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.
   (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.

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

<table>
<thead>
<tr>
<th>Disease framework</th>
<th>Illness framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>The biomedical perspective</td>
<td>The patient's perspective</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Ideas</td>
</tr>
<tr>
<td>Signs</td>
<td>Concerns</td>
</tr>
<tr>
<td>Investigations</td>
<td>Expectations</td>
</tr>
<tr>
<td>Feelings and thoughts</td>
<td>Feelings and thoughts</td>
</tr>
<tr>
<td>Underlying pathology</td>
<td>Effects on life</td>
</tr>
<tr>
<td>Differential diagnosis</td>
<td>Understanding the patient's unique experience of the illness</td>
</tr>
</tbody>
</table>

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 had been used 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>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gathering data</td>
<td>a) Open-ended questions</td>
</tr>
<tr>
<td></td>
<td>b) Open to closed cone</td>
</tr>
<tr>
<td></td>
<td>c) Facilitation</td>
</tr>
<tr>
<td></td>
<td>d) Checking</td>
</tr>
<tr>
<td></td>
<td>e) Survey of problems</td>
</tr>
<tr>
<td></td>
<td>f) Negotiate priorities</td>
</tr>
<tr>
<td></td>
<td>g) Clarification and direction</td>
</tr>
<tr>
<td></td>
<td>h) Summarising</td>
</tr>
<tr>
<td></td>
<td>i) Elicit patient’s expectations</td>
</tr>
<tr>
<td></td>
<td>j) Elicit patient’s ideas about aetiology</td>
</tr>
<tr>
<td></td>
<td>k) Elicit impact of illness on patient’s quality of life</td>
</tr>
<tr>
<td>2. Developing rapport</td>
<td>a) Reflection</td>
</tr>
<tr>
<td></td>
<td>b) Legitimation</td>
</tr>
<tr>
<td></td>
<td>c) Support</td>
</tr>
<tr>
<td></td>
<td>d) Partnership</td>
</tr>
<tr>
<td></td>
<td>e) Respect</td>
</tr>
<tr>
<td>3. Education and motivation</td>
<td>a) Education about illness</td>
</tr>
<tr>
<td></td>
<td>b) Negotiation and maintenance of a treatment plan</td>
</tr>
<tr>
<td></td>
<td>c) Motivation of non-adherent patients</td>
</tr>
</tbody>
</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”.
Smith has developed an evidence-based, step-wise, chronological model of the medical encounter that integrates patient-centred and doctor-centred communication skills into a unified method. This model has been tested in a number of randomized controlled trials where it has been shown to be effective and easily taught. Smith’s text, now in its third edition, is endorsed by the AACH which receives all royalties; the model is used by the AACH in its courses.

The first five steps of the model (also known as the 5-Step Model) are behaviour-based and stress rapport-building, thorough agenda-setting and skills to elicit the patient’s symptom story, and the personal and emotional context of the illness; it provides guidance for verbal empathic responses. Time-guides are used to stress the efficiency of patient-centred communication in busy practices.

The first five steps are:
1. Set the Stage for the Interview
2. Elicit the Chief Concern and Set Agenda
3. Begin Interview: Non-focusing Skills that Help the Patient to Express Her/Himself
4. Use Focusing Skills to Learn 3 Things: Symptom Story, Personal Context and Emotional Context
5. Transition to Middle of the Interview (Clinician-centred Phase)

See appendix for the full version of the instrument
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)
14. **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**

15. **The Maastricht Maas Global (van Thiel and van Dalen 1995)**

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**
16. **The Four Habits Approach to Effective Clinical Communication** (Permanente Medical Group 1999)

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 increase 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**

17. **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
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)
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**

1. **Prior** to the consultation – Thoughts, feelings and actions

2. **Relationship** – Hello, let the patient talk! Show that you see, believe and want to help

3. **Anxieties** – ideas, concerns and expectations

4. **Common language** – a summary of the problems presented

**The Doctor’s part**

5. **Translating** – enquiry into history, clinical examination and finally explanation, suggesting a plan

**The Common part**

6. **Interaction** – negotiation re solutions, possibly change of frame of reference, contract, e.g. a shared understanding

7. **Converting insight into action** – what can impede or promote. From insight to action

8. **Agreement check** – Follow up – safety net

9. **Let’s try it** – Anything else? Goodbye and housekeeping
REFERENCES

1 Working Party of the Royal College of General Practitioners (1972)

2 Stott N C H & Davis R H (1979)
The Exceptional Potential in each Primary Care Consultation:

3 Byrne P S & Long B E L (1976)
Doctors talking to Patients: London HMSO

4 Heron J (1975)
A Six Category Intervention Analysis: Human Potential Research Project, University of Surrey

5 Helman C G (1981)
Disease versus Illness in General Practice

6 Stewart Ian, Jones Vann (1991)
T A Today: A New Introduction to Transactional Analysis
Lifespace Publishing

The Consultation: An Approach to Learning and Teaching:
Oxford: OUP

8 Neighbour R (1987)
The Inner Consultation
MTO Press; Lancaster

Patient Centred Medicine
Sage Publications

The Medical Interview, The Three Function Approach
Mosby-Year Book

11 Smith RC & Hoppe R (1991)
The Patient's Story: Integrating the Patient- and Physician-Centered Approaches to Interviewing.

Patient-Centered Interviewing: an Evidence-Based Method. 2nd ed.
Lippincott Williams & Wilkins.

Smith's Patient-Centered Interviewing: An Evidence-Based Method. 3rd ed.
McGraw-Hill.
12 Kurtz S & Silverman J (1996)
The Calgary-Cambridge Observation Guides: an aid to defining the
curriculum and organising the teaching in Communication Training
Programmes.
Med Education 30, 83-9

Skills for Communicating with Patients

Marrying Content and Process in Clinical Method Teaching; Enhancing the Calgary-
Cambridge Guides Academic Medicine volume 78 no. 8 pp 802-809

14 Makoul G. (2001)
The SEGUE Framework for teaching and assessing communication skills Patient Educ
Couns. 45(1):23-34.

15 Jacques van Thiel, Paul Ram, Jan van Dalen (2000)
MAAS-Global 2000
Maastricht University, Netherlands

16 Makoul G. (2001)
Essential Elements of Communication in Medical Encounters: The Kalamazoo Consensus
Statement Academic Medicine: 76 - Issue 4 - p 390-393

Patient Education and Counseling 23(2): 131-140.

18 Richard M. Frankel and Terry Stein (1999)
Getting the Most out of the Clinical Encounter: The Four Habits Model
The Permanente Journal / Fall 1999 / Volume 3 No. 3

19 J H Larsen, O Risør and S Putnam (1997)
APPENDIX
ENHANCED CALGARY-CAMBRIDGE GUIDE TO THE MEDICAL INTERVIEW

THE BASIC FRAMEWORK

Providing Structure

Initiating the Session

Gathering information

Physical Examination

Explanation and

Closing the Session

Building the relationship

THE EXPANDED FRAMEWORK
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)
- sequence of events
- symptom analysis
- relevant systems review

the patient’s perspective
- ideas and beliefs
- concerns
- expectations
- effects on life
- feelings

background information - context
- past medical history
- drug and allergy history
- family history
- personal and social history
- systems review
# REVISED CONTENT GUIDE TO THE MEDICAL INTERVIEW

<table>
<thead>
<tr>
<th>Patient's Problem List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploration of Patient's Problems</td>
</tr>
<tr>
<td><strong>Medical Perspective – disease</strong></td>
</tr>
<tr>
<td>Sequence of events</td>
</tr>
<tr>
<td>Symptom analysis</td>
</tr>
<tr>
<td>Relevant systems review</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Background Information - Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past Medical History</td>
</tr>
<tr>
<td>Drug and Allergy History</td>
</tr>
<tr>
<td>Family History</td>
</tr>
<tr>
<td>Personal and Social History</td>
</tr>
<tr>
<td>Review of Systems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differential Diagnosis - Hypotheses</td>
</tr>
<tr>
<td>Including both disease and illness issues</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician's Plan of Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigations</td>
</tr>
<tr>
<td>Treatment alternatives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Explanation and Planning with Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>What the patient has been told</td>
</tr>
<tr>
<td>Plan of action negotiated</td>
</tr>
</tbody>
</table>
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 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
The SEQUEL Framework (long form) Patient: ___________________________ Physician: ___________________________

Set the Stage Y Y N
1. Greet pt appropriately | | |
2. Establish reason for visit | | |
3. Outline agenda for visit (e.g., "anything else?", issues, sequence) | | |
4. Make a personal connection during visit (e.g., go beyond medical issues) | | |
→ 5. Maintain pt’s privacy (e.g., knock, close door) | | |

Elicit Information n/a Y Y No
6. Elicit pt’s view of health problem and/or progress (ideas, concerns) | | |
7. Explore psychosocial/physiological factors (signs, symptoms) | | |
8. Explore psychosocial/intentional factors (e.g., living situation, family relations, stress) | | |
9. Discuss antecedent treatments (e.g., self-care, last visit, other care) | | |
10. Discuss how health problem affects pt’s life (e.g., quality-of-life) | | |
11. Discuss lifestyle issues/prevention strategies (e.g., health risks) | | |
→ 12. Avoid directive/leading questions | | |
→ 13. Give pt opportunity/time to talk (e.g., don’t interrupt) | | |
14. Listen. Give pt undivided attention (e.g., face pt, verbal acknowledgement, non-feedback) | | |
→ 15. Check/listen information (e.g., recap, ask "how much") | | |

Give Information n/a Y Y No
16. Explain rationale for diagnostic procedures (e.g., exam, tests) | | |
17. Teach pt about his/her own body & situation (e.g., provide feedback from examination, explain anatomy/diagnosis) | | |
18. Encourage pt to ask questions | | |
→ 19. Adapt to pt’s level of understanding (e.g., avoid/explain jargon) | | |

Understand the Patient’s Perspective n/a Y Y No
20. Acknowledge pt’s accomplishments/progress/challenges | | |
21. Acknowledge waiting time | | |
→ 22. Express caring, concern, empathy | | |
23. Maintain a respectful tone | | |
End the Encounter Y Y No
24. Ask if there is anything else pt would like to discuss | | |
25. Review next steps with pt | | |

If suggested a new or modified treatment/prevention plan: n/a Y Y No
26. Discuss pt’s interests/expectations/long-term societal impact | | |
27. Involve pt in decision-making plan (e.g., options, rationale) | | |
28. Explain likely benefits of the option(s) discussed | | |
29. Explain likely side-effects/risks of the option(s) discussed | | |
30. Provide complete instructions for plan | | |
31. Discuss pt’s ability to follow plan (e.g., attitude, time, resources) | | |
32. Discuss importance of pt’s role in treatment/prevention | | |

MASS-Global Rating List for Consultation Skills of Doctors
Jacques van Thielen, Paul Rosse, Jan van Delden
Maastricht University, Netherlands
2000

doctor name ___________________________ registration number ___________________________

case patient observer

0 = not present 2 = unsatisfactory 4 = satisfactory 6 = excellent
1 = poor 3 = doubtful 5 = good
n = not applicable

The rating boxes are cancelled only as a reminder for the observer. Circle the relevant rating for each item.

SECTION 1: COMMUNICATION SKILLS FOR EACH SEPARATE PHASE

1. INTRODUCTION
   giving the patient an “initial” general overview of the reasons for visit
   asking about other reasons for visit
   0 1 2 3 4 5 6

2. FOLLOW-UP CONSIDERATION
   naming previous complaints, requests for help and management plan
   asking about adherence to management plan
   asking about the course of the complaint
   0 1 2 3 4 5 6

3. REQUEST FOR HELP
   naming requests for help, wishes or expectations
   naming reasons that prompted the patient to come new
   0 1 2 3 4 5 6

4. PHYSICAL EXAMINATION
   instructions to the patient
   explanation of what is being done
   treating the patient with care and respect
   0 1 2 3 4 5 6

5. DIAGNOSIS
   naming findings and diagnostic hypotheses
   naming cause or the relation between findings and diagnosis
   naming prognosis or expected course
   asking for pt’s response
   0 1 2 3 4 5 6

6. MANAGEMENT
   named diagnosis,
   discussing alternatives, risks and benefits
   discussing feasibility and adherence
   determining who will do what and when
   asking for pt’s response
   0 1 2 3 4 5 6

7. EVALUATION OF CONSULTATION
   general question
   responding to requests for help perspective for the time being
   0 1 2 3 4 5 6

SECTION 2: GENERAL COMMUNICATION SKILLS

8. EXPLORATION
   exploring requests for help, wishes or expectation
   exploring patient’s response to information given
   within patient’s frame of reference
   responding to successful behavior and cues
   0 1 2 3 4 5 6

9. EMOTIONS
   asking about explorer findings
   reflecting feelings (including nature and intensity)
   sufficiently throughout the entire consultation
   0 1 2 3 4 5 6

10. INFORMATION GIVING
    summarizing, reiterating
    in small quantities, concrete expressions in understandable language
    asking whether the patient understands
    0 1 2 3 4 5 6

11. SUMMARIZATIONS
    content is correct, complete
    concise, explained
    sufficiently throughout the entire consultation
    0 1 2 3 4 5 6

12. STRUCTURING
    logical sequence of phases
    balanced division of time
    announcing (history taking, examination, other phases)
    0 1 2 3 4 5 6

13. EMPATHY
    concerned, caring and sincerely empathetic
    in intonation, gesture and eye contact
    expressing empathy in brief verbal responses
    0 1 2 3 4 5 6

SECTION 3: MEDICAL ASPECTS
   Rate according to professional guidelines if they are available.
   Obtain scores to the best of your ability.
   0 1 2 3 4 5 6

34. HISTORY TAKING

35. PHYSICAL EXAMINATION

36. DIAGNOSIS

37. MANAGEMENT

OTHER FEEDBACK
<table>
<thead>
<tr>
<th>Habit</th>
<th>Skills</th>
<th>Techniques and Examples</th>
<th>Insight</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Four Habits Model</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Make the visit patient-centered</strong></td>
<td>Establish rapport quickly</td>
<td>- Introductory call to everyone in the room&lt;br&gt;- Introduce yourself&lt;br&gt;- Establish trust by reassuring the patient about their values and priorities&lt;br&gt;- Address patient’s concerns&lt;br&gt;- Ask questions in a sensitive manner&lt;br&gt;- Ask if the patient understands the questions or if they need a summary of the discussion&lt;br&gt;- Use non-verbal language, style, and pace in response to patient</td>
<td>- Establishes a welcoming environment&lt;br&gt;- Encourages open communication&lt;br&gt;- Facilitates understanding and trust&lt;br&gt;- Reduces patient anxiety&lt;br&gt;- Enhances patient satisfaction&lt;br&gt;- Increases potential for accuracy</td>
</tr>
<tr>
<td></td>
<td>Meet the next with the patient</td>
<td>- Introduce yourself&lt;br&gt;- Use respectful language&lt;br&gt;- Use the patient’s name&lt;br&gt;- Establish a connection by asking the patient about their concerns&lt;br&gt;- Use non-verbal language, style, and pace in response to patient</td>
<td>- Establishes a respectful environment&lt;br&gt;- Encourages open communication&lt;br&gt;- Facilitates understanding and trust&lt;br&gt;- Reduces patient anxiety&lt;br&gt;- Enhances patient satisfaction&lt;br&gt;- Increases potential for accuracy</td>
</tr>
<tr>
<td><strong>Talk to patients in their language</strong></td>
<td>Ask for patient’s ideas</td>
<td>- Ask patients about their goals&lt;br&gt;- Ask what their main concerns are&lt;br&gt;- Ask about their values and priorities&lt;br&gt;- Use non-verbal language, style, and pace in response to patient</td>
<td>- Establishes a respectful environment&lt;br&gt;- Encourages open communication&lt;br&gt;- Facilitates understanding and trust&lt;br&gt;- Reduces patient anxiety&lt;br&gt;- Enhances patient satisfaction&lt;br&gt;- Increases potential for accuracy</td>
</tr>
<tr>
<td></td>
<td>Check specific requests</td>
<td>- Check specific requests&lt;br&gt;- Check for understanding&lt;br&gt;- Use non-verbal language, style, and pace in response to patient</td>
<td>- Establishes a respectful environment&lt;br&gt;- Encourages open communication&lt;br&gt;- Facilitates understanding and trust&lt;br&gt;- Reduces patient anxiety&lt;br&gt;- Enhances patient satisfaction&lt;br&gt;- Increases potential for accuracy</td>
</tr>
<tr>
<td><strong>Make at least one empathetic statement</strong></td>
<td>Support the impact on the patient’s life</td>
<td>- Support the impact on the patient’s life&lt;br&gt;- Use non-verbal language, style, and pace in response to patient</td>
<td>- Establishes a respectful environment&lt;br&gt;- Encourages open communication&lt;br&gt;- Facilitates understanding and trust&lt;br&gt;- Reduces patient anxiety&lt;br&gt;- Enhances patient satisfaction&lt;br&gt;- Increases potential for accuracy</td>
</tr>
<tr>
<td></td>
<td>Be aware of your own reactions</td>
<td>- Be aware of your own reactions&lt;br&gt;- Use non-verbal language, style, and pace in response to patient</td>
<td>- Establishes a respectful environment&lt;br&gt;- Encourages open communication&lt;br&gt;- Facilitates understanding and trust&lt;br&gt;- Reduces patient anxiety&lt;br&gt;- Enhances patient satisfaction&lt;br&gt;- Increases potential for accuracy</td>
</tr>
<tr>
<td><strong>Define diagnostic information</strong></td>
<td>Provide education</td>
<td>- Provide education for tests and treatments&lt;br&gt;- Use non-verbal language, style, and pace in response to patient</td>
<td>- Establishes a respectful environment&lt;br&gt;- Encourages open communication&lt;br&gt;- Facilitates understanding and trust&lt;br&gt;- Reduces patient anxiety&lt;br&gt;- Enhances patient satisfaction&lt;br&gt;- Increases potential for accuracy</td>
</tr>
<tr>
<td></td>
<td>Invite patient in making decisions</td>
<td>- Invite patient in making decisions&lt;br&gt;- Use non-verbal language, style, and pace in response to patient</td>
<td>- Establishes a respectful environment&lt;br&gt;- Encourages open communication&lt;br&gt;- Facilitates understanding and trust&lt;br&gt;- Reduces patient anxiety&lt;br&gt;- Enhances patient satisfaction&lt;br&gt;- Increases potential for accuracy</td>
</tr>
<tr>
<td></td>
<td>Complete the visit</td>
<td>- Complete the visit&lt;br&gt;- Use non-verbal language, style, and pace in response to patient</td>
<td>- Establishes a respectful environment&lt;br&gt;- Encourages open communication&lt;br&gt;- Facilitates understanding and trust&lt;br&gt;- Reduces patient anxiety&lt;br&gt;- Enhances patient satisfaction&lt;br&gt;- Increases potential for accuracy</td>
</tr>
</tbody>
</table>
Smith’s Patient-Centered Interviewing

- **Step 1. Set the Stage (30-60 sec)**
  - Take a breath, knock, wait
  - Welcome/greet the patient/parent
  - Use the patient’s/parent’s name
  - Introduce yourself and identify your specific role
  - Ensure patient readiness and privacy
  - Remove barriers to communication (sit down)
  - Ensure comfort and put patient at ease (social talk)

- **Step 2. Elicit chief concern and set agenda (1-2 min)**
  - Indicate time available
  - Forecast what you would like to have happen in the interview
  - Obtain list of all issues patient wants to discuss: specific symptoms, requests, forms, expectations, understanding
  - Summarize and finalize the agenda; negotiate specifics if too many agenda items.

- **Step 3. Begin the interview with non-focusing skills that help the patient to express her/himself (30-60 sec)**
  - Start with an open-ended request/question
    - “Tell me about your headache.”
  - Use nonfocusing open-ended skills (attentive listening):
    - silence, neutral utterances, nonverbal encouragement
  - Obtain additional data from nonverbal sources
    - Nonverbal cues, physical characteristics, autonomic changes, accoutrements, environment, Self

- **Step 4. Use focusing skills to learn 3 things: Symptom Story, Personal Context, and Emotional Context (3–10 min)**
  - **Elicit symptom story**
    - Description of symptoms, using focusing open-ended skills such as:
      - Echoes (repeat the patient’s words, eg, “excruciating pain?”)
      - Requests (“That sounds important; can you tell me more about it?”)
      - Summaries (“First you had a fever, then 2 days later your knee began to hurt, and yesterday you began to limp.”)
  - **Elicit personal context**
    - Broader personal/psychosocial context of symptoms, patient beliefs/attributions, again using focusing open-ended skills.
  - **Elicit emotional context**
    - Use emotion-seeking skills.
      - Direct: “How are you doing with this?.” “How does this make you feel?.” “How has this affected you emotionally?”
      - Indirect: Impact (eg, “How has this affected your life?” “What has your knee pain been like for your family?”); Beliefs about the problem (eg, “What do you think might be causing your knee pain?”); Triggers (eg, “What made you decide to come in now for your …?” “What else is going on in your life?”); Self-disclosure (eg, “I think I might be frustrated if that happened to me.”)
    - Respond to feelings/emotions
      - Name: “You say being disabled by this knee pain makes you angry.”
      - Understand: “I can understand your feeling this way.”
      - Respect: “This has been a difficult time for you. You show a lot of courage.”
      - Support: “I want to help you get to the bottom of this and see what we can do.”
    - Expand the story
      - Continue eliciting further personal and emotional context, address feelings/emotion with NURS.

- **Step 5. Transition to middle of the interview (clinician-centered phase) (30–60 s)**
  - Brief summary.
  - Check accuracy.
  - Indicate that both content and style of inquiry will change if the patient is ready (“I’d like to switch gears now and ask you some questions to better understand what might be going on.”).
  - Continue with Middle of interview

- **Step 6 – Obtain a Chronological Description of the HPI/OAP**
  - Obtaining and describing data without interpreting it
    - Describe symptoms already introduced by the patient
    - Describe symptoms not yet introduced in the already identified body system (and general health symptoms)
  - Interpreting data while obtaining it: Testing hypotheses about the possible disease meaning of symptoms
    - Describe relevant symptoms outside the body system involved in the HPI
    - Inquire about the presence or absence of relevant nonsymptom data (secondary data) not yet introduced by the patient
  - Understand the patient’s perspective
    - Impact (Meaning) of Illness on Self/Others
Health beliefs
• Triggers for seeking care
*(Only clinical-level students are expected to be proficient with this style of inquiry.)*

Step 7—Past Medical History
• Inquire about general state of health and past illnesses
  • Childhood: measles, mumps, rubella, chicken pox, scarlet fever, and rheumatic fever
  • Adult: hypertension, heart attack, stroke, heart murmur, other heart disease, diabetes, tuberculosis, sexually transmitted infections, cancer, major treatments in the past (blood transfusions, steroid treatments, anticoagulation), and visits to healthcare providers during the last year
• Inquire about past injuries, accidents, psychological problems, unexplained problems, procedures, tests, psychotherapy
• Elicit past hospitalizations (medical, surgical, obstetric, rehabilitation, and psychiatric)
• Review the patient’s immunization history
  • Childhood: measles, mumps, rubella, polio, hepatitis B, tetanus/pertussis/diphtheria, HPV, influenza, meningococcal, varicella, haemophilus influenzae type B, rotavirus
  • Adult: Diphtheria/tetanus/pertussis boosters, hepatitis B, hepatitis A, influenza, pneumococcal pneumonia, herpes zoster
• Inquire about status of age-appropriate preventive screening
• Obtain the female patient’s women’s health history
  • Age of menarche, cycle length, length of menstrual flow, number of tampons/pads used per day
  • Number of pregnancies, complications; number of live births, spontaneous vaginal deliveries/cesarean section; number of spontaneous and therapeutic abortions
  • Age of menopause
• List current medications, including dose and route
  • *Environmental, medications, foods
  • Ensure that medication “allergies” are not actually expected side effects or nonallergic adverse reactions

Step 8—Social History

<table>
<thead>
<tr>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workplace</strong></td>
</tr>
<tr>
<td><strong>Level of responsibility</strong></td>
</tr>
<tr>
<td><strong>Daily routine and schedule</strong></td>
</tr>
<tr>
<td><strong>Health hazards</strong></td>
</tr>
<tr>
<td><strong>Occupational exposures</strong></td>
</tr>
<tr>
<td><strong>Work stress</strong></td>
</tr>
<tr>
<td><strong>Financial stress</strong></td>
</tr>
<tr>
<td><strong>Satisfaction</strong></td>
</tr>
</tbody>
</table>

Health Promotion

Diet

Physical activity/exercise history

Functional status
• Dressing
• Bathing
• Feeding
• Transferring
• Walking
• Shopping
• Using the toilet
• Using the telephone
• Cooking
• Cleaning
• Driving
• Taking medication
• Managing finance
• Cognitive function
• Extent of interference with normal life

Safety
• Seatbelt use
• Safety helmet use
• Smoke detectors in home
• Toxins at work and home
• Safe gun storage
Exposures
- Pets
- Travel
- Illness at home, in the workplace
- Sexually transmitted infections

Substance Use
- Caffeine
- Tobacco
  - Forms
  - Pack-years
- Alcohol
  - Type and amount consumed at 1 time/daily/weekly
  - “CAGE” questions
- Drugs
  - “Recreational” or “street” drugs
  - Illicit use of prescription drugs

Personal
- Living arrangement (with whom, how are things at home?)
- Personal relationships and support systems (Who do you count on? How have people responded to your illness?)
- Sexuality
  - Orientation

- Practices
- Difficulty

Intimate partner violence/abuse
Life stress
Mood
Spirituality/religion
  - “FICA”

Health literacy
Hobbies, recreation
Important life experiences
- Upbringing and family relationships
- Schooling
- Major losses/adversity
- Military service
- Financial situation
- Aging
- Retirement
- Life satisfaction
- End-of-life planning
- Cultural/ethnic background

Legal issues
- Living will or advance directives
- Power of attorney
- Emergency contact

Items in bold should be asked about in most new patient encounters; they have high yield for risk factor modification, assist in building the doctor-patient relationship, and/or are important to patients but rarely brought up by them. Ask about other items as time allows and as indicated by the patient’s symptom(s).
Step 9—Family History

1. General inquiry
2. Inquire about age and health (or cause of death) of grandparents, parents, siblings, and children
3. Ask specifically about family history of:
   - Diabetes
   - Tuberculosis
   - Cancer
   - Hypertension
   - Stroke
   - Heart disease
   - Hyperlipidemia or high cholesterol
   - Bleeding problems
   - Anemias
   - Kidney disease
   - Asthma
   - Tobacco use
   - Drug use
   - Alcoholism
   - Weight problems
   - Mental illness
   - Depression
   - Suicide
   - Schizophrenia
   - Multiple somatic concerns
   - Symptoms similar to those the patient is experiencing
4. Develop a genogram
   a. Two generations preceding the patient and all subsequently; involves parents, siblings, children, and significant members outside the bloodline for each generation
   b. Age, sex, mental and physical health, and current status are noted for each; note age at death and cause
   c. Note interactions among family members for psychological and physical/disease problems
4. Psychological
   a. Dominant members and style (eg, love, anger, alcoholism)
   b. Major interaction patterns (eg, competition, abuse, open, distant, caring, manipulation, codependent)
   c. Family gestalt (eg, happy, successful, losers)
5. Physical/disease:
   a. Patterns of disease (eg, dominant, recessive, sex linked, no pattern)
   b. Patterns of physical symptoms without disease (eg, bowel trouble, uncoordinated, headaches)
   c. Inquire about others with similar symptoms (eg, infection, toxic, anxiety, anniversary reaction)

Step 10—Review of Systems

General
Usual state of health
Fever
Chills
Night sweats
Appetite
Weight change
Weakness
Fatigue
Pain
Skin
Sores/skin ulcers
Rashes
Itching (pruritus)
Hives
Easy bruising
Change in size or color of moles
Lumps
Loss of pigment
Change in hair pattern
Change in nails
Hematopoietic
Enlarged lymph nodes (lymphadenopathy)
Urges to eat dirt (pica) or ice
Abnormal bleeding or excessive bruising
Frequent or unusual infections
Head
Dizziness
Headaches
Fainting or loss of consciousness
Head injuries
Eyes
Use of glasses
Change in vision
Double vision (diplopia)
Pain
Redness
Discharge
History of glaucoma
Cataracts
Dryness
Ears
Hearing loss
Use of hearing aid
Discharge
Pain
Ringing (tinnitus)
Nose
Nosebleeds (epistaxis)
Discharge
Loss of smell (anosmia)
Mouth and throat
Bleeding gums
Sore throat
Neck
Lumps
Goiter
Stiffness
Breasts
Lumps
Milky discharge (galactorrhea)
Bleeding from the nipple
Pain
Cardiac and pulmonary
Cough
Shortness of breath (dyspnea)
Shortness of breath with activity (exertional dyspnea)
Shortness of breath when lying down and need to sit up to breathe (orthopnea)
Awaking at night with shortness of breath (paroxysmal nocturnal dyspnea)
Sputum production
Coughing blood (hemoptyis)
Wheezing
Chest pain
Pounding or fluttering sensation in the chest (palpitations)
Shortness of breath on exertion
Swelling of feet or other regions (edema)
Vascular
Pain in legs, calves, thighs, hips, or buttocks when walking (claudication)
Leg swelling
Blood clots (thrombophlebitis)
Leg ulcers
Gastrointestinal
Loss of appetite
Weight change
Nausea
Vomiting (emesis)
Vomiting blood (hematemesis)
Swallowing difficulty (dysphagia)
Swallowing pain (odynophagia)
Heartburn (dyspepsia)
Abdominal pain
Difficult or infrequent bowel movements
(constipation)
Loose, frequent bowel movements (diarrhea)
Passing mucus
Change in stool color / caliber
Black, tarry stools (melena)
Rectal bleeding (hematochezia)
Hemorrhoids
Rectal pain (proctalgia)
Rectal discharge
Rectal itching (pruritus ani)
Yellow discoloration of sclerae and skin (jaundice)
Dark urine the color of tea or cola drink
Excessive upper (belching or eructation) or lower (flatus) bowel gas
Lump in groin or scrotum

**Urinary**
Frequent urination (polyuria)
Awakening at night to urinate (nocturia)
Infrequent urination
Abrupt urge to urinate (urinary urgency)
Difficulty starting stream (urinary hesitancy)
Loss of control of urination (incontinence)
Blood in urine (gross hematuria)
Pain or burning on urination (dysuria)
Particulate matter in urine (urinary gravel)

**Female genital**
Lesions / discharge / itching

<table>
<thead>
<tr>
<th>Medical terms</th>
<th>Medical terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at menarche</td>
<td>Intervals between menses</td>
</tr>
<tr>
<td>Duration of menses</td>
<td>Amount of flow</td>
</tr>
<tr>
<td>Last menses</td>
<td>Painful menses (dysmenorrhea)</td>
</tr>
<tr>
<td>Absence of menses (amenorrhea)</td>
<td>Irregular, heavy menses</td>
</tr>
<tr>
<td>(menometrorrhagia)</td>
<td>Bleeding between periods</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Abortions / miscarriages</td>
</tr>
<tr>
<td>Libido</td>
<td>Orgasm function</td>
</tr>
<tr>
<td>Painful intercourse (dyspareunia)</td>
<td>Age at menopause</td>
</tr>
<tr>
<td>Menopausal symptoms</td>
<td>Postmenopausal bleeding</td>
</tr>
<tr>
<td><strong>Male genital</strong></td>
<td>Lesions / discharge</td>
</tr>
<tr>
<td>Erectile function</td>
<td>Orgasm function</td>
</tr>
<tr>
<td>Bloody ejaculation (hematospermia)</td>
<td>Testis swelling / pain</td>
</tr>
<tr>
<td>Libido</td>
<td>Hernia</td>
</tr>
<tr>
<td><strong>Neuropsychiatric</strong></td>
<td><strong>Endocrine</strong></td>
</tr>
<tr>
<td>(See Head, Eyes, Ears, Nose, Throat for cranial nerves)</td>
<td>Excessive Thirst</td>
</tr>
<tr>
<td>(See Musculoskeletal for motor)</td>
<td>Frequent Urination</td>
</tr>
<tr>
<td>Fainting</td>
<td>Numbness or tingling of hands / feet</td>
</tr>
<tr>
<td>Paralysis</td>
<td>Weight gain or loss</td>
</tr>
<tr>
<td>Tingling (paresthesia)</td>
<td>Episodes of confusion, sweating, light-headedness (hypoglycemic reaction)</td>
</tr>
<tr>
<td>Decreased sensation (hypesthesia)</td>
<td>Blurred vision</td>
</tr>
<tr>
<td>Absent sensation (anesthesia)</td>
<td>Date of last eye exam</td>
</tr>
<tr>
<td>Tremors</td>
<td>Swelling in neck</td>
</tr>
<tr>
<td>Loss of memory</td>
<td>Weight gain or loss</td>
</tr>
<tr>
<td>Depression</td>
<td>Palpitations or racing heart</td>
</tr>
<tr>
<td>Mania</td>
<td>Tremulousness</td>
</tr>
<tr>
<td>Apathy or loss of interest</td>
<td>Hair loss (alopecia)</td>
</tr>
<tr>
<td>Loss of enjoyment of life (anhedonia)</td>
<td>Dry skin</td>
</tr>
<tr>
<td>Constipation or diarrhea</td>
<td></td>
</tr>
</tbody>
</table>

Medical terms (used in Oral and Written Presentations) are in parentheses.
Many of these symptoms can occur in several systems (including other than where listed).

---

**11. End of the Interview**

- **A. Share the Diagnosis**
  
  Frame diagnosis, treatment and prognosis:
  Revisit the patient’s / parent’s original concerns “You said at the beginning of the visit that you were concerned about your headaches...”

  Many patients / parents come in with a self-diagnosis
  Usually heard during beginning of interview (steps 3 and 4) “…and you were worried that you might have a brain tumor...”

  If not, use ARTS-A (see B.) to learn about patient’s / parent’s perspective and understanding

- Use simple, clear language “Based on what you told me and what I found when examining you, I believe you have...”

- Use pictures or models

- **B. Assess Understanding: Use ARTS-A Iteratively**

  Ask for the other’s perspective- “What do you know about migraine headaches?”

  Respond with empathy (NURS)

  Tell your perspective

  Share decision-making

  Invite the patient / parent to contribute his / her own thoughts, ideas, suggestions and preferences to tailoring diagnostic / treatment plan to his / her individual lifestyle:

  Listen for / ask about the patient’s preferences “People differ in how much they want to be part of making choices about their medical care. How much do you like to be involved?”
Develop plan based on shared treatment goals. “I want to make sure that whatever we decide works for you, so I want you to let me know your preferences and concerns about where to go from here.”

- Focus on achievable goals
- Explore barriers to implementing the treatment plan
  Ask for a teach-back
- “When your family comes to visit what will you tell them about what we discussed?”
- “So that I know if I did a good job explaining things, can you tell me what you have agreed to do?”

C. Close the Visit

Indicate visit closure
Clearly specify the future plans:
  What you will do (leave and write orders, make referrals)
  What the patient will do (wait, drink prep, be brought to MRI)
  When the time of the next communication will be

Elicit final questions
“What questions do you have?”

Acknowledge and support the patient/parent
“It has been a pleasure to meet you and be involved in your care.”
“I’ll be here if you need help.”
“The team at the hospital is here to support you.”
“I’ll see you tomorrow morning.”