How should trainees be taught to open a clinical interview?

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AIM To characterise the opening of secondary care consultations.

METHOD We audio-taped 17 first consultations in medical clinics, transcribed them verbatim, and analysed verbal interactions from when the doctor called the patient into the consulting room to when she or he asked clarifying questions.

RESULTS The interviews did not open with the sequence, reported by previous researchers, of 'doctor's soliciting question, patient's opening statement, interruption by the doctor'. Doctors (1) called the patient to the consultation; (2) greeted them; (3) introduced themselves; (4) made a transition to clinical talk; and (5) framed the consultation. They used a referral letter, the case notes, computer records and their prior knowledge of the patient to help frame the consultation, and did so informally and with humour.

CONCLUSION These 5 steps could help trainees create a context for active listening that is less prone to interruption.

KEYWORDS education, medical, undergraduate/ *methods; *communication; *physician–patient relations; referra; and consultation/ *methods.

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INTRODUCTION

Talking and listening to other people is a fundamental medical skill. Under the guise of interviewing, it dominates early medical training and gives students an 'entry ticket' to the clinical environment. While the success of an interview is influenced strongly by its opening moments, research in primary care has suggested that doctors often mishandle them by interrupting patients' opening statements.[1,2] We set out to characterise the opening of consultations in secondary care.

METHODS

With ethics committee approval, a purposive sample of 21 first-time attenders at hospital clinics in medical specialities gave informed, written consent for their consultations to be audio-taped, transcribed verbatim and analysed qualitatively. They were selected to cover a variety of disease states, and trainee as well as trained doctors. Nine had endocrine, 4 general medical, 2 rheumatological and 2 gastroenterological presentations. Four senior clinicians saw 9 patients and 3 senior trainees saw the remaining 8. Four recordings were technically unsatisfactory. The recording, transcription and conversation analysis (CA)[3] went from the participants' first interaction to when the doctor clarified something the patient had said.[4] We first sought the previously described sequence of soliciting question, opening statement, interruption, then analysed the interaction in greater depth considering:

- Turn-taking: the length and order of conversational turns, and how they alternated
- Sequential organisation: patterns such as presequences ('can I just ask a question?'), and 'adjacency pairs' (e.g. question–answer, invitation–acceptance)

Overview

What is already known on this subject

Previous studies have framed the interviewer's task in the opening phase of patient-centred interviews as listening without interrupting, a task in which they more often fail than succeed.

What this study adds

An alternative framing, in which the interviewer and interviewee interact informally to establish a mutual sense of identity and reason for the encounter. This does not take away the need for active listening, but creates a context that might be less prone to failure.

Suggestions for further research

Replicate these observations in primary as well as secondary care using research methods that, like ours, start from the moment of first interaction and do not impose an interpretive framework.

- Repair organisation, e.g. resolving a misunderstanding
- Turn construction: how participants designed turns for one another

We sought comparable sequences and deviant cases that challenged our interpretations and were able to achieve theoretical saturation.

RESULTS

The consultations opened with conversational interactions that were far more complex and dynamic than 'solicit, listen and do not interrupt'. Extract 1 (Box 1) shows a typical opening sequence of: calling the patient; greeting him; introducing oneself; using information from a referral letter to make a transition to clinical talk; framing the consultation. The transition to clinical talk was always led by the doctor. Extract 2 shows a similar, but less fluent sequence. The pause in line 21 and quieter speech in line 22 suggest that the doctor's 'medical' response to the comment about 'calming her down' was located inappropriately within a social interchange. A sharp intake of breath preceded the doctor's second attempt at transition in line 25. The ambiguous question 'how are you doing?' in line 8 of extract 3 caused a similar problem, because it was unclear whether it was a greeting or request for information. After the transitions came a framing of the reason for the consultation. There was clarification of the 'epistemological position' (who knew what information) using a referral letter and other sources of information. Extract 4 has a complex framing sequence, in which the doctor referred to various sources. Over multiple turns, and using humour, doctor and patient constructed an explanation for the attendance. Eventually, the patient was asked to give an account of the problem in line 39. The doctor in extract 5 used a different approach, acknowledging but deliberately setting aside the referral letter so the consultation was framed in the patient's terms.

DISCUSSION

Since Beckman and Frankel's classic research on interruptions,[2] a prevalent model of communication education has been for the trainee to ask a soliciting question, then concentrate on not interrupting; but interruptions remain just as frequent.[5] Our transcripts did not conform to the classical model. The doctor and patient constructed a reason for the encounter conversationally.

One explanation for the discrepancy is that secondary care consultations are fundamentally different from primary care ones. Another is that we recorded a phase of the consultation others omitted because it came before a soliciting question. A third is that our very open methodology allowed a characterisation that the 'solicit, listen and do not interrupt' framework would have concealed. Put differently, one person's interruption is another person's dialogue. A fourth is that we cut short our analysis too early. We doubt that, because we stopped it only when the doctors asked a clarifying question.

The traditional interview model works best for patients with a clear-cut, acute presenting complaint. However, practising doctors must also relate to people who have chronic disease, do not understand themselves or do not know why they are there. Medical interviews must, of course, retain their emphasis on active listening. We suggest teaching trainees to manage the transition from

Box 1 Extracts of consultations

Extract 1: Patient 4

Line	Speaker	Utterance
1	D	Mr Beswick? James Beswick ((calls from door to waiting room))
2	(7)	
3	P	Hi
4	D	Hello Mr Beswick. Come in. please take a seat.
5	P	Cheers.
6	(5) ((while sitting down))	
7	D	[Dr Keane is my name.] Dr Keane's my name, this is Gemma
8		[((noise from chairs))]
9	P	Hi[-ya
10	D	[who's nurse with us today. (.).hhh Dr *Gra*ham is Dr Graham has asked
11		us to see you today about er:: (1).hh various complaints you've been
12		having (.6) in your shoulders neck and knee. Could you tell me about
13		those?

Extract 2: Patient 15

Line	Speaker	Utterance
9	D	= I'm one of the medical registrars and you are sir::?
10	C	I'm e[r:::] (we're) friends just e:r moral support.
11	P	[just a friend]
12	D	Okay that's fi[ne. that's] fine with me
13	P	[hu-hu-hu-hu-hu] ((giggles))
14	F	( ) like that
15	(.)	
16	D	Absolutely right.
17	P	= he-he-he
18	F	Calms 'er down a bit
19	D	Okay. and– have you always been like that or or you think that is
20		something new (.7) being a bit on the nervier side.
21	(3)	
22	P	Yeah a've always been nervous [°yes°.
23	D	[huh, okay
24	(.9)	
25	D	0.hh erm:: (1) I've got a letter fro::m (2) yer GP doctor (.) Anderson
26	(1)	

Extract 3: Patient 11

Line	Speaker	Utterance
1		((start of tape))
2		((noise as entering room, inaudible speech 8 seconds))
3	P	°Yes. I don't have a problem°
4	P	Mind if a take my jacket off?
5	D	Make yourself comfortable.
6		(10) ((chairs moving, seating))
7	P	°right°
8	D	How are you doing.
9	P	E:::rm. (.) Much better than when I went to see Andrew °(two syllables)°
10		(.) er::m [my own GP
11	D	[right
12	D	Right OK. Te- tell me what's been happening?
13	P	Er::m. (.) Basically I was > just explaining to the young med student <
14		Er::m er::r it's Dr McBride.hh I don't practice any more I now use my
15		PhD title [er::m ( ) ((inaudible speech))
16	D	[awright OK. Are you a doctor or (a)

Extract 4: Patient 17

Line	Speaker	Utterance
1	D	Ri::ght. D'you want to just come through
2	D	Okay do you want to just have a seat there

Box 1 (Continued)

3	P	thank you
4	D	have a seat
5	D	Okay I'm doctor Sarkar I'm doctor Smith's registrar e::m now we've had
6		a letter from your GP
7	P	Mhm
8	D	who's doctor Ridley isn't it a::nd doctor Ridley ha:s written er::m about
9		the fact that you:: (2) er::m were under Trafford with the elevated
10		prolactin level. Have you had any blood tests done here at all.
11	P	No
12	D	↓Okay let's jus:t
13	((Dr types on computer))	
14	D	°Okay°
15	(?)	
16	D	So: so really from what what I can gather e:m it's e::m it – it's a case of
17		> sort of him < wanting you to be be followed up by an endo- or her
18		sorry isn't it
19	P	= Yeah
20	D	Rachel H
21	P	= Yes.
22	D	= Isn't it.hh E::m wanting (.) she wants you to be followed up by an
23		endocrinologist.hh e::m and that's really why we we're seeing you
24		here.hh Now she sent quite a- a comprehensive list of all the (light)
25		the print-out £from your surgery just explaining everything you've
26		ever had done£ > which I was just having a quick look at < before.hh
27		e::m (.8) e- (1) so: if if you don't mind
28	P	N[o carry on sh -sh -sh -sh -sh]
29	D	[rather than £ploughing through all of this£].hh I might just y'know I
30		might just have a quick chat with [you I mean I I can get the gist of it
31	P	[hu-hm ((laughs)
32	D	= but y'know.hh e::m (1) I mean jus- just to go (.7) through this I think
33		it was back in 99
34	P	[Yeah
35	D	[e::m if I'm right that you:: e::m you were first seen it was actually in
36		the ophthalmology clinic is that right the eye clinic (.7) was that where
37		you were first referred? or [or how] how was this well why don't you
38	P	[No::]
39	D	= just tell me how was i[t (.) how] was it first discovered.
Extract 5: Patient 18		
3	D	I'm doctor Burns
4	(2)	
5	D	So:: Mr Allen welcome (2) just make a little space on the desk (2) a::nd I
6		have a letter from your doctor (.8) I was just refreshing my memory of
7		it which was what that frown was about just now ↑(but) what brings
8	P	you here today,
9		Er:: o::h I went to the doctors (.) I started getting (.) the shakes a lot
10		li:ke
11	D	Mhm
12	P	= Er:: (.6) they did a blood test on me (.5) an' 'e said that there
13		everything weren't where is should have been.hhh [((laughs))
14	D	[Ri::ght did he say
15		anything <u>more</u> than that [about it (.) did he say what was not right

Box 1 (Continued)

16	P	[Er::
17		Er:: something to do with the thyroid gland.
18	D	= The °thyroid° ((whispered with added emphasis)) gland okay:

Square brackets indicate overlapping speech, [the beginning and] for the end.
(.X) indicates a pause .X seconds long (.) is a micropause, audible but less than .2 seconds and not possible to time.
Colons indicate the extension of the previous sound, roughly in proportion to the number.
Equal signs show contiguous or latching speech where there is no discernable gap between utterances.
Punctuation is not grammatical but represents intonation: a question mark denotes upward intonation, full stop, downward or 'closing' intonation and a comma, equivocal.
Up- and downward arrows mark the onset of raised or lower pitch.
H shows audible breathing in proportion to length, the in-breath is preceded by a dot.
Degree signs surround passages of quieter speech.
British pound signs indicate passage of speech characterised by smiling or laughter.
Laughter particles may be represented as 'huh' or 'he' or whatever the closest approximation of sound is and are hyphenated together.
Underlining denotes emphasis of a word of syllable while capitals indicate very marked emphasis or speech which is particularly loud.
Single brackets enclose speech about which there was doubt about the transcription, if the brackets are empty no attempt was made at transcription.
Double brackets contain description or features which are difficult to transcribe.
A hyphen shows where the preceding sound has been cut short.
This is standard conversation analysis notation, as described by Jefferson and reported in more detail elsewhere[6].
D indicates 'doctor' and P 'patient', also H, F and C, husband, friend and carer, respectively. Names have been altered to preserve anonymity.

social into clinical talk and frame the consultation could create a context for active listening that is responsive to the many reasons patients meet doctors. We expect that the same framework would be applicable in primary care, but that is a topic for future research.

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