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COMMUNICATION SKILLS STATION: REASONS FOR INTRODUCTION INTO THE STATE FINAL EXAMINATION

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A «Practical Skills Station» is an episode of a specialist's working time in specially organized conditions (simulation), as close as possible to the future workplace, where standardized patients are used as a patient (this is a specially trained person who plays the role of a patient). The task of the examinee is to question the patient in the conditions of the primary outpatient appointment and establish the most probable diagnosis (syndrome). Working time at the station – 10 minutes.

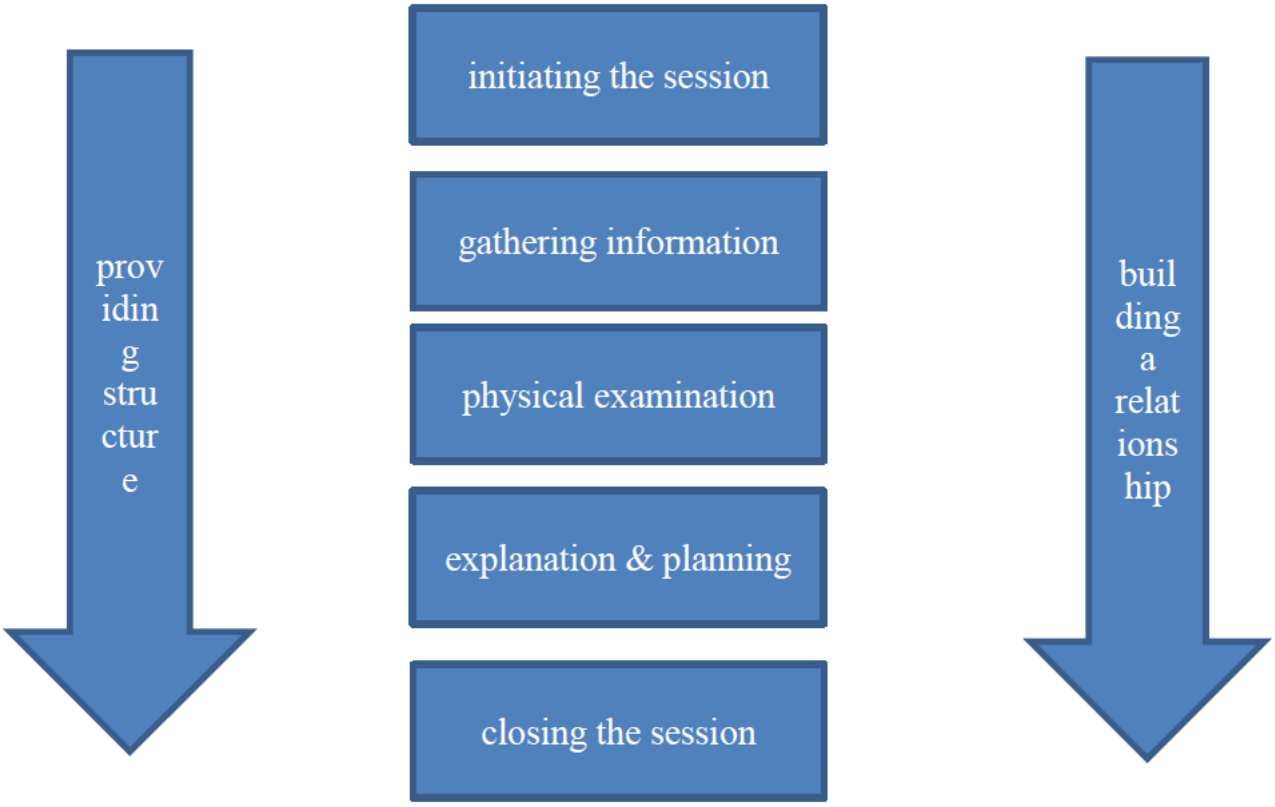
The assessment of the specialist's actions is carried out according to the checklist, the positions of which are consistent with the methodology (a kind of ideological basis) of the patient-oriented model of medical consultation. One of its variants is the Calgary-Cambridge model.

This guide was developed by the University of Cambridge School of Medicine and the University of Calgary, Canada. First published in 1996 by Jonathan Silverman, Suzanne Kurtz.

In this consultation model, five successive stages are distinguished. At each stage there are tasks that need to be solved using certain skills. There are also two continuous processes that go from the beginning to the end of the consultation: this is structuring and building relationships.

At the «Communication Skills» station only the skills of the doctor regarding the collection of information are assessed.

THE CALGARY-CAMBRIDGE MODEL OF AN OUTPATIENT SESSION



The introduction of the Calgary-Cambridge model was dictated by the research results provided by many scientists. Among them are:

Beckmanand and Frankel (1984) showed that primary care physicians in the United States often interrupted patients so soon after the start of their introductions –18 seconds on average – that other equally important complaints were not detected.

A study in the US ER (Rhodesetal. 2004) showed that residents only introduced themselves to patients two out of three times and only rarely disclosed their trainee status (8%). Despite the fact that clinicians tend to start with open-ended questions (63%), only 20% of patients spoke about their complaints without being interrupted, and after an average of 12 seconds.

Low et al. (2011) showed a significant number of unspoken needs and concerns in the context of primary care in Malaysia.

The classic study by Byrne and Long's (1976) of 2,000 consultations in British primary care found that physicians exhibited a remarkably consistent style despite differences in the problems presented to them and in patient behaviour. They often took a closed «physician-centered» approach to

information gathering that prevented patients from explaining their history and voicing complaints.

Bowes et al. (2012) showed that patients used the Internet to be more aware of their health, to make the best use of their limited consultation time, and to get them to take their problem more seriously. Patients expected doctors to accept this information, discuss it, explain it, place it in the proper context, and express their professional opinion. Patients tended to prioritize physician opinion over Internet information. However, if the doctor appeared uninterested, dismissive, or arrogant, patients reported to the researchers about the damage done to the doctor-patient relationship, sometimes to the point of seeking another opinion or changing doctors.

We worked out a checklist for the students from India revising for the State Final Examination in a Russian University. We tried to take into consideration mentality & language aspects of the students.

1. Greeting: greet the patient.

2. Caring for the patient's comfort: tell where to stay, where to put things.

3. Self-presentation: introduce themselves.

• Name their role.

• Define the nature of the consultation (purpose of the meeting).

4. Consent to questioning: ask if the patient had any objections to the questioning.

5. Identification of the patient's personality: ask the patient's full name, year of birth (age).

Inquiry:

6. Open question (at the beginning): use the open question «What brought you?» or «What would you like to discuss today?» or «hat did you come with?»

7. Start the questioning with the phrase «What are you complaining about?»: use the open-ended question «What are you complaining about?» or «What's bothering you?»

8. Listening: listen without interrupting.

9. Summarize: repeat what the patient said to confirm correct understanding of what the patient was saying, inviting the patient to correct or add information.

10. Screening: try to identify other (minor, latent) problems through the question «What else is bothering you?» «Is that all you're worried about?»

• use «address by name, patronymic, is there anything else that bothers you?»

• conduct a screening prior to the start of revealing the details.

11. Taking into account the patient's opinion: ask what the patient associates their condition with, without offering answers.

12. Use of open-ended questions: use an open-ended question when collecting information about something specific, for example, «Tell me more about it», «What can you say about this problem.»

13. Offering your own answers to the questions ask: when asking a question, offer options for choosing an answer.

14. Series of questions: ask several questions in a row. Building relationships through communication.

15. Eye Contact: maintained eye contact for at least half of the time during the entire interview.

16. Interruption: interrupt the patient - speak out late (replicas), and also use phrases that cannot be regarded as clarifying questions or as facilitation of the patient's story.

17. Appeals to the patient: address by name (first name).

18. Comments and evaluates the patient's behavior: express regrets about late treatment, give recommendations for calming down, draw attention to the undesirability of such a reaction, etc.

19. Maintaining pauses: when the patient is silent for a while, give the opportunity to continue.

20. Posture: listen to the patient, not looking up from the notes, standing, etc.

21. Empathy: demonstrate understanding of feelings, concerns, problems, etc.

22. Facilitation of the patient's response: help the patient with encouragement, repetition, paraphrasing but without clarifying questions

In our opinion, research testifies to universal problems in the field of clinical communication, which do not depend on any features of the mentality and economic structure of society. We hope that the checklist worked out at ASMU will enable Indian students to show good performance in the State Final Examination.

References:

1. Beckmanand and Frankel The effect of physician behavior on the collection of data 2. Rhodesetal. 2004. https://pubmed.ncbi.nlm.nih.gov

2. Low et al. Medical devices & e-health solutions. 2011 https://apps.who.int/iris/bitstream

3. Byrne and Long's A pragmatic analysis of the impact of co-operative principle on outpatient discourse. 1976 https://www.scirp.org

4. Bowes et al. Reducing safety-related drug attrition: the use of in vitro pharmacological profiling. 2012 https://www.nature.com

5. Calgary-Cambridge Guide to the Medical Interview - Initiating the Session. https://www.physio-pedia.com

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