

Enhanced Communication Skills Training Programme

Participant Handbook



Introduction

Effective communication between patient and clinicians as well as between healthcare professionals is fundamental to delivery of high quality care. For many senior healthcare professionals, communication is their primary clinical skill and for those who are technically gifted and able to perform interventional procedures there is still a need to be able to communicate the procedure in a manner individualised for each patient so informed consent may be obtained and patient centred care may be provided.

The NICE guidance for Patient Experience states that clinicians should:

- Tailor healthcare services for each patient
- Know patients as an individual
- Enable patients to actively participate in their care

Providing services that are person-centred and involve people in their own care is at the heart of recent quality initiatives. The NHS defines positive patient experience as '*...having information to make choices, to feel confident and feel in control; being talked to and listened to as an equal; and being treated with honesty, respect and dignity.*' This requires clinicians to enable patients to express their personal needs and preferences for care, treatment, management and self-management. Such consultations require clinicians to be skilled in communication to encourage dialogue and enable patients to actively participate in their care.

The ECST programme has been adapted from the Frimley Health Foundation Trust course. The programme is evidence based and incorporates the most effective techniques that are learner centred and involve role play and feedback in a safe environment. The evaluations from the course have been positive and favourable from clinicians working in all settings of health care.

We hope you enjoy and benefit from the programme and use your enhanced skills to support others in your team and especially the patients in your care.

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Message from Professor Bee Wee, National Clinical Director for End of Life Care, NHS England and Consultant in Palliative Medicine, Sir Michael Sobell House

“The quality of communication has a powerful effect on the experience of patients and those close to them, and staff involved in their care. High quality communication means that patients feel properly listened to, can ask questions and express concerns openly and easily, are better informed about the options available to them, and can be as involved in decisions about their own care and treatment as they wish. Those close to them feel supported in their own right, irrespective of the extent to which the patient wishes them to be involved in decision making. Staff feel more satisfied and confident about their own performance and connection with what really matters to patients and those close to them: this helps to build their own resilience.

The ability to initiate and hold high quality conversations about difficult matters, whatever the clinical situation, requires training, feedback, reflection and self-awareness. Participating in advanced communication skills training – whether for the first time or as a refresher – is an important professional development opportunity”



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Why is communication important?

The importance of effective communication between healthcare professionals and patients and families is well documented. This is particularly so for patients with advanced life threatening illness where surveys indicate that patients place good communication with healthcare professionals high on their list of priorities (DH, 2000; NICE, 2004; DH, 2007). Most patients want all possible information, both good and bad, about their illness (Cox et al, 2005), and even if their life expectancy is short, the majority report wanting to know so that they can make important decisions about the time they have left (Jenkins et al, 2001). Reports of patient preferences show that patients want to be included in the conversation, asked open questions about themselves so that the doctor gets to know them personally; they want professionals to seek permission from them, to feel like the person has time for them and to share their decision making (Cousin et al, 2012; Janssen & Macleod, 2010).

The report of Lord Darzi (2008) highlighted that patients in all settings give a high priority to communication as a key aspect of care. It tells us patients above all want to be treated with **humanity, dignity and respect**. Studies from all groups or patients tell us people also want

- **Honesty with straight forward understandable information**
- **Empathic clinicians, sensitive to their emotions**
- **Clinicians who will listen to them, and involve them in decision making**

At a recent Macmillan Cancer Voices conference (2011) a survey was conducted amongst “cancer patients/carers”. Of the people surveyed, 85% supported communication skills training for doctors and nurses. Below is a selection of the issues raised by patients:



- Communication has an effect on the mind, which in turn, affects the body
- Communication is the key to helping patients get the best possible “joined-up” treatment and support
- Effective communication makes things clearer to all concerned
- Poor communication causes distress whereas good communication helps the patients understand, feel respected and important

The following are quotes from patients and relatives about their experience of communication (*taken from Finding the Words; patients and families views of communication; End of Life July 2011*)

"My father had motor neurone disease and he was dying and all we could do when we visited him was cram around his bed as best we could because there wasn't much room in between the beds.....And the only time the consultant, the registrars, the doctors, the matron, the nurses got us all together in one room was on the day he died, to say to us he was not going to survive the weekend. This was the first time anyone had really broached this sort of possibility"

"The first really good thing was the first question they asked him. It was "what do you actually want?" What he wanted was to back to his own flat. They said ...we'll see if we can make it possible. He got back to his own flat. He only lived 6 hours, but he died happy"

"I was given a phone call by the respiratory nurse to tell me "by the way thought you'd better know because you're going to get a copy of the letter you're actually end stage now". "The way she told me was just so cold, I was on my own"

Unfortunately negative experiences of communication are not uncommon and are consistently brought to our attention through patient audits, surveys and also through the ombudsman's reports and reviews of complaints and litigation. Sadly, the message from patients and their families seems to be that there are many aspects of our communication which could easily be improved.

Reports you may like to access to see more about what patients value in us as health professionals include:

- NHS Cancer Plan Sept 2000
- Worried Sick; the emotional impact of cancer; Macmillan April 2006
- Cancer follow-up care; view of patients and carers; Picker Institute May 2008
- Finding the words; patients and families view of communication; End of Life July 2011
- 2010 National Cancer Patient Experience Survey Report; DoH December 2010

Outcomes linked to good and poor communication

Communication can affect measurable patient outcomes. The evidence linking professional communication to such factors as length of hospital stay, level of pain control and use of analgesia, number of follow up appointments and frequency in visiting the GP is growing, as is the clear link between communication and complaints (Stewart, 1996; DH, 2000; Healthcare Commission, 2007/2008/2009). In August 2010 the Guardian Newspaper reported the second biggest category of all complaints received by the NHS related to communication, the Ombudsman attributes only 12-15% of complaints directly to health professionals attitude and communication, however it is reported as part of almost every complaint received (Healthcare Commission, 2008/2009).

Reports have linked inadequate levels of communication with patient dissatisfaction; it often leaves people feeling confused, frustrated and anxious with a sense of uncertainty which may impair their inability to comply with recommended treatments (Butow et al, 2002; NAO, 2005). Conversely good communication has been shown to influence patients' emotional health, symptom resolution, function and physiological measures (blood pressure) and to decrease reported pain and drug usage (Stewart, 1996).

The impact of not feeling confident about communicating with patients on health professionals themselves has also been recognised. Insufficient training in communication was reported as a major factor contributing to the experience of workplace stress, lack of job satisfaction and emotional burnout in senior medical healthcare professionals (Fallowfield and Jenkins, 1999; Taylor et al, 2005) and also those in training to be clinicians (Burman et al, 2007). Stress in relation to communication has also been reported in nursing and allied health professional roles (Heaven et al, 2006).

Reports, guidance and policy linked to improving communication

Despite the knowledge that effective communication is an essential part of caring for patients, there is evidence that in practice communication continues to be problematic (DH, 2000; NICE, 2004). For this reason the majority of government reports looking at the quality of patient services point to the need for open, honest, and respectful communication involving patients and also to the need for skills training. The Cummings report (2012) highlights communication as one of the six core "C's" essential in delivering high quality nursing care, and is backed by the Willis commission on nurse education (2012) which described "patient centred care as being a golden thread running through all pre-registration education and continuing professional development". The Improving Outcomes Guidance across acute and palliative services point to communication as being a key factor in delivering care as does the recent end of life care guidance both for adults and children.

The need for communication skills training

Research suggests very clearly that communication skill is not something that improves through experience alone (Maguire, 1999), it is a skill set that needs to be taught and assimilated into practice.

There are a number of reasons why experience is not a good teacher when it comes to communication skills. Firstly in busy jobs we rarely have time to look critically at our actions to see 'where we have been or have not been' and to assess our success in creating what we desire in terms of the consultation. Secondly, we rarely get the opportunity to consider what really motivates our actions and uncover the unconscious beliefs and programming that governs our choices in behaviour; and thirdly we almost never get the opportunity to contemplate the effect of how we communicate, and how alternative approaches might impact on the recipient differently (Ferlic, 2012).

Within communication skills training research there is evidence that, with appropriate teaching, the consultation skills for patient centred medicine can be acquired and retained (Heaven et al, 2006); Fallowfield et al, 2002; Finset et al, 2003; Kurtz et al, 2003; Wilkinson et al, 2008). This awareness has led to an increasing demand for communication skills training. Furthermore, the expectation is that over time all senior healthcare professionals within the NHS will be able to demonstrate that they have the level of competence to assess needs, communicate complex information, involve patients in clinical decisions and offer choice (DH, 2007).

Barriers to effective communication

The more worries and concerns patients have about their situation the more likely they are to experience distress and develop an affective disorder (Brown et al 2000; Heaven and Maguire, 1997; Parle et al, 1996).

Psychological distress occurs commonly in patients in all disease and care groups. It may be passing or may lead to clinically significant anxiety or clinical depression. Psychological morbidity affects a number of patients with acute illness but affects a considerable number of those managing chronic illness such as renal failure, heart disease and cancer, where it is estimated that between 25 and 40 percent of patients suffer from clinically significant anxiety or depression (Lan Ly et al, 2002; Stark et al, 2002; Kadan-Lottick et al, 2005; Burgess et al, 2005; Farrell et al, 2005; Massie et al, 2004; Friedmann et al, 2006; Kouwenhoven et al, 2011; Zheng et al, 2011).

Unfortunately we know from research, and the message from patients, is that we are not very good at recognising this distress. Even for those receiving 'good' follow-up care, regularly seeing their GP and specialist nurses and having regular routine outpatient appointments, distress and particularly psychological morbidity is missed (Sharpe et al, 2004; Pfeil et al, 2009; Putman-Casdorph et al, 2009). Psychological and psychiatric symptoms have a detrimental effect on quality of life (Shapiro, et al 2001) and are commonly overlooked meaning that patients miss being referred for the appropriate treatment and support they require (Fallowfield et al, 2001; Lloyd-Williams & Friedmen, 2001; Sharpe, 2004).

We also know from the literature that less than half of patients' concerns are identified by those caring for them both in acute and palliative settings (Heaven and Maguire 1997; Farrell et al, 2005; Kurella et al, 2010), despite nurses, doctors and allied health professionals believing in holistic care and genuinely attempting to assess the current situation for the patient and their family.

The barriers therefore to effective communication lie with both the professional and the patient. From literature cited above and from talking to patients and health professionals it is clear a great number of factors affect the likelihood of communication being effective (Heaven & Maguire, 1997). These have been divided into four factors for simplicity.

Health Care Professionals barriers

Fears

Fear of unleashing strong emotions for example anger, uncontrollable tears, expressions of horror, screaming.

Fear of upsetting the patient or relative. Saying something which might upset the person, or make them lose control. Concern that you might push someone too hard to talk about something when you are not sure they want to.

Fear of damaging the person causing more harm than good by saying the wrong thing, by forcing someone to face something or by giving too much information; fear of adding to the person's difficulties and making the situation worse for the person.

Fear of being asked unanswerable or difficult questions that might out you on the spot, bring you into conflict with colleagues, or open you up to further difficult questions that might have legal consequences. Examples might be "could this have been picked up earlier?", "did someone do something wrong?", "why did I get this, my lifestyle is good" or "what has my child done to deserve this?"

Fear of saying the wrong thing to the person because you are unsure that you have fully understood yourself, if the information is complex and difficult to explain, or you yourself have strong beliefs about certain approaches to the situation.

Fear of a person's refusal to accept your opinion, and potentially refuse life saving treatments.

Fear of taking up too much time by opening up the "can of worms" in a busy clinic by triggering someone to break down and cry, or by entering into a complex conversation when time is limited.

Beliefs

The belief that **emotional problems are an inevitable** part of complex and life threatening illness and that as such we should accept them. There is also the belief that nothing can be done about mood disturbance, therefore we should not raise expectations by talking about the issues.

The belief that it is "**my particular role**" not to discuss certain things, for example believing that only the doctors should be talking to the patient about their medication or treatment, or that the person should talk about their emotions only to the specialist nurse.

The belief that there is **no point talking about fears** especially when there may currently be no answers to the patient questions, and the concern that by allowing the patient to talk about "what if" scenarios we only raise anxiety and raise expectation that we can do something to help.

The belief that **patients cannot cope with certain information** and that the role of the professional is to protect people from things as they might fall apart and might even end up committing suicide.

The belief **that it will take too much time to listen to the patient**, acknowledge emotions and give information, advice and reassurance.

Skills Lacking the skills to **know how to pick up patient cues**, assess knowledge and perceptions adequately.

Not feeling able to **integrate the different elements of the consultation**, establishing rapport, assessing knowledge and concerns, giving information, and closing or moving through the medical, psychological, social and spiritual agendas.

Not knowing how to **move both into and out of feelings safely**.

Being uncertain how to handle specific situations, for example the garrulous patient, an angry person, having to break bad news to someone to have never met or managing a complaint.

The working environment

Lack of **privacy and space** to talk to the person in a dignified manner with reasonable confidentiality.

Lack of **time** to deal with unexpected, or to adequately manage difficult consultations.

Interruptions from phones, pagers, and other electronic devices.

Feeling that there is **no support or referral pathway** for the person when problems are identified, i.e. having nowhere you can refer the person to for additional help.

Lack of **space away from other people** who are present, but who might inhibit the conversation. For example relatives, colleagues, students etc.

People not being available who need to be there to allow a discussion to take place, for example relatives, colleagues etc.

Feeling that you will receive no **support yourself** if you have difficult situations with a patient or relatives.

Conflict with the team meaning that emotional energy you might invest in the patient is spent watching your own back or helping others in the team.

Patients' barriers

There is evidence that patients disclose as few as 40 percent of their concerns (Heaven and Maguire, 1997), and that those who are most anxious or most distressed disclose the least.

To make communication more effective it is important to consider the barriers which might inhibit patients or carers disclosing to us as health care professionals.

Fears

Fear of being stigmatised for admitting to the illness or the ability to cope with it. There is still a culture amongst some that illness always results from poor lifestyle choices. This often leads to stigmas being associated with certain types of illness e.g. lung cancer, cervical cancer, HIV/AIDS etc. Because of this some people may fear being open and honest about illnesses. Struggling to cope with what life throws at you can also be stigmatising. People can be ostracised or even ridiculed if they are perceived to be struggling emotionally or mentally, meaning that few admit, certainly initially, to the cost of coping emotionally with adjustment to life threatening illnesses.

Fear of losing control and breaking down. Patients and relatives also worry about losing control, breaking down or crying in front of professionals. Many people are very private and might never have cried in front of anybody outside of their closest family and friendship circle.

Fear of having their worst fears confirmed. Many people who have experienced serious illness talk about being fearful of asking questions as it might lead to their worst fears being confirmed. We know from the literature that the majority of patients want to know what is happening to them, however bad the news, but there are some who prefer not to know. These people often avoid asking questions and avoid picking up the cues from the health professionals that all is not well.

Fear of burdening the health care professional. Patients often worry about the impact of their illness on their families. There is a vast amount of evidence to show that they protect their loved ones from knowing about their concerns and worried and that they worry about being a burden to them. There is an increasing amount of evidence to show that patients and also relatives also worry about the burden to the health professionals who care for them. They are very aware of how busy health professionals are and express concerns about taking up too much time or overwhelming the professionals with the breadth of their worries or questions.

Fear of causing distress to the health care professional. Research looking into why patients disclosed some concerns and worries to some people and different ones to others revealed that the same protective mechanisms known to affect openness in families can be transferred to patient-professional relationships. It appears that when patients become more familiar with us as health professionals and form relationships, they can start to protect us from the pain of hearing about some of the difficult concerns they have to manage.

Beliefs

The belief that healthcare professionals are too busy to listen. Patients and relatives recognise the strain the NHS services experience and that the healthcare professionals themselves experience.

Waiting times and general busyness adds to the belief that the healthcare professional's time is very limited, the impact of this being that patients or carers do not disclose some of their concerns as they may feel the professional will not have time to listen.

The belief that healthcare professionals are only concerned with certain aspects of care, for example nurses with physical care, doctors with disease and treatment. This incorrect belief means that patients often do not disclose major concerns as they do not know who they should talk to about that aspect of concern.

The belief that “my concerns are not as important as other people’s” or they are insignificant in the greater scheme of things. This is a common comment from patients who altruistically or as part of their own coping mechanisms minimise concerns and believe that others are worse off and need the health professionals attention more.

The belief that my life depends on this treatment. Another conundrum for patients is the belief that if they mention difficulties or side effects, it might be seen as complaining and affect their relationship with the care team, or alternatively that it will lead to the withdrawal or reduction in efficacy of the treatment, thus affecting outcome.

My beliefs mean that I should cope with this without complaint. Whether personal, cultural, religious some people believe in the adage that “one should suffer in silence”, or that it would be disrespectful to themselves, their family, their community or their god to talk about their problems in an open way or express negative feelings.

My family would not like it if I talked openly about my concerns, worries and fears. They would be angry.

Skills

Not being able to find the right words. Many patients find it difficult to express themselves in anything more than a factual way. For those who have never talked about their feelings, a conversation about the impact on emotions, fears and worries might be very difficult.

Not having sufficient command of the English language. This is a factor for many more people than we might at first think. Many for whom English is not a first language, have perfect competency in everyday affairs, but when talking about medical matters and talking about feelings, fluency may be more problematic. The speech and hearing impaired are also at a major disadvantage when communicating with health professionals.

Literacy levels and embarrassment at acknowledging poor literacy levels. The World Literacy Foundation reported in March 2012 that “one in five of the UK population are so poor at reading and writing they struggle to read a medicine label or use a cheque book”. Health literacy is an increasingly discussed problem worldwide and one health professionals need to consider. Patients with poor health literacy are unlikely to flag this to health

professionals, but instead leave consultations bewildered and confused, and often become non-compliant.

Not understanding enough to know how to clarify things. Asking questions for clarification is difficult even for those who usually do not struggle with such things. Patients and carers report difficulties in understanding sufficiently to be able to know what questions to ask about their predicament. The adage “I do not know what I do not know” is something often described (Manning, & Dickens 2006).

Issues of mental capacity. This is an area of concern for patient, carers and professionals alike. Issues of mental capacity not only affect the old and infirm and the young, but also affect those living with lifelong mental capacity issues and those who’s mental capacity is affected by illness, anxiety, lack of sleep and side effects of drugs and symptoms, for example pain.

Environment

Not having privacy affects patients and carers as well as staff. Patients report feeling inhibited in asking key or personal questions due to lack of privacy and dignity.

Protecting a relative who is present. The literature tells us that patients protect their nearest and dearest and therefore do not openly disclose all their concerns. The literature reminds us that a large percentage of patients worry about the consequences of illness on their relatives and carers. Expression of these types of concerns are inhibited when that person is present.

Not having somebody present who should be. Conversely some patients may not ask questions, clarify or express concerns when they are not accompanied by someone who they feel should be present.

Effective communication

Interview content, skills and structures

To achieve the optimal interview the professional needs to consider three aspects of the interview/ consultation.

Context of the interview. The context will dictate the appropriateness, the interviewer's approach to an interview and also their use of skills. Contextual factors will not be explored in this manual but include things such as:

- The setting: Emergency, acute or chronic care which might create a primary objective or an imperative to focus on certain issues
- Prior relationships: Have the two people already established a way of behaving or communicating with each other?
- Prior knowledge: Do the two people know each other, have they talked before about these issues, is there a common understanding?

Interviewing skills. The individual needs to have skills required to interview effectively. These include skills relating to:

- Eliciting key information and picking up cues
- Acknowledging and checking that information
- Giving information
- Negotiating actions and preferences in decision making

Interview structure. Having a clear sense of structure in moving through an interview from beginning to middle to end. It is helpful to have an overall framework to work within and also a framework with which to approach difficult types of conversations.

Assessment

The assessment guidance in medical and non-medical fields suggests that all patients should routinely be offered a holistic assessment (Kurtz Silverman & Draper, 2003; DoH, 2012 End of Life Care Strategy, 2008; DoH Vision for Nursing, 2012). Aristotle was the first to describe holism: "The whole is greater than the sum of its part". In short, to be completely holistic you must see a person as more than just organ systems, mental health, sexuality, etc. You must see how all aspects of their life impact on each other and the factors that influence them.

Holistic assessment is an integral part of medical and nursing practice. An assessment must be undertaken in order to provide care that will meet the patients' needs. To assess we must be able to communicate effectively and efficiently. As early as 1967, it was said:

"Assessment includes the collection of subjective data: the individual's beliefs, expectations and understanding of the situation, together with a complete history of the patient's normal habits and coping mechanisms" (Little and Carnevali, 1967).

What should be assessed?

There are five key 'domains' to a full assessment and their importance might change as a person moves along the care pathway. These are:

- Background information and assessment preferences (often drawing on the individual's care record and previous assessments)
- Physical needs (discuss possible future symptoms but emphasis they are not inevitable)
- Social/ occupational needs (e.g. family, social life and money issues)
- Psychological wellbeing (the assessment should start with an exploratory question that invites the individual to identify any concerns)
- Spiritual wellbeing and life goals (with sensitivity to cultural differences).

(<http://www.endoflifecareforadults.nhs.uk/publications/holisticcommonassessment>)

The NICE Guidance on Supportive and Palliative Care for people with cancer (2004) recommends that assessment should be an ongoing process throughout the course of a patient's illness with structured assessments being undertaken at the following key points:

- Around the time of diagnosis
- Commencement of treatment
- Completion of the primary treatment plan
- Each new episode of disease recurrence
- The point of recognition of incurability
- The beginning of end of life
- The point at which dying is diagnosed
- At any other time that the patient may request
- At any other time that a professional carer may judge necessary

Communication skills

Communication involves three components:

- **Verbal Messages** – the words we choose
- **Para verbal Messages** - how we say the words
- **Non-verbal Messages** - the expressions and gestures we use when we are communicating

Paul Watzlawick et al (1967) in the pragmatics of human communication describe every communication we have as being distinguished on two levels, the content level and the relationship level. Watzlawick states that the relationship level is ALWAYS conveyed by the non-verbal. Research suggest that non-verbal communication accounts for approximately 50% of our communication, with para verbal accounting for approximately 30%, meaning what we actually say counts for only 20% of the message we convey to a person.

Non-verbal communication

Body language refers to those movements and positions of the head, limbs and body that convey meaning. The function of body language is to give and seek information, express emotion, communicate attitude, establish and maintain relationships and regulate social interaction. Non-verbal expression of emotion is known to be cross cultural, and is established very young. It is the primary means by which babies and young children communicate.

Body language has six aspects:

Personal space

The distance that individuals maintain between themselves. This can be subdivided into four zones:

- Intimate (18 inches or less) - when a loving or intimate relationship exists
- Personal (18 inches to four feet) - talking to friends or during an informal conversation
- Social or consultative (four to 12 feet) meeting new people in a social situation or consulting a professional advisor
- Public (over 12 feet) - usually employed by public speakers

Healthcare professionals usually maintain a social or consultative distance but, because of their role, can legitimately enter the personal or even the intimate zone as diagnosis, treatment and interventions often involve close physical contact.

Touch

Touch is a powerful form of communication. Each culture has rules about bodily contact. Touch evokes powerful reactions, however it must be noted that not everyone likes to be

touched. There have been a number of studies published that investigate the effect of touch, both on the well-being of patients and in its therapeutic uses. Few, however, have specifically looked at the use of touch within a clinical interview situation.

Expressive touch is the definition given to that form of touch which is a spontaneous expression of affection and not connected to a procedure, such as massage. There is some evidence that expressive touch can increase attention and responsiveness in patients and possibly reduce anxiety.

Eye contact

This includes how often and for how long a person looks at someone else and whether the gaze is returned. Looking is a channel for collecting information, by getting feedback and monitoring non-verbal behaviour. Eye contact also communicates attitude. It is an important signal for turn taking in conversation. It can be influenced by culture in that people tend more to look if they are from a culture in which bodily contact is more acceptable. People from some cultures will offer their ear to show they are listening rather than looking in the eye - a sign that they do not believe you. Too much eye contact is perceived as threatening or superior, too little is viewed as inattentive or insincere. Eye contact also changes with mood disturbance; sad or depressed people tend to look less and to look down.

Facial expression

Facial expression signals attitude and emotion. Facial expressions may give information about a person's true feeling by supporting or conflicting with what is being said.

Gestures

- Gestures are voluntary movements that communicate a message to another person. They can also indicate the mood of the speaker.
- Emblems are gestures that have a direct verbal equivalent such as waving or nodding. These may be very sophisticated and form a recognised language, for example British Sign Language
- Illustrators serve to emphasise, clarify or add to speech for example pointing or mime of actions
- Reinforces are actions that help to regulate the flow of speech, such as nodding your head to encourage the speaker to continue

Posture

Posture can signal the strength of a person's emotional response. Depression is characterised by low tone, drooping head and shoulders. Anxiety is associated with an

increased muscular tension. Open position is seen as being more friendly and warm, whereas a closed body position is usually interpreted as less friendly or even rejecting.

Para verbal interviewing skills

Para verbal communication refer to the messages that we transmit through the tone, pitch, and pacing of our voices. It is how we say something. Interpretation of para verbal communication is highly relationship based; for example the use of “friendly” insult, black humour or sarcasm to convey alternative meaning with a close friend or family member.

Para verbal communication affects the interpretation of a sentence, through emphasis. The following commonly used example shows how a sentence can convey entirely different meanings depending on the emphasis on words and the tone of voice.

“I didn’t **SAY** you were stupid”

“I didn’t say **YOU** were stupid”

“I didn’t say you were **STUPID**”

Facilitative verbal interviewing skills

Facilitative skills are those skills which enable professionals to:

- Elicit key information and cues about concerns
- Acknowledging the person’s agenda, cues and concerns and checking the information given
- Give information both simple and complex in a tailored manner effectively
- Negotiating action plans, preferences and decisions

The language we use may vary according to nationality. There will be cultural variations in how language is used.

Facilitative Skills associated with gathering information

Questions and question style

We ask questions to seek information. However, questions come in a variety of different formats, some of which are helpful in encouraging disclosure than others. Questions may be broad open, open directive/focused, directive, closed, multiple or leading.

Broad open questions

A broad open question is 'open' as it requires more than a yes or no answer, so encouraging the patient to talk freely. These questions often start with 'how' or 'what' or 'tell me'. However it is also 'broad' – somewhat vague in nature, giving the patient no clear focus. For example: "How are you?"

Open directive/open focused questions

An open directive question is one that remains open, requiring more than a yes or no answer, but creates or maintains a clear focus relating to a topic or time frame. For example:

"How have you been physically since I last saw you?"

"How did you feel when you heard that?"

"What sort of things does your breathlessness stop you doing?"

Screening questions

Screening questions are commonly used towards the end of an interview to ensure nothing has been missed. For example:

"Is there anything else we intend to cover before we finish?"

However they are an excellent way of clarifying or exploring further in the middle of a consultation. Using screening questions ensures that no assumptions are made and that everything has been said.

"Is there something else about this pain that is troubling you?"

An interesting randomised trial, conducted by Heritage et al (2007), investigated how linguistic theories about language can affect consultations and the use of screening questions. Linguistic theory shows that the word "ANY" has a negative connotation and the word "SOME" a positive one. Using this construct, Heritage randomised primary care consultations to use the phrase "is there anything else you want to address in the visit" vs "is there something else you want to address in the visit". Heritage showed that within the English language using the phrase "something else" is significantly more likely to elicit further concerns than using the phrase "anything else" leading to the outcome that 78% of unmet concerns were addressed in the intervention group.

Directive questions

A directive question is one that while being grammatically open, restricts the patient to a predetermined factual answer. It is often used when additional clinical information is being sought. For example:

"Who did you see in clinic?"

"Where is the pain?"

“When did you first notice this pain?”

Closed questions

A closed question is direct and specific. It anticipates the answer and requires the interviewee to respond yes or no. While useful at times, it is important to recognise that closed questions will severely limit patient disclosure. For example:

“Did you sleep well?”

“Have you made an advance care plan?”

“Have you seen the doctor today?”

Silences

Silence is the most powerful behaviour in facilitating people to say more about themselves and their predicament (Eide et al, 2004). Silences are more important as they allow both parties time to think and assimilate what has been said. Silences may naturally facilitate the patient to say more by providing a space to talk and follow their own, rather than the clinician’s agenda.

There is however a delicate balance between comfortable and uncomfortable silence. If the healthcare professional feels the silence is becoming uncomfortable for the patient they may need to encourage the patient to speak.

Phrases such as “You seem deep in thought, can you tell me what you are thinking about?” may help as a prompt to continue.

Encouragement/minimal prompts

This is a more active skill compare with acknowledgement; actively showing interest and understanding encourages patients to continue. It is important for the maintenance of the interaction. For example:

“Really, that is interesting. Please do go on.”

Facilitative skills associated with listening and acknowledging

Listening

Listening is an active skill that requires great concentration if patients’ cues are to be picked up. Active listening involves the act of relinquishing preconceived ideas about the patient, giving our attention, completely and freshly, to what is before us, not really knowing what we will hear or what that will mean. We should listen with a willingness to be changed by what we hear.

Acknowledgement/facilitation

Utterances which indicate the patient is being heard and taken notice of include:

“Uhuh” “Yes” “Mmh”

Reflection and paraphrasing

- This technique encourages people to talk about a topic or problem they have raised and may want to discuss further. Reflecting is when the person’s words are directly repeated back to them thus encouraging them to expand, say more or clarify. Reflection is often turned into a question or an encouragement using the non-verbal or para verbal... e.g. leaving a pause “Worried?”, “He said it wasn’t a normal blood test.”
- Paraphrasing, like reflection, uses the words of the patient, but is not a direct quote from what they say. Rather it is reflecting back the meaning or significance of the phrase. This shows listening, but stops the conversation becoming repetitive or pedantic. The professional should try to put paraphrase slightly tentatively in case they misinterpret what has been said “the family have been upsetting you?”

Summary

Summarising is the deliberate act of providing an explicit verbal summary of the discussion to the patient. There are two types of summary:

An internal summary focuses on a specific part the interview. For example:

Healthcare professional: “So to recap on what you have told me so far about your pain, you say that you have had this pain in your leg for nearly four weeks which is made worse by movement and is not relieved by your current pain killers.”

Patient: “Yes, that’s right, and I’m finding it increasingly difficult to manage my job because of it.”

An end summary pulls together the entire interview. For example:

Healthcare professional: “I would just like to check out that I have understood what you have said correctly. You’ve told me today that both the pain and the breathlessness are becoming more of a problem to you. On top of that since having your last treatment you are feeling increasingly tired and low in mood, so much so that caring for your children is becoming quite a problem now?”

Patient: “Yes, I really do feel that I need help with my energy levels otherwise I will never be able to make it up to the hospital for my next chemo.”

As you can see, the summary provides intentional feedback to the patient, demonstrating that you have been listening to their story. It also gives the patient the opportunity to correct any inaccuracies. Both physical and emotional concerns can be summarised.

Empathy

Statements which demonstrate understanding from the patient's point of view will encourage the patient to go into more depth. For example:

"It sounds as if it has been very hard for you lately."

"From what you have said, I get the feeling that you have been feeling pretty low."

The understanding is not the healthcare professional's point of view. For example:

"I know how you feel. I understand how you feel."

Educated Guess

An educated guess aims to deepen the professional's understanding of a person's predicament. It is a combination of a suggestion, which might include paraphrasing and empathy, put in a tentative style which allows the person to accept or refute the suggestion

"It sounds to me as if it has all been very hard for you lately? Would that sound right?"

Educated guesses are powerful behaviours as they show the individual that the professional is trying to get alongside them and truly understand the experience from their point of view. It is vital that the professional offers an educated guess in a tentative manner so that if wrong the individual can correct them

"It's not that it's hard. It's just that it was so unexpected it's knocked me for six"

Challenge

These are questions or statements that challenge discrepancies in what patients say. For example:

"You've said you are feeling fine and have no worries but you have just said that you are feeling anxious. Can you just tell me a bit more about this?"

"You say that you want to go home as quickly as possible, but you have also said that you cannot be on your own and your daughter cannot help. Can we talk about this?"

Facilitative skills associated with information giving and negotiating decisions

Information giving

Patients should be given only the information they require. Assessment of patients' information needs should be done before giving information. Patients are only able to retain small amounts of information at a time, which needs to be given slowly without using jargon or technical terms.

Research tells us that patients don't cope well psychologically with their illness either if they are given too much or if they have too little information (Fallowfield et al, 1990; Butow et al, 2000).

A key clinical skill for health professionals is being able to assess information needs and give information in a sensitive, understandable and tailored way to optimize adjustment and ensure understanding and compliance with treatment and advice (DoH, 2008; Zimmerman et al, 2003).

In the previous section the skills required to conduct an assessment and gather were considered. The skills of assessing information needs are the same as those already discussed. In this section the skills associated with information giving will be considered.

Information giving skills

Checking what a person already knows

When giving information it is vital to start in the right place. The first step to giving any information is to find out what somebody already knows about a situation. This can be done by asking open

questions, clarifying, checking and acknowledging what is heard to ensure that there is no misunderstanding.

“So before I start to go through things, can you start by telling me what you understand already about this - what is going on?”

“What exactly was it that you were told by your GP surgery about this problem?”

“Did anyone give this condition you talk about a name?”

“When you say diabetes - what is it you understand that to mean?”

Giving an overview and navigating people through complex information

This refers to the skill of providing the patient with a clear map of how the professional is going to give the information. This allows a person to understand how things fit together and helps them maintain a mental image as they piece things together.

“There is a lot to go through today, so I am going to break it into sections for you, would that be ok?”

“First we will talk about the illness itself what it is; then we can move onto what I think we need to do for you medically and finally we can discuss the things I think you can do to help yourself manage this at home. How does that sound?”

NB: If breaking bad news refer to the strategy on page 37

Giving information in small “bite sized chunks”

When giving large amounts of information or complex information it is important to break the messages down into small sections. Whilst this seems self-evident a common mistake for health professionals is making the “chunks too large”, so that the patient, relative or carer cannot digest the message. Analysis of many medical and nursing consultations show that

healthcare professionals are often given information in paragraphs. However reviews of patient experience show that they need the information given one sentence at a time.

“Unfortunately you are going to need an operation on your stomach”

PAUSE

“The operation will allow us to repair the part of your stomach wall that is bleeding”

Pausing and allowing space

It is important when giving information to allow the recipient sufficient time to digest each message before moving on. A simple pause, or silence between each statement can make the difference between a patient feeling bombarded with information or following the message. Clearly if a silence is too long it can be as unhelpful.

Non-verbal cues from the recipient are very helpful in judging the speed of information delivery. More than 50% of our communication is non-verbal and eye contact is particularly key in “reading” how fast to deliver information. Verbal cues asking explicitly for more information are clear, but verbal cues may include phrases like “yes, mmm, ok” which may need clarifying.

If unsure whether to move on or not it can be helpful to check with the patient.

“Is that clear, would you like me to go on?”

“Is it ok if I move on and tell you what that means?”

Using clear and simple language and avoiding unnecessary detail

Health professionals talk to each other in health care language. This language involves many abbreviations, many technical words and many complex descriptors. Given that the average reading age in the UK is less than 12 years (in some areas less than 7 years) and that our patients are often unwell, anxious and tired it is vital that we reduce the complexity of our messages.

Many people are very good at using simple language when talking to patients, using great every day descriptors (about the size of a pea) and avoiding medical terminology (“it’s in your stomach” rather than “in your gastric tract”). However it is common to see in analysed conversations large amounts of detail given to try and reassure. This often does the opposite and raises anxiety or simply confuses.

Key considerations when giving information are:

Firstly - what is the MOST SIMPLE message that I NEED this person to understand

Secondly - to consider everything else as INITIALLY unnecessary

Finally – to offer to clarify further and give more detail not to ASSUME that the person will want the level of detail you yourself would want.

Check what the person has understood

The final skill used when giving information is checking understanding. This can be done in a number of ways:

Overtly by directly asking

“Tell me what you have understood from what I have just said?”

“Can you tell me what you now understand?”

Or more implicitly through listening to the questions that the person is asking you. For example if a patient asks

“Why is the acid in my stomach that is causing my ulcer, so high?”

You can tell that they have understood that they have an ulcer and that the ulcer is linked to acid.

The question which is commonly used, but which is unhelpful in this situation is “Does this make sense, or do you understand?”

A person may reply yes, but have completely the ‘wrong end of the stick’.

Picking up cues

Cues are

“A verbal or non-verbal hint which suggests an underlying unpleasant emotion and would need clarification from the health provider”. (Del Piccolo et al, 2006)

In the majority of cases, people in medical encounters do not say things explicitly, but test the water by hinting in a verbal or non-verbal way that all is not well. These hints are what referred to in medical interviewing as cues. (Butow et al, 2002; Del Piccolo et al, 2006).

There is much research evidence to suggest that interviews which are cue based are more effective. Short term there is a greater degree of information disclosure (Zimmerman et al, 2003), patients are more likely to feel understood and show better information recall (Jansen

et al, 2010) and report being more satisfied with their consultations (Zandbelt et al, 2006, Utterhoeven et al, 2009).

Furthermore there is evidence to suggest that doctors who respond cues appropriately may have reduced consultation times (Levinson et al, 2000, Butow et al, 2002). Cue responding also leads to patients perceiving their relationship as being better 6 months into treatment (Dibbelt et al, 2009) and adherence to treatment and self-management programmes is reported as better when cues have been addressed (Levinson, 2010; Charlton et al, 2008).

Verbal cues may include:

- A mention of psychological symptoms – “I am worried”
- Words or phrases which describe physiological symptoms of unpleasant emotional states such as sleep disturbances, loss of libido

- Words or phrases which suggest vague or undefined emotions – “it feels odd”
- Verbal hints to hidden concerns – “It was difficult”
- Neutral mention of an important/potentially stressful life event – “ I lost my job” or “my mum died”
- Repetition of a neutral expression – “I don’t know how I feel”
- Communication of a life-threatening diagnosis – “He told me I had cancer”.

Cues may also be non-verbal. Crying for example, may indicate negative or distressing emotions. Behaviours such as sighing, frowning or a look of despair often suggests there may be hidden emotions.

Healthcare professionals need to develop skills to pick up and explore such cues. For example:

Healthcare professional: “How are you today?”

Patient: “I’m fine really; it’s the family that has been upsetting me.”

The cue is “the family have been upsetting me”. The way of dealing with this is to use some of the skills identified.

Behaviours that block communication

There are a number of behaviours that have been commonly identified as inhibiting communication. These are known as blocking behaviours, and fall into the three categories set out below.

Research shows us that during conversations people try to cue us into their concerns a number of times (Heaven et al, 2006). However, if we ignore these cues, switch away from them or overtly block them, people “give up” and stop trying to give us key messages. It is believed that on average patients will try and cue us into key worries 3-5 times in each encounter (Maguire, 1999).

However the impact of the professional’s behaviour on the interview can be seen from the very beginning. More recent work has shown that the number of cues in an interview can be reduced as much as 20% as a result of what happens to the very first patient cue, irrespective of the professional’s behaviour in relation to subsequent cues (Fletcher et al, 2006).

Blocking

Blocking is the term used to denote many different types of behaviour that have the function of moving away from, or inhibiting someone saying more about how they feel about their predicament. (Maguire et al, 1996; Wilkinson et al, 2008; Del Piccolo et al, 2011).

Blocking can happen on a number of levels. Full blocking can have the function of moving away from the content and the emotion of what is being said

Patient: "I was worried about what the doctor told me at the hospital"
Healthcare professional: "And how have you been physically?"

Distancing strategies

Often our blocking behaviours are more subtle than the example given above. These behaviours are referred to as distancing strategies.

Switching focus

Switching happens when the interviewer picks up part of the content of what has been said, but moves away from the emotional element

Patient: "I went to the doctor; he told me it was not curable. I was devastated, I had no idea."
Healthcare professional: "what symptoms were you experiencing at the time?"

Switching time

The healthcare professional moves the time-frame of the interview, so stopping the patient, for example,

Patient: "It was awful, I felt so ill, and so fed up, it seemed to go on forever."

Healthcare professional: "And so how do you feel now?"

Switching person

The healthcare professional sticks with the subject matter and even the emotions, but changes the frame of the conversations by asking about another individual rather than the individual themselves.

Patient: "I was in pain, weak and tired and was absolutely terrified that the treatment wasn't working".

Healthcare professional: "and was your wife worried about the treatment not working too?"

Distancing behaviours

There are a number of behaviours commonly seen within clinical interviews which have the impact of reducing disclosure from the patient's or relative's perspective.

NB: It should be noted that these behaviours are not necessarily poor behaviours; it is their use as a direct response to a person's disclosure which makes them inhibitory.

Giving premature information or advice

There are many occasions in which professionals are called upon to give advice to patients. The giving of advice itself is not a problem; it is the timing that can lead to the occurrence of blocking.

Giving advice prematurely, that is before an issue has been fully explored or before the end of an interview, significantly decreases subsequent patient disclosure. Information acts as a block by switching the recipient into listening mode, thus giving control of the interview to the health professional and reducing the space for the patient or reactive to speak. It focuses the professionals and the patient on solving the problem and thus deters them from exploring the issues or the impacts the issues are having on the person ability to do things.

Giving premature or false reassurance

In much the same way as information giving, reassurance is something that the healthcare professional is called upon to do on a regular basis.

Gain it is the timing of the giving of reassurance that acts as a block. If reassurance is given prematurely, that is before the problem, worry, or concern has been fully explored, then it will block subsequent disclosure.

Giving false reassurance should be avoided at all times.

Passing the buck

This is a particular form of premature advice in which the interviewer, in direct response to the patient's cue or concerns, gives advice about contacting or talking to a third party, with the intention of discussing the matter further with them.

While this may be very appropriate advice at the end of an interview after discussing the matter and having allowed the patient opportunity to ventilate feelings, the inference in using it as soon as a patient mentions a problem, before full exploration, is: "Do not discuss this with me".

Normalising

This is a particular form of reassurance in which fears are minimized in an attempt to make a patient feel better, but with the function of blocking the patient from talking about or expressing those fears. For example:

Patient: "I feel so shocked by the news"

Healthcare professional: "It's only natural that you should feel that way at first, All patients do".

Giving reassurance in this manner not only inhibits the patient from saying more but also detracts from that individual's experience of being given bad news. As with giving advice, it may be very reassuring for a patient to know that feeling upset or depressed is not uncommon. It is timing that is crucial.

Using jargon

Using jargon which patients may or may not understand can be very confusing and can lead to blocking of disclosure.

Similarly, allowing the patient to use every day medical jargon may also lead to confusion, as he or she may simply be repeating words which have been heard but have not been understood.

Leading questions

These are questions asked in such a way that they assume the answer or put words into the patient's mouth. They provide virtually no freedom for the patient to express themselves. For example:

"I expect you were worried at the time, weren't you? "No trouble with the blood pressure?" or "That's good news isn't it?"

Multiple questions

Multiple questions link a number of questions of any type in quick succession without allowing a response from the patient. Using multiple questions can lead to difficulties as it can confuse patients and make the response difficult to interpret accurately.

Multiple questions can contain questions that are differently or simply a rephrasing of the same question in different styles. For example:

"When you saw the doctor what did he say? Did you understand him? Who was with you?"
"How are you? Feeling better? Has the bleeding stopped?"

The interview process

Taking a history

When taking a history of the illness it is important to go back to the beginning of the patient's experience, namely their first symptoms and not simply their first contact with the healthcare system.

When going through a history it is important to do it sequentially. At each key event the following need to be established:

- Facts – what was found, what happened, what the patient was told
- Perceptions – what was understood, what the patient thought was happening, what sense the patient was making of things, any links the patient was making

- Feelings – how the patient felt about what was happening or what they were experiencing
- Coping – how the patient coped with the events, symptoms and feelings
- Previous experience – whether the patient had previous experience of the illness, the treatments or the symptoms from relatives or friends.

Integrating the feelings and perceptions during the enquiry gradually educates the patient that the healthcare professional is interested in all aspects of the patients' experiences and not merely in the factual events of the story.

Within a typical clinical history the key events might be:

- At screening
- When the patient first noticed the symptoms
- First contact with the doctors, for example the GP
- At initial investigations
- At diagnosis

The history might continue with the following key events:

- During surgery and after surgery
- Experiences of treatments and side effects
- After treatment has finished - returning to 'normal life'
- Return of symptoms
- Diagnosis recurrence

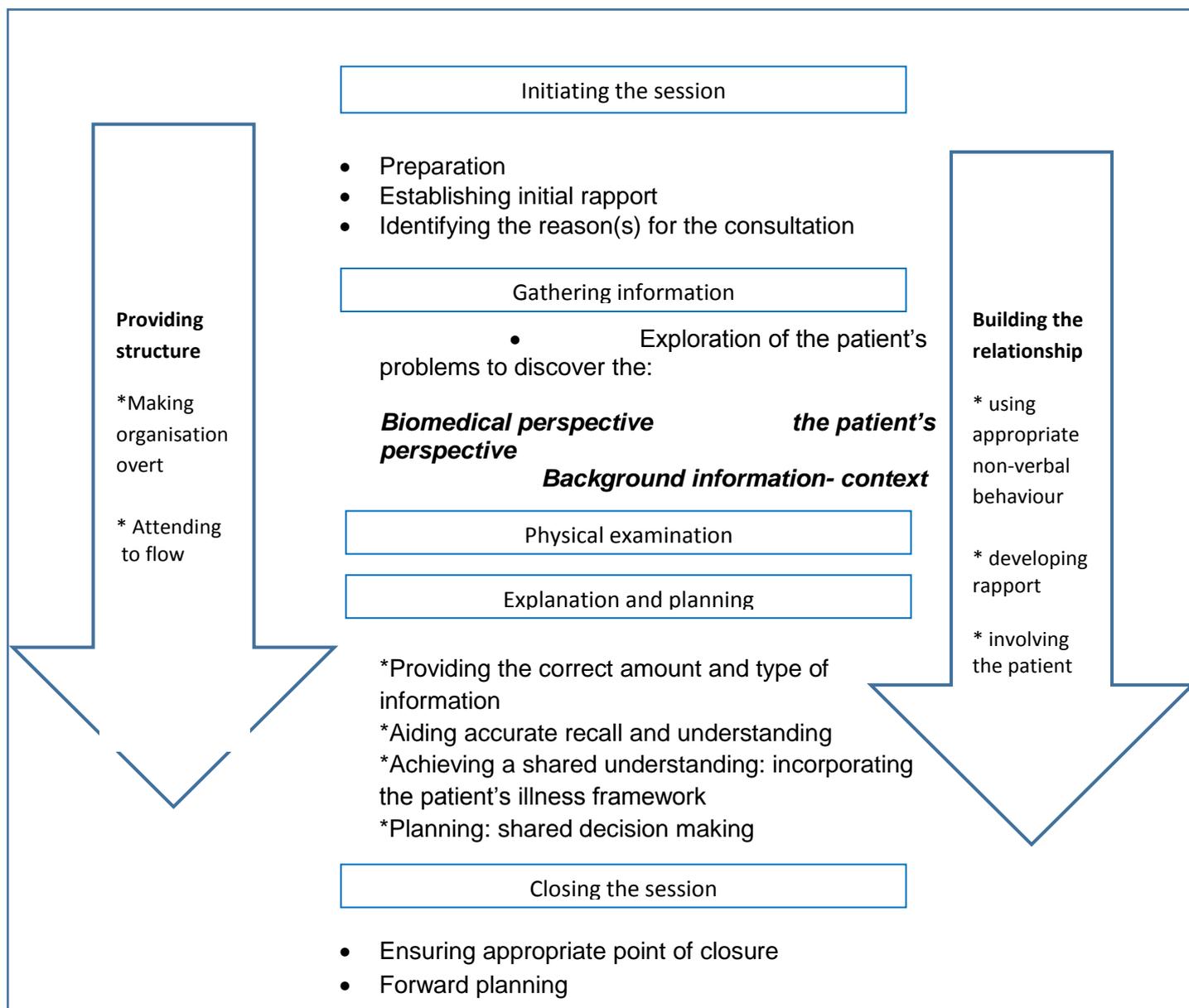
Other considerations during assessment

- Introduction of self: Name, position and exact purpose of the assessment.
This is not a chat
- Establish the patient's understanding of admission or visit

- Establish the patients understanding of their diagnosis/prognosis: Not just what the doctor has said
- Establish previous medical history and feelings related to it
- Physical assessment: Establish the patient's current problems, their extent and how the problem is affecting the patient's normal daily life
- For social assessment establish:
 - Who the patient has meaningful relationships with (partner, children, friends and so on), the extent of support from the relationships and whether the illness has affected the relationships in any way. This should include a sexual relationship, if appropriate
 - Home conditions and ability to cope
 - The patients occupation, hobbies or leisure activities
- Spiritual assessment: Establish what values and beliefs (including religion) are important for the patient and any concerns they may have
- Psychological assessment: Establish the patient's present mood state, in terms of how the illness is affecting them. Pick up on any cues about how the patient has been feeling in terms of anxiety and depression
- Coping: Establish how the patient is coping with their illness, what their coping mechanisms are and how effective these are
- Closure of assessment: Summarise and prioritise the patient's concerns. Invite questions, discuss a plan of action and close assessment. The specific use language when inviting patients' questions can influence the patients' level of disclosure. For example: "Is there something else you would like to discuss?" is much more likely to elicit further concerns than "Is there anything else you would like to discuss?" (Heritage et al, 2007).

Silverman, Kurtz and Draper (2005) have described a similar framework for structuring medical consultations which also ensures that both the content and the process of the consultation are addressed sufficiently. This framework, known as the Calgary Cambridge Framework is outlined below and has now been incorporated into a large number of medical undergraduate curricula

The Cambridge Calgary Model



Adapted from Silverman, Kurtz and Draper (2005)

The disease/ illness model is a central concept in the Calgary Cambridge Guide. It proposes that in any account of ill health there are two complementary descriptions of the same situation. An understanding of the disease enables you to reach the diagnosis and recommend appropriate treatment. An understanding of illness enables you to appreciate the uniqueness of this particular situation, how the patient is coping and what impact it is currently having on their lives.

An understanding of the dual nature of the diagnosis and treatment is likely to maximise concordance, understanding and satisfaction for both.

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