Medical Student's Communication Ability during the Medical Interview – Perceptions of Self, Patients and Faculty

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Authors' contributions

This work was carried out in collaboration between all authors. All authors designed the study. Author MM managed the literature search and authors MM and COC collected the data. Author MM performed the statistical analysis and wrote the first draft of the manuscript. Authors GD and MH supervised the research. All authors read and approved the final manuscript.

Original Research Article

ABSTRACT

Background: Research indicates that students struggle to transfer class room taught communication skills into the reality of clinical practice. Students have previously been shown to be poor at self assessment of communication skills with over or under estimation of ability. Patients have previously shown little correlation with faculty.
Methods: This study sought to investigate medical student's actual communication skills at the bedside, during a medical interview, from the perspectives of faculty (behavioral scientists) patients and self assessment. A validated Calgary - Cambridge observation tool was utilized.
Results: Patients and faculty reported clear evidence of classroom taught skills being utilized clinically. The median scores achieved were similar with faculty reporting 64.5 %, (Q1, 59.5: Q3, 70.75), Patients 64% (Q1, 56.25: Q3, 71) and students' self- assessment at 63% (Q1, 56: Q3 68), (Range 0-100%). Students underestimated their skills in "initiation of interview", "gathering information" and "building structure". Students over estimated their abilities in "understanding the patients perspective", "building a relationship" and "closing

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the interview". A medium correlation of 0.584 was determined between faculty and patients with a p- value of 0.00069. There was no correlation between students self assessments and faculty nor between students and patient assessments

Conclusion: Medical students can transfer some classroom taught communication skills to the clinical setting, during the medical interview, to the satisfaction of faculty and patients. Students in the early years of training appear poor at self - assessment of their actual ability in some aspects of communication skills. This concurs with previous findings. However, patients had good agreement with faculty - this has been seen previously with standardized patients but not with actual hospital in-patients.

1. INTRODUCTION

The first mention in the literature advocating structured interviewing was in 1850 when Peabody [1] highlighted the importance of "speaking with patients" and the 'medical encounter' being integrated concepts. The relevance of having good communication skills to attain proficiency in medical interviewing cannot be over- emphasized and is cited as such in the literature from the 1970's to date [2,3,4]. Indeed Brown [5] asserts that 60-80% of diagnosis is based on the history a doctor elicits from a patient. The initial encounter between the patient and physician sets the stage for what we all hope will be a lasting and therapeutic relationship. Roter [6] continued this theme into the 1980`s stating "talk is the main ingredient in medical care and it is a fundamental instrument by which the doctor-patient relationship is crafted and by which therapeutic goals are achieved". However, it was a further 10 years before the patient's perspective of the medical encounter was sought by Cooper & Mira [7] and indeed this remains an area largely under investigated in medical education research today.

Despite Peabody's[1] forward thinking regarding the need for direct patient contact to maximize learning, early medical teaching up to the 1980`s was predominately through traditional didactic large group lectures. The eventual shift away from didactic lectures as a method of teaching communication commenced in the 1980`s with research emerging in the United States and Canada identifying patient dissatisfaction with the medical encounter [9]. The literature continued to evolve with a new focus on alternative approaches to communication skills teaching and assessing in the undergraduate medical curriculum. Fadlon [10] cautioned that when communication skills were taught in an informal, unstructured manner, medical students viewed this knowledge as unspecialized, repetitive and even boring. Thus he recommended the employment of a structured model for teaching doctor-patient communications to facilitate psycho-social issues achieving the status of formal knowledge.

To address this remit a Communication Skills Advisory Group was set up in the Medical School to plan and deliver a structured communications skills programme starting in the 2nd Medical Year with medical interviewing. A review of the literature revealed a number of proven reliable and valid communication skills observation tools had been developed in recent years to allow objective assessment of observed behaviours in a doctor/patient interaction. These included the Harvard Medical School Communication Skills form based on the Kalamazoo Consensus statement [12] and the SEGUE [13]. The 360 degree assessment [14] although very comprehensive was deemed inappropriate for this study owing to its

length and complexity and its requirement of multi-disciplinary assessment. The 2nd medical year programme consisted of students spending approximately four hours a week in a large variety of hospital areas and so personal relationships with specific team members would not develop in such a limited time frame. The 360 degree assessment could, however, be considered later in the course as the students are clinically attached to specific teams allowing inter professional relationship development. Investing in the beginning, eliciting patient perspective; demonstrating empathy and investing in the end are common categories in the aforementioned assessment tools. However, the delivery of diagnostic information, provision of education and involving the patient in the decision making was deemed as not applicable in the earlier undergraduate years by the Committee.

Ultimately, although of varying lengths these tools shared the inclusion of the fundamentals of a medical interview, namely , assessing the interviewer on their ability to open a session, gather information, understand the patient perspective, build a therapeutic relationship, provide explanations, plan together and finally formally close the session. Arguably, although the Harvard Tool [12] is more simplistic and shorter the 'Calgary-Cambridge Observation Tool [13] ' was ultimately chosen for the purposes of this study as this conceptual framework would also underpin the taught course. It also met all the criteria suggested by ACGME 14 as requirements of a focused observation tool- namely, it directed the observer to the important skills and qualities, it enabled improvement to be tracked, it allowed immediate feedback based on actual behavior rather than depend on more global impressions and it can yield valid and reliable data. To maximize the successful use of this teaching framework and observation tool, this study also involved Behavioral Scientist Observers and observed students in settings most representative of where they would actually provide care to patient's i.e. acute hospital wards. Furthermore this study observed students early in their educational programme to identify skills in need of improvement and will be repeated later in the programme to gauge improvement as recommended [14]. In summary, as previous research [10] identified that medical students tended to overestimate their communication skills abilities this study sought to objectively quantify the student's perceptions on their skills and compare these findings with the patients and faculty.

2. METHODOLOGY

2.1 Participants

In the final term of the second medical year of a five year undergraduate medical training programme thirty one students were allocated to clinical skills by the central school office. All were invited to participate in this research project. One student was excluded following discussion and agreement as they were repeating the 2nd year and had therefore had previous communication skills training. Of the thirty remaining students all agreed to participate. The final sample compromised 21 females and 9 males, 19 students spoke English as a first language (EFL) and 11 spoke English as a second language. All students had attended four experiential sessions of two and a half hours duration based on the Calgary-Cambridge Communication Criteria [13] (Appendix 1) in the first two terms.

2.2 Research Sample – Patients

All Hospital Consultants were written to by MM outlining the research proposal and seeking their consent to recruit their patients to this study. Approval was given with a number of stipulations as follows- Table 1.

Table 1. Patient Inclusion Criteria

Inclusion criteria agreed were:
1. Patient was deemed well enough clinically by the Senior Registrar to tolerate a 20 minute interview on 2 separate occasions in the same day.
2. Patient had full cognitive ability (a mini mental score of thirty) to facilitate feedback of their opinions on the encounter.
3. Patients with regularly seen conditions rather than complex rare conditions to be included owing to the junior status of the students.
4. Patients who spoke English as a first language owing to the junior status of the student.

The researcher (MM) visited each patient forty eight hours before the planned student visit. Each patient was given a full verbal explanation of the study and this was supported with written summary of the study .The researcher's mobile number was given also should the patients have any later queries. The researcher went through the observation sheet to inform the patients of the questions that would be asked of them after the interview. The patients were encouraged to be as honest as possible in the feedback and reassured that all documents were coded and so they would not be identified. Written informed consent was obtained to participate in the study and to use the data gathered in research papers.

2.3 Pilot Study

Ten independent patients i.e. non-participating patients were asked to read and comment on the Abridged Calgary Cambridge Observation Tool [13] (Appendix 1). All ten concluded that having three distinct options was easier and less ambiguous than five to complete. The observation tool (faculty, patient and student sheets) were thus amended to include just three options. Following the pilot study the tool was shortened to include only sections relevant to 2nd year medical students namely, "initiating the session", "gathering information", "building structure", "building relationship" and "closing the session". "Sharing information" and "planning together" were removed as it was agreed by all the researchers that a student's lack of medical knowledge in the 2nd year may prohibit their abilities in these areas. Content and face validity [15] were checked following these amendments and it was agreed by the researchers that the amended tool was fit for purpose in this study setting.

2.4 Inter-Rater Reliability

As there were three data collectors (two faculty and one clinical skills tutor collecting patients data), it was of paramount importance that inter-rater reliability[15] was assured following amendments to the observation tool. To achieve this, all 3 data collectors agreed to assess a student simultaneously on 4 occasions and discuss the findings. It was agreed that should there be a large discrepancy between ratings an average rating would be accepted. However, as there were only 3 options to choose from on the adapted assessment tool there was 100% agreement between all three data collectors on four separate occasions. This indicated the data collected by three individuals was consistent and therefore reliable.

2.5 Study Format

During a supervised extra ward visit arranged for the purpose of the research project, students elicited a patient's medical history utilising a patient centered interview approach as taught in the communication skills course. This occurred under the direct observation of a

Behavioural Scientist (BS) .The students were assessed by the BS during the interaction using an abridged version of the Calgary- Cambridge Communication Guide [13] (Appendix 1). Historically students attended the ward under the supervision of a physician and received verbal feedback from the physician's perspective only. Each student interviewed one patient and each patient assessed one student. At the end of the interview the patient completed a similar tool with the assistance of the clinical skills tutor (MM). The students were then furnished with the assessment sheet and asked to self assess.

Direct observation was deemed an essential methodology in this study to objectively identify student's actual behaviors' in the realities of an acute clinical setting. Students had attended four classroom based sessions previously which included role play with peers. These sessions were video recorded and peer and faculty reviewed with feedback. In the ward setting the student received immediate verbal feedback from the Behavioral Scientist on all assessments i.e. faculty perspective, the patient's perspective and their self assessment. Within one week of the ward visit the researcher (MM) provided written feedback to the student on faculty, patient and self assessment communication scores awarded during the interview. The students were encouraged to reflect on the experience and identify strengths and weaknesses in their abilities to communicate with hospital patients. The reflection could be recorded in the student's logbooks.

2.6 Analysis and Treatment of Data

The quantitative data was analyzed by the statistical software package 'R'[16]. As all quantitative data collected was ordinal, medians rather than means were analyses and non-parametric tests were utilised for descriptive statistical analysis [16]. For the purposes of this study statistical significance was accepted at the 95 % level with 'Weak statistical significance 'accepted when the p value was between .05-0.1 and 'Strong statistical significance' accepted when the p value was <0 .05.

An Exact Wilcoxin Rank Sum Test was utilised for testing distribution differences in independent groups [16]. An Exact Wilcox in Paired- Signed Rank Test was utilised for testing for differences in distribution between groups [16]. Exact tests were used to elicit exact rather than approximate p- values. Spearman's Rank Correlation tests were utilised for correlation analysis [16]. Basic training in statistical tests and analysis was undertaken by the researcher (MM) and expert advice was sought to check and confirm accuracy of in putted data and verify the appropriate statistical tests to utilise for analysis of data. Data was entered by the researcher in short sittings to reduce the risk of potential fatigue and subsequent error and later checked for input accuracy by the statistician.

3. RESULTS AND DISCUSSION

In the interview the median scores for communication skills were similar in all 3 assessors with faculty median scores equaling 64.5 (Q1:Q3) (59.5: 70.75), Range 0-100, patient 64 (56.25:71) and student 63 (56:68) -Table 2.

Table 2. Observed communications skills

	Interview		
Measure	**1st Quartile**	**Median**	**3rd Quartile**
Faculty	59.5	64.5	70.75
Patient	56.25	64	71
Student	56	63	68

With regard to the results of the observations of the subsections of the medical interview the "initiating the session" subsection showed no statistically significant difference between assessors with all scoring the student highly (median score 71-78 ,range 0-100). In the "gathering information" subsection there were no statistically significant differences between assessors with scores ranging from 72-85, range 0-100 .In the "patient's perspective" subsection of the interview, there were no statistically significant differences between assessors with scores ranging from 0-50, range 0-100. There was no statistical difference in the subsection "building a relationship" between assessors in the interview with medians ranging from 59-62 range 0 -100. In relation to the subsection "closing the interview" there was no statistical difference between groups with scores ranging from 0-12.5 (Table 3).

Table 3. Communications skills Behaviours

	Interview		
Measure	**Q1**	**Median**	**Q3**
Initiate (Faculty)	64	78	86
Initiate (Patient)	65.75	71	86
Initiate (Student)	71	71	78
Gather Info (Faculty)	72	80.5	87.5
Gather Info (Patient)	61	72	83
Gather Info (Student)	61	72	78
Patient Perspective (Faculty)	0	12.5	50
Patient Perspective (Patient)	0	0	50
Patient Perspective (Student)	31.25	50	50
Structure (Faculty)	50	62	75
Structure (Patient)	50	50	75
Structure (Student)	40.25	50	62
Building Relationship (Faculty)	50	59	75
Building Relationship (Patient)	45.5	56	73.5
Building Relationship (Student)	50	62	75
Close (Faculty)	0	0	50
Close(Patient)	0	0	50
Close (Student)	0	12.5	50

3.4 Testing for Correlations

Spearman's rank-correlation tests were conducted to determine whether correlations existed between faculty and patient, faculty and student and patient and student within the interview. Within the interview a correlation of 0.584 was determined between faculty and patient with a statistical significance of p=0.00069. No other statistically significant correlations were determined.

3.5 DISCUSSION

In response to the question as to whether students can transfer classroom taught communication skills to the clinical setting, during a medical interview, the results show that faculty, patients and students did report student's utilisation of classroom taught communication skills in the clinical area. During the medical interview the median scores for communication were similar in all 3 assessors with faculty scoring 64.5 (range 0-100), patients 64 and students 63 thus the students appeared to utilise acceptable communication skills as assessed on the Calgary–Cambridge Communication Tool [13] .

With regard to the results of the observations of the subsections of the medical interview the "initiating the session" subsection showed no statistically significant difference between assessors with all scoring the student highly (median score 71-78 – range 0-100). However, students underestimated their abilities in this section scoring 71 % as faculty awarded a median score of 78%. In the "gathering information" subsection of the interview, there were no statistically significant differences between assessors, however, again students underestimated their abilities self assessing at a median of 72% whereas faculty awarded a median score of 80.5%. There was a wide disparity of scores in the "understanding the patients perspective" subsection with faculty median score of 12.5%, the patients scored the students a median of 0 and the students scored themselves a median score of 50%. This warrants further investigation as faculty and patients scored the students poorly here, with faculty reporting the students had some insight into the patient perspective at interview (median =12.5) yet this was apparently not perceived by the patient (median = 0).

Explorative patient interviews to elicit their views on the term "understanding the patient's perspective" is essential as there is a large discrepancy here between students and patients opinions of observed skills. As Masur [17] asserted "there is still much truth in the ancient quotation from the Isle of Cos that some patients recover their health simply through contentment with the goodness of the physician". It is essential that the patient feels their perspective on their illness is acknowledged and appreciated if a truly therapeutic relationship is to ensue. The student's perceptions in this area needs to be explored in a focus group discussion as they consistently scored themselves well in the interview which was in conflict with faculty and patients observations. It would be enlightening to elicit what the student understood by "understanding the patient's perspective" and how they feel this understanding can be displayed in a patient interaction. This is an area ripe for further research. With regard to "structuring the interview" students under estimated ability with a median score of 50% whereas faculty awarded a median of 62%. Finally, in both the "building relationship" and "closing the interview" subsections students over estimated their abilities when compared to patients and faculty.

3.6 Discussion of Correlations

Spearman's rank-correlation tests were conducted to determine whether correlations existed between faculty and patients, faculty and students, and patients and students. Within the interview a medium correlation of 0.584 was determined between the faculty and patients with a p- value of 0.00069. This conflicts with previous research where Cooper and Mira[7] found a poor correlation between faculty and patients assessment of student's communication skills. Of note is that these findings are a decade ago and patients may be better informed today. Equally, Cooper [7] included medical personnel as assessors whereas this study utilised Behavioral Scientists which may explain the different findings.

No other correlations were determined which concurs with Aspergens [18] findings that students were prone to over estimating their communication abilities. Moreover, previous research also reports a tendency for medical students to under estimate communication abilities [10]. This supports the "conscious competent model" whereby students who are "unconsciously incompetent" tend to over score themselves whereas students who are "unconsciously competent" tend to underscore their abilities. These findings support the inclusion of a real time bedside assessment with immediate feedback to facilitate students' attainment of conscious awareness of their competence or incompetence in communication. This may assist their progression towards "mastery" [19] of these essential clinical skills.

The utilisation of Behavioral Scientist as subject experts was deemed essential to reduce potential misplaced bias of medical personnel as raters. Research suggests[20] that clinical assessments by other health care professionals results in students being judged with leniency as assessors are often uncertain about their judgment or indeed afraid to take responsibility for the potential consequences of a negative finding .Within this context, it is concluded that medical student's communication skills can be reliably measured through standardised observation by Behavioral Scientists in the clinical setting. This approach involving immediate verbal and subsequent written feedback may promote student reflection and encourage the start of lifelong learning and refinement of communication skills.

Research suggests that teaching and assessment of communication skills needs to be continued longitudinally throughout the entire undergraduate programme to address the "rise and fall of student's communication and history taking skills" [20,21]. Early training assists with the identification of students with specific problems either in attitude or skills to communication skills learning and so re-mediation can be offered. Regular rehearsal of skills will lead to improved acquisition and retention of these core skills. Communication skills need to be embedded in a patient and student orientated curriculum so that these skills are seen as core elements of good doctoring.

4. LIMITATIONS

This study is very specific in its focus namely communication between undergraduate medical students during a medical interview with hospital in- patients. Students are of course required to "communicate" in a far more wide reaching domain throughout their medical careers. This study aimed to form a basis for the introduction and attainment of a focused skill set early in the programme. The communication skills acquired can be continuously refined and developed throughout their medical career. Inter and intra disciplinary communication, communication with relatives, sensitive issues, cultural diversity, and written communications are but a few of more advanced skills the student will also develop over time. This study suggests a specific starting point of learning with the fundamental skill of medical interviewing for which good communication skills are essential.

The sample size was small with a total of 30 students and patients making demographic analysis inconclusive due to the relatively small numbers in each demographic category (gender, age, first language). A limitation in statistical analysis of the data gathered by the Adapted Communications Observation Tool is that the individual sections only have a low number of distinct possible scores for example on the closing interview section students can only score from 0-4 which means that in order to detect differences between the two groups one either needs to have a large difference between the two groups or one needs a larger sample size. A finer grained tool with seven or nine distinct scores would be more sensitive to identifying differences in a smaller sample.

Students need to be perceptive to non verbal communication in the patient as well as what occurs in conversations. A limitation in this study design is that it focused specifically on verbal communication with little emphasis on non verbal communication behaviors. This was owing to the junior status of the students and the study focus being more specifically on verbal interactions. Further studies should ideally examine both verbal and non verbal communications abilities to give a more global perspective on communication skills.

All observational studies have the limitation of a potential "Hawthorn Effect" with participants altering their behavior owing to being observed. As students were self assessing also this may have reduced this potential confounder. Recording the interview could address this potential limitation in future studies.

5. CONCLUSION

In conclusion, it appears that 2nd year medical students can apply classroom taught communication skills, during a medical interview, in a manner acceptable to faculty and patients. This study finding concurs with previous research showing students have a tendency to under or over estimate ability. A new finding here is the medium correlation between faculty and patients scores - this is in opposition to previous research reports and indicates patients are better informed today with regard to communication skills. This study suggests a structured approach to teaching and a comprehensive multi-faceted approach to assessment in a clinical setting with immediate feedback can identify strengths and weaknesses early in the curriculum enabling prompt remediation. This approach will support the acquisition and refinement of good communication skills which are fundamental to medical practice today.

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COMPETING INTERESTS

All authors declare that no competing interests exist in researching and writing this paper.

REFERENCES

1. Peabody F.W. The Care of the Patient. JAMA. 1927;88,877-82.
2. Hampton J.R, Harrison M.J et al. Relative contributions of history taking, physical examination and laboratory investigation to diagnosis and management of medical outpatients. Br Med J. 1975;2(5969):486-9.
3. Peterson MC, Holbrook JH, et al. Contributions of the history, physical examination and laboratory investigation in making medical diagnoses. West J Med.1992;156(2): 163-5
4. Roshan M, Rao AP. A study of relative contributions of the history, physical examination and investigations in making medical diagnosis. J Assoc Physicians India. 2000;48(8):771-5.
5. Brown J. How clinical communication has become a core part of medical education in the UK. Medical Education. 2008;42:271-278.

6.   Roter DL. Patient –physician communication: a descriptive summary of the literature. Patient Educ Couns. 1988:12;99-119.

7.   Cooper C, Mira M. Who should assess medical student's communication skills: their academic teachers or their patients? Med Education.1998;32:419-21.

8.   Beckman HB. The effect of physician behaviour on the collection of data. Ann Intern Med .1984;101:692-696.

9.   Fadlon J. Teaching medical students what they think they already know. Education for Health, 2004;17(1):35-41.

10. Bayer-Fetzer Conference on Physician – Patient Communication in Medical education. Essential elements of communication in medical encounters: the Kalamazoo consensus statement. Academic Medicine. 2001;76:390-393.

11. Makoul G. Communication Teaching and Assessment in Medical Education: An International Consensus Statement. Patient Education and Counselling. 1999;37(2), 191-195

12. Kurtz SM, Silverman JD. The Calgary-Cambridge Referenced Observation Guide: an aid to defining the curriculum and organising the teaching in communication training programmes. Med Educ. 1996;30(2):83-9

13. Accreditation Council for Graduate Medical Education. (ACGME) Outcome Project: Toolbox of assessment methods. Chicago; 2001.

14. Oppenheim AN. Questionnaire Design, Interviewing and Attitude Measurement. London; Pimpter Publications; 1992.

15. Greene J. Learning to use statistical tests in psychology. Second Edition; Open University Press. Bucks. UK; 1999.

16. Masur J. The Quest for better hospital care. Public Health Reports.1962;77(12)1033-1039.

17. Aspegren K. What basic communication skills in medicine are learnt spontaneously and which need to be taught and learned? Medical Teacher. 2005;27(6);539-543.

18. Bloom BS. Taxonomy of Educational Objectives: Handbook I. Cognitive Domain. 1956; New York. Mackay.

19. Pfeiffer C, et al. The rise and fall of student's skill in obtaining a medical history. Medical Education.1998;32,83-288.

20. Von Fragstein M. UK consensus statement on the content of communication curricula in undergraduate medicinal education. Medical Education; 2008.

APPENDIX 1

Adapted Calgary-Cambridge Guide to Medical Interviews

Study No.:...............................

Faculty / Patient / Student - Please Circle Assessor Category

COMMENTS

Initiating the session	Clearly present 2	Partially present 1	Not present at all 0
1. Greets patient and gets their name			
2. Introduces self, role, nature of interview			
3. Demonstrates respect and interest			
4. Identifies problems/issues which patient wishes to discuss, with appropiate opening question (e.g. what problems brought you into hospital?)			
5. Listens attentively to patients opening statement without interupting or directing the patient's response			
6. Identifies and confirms problem list			
7. Negotiates an agenda			

Gathering Information	Cleary present	Partially present	Not present at all
8. Encourages patient to tell the story			
9. Appropriately moves from open to closed questions			
10. Listens attentively, allowing patient to complete statements without interuption and leaving space for patient to think before answering or go after pausing			
11. Facilitates patient's responses verbally and non verbally e.g. use of encouragement, silence, repitition, paraphrasing, interpretation			
12. Picks up verbal and non-verbal cues, and checks and acknowledges as appropriate			
13. Clarifies patients statements that are unclear and need amplification			
14. Periodically summarises to verify own understanding of what the patient has said			
15. Uses concise easily understood			

questions and comments

16. Establishes dates and sequence
Understanding patient's perspective
17. Actively determines and appropriately explores patients ideas, concerns and how problem affects patients life

18. Encourages patient to express feelings

	Scores	2	1	0
COMMENTS				

Building structure	Clearly present	Partially present	Not present at all
Making structure overt 19. Summarises at the end of a line of a specific line of enquiry to confirm understanding before moving on 20. Progresses form one section to another using signposting, transitional statements; includes rationale for next section			
21. Structures interview in logical sequence			
22. Attends to timing & keeping interview on task			

Building Relationship	Clearly present	Partially present	Not present at all
Appropriate Non-verbal Behaviour 23. Demonstrates appropriate non verbal behaviour 24. If taking notes, does so in manner that doesn't interfere with dialogue and rapport 25. Demonstrates appropriate confidence			
Developing rapport 26. Accepts legitimacy of patient's views and feelings; is not judgemental 27. Uses empaty to overtly acknowledge patient's views and feelings 28. Provides support, expresses concern, understanding, and acknowledgdes coping efforts and appropriate self care 29. Deals sensitively with embarassing or disturbing topics , physical pain 30. Share's thinking with patient to encourage involvement (what I'm thinking now is……)			

Closing the session

Ensuring appropriate point of closure

31. Summaries session briefly

32. Final checking- Checks if patient has any
questions or items to discuss

OVERALL IMPRESSIONS OF STANDARD OF INTERVIEWER

2	1	0
Clearly Satisfactory	Partially Satisfactory	Not Satisfactory at all

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