GUIDE FOR MEDICAL STUDENTS
COMMUNICATION WITH THE PATIENT

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ORGANIZATION AND COURSE OF CLASSES

A simulated patient (SP) is a properly trained person (usually healthy) who can realistically and accurately recreate the history of a given disease, demonstrating the physical and emotional symptoms of a real patient's disease.

During medical communication classes, students will conduct consultations with simulated patients in a room imitating a doctor's office. The conversation will be recorded, then played back and discussed in the student group. Depending on the scenario, the aim of the classes may be, for example, to practice collecting medical history, making hypothetical diagnosis based on an interview, physical examination and additional tests, planning further treatment of the patient, providing the patient with information, obtaining the patient's consent for the procedure, or other.

At the beginning the teacher will explain the context of the conversation - that is, in what conditions the consultation takes place, whether it is a clinic, emergency room, ER or hospital ward. While playing the role, you can be yourself, i.e. a student, or you can play the role of a doctor and introduce yourself to the patient as a doctor. This will depend on the specific scenario.
The teacher will also explain your task to you. It is most effective to record, play back and discuss short excerpts from the consultation focused on practicing 2-3 skills.

Example:
Teacher: *"Now we will practice starting a consultation and making contact with the patient. Your task will be* ***to invite the patient to the office, introduce yourself and find out what is the problem the patient came with****. You will talk to the patient alone in the office; the conversation will be recorded for about 3-4 minutes. It will be interrupted whether you have finished or not. Other students will observe what is happening in the office through a two-way mirror. Then they will enter the office, watch the recording on the monitor and give you feedback."*

Each student will have the opportunity to practice the same situation. Films with recorded simulated consultations with the participation of students will be used for didactic purposes only. Their dissemination without the student's consent is prohibited and unacceptable.

There will be **no physical examination** during role-play with SP, if the scenario involves making a diagnosis, you will receive information about abnormalities in the physical examination on a paper card.

Before role-playing (before inviting a patient to the office), read the patient's documentation, if the scenario calls for it.

PRINCIPLES OF GIVING CONSTRUCTIVE FEEDBACK

After watching the role-play between the SP and the student, the participants of the session will give feedback, i.e. they will discuss what they saw. **The student who participated in the scene will speak first.** Often, just a moment after the end of the recording, the person playing the role of the doctor is aware that something did not go as well as it was supposed to, that he/ she made mistakes, that next time he/ she would do it differently. Give him/ her a chance to comment on his/her own behavior and express his/ her emotions.

Giving feedback - DESCRIBE what you saw or heard.
DO NOT JUDGE!

Do not use words like *bad, good, right, wrong, awful, stupid, great, perfect, wonderful*. Using such phrases does little for the learner.

Negative assessment, such as:

The beginning was terrible, you ignored the patient! - is not helpful to the learner. It can cause resistance, sometimes even extreme emotions, e.g. crying because of humiliation. It doesn't say anything about what the errors were.

An example of descriptive feedback:

"At the beginning of the conversation, you looked at your notes for quite a long time, you did not make eye contact."

Such feedback is a statement of fact, it is given **without judgment**. This makes it easier for the learner to accept it. It contains specific information about what needs to be changed in the behavior, defines the problem.

Positive evaluation can be equally unhelpful if it is not specific and contains judgment, e.g.:

You were great! It went perfectly!

Such information does not provide anything, because it does not describe the specific behavior that was correct. Despite the praise, the student does not know what to do next time to achieve a similar effect.

An example of descriptive feedback:

"You looked very focused, you watched the patient as he/she spoke and didn't interrupt him/her. I saw you nodding your head, and that encouraged him/her to talk."

Feedback should be DETAILED

Avoid generalizations when giving feedback. Statement, e.g.:

"You were very impatient with the patient, you wanted to get rid of him." - doesn't say anything about why what happened gave that impression.

Feedback should be detailed and accurate. Be very specific about what you saw and heard.

"You looked at your watch while the patient was talking and you interrupted him/her once. You both spoke at the same time for a few seconds."

Such a description is non-judgmental and can provoke a very useful discussion:

"Yes, I was nervous that the patient was talking for so long, going off topic. I didn't know how to interrupt him/her and get the conversation back on track."

Use "I" messages

When giving feedback, **speak for yourself using the first person singular**, i.e.: "*I believe that ...., I saw ..., I noticed, I heard. ., I think..."*

Do not use phrases such as: *"we think....;we saw....; people think.....; others don't like...; it's sad when...; most people think that..."*

Concentrate on your own point of view and on this particular situation.

Focus on BEHAVIOR, not personality.

If you say that someone is *"a hothead"*, you are describing a personality trait, someone's character, which is difficult to change.

If you say to someone: "*You were talking very fast, you were moving your leg in a nervous manner*" - you are describing a behavior that can be changed. You can practice the same situation and a colleague can try to control the pace of speaking and control the legs.

Feedback is given to HELP the LEARNER.

Judgment, ridicule, haughty comments humiliate learners. They do not motivate or encourage behavioral changes.

Feedback should be tailored to the needs of the learner. It should take into account the stage of

teaching (you cannot expect skills or knowledge expected at the 6th year from someone who is in the 3rd year of medicine). Feedback, which is supposed to show one's own superiority, gives nothing, it has a destructive effect on the learner and the whole group. It paralyzes participants, kills openness and creativity.

Positive feedback REINFORCES desirable behaviors

Some people wonder if we should comment the correct behavior. Well, it's worth it - the student, giving positive feedback, identifies, names, realizes the correct behavior, which causes their reinforcement.

Do not give advice.

By providing feedback, we leave the recipient the opportunity to decide which way of acting is the most appropriate for him/ her.

Giving advice is telling someone how to act. This takes away the freedom to make decisions and inadvertently depreciates the people to whom our advice is directed.

There is a very fine line between giving feedback and giving advice. We should avoid giving advice as the primary form of feedback, and lean towards proposing alternative solutions.

Check the interpretation of the feedback

Giving feedback, you should be aware of the consequences of the feedback provided and take responsibility for it. Watch the recipient's reaction carefully – his/her verbal and non-verbal messages.

On the other hand, in case of doubt the recipient of the feedback should verify whether he/she understood it correctly: *"If I understand correctly, you meant that ..."*, or: "*So according to you, it looked as if ....”* This prevents misunderstandings and distortions that often occur when the recipient does not agree with what he/she heard (he/she had other intentions).

It is helpful if both the giver and receiver of feedback make sure that the rest of the group agrees with their perception.

Give only as much information as the recipient is able to accept

Overloading a person with the amount of feedback reduces the effectiveness of feedback. This would be more effective to the teacher than to the learner. The teacher may think that he/she has failed the task if he/she does not refer to everything he/she noticed. It is more effective to focus only on the areas most important to the learner. We have to believe that there will be other opportunities to revisit issues missed during the learning process - there is no point in focusing on everything if the learner cannot take it all in at once.

Give feedback on what can be changed only.

Pointing out someone's faults is pointless. Stuttering, nervous tics can be a problem to be aware

of, but commenting too much on them does not lead to anything constructive. Information such as: "*You didn't look the patient in the eye"* given to a person who has incurable strabismus does nothing, because it cannot be changed.

Similarly, an organizational problem such as a constantly ringing phone may be more difficult to change for the attending physician in the hospital ward, than if the learner is a student or resident. Developing a way to deal with interruptions can be more valuable to the learner than preventing them.

DESCRIPTION OF SKILLS ASSESSED IN STUDENTS DURING A SIMULATED MEDICAL CONSULTATION

ESTABLISHING CONTACT WITH THE PATIENT

Student:

1. **invites the patient from the corridor to the office**: he/ she goes to the door, opens it and invites the patient waiting for a consultation inside
2. **appropriately addresses the patient** (per *"Mrs.", "Mr."*). He/ she does not fraternize, does not use plural "*So how do we feel?"*); does not address the patient in the third person (*"Did she eat breakfast?");* does not use diminutives for people he/she sees for the first time**.**
3. **introduces himself/herself**, explains his/her role, the nature of the interview, if necessary, obtains the patient's consent for the interview
4. **points to a place to sit** at the right distance from each other (not too close and not too far)
5. **confirms the patient's details -** asks for the patient's surname and first name, age, possibly date of birth, or address to make sure that he/she is dealing with the right person.

Useful phrases:

"Good morning my name is……"

"I'm a …… year student of medicine, can I talk to you about your health (disease)?"

"I am a student of ... year of medicine, Doctor Kowalski asked me to talk to you about your ailments, can we do that? "

"Can we talk about the reason for your stay in the hospital?"

"Can you tell me what your name is?"

"How old are you?"

"Could you give me your date of birth/your address?"

IDENTIFICATION OF THE REASON(S) FOR THE CONSULTATION

Student:

1. starts a conversation with the patient by asking an **open question**.

Examples of open questions:

- *"Can you tell me about your health problems?"*
- *"What problems brought you to the clinic?"*
- *„How can I help you?”*
- *"What made you decide to come?"*
- *"What would you like to discuss today?"*
- *"What questions would you like answered?"*
- *"What kind of help are you looking for?"*
- Examples of questions when the consultation takes place in a hospital:
- *"What happened that you were referred to hospital?"*
- *“How did it happen that you were accepted to the ward?”*
- *"Was it a sudden illness?"*

"Can you tell me how you got here, what happened?"

ACTIVE LISTENING TECHNIQUE

Student:

1. makes **eye contact**

2. **does not interrupt the patient** after asking an open question (ask questions about symptoms only after listening to the patient's answer to the open question)

3. **confirms hearing:** nods, uses paralinguistic sounds (*mhmm, aha, uhm*), says: *"I understand", “I see”*

3. **is turned** towards the patient, is sitting leaning towards him

4. **gesticulates carefully** (does not show impatience with involuntary gestures of hands or feet, does not click a pen, does not look around)

5. **does not deal with other matters:** does not answer phone calls, does not read patient records while the patient is talking.

6. **If he/ she reads, writes or uses a computer, he/ she does so in a way that does not interfere with the dialogue and relationship with the patient. Notes individual words only**

so as not to break eye contact. When he/ she wants to make notes in the documentation – he/ she warns the patient about it. *("Now I want to put your symptoms in the documentation"*)

7. **confirms the problem or list of problems** with which the patient came to the doctor

8. **asks questions about not-mentioned issues** (so called **"screening")**

Examples of the **screening**:

- *"So you have back pain**, is there anything else bothering you?"***
- *"I understand that your main problems are headache and weakness, **does anything else bother you?"***
- ***"Would you like to add anything else?"***
- *"I understand that you have lost weight and have troubles with sleeping **is there anything else?"***
- *"So you suspect bronchitis **or perhaps something else?"***
- ***"Have you covered all the problems?"***
- *Is that all? **Anything else** comes to your mind?*

9. **Summarizes** the patient's statements by using **paraphrase** (repeating the patient's own words)

Examples:

- *"From what you say, I understand that your biggest problem is knee pain."*
- *"I see that you are concerned about ……."*
- *"From what I understood……."*
- *"From what you've told me, your biggest problem with……."*
- *"From what I've heard, it appears that ……."*
- *"I understand that you came because ...."*
- *"So you have had a cough and a sore throat for 2 days"*

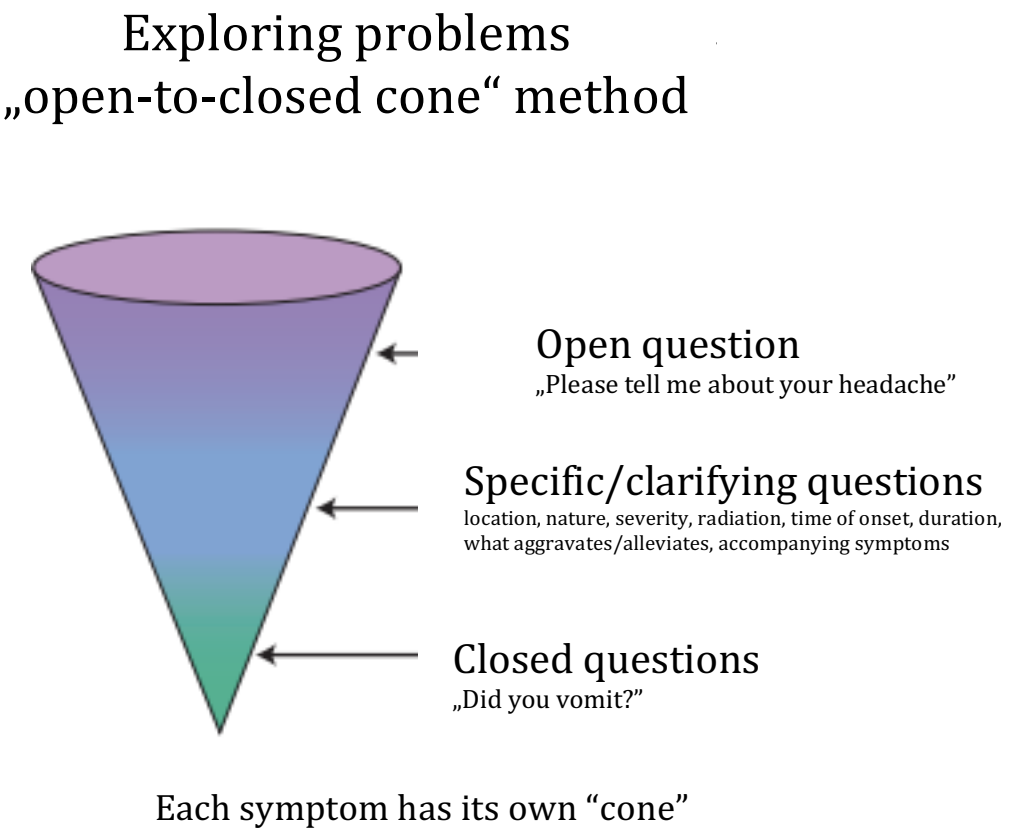
10. **negotiates the consultation plan** (in case the patient reports many problems), creates a list of problems to be discussed, takes into account the patient's needs and the doctor's capabilities. *("So you came in today to renew your prescription for high blood pressure medication, you've had cough for a week, and you need a referral to an eye doctor, is that right?*")

EXPLORING THE PATIENT'S PROBLEMS

Student:

1. encourages the patient to talk about the problem(s) from the beginning to the present in their own words; clears the reason for reporting them **now**

2. uses the correct technique of asking **open and closed** questions; **moves from open to closed questions (so-called <u>cone method</u>)** - explores each reported problem/ symptom asking an open question focused on the problem first, then specific questions, and finally closed questions.



Examples:

<u>Open, problem-oriented questions</u>:

- *"Can you tell me about the dizziness?"*
- *"What's happening to you?"*
- *"Please tell me everything from the beginning"*
- *“So your chest hurts. Please tell me about it, I'm listening."*

<u>Specific questions about the characteristics of the symptom</u>:

- *Where does it hurt you the most?*
- *Can you describe the nature of the pain?*

- *Can you describe the severity of the pain?*
- *How bad is the pain? Can you rate it on a scale of 0 to 10?*
- *Can you tell me when the pain gets worse?*
- *How long do coughing fits last?*
- *How often do you get dizzy?*
- *Are there things that ease the pain?*
- *Does anything bring you relief?*
- *Is there anything that makes these cramps worse?*
- *What causes the symptoms to worsen?*
- *Please tell me where the pain is radiating.*
- *Is it accompanied by other symptoms?*
- *Do you feel anything else?*
- *Did you notice anything else?*

Closed questions (YES or NO answers):

- *Have you vomited?*
- *Did you lose consciousness when you fainted?*
- *Do you remember what happened after the fall?*
- *Was the urine dark in color?*
- *Have you seen blood in your stool?*

Exploring the 7 characteristics of the symptom, questions about:

- beginning
- location,
- properties - e.g. nature of pain,
- severity (e.g. pain on a scale of 1 to 10) or quantity,
- the moment of occurrence and duration, under what conditions the symptoms appear (during exercise, during sleep, after eating, on an empty stomach)
- exacerbating and relieving factors,
- accompanying symptoms

The following mnemonic shortcuts are helpful in evaluating these 7 characteristics:

Acronym "SOCRATES" – especially useful for describing the characteristics of pain

Site, **O**nset – sudden or gradual, increasing or decreasing; **C**haracter – type of pain: burning, stabbing, dull, throbbing; **R**adiation, **A**ssociations – accompanying symptoms, **T**ime course – pain over time, **E**xacerbating/relieving factors, **S**everity – how severe the pain is, e.g. on a scale of 0 to 10

Acronym "OLD CARTS":

Onset,

Location,

Duration,

Character,

Aggravating/Alleviating factors,

Radiation,

Timing

3. uses silence, pauses (without breaking eye contact) - silence allows the patient to gather his/her thoughts, think about the answer.

4. **makes it easier for the patient to express himself verbally and non-verbally -** if he/ she sees that the patient has difficulty answering (does not understand the question) he/ she formulates the question in a different way

5. appropriately **intones his/ her voice**, expressing calmness and composure

6. **picking up verbal and non-verbal cues** (body language, manner of speaking, facial expression of the patient) betraying emotions (embarrassment, shame, nervousness, fear, affection, sadness, stress, joy, despair); if appropriate, he/ she **confirms whether he/she understands them well.**

7. **clarifies** the patient's statements that are imprecise or need to be expanded - this technique is **CLARIFICATION**

Examples:

"Could you explain what you mean by 'it takes your hands away'?"

"You said you felt terrible. Can you describe your ailments?"

"You took everything, can you tell me the names of these medicines?"

"What do you mean by you were sick? What did you feel?"

"You said that you were „high" after this drug. What exactly happened to you?"

"You took protective medicines, what do you mean by that?"

8. periodically **summarizes or repeats the patient's statements** to verify one's own understanding of what the patient has said, encourages correction of this interpretation, encourages further explanation (sometimes it is enough to repeat the patient's word in a questioning tone)

Example:

Patient: „*Yesterday I thought I am going to explode*"

Student: *„Explode?"*

Patient*: „Well, I was so bloated."*

9. uses concise, e**asy-to-understand questions** and comments,

10. **avoids medical jargon** or explains terms that the patient may not understand

*11. **sets** the time (dates) and **sequence of events:***

"How many days ago did you start taking the antibiotic?"
"What happened then?"
"Please tell me everything in order"

12. asks about ailments from **other organs and system**s

LEARNING THE PATIENT'S PERSPECTIVE

The scientific literature of the last 30 years has made it clear, that effective healthcare requires not only making a diagnosis, but also examining what the symptoms and diagnosis mean to the patient, as well as the impact of the disease on his/her life. This model distinguishes and at the same time combines two perspectives: biomedical (diagnosis/disease) and the patient's perspective (illness). The biomedical perspective leads to the collection of information in a way that makes it possible to make a medical diagnosis. The patient's perspective, known as the illness perspective, concerns the impact of the disease on the patients' life, and how they feel and interpret their symptoms. It is extremely important to consider both of these perspectives when interviewing.

Issues that make up the Patient's perspective:
- the patient's thoughts, knowledge and beliefs about the type and cause of the problem,
- Patient's emotions, especially concerns regarding the problem,
- Patient's expectations towards the doctor and health care,
- the impact of this problem on the patient's life and daily functioning,
- previous personal or family experience of a similar illness.

To remember it better, you can also use an acronym **FIFE: Feelings, Ideas, effect on Function, Expectations**

Besides everything, opening to the perspective, emotions and subjective experiences of the Patient can bring key information for further diagnostics, e.g.: *"I'm worried I might have an aortic aneurysm. My uncle died from it"*

In planning the procedure and treatment, both perspectives- the biomedical and the patient's perspective- should be taken into account. **We do not treat symptoms and laboratory tests, we treat specific people in specific life situations**. Effective treatment involves not only knowing and influencing the biological functioning of a person, but also insight into his/ her perception of the disease and the best actions in the context of his/ her expectations and quality of life.

In many other cases research shows that the inclusion of communication parts also has a positive impact on biomedical management. **It has been proven, that taking the patient's perspective into account results in reduction of costs associated with diagnostic tests.**

How to reach the patient's perspective? In terms of biomedical content the medical interview is structured - there is a fairly fixed schedule of when to explore particular topics and it has a full practical justification.

It is more difficult to compose a structured prescription for exploring the patient's perspective. The method of its effective examination will differ in different contexts and with different patients.

Certainly, revealing the patient's perspective is conducive to leaving the patient space for expression, open questions, active listening, summaries, screening, clarifications - i.e. all these communication techniques mentioned above, which support obtaining biomedical content. The very attitude to search for this content is extremely important - as we know, we usually find the things that we ARE looking for. It is also extremely important to

pick up hidden verbal and non-verbal cues from the patient described above - they are mostly from the patient's perspective. In many cases, it may be effective and advisable to ask directly about fears, expectations, understanding of the disease, or the impact on functioning, e.g. *“Is there anything about these symptoms that particularly bothers you?” “Do you associate the occurrence of these symptoms with anything?” "Do the symptoms you describe interfere with your daily life?" Is there a symptom that is the most annoying and that you would like to get rid of?"*

The patient's perspective is related to the subject of empathy. In a sense, getting to know the patient's perspective allows you to turn empathy or the desire to help the patient into concrete action. Getting to know the real and not imagined needs of the patient enables the most effective help, which is the main goal of our profession.

PATIENT PERSPECTIVE EXPLORING SKILLS CHECKLIST

The student determines, defines and properly explores:

1. patient's **ideas** (e.g. about the causes of ailments)

• *What do you think may have caused these symptoms?*

• *Do you have any guesses as to why this happened?*

• *Do you associate these symptoms with anything?*

• *Do you have any suspicions?*

• *Maybe you have an idea what harmed you?”*

2. the patient's **concerns** about each problem

• *Do you suspect something worse?*

• *What worries you most about this weakness?*

3. patient’s **expectations** related to reported problems

• *Do you expect anything from me?*

• *I understand that it's better now. How can I help you now?*

• *Do you expect something specific from me?*

4. **impact of problems on the patient's life**

• *Does it affect your work?*

• *Are you able to look after the children as usual?*

• *How do you deal with household chores?*

• *Do you go to work normally despite the pain?*

• *You have such problems with walking, how do you function at work?*

5. **feelings** related to illness, ailments: e.g. anxiety, fear, unrest

MEDICAL HISTORY INTERVIEW

Student asks about:

1. **past illnesses** (injuries, surgeries, hospital stays)
2. **chronic diseases -** (is the patient treated in specialist clinics?)
3. m**edications taken -** what are they?
4. **Is he/ she allergic to something** - to what?
5. whether he/ she has observed **medications intolerance** in his/her life (abdominal pain, diarrhea, cough, dizziness)
6. **vaccinations -** in childhood - according to the vaccination calendar? Was the patient vaccinated against other diseases in adulthood (influenza, viral encephalitis, travel vaccinations)
7. **preventive examinations -** how long ago were preventive examinations related to the performed work, were there deviations from the normal state, does he/she regularly participate in screening examinations (breast examination, cytology, mammography, prostate examination, colonoscopy)
8. **diseases in the family** - parents, siblings, children. Occurrence of symptoms similar to the patient's. If the parents are dead - what was the reason for their death, at what age did they die?

SOCIAL HISTORY

Problems discussed:

1. **family** - does the patient live with a family or alone? Does he/ she have children (their age); husband, wife, parents, siblings
2. **work** - occupation, education; lifestyle - is work associated with frequent trips, absence from home? Exposure to harmful factors in the workplace
3. **housing** - single-family house or apartment; in the countryside or in the city? How many people live together? The area of the apartment, the number of rooms, having a bathroom, access to running water.

4. **physical activity** - way of spending free time, travelling to work (on foot, by bike, by car), doing sports, traveling.

5. **nutrition -** does the patient follow a slimming, vegetarian diet, for example? Does he/ she eat home-cooked meals? Are they regular?

6. **stimulants:** tobacco/nicotine - mode of use (cigarettes, e-cigarettes, or is he/ she a passive smoker?), alcohol, recreation drugs.

PROVIDING STRUCTURE OF THE CONSULTATION

1. **summarizes the individual threads** of the patient's statement; confirms the agreement of what he/she heard with what the patient meant (by paraphrasing), then moves on to the next point of the conversation; makes sure that important information has not been missed *("Is there anything else?"*)

2. **moves** from one point of consultation to the next **using "transitional" phrases** justifying moving to the next stages of the conversation.

"So far we have talked about your current problems, now I would like to ask about your past illnesses"

"Now I would like to examine you. I'd like to see the throat and listen to the lungs."

KEEPING THE CONVERSATION FLOW

1. **maintains a logical structure and sequence** of information collection (doesn't ask the same questions several times)

2. tries to **control time and sticks to the purpose** of the consultation (does not deviate from the topic)

BUILDING RELATIONSHIP WITH THE PATIENT

1. **understands the patient's point of view and feelings,** does not judge

2. **shows empathy, understanding of the patient's situation and the legitimacy of his feelings**

3. supports the patient: expresses concern, understanding, willingness to help, appreciates the patient's efforts in dealing with a difficult situation and proper self-care, offers cooperation

4. **remains sensitive when discussing topics that cause shame and anxiety** (e.g. questions about the sexual sphere)

“In order to find the cause of your ailments, I need information about your intimate life. May I ask a few questions about this?"

INVOLVING THE PATIENT, PROVIDING EXPLANATION

1. **shares his/her thoughts** to encourage patient participation in decision-making (e.g. *"I think that ....."*)
2. **justifies the need** to ask some questions or the need for a physical examination that may seem illogical to the patient or unrelated to the reported problem.
3. during the physical examination, he/ she **explains what he/ she is doing**, asks for permission.
4. **provides explanations at the right time;** avoids comforting, giving advice, giving information too early.
5. **provides introductory information in a clear, structured way** without overloading the patient with facts, avoids jargon, explains technical terms
6. **concludes an agreement with the patient** regarding the next steps to be taken by the patient and the doctor
7. **checks whether the patient understands** and accepts the explanations and the proposed proceeding plan; acknowledges the patient's concerns
8. summarizes the consultation
9. **encourages and enables the patient to ask questions about not-mentioned issues** (e.g.: *"Do you have any other questions, doubt? Would you like to ask something else? Is there anything else you would like to discuss?")*

CORRECT AMOUNT AND CONTENT OF INFORMATION PROVIDED TO THE PATIENT

1. **begins by summarizing the facts,** defining expectations, establishes a plan
2. **gives information in “small doses” and checks** if the patient understands it; uses the patient's responses as a guide to how much information he or she is able to absorb
3. **evaluates the current state of the patient's knowledge** on a given topic (during previous visits to other doctors, from the Internet, press, own experience); determines how much and what information the patient expects

"Has any other doctor talked to you about this before?”

Have you been in contact with other people who also suffer from diabetes?

4. **asks the patient if he/ she expects other (additional) information** (e.g. on etiology, prognosis)

5. **provides explanations at the right time;** avoids comforting, giving advice, giving information too early

HELP IN PROPER REMEMBERING

AND UNDERSTANDING THE INFORMATION

Student:

1. **organizes explanations:** divides information into separate sections, gives in logical order

2. **uses explicit categorization, clear guidelines, e.g.:**

"There are three important things I would like to discuss. The first one is…"

"Now I'd like to move on to discussing….."

3. **uses repetitions and summaries** to reinforce statements

4. uses concise, **understandable language**, avoids medical jargon, explains medical terms

5. **provides information visually** using diagrams, models, drawings and **in writing**: writes down information on a piece of paper, gives instructions, information leaflets

6. **checks whether the patient understands the information** being conveyed or the planned action, e.g. asking them to repeat the instructions in their own words; explains again if necessary

"I'm not sure if I made myself clear, could you repeat the recommendations?"

IF HE/ SHE INFORMS ABOUT A NEW DIAGNOSIS AND TALKS ABOUT THE SIGNIFICANCE OF THE PROBLEM, THEN:

1. talks about what is happening to the patient and makes a diagnosis, **names the disease**, if possible

2. **reveals the premises of his/her opinion -** lists deviations from the norm in the medical history, physical examination and additional tests that justify the diagnosis

3. **explains possible causes** of the patient's condition, threat, expected effects, possible long-term and short-term consequences of the disease

4. **checks how the patient understands** what has been said

5. **reveals the patient's views, reactions, doubts,** e.g. whether the doctor's opinion agrees with the patient's suspicions

WHEN NEGOTIATING A MUTUAL PLAN OF ACTION:

1. **discusses various possibilities,** gives a choice, e.g.: no action and observation, additional tests, conservative or surgical treatment, non-pharmacological treatment (e.g. physiotherapy, orthopedic supplies, counselling), preventive examinations.
2. **explains the procedure or treatment offered**:

- names the treatment
- describes its stages
- talks about benefits and advantages
- explains possible side effects

3. reveals how the patient understands the management and treatment plan, **pays attention to the patient's reactions and doubts**; can assess whether the patient accepts the plan
4. **learns the patient's point of view on the need for medical intervention, perceived benefits, barriers, motivation of the patient;** can accept an alternative solution

5. takes into account the patient's lifestyle, cultural patterns and intellectual abilities

6. is interested in whether the patient has support in the environment, discusses various possibilities of support
7. **encourages the patient to join** the plan and **take responsibility** for himself/ herself

WHEN TALKING ABOUT FURTHER DIAGNOSTIC TESTS AND TREATMENTS:

1. **clearly explains what the medical procedure**/intervention, diagnostic test is supposed to consist of, e.g. what the patient may feel, how he/she will be informed about the results

2. **relates the procedures to the treatment plan**: talks about their value and purpose

3. **encourages asking questions and expressing what the patient thinks** about potential side effects, poor results; what is he/she afraid of

CLOSING THE CONSULTATION

1. concludes an agreement with the patient: what next step is to be taken by the patient and the doctor

2. provides security (safety nets): tells what to do if unexpected circumstances complicate the implementation of the plan; informs where and how to seek help

3. Concisely summarizes the consultation and explains the treatment plan

4. **makes sure the patient agrees with the plan,** has any concerns, wants to make any changes, has questions, or wants to discuss anything else.

"Do you have any questions?"

"Would you like to clarify anything else?"

After completing the course, the student is able to:

properly initiate a consultation, start a conversation, establish a relationship with the patient
use active listening techniques
read the patient's non-verbal messages
paraphrase the patient's statements
know the specificity of open, deepening and closed questions
use the "open-to-closed cone" method to explore problems
create a list of patient problems that are the subject of consultation
gather information on the main problem
understand the patient's perspective
structure the consultation
rationally manage time during consultations
collect information about the patient's medical history
collect a social history
note in medical records in a way that does not interfere with the relationship with the patient
provide explanations to the patient
inform the patient about the diagnosis in a way that is understandable to the patient
plan patient management
negotiate a joint action plan with the patient
close the consultation

Literature:

1. Silvermann JD, Kurtz SM, Draper J. (2013): *"Skills for Communication with Patients"* Taylor & Francis Ltd
2. Calgary-Cambridge Guide for the Medical Consultation: https://journals.lww.com/academicmedicine/Fulltext/2003/08000/Marrying_Content_and_Process_in_Clinical_Method.11.aspx

Supplementary literature

1. Lynn S. Bickley, MD (red) (2010): *„Bates' Guide To Physical Examination and History Taking"* Wolter Kluwer Health 2023
2. Dover AR, Innes JA. (red) (2023): *„Macleod's. Clinical Examination"* . Elsevier LDT Oxford

Recommended films on Youtube presenting consultation skills:
https://www.youtube.com/@Consultations4Health/featured