspective
  - the patient’s perspective
  - background information - context

Physical examination

Explanation and planning
- providing the correct amount and type of information
- aiding accurate recall and understanding
- achieving a shared understanding: incorporating the patient’s illness framework
- planning: shared decision making

Closing the Session
- ensuring appropriate point of closure
- forward planning

Building the relationship
- using appropriate non-verbal behaviour
- developing rapport
- involving the patient

Providing Structure
- making organisation overt
- attending to flow
AN EXAMPLE OF THE INTER-RELATIONSHIP BETWEEN CONTENT AND PROCESS

Gathering Information

Process Skills for Exploration of the Patient’s Problems
- patient’s narrative
- question style: open to closed cone
- attentive listening
- facilitative response
- picking up cues
- clarification
- time-framing
- internal summary
- appropriate use of language
- additional skills for understanding patient’s perspective

Content to Be Discovered

the bio-medical perspective (disease)  the patient’s perspective (illness)
sequence of events ideas and beliefs
symptom analysis concerns
relevant systems review expectations
drugs and allergies effects on life
background information - context feelings
past medical history
family history
personal and social history
systems review
Patient's Problem List

Exploration of Patient's Problems

<table>
<thead>
<tr>
<th>Medical Perspective – disease</th>
<th>Patient's Perspective – illness</th>
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<tr>
<td>Sequence of events</td>
<td>Ideas and beliefs</td>
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<td>Symptom analysis</td>
<td>Concerns</td>
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<td>Relevant systems review</td>
<td>Expectations</td>
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<td>Effects on life</td>
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<td>Feelings</td>
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Background Information – Context
Past Medical History
Drug and Allergy History
Family History
Personal and Social History
Review of Systems

Physical Examination

Differential Diagnosis – Hypotheses
Including both disease and illness issues

Physician's Plan of Management
Investigations
Treatment alternatives

Explanation and Planning with Patient
What the patient has been told
Plan of action negotiated
INITIATING THE SESSION

Establishing Initial Rapport

1. **Greets** patient and obtains patient’s name
2. **Introduces** self, role and nature of interview; obtains consent if necessary
3. **Demonstrates respect** and interest, attends to patient’s physical comfort

Identifying the Reason(s) for the Consultation

4. **Identifies the patient’s problems** or the issues that the patient wishes to address with an appropriate opening question (e.g. “What problems brought you to the hospital?” or “What would you like to discuss today?” or “What questions did you hope to get answered today?”)

5. **Listens** attentively to the patient’s opening statement, without interrupting or directing patient’s response
6. **Confirms list and screens** for further problems (e.g. “so that’s headaches and tiredness, anything else?”)
7. **Negotiates agenda** taking both patient’s and physician’s needs into account

GATHERING INFORMATION

Exploration of Patient’s Problems

8. **Encourages patient to tell the story** of the problem(s) from when first started to the present in own words (clarifying reason for presenting now)

9. **Uses open and closed questioning techniques**, appropriately moving from open to closed

10. **Listens** attentively, allowing patient to complete statements without interruption and leaving space for patient to think before answering or go on after pausing

11. **Facilitates** patient’s responses verbally and non-verbally e.g. use of encouragement, silence, repetition, paraphrasing, interpretation

12. **Picks up verbal and non-verbal cues** (body language, speech, facial expression, affect); **checks out and acknowledges** as appropriate

13. **Clarifies** patient’s statements that are unclear or need amplification (e.g. “Could you explain what you mean by light headed?”)

14. Periodically **summarises** to verify own understanding of what the patient has said; invites patient to correct interpretation or provide further information.

15. **Uses** concise, easily understood questions and comments, avoids or adequately explains jargon

16. **Establishes dates and sequence** of events

Additional Skills for Understanding the Patient’s Perspective

17. Actively determines and appropriately explores:
   - patient’s **ideas** (i.e. beliefs re cause)
   - patient’s **concerns** (i.e. worries) regarding each problem
   - patient’s **expectations**: (i.e. goals, what help the patient had expected for each problem)
   - **effects**: how each problem affects the patient’s life

18. **Encourages patient to express feelings**
PROVIDING STRUCTURE TO THE CONSULTATION

Making organisation overt

19. **Summarises** at the end of a specific line of inquiry to confirm understanding before moving on to the next section

20. Progresses from one section to another using **signposting, transitional statements**; includes rationale for next section

Attending to flow

21. Structures interview in logical **sequence**

22. Attends to **Timing** and keeping interview on task

BUILDING RELATIONSHIP

Using appropriate non-verbal behaviour

23. **Demonstrates appropriate non-verbal behaviour**
   - eye contact, facial expression
   - posture, position & movement
   - vocal cues e.g. rate, volume, intonation

24. If reads, writes **notes** or uses computer, does in a **manner that does not interfere with dialogue or rapport**

25. **Demonstrates appropriate confidence**

Developing rapport

26. **Accepts** legitimacy of patient’s views and feelings; **is not judgmental**

27. **Uses empathy** to communicate understanding and appreciation of the patient’s feelings or predicament, overtly **acknowledges patient’s views and feelings**

28. **Provides support**: expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self care; offers partnership

29. **Deals sensitively** with embarrassing and disturbing topics and physical pain, including when associated with physical examination

Involving the patient

30. **Shares thinking** with patient to encourage patient’s involvement (e.g. “What I’m thinking now is .......”)

31. **Explains rationale** for questions or parts of physical examination that could appear to be non-sequiturs

32. During **physical examination**, explains process, asks permission

EXPLANATION AND PLANNING

Providing the correct amount and type of information

**Aims**: to give comprehensive and appropriate information to assess each individual patient’s information needs to neither restrict or overload

33. **Chunks and checks**: gives information in assimilatable chunks, checks for understanding, uses patient’s response as a guide to how to proceed

34. **Assesses patient’s starting point**: asks for patient’s prior knowledge early on when giving information, discovers extent of patient’s wish for information

35. **Asks patients what other information would be helpful** e.g. aetiology, prognosis

36. **Gives explanation at appropriate times**: avoids giving advice, information or reassurance prematurely
Aiding accurate recall and understanding
Aims: to make information easier for the patient to remember and understand

37. Organises explanation: divides into discrete sections, develops a logical sequence

38. Uses explicit categorisation or signposting (e.g. “There are three important things that I would like to discuss. 1st...” “Now, shall we move on to...”)

39. Uses repetition and summarising to reinforce information

40. Uses concise, easily understood language, avoids or explains jargon

41. Uses visual methods of conveying information: diagrams, models, written information and instructions

42. Checks patient’s understanding of information given (or plans made): e.g. by asking patient to restate in own words; clarifies as necessary

Achieving a shared understanding: incorporating the patient’s perspective
Aims: to provide explanations and plans that relate to the patient’s perspective
to discover the patient’s thoughts and feelings about information given
to encourage an interaction rather than one-way transmission

43. Relates explanations to patient’s perspective: to previously elicited ideas, concerns and expectations

44. Provides opportunities and encourages patient to contribute: to ask questions, seek clarification or express doubts; responds appropriately

45. Picks up and responds to verbal and non-verbal cues e.g. patient’s need to contribute information or ask questions, information overload, distress

46. Elicits patient’s beliefs, reactions and feelings re information given, terms used; acknowledges and addresses where necessary

Planning: shared decision making
Aims: to allow patients to understand the decision making process
to involve patients in decision making to the level they wish
to increase patients’ commitment to plans made

47. Shares own thinking as appropriate: ideas, thought processes and dilemmas

48. Involves patient:
- offers suggestions and choices rather than directives
- encourages patient to contribute their own ideas, suggestions

49. Explores management options

50. Ascertains level of involvement patient wishes in making the decision at hand

51. Negotiates a mutually acceptable plan
- signposts own position of equipoise or preference regarding available options
- determines patient’s preferences

52. Checks with patient
- if accepts plans,
- if concerns have been addressed

CLOSING THE SESSION

Forward planning

53. Contracts with patient re next steps for patient and physician

54. Safety nets, explaining possible unexpected outcomes, what to do if plan is not working, when and how to seek help

Ensuring appropriate point of closure

55. Summarises session briefly and clarifies plan of care

56. Final check that patient agrees and is comfortable with plan and asks if any corrections, questions or other issues
<table>
<thead>
<tr>
<th>The SEGUE Framework (long form)</th>
<th>Patient</th>
<th>Physician</th>
</tr>
</thead>
</table>

### Set the Stage

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Greet pt appropriately</td>
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<tr>
<td>2.</td>
<td>Establish reason for visit</td>
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<td>3.</td>
<td>Outline agenda for visit (e.g., “anything else?”, issues, sequence)</td>
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<td>4.</td>
<td>Make a personal connection during visit (e.g., go beyond medical issues)</td>
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<td></td>
<td>→ Maintain pt's privacy (e.g., knock, close door)</td>
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</table>

### Elicit Information

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<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>n/a</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>6.</td>
<td>Elicit pt's view of health problem and/or progress (ideas, concerns)</td>
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<td>7.</td>
<td>Explore physical/physiological factors (signs, symptoms)</td>
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<td>8.</td>
<td>Explore psychosocial/emotional factors (e.g., living situation, family relations, stress)</td>
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<td>9.</td>
<td>Discuss antecedent treatments (e.g., self-care, last visit, other care)</td>
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<td>10.</td>
<td>Discuss how health problem affects pt's life (e.g., quality-of-life)</td>
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<td>11.</td>
<td>Discuss lifestyle issues/prevention strategies (e.g., health risks)</td>
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<td></td>
<td>→ 12. Avoid directive/leading questions</td>
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<td>→ 13. Give pt opportunity/time to talk (e.g., don't interrupt)</td>
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<td></td>
<td>→ 14. Listen. Give pt undivided attention (e.g., face pt, verbal acknowledgement, non feedback)</td>
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<td>→ 15. Check/clarify information (e.g., recap, ask “how much”)</td>
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### Give Information

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<tr>
<th>Step</th>
<th>Description</th>
<th>n/a</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>16.</td>
<td>Explain rationale for diagnostic procedures (e.g., exam, tests)</td>
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<td>17.</td>
<td>Teach pt about his/her own body &amp; situation (e.g., provide feedback from exam/tests, explain anatomy/diagnosis)</td>
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<td>18.</td>
<td>Encourage pt to ask questions</td>
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<td></td>
<td>→ 19. Adapt to pt's level of understanding (e.g., avoid/explain jargon)</td>
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<tr>
<td>Understand the Patient's Perspective</td>
<td>n/a</td>
<td>Yes</td>
<td>No</td>
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<td>20. Acknowledge pt's accomplishments/progress/challenges</td>
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<td>21. Acknowledge waiting time</td>
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<td>→ 22. Express caring, concern, empathy</td>
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<td>→ 23. Maintain a respectful tone</td>
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<td><strong>End the Encounter</strong></td>
<td>Yes</td>
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<td>No</td>
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<td>24. Ask if there is anything else pt would like to discuss</td>
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<td>25. Review next steps with pt</td>
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<tr>
<td>If suggested a new or modified treatment/prevention plan:</td>
<td>n/a</td>
<td>Yes</td>
<td>No</td>
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<td>26. Discuss pt's interest/expectation/goal for treatment/prevention</td>
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<td>27. Involve pt in deciding upon a plan (e.g., options, rationale)</td>
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<td>28. Explain likely benefits of the option(s) discussed</td>
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<td>29. Explain likely side-effects/risks of the option(s) discussed</td>
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<td>30. Provide complete instructions for plan</td>
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<td>31. Discuss pt's ability to follow plan (e.g., attitude, time, resources)</td>
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<tr>
<td>32. Discuss importance of pt's role in treatment/prevention</td>
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### SECTION 1: COMMUNICATION SKILLS FOR EACH SEPARATE PHASE

1. **INTRODUCTION**
   - giving the patient room to tell his story
   - general orientation on the reason for visit
   - asking about other reasons for visit

2. **FOLLOW-UP CONSULTATION**
   - naming previous complaints,
   - requests for help and management plan
   - asking about adherence to management plan
   - asking about the course of the complaint

3. **REQUEST FOR HELP**
   - naming requests for help, wishes or expectations
   - naming reasons that prompted
   - the patient to come now
   - completing exploring request for help

4. **PHYSICAL EXAMINATION**
   - instructions to the patient
   - explanation of what is being done
   - treating the patient with care and respect

5. **DIAGNOSIS**
   - naming findings and diagnosis/hypothesis
   - naming causes or the relation
   - between findings and diagnosis
   - naming prognosis or expected course
   - asking for patient's response

6. **MANAGEMENT**
   - shared decision-making, discussing
   - alternatives, risks and benefits
   - discussing feasibility and adherence
   - determining who will do what and when
   - asking for patient's response

7. **EVALUATION OF CONSULTATION**
   - general question
   - responding to requests for help
   - perspective for the time being
SECTION 2: GENERAL COMMUNICATION SKILLS

8. EXPLORATION
   exploring requests for help,
   wishes or expectations
   exploring patient’s response to information given
   within patient’s frame of reference
   responding to nonverbal behavior and cues

9. EMOTIONS
   asking about/exploring feelings
   reflecting feelings (including nature and intensity)
   sufficiently throughout the entire consultation

10. INFORMATION GIVING
    announcing, categorizing
    in small quantities, concrete explanations
    understandable language
    asking whether the patient understands

11. SUMMARIZATIONS
    content is correct, complete
    concise, rephrased
    checking
    sufficiently throughout the entire consultation

12. STRUCTURING
    logical sequence of phases
    balanced division of time
    announcing (history taking,
    examination, other phases)

13. EMPATHY
    concerned, inviting and sincerely empathetic
    in intonation, gesture and eye contact
    expressing empathy in brief verbal responses

SECTION 3: MEDICAL ASPECTS
Rate according to professional guidelines if they are available.
Otherwise rate to the best of your ability.

14. HISTORY TAKING

15. PHYSICAL EXAMINATION
    n.a.

16. DIAGNOSIS

17. MANAGEMENT

OTHER FEEDBACK
<table>
<thead>
<tr>
<th>HABIT</th>
<th>SKILLS</th>
<th>TECHNIQUES AND EXAMPLES</th>
<th>PAYOFF</th>
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</thead>
<tbody>
<tr>
<td><strong>INVEST IN THE BEGINNING</strong></td>
<td>Create rapport quickly</td>
<td><em>Introduce self to everyone in the room</em>  &lt;br&gt; <em>Acknowledge wait</em>  &lt;br&gt; <em>Convey knowledge of patient's history by commenting on prior visit or problem</em>  &lt;br&gt; <em>Attend to patient's comfort</em>  &lt;br&gt; <em>Make a social comment or ask a nonmedical question to put patient at ease</em>  &lt;br&gt; <em>Adapt own language, pace, and posture in response to patient</em></td>
<td><em>Establishes a welcoming atmosphere</em>  &lt;br&gt; <em>Alleviates fear of visit</em>  &lt;br&gt; <em>Increases diagnostic accuracy</em>  &lt;br&gt; <em>Requires less work</em>  &lt;br&gt; <em>Minimizes &quot;Oh, by the way...&quot; at the end of visit</em>  &lt;br&gt; <em>Facilitates negotiating an agenda</em>  &lt;br&gt; <em>Decreases potential for conflict</em></td>
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<tr>
<td></td>
<td>Elicit patient's concerns</td>
<td><em>Start with open-ended questions:</em>  &lt;br&gt; &quot;What would you like help with today?&quot;  &lt;br&gt; &quot;What worries you most about this problem?&quot;  &lt;br&gt; &quot;What else?&quot;  &lt;br&gt; Speak directly with patient when using an interpreter</td>
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<td></td>
<td>Plan the visit with the patient</td>
<td><em>Repeat concerns back to check understanding:</em>  &lt;br&gt; <em>Let patient know what to expect:</em> &quot;How about if we start with talking more about... then I'll do an exam, and then we'll go over possible tests/ways to treat this? Sound OK?&quot;  &lt;br&gt; <em>Prioritize when necessary:</em> &quot;Let's make sure we talk about X and Y. It sounds like you also want to make sure we cover Z. If we can't get to the other concerns, let's...&quot;</td>
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<tr>
<td><strong>EXCITE THE PATIENT'S PERSPECTIVE</strong></td>
<td>Ask for patient's ideas</td>
<td><em>Assess patient's point of view:</em>  &lt;br&gt; &quot;What do you think is causing your symptoms?&quot;  &lt;br&gt; &quot;What worries you most about this problem?&quot;  &lt;br&gt; Ask about ideas from significant others</td>
<td></td>
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<tr>
<td></td>
<td>Elicit specific requests</td>
<td><em>Determine patient's goal in seeking care:</em> &quot;When you've been thinking about this visit, how were you hoping I could help?&quot;</td>
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<td></td>
<td>Explore the impact on the patient's life</td>
<td><em>Check context:</em> &quot;How has the illness affected your daily activities/work/family?&quot;</td>
<td></td>
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<tr>
<td><strong>DEMONSTRATE EMPATHY</strong></td>
<td>Be open to patient's emotions</td>
<td><em>Assess changes in body language and voice tone</em>  &lt;br&gt; <em>Look for opportunities to use brief empathic comments or gestures</em></td>
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<td></td>
<td>Make at least one empathic statement</td>
<td><em>Name a likely emotion:</em> &quot;That sounds really upsetting.&quot;  &lt;br&gt; <em>Compliment patient on efforts to address problem</em></td>
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<td>Convey empathy nonverbally</td>
<td><em>Use a pause, touch, or facial expression</em></td>
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<td></td>
<td>Be aware of your own reactions</td>
<td><em>Use own emotional response as a clue to what patient might be feeling</em>  &lt;br&gt; <em>Take a brief break if necessary</em></td>
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<tr>
<td><strong>INVEST IN THE END</strong></td>
<td>Deliver diagnostic information</td>
<td><em>Frame diagnosis in terms of patient's original concerns</em>  &lt;br&gt; <em>Test patient's comprehension</em></td>
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<td></td>
<td>Provide education</td>
<td><em>Explain rationale for tests and treatments</em>  &lt;br&gt; <em>Review possible side effects and expected course of recovery</em>  &lt;br&gt; <em>Recommend lifestyle changes</em>  &lt;br&gt; <em>Provide written materials and refer to other sources</em></td>
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<td></td>
<td>Involve patient in making decisions</td>
<td><em>Discuss treatment goals</em>  &lt;br&gt; <em>Explain options, listening for the patient's preferences</em>  &lt;br&gt; <em>Set limits respectfully:</em> &quot;I can understand how getting that test makes sense to you. From my point of view, since the results won't help us diagnose or treat your symptoms, I suggest we consider this instead.&quot;  &lt;br&gt; <em>Assess patient's ability and motivation to carry out plan</em></td>
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<td></td>
<td>Complete the visit</td>
<td><em>Ask for additional questions:</em> &quot;What questions do you have?&quot;  &lt;br&gt; <em>Assess satisfaction:</em> &quot;Did you get what you needed?&quot;  &lt;br&gt; <em>Reassure patient of ongoing care</em></td>
<td></td>
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