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# Unit 1 Receiving the patient

## LEARNING OUTCOMES

At the end of this unit, learners will be able to:

- greet a patient and put them at ease
- introduce themselves and their role
- ask the opening question and set the agenda for the interview

## Background

### Establishing rapport

Being able to establish rapport with the patient is the crux of the whole interview; indeed, the way in which a doctor receives a patient can make or break the consultation that follows. A doctor needs to treat their patient with respect, of course, but establishing rapport within the first few minutes is also about how doctors greet the patients and introduce themselves, ensuring that they have clarified their role, making sure patients are comfortable and even that the seating arrangement is appropriate (see audio 1.1).

### Opening question

The next step is to understand the issues the patient wishes to address or the reason for their visit. The doctor's opening question needs to require more than simply a *Yes* or *No* answer so that the patient will express his/her story. It should be a question that opens up the discussion, e.g. *What would you like to discuss today?* or *What brings you here today?* The patient will then produce his/her opening statement. Note that a follow-up visit might start with *Am I right in thinking you have come about your routine check up?* but could then follow with *Is there anything else you would like to discuss today?* to ensure that all avenues are covered – the patient may well wish to bring up other issues.

### Opening statement

The opening statement is when the patient reveals the issues he/she wishes to discuss. Interrupting the opening statement (which is something many doctors do) means that fewer complaints are elicited and vital signs and symptoms may be missed, possibly resulting in misdiagnosis. Instead, doctors should use active listening skills to determine the salient points of the statement in order to set the agenda for the consultation, using the verbal and non-verbal patient cues (looking upset, sounding frustrated, etc.) that determine both the physical and emotional state of the patient.

### Setting the agenda

Setting the patient's agenda, as opposed to carrying out the doctor's agenda, is important. Based on the salient points of the opening statement, the doctor must decide on a schedule or structure to the encounter, e.g. *Shall we start with ... and then we'll come back to the problems you've been having with ...?* Doctors should not forget to obtain the patient's agreement on the agenda, e.g. *... if that's OK with you?*

### William Osler (1849–1919)

The celebrated 19th-century physician from Ontario, Canada, Osler, known as one of the most influential physicians in history, is still quoted today by many experts in medical communication skills. He believed students learnt best by doing and that clinical instruction should begin and end with the patient. Quotes from Osler include: *Medicine is learnt by the bedside not in the classroom* and *Care more for the individual patient than for the special features of the disease.* For more information, see www.medicalarchives.jhmi.edu/osler/biography.htm



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## US versus UK English

| UK | US |
|---|---|
| be sick | vomit / throw up |
| collect the kids | pick up the kids (audio 1.2) |
| consultant | MD (Medical Doctor) |
| diarrhoea | diarrhea |
| GP (General Practitioner) (audio 1.3) | PCP (Primary Care Physician) |
| hospital ward | hospital department |

| UK | US |
|---|---|
| locum | I'm covering for Dr ...'s practice |
| playing up | acting up / giving me trouble |
| registrar | resident |
| student doctor | medical student |
| surgery / consulting room | doctor's office |
| waterworks (audio 1.3) | plumbing |

## Lead in

*Rationale:* To highlight the fact that the simplist form of contact with the patient can be the most effective means of establishing initial rapport

- Give learners a minute to think about the quote before getting them to share their thoughts as a group.

Osler's quotation is highly relevant, even today, especially as many doctors are still not engaging in the most basic of relationship-building skills with their patients. This initial contact with the patient is vital. Doctors who don't take the time to greet their patients risk alienating them from the outset. Patients may or may not understand much about their condition, but what they do understand and appreciate is warmth and empathy, which can so easily be conveyed by the doctor, can be reassuring, and will eventually facilitate the encounter.

## Putting yourself in the patient's shoes

*Rationale:* to remind learners what it feels like to be a patient and to draw on their own experience as a patient

**1**

**Suggested answer**

Patients are likely to be more frightened than the doctor (even during a first consultation) or to think their condition is more serious than the doctor says. They may even be afraid of the doctor. Patients may be even more anxious in a hospital because: of the unfamiliar environment; they don't know the doctor; it's busy and noisy; they might have to wait longer.

**2a**

- Ask learners to think about the experience from the patient perspective. Encourage them to put themselves in the patient's shoes – not necessarily an easy task but vital if they are to embrace the patient-centred approach.
- You might want to ask learners to visualise themselves in the role (of patient) before completing the questionnaire; it might help some to 'get into character'.

OR

Ask learners how often they visit the doctor, when the last time was they visited the doctor, or how they felt about the experience.



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- **Suggestion:** If you haven't already done so, complete the questionnaire yourself along with your learners.

**2b**

**Suggested answers**

1 Administrative and nursing staff keep you waiting and are unfriendly; doctor too hurried and impatient; doctor interrupts; surroundings are stark and depressing (not geared for the best comfort); lack of privacy

2 A doctor may not relate well to patients of different ages or may be more dismissive of certain age groups. Others may find it difficult to build rapport with different genders. Appearance may also play a role – a doctor may be unconsciously judgemental, depending on how a person is dressed or their general appearance. These aspects could be blocking factors in the relationship-building process with the patient. Medical students are encouraged to take these into consideration when interviewing their patients.

**Quotation** (Bickley)

- Ask learners to read the quotation and then ask them to give suggestions as to how to best receive the patient.

**Suggested answers:**
Smiling, eye contact, handshake, tone of voice, sitting forward, being prepared to receive the patient, giving them your full attention, etc.

## Think about

*Rationale:* to assess their own skills at this stage, considering their own experience of establishing rapport with a patient in English

**3a**
- Some learners might not have experience of doing this in English. They should evaluate their current level of competence as they see it; it is a kind of self-assessment.
- Be aware that learners tend to overestimate their competency.

**3b**
- At this stage there are no right or wrong answers; the activity serves as a Needs Analysis for the unit for you and the learners. Learners are likely to be less competent in terms of the pragmatics of spoken communication.

## Establishing initial contact (non-verbal and verbal communication, cultural awareness)

*Rationale:* to develop learners' understanding of the importance of the physical setting, and the doctor's ability to establish initial contact with the patient

- Start by asking learners to describe a doctor's office that they know well.
- Ask learners what they think would be the best seating arrangement in the office.

▶ 1.1 **4a**
- Contextualise the dialogue: tell learners they are going to listen to a communications expert talk about the importance of seating arrangements in a consulting room (UK English).
- Play the recording. Reassure learners that on first hearing they might not understand everything, but they'll get a second chance to listen.

Audio script >>
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Seating arrangement 1.



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**4b**
- Ask learners to predict the answers before listening in detail.
- Play the recording again.

**1** Because the patient is more relaxed and therefore more forthcoming if the seats are placed at right angles to each other, and the doctor is not behind a desk.
**2** c
**3** Because you don't want to be so far away from your patient that you can't hear them or that they feel you aren't interested in what they're saying; neither do you want to make them feel threatened by being too close.

**4c**
- **Suggestion:** Ask learners to mark out the distance in the classroom and then ask them Question 1.
- Emphasise that this is just one opinion and that they can disagree – it might depend on cultural factors.

**2** c
**3** To ensure that he/she is on the same level as the patient, e.g. by pulling up a chair to carry out the encounter. He/She shouldn't lean over the patient, as this might be intimidating.

▶ 1.2 **5a/b**
- Contextualise the dialogues: Tell learners they are going to hear two patients talking to friends about a recent encounter with their consultants; accounts are given from the patient perspective (UK English).
- Point out to learners that the criteria used to analyse the consultants' skills to establish a rapport are the same as the 'Think about' in Exercise 3. Also point out that they don't need to worry about the Examples column the first time they listen. Play the recording.

Audio script >>
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**Consultant 1 (outpatients)**
**1** needs improvement (didn't acknowledge patient or ask her to sit down)
**2** needs improvement (didn't greet patient)
**3** needs improvement (sounded bored)

**Consultant 2 (ward round)**
**1** fairly competent (took his time with patient, but stared at her and didn't suggest more private place for interview)
**2** competent (polite / shook hand)
**3** competent (not mentioned, but can assume was appropriate, as patient described him as having a lovely voice)

**5c**
- Encourage learners to give their own advice based on what they have already covered.
- Encourage learners to give explanations for each point of advice, as if giving feedback to a medical student.

**Quotation** (Bickley)
- Ask learners to read the quotation and then ask them what they understand by the expression *undivided attention*. Then ask learners to what extent they think it is possible to make up for poor initial contact later on in the encounter.



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## Greeting and putting your patient at ease (verbal communication)

*Rationale:* to develop linguistic competency in establishing rapport with a patient

▶ 1.3 **6** • Contextualise the dialogues: Tell learners they are going to listen to three doctors welcoming their patients (UK and US English). Play the recording.

Audio script >>
STUDENT'S BOOK **page 137**

**1** GP's surgery (Familiarity – use of first name with patient might indicate the doctor already knows the patient.)
**2** specialist's office (This is a referral for further investigation.)
**3** hospital ward (The doctor introduces himself as being the registrar on the ward this evening.)

**7a** • **Suggestion:** Ask learners how they feel when they meet someone for the first time and that person automatically calls them by their first name.
• Ask learners to fill in the table, giving each objective a heading. This will serve as a reference.

**Suggested answers**

| | |
|---|---|
| Objective 1 | Greet the patient and obtain his/her preferred form of address (unless already known). |
| Objective 2 | Introduce yourself and clarify your role. |
| Objective 3 | Explain the purpose and agenda of the interview. |
| Objective 4 | Obtain permission for special circumstances (e.g. for another doctor to attend, to take notes). |

• Remind learners that in some cultures, obtaining a patient's preferred form of address is not necessarily considered; it is assumed the family name will be used.
• Ask learners what doctors should also consider when using a patient's name. Out of respect, doctors should not assume a woman is married nor that a patient wants to be called by his/her first name – or indeed surname (this may create too much formality and even hinder relations).

**8**

**1** With some patients, the use of the phrase *have a little chat* might encourage patients to talk; it lessens the formality and makes them feel more at ease.
**2** The verb *chat* for some patients reduces the seriousness of the situation, so it should be avoided if the doctor has to break any kind of bad news, for example. The doctor needs to try to gauge his/her audience.

• **Suggestion:** With a monolingual group, reinforce the rationale behind the use of the verb *chat* by eliciting the translation and asking learners to what extent it would be appropriate to use (the translation of) this verb in their own language during a patient interview.

▶ 1.4 **9a** • Contextualise the dialogue: Tell learners they are going to listen to the beginning of a patient encounter (UK English). Refer learners back to the box in 7a. They should tick the objectives in the order they hear them. Play the recording.

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The doctor achieves all the objectives in order (1, 2, 3, 4).



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**9b** The doctor also makes sure the patient is at ease by asking if she is comfortable / would like another pillow.

## Communication Skills

- Point this out to learners and then ask them to stand up and mingle. Ask learners to introduce themselves to three different members of the group, practising this sentence.

**10** • **Suggestion:** Brainstorm two or three different scenarios for your learners to work with before they practise. The group should be able to come up with these based on what you have already covered.

## Conveying warmth (voice management)

*Rationale:* to develop awareness of an appropriate tone of voice and its importance in enhancing rapport with the patient in English

- Refer learners to the Introductory Unit, to Thompson's quotation about voice management on page 10. Ask learners to visualise how a doctor might convey warmth through his/her voice.

▶ 1.5 **11a** • Contextualise the dialogue: Tell learners they are going to hear two versions of two different patient encounters (UK English). They need to decide if the doctors sound welcoming or unwelcoming.

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**Encounter 1, Version A:** welcoming
Registrar is lively and friendly.
Encounter 1, Version B: unwelcoming
Registrar speaks in a monotone.
Encounter 2, Version A: unwelcoming
Dr Patel is abrupt and doesn't respond to the patient's frustration at having been kept waiting.

**Encounter 2, Version B:** welcoming
Dr Patel apologises for the situation.

- **Suggestion:** Ask learners to comment on the attitude of Dr Patel. Ask them what the difference is between the way he responds to the patient in Version A and how he responds in Version B. Play the recording.

**11b** In English, the rising and falling intonation, speed, pitch and tone of the voice determine if a voice is welcoming or not.

### Language Note:

**Showing a welcoming voice**
It is imperative that a doctor is able to convey a positive welcoming attitude when receiving their patient.

A welcoming voice is shown through a moderate pitch and speed, and a gentle rise and fall intonation pattern.

**Registrar:** Good evening. Ms Finley, isn't it?

**Registrar:** I'm Dr Cameron. I hope I'm not disturbing you.



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- **Suggestion:** Discuss the possible outcomes of inappropriate tone of voice / intonation; e.g. the patient is made to feel nervous and uneasy, and may not feel he/she has the trust of the doctor; as a result the patient may not divulge all the issues he/she had wanted to discuss, which could lead to misdiagnosis, etc.

▶ 1.6 **12a** • **Suggestion:** Ask learners to come up with a context for each greeting before listening to the recording.

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- Tell learners that tone of voice / intonation is dependent on context.

1 Specialist visiting patient in a hospital ward. (This is the most likely answer as the doctor refers to the patient's consultant.)
2 Woman coming to surgery / clinic. (A six-month check-up might be in the case of a patient with a particular condition that needs checking regularly by his/her GP, e.g. dermatological conditions.)
3 Patient attending appointment at surgery/clinic. (In the UK, patients can either be called in to the doctor's consultation room by the doctor him/herself or sent to the room by the receptionist, depending on the size of the practice.)
4 Doctor calling in next patient at surgery/clinic.

- Point out that in the UK, *clinic* means a place where a group of practising doctors are located in the same building; in the US it means *doctor's office*.

## Cultural awareness

Point out to learners that eye contact may not be acceptable with some of their patients. They need to learn how to be able to read their audience.

**13** • Tell learners they will now have a chance to consolidate what they have covered so far in the unit. They will role-play the initial introduction to an interview in each case. Tell them you will be giving feedback.
- **Suggestion:** Put the following on the board as a reminder – 'Eye contact', 'Tone of voice', 'Setting', 'Proximity', 'Facial expression'.
- Give feedback to learners on the above points.

## Think about

*Rationale:* to assess learners' current understanding of the opening question and how it is formed in English

**14a** • Remind learners that with 'Think about' activities it is not a correct answer that is important, but the process they go through – they will have the chance to develop their skills in the activity that follows.
- Be aware that some learners may not fully understand the concept of the opening question, having not come across this in their training (see 'Background' at the start of this unit), or may not know how to form one in English. Tell them they will be looking at these in more detail in Unit 2.

**14b** The doctor's opening question invites the patient to explain the reason for his/her visit. The question needs to be sufficiently open and not exclude non-medical concerns the patient may have. From the response, the doctor will be able to set the agenda for the interview.



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**14c** • Write both opening questions up on the board. Look back at the questions learners suggested in Exercise 14a and decide on the suitability of these two, as a class.

*So, what's the problem?:* This could be perceived as very negative. It assumes the patient has a problem (or what could be perceived as a problem) and that what the patient fears (with or without reason) could be a problem.
Some learners might have given this as the suggested answer for 14a. It is grammatically correct, but learners might not realise the negative connotation behind the use of the word *problem*, especially in a medical context. (It could be a negative transfer for learners with a Latin-based first language.)

*What's up?:* This may come across as being very rude and is too colloquial a register for this context.

- Point out there are many different types of opening question, depending on the situation (see next exercise).

## Asking the opening question (verbal communication)

*Rationale:* to highlight the need for different opening questions, depending on the situation

**15a** • **Suggestion:** Go through one or two of these first, as a group.

**Suggested answers**

**a** 2, 5, 7, 9
**b** 2, 4, 6, 7
**c** 2, 4, 5, 6, 7, 9, 10
**d** 2, 3, 5, 9, 10
**e** 1, 2, 5, 7, 8, 9

**15b**

**Suggested answers**

**1** Doctor refers to the patient's GP, so the most likely answer is (e).
**2** This question is a very general question that a doctor in any situation would use to open up the discussion in a patient-centred approach.
**3** (d) is the only possible situation, as the doctor refers to a baby, and carers of newborns are required to attend surgery for routine check-ups.
**4** The patient might have been given a course of tablets on a previous visit and is on his/her follow-up visit to the surgery (c) or he/she has been hospitalised and is being followed up on by the registrar/doctor during the ward round on a course of treatment (b).
**5** Only (b) would be an inappropriate situation for this question, as the doctor would already know why the patient is in his/her care if currently in the ward.
**6** As for question 4.
**7** Only (d) would be inappropriate, as the doctor is asking about the patient's health (and not that of a baby).



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**8** As for question 1.
**9** Only (b) would be inappropriate, as this question assumes the doctor is not aware of the patient's reason for visiting. A doctor/registrar during a hospital round would know the reason for the patient being on the ward.
**10** The doctor could quite possibly be referring to a small child or a baby, and so either (c) or (d) would be appropriate. The doctor appears to know the child and therefore (c) is possible.

▶ 1.7 **16a** • Contextualise the dialogue: Ask learners to think back to the encounter they listened to with Mr Mahoney (from Exercise 11) and say what they remember about it. Play the recording.

Audio script >>
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**1** *Any improvement in the arthritis since I saw you last?*
**2** Recurring headaches
**3** It was not the most appropriate opening question, as Dr Patel assumes Mr Mahoney wants to talk about his arthritis and doesn't allow for Mr Mahoney's own agenda. This type of question is therefore limiting and doesn't encourage the patient to express him/herself in his/her own words. The doctor shouldn't assume anything.

**16b** *Am I right in thinking you've come about the arthritis?*

### Language Note:

***Am I right in thinking you ...* + present simple OR present perfect**

Point out to learners that there is no difference in meaning between the use of the present simple or present perfect in this construction.

Example: *Am I right in thinking you're here about your arthritis? / Am I right in thinking you've come about your arthritis?*

- **Suggestion:** Brainstorm reasons for using this opening phrase, e.g. the doctor does not automatically assume the reason for the visit, but as the patient is known to him he acknowledges the possibility of the patient's need to talk about his arthritis. This form of opening question checks the reason for the visit and allows the patient to correct if necessary, thus ensuring a more patient-centred approach.

### **Quotation** (Silverman et al.)

- Refer learners to the quotation to reinforce the previous activity (16b).
- Ask learners to share instances of when they have followed their own agenda and not considered their patient's second agenda. Then ask how they managed the rest of the consultation. Did they feel their patient left the consultation having finally been able to discuss his/her own agenda?

**17** 3, 4, 6, 8, 10



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## Out & About

*Rationale:* to encourage learners to notice native speaker usage and further develop their competence in posing the opening question

- Explain the rationale behind 'Out & About' activities, as this is the first one of the book (see Introduction to Teacher's Book, page 4). If time allows, discuss the benefits of this type of activity for language learning.

**18**

- Ask stronger learners to demonstrate possible body language used in their country and then ask other members of the group to do the same.

**Suggested answer**

In Anglo-Saxon countries, the following body language can be used to open the interview: open seating position (no crossed arms/legs), slight inclination of the head, sitting slightly forward, eye contact and a smile.

- Point out that some patients may not respond to this, and that it may need to be followed up with the appropriate opening question.

## Setting the agenda (active listening)

*Rationale:* to train learners to activate their listening skills and achieve Objective 4 (see 7a), which opens the interview

Well, yes, I'm sure you've got all this information, but … my arthritis has been playing me up a bit as usual – I'm having difficulty sleeping and I'm in some pain first thing in the morning. But it's the headaches that are really getting me down. They're so painful, sometimes I've been sick with them … literally. I'm starting to have time off work now because of them. My wife's really worried. She's the one that insisted I go and see Dr Patel …

**Language Note:**

*[It's] getting me down* = [It's] making me feel depressed

**19**

- Learners should have no problem picking out the important points – they will bring their medical knowledge to the task.
- … *have time off work* and *My wife's really worried* indicate that the complaint is going beyond the illness itself and that the doctor needs also to consider these points during the interview.
- Be aware that some learners may not pick up on the more social aspects of the opening statement at this stage. (Learners will cover these in Unit 4.)

**20a**

**Suggested answers**

- Enables the doctor to hear the patient's story
- Prevents the doctor from making premature hypotheses and chasing down blind alleys
- Reduces late-rising complaints
- The doctor doesn't have to think of the next question (which blocks the listening capacity of doctor). The patient, who is mostly answering questions, tends to be more passive.



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- Gives the doctor an indication of the patient's emotional state
- Enables the doctor to observe more carefully and pick up on verbal and non-verbal cues
- Is helpful to patients for whom it is not easy to define problems – allows them time to clarify what they want to discuss
- Signals the doctors interest in the patient

- Be aware that learners may not be able to offer all of these responses, especially if they are not used to the holistic, patient-centred approach (see Unit 2).

▶ 1.8 **21** • Play the recording.

Audio script >>
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**I can see it's** the headaches that are really bothering you, so **if we can start by** looking at those. **We'll come back to** the arthritis later, if that's **OK with you.** Is there **anything else** you want to discuss today?

- After listening, elicit the significance of *if that's OK with you?* (i.e. doctor obtains permission to set the agenda in this way) and *Is there anything else you want to discuss today?* (i.e. doctor gives patient the opportunity to add other points for discussion if necessary). Both are examples of the patient-centred approach.
- Refer the group to the 'Language for setting the agenda' box.

**22** • Tell learners they will now have the chance to practise setting an agenda.

## Piecing it all together

- Explain the rationale behind 'Piecing it all together' activities (i.e. to get learners to reflect on their level of communication skills in the light of what they have covered in the unit). If time allows, discuss the benefits of this type of activity for language learning.

**23a/b** • Take time to monitor each pair to check they are able to set up the role-play correctly, especially as this is the first one of the book.
- Tell learners you will give them feedback on both positive and negative points of their verbal and non-verbal communication, their voice management, and their active listening skills.

## Progress check

- Explain the rationale for the Progress check (see Introduction to Teacher's Book).
- Ask learners to go through the Progress check.
- Give learners some group feedback and indicate where they might need to improve.
- Give individual feedback to those who wish.

## Recommended reading

- If you would like a little more information on this topic, we suggest you read the following:
Silverman J et al. *Skills for Communicating with Patients*. Oxford: Radcliffe, 1998 (35–55)

## Reading for discussion

- Go to page 147.



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