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 technique, 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

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, tone

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
33. Chunks and checks: gives information in manageable 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
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
43. Relates explanations to patient’s illness framework: 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 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
47. Shares own thinking as appropriate: ideas, thought processes, dilemmas

48. Involves patient by making suggestions rather than directives

49. Encourages patient to contribute their thoughts: ideas, suggestions and preferences

50. Negotiates a mutually acceptable plan

51. Offers choices: encourages patient to make choices and decisions to the level that they wish

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 items to discuss

**OPTIONS IN EXPLANATION AND PLANNING (includes content)**

**IF discussing investigations and procedures**
57. Provides clear information on procedures, eg, what patient might experience, how patient will be informed of results

58. Relates procedures to treatment plan: value, purpose

59. Encourages questions about and discussion of potential anxieties or negative outcomes

**IF discussing opinion and significance of problem**
60. Offers opinion of what is going on and names if possible

61. Reveals rationale for opinion

62. Explains causation, seriousness, expected outcome, short and long term consequences

63. Elicits patient’s beliefs, reactions, concerns re opinion

**IF negotiating mutual plan of action**
64. Discusses options eg, no action, investigation, medication or surgery, non-drug treatments (physiotherapy, walking aides, fluids, counselling, preventive measures)

65. Provides information on action or treatment offered
   - name
   - steps involved, how it works
   - benefits and advantages
   - possible side effects

66. Obtains patient’s view of need for action, perceived benefits, barriers, motivation

67. Accepts patient’s views, advocates alternative viewpoint as necessary

68. Elicits patient’s reactions and concerns about plans and treatments including acceptability

69. Takes patient’s lifestyle, beliefs, cultural background and abilities into consideration

70. Encourages patient to be involved in implementing plans, to take responsibility and be self-reliant

71. Asks about patient support systems, discusses other support available

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References: