

Quality Assurance Methodology Refinement Series

Improving Interpersonal Communication Between Health Care Providers and Clients

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Part 1

A Conceptual Framework for Interpersonal Communication





Improving Interpersonal Communication Between Health Care Providers and Clients

I. Introduction

Effective interpersonal communication (IPC) between health care provider and client is one of the most important elements for improving client satisfaction, compliance and health outcomes. Patients who understand the nature of their illness and its treatment, and who believe the provider is concerned about their well-being, show greater satisfaction with the care received and are more likely to comply with treatment regimes. Despite widespread acknowledgement of the importance of interpersonal communication, the subject is not always emphasized in medical training.

Over the past 30 years substantial investments have been made to enhance access to basic health services in developing countries. However, there have been relatively few studies that investigate the quality of the services delivered, and fewer still that study the quality of interpersonal communication.¹ The quality of care research that has been done shows that health counseling and provider-client communication are consistently weak across countries, regions and health services.² Even when providers know what messages to communicate, they do not have the interpersonal skills to communicate them most effectively. They often do not know how to communicate with their patients. Despite widespread acknowledgement of the critical importance of face-to-face communication between client and provider, there are few rigorous studies of health communication in developing countries.³

Evidence of positive health outcomes associated with effective communication from developed countries is strong. Patient satisfaction, recall of information, compliance with therapeutic regimens and appointment keeping, as well as improvements in physiological markers such as blood pressure and blood glucose levels and functional status measures have all been linked to provider-client communication.⁴ Thus, experience in the developed world has shown that providers can improve their interpersonal skills, leading to better health outcomes. The research described here explores whether these findings are valid and replicable in the developing countries.

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- 1 Roemer MI, Montoya-Aguilar C. Quality assessment and assurance in primary health care. Geneva: WHO Offset Publication, 1988.
 - 2 Nicholas DD, Heiby JR, Hatzell TA. The Quality Assurance Project: introducing quality improvement to primary health care in less developed countries. *Quality Assurance in Health Care* 1991, 3(3):147-165.
 - 3 Loevinsohn BP. Health Education Interventions in Developing Countries: A Methodological Review of Published Articles. *International Journal of Epidemiology* 1990 Dec:19(4):788-794.
 - 4 Hall J, Roter D, and Katz N. Correlates of provider behavior: a meta-analysis. *Medical Care* 1988 26:657-675.

Unfortunately, effective communication does not always occur naturally, nor it is easily acquired. Even when client and provider come from the same geographic area and speak the same language, they often have different educational, socio-economic and cultural backgrounds. Moreover, their expectations about the health encounter may be different, or they may be faced with other problems, such as lack of privacy during the encounter, or time constraints due to heavy patient loads.

Better communication leads to extended dialogue which enables patients to disclose critical information about their health problems and providers to make more accurate diagnoses. Good communication enhances health care education and counseling, resulting in more appropriate treatment regimes and better patient compliance. Effective interpersonal communication also benefits the health system as a whole by making it more efficient and cost effective. Thus, clients, providers, administrators and policy makers all have a stake in improved provider-client interactions.

This monograph discusses the importance of IPC as a tool for improving health care outcomes in developing countries and describes techniques for enhancing provider communication skills. It also provides a job aid and several data collection instruments that can be used in various settings. Our field experiences in Honduras, Egypt and Trinidad, described later in the text, suggest that test results in developed countries are valid and replicable in developing countries. Therefore, we hope that our findings will serve as useful models for implementing future interpersonal communication programs, and that the monograph will help interested health care policy makers and practitioners improve the quality of health care in their facilities through improved interpersonal communication. The monograph can serve as:

- ◆ an introductory overview on provider-client communication skills
- ◆ a framework for assessing IPC skills
- ◆ a guide for developing IPC training activities
- ◆ a resource describing important IPC experiences in selected developing countries.

Because each health care setting requires locally-appropriate strategies, the guide provides only a general framework for action, leaving health care policy makers, managers and providers to develop their own analyses and interventions. Therefore, we encourage readers to modify the content of the monograph as needed and to develop locally-appropriate examples for training and other IPC interventions.

II. Background

The research and training activities reported here were carried out by an inter-disciplinary team of experts in health service delivery, counseling, health communication and training. Our effort began with a literature review⁵ to assess current knowledge on client-provider communications in both developed and developing countries, and to identify the critical issues that needed to be addressed in developing countries.

Following the literature review, we developed a set of IPC guidelines for health care providers.⁶ The guidelines drew on counseling and IPC themes found in the professional literature and on insights gained from the cross-cultural field experiences of our team.

After preparing a preliminary set of guidelines, we developed the format and materials for provider training workshops based on cross-cultural insights into IPC. We found that provider-client communication problems exist worldwide, and that several principles about good communication can be generalized. We expect that IPC improvement initiatives could build on universal principles to develop effective solutions that take into account local socio-cultural factors and resources at hand.

Accordingly, we field-tested our materials in three different developing country settings and collaborated with local health care providers to tailor the IPC guidelines and training course to local socio-cultural environments. Collaboration in Honduras, Trinidad and Egypt enabled us to refine the guidelines and test our methods for training providers on how to apply the guidelines. Following each workshop, we conducted evaluation and observation surveys among trainees to gauge training effectiveness. We found that providers could improve IPC practices with patients in small but important ways, to the greater satisfaction of all parties.⁷ For the most part, physicians were willing to apply IPC skills once they were convinced that use of the techniques would not necessarily lengthen medical visits and that concrete skills could be mastered through short training programs that emphasized practical approaches. A detailed description and analysis of the three country programs is presented later.

5 Quality Assurance Project Working Group on Counseling and Health Communication “Annotated Bibliography” April 1992, Bethesda, MD. (See Appendix F)

6 It is important to acknowledge that both clients and providers contribute to successful communication in medical encounters. While it would be possible to intervene on either side of this relationship, we have chosen to focus on health care providers, since most providers do not currently have, or practice, many of the basic communications skills that would enable them to carry out their responsibilities efficiently and cost-effectively. We recognize that it would also be important to work with health care clients, to help them become aware of their rights, to encourage them to ask questions, and to familiarize them with basic information that allows them to take full advantage of the health care system. Such interventions are outside the scope of this monograph, but are considered by the researchers to be vital topics for future research.

7 DiPrete Brown, Lori, et al. “Training in Interpersonal Communication: An Evaluation of Provider Perspectives and Impact on Performance in Honduras”; March 1995; Quality Assurance Project, Bethesda, MD. (Included here as Case Study A)

III. Why Is Interpersonal Communication Important?

IPC is important because it leads directly to better health outcomes. A pathway is clearly established which links processes, such as the way health care providers communicate, to proximate outcomes, such as patient satisfaction and recall, to final outcomes, such as client compliance with treatment regimes and improved health results. Hence, our emphasis on the importance of improving provider communication skills. Figure 1 illustrates a system linking communication processes with short-term, intermediate and long-term outcomes.

As can be seen in Figure 1, the communication context is shaped by the socio-demographic characteristics of the patient and provider, as well as by the environment in which the communication takes place. The age, sex, ethnicity, and educational background of providers and clients affect how they communicate with each other. Other factors such as degree of privacy, time allotted for encounters, comfort and cleanliness of the clinic, and treatment of clients from the time they enter the clinic until they are seen by a provider, can also inhibit or enhance client-provider interaction.

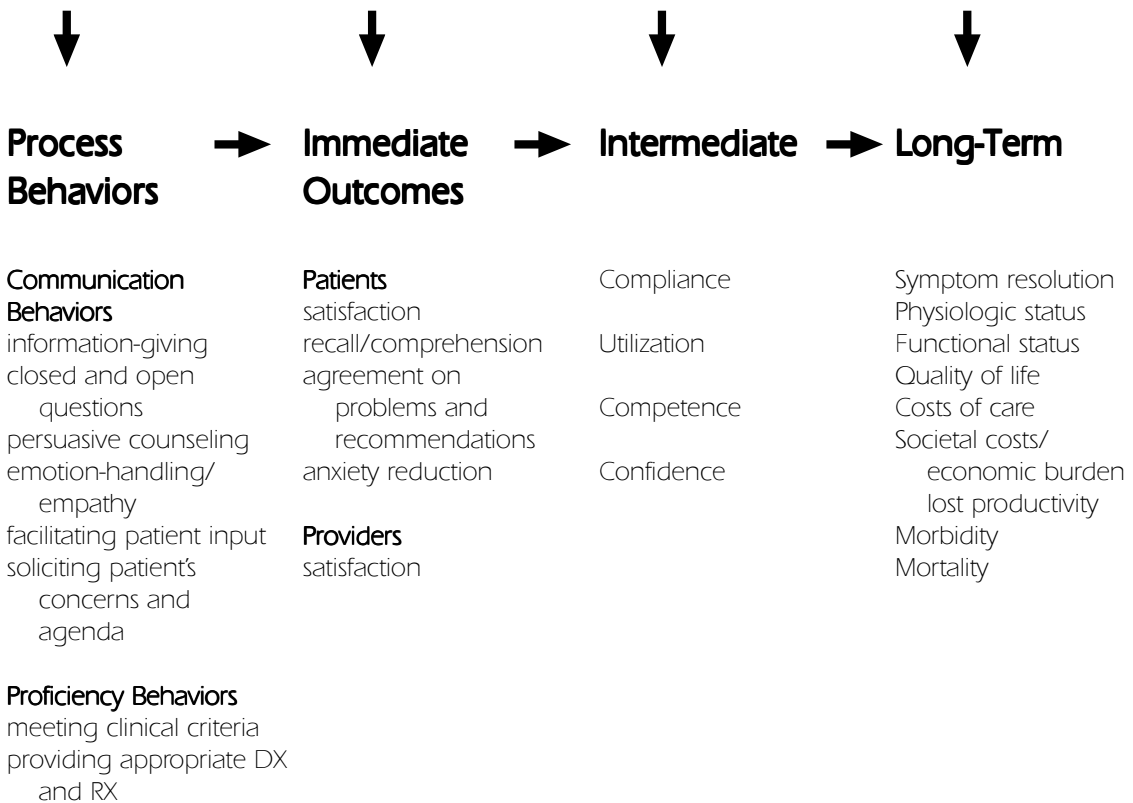
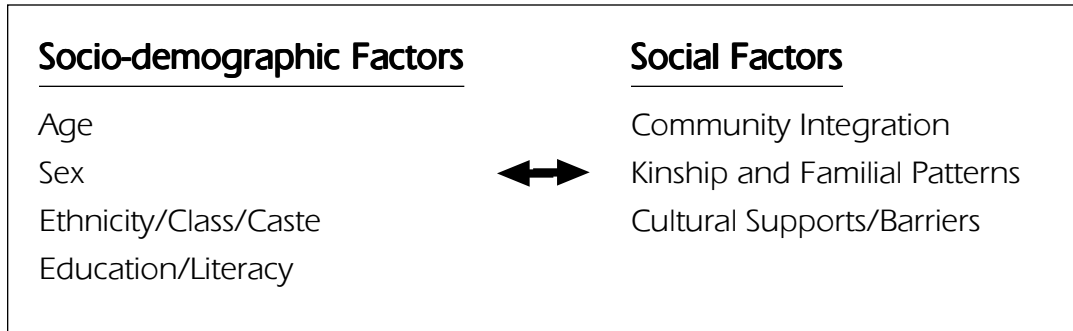
While many of these socio-demographic and environmental factors are beyond their control, providers can improve IPC practices in their own clinics by adopting specific behaviors and techniques which lead to distinct positive outcomes. In the short-term, improved communication leads to more effective diagnosis and treatment of health problems; in the medium-term, to greater compliance with treatment programs, better utilization of services, and enhanced feelings of awareness and confidence for both client and provider; in the long-term, to greater relief of symptoms, enhanced prevention and reductions in morbidity and mortality. In some cases, overall health care costs are also reduced.

IV. What Are the Characteristics of Effective IPC?

IPC is effective when it leads to the following five outcomes: 1) the patient discloses enough information about the illness to lead to an accurate diagnosis; 2) the provider, in consultation with the client, selects a medically appropriate treatment acceptable to the client; 3) the client understands his or her condition and the prescribed treatment regimen; 4) the provider and the client establish a positive rapport; 5) the client and the provider are both committed to fulfilling their responsibilities during treatment and follow-up care.

The above outcomes, however, do not describe the steps in the **process** of effective communication. These steps generally include encouraging a two-way dialogue, establishing a partnership between patient and provider, creating an atmosphere of caring, bridging any social gaps between provider and client, accounting for social influences, effectively using verbal and non-verbal communication, and allowing patients ample time to tell their story.

Figure 1: Organizing Framework for Studying the Effects of Provider Communication



Two-way Dialogue

Good interpersonal interaction between client and provider is, by definition, a two-way street where both speak and are listened to without interruption, both ask questions, express opinions and exchange information and both are able to fully understand what the other is trying to say.

Partnership Between Provider and Client

Providers and clients should view health care as a partnership in which each party contributes to maximize end results. Mutual respect and trust and joint decision-making will result in a greater likelihood of a positive outcome. Both provider and client must realize that, even though the provider is the medical expert, both are responsible for the outcome of their interaction. The patient must disclose all relevant information in order for the provider to determine a proper diagnosis and treatment; the provider must interpret and analyze the information received and effectively explain the condition and treatment options to the patient. Both should make decisions about treatment regimes, with the client making every effort to comply with the prescribed treatment and any necessary lifestyle changes the treatment implies. Providers should foster an active role for patients in their care and treatment. Providers should encourage active questioning and interaction during office visits and should involve patients in their own health care regimes.

Atmosphere of Caring

Patients need to believe that their provider cares about them and is committed to their welfare. Both verbal and non-verbal communication help the provider convey interest and concern to patients. Being attentive, making eye contact, listening and questioning thoughtfully, and demonstrating understanding and empathy make patients feel important and worthy. On the other hand, being brusque or appearing busy or distracted makes patients feel insecure, anxious or fearful of their relationship with the provider.

Effective Bridging of Social Distance

Social distance refers to the socio-cultural-economic factors that make people feel they belong to different class tiers. Education, economic status, class, race or ethnicity, gender and age may all contribute to how close or distant two individuals feel about each other. For example, an illiterate peasant woman and a young, highly trained, city-dwelling male physician who share the same language and were raised within miles of each other are still worlds apart socially. Clients bring to medical visits a whole range of emotional, socio-cultural, economic, educational and psychological traits that affect communication. Social distance should not impede good communication, and providers must realize that many people, even those in their own circles, may not be conversant with their “language.” Therefore, they should strive to bridge any social gap that might exist between them and their clients and establish an open dialogue, a partnership and an atmosphere of caring. Clients must also do their part to bridge the social distance by being candid and communicative.

Social Networks

Social networks refer to those interpersonal relationships that bind people together. Typically consisting of family, friends, acquaintances, neighbors and colleagues, social networks influence differently—depending on the individual and his or her environment—a person’s desire and ability to understand and comply with professional advice. For example, in some societies the mother or mother-in-law is key decision-maker in the extended family. Therefore, teaching the young woman about the benefits and methods of birth spacing may be ineffective if her mother or mother-in-law is uninformed or opposed to this practice. Similarly, in a home where a woman cooks for the whole family, dietary recommendations that could enhance her health may not be put into effect if they interfere with the family’s culinary customs and tastes.

Effective Use of Verbal Communication

Verbal communication consists of spoken and written words people use to convey ideas. In a health care encounter, the choice of words clients and providers use greatly influences how well they understand each other. The medical jargon physicians use to describe symptoms and treatments allows them to communicate clearly and precisely with other clinicians. However, because the scientific and clinical terms may be confusing to patients, the use of such terms with patients is inappropriate.

Patients communicate during medical visits in their particular dialects, accents, cadences and slang, often making comprehension difficult for providers from other parts or regions of the country. Patients also describe health problems in peculiar ways, often reflecting their unique

Use Simple Language

Medical jargon	The clinical spectrum of cholera is broad, ranging from inapparent infection to severe cholera gravis, which may be fatal in a short time period. After an incubation period of 6 to 48 hours, there is an abrupt onset of watery diarrhea. Vomiting often follows in the early stages of the illness. Signs of severity include cyanosis, tachycardia, hypotension, and tachypnea. The symptoms and signs of cholera are entirely due to the loss of large volumes of isotonic fluid and resultant depletion of intravascular and extracellular fluid, metabolic acidosis, and hypokalemia.
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Simple explanation	Not all persons that get cholera look equally sick. Some cholera patients seem to have a minor illness, while others look very sick. Some others can even die after hours of getting cholera. Because cholera germs spread within 6 to 48 hours of entering the body, the person may suddenly have a lot of watery diarrhea. Many patients also begin to vomit. When the sick person is getting worse, his skin can become blue (especially at the lips, nose, and fingertips), he may begin to breathe quickly, his heart works very rapidly, and blood pressure drops. All this happens because the body has lost a lot of liquids and minerals through diarrhea and vomiting. The body cannot survive when it loses too much liquid and minerals.
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perspective on the illness' origin or severity. Sometimes local perceptions can influence the way a patient describes the illness' onset and symptoms. For example, if diarrheal diseases are common in their area, patients may not report symptoms of the disease unless they are quite severe. Because they view the symptoms as routine, patients simply neglect to mention them. For the provider, however, detection of early symptoms, even mild ones, is important in making proper diagnoses and developing appropriate treatment regimes.

Effective Use of Non-verbal Communication

Words express only part of a message being conveyed; tone, attitude and gestures convey the rest. Avoiding distractions, such as answering the telephone during a patient's visit or scribbling notes on other cases, and appearing fully attentive communicate positive messages to clients. Smiling, listening thoughtfully, sitting on the same level as the patient also enhance interaction. Much non-verbal communication is specific to cultural customs. For example, while in some cultures direct eye contact is a sign of positive regard and respect, in others it is deemed improper or aggressive, particularly with members of the opposite sex. Also, while in some cultures physical contact during a conversation is considered a sign of affection, in others it might be construed as highly improper. What is important to remember is that all forms of non-verbal communication convey a message.

Often, simple gestures by the provider, such as a warm greeting or a thoughtful question, can help put the client at ease and enhance communication. Such actions do not require great effort but can have significant results. Following is an example of non-verbal communication conveying a positive message.

Non-verbal Communication

Dr. Green is seated behind a desk when Mrs. Sierra enters the examining room. He stands, greets her warmly by saying "Good morning, Mrs. Sierra" and walks to the other side of his desk, where there are two chairs. He offers one chair to Mrs. Sierra and sits in the other. He leans forward and, with his full attention on his new patient, he thoughtfully asks, "How can I help you today?"

Non-verbal communication can have as great an impact as verbal communication but can be more easily misinterpreted. Thus, it is important for health care providers to be aware of the non-verbal messages they convey to their patients and of those their patients convey to them.

Opportunity for Patients to Speak About Their Illness

The medical visit should provide ample opportunity for a patient to describe his or her illness. Storytelling has its own healing value in that it provides patients with a release and opportunity for insight and perspective. It may also afford the health provider the insights needed to understand, interpret and explore the significance of the symptoms and clues the

patient provides. A patient's comprehension and feelings about a medical problem may be extremely important in prescribing appropriate treatment. A great deal of distress, for example, may stem from a patient's perception about the seriousness of his or her illness, not from its actual seriousness. Providers should not minimize a patient's anxieties, but strive to alleviate them.

All of the factors described above have been shown to enhance communication between patient and provider. However, the fact that providers follow individual approaches increases the complexity of formulating a communication skill program. To change provider behavior in concrete ways, the above factors must first be broken down into concrete skills and behaviors as illustrated in the following guidelines.

V. Guidelines and Norms for Effective IPC

Our research and analysis of effective IPC has led us to develop a set of guidelines and norms for health care providers. While these norms should be further tested, refined, and validated, we are confident that the issues and skills presented here are both useful and valid in improving IPC. We define three types of IPC.

- ◆ **Caring/socio-emotional communication:** The objective of caring or socio-emotional communication is to establish and maintain a positive rapport with the patient throughout the encounter. This is an integral part of all IPC and enhances patient disclosure and compliance.
- ◆ **Diagnostic communication/problem solving:** The objective of diagnostic communication is for the patient and provider to share all the information needed for accurate diagnoses and appropriate treatment prescriptions.
- ◆ **Counseling:** The objective of counseling is to ensure that clients understand their condition and treatment options. Counseling helps them to follow treatment regimens and behavioral change recommendations, by ensuring that these are comprehensible, acceptable, and feasible. Counseling emphasizes making decisions together with the client and helping solve actual or anticipated problems.

A provider should convey expressions of caring at the outset of the encounter when rapport with the client is being established; rely on diagnostic or problem solving techniques during the history taking portion of the encounter; and use counseling skills at the end of the encounter to explain treatment and provide health education. However, all three approaches may be applicable throughout the encounter.

Within the broad category of each approach, specific communication techniques or behaviors can be identified which can improve IPC. These and related examples are presented in the following section.

Caring

A caring behavior emphasizes respect for patients and recognition that their concerns are important. Health care providers should display caring throughout the medical encounter in order to establish a trusting relationship and good rapport with the patient.

- ◆ **Frame the encounter** — Set the tone for the interaction by greeting clients in culturally appropriate ways that communicate openness and concern. For example, the provider might frame an encounter by saying “Good morning Mrs. N., my name is Dr. N.. I’d like you to feel free to tell me about any health concerns you have.”
- ◆ **Use appropriate non-verbal communication** — Be sure your posture, eye contact, gestures, tone of voice, manner and attitude are appropriate and conducive to dialogue with the client. For example, a provider who is scribbling notes on a chart when a patient enters, might put down the pen, close the chart, and stand up or lean forward as he greets the patient. This shows the patient that he or she has the provider’s full attention.
- ◆ **Solicit feelings** — Invite patients to talk about how they feel, both physically and emotionally. A provider might ask a patient who is describing symptoms of her headaches, “How do the headaches make you feel? How do they affect your other activities?”
- ◆ **Show positive regard** — Show clients, explicitly and implicitly, that they are respected and valued. For example, a provider might show positive regard for a patient by being courteous, smiling, asking the patient whether he or she is satisfied with the care received so far, or complimenting the patient’s efforts in seeking medical assistance or following treatment recommendations. Positive regard is especially important when dealing with conditions that may have a social stigma attached to them, such as tuberculosis and AIDS. It is also helpful to bridge any social distance between provider and client that might be based on age, sex, social and educational status, race, religion, or ethnicity.
- ◆ **Validate the patient’s experience and efforts** — Recognize the patient’s experience and efforts in an honest and straightforward manner. This may be done through statements of concern, empathy or legitimizing that show the provider cares about the patient and his or her problem. For example, when dealing with a hypertensive patient who does not take his or her medicine regularly, a provider might say, “I’m concerned that you’re not taking care of yourself.” This is likely to be more effective than scolding. Statements of empathy show that the provider understands and shares the patient’s feelings. Legitimizing statements validate the patient’s feelings. For example, a provider might tell a patient who is nervous about surgery, “I understand that you are worried about this operation,” or when counseling a cancer patient, a provider might say, “It’s easy to understand why you feel afraid and angry. Most people in your situation feel the same way at first.”

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- ◆ **Echo patients' emotions** — Help patients express their feelings by echoing them. For example, when a patient says “I’ve been feeling very depressed lately,” the provider might respond with “It sounds like something is really getting you down.” This technique provides the patient with an invitation to elaborate further on the topic.
 - ◆ **Express support and partnership** — Let clients know you will work with them to help them get better. A provider might say, “I’m going to use all my skills and expertise to help you get better, and I’m counting on you to do your part to take care of yourself.”
 - ◆ **Give reassurance** — Encourage and reassure clients about the outcome of their condition. For example, a midwife might say to a patient, “I know you’re feeling a lot of pain and anxiety right now, but tomorrow you’ll feel much better, and you’ll have a new baby to take home with you.” In reassuring patients, it is important to be honest and realistic about the medical prognosis and to avoid premature or unjustified reassurance.

Diagnosis and Problem Solving

These skills help health care providers gather critical information for diagnoses. Use of data-gathering skills enables them to improve their accuracy and effectiveness in performing this function. The skills involve a variety of questioning techniques designed to encourage the patient to talk about all aspects relevant to the problem.

- ◆ **Listen attentively and actively** — Use gestures to show patients they have your full attention and ask relevant questions to indicate your understanding of what they say. You may want to face patients and nod or comment occasionally as they describe their medical condition.
- ◆ **Encourage dialogue** — In addition to yes/no questions, ask patients open-ended questions that encourage them to provide details about their problem. Often, one open-ended question will elicit a response that covers several yes/no questions. For example, instead of asking a patient “Do you have a fever? Do you get headaches? Are you nauseated?” You may simply say “Tell me about any pain and discomfort you’ve been feeling.” Once the patient describes the condition, you might need to ask one or two yes/no questions to supplement the information.
- ◆ **Avoid interruptions** — Do not interrupt patients when they are speaking. Wait until they have finished their thought before asking a new question. Also, avoid being interrupted by the telephone or other distractions during a patient’s visit.
- ◆ **Avoid premature diagnosis and resist immediate follow-up** — Wait until you have listened to the patient’s full story and have asked all the relevant questions before determining a diagnosis and treatment. The patient’s first complaints are not always the most important ones. Hasty conclusions can lead to diagnostic

error. For example, when a patient reports headache pain, resist the urge to immediately assume the ailment is minor and to prescribe pain relief drugs. Instead you might say “Tell me more about how you’re feeling.” Often, a simple cure for headaches is all that is needed, but at other times the client might respond, “I’m so worried and upset, there are times when I don’t feel like getting out of bed and feel like I could die.” Such a case warrants further inquiry into the psychological and physical causes of the condition.

- ◆ **Probe** — Encourage patients to provide more information by asking questions or inviting them to continue speaking. For example, the provider might use phrases like “Tell me more” or “Please go on” to help patients delve deeper into the nature of their problem and their reaction to it.
- ◆ **Ask about causes** — Help patients share more information about their condition by asking their opinion on the causes of the ailment and what they think might help them. This technique will provide information needed to make a diagnosis and help providers evaluate the patient’s understanding of the illness.

Counseling and Education

These skills enhance providers’ ability to explain to patients their conditions, the circumstances of their illness, diagnoses and treatment options. Providers should remember that patients’ compliance with treatment regimes depends on how well they understand the nature of their illness and how they feel about the prescribed treatment.

- ◆ **Explore patient understanding** — Find out patients’ opinions of their illness by asking how they contracted it, whether they had the problem before and what they did about it at that time. For example, if a mother is seeking care for a child with diarrhea, the provider might ask, “How do you think children usually get diarrhea?” “How do you think your child got it?” “How did you take care of it in the past?”
- ◆ **Correct misunderstandings or misinformation** — Sometimes clients hold inaccurate notions about the etiology or effects of a disease, which can affect their behavior toward treatment and adversely impact on their recovery. Providers should determine a patient’s understanding of his or her problem, and politely correct any misconceptions the client may have. For example, a provider might say, “While many people believe that taking the birth control pill right before intercourse will be effective, that’s incorrect. You need to take the pill every day, whether you are going to have sex or not.” Providers should be careful not to make the client feel uneasy or inadequate for having inaccurate ideas or information, and should strive to educate by providing appropriate information.
- ◆ **Use appropriate vocabulary** — Providers should avoid using jargon or technical language when speaking with patients, making instead every effort to use terms that are meaningful to patients. For example, instead of asking “Have you

had any respiratory difficulties lately?” the provider might say, “Have you had any difficulty breathing lately?” or “Tell me about your breathing?”

- ◆ **Present information in blocks** — It is important to present information in a way that the patient can easily absorb and remember. Providers should explain the diagnosis in a clear and comprehensible fashion, never in a condescending or patronizing manner. Subdividing the information into separate categories may help this process. Presenting separate blocks of information sequentially, enables the provider to monitor for understanding and absorption before moving on to the next block. This kind of presentation helps patients internalize the information presented and enhances the likelihood of effective compliance with the treatment prescribed. For example, the provider may address and sequentially convey brief information on the following topics:
 - name of the disease and its etiology
 - recommended treatment for the patient
 - ways to prevent recurrence of the disease
 - other relevant information.

- ◆ **Use visual aids and/or printed materials when possible** — When conveying information to patients on diseases, preventive or treatment programs, or medical devices, it is often helpful to refer to a visual display. Visual aids help patients better understand and remember the information provided. It is also helpful to make use of pamphlets with simple text and pictures about important health problems, their prevention, and their treatment.

- ◆ **Recommend concrete behavioral changes** — After making a diagnosis and prescribing a treatment regime, providers may recommend certain behavioral changes to their patients that would prevent the illness from recurring. These recommendations should take into consideration the patient’s ability to implement them. Rather than simply emphasizing the end results of the behavioral change, providers should identify and suggest specific steps in the behavioral change. For example, instead of telling a hypertensive patient that he needs to lose 30 pounds, the provider might say, “I’d like you to try to lose some weight by taking a 20 minute walk every day and cutting down on the amount of sugar and oil you eat.”

- ◆ **Select an acceptable and feasible treatment** — To the extent possible, provide the patient with a range of treatment options from which to select the one he or she prefers. For example, in providing family planning services to a mother, discuss available options and help her select the one that is best suited to her lifestyle. Conditions such as pain management, weight loss, etc., may have a number of treatment options from which the patient may choose.

- ◆ **Motivate patients to comply with treatment** — Once a treatment has been mapped out, the provider should try to motivate compliance with the treatment prescribed by pointing out to the patient the importance and benefits of such action. For example, in prescribing antibiotic treatment, a provider might say,

“It is important for you to take your medicine three times a day until all the pills are gone. You may feel better after a few days, but if you don’t take all the pills the illness will come back, and it may be harder to cure the next time.”

- ◆ **Summarize** — Restate the diagnosis, treatment and its recommended steps in simple terms. In summarizing, repeat only key points. For example, a provider might conclude a counseling session by saying “I think you have a respiratory infection. Take these antibiotics with every meal until they are all gone. I’d like to see you again in two weeks to make sure you’ve completely recovered.”
- ◆ **Check for understanding and absorption** — Ask the client to repeat or describe the treatment instructions. Then clarify any misunderstandings the patient might have and find out whether there are any reasons that would impede the patient’s compliance with the prescribed treatment. For example, a provider might say “Just to be sure you understand how to take your medicine, would you tell me how much and how often you’ll take it?”
- ◆ **Additional questions** — Urge patients to ask any additional questions they may have on their current or any other medical problem. Allow ample time for a response. Avoid missing the opportunity to consult. For example, if prompted to share any additional health concerns, a mother seeking care for a baby with diarrhea may mention that she is interested in exploring birth spacing techniques, or that she is not sure of the vaccination schedule for another of her children.
- ◆ **Confirm follow-up actions** — Remind the patient of the next appointment date or of the next treatment action he or she will need to take. Remind the patient what to do if symptoms persist or worsen, and about danger signs that indicate he or she should seek prompt medical assistance.

In this section, we have presented a set of specific guidelines for improving the IPC skills of health care providers. The next section will outline steps in planning and implementing a training program designed to further develop these skills.

VI. Planning and Implementing Training Activities

This section deals with planning and implementation of training activities. The information provided should enable health care providers to conduct small training workshops in their own clinics or enable outside experts to train health care providers in their areas or communities. The training format and methods presented here have been tested in a variety of settings and have proven effective in the IPC training of health care providers. **We have found that revisions in our training methods are always necessary to adapt the techniques to local circumstances and insights. We, therefore, encourage providers and trainers to use their own ingenuity and expertise to modify the techniques to suit local realities.**

Improving IPC skills generally implies some behavior change on the part of health care providers. Programs inducing effective behavior change require both an understanding of the issues and skills involved and practice sessions in the new skills. Practice may entail first conducting exercises among peers in a controlled environment (involving self-evaluations or evaluations and feedback from colleagues or supervisors), then holding supervised or self-monitored practice runs with actual patients and leading eventually to internalization of the new skills when they become second nature to providers who apply them instinctively.

Overall Training Approach

The IPC training program is highly flexible, allowing participants to adapt the program to local socio-cultural realities or to pinpoint specific techniques that can improve daily operations. The training activities employ a variety of methods to ensure that participants develop and learn to effectively apply new IPC skills. The methods used include:

- ◆ participatory plenary sessions that employ brainstorming and question and answer sessions, allowing participants to discover and tailor new IPC skills;
- ◆ dynamic role playing which illustrates various communication strategies and allows participants to practice them;
- ◆ mental rehearsal techniques which allow participants to test the degree of difficulty of individual IPC skills and to develop methods to master them;
- ◆ videotapes on non-verbal communication skills which are used as instructional tools.

Prior to the course, we developed:

- ◆ a guide to help participants practice the skills, which is referred in the text as “the pocket guide”, or “job aid”;⁸
- ◆ a training manual which allows the trainer to adapt the manual to the participants’ needs and to local realities.

Training Agenda and Format

Our IPC training program consists of approximately 20 course hours covering a 3 to 4 day span. The initial session focuses on the relevance of the skills. The following session deals with the guidelines and gives participants an opportunity to practice the new skills. The training course has a prepared list of skills or behaviors the trainer introduces to the group (Table 1).⁹ Each type of behavior is discussed and practiced in the participants’ native language aiming for potential improvements and adaptation to the local environment.

8 The job aid guide is included in Appendix A.

9 Please note the differences between the list and the Section V (Guidelines and Norms for Effective Communication). Section V incorporates revisions that had not yet been made at the time of the training.

Table 1: Interpersonal Communication Behaviors

Overall socio-emotional communication

The following nine behaviors reinforce ways to make people feel comfortable during medical visits:

- Welcome patient in a warm and culturally acceptable manner.
- Use appropriate verbal and non-verbal communication (gestures, attitude, words).
- Inquire about the patient's feelings.
- Acknowledge the patient's initiative (to have come, to have brought the child).
- Enhance legitimizing. (Reinforce feelings that are normal.)
- Show empathy.
- Echo the patient's emotions by encouraging him or her to express feelings freely. (Paraphrase what patient says.)
- Convey support and partnership.
- Reassure the patient. (Ease the patient's concern by suggesting specific things he or she can do.)

The health provider's tone of voice and attitude are primarily responsible for setting the socio-emotional tone of the encounter.

Problem solving skills

Systematic use of data gathering skills enables providers to become more efficient. The following seven behaviors help providers gather necessary information for determining diagnoses:

- Listen attentively (actively).
- Encourage dialogue by asking open-ended questions.
- Avoid interruptions.
- Avoid premature diagnosis (Determine the problem only after all facts have been gathered.)
- Resist immediate follow up by listening carefully before making clinical decisions.
- Probe (explore) for more information.
- Inquire into causes, difficulties and worries related to the problem.

Counseling and Information-Education-Communication (IEC)

The following ten behaviors are effective ways to explain health issues, treatment and decisions taken.

- Check the patient's understanding of the illness.
- Correct misunderstandings about facts.
- Use appropriate vocabulary.
- Present (explain) what the patient needs to know or do in a logical way (in blocks).
- Correct misconceptions.
- Discuss and prescribe concrete behavioral changes that are appropriate for the patient.
- Repeat, summarize key information.
- Motivate the patient to follow the recommended treatment.
- Check on acceptability/mutuality of decision making (if patient will follow the treatment).
- Make sure patient knows when to return for a follow-up visit.
- Ask patient if there is anything else he or she would like to know.

In many of the courses given, we encouraged providers to complement training activities by trying out the skills they learned in their own practice between course sessions. These “transitional” encounters were often taped, allowing providers to work in groups to review their shared experiences, apply the skills in their local setting, and critique their newly acquired skills in a supportive environment. Different agendas for the course are included at the beginning of the training manuals presented in Appendices B, C and D.

Training Materials and Methods Used

The use of training materials that document the concepts and guidelines presented is essential. Without this written documentation, participants do not have an opportunity for self-evaluation and will not be able to follow through in gaining an in-depth understanding of the new skills. The training manuals presented in the Appendices include materials that have occasionally been adapted and completed prior to the start of training sessions with the local team. For example, training methods include:

Role playing. One of the most effective methods for learning skills in a controlled setting is through role playing. Role playing enables providers to “try on” a variety of different styles and identify the ones that best suit them. Role playing also requires providers to play the part of a patient and, therefore, to experience the other side of the health care diad, and learn how providers’ different IPC styles can affect patients’ attitudes. One of the great benefits of role playing is that it can be both educational and fun. A variation on standard role playing is pantomime role playing in which the players act out a particular scene without speaking. Pantomime is particularly useful for analyzing the impact of non-verbal communication such as eye contact, physical contact, postures, gestures, smiles, attitude, etc. Because no words are spoken, players and observers can focus all their attention on the slightly exaggerated non-verbal communication.

Video and audio-taping. Another highly effective training device includes video or audio taping. Seeing or hearing oneself on tape makes one much more aware of one’s own communication style. Video or audiotape can be used in a variety of ways. Role playing can be recorded and played back instantly so that players can see how they acted and how their behavior impacted on others. Real clinical encounters can also be video or audio-taped and played back for group analysis. This technique was used effectively in training workshops in Egypt. The advantage of recording role plays or actual encounters is that the tapes can be played over and over and used to analyze various points. Moreover, tapes can be made following the training program to monitor the program participants’ IPC improvements. (Improvements can be measured more accurately and easily when a recorded baseline for comparison exists.)

Video playing. In Honduras the participants saw a video on IPC provided by the Ministry of Health in addition to a Spanish language video provided by AED.¹⁰ Unfortunately, we did not have a similar video in Arabic. In Egypt, participants expressed, in their course evaluation, a desire to view such a video, which they believed would help them more accurately master the skills required.

¹⁰ “A Traves del Espejo: El Papel del Consejero en la Prevencion del SIDA”, Video AIDSCOM/AED 1991.

Mini case study or simulation guide. Throughout the course, mini case studies or simulation guides were used to develop understanding and reinforcement of IPC skills. Often these mini case studies were developed or adapted in-country, based on actual encounters. For example, to “Practice problem solving skills: Gathering data to understand client situations and problems,” participants received simulation guides for role playing of the health provider and patient. Practice sessions with open-ended questions and increased interaction between participants led to improved skills. Examples of these mini case studies are presented in the training manuals. Mini cases for Honduras can be found in Annex 8 and 8bis (Appendix D). In Egypt, the last day of training focused on improving the quality of IPC skills among colleagues and on teamwork. Following a brainstorming exercise in which participants complained about poor leadership, poor group dynamics and poor supervision in their work environment, trainers developed three mini case studies to be used as group exercises at a later date. These exercises are presented in Annexes 8, 9, and 12 of the Egyptian training manual in Appendix B.

Evaluation form. At the end of the course, participants were asked to complete evaluation forms assessing trainer effectiveness. The forms provided participants with the opportunity to comment on their learning experience and course methodology. At the same time, it provided trainers with the necessary feedback for improving their workshops. Moreover, each training day began with a plenary discussion among participants, which allowed them to focus on essential elements discussed the previous day. Sample evaluation forms in Spanish and English are presented in Appendix D, Annex 10 (Honduras) and Appendix B, Annex 13 (Egypt).

Training Supervision, Monitoring, Evaluation and Follow-up

An effective training program does not end at the conclusion of the workshop but represents an element in a protracted learning cycle. After the workshop or intensive training program, providers are expected to return to their clinical settings and apply what they have learned to their daily work environment. Effective supervision and support is critical at this time to ensure that providers adopt the new skills within their old settings. In order to establish a true learning environment, supervision should be supportive rather than constraining, providing feedback and encouragement rather than threats or punishments. An important aspect of supervision and feedback is monitoring—a process in which information is collected in an ongoing manner to measure progress toward established goals or objectives. Monitoring can take a variety of forms, including (but not limited to):

- ◆ providing self-evaluation on a variety of behaviors, using a check list or other standard form such as a questionnaire
- ◆ having a supervisor or colleague observe an encounter with a patient
- ◆ recording audio or video tape encounters, followed by self and/or team evaluations
- ◆ conducting exit interviews with clients.

Sustained routine monitoring of clinical practices is an effective tool for improving the quality of health care services and follow-up of training programs. Monitoring procedures and protocols should be simple, user-friendly, and limited to a few key questions or observations that will yield information by which progress and the design of follow-up training activities can be gauged.

Follow-up is the process by which trainers, supervisors or colleagues determine which skills need reinforcing, additional training, or further development. Follow-up is based on the understanding that learning occurs through repetitive drill, practice, and constructive feedback. Follow-up is, therefore, an integral part of the learning cycle, as it allows for focusing on problem areas or delving deeper into areas of particular interest to participants.

Six months after the IPC training in Egypt, a follow-up effort was carried out in response to a wish by physicians to improve the quality of health services delivery and enhance patient satisfaction. These activities consisted of field visits to work sites, discussions with health providers on the relevancy of the IPC skills acquired during the training session, observation of provider-patient encounters, the compilation of physician questionnaires, and the recording of patient exit interviews. Details of the results of these follow-up activities are explained in the next chapter which presents the country's case study.

VII. Case Studies

Sections I through VI have presented a conceptual framework, outlined training strategies and described tools that can help improve the quality of IPC between providers and patients. This section presents our research experiences to date in three countries—Honduras, Trinidad and Tobago, and Egypt. We hope that our field experiences will complement the theory presented, so that readers may feel confident in experimenting with IPC improvement efforts.

In all three countries we focused on training doctors. In Honduras and Egypt a number of nurses were included in the IPC training effort. We expect that the materials derived are appropriate for training all professional health personnel, but may need some adaptation and simplification for use with peripheral health workers or community health volunteers.

In each of the three countries the training sessions covered approximately 10-15 hours of classroom work, which included presentation, discussion and practice of the new skills. The training manuals are included in their entirety in the appendices, because we felt they could provide, with minor adaptations, the basis of IPC interventions in new settings. The training manual used in Trinidad most closely follows IPC improvement models that are used in developed countries. The training manual for Honduras relates more to a developing country setting. The training manual for Egypt is based on the manual from Honduras, but benefits from revisions and improvements that were made as a result of the Honduras experience.

All three countries also used a job aid, the IPC Pocket Guide, to reinforce the training content. The job aid is presented in Appendix A in English and Spanish. In our experience, we found that it was important to allow each training group to modify the job aid as they saw fit, adapting and personalizing the IPC norms to the local environment and to individual needs.

All three case studies had a research component. The research component in Honduras was the most rigorous in terms of sampling, methods, and research design. It was based on analysis of audio-tapes and of patient exit surveys. As a result of the IPC interventions, the research resulted in improvements in practices and in documented satisfaction of providers and patients. In Trinidad, the research also relied on audio-tapes and exit interviews. Even though sampling methods were simpler, we found that the method was able to detect improvements in practices and satisfactions. In Egypt we attempted to replace the audio-tapes with an observation check list and had an even smaller sample. Unfortunately, the observation method used was not reliable, and we were unable to detect improvement in provider practices. We feel that this situation resulted from a lack of adequate training for all observers. We hope to continue to experiment at a later date using a different research procedure.

While our field experiences yielded much information on how IPC improvement strategies can be adapted to different cultures and health settings, we feel that our findings are still incomplete and that many additional insights on cross-cultural and organizational issues will emerge as these survey tools and approaches are applied to other geographic regions (such as Africa and Asia), and in other settings (especially peripheral health services in rural areas). We would like to encourage those who experiment with IPC interventions to share their experiences with the QAP staff, so that these experiences can be used to further develop the IPC framework and its strategies.

Case Studies

A. HONDURAS

B. TRINIDAD AND TOBAGO

C. EGYPT



Training Health Care Providers in Interpersonal Communication

**An Evaluation of Impact on
Performance in Honduras**





Training Health Care Providers in Interpersonal Communication: An Evaluation of Impact on Performance in Honduras

Introduction

Our study in Honduras had three specific goals: 1) to determine whether in-service interpersonal communication (IPC) training is deemed relevant and acceptable by health providers in a developing country; 2) to evaluate whether training could improve IPC practice as evidenced by a sample of routine medical visits; and 3) to determine the extent to which IPC training would affect patient satisfaction.

Methodology and Selection of Research Subjects

The study design called for a randomized pre-post design with a control and an experimental group. IPC performance was evaluated using interaction analysis of audio-taped clinical encounters. Patient perspectives were evaluated through exit interviews. Health provider perspectives about the relevance and utility of training were evaluated through a self-administered questionnaire followed by a participatory discussion.

1. Selection of Physicians

Assessment of IPC performance through audiotapes of clinical encounters. Fifty-eight health providers from the Ministry of Health and the Social Security Institute participated in the component of the study which assessed their IPC practice through audio-taping of clinical encounters. All providers were from one administrative health region, which includes the Metropolitan area of Tegucigalpa, Honduras' capital. Researchers randomly assigned providers to the two study groups. Organizational representatives then chose who would participate in the study based on interest of the provider and representativeness of the institution. (Fewer than 3 providers refused to participate in the study. An additional 4 providers were eliminated from the study because they could not participate in the assessment due to their schedules or administrative barriers.) Of those chosen, 30 were general practitioners, 13 were pediatricians and 6 were nurses. The sample selection process aimed to ensure the comparability of the experimental and control groups.

Evaluation of training and training content. IPC training was given to 87 trainees including the experimental group, the control group (after completion of the study) and an additional group of government health personnel who were selected to replicate future IPC training in Honduras. Training took place during 5 workshops that were held from

*From left to right:
Dr. Maritza Gómez,
MOH Hospital
Division; Dr. Sergio
Carías, Metropolitan
Region; Dr. Lilian
Domínguez, QAP
Project Coordinator
and Dr. Victor
Melendez, MOH
Hospital Division
discussing their roles
as IPC co-trainers.*



December 1993, through February 1994. Seventy-nine of the 87 trainees responded to self-administered questionnaires upon completion of the training course. At a later date, the survey was administered again and an evaluative discussion was held with 18 members of the experimental group.

2. Selection of Patients

Conditions for inclusion in the sample of audio-taped provider-patient encounters were: 1) the encounter must be the first consultation during the illness episode (follow-up visits were excluded); and 2) patients were seeking care for one of four pre-selected conditions (diarrhea or acute respiratory infection in children, and hypertension or diabetes in adults). For each provider who participated in the study, the first 4 or 5 encounters which met the above criteria were studied in the pre-test and post-test, resulting in a total sample of 225 pre-test audio-tapes (100 experimental and 125 control) and 221 post-test tapes (97 experimental and 124 control). The pre-test measurement was made during the week immediately before the IPC training, and the post-test was carried out during the week immediately following training. An exit survey was conducted with patients for each encounter. A small number of patients were unable or unwilling to respond to the exit interview, resulting in slightly smaller samples for the exit survey pre-test (n=220) and post-test (n=218).

3. Intervention

In December 1993 and January-February 1994 the same trainer from the Academy for Educational Development (AED) conducted all the IPC/QAP training workshops, including the two-day training for trainers. The objective of IPC training was to enable health providers to use interpersonal communication skills to improve patient satisfaction, compliance and health outcomes. The training model and strategies were adapted from a successful randomized clinical trial of IPC skills with physicians in the US. Each IPC training was conducted in three half-day sessions for no more than 20 participants. The course focused on communi-

Table 1: Summary of Interpersonal Communication Skills

<u>Overall Socio-emotional Communication</u>	<u>Diagnostic/Problem Solving Skills</u>	<u>Counseling Skills</u>
Welcome patient/ frame encounter	Listen attentively	Explore Client Beliefs
Use appropriate non-verbal communication	Encourage dialogue	Correct facts
Solicit feelings	Avoid interruptions	Use appropriate vocabulary
Show positive regard	Resist immediate diagnosis/ treatment	Present info in blocks
Give legitimation	Resist immediate follow-up by listening	Check patient understanding
Show empathy	Probe	Recommend behavioral change
Reflect patient's emotions	Ask about causes	Repeat and summarize
Convey support and partnership		Motivate patient
Reassure patient		Check on acceptability and feasibility of treatment
		Confirm return visit
		Ask for questions

cation methods rather than messages, and the course content was based on the set of IPC behaviors that had been identified as potentially effective by the research team through meta-analysis and expert review. The skills can be grouped into three areas: overall socio-emotional communication (9 behaviors); problem solving skills (7 behaviors); and counseling (11 behaviors). A summary of these skills is presented in Table 1.

Participatory methods were essential to the effective delivery of the training. The training methods used included: 1) participatory plenary sessions that allowed participants to “discover” the new skills for themselves; 2) brief presentations about specific communication skills that included concrete examples of “do’s” and “don’t’s”; 3) dynamic role plays; 4) video-tapes on non-verbal communication and counseling skills; 5) analysis of transcripts of local patient-provider encounters; 6) mental rehearsal techniques which allowed participants to experiment with the new skills and to determine how they could adapt them for their own use; 7) analysis of participants’ own audio-tapes of patient encounters (Audio-tapes were analyzed and critiqued by peers, and specific feedback and suggestions were discussed about how to improve.); and 8) a job aid (pocket guide) developed by the research team to help the participants practice the skills and serve as a reference for later use. Each IPC behavior listed in Table 1 was presented, discussed and practiced during the training. From the outset the research team was concerned about adapting and applying the IPC skills in a culturally appropriate way. The team and the MOH also wanted to assure that technology transfer took place as a result of Honduran collaboration in the study. To address both of these

concerns, local trainers were involved in the review of training materials. To further support these goals, the training manual had a self-instructional design that could be used by a trainer with minimal experience. Also, nine local trainers participated in a two-day training-of-trainers session and assisted with the delivery of the course.

4. Measures

Three sources of data were used in this study: 1) audiotapes of clinical encounters; 2) patient exit questionnaires; and, 3) physicians' evaluation of the training.

Audiotapes. Changes in provider IPC practices were measured by analyzing audiotapes of clinical encounters, and comparing the performance of the trained and non-trained doctors. Audiotapes of the medical visit were coded by judges using the Roter Interaction Analysis System (RIAS). The system codes each phrase or complete thought in the visit, by either the patient or physician, in one of 34 mutually exclusive and exhaustive categories. In addition, coders rated the emotional tone of the visits (with regard to anger, anxiety, dominance, friendliness, and interest) on a six point scale after listening to the entire audiotape. As in several prior studies, the coding system demonstrated adequate inter-coder reliability. A random sample of 43 audiotapes coded by different coders had an average Pearson correlation coefficient of .83 for provider communication categories and .76 for patient communication categories. Where there were discrepancies, determination of which coder's data would be used for each discrepancy was made by random assignment.

Physicians assessment. A self-administered questionnaire for providers included 7 closed-ended questions which asked participants to rate course methods on a scale of 1 to 10. It also included 6 open-ended questions asking providers to identify what they liked most and least about the course, and asking them to identify which aspects of the course were most and least useful. Seven weeks after the first IPC training the perspectives of providers of the experimental group were evaluated again using a second self-administered questionnaire which asked an open-ended question about what they liked about the course, and then asked them to rate the frequency with which they used each IPC skill in their daily work on a scale of 1 (never) to 5 (always). Finally, they were asked whether they used the job aid (IPC pocket guide) always, sometimes, or never, and to list the reasons for use.

Exit questionnaires. A 16-item patient satisfaction scale was administered to patients immediately following their medical visit. These exit interviews focused on specific measures of patient satisfaction and patient perceptions about overall rapport and communication with the provider. Patient opinions were measured using a two-step Likert type scale which allowed the responses to be analyzed over a 5 point scale ranging from -2 to +2. Respondents were first asked to answer yes, no, or no opinion to a question about each parameter, such as, "Was the doctor (attentive, respectful, kind, etc.)?" If yes, the respondent was asked if they were "very" or "somewhat" attentive. If no, they were asked if they were "somewhat" or "not at all" attentive. In this way a 5 point scale (very positive, somewhat positive, no opinion, somewhat negative, very negative) was created for a respondent group in which other types of 5 point scale were not valid during the pre-test of the instrument.

*Simulation:
health
provider-client
interaction
(problem
solving)*



5. Analysis

This study did not intend to establish a one-to-one correspondence among IPC skills emphasized in training, specific measures of IPC performance, and parameters of patient satisfaction. Rather, its aim was to train providers to use a cluster of IPC skills that work together to reinforce each other, and to measure the overall impact of these skills on provider performance and patient satisfaction. The rigorous study design, which included a control group and a short time frame, made it unlikely that confounding factors caused the observed changes in practice or satisfaction levels.

Results

Overall, the IPC intervention resulted in more communication by trained providers, and more extensive use of practices that enhance the effectiveness of communication. Further, patients responded to these improvements in communication skills by communicating more and disclosing more medical information. Finally, patient satisfaction ratings were higher for providers who had received the training, and patients perceived more informative behaviors in these providers. These results are described in detail below.

Changes in Communication Practices and Patient Satisfaction

While untrained providers averaged a total of 94.4 statements or utterances per encounter, trained providers communicated more, averaging 136.6 ($p = .001$). Positive talk by the provider (affirming statements of agreement or approval) was 15.93 for the trained group and 7.99 for untrained providers ($p = .001$); at the same time criticism and negative talk were less common in trained providers (.11 vs. .59, $p = .018$). Trained providers also used 3 times more emotional talk, expressing caring, concern and empathy more frequently (15.7 vs. 5.5, $p = .021$). Statements relating to procedures and instructions were higher for trained providers (19.7 vs. 11.2, $p = .032$), and they were also more likely to ask the patient if he or she understood instructions (9.1 vs. 3.7, $p = .025$). Medical counseling, arguably the

Table 2: Comparison of Communication Practices by Trained and Untrained Providers*

Communication Behavior	Trained (n=24)	Not Trained (n=8)	F	p value
TOTAL TALK	136.6	94.4	12.4	.001
Positive Talk	15.93	7.99	13.2	.001
Negative Talk	.11	.59	6.3	.018
Emotional Talk	15.7	5.5	6.0	.021
Social Talk	3.6	4.3	.4	.525
Procedural Talk	19.7	11.2	5.1	.032
Paraphrase	7.3	4.7	2.2	.148
Asks patient opinion	.8	.03	2.8	.104
Asks if patient understands	9.1	3.7	5.6	.025
Closed Questions	18.1	16.1	.2	.634
Open Questions	9.9	7.4	3.0	.092
Information Giving/Counseling				
Medical Info	18.9	14.7	1.9	.182
Therapeutic info	3.0	2.6	.6	.465
Lifestyle info	.7	1.4	1.8	.188
Socio-emotional info	.5	.1	1.9	.177
Medical counsel	17.3	11.3	5.5	.026
Socio-emotional counseling	.93	.95	.04	.833

*This table compares trained and untrained providers, reporting the average number of statements per encounter for each type of communication. Analysis was conducted using ANOVA with pretest as covariate.

most important information given to the patient, was given more frequently by trained providers (17.3 vs. 11.3, $p = .026$). A number of communication behaviors were unaffected by the training, including social talk, use of paraphrasing, and asking the patient about his or her opinion. Question asking behavior was also unaffected, although trained providers asked more open-ended questions than untrained at a level of marginal significance (9.9 vs. 7.4, $p = .09$). Finally, while trained providers gave more medical counseling, they were not more likely to give more information about medical issues, the therapy chosen, lifestyle issues, or socio-emotional counseling.

Improvements in provider communication resulted in a change in patient communication as well. Patients of trained providers spoke more overall (113.8 vs. 79.6, $p = .011$), used more positive talk (17.8 vs. 11.6, $p = .029$), and perhaps most importantly, gave more medical

Table 3: Comparison of Communication Behaviors by Patients of Trained and Untrained Providers*

Communication Behavior	Trained (n=24)	Not Trained (n=8)	F	p value
TOTAL TALK	113.8	79.6	7.3	.011
Positive talk	17.8	11.6	5.3	.029
Negative talk	.3	.6	.4	.530
Emotional talk	3.4	2.7	.59	.447
Social talk	2.9	2.8	.04	.833
Paraphrase	2.5	1.4	3.2	.082
Questions	2.8	2.3	1.5	.230
Information Giving				
Medical Info	54.7	41.7	11.5	.002
Lifestyle Info	6.5	7.3	.02	.889
Therapeutic Info	1.9	2.1	.01	.978

*This table compares patients of trained and untrained providers, reporting the average number of statements per encounter for each type of communication. Analysis was conducted using ANOVA with pretest as covariate.

information (54.7 vs. 41.7, $p = .002$). There was no significant difference in negative talk, emotional talk, social talk, paraphrasing, question asking, or the disclosure of information about lifestyle or therapy.

Patient satisfaction rates are reported in 4 categories: global satisfaction, positive behaviors (including concern, kindness, attentiveness, understanding, and whether the provider gave the patient opportunities to talk), negative behaviors (scolding, preoccupied/busy, arrogant, and whether the patient had issues or concerns that he or she was not able to discuss), and informative behaviors (clarity, encouragement, support, emphasis on compliance with treatment, attention to impact of illness on daily life). Trained providers received significantly higher ratings in two categories, global satisfaction ($p = .01$) and informative behaviors ($p = .045$). It is important to note that the changes in average scores on satisfaction are small because satisfaction is traditionally positively skewed, resulting in a small range of responses and smaller magnitude of variation. However, these small differences are statistically significant. Regarding patient perceptions of positive and negative behaviors for trained vs. untrained providers, there was no significant difference.

Provider Perspectives

Providers rated nearly all training components above 9 (on a 1 to 10 scale), indicating that providers found the training content useful and relevant for their work. When asked about what could be done to improve the course, the most frequent responses were 1) practice

Table 4: Patient Satisfaction

Satisfaction Measure	Patients of Trained	Patients of Untrained	F	p value
Global Satisfaction	3.60	3.27	7.6	.010
Informative Behaviors	18.1	15.5	4.4	.045
Positive Behaviors	19.2	19.5	.1	.750
Negative Behaviors	2.67	2.85	.1	.700

*This table compares composite satisfaction scores in four categories based on a comparison of exit interview data from patients of trained and untrained providers. Analysis was conducted using ANOVA with pretest as covariate.

skills with real patients; 2) use more educational videos; 3) spend more time practicing skills; 4) develop more examples of care in urban settings; and 5) provide follow-up support.

In response to an open-ended question about which skills were most useful and relevant for their work, 53% of the trainees stated that all the skills were “most useful.” Among the skills identified by 4 or more providers as useful were overall socio-emotional communication, counseling techniques, problem solving skills, skills for encouraging dialogue, and use of open-ended questions.

In a follow-up questionnaire administered 7 weeks after the course the health providers trained remained very positive about the training. When asked why they liked the course over 7 of the 18 respondents listed the following reasons: 1) it improves my relationship with patients; 2) it helps to organize my listening skills; 3) it emphasizes the human aspect of the work; and 4) it helps me deal better with clients. Other responses included improved organization, better non-verbal communication, improved counseling, more patient disclosure of information, and a better understanding of the clients’ point of view.

When asked to assess the frequency with which they use IPC skills in daily work on a scale of 1 to 5, most behaviors fell in the 4.2-4.4 range. Welcoming the patient, using effective non-verbal communication, and using appropriate vocabulary were nearly always used according to provider self-reporting. Less frequent but still common practices (scoring 3.5-3.9) were repeating what the patient said to elicit more information, avoiding interruptions, and making concrete behavioral recommendations.

When asked about their use of the IPC pocket guide, 13 providers reported that they always used it, 5 that they sometimes used it and none reported never using the guide. Users said that it helped them to remember and improve skills, to apply skills, to get better organized during the encounter, to get more information from the patient, and to provide better care.

Discussion

IPC improvements on the part of providers tended to be related to skills that they already possessed but did not exploit fully. Increases in overall communication, procedural explanations, positive talk, and medical counseling, as well as decreases in negative talk are examples of this. These improvements were easier to attain because they were familiar to providers and were not controversial within the clinical paradigm.

Some IPC behaviors did not change in spite of training efforts. For example, the training encouraged providers to use more open-ended questions, ask about patients' opinions, and to discuss relevant socio-emotional issues and lifestyle, however, providers did not put these new skills into practice. This may be due to providers' hesitancy to contradict the paradigm of their medical training, which is based on technical expertise and authority, and an algorithmic approach to identify discrete symptoms and causes. Doctors may not have been convinced of the value of the more narrative style in which the patient gives opinions and information in his or her own way. Also, many felt time pressures because they are required to see a specified number of patients per hour, and were concerned that the patient would talk at length if given the opportunity. However, the use of open medical questions was marginally more prevalent among trained doctors (9.9 vs. 7.4, $p = .092$) suggesting that trained doctors may have experimented with open-ended medical questions as a result of the training.

While changes in provider practice led to some improvements in patient communication, such as more overall communication and more disclosure of medical information, it resulted in no change in question asking, disclosure of life-style information, or discussion of the patients therapy. When given more of an opportunity to talk, patients focused on their medical condition and did not digress to less relevant topics, as some of their doctors feared they might. However, there are times when such lifestyle and social information can be very important in determining the diagnosis and the best course of treatment. This study suggests that a more direct intervention with patients would be needed if the goal of IPC efforts was to increase patient participation in the encounter more dramatically. For example, in addition to teaching doctors to be receptive listeners, it might be necessary to raise awareness among patients about their right to participate in decisions about their health and the importance of asking questions so that they understand what they need to know to safeguard their health.

Patient overall satisfaction and perceptions about the information they received from their doctors also improved as a result of the IPC training intervention. While satisfaction improvements were not documented across the board, the improvements that were realized could result in enhanced rapport and better compliance with treatment and follow-up appointments.

In addition to these statistically significant results and conclusions about communication, the study also provided a number of insights about how programs to improve IPC might be developed. It showed that IPC training is effective and feasible and can be institutionalized easily so that local staff can conduct the course. It was frequently mentioned by trainees and trainers alike that IPC skills should be included in the formal professional training received

by all health providers, and that in-service training should be made available. Further, providers and researchers alike felt that IPC training supports other efforts to improve quality of care. Other efforts include enhancing the quality of information upon which to base diagnosis and treatment, and enabling providers to more effectively deliver counseling messages.

In addition to showing that IPC training can lead to behavior change, the study showed that providers are receptive to receiving IPC training, find the content relevant, and are willing to put the new skills into practice. This is an important finding, underscoring that those who would promote IPC skills need not refrain from doing so for fear that health providers would resist such initiatives or refuse to participate.

While the above conclusions suggest that the quality of medical care in developing countries can be significantly enhanced by improving the counseling skills of providers, a number of cautionary comments must be made. First, the proposed “norms” for interpersonal communication must be further studied and validated. In order to do this the study design, instruments, and methods must be simplified to make developing country research feasible.

Also, cultural factors are extremely important in the communication between patient and provider. Thus, this study should be replicated in diverse cultural settings.

In addition to determining whether these results are generalizable across cultures, the impact of the communication intervention over time must be studied to determine how well new skills and practices are sustained.

Finally, and perhaps most importantly, methods for IPC assessment and improvement must be developed further so that they may become part of routine monitoring and quality improvement in health care facility. The design of practical job aids and assessment tools, and the implementation of simple, efficient methods of providing ongoing in service support are essential if the health benefits of improved patient provider communication are to be fully realized.

Acknowledgements

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The Case of Trinidad and Tobago



Training Health Care Providers in Interpersonal Communication: The Case of Trinidad and Tobago

Background

In 1993, the QAP solicited the collaboration of the Ministry of Health of Trinidad and Tobago in carrying out a training and research study to further validate the impact of improved provider-patient interaction. Official government approval was received in April 1994.

QAP/IPC activities in Trinidad and Tobago had two components: a health provider training program and an accompanying evaluation research component. The research component measured the impact of training on improved communication skills and on patient satisfaction. From the outset, activities were designed to be small-scale and simple. The objective was to validate established models, in particular the results of the more elaborate study in Honduras. No attempts were made to measure relationships between patient compliance with treatment regimes or with health outcomes. Because a link had been previously established between patient satisfaction and compliance and health outcome, this study was designed to only identify the relationship between IPC training and client satisfaction. If a statistical relationship between improved IPC and greater patient satisfaction can be established, it could then be inferred that improved client compliance treatment outcomes would also naturally ensue.

Design

Audio-taped physician-patient encounters recorded before and after a two-day IPC training session were used to measure the impact of improved communication skills on patient satisfaction. Patient satisfaction was evaluated on the basis of a 53-item exit questionnaire which took approximately 15-20 minutes to complete. The degree of overall satisfaction was measured in specific areas such as information access, perceived provider competence and interpersonal interaction. To relate physician skills to client satisfaction, questionnaires and corresponding encounters were paired. Physicians were also requested to complete a 13-item questionnaire following the completion of all pre-test audio recordings and patient interviews. Questions focused on demographics and on physicians' views on communication and barriers to patient compliance.

Audiotapes were analyzed using the Roter Interaction Analysis System. The system, developed by Dr. Debra Roter, encodes doctor-patient interactions in a set of categories. Coders rate specific "proficiencies," such as emotional tone, interruptions, appropriate language, etc.; code frequencies, clusters and ratios (e.g., physician and patient dialogue; open-ended

and closed-ended questions) then allow examination and assessment of the interaction. Changes in communication patterns can be assessed over time intervals.

Patient satisfaction surveys were analyzed using standard statistical analysis. Following intensive discussions and extensive pre-testing, it was decided that a four-point scale to measure satisfaction levels would be used (see discussion below). Pre-testing by two QAP/IPC specialists versed in the local culture was conducted to identify “local” words and word patterns comprehensible to a variety of respondents that could serve as evenly-spaced benchmarks on the scale. (Focus groups and interviews were exclusively used to validate the scale.)

Baseline Study

In addition to rigorous pre-testing of scales and assessment techniques, formal and informal meetings were held over a period of several days with colleagues, county medical officers and high-ranking ministry officials to review project objectives and organize field activities. A field team was selected, materials prepared, vehicles rented and letters requesting participation in the study and training drafted and hand-delivered to doctors in participating counties. Interviewers also underwent formal training which reviewed interview and other procedures, assessment techniques and logistics. A field practice in a health center located beyond the limits of the participating counties was also held.

Four interviewers and two international specialists, one from Trinidad, made up two work teams. The teams visited 23 doctors in three counties during chronic illness encounters or adult health clinic sessions, conducting a systematic selection of five chronic disease patients per physician. In two instances, when fewer than five chronic disease patients could be found, all chronic patients attending (four from each center in both cases) were included in the study. Visits were audiotaped and patients completed a satisfaction survey at the end of their visit. Doctors also completed a short, self-administered questionnaire at the end of the five-patient visits. Except for two physicians who refused to participate in the study, two who were on leave during the entire data collection period and one who was not scheduled for clinic visits, no problems or delays were encountered. The total number of participating physicians was 18, and the total number of interviews was 88.

Initial Findings

A preliminary review of the data indicated that the study was successful in achieving its goals. All audiotapes and exit interviews were completed, and the quality of the data collected was relatively clean. There was little variance in patient satisfaction data, with all patients being relatively satisfied with the treatment received. Patients did, however, express lower satisfaction in several areas, including a lack of confidence in providers, the thoroughness of exams and the treatment practices, areas which were emphasized in the training sessions.

Training

QAP training standards were adapted to prevailing conditions in Trinidad and Tobago. Shortcomings identified through patient questionnaires and audiotapes in pre-test evaluations received special emphasis during the study. Several pre-test audiotapes were transcribed for use in the study.

Training focused on introducing and practicing IPC skills associated with improved interactions, patient satisfaction, compliance and outcome. Specifically, training focused on three types of IPC skills: 1) socio-emotional communication, 2) problem solving, and 3) counseling. The specific behaviors associated with each category are outlined in Figure 1.

Figure 1: IPC Skills

I. Socio-emotional Communication: Verbal and Non-verbal

A. Verbal Communication Behaviors

1. Signaling Receptivity

- Framing the encounter (using phrases which show general interest in the patient and set the stage for open communication)
- Asking about feelings
- Listening more/talking less
- Following up on distress cues (both verbal and non-verbal)
- Using conversation facilitators (ah-ha, I see, sure...) to encourage conversation

2. Demonstration of Positive Regard

- Complimenting the patient's effort
- Legitimizing (using statements to confirm the patient's actions, emotions or thoughts as understandable and normal; for example, "I can see why you're worried..." "Who wouldn't be afraid of cancer?" "...I've felt the same way myself.")

3. Expression of Mutual Feelings

- Showing empathy (repeating what the patient says or giving a name to what the patient feels)
- Demonstrating partnership/support (using statements such as "That must be uncomfortable..." "I hope that doesn't hurt too much.")
- Using statements of concern or reassurance (for example, "This might hurt..." "I'll be gentle..." "Are you okay?")

continued

Figure 1: IPC Skills continued

B. Non-verbal Communication Behaviors

- Being aware of tone of voice (anger, anxiety, dominance, interest, friendliness and responsiveness)
- Avoiding interruptions, phone calls, questions from other clinic personnel unrelated to visit

II. Problem Solving

Though explicitly more cognitive than emotional, these behaviors carry emotional content through tone of voice and body language and are especially critical during history taking.

A. Identification of Patient Concerns

- Resisting immediate reaction to patient's initial concern (Patients are often reluctant to reveal the real reason for a visit. Research shows that second and third problems mentioned are often of equal or greater importance than the first.)
- Probing for additional concerns
- Asking open-ended questions about patients' complaints
- Using facilitators to encourage patient talk

B. Delineation of Problem

- Asking explicitly about problems or stresses in daily living
- Exploring the impact of the health problem and its symptoms on patient's life

C. Understanding of Patient's Perspective

- Probing for patient's understanding of the disease (including "folk" explanation of illness and treatment)
- Clarifying patient's expectations (What results does he or she expect from the medical visit?)

III. Counseling

A. Fulfillment of Patient's Informational Needs

- Asking about patient's understanding of his or her illness and monitoring accuracy
- Correcting misconceptions
- Summarizing key points and underlining the importance of the advice given

B. Provision of Counsel

- Giving concrete behavioral recommendations; convincing or motivating patient compliance; discussing impediments to carrying out treatment recommendations and strategizing how impediments can be overcome

In March 1995, two trainers and IPC specialists from Johns Hopkins University conducted the QAP Training in Interpersonal Communication Skills for Primary Care Physicians. The trainers used a training of trainers (TOT) model to encourage training beyond the scope of this small demonstration project. Health administrators expressed interest in extending the training to other counties and health sectors. This training format ensured that activities could continue with minimal external inputs.

Seven Medical Health Officers attended the two-day TOT session. The training of medical officers, scheduled to begin immediately after the TOT session, was postponed until the following week due to a sudden death of a family member of the principal trainer. The first day of training was attended by 22 officers and the second by 18, with the three counties being fairly evenly represented. Unfortunately, only seven of the eighteen doctors who took part in the baseline study attended both training days. The rescheduling due to the principal trainer's unexpected departure midway in the first week may partially account for this poor attendance. Supervisors of the attending public health physicians offered no additional explanations.

At the end of the session, 14 evaluation forms were collected in which participants commented on the following: likes and dislikes about the workshop, training methods they felt were most effective, aspects of training they believed to be most useful in their daily practice and advisability of recommending the training to other physicians and health workers in the Trinidad public health care system.

Evaluations were overwhelmingly positive. Most participants enjoyed the workshop, particularly the role playing and the interactive training style. With the exception of one participant who recommended a shorter training session, all others recommended a longer session, perhaps in a more secluded and spacious location. Some participants commented on travel time (up to three hours) needed to reach the training center. Little diversity was evident in participants' assessment of training methods and applicability of skills. Most felt the methods helped "a lot" or "significantly." Several participants suggested greater use of video feedback and visual aids. When assessing the usefulness of the skills in their practice, most physicians reported they would use the skills fairly or significantly often. All participants would recommend the training to colleagues, and 93% believed it should be offered to other health personnel.

Post-training Study

The relatively poor attendance at the IPC training by baseline physicians actually strengthened the study. Though only seven out of the original 18 doctors attended both training days, it was decided that the post-training evaluation would be carried out with as many of the original doctors as possible, thereby creating a control group of untrained doctors against which to compare the trained doctors.

Because of the low attendance of "baseline physicians" in the training, the design was further modified to evaluate the impact of skills training on the participants' private practices. (All public sector physicians also had private practices.) Eight doctors agreed to participate

in the modified study component which involved recording patient encounters and interviewing patients in both private and public settings. Five of the eight physicians participated in both days of training; the remaining three did not attend either.

The matrix below illustrates the modified design and the types of comparisons it entails. The issue of communication in the public and private sectors is of particular interest because inadequate medical counseling and communication in the public sector is frequently explained by “lack of time” or “too many patients waiting.” Though not included in this case study, a private vs. public physician communication analysis would allow for a comparison between communication activities in different clinical settings.

	PUBLIC		PRIVATE	
	Experimental Group (# of MDs)*	Control Group (# of MDs)	Experimental Group (# of MDs)*	Control Group (# of MDs)
PRE-training	10	8	—	—
POST-training	9	6	5	3

*Five encounters were recorded and analyzed for each participating physician. Slightly fewer encounters were recorded per physician in private office settings.

Encounters, each involving five patients, were audiotaped for 15 (7 trained and 8 untrained) of the original 18 physicians. Of the remaining three, one was on sick leave, one on vacation leave, and one had been transferred to administrative duties.

Over the next three weeks, two teams of two interviewers each visited health centers in the three counties and audiotaped visits with doctors and five of their chronic disease patients. At the end of their visit, patients completed a brief satisfaction questionnaire, the same used in the pre-test study. Few problems were reported in the field, and 75 audiotapes and questionnaire forms were collected.

During the last week, the teams visited the private practices of eight trained doctors, audiotaping 20 physician-patient encounters and conducting patient exit interviews. It was not possible to record and interview five visits per physician as was done in the public sector, because of fewer private practice patients, many patient refusals to participate and more ineligible patients (those visiting for reasons other than chronic disease).

Results

Effects of Two-day Training on Physician Skills and Patient Satisfaction

A pre/post analysis of the audiotapes was made. Data analysis was based on post comparisons between trained and untrained physicians observed during 4-5 chronic care visits. In this analysis, pre-test scores were held constant to minimize the influence of pre-training differences among physicians. Results were compared with findings from the patient exit interviews, and patient satisfaction was correlated to individual physicians.

Trained physicians performed better, often statistically, in certain areas such as positive talk, attentive listening, open-ended questions and overall interaction with patients. More information was shared between physicians and patients within the context of a limited dialogue. There was no significant increase in counseling or lifestyle information, but a significant increase in psycho-social exchange. Increased use of positive talk and conversation facilitators enabled patients to more easily impart psycho-social information. This was evidenced by a significant increase in how much patients said and in the biomedical, lifestyle and psycho-social information they volunteered.

Medical visits with trained physicians tended to be longer ($p=.09$); the average visit with trained physicians lasted five minutes, while that with untrained ones lasted only three minutes.

Patients readily noticed the improvements in the doctors' skills. Overall performance ratings improved. Blind data coders noted that trained physicians were more friendly, responsive, sympathetic and less irritable and overbearing than untrained physicians ($p<.05$). Patients of trained physicians had overall ratings which evidenced higher poise, interest, friendliness and responsiveness than patients of untrained physicians.

Patient satisfaction was also evaluated and a significant bias in favor of the trained group of physicians at post-test ($p=.002$) was found. Preference for trained physicians is noteworthy since in the pre-intervention measure, there was a trend toward higher satisfaction among patients of untrained physicians ($p=.059$).

Results Derived from Pre-training Physician Questionnaires

To express their views on barriers to effective communication and patient compliance, all physicians participating in the pre-training data collection were asked to complete a brief questionnaire consisting of three open-ended questions and six demographic close-ended questions following all audio recordings and exit interviews. The questionnaire, which all physicians agreed to complete, provided for demographic information to be analyzed together with patient satisfaction questionnaires.

Most physicians in the pre-training were East Indian males (89%) who had been in the health service for more than 10 years (72%, with 39% having more than 20 years of public service). Most resided in the county where they worked (72%) and most supplemented their public health service with a private medical practice (72%).

Physicians were asked to identify the major difficulties in communicating effectively with their patients. Almost half (47.1%) attributed difficult communication to lack of adequate time and overcrowded clinics; a third (35.3%) to patient inclinations, beliefs, or education; and 12% to poor physician training or techniques.

When asked to name three items that would facilitate and improve their practice, physicians responded as follows:

Item	Percent *
Availability of medication	66.6
More time with patients/fewer patients per clinic session	66.6
Better working environment: enhanced facilities and more staff	61.1
More health education/improved patient compliance	44.4
Better ancillary/support services (labs, tests, etc.)	33.3
Other (better pay, more political support, etc.)	11.1

* Respondents were allowed up to three unprompted responses.

Finally, when asked why they thought it was difficult for patients to comply with their treatment regimens, physicians overwhelmingly blamed the unavailability of medication. All responses are indicated below:

Reason	Percent*
Availability of medication	94.4
Poverty (unavailability of money for medicines; poor home conditions)	27.7
Lack of health education/competing local beliefs	27.7
Overcrowded clinics	16.6
Other	11.1

* Respondents were allowed up to three unprompted responses.

Discussion

The significant changes and positive trends noticed in such a small sample are important. It appears that a relatively minor effort involving a two-day training program significantly improved health worker communication skills. The Trinidad findings support the QAP model predictions which hold that improved physician IPC skills can improve patient satisfaction. On the basis of this relationship we can infer that improved satisfaction leads to improved patient compliance and health outcomes.

Several questions still remain unanswered. Factors determining satisfaction may vary in different settings (inclusive of, but not limited to, public and private sector health delivery) and in various cultural contexts, as may the measure and expression of satisfaction.

For Any Number of Reasons, People May Have Difficulty Expressing Their Level of Satisfaction

1. Satisfaction is contextually relative. Little variance in expressions of patient satisfaction was evident in the pre-test. All patients were evaluated as being very much or somewhat satisfied on the basis of the different variables that together assess satisfaction. Yet, pre-test analysis of the audiotapes showed a number of shortcomings in the care patients were receiving. Shortcomings were also apparent from informal assessments and observations of clinic operations. Why then are patients satisfied with mediocre care?

All respondents received free medical care. Few had the option of private care. While they could choose any health center, their options were limited by financial and travel considerations. Unless they changed health center, patients had no choice in selecting a physician, as they quite literally took a number and waited for the next available physician. Therefore, most patients were “stuck” with the public health physician assigned to the center nearest their home. Patients were grateful for any care they received and, to a large degree, had few options. Their expressions of extreme satisfaction are, therefore, relative.

2. Factors that determine satisfaction for public health center patients in Trinidad and Tobago may differ from those identified in existing literature studies for private health sector patients in “developed” countries. Most tests of satisfaction presume that patients’ involvement in their own healing process is a positive factor. Patient involvement, however, is a relatively new phenomenon in allopathic (or “Western” medicine). Consideration of behavioral and environmental influences is also a relatively new element of health therapy. For example, some people in Trinidad may, because of their cultural and/or educational background, expect their doctors to talk down to them (this may be viewed as a sign of an important and accomplished doctor), to do most of the talking (the doctor is the one who knows the most), etc.

*Patients
(clients) wait
in turn to see
a physician*



To evaluate the relative importance of various variables, respondents were polled on the weight they assigned to diverse aspects of their interactions with doctors. Over 93% of respondents valued the following “very much”:

- Doctor showing interest in what they had to say
- Doctors asking about their overall health well being
- Their understanding what the doctors tell them
- Doctors allowing them as much time as necessary to relate their health problems
- Privacy.

Other characteristics were rated as important but with greater variation. Two-thirds of the respondents found the following “very” important, and about one-fifth found them “some-what important”:

- Doctor noticing their feelings
- Doctor and patient mutually deciding on a treatment plan.

No variables were rated as “slightly important” or “not important at all.” Whether this was a result of the methodology used, the survey’s context or the reliability of the ratings is unclear. For example, over 93% of patients felt that privacy was very important during a medical visit and 98% believed they had utmost privacy during their visits. Yet, investigators attested to an extreme lack of privacy during many visits, with health personnel and patients frequently entering the doctor’s office without even knocking. In some instances, only a curtain divided the examination room from other rooms in the health center. In two cases, the investigator observed rectal exams being performed without complete privacy. Clearly, respondents were defining privacy differently than investigators.

3. People may not feel free to express dissatisfaction. While the pre-training survey was being conducted, a popular columnist of one of the country's two news dailies coincidentally wrote a column on her outrageous treatment at a local public health center. She described the attending nurse's attitude and behavior as *abrupt, officious and hostile; face of thunder; absolute authority; decided to ignore me; cultivated lack of accountability*, and her own feelings as a patient as *struggling, fighting back my mounting temper, supposed to be humbly grateful, helpless*.

The journalist reported that she repeatedly tried to solicit the support of other waiting patients and to awaken outrage at their mistreatment—in her words, “to raise a populist rant.” As no one responded to her appeals, she mused about why no one seemed bothered by the mistreatment, protested it or even noticed it. One explanation she offers is that of resignation (patients not bothering to complain about injustices that beset them or even realize they have rights to do so) and voluntary victimization. To that list, her baby-sitter added another—fear. Fear that in a small town on a small island, where one's health care options are restricted, people are ‘*fraid that the next time they go ther', the nurse go' spite them*.

Anecdotally, while supervising the pre-test field work, one of the principal investigators noted that numerous respondents were afraid to participate in the study because they feared some sort of retribution, such as loss of pensions or benefits, from the health center or the government.

Patient Satisfaction and the Availability of Medicine

Research and experience have shown that many developing country health center patients often equate “good care” or satisfactory treatment with receiving an injection or prescribed drugs. Patients depend on public health dispensaries for most prescribed medicines because they cannot afford to have what are considered extremely expensive prescriptions filled at private pharmacies. Informal interviews with health centers revealed that they were unable to keep their dispensaries stocked with even essential items throughout the year. Some centers had problems keeping stocked throughout the month, others described the problem as seasonal, and still others felt the problem was chronic. Cynics, including many patients and health personnel, believed that the only time the dispensaries were properly stocked with even essential medicines was around election time. As a result, investigators were curious to find out whether overall patient satisfaction was associated with the receipt of prescribed drugs. These analyses are still pending.

Improved Patient Outcome and the Availability of Medicine

There is a direct relationship between the ability to access prescribed medicines and improved health outcomes. Clearly, if patients cannot access medicines they cannot comply with treatment regimens and other than lifestyle changes “prescribed” as treatment. At the time of the patient exit interviews, only 12.3% of patients had received their prescribed medicine from the clinic dispensary. (Because some interviews were conducted while the patients were waiting to get their prescriptions filled, this percentage may actually represent a lower estimate.)

*QAP interviewer
conducts patient
satisfaction
interview
following
physician visit.*



Doctors completing the physician questionnaire overwhelmingly identified lack of medicines as the main reason why patients failed to comply with treatment regimens, and availability of medicines as the main factor that would make their job easier.

Patient Satisfaction and Ethnic “Match” of Physician and Patient

The questionnaire in our study was designed to test whether satisfaction was related to the match in ethnic background of physician and patient. Trinidad and Tobago is a country of primarily African, East Indian and mixed ethnicities which is proud of the racial harmony achieved at institutional and social levels. Yet Trinidadians, like many others, appear to gravitate to those most ethnically similar to themselves.

Unfortunately, because of the small number of physicians of African descent (only 6% identified themselves as being of African descent) we were unable to detect any relationship between ethnicity and satisfaction. Whether a relationship exists still remains unclear.

Patient Satisfaction and Measurement Issues

As stated earlier, very little variance was detected in the responses on patient satisfaction. This was partly due to the relatively compressed scale range on which respondents were asked to grade their degree of satisfaction. (The larger the scale, the easier it is to detect variation in satisfaction.) Respondents were asked to rate questions in the following categories: very much, somewhat, slightly, not at all, or don't know. For instance, “*How much privacy would you say you had in today's visit? very much, somewhat, slightly, or not at all?*”

Because respondents had a limited number of choices, all but the really dissatisfied would end up responding “very much” or “somewhat,” thus causing the data to cluster at the upper end of the scale. If responses to the pre-training survey tend towards the upper end of the satisfaction scale, then post-training evaluation can only pick up marginal improvements due

to measurement constraints, even if respondents perceive a difference in satisfaction due to improved communications with physicians.

Why then did we not construct a six- or seven-point scale? Our four-point scale was constructed after extensive pre-testing in the environment where we conducted our study. In a questionnaire administered by an interviewer, we found respondents could not handle more than four possible responses in an oral question, even when the response pattern is repetitive. When various visual aids were used in the pre-test phase to assist respondents with larger scales, respondents became confused when the number of options exceeded four. For these reasons, the survey design limited the range of responses, restricting their possible variance.

Given that the design limited our ability to measure changes in satisfaction, it is particularly promising to note that patients reported greater satisfaction from visiting trained doctors than untrained doctors.

Improved Physician IPC Skills, Patient Satisfaction and Length of Clinic Visit

The minimal training provided clearly improved physician IPC skills and skill improvements were significantly related to patient satisfaction. Visits of physicians who received the training lasted about two minutes longer than visits of untrained physicians. While two minutes may appear as a minimal increment, the span represents an approximate 60% increase in the length of the visit. Given that physicians and health officials already recognize that health clinics are overcrowded and that not enough time is allotted to each patient, a 60% increase in duration of visit would be hard to justify if other efficiencies could not be realized to offset the longer visit time.

Conclusion

The Trinidad study validated the findings of the QAP Honduras study, with both studies demonstrating that minimal training in IPC skills can have a significant effect on patient satisfaction. Building on an already established relationship, we can further infer that improvements in Trinidadian patient satisfaction will lead to improvements in patient compliance with treatment and related improvements in health outcome.

The QAP methodology offers developing country health planners a promising strategy to improve community health in an era of shrinking health resources. As discussed above, some questions still remain about the advantages of developing culturally specific satisfaction criteria and corresponding health communication skills.



Training Health Care Providers in Interpersonal Communication

**Improving Patient Satisfaction in an
Egyptian Public Hospital**





Training Health Care Providers in Interpersonal Communication: Improving Patient Satisfaction in an Egyptian Public Hospital

1. Background

May 15 Hospital, a 130-bed hospital located at the outskirts of Cairo, is the first public hospital in Egypt to implement a quality assurance program. Initiated in May 1993, the program targeted and prioritized several areas for improvement, one of which was the quality of customer services and patient satisfaction. For the past few years, administrators and other hospital personnel have received numerous complaints from patients and visitors about the poor treatment and lack of information they receive and the snags in processing patients in the hospital.

To solve these problems, the Quality Assurance Committee at May 15 Hospital undertook a three-part strategy consisting of:

1. the installation of a reception desk in the out-patient department to provide visitor information
2. the training of non-medical, front-line workers in the principles and techniques of quality customer service
3. the training of doctors and nurses in interpersonal communication (IPC) skills.

The Committee, together with the trained physicians, decided that after physician training follow-up activities should take place to ensure a greater impact on performance and to increase patient satisfaction.

This case study presents the IPC training of doctors and nurses and the follow-up IEC activities that took place six months after the training. A total of 49 physicians and 30 nurses participated in the training workshops. The training curriculum, used in other countries, was revised and adapted to the needs of Egyptian providers and their patients at May 15 Hospital. The same AED trainer who trained all the physicians in the Honduras study, trained the Egyptian physicians. An Egyptian medical doctor and an Egyptian nurse were trained to become co-trainers of these workshops. The medical doctor became the main trainer for the nurses who received a slightly different version of the course translated into Arabic and better suited to the nurses' needs and levels of interaction. Thirty nurses received IPC training between September 1994 and December 1994.

2. Training

Between July 1994 and January 1995, IPC training in three half-day sessions was offered five times to a total of 49 physicians. The training sessions were conducted at May 15 Hospital in Cairo and at El Quantara Hospital outside of Ismailia. The primary objective of the training was to improve the IPC skills of health providers in order to improve patient satisfaction, compliance and health outcomes. The course agenda is presented in Appendix B.

Participants in the training first agreed on a definition of IPC.¹ They then reviewed basic IPC concepts, such as non-verbal communication and language efficiency. The training activities focused on skills presented within three areas:

- 1) overall socio-emotional communication (building rapport and responding to clients' emotions: guidelines for talking with patients)
- 2) problem solving skills (gathering data to understand clients' situation and problems)
- 3) counseling and Information-Education-Communication (IEC).

The training course had a proposed list of skills or behaviors that the trainer introduced to the group (Table 1). Each behavior was discussed and then practiced in Arabic or English so that participants could improve or adapt them. The training activities employed a variety of training methods to ensure that participants developed these new skills, enhanced their sense of proficiency and applied state-of-the-art IPC techniques, building on their existing skills and strengths. Participants completed a two-page evaluation form at the end of each workshop session. The 46 physicians who completed the form were quite pleased with the course, especially with the instruction on IPC basic concepts, the use of non-verbal communication, the guidelines for communicating with patients and the instruction on providing counseling and information. They were also pleased with the role play/simulation exercises, the group work, and the use of video. Physicians mentioned that welcoming, listening to and empathizing with the patient, encouraging dialogue through the use of open-ended questions and avoiding premature diagnosis were among the most useful skills. Participants suggested that the IPC video developed in Egypt should be presented together with a video describing the desired IPC skills.

Participants asked that the course be given to the nurses and that follow-up activities, such as observations and discussions among the trained doctors, take place in order to reinforce the learned skills. They also suggested that the skills be practiced and observed with real patients. Overall, these results show that participants were highly satisfied with the content and methodology used during the course. They mostly liked the dynamics occurring between the trainers and participants, and found the exchange of ideas between colleagues quite enriching. They liked the atmosphere and the feeling that each of them contributed something to the course. They liked the atmosphere of mutual respect during the training and the

1. Interpersonal Communication is the face-to-face verbal and non-verbal information or feelings between two or more people.

Table 1: Interpersonal Communication (IPC) Behaviors

Overall Socio-emotional Communication

These nine behaviors reinforce ways to make people feel comfortable with their health care provider

- Welcome the person warmly in a culturally-accepted manner.
- Use appropriate verbal and non-verbal communication (gestures, mimics, words, the way you sit).
- Ask about the patient's feelings.
- Compliment the patient's efforts (for coming themselves or bringing their child to the encounter).
- Legitimize (reinforcing feelings that are normal).
- Show empathy.
- Reflect the patient's emotions to encourage him or her to speak more (echoing what patient has said).
- Be supportive and establish a partnership with the patient.
- Reassure the patient (helping the patient not worry by suggesting specific things he or she can do). It is the provider's tone of voice and attitude which mostly sets the tone of the social-emotional aspect of the encounter.

Problem Solving Skills

These seven behaviors help providers gather the information necessary for making a diagnosis.

The systematic use of data-gathering skills enables providers to become more proficient.

- Listen attentively (actively).
- Encourage dialogue by asking open-ended questions.
- Avoid interruptions.
- Avoid premature diagnosis. (Do not diagnose the problem before finding out all the details.)
- Resist immediate follow-up by listening carefully before making clinical decisions.
- Probe or explore for more information.
- Ask the patient about causes, difficulties and worries related to the problem.

Counseling and Information-Education-Communication (IEC)

These ten behaviors are effective ways to explain health issues, treatment, and needed decisions.

- Explore and find out what the patient's understanding of his or her illness is.
- Correct any misunderstanding about the facts.
- Use appropriate vocabulary.
- Present and explain what the patient needs to know or do in a logical way (in blocks).
- Discuss and give concrete behavioral changes the patient can make.
- Repeat and summarize key information.
- Motivate the patient to follow the recommended treatment.
- Check on acceptability/mutuality of decision-making (whether the patient is willing to follow the treatment regimen).
- Make sure the patient knows when to return for a follow-up visit.
- Ask the patient whether there is anything else he or she would like to know.

seriousness displayed in the role-playing simulations. Often the simulations were taking place in Arabic, allowing the participants to be more real in their role-play. Twice, participants came to the trainer talking in Arabic...even though the trainer did not speak one word in Arabic! This anecdote shows the importance of letting the participants “control” the cultural interaction—the trainer noticed that if, between themselves, the participants had a doubt, they would in English or French, ask the trainer her opinion or advice.

3. Follow-up and Evaluation of IEC Activities

After the completion of all training courses in January 1995, the Egyptian trainer and QA consultant visited the May 15 Hospital several times to observe the physicians and discuss the different factors influencing their IPC performance. The group of trained doctors and other staff felt that an evaluation of the IEC effort would be valuable to determine whether the training had any discernible impact on performance.

The trained doctors agreed to be observed by colleagues and to be compared with non-trained doctors. This assessment was carried out in the out-patient department six months after the IPC training course. The methods, measures, results and conclusions are discussed below.

Methods

Six physicians were trained in the use of the observation check list; three of them had received previous IPC training and three were untrained. Five nurses were trained to administer the patient exit interview; three of these nurses had received prior IPC training, two had not. Over a period of thirty days, the observers gathered data about 23 trained and 25 untrained physicians, specializing in pediatrics, orthopedics, gynecology, internal medicine, and general surgery. Each of these physicians was observed in two to five clinical encounters. A total of 194 observations were made. The average time of encounters was ten minutes. Of the encounters, 66 were studied by two observers in order to assess inter-observer reliability. Exit interviews were administered to patients immediately after they left the physician’s office. A total of 162 exit interviews were conducted. Because of time constraints or patient refusals, 32 interviews could not be conducted. Following observations, 53 provider interviews took place. The following table shows the overall observations made.

Number of Observations

69	observations for 23 trained physicians
125	observations for 25 untrained physicians
194	total observations
53	provider interviews (only 48 were included in the study)
162	exit interviews

Measures

Three instruments were used: 1) an observation check list to assess physician performance; 2) a questionnaire for physicians which focused on assessing the value of the IPC training and asked physicians to assess changes in their own performance as a result of the study; and 3) a patient exit interview which focused on patient satisfaction.

Observation check list: Structured observation is a systematic way of keeping a simple count of specific observable behaviors. In this case, observations were done with the help of a check list. The check list recorded behaviors that the QAP staff expected to see during an encounter as a result of training. The behaviors observed were as follows:

- 1. socio-emotional:** welcome patient, use positive non-verbal communication, repeat what patient said, show empathy
- 2. problem solving skills:** encourage dialogue, ask what causes problem, avoid premature diagnosis, explore for more information
- 3. patient counseling, information, education and communication:** present information in blocks, use appropriate vocabulary, give specific behavior recommendation, check acceptability of treatment.

The observation check list is presented in Appendix E, page E-13.

Physician questionnaire: The observed physicians were asked to complete a questionnaire after their monitored encounters. The questionnaire completed by trained doctors was slightly longer than that completed by the untrained group since the second part of the questionnaire focused on training outcomes. The physicians were asked to comment on what makes communication with patients difficult and what three things would help them improve the dialogue. Trained physicians were asked to name the most useful IPC skills they used during an encounter. The physician questionnaire is presented in Appendix E, page E-15.

Exit interview: Each patient received an exit interview. The questionnaire had 41 questions related to patient satisfaction and his or her relationship with the physician. Most patients responded to the questionnaire. However, some questionnaires were incomplete and therefore eliminated from the study. The exit interview instrument is presented in Appendix E, page E-17.

Results

A. Results of Observation

Based on the results of the observations, we cannot draw any conclusion about the impact of training, as the reliability test for observation failed. The intercoder reliability ranged from -0.10% to 0.55%, invalidating the analysis of the observations. The failure of the survey's methodology to identify differences in performance as a result of training could be attributed to several causes. First, the use of an observation check list for this IPC research was experi-

mental. We attempted to simplify the laborious coding methods that require audio-taping and coding of each utterance. While there might have been differences in performance, the resultant simplified instrument may not have been sensitive enough to detect them. Another factor which may have reduced reliability is that some of the observers did not have previous IPC training and did not receive adequate training in how to use the simplified instrument. This could have biased the observations and made the data statistically unreliable. Further, the sample size and method may have been inadequate to detect differences between groups.

In spite of the fact that the observational methodology employed was not reliable, we can say that the general attitude toward the IPC training was positive. The overall analysis of IPC skill performance shows that all physicians surveyed performed well in communicating with patients. Use of appropriate vocabulary was the skill that scored highest, with 93.3% of observed physicians using appropriate vocabulary with their patients. The lowest-ranking skills were “repeating what patient said” (59.3%) and “presenting information to patients in blocks” (51%).²

B. Results of the Provider Questionnaire

Fifty-three physicians completed a questionnaire at the end of the observed patient encounters. Of this group, 25 were trained physicians and 28 were not. Five physicians did not provide information about their IPC training and, therefore, were not included in the study.

Most doctors surveyed believed that the greatest obstacle in communicating with their patients is ignorance and low levels of education (45.3%). External interruptions and the lack of privacy were also frequently mentioned as obstacles, while 15% of the doctors did not believe they faced any difficulties. Physicians believed that a reorganization of the out-patient clinic would help them improve their services. Better equipment and facilities ranked second. Only a few physicians believed that IPC training would improve their performance. Lack of provider continuity was also perceived as an obstacle. Physicians felt that poor education was a barrier to patient compliance with prescribed treatment. All physicians cited lack of drugs and money to buy medication as important shortfalls.

Of the 25 trained physicians, 31% mentioned that a warm, appropriate welcoming of the patient really helped to improve the atmosphere of the encounter. More than 27% of the respondents mentioned that listening skills also improved interpersonal communication. Ensuring patient acceptance of treatment (16%) and showing empathy with the patient (11%) were equally important. Of the 25 trained physicians, 55% mentioned that they were still using the “job aid” pocket guide (see Appendix A) which helped them to frame the encounter and improve specific skills. All but one said they found it useful. Almost all of the skills were equally cited. All of the trained physicians agreed that, besides themselves and nurses, IPC training should be provided to other hospital personnel, including receptionists and orderlies in order to increase the overall quality of the hospital’s services and to enhance team-

2. Presenting information in blocks refers to a communication technique where physicians present their message to patients in coherent and logical categories of care such as treatment, side-effects, follow up and diet. This technique is expected to provide patients with information in an orderly manner and assists them in recalling important messages.

work and spirit among the employees. It is interesting to note that, among the physicians in the group, trained physicians seemed to value and recognize IPC's potential for improving care. This indicates that the training did raise awareness about IPC and promoted a positive attitude toward developing IPC skills among physicians. Based on self-reporting, it seems that providers made efforts to incorporate the new IPC skills into their practices by using the skills and the job aid.

C. Results of Patient Exit Interview

An exit interview of 41 questions was given to 162 patients. Most often it was the patient's first visit with the doctor. The results showed no significant difference in satisfaction levels between patients of trained and untrained providers. Ninety-nine percent of the time, the patients expressed great satisfaction in the care they received. Patients felt they were welcomed (93.8%), received respect (93.8%) and were listened to attentively by their doctor (98%). Some patients expressed that they were often interrupted by external factors, such as someone entering the room. They mentioned that sometimes the doctors did "cut them short." They felt encouraged by their doctor to buy or take the prescribed medicine. They did not think it was important that doctors asked their opinion and feelings about their health problems, complaints and concerns. In general, patients noticed that on the day of the visit they were treated in a better way. Some patients mentioned that on that day they got more time, more explanation, and more care than usual. They all said they understood their doctor fairly well and that their doctor explained the treatment regimen fully. Overall, they were quite satisfied.

Conclusions and Lessons Learned

Based on these results, we cannot conclusively say that the IPC workshops given to physicians, nurses and the QAP staff in Egypt resulted in changes in performance or improved satisfaction. However, the training succeeded in raising provider awareness about the importance of communication and encouraged providers to develop and maintain their IPC skills on par with their clinical skills. Trained doctors suggested that the training course be given to more hospital personnel and that it be added to the university curriculum of medical students to allow them to provide better care.

Perhaps the most important implication of this study is the need to develop effective and sensitive evaluation methods so that differences between groups can be detected. The observation check list that we developed was not reliable, and we believe that further experimentation with check lists (and sampling) should be carried out before this method is abandoned or judged categorically unreliable.

This study also demonstrated that exit interviews may not be the best methodology to analyze patients' opinion about the care they receive. In the Egyptian culture, patients are not used to being asked about their opinion and may have been trying to be cordial to the interviewers and to the physicians. Focus group discussions may prove to be a better approach for analyzing patients' opinion. This study demonstrates the need to improve research design methods to help us better analyze quality-related problems and be able to improve them.



Job Aid
Training Manuals
Data Collection Tools
Bibliography



Appendix A

Job Aid



The following job aid can be cut out, folded, and used as a pocket guide.

Job Aid



Counseling— Education Giving

- ◆ Find out how client perceives illness
- ◆ Correct misconception of facts
- ◆ Use appropriate vocabulary
- ◆ Explain in an organized way what needs to be known/done next (in blocks)
- ◆ Check client's understanding about illness
- ◆ Recommend concrete behaviors to client
- ◆ Motivate client to follow treatment
- ◆ Make sure client accepts the treatment

Closing

- ◆ Make sure client knows when to come back
- ◆ Ask patient if there is anything else he/she would like to know

Skills Needed for Effective Interpersonal Communication

Self-Assessment Check List

Overall Socio-Emotional Communication

- ◆ Welcome patient
- ◆ Use verbal and non-verbal communication behaviors

CHS/QAP, JHU, AED, 1993

Guía de Ayuda

La siguiente guía de ayuda en el trabajo se puede cortar, doblar, y utilizar



Asesoría/Información/Educación

- ◆ Descubra cómo percibe la enfermedad el cliente
- ◆ Corrija las ideas equivocadas de los hechos
- ◆ Utilice el vocabulario adecuado
- ◆ Explique de forma organizada lo que se necesita saber/hacer a continuación (en bloques)
- ◆ Compruebe la comprensión que tiene el cliente acerca de la enfermedad
- ◆ Recomiende al cliente comportamientos concretos
- ◆ Incite al cliente a que continúe el tratamiento
- ◆ Asegúrese de que el cliente acepte el tratamiento

Cierre

- ◆ Asegúrese de que el cliente sabe cuándo volver
- ◆ Pregunte al cliente si desea saber algo más

GUIA PRACTICA PORTATIL

Destrezas Requeridas para una Comunicación Interpersonal Eficaz


Para los Proveedores de Salud Hondureños

Comunicación Socioemocional General

- ◆ Dé la bienvenida al paciente
- ◆ Recorra a comportamientos de comunicación verbal y no verbal


CHS/QAP, JHU, AED, 1993

Job Aid



Guidelines To Talk With Patient — Dialogue	Problem Solving Skills — Gathering Data
<ul style="list-style-type: none">◆ Ask for feelings◆ Compliment patient efforts◆ Reinforce feelings that are normal and understandable◆ Reflect the patient's emotions<ul style="list-style-type: none">· repeat what patient said· invite him/her to speak more◆ Show empathy◆ Show support/partnership◆ Help patient not to worry	<ul style="list-style-type: none">◆ Listen effectively◆ Encourage dialogue: ask open-ended questions◆ Avoid interruption◆ Avoid premature diagnosis◆ Resist immediate follow-up◆ Probe (explore) for more information◆ Ask about causes, difficulties and worries related to the problem

Guía de Ayuda



Pautas para Hablar con el Cliente — Diálogo	Destrezas para Resolver Problemas— Recopilación de Datos
<ul style="list-style-type: none">◆ Averigüe qué siente el paciente◆ Felicite al paciente por sus esfuerzos◆ Refuerce los sentimientos normales y comprensibles◆ Refleje lo que el paciente dice<ul style="list-style-type: none">· repita lo que dice el paciente· invítele a hablar más◆ Demuestre empatía◆ Demuestre apoyo/camaradería◆ Ayude al paciente a no preocuparse	<ul style="list-style-type: none">◆ Escuche con eficacia◆ Alente el diálogo: haga preguntas abiertas◆ Evite la interrupción◆ Evite el diagnóstico prematuro◆ Resista el seguimiento inmediato◆ Indague (explore) para obtener mayor información◆ Averigüe las causas, dificultades y temores relacionados con el problema

Use this page to make additional copies of the Job Aid

Job Aid

Counseling— Education Giving

- ◆ Find out how client perceives illness
- ◆ Correct misconception of facts
- ◆ Use appropriate vocabulary
- ◆ Explain in an organized way what needs to be known/done next (in blocks)
- ◆ Check client's understanding about illness
- ◆ Recommend concrete behaviors to client
- ◆ Motivate client to follow treatment
- ◆ Make sure client accepts the treatment

Closing

- ◆ Make sure client knows when to come back
- ◆ Ask patient if there is anything else he/she would like to know

Skills Needed for Effective Interpersonal Communication

Self-Assessment Check List

Overall Socio-Emotional Communication

- ◆ Welcome patient
- ◆ Use verbal and non-verbal communication behaviors

CHS/QAP, JHU, AED, 1993

Guía de Ayuda

La siguiente guía de ayuda en el trabajo se puede cortar, doblar, y utilizar

Asesoría/Información/Educación

- ◆ Descubra cómo percibe la enfermedad el cliente
- ◆ Corrija las ideas equivocadas de los hechos
- ◆ Utilice el vocabulario adecuado
- ◆ Explique de forma organizada lo que se necesita saber/hacer a continuación (en bloques)
- ◆ Compruebe la comprensión que tiene el cliente acerca de la enfermedad
- ◆ Recomiende al cliente comportamientos concretos
- ◆ Incite al cliente a que continúe el tratamiento
- ◆ Asegúrese de que el cliente acepte el tratamiento

Cierre

- ◆ Asegúrese de que el cliente sabe cuándo volver
- ◆ Pregunte al cliente si desea saber algo más

GUIA PRACTICA PORTATIL

Destrezas Requeridas para una Comunicación Interpersonal Eficaz

Para los Proveedores de Salud Hondureños

Comunicación Socioemocional General

- ◆ Dé la bienvenida al paciente
- ◆ Recorra a comportamientos de comunicación verbal y no verbal

CHS/QAP, JHU, AED, 1993

DO NOT CUT OUT — USE AS A MASTER ONLY

Use this page to make additional copies of the Job Aid

Job Aid



Guidelines To Talk With Patient — Dialogue

- ◆ Ask for feelings
- ◆ Compliment patient efforts
- ◆ Reinforce feelings that are normal and understandable
- ◆ Reflect the patient's emotions
 - repeat what patient said
 - invite him/her to speak more
- ◆ Show empathy
- ◆ Show support/partnership
- ◆ Help patient not to worry

Problem Solving Skills — Gathering Data

- ◆ Listen effectively
- ◆ Encourage dialogue: ask open-ended questions
- ◆ Avoid interruption
- ◆ Avoid premature diagnosis
- ◆ Resist immediate follow-up
- ◆ Probe (explore) for more information
- ◆ Ask about causes, difficulties and worries related to the problem

DO NOT CUT OUT — USE AS A MASTER ONLY

Guía de Ayuda



Pautas para Hablar con el Cliente — Diálogo

- ◆ Averigüe qué siente el paciente
- ◆ Felicite al paciente por sus esfuerzos
- ◆ Refuerce los sentimientos normales y comprensibles
- ◆ Refleje lo que el paciente dice
 - repita lo que dice el paciente
 - invítele a hablar más
- ◆ Demuestre empatía
- ◆ Demuestre apoyo/camaradería
- ◆ Ayude al paciente a no preocuparse

Destrezas para Resolver Problemas— Recopilación de Datos

- ◆ Escuche con eficacia
- ◆ Alente el diálogo: haga preguntas abiertas
- ◆ Evite la interrupción
- ◆ Evite el diagnóstico prematuro
- ◆ Resista el seguimiento inmediato
- ◆ Indague (explore) para obtener mayor información
- ◆ Averigüe las causas, dificultades y temores relacionados con el problema

Training Manual for IPC

EGYPT



Training Manual

**Interpersonal Communication (IPC)
Skills for Primary Health
Care Providers**

Egypt

January 1995



Quality Assurance Project

Center for Human Services

in collaboration with

The Academy for Educational Development

and

The Johns Hopkins University

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Acknowledgement

The present manual has been realized by the Quality Assurance Project (QAP), a project funded by the United States Agency for International Development (USAID) and conducted by the Center for Human Services (CHS), in collaboration with the Academy for Educational Development (AED) and The Johns Hopkins University (JHU). This Interpersonal Communication (IPC) manual was originally adapted from “Communication Strategies in the Medical Interview,” a Pfizer project, USA. It was created to respond to the needs of a validation study on Interpersonal Communication skills carried out in Honduras by QAP in 1993-1994. This manual served for the training intervention of the study. We recognize the contribution of the Honduran health providers who attended the course and improved its quality.

In July 1994, this course was given to medical staff from the May 15 Hospital in Cairo, Egypt. We thank the Egyptian medical doctors who improved this course.

Abbreviation List

AED	The Academy for Educational Development
CHS	Center for Human Services
IEC	Information Education Communication
IPC	Interpersonal Communication
JHU	Johns Hopkins University
QAP	Quality Assurance Project
USAID	United States Agency for International Development

INTERPERSONAL COMMUNICATION (IPC) SKILLS FOR PRIMARY CARE PROVIDERS

Introduction

This training manual for improved interpersonal communication skills has been developed by the Quality Assurance Project of the Center for Human Services (CHS) in collaboration with The Johns Hopkins University (JHU) and The Academy for Educational Development (AED) to be adapted and applied to the needs of the Egyptian health system. The principal training objective is to enhance the communication skills of health providers and improve their interpersonal interactions with patients, so that health outcomes will improve. The training will also concentrate on improving communication skills in the work place, so that work relations will be improved. The training is designed so that Egyptian training experts can easily replicate the course throughout the country as appropriate.

The training activity will employ a variety of training methods to ensure that participants develop new skills, enhance their sense of self-efficacy and apply state-of-the-art interpersonal communication methods, building on their existing skills and strengths. The methods to be used will include:

- ◆ Brief presentations about specific communication skills that will include concrete examples of “do’s” and “don’t’s”.
- ◆ Participatory plenary sessions that employ brainstorming and question and answer sessions so that participants can “discover” the new skills for themselves.
- ◆ Dynamic role plays which will demonstrate the various communication strategies and allow participants to practice these methods.
- ◆ Videotapes will be used as instructional tools as appropriate. Mental rehearsal techniques will also be used to allow participants to explore what aspects of the new interpersonal communication skills will be most easy or difficult for them, and how they as individuals will overcome these difficulties.
- ◆ A practicum will also form a part of the course. Each participant will audio-tape some actual patient encounters. Audio-tapes will be analyzed and critiqued by the group so that each provider can get specific feedback and suggestions about how to improve. In Egypt, a videotape of actual Egyptian encounters will be used to reinforce and demonstrate IPC skills.

Objectives of the Training

- ◆ To enhance the communication skills of health providers and improve their interpersonal interactions with patients, so that patient's satisfaction, compliance, and health outcomes will improve.
- ◆ To enhance the communication skills of health providers and improve their interpersonal interactions with colleagues, so that their work relations will be smoother and their work more efficient.
- ◆ To focus on the interpersonal communication skills that are recognized by the Egyptian health providers as the most used and acceptable within the Egyptian context.
- ◆ To enable Egyptian training expert(s) to replicate the course throughout the country as appropriate.

Content of the Course

I. DAY 1: Interpersonal Communication (IPC) Skills (4 and one-half hours of instruction)

1. Introduction: (2 hours)
 - A. Orientation to IPC intervention
 - B. Basic concepts of IPC
2. Skills needed for effective communication (2 hours, 30 min.)
 - A. Socio-emotional communication skills

II. DAY 2: Interpersonal Communication (IPC) Skills (4 and one-half hours of instruction)

1. Skills needed for effective communication, (cont.) (3 hours)
 - A. Problem solving skills
 - B. Counseling and IEC
2. Group review and analysis of participant audiotapes (participant teams identify strengths, weaknesses and recommendations) (time depends on option).
3. Skills practice (transcripts, role-play, mini-case studies)
4. How to keep alive these skills - Job aid use (15 min.)

III. DAY 3: Interpersonal Communication (IPC) Skills between Health Providers (4 hours of instruction)

1. Issues causing difficulties in working environment and the role of IPC skills in working environment (3 hours)
2. Participants' evaluation of course (30 min.)
3. Recommendations about future IPC training in country (30 min.)
4. Closing session - certificate (30 min.)

Training Content

DAY 1

This first day (4 and one-half hours) of the course is divided into two parts:

- (1) A two hour plenary session for (a) an introduction: presentation of trainers and participants, (b) a revision of the basic concepts of Interpersonal Communication (IPC).
- (2) A 2 and one-half hour session to review the skills needed for effective communication. Participants will be divided into small groups of 4-5. The groups will be guided by trainer(s). Flip charts or transparencies, slides, and video films will be used. Skills will be learned through role plays and simulation carried out by participants and/or trainers. Findings/comments will be presented in plenary. There is no need to lecture. Prove to the participants that they have the skills, which just need to be reinforced or changed/improved.

Note: This training manual is made for the participants, but includes comments (trainer's notes) that can help anyone who feels able to facilitate the course. Encourage participants to use their manual, adding their personal notes/comments.

A. Introduction (30 minutes)

Trainer's Notes

Subject — Activities

(a) Co-trainers introduce themselves.

(b) Icebreaker exercise:

Participants work in pairs: They listen to each other for two minutes, then present their partner to the group.

(c) Principal trainer presents training objectives.

Co-trainers can finish their presentation by stating three things that they particularly like and two things that they don't like.

Transparency 1

Objectives of the IPC training

- ◆ To enhance the communication skills of health providers and improve their interpersonal interactions with patients;
- ◆ To enhance the communication skills of health providers and improve their interpersonal interactions with colleagues;
- ◆ To focus on the interpersonal communication (IPC) skills that are acceptable within the Egyptian context;
- ◆ To enable Egyptian training expert(s) to replicate the course throughout the country as appropriate.

NOTE: The trainer can briefly go over the agenda and the participants' manual with them, in order to familiarize the participants with its format.

B. Basic Concepts of Interpersonal Communication *(one hour and half)*

Values Clarification

Trainer introduces the session with an exercise on values.

Different characteristics of Interpersonal Communication (IPC)

Brainstorming with participants on the characteristics of IPC (verbal and nonverbal).

Non-Verbal Communication

Body talk: Group members take turns trying to express various emotions with their bodies/faces. Other participants try to guess the feelings expressed.

Simulation: ask the participants to form pairs and ask them to identify themselves as A and B. Ask that all A's talk for 3 minutes; B's cannot interrupt or say anything, but only pay attention to what is said by A's. After 3 minutes, ask them to switch; now B's will talk and A's will be listening.

In plenary, discuss participants' feelings with them.

Ask participants if they sometimes communicate negative messages, especially non-verbal ones. Which ones?

Trainer's Notes

Give to the participants the "list of values" (*annex 1*) and ask them to fill it out individually. Tell participants that all answers are good. (*5 minutes*).

Coding will be made later on by a co-facilitator/co-trainer. Conclusion on values clarification will be given once the results are known. (*see annex 1 bis for additional information for coding. Use it for transparency #2 to present results*).

When concluding, ask participants the meaning of the results: why are they different? Why is it important to talk about values?

Transparency 2

Use Annex #1 bis, filled out with group's results.
--

e.g., fright, anger, boredom, happiness, etc.

First ask for non-verbal communication (behaviors), body language, visual contact, feelings (embarrassment); ask for specificity regarding body expressions: comfort, comprehension, help.

Possible answers: distraction, by phone calls, someone coming in, facial expression, no chair for client.

Listening Skills

Discuss with participants the importance of listening.

Conclude with participants talking about the different aspects of intercultural communications and the importance of interpreting non-verbal communication accurately.

Language Efficiency

Exercise: translation—the use of simple language. Read and show an example of a text which is difficult to understand. Ask the participants to propose a simple text.

Distribute the sheet (annex 2): “Language efficiency: “Translate” the medical information” and ask them to work individually (5 min). Ask volunteers to read their “translation”.

Trainer’s Notes

Refer participants to annex #2 “self-evaluation of listening skills”.

Possible answers:

- ◆ It helps clients release their feelings, fear or anxiety; expressing these feelings makes the client feel better;
- ◆ It helps clients to become less afraid to share information that might be embarrassing;
- ◆ It encourages clients to communicate, to share information;
- ◆ It treats the client like an adult, rather than a child, and therefore facilitates problem solving by the client;
- ◆ It encourages them to find solutions to their own problems;
- ◆ It promotes a warm and close relationship with the hospital staff.

Too often we complicate language, using words that people do not understand. This exercise will help us to “translate” difficult terminology by simple words that our clients will understand.

Show transparency #3: example of language too difficult, and its “translation.” Sheet in annex # 3 for the exercise: “Translation - Language efficiency”.

Transparency 3

Language efficiency

COMPLICATED LANGUAGE

“Voluntary surgical contraception is a surgical procedure for permanent contraception. In women, the operation involves blocking or cutting both fallopian tubes to prevent the passage of both ova and sperm.”

SIMPLE LANGUAGE

“People can choose to have an operation that will prevent them from having any more babies. In women, the tubes (ropes) are tied so that eggs and sperm can’t meet.”

Trainer's Notes

Discuss why it is important to use simple and direct words.

Possible answers: to avoid misunderstanding, to avoid creating myths,

At the end of the exercise, refer participants to “Give Clients clear information in a way they understand” (annex #4).

Definition of Interpersonal Communication (IPC)

Lead participants in discussion on the definition of IPC.

Write participants definition on the blackboard, using their words. Inputs are given until all the elements of interpersonal communication are present, using participants' words. If wanted, a general definition can be shown (transparency # 4).

Transparency 4

Definition of Interpersonal Communication (IPC)

IPC is the face-to-face, verbal and non-verbal exchange of information or feelings between two or more people.

Slides presentation: Introduction to IPC (use of posters, radio and TV spots; encounter between two persons; different levels of communication; IPC: verbal and non verbal, attitudes, expressions, external look -12 slides from PCS/JHU).

If the slides are not available, discuss with the group the different levels of communication, and the importance of each one. Show how complementary they are.

The facilitator explains each slide. The last slide shows the different levels of communication. Refer participants to annex #5 “Levels of Communication”. Show that the interpersonal communication level is at the central point. Talk about the impact and role of the different modes of communication.

2. Skills Needed for Effective Communication *(2 and one-half hours)*

Trainer explains that the skills that are presented next are not new. They are sometimes by-passed due to other obligations, or are not perceived as important. This training has two objectives: (1) offer techniques to reinforce the Interpersonal Communication skills, and (2) see how to integrate them within the actual structured encounters carried out by the Egyptian doctors (transparency #5: objectives).

By mastering the techniques presented, the clinician develops not only more skills, but a framework for their application. The skills are presented in three parts: (1) Overall Socio-emotional Communication Skills: Guidelines for talking to patients, (2) Problem Solving Skills, (3) Counseling, Education and Information giving skills (transparency #6). However, trainer emphasizes that in real life, an encounter does not always occur at the same sequence. What is important is that the interpersonal communication skills take place during the encounter. At the beginning of the session, participants receive a “job aid”. Each one can complete it with their preferred examples. In annex # 6, the job aid is presented. To use, cut out and fold. (We provide you with two of them.)

A. Overall Socio-Emotional Communication: Building Rapport and Responding to Clients’ Emotions: Guidelines for Talking with Patients

(1 hour and 30 minutes)

Mini-presentation: With the help of transparencies (*tr.* #7, 8), the main trainer briefly gives (1) the definition of socio-emotional communication and (2) explains 9 behaviors that reinforce the interpersonal contact between the client and the provider.

I. Definition of socio-emotional communication: the provider establishes and maintains a positive rapport with the client throughout the encounter. Positive regard means a set of techniques helping the provider to show receptivity and respect to the patient (*transparency #7*).

Transparency 5

Objectives of the training

- (1) offer techniques to reinforce the Interpersonal Communication skills;
- (2) see how to integrate them within the actual structured encounters carried by the Egyptian doctors;
- (3) see how to reinforce them to allow better work relations.

Transparency 6

Interpersonal Communication Skills

- (1) Overall Socio-emotional Communication Skills: Guidelines for talking to patients,
- (2) Problem Solving Skills,
- (3) Counseling, Education and Information giving skills.

Transparency 7

Definition of socio-emotional communication

The provider establishes and maintains a positive rapport with the client throughout the encounter.

2. The following nine behaviors will help the provider to achieve this goal, reinforcing the interpersonal contact between him/her and the patient.

Transparency 8

Behaviors that Reinforce the Interpersonal Contact Between the Client and the Provider

- ◆ Framing statement
- ◆ Appropriate non-verbal communication
- ◆ Ask for feelings
- ◆ Compliment patient efforts
- ◆ Legitimation
- ◆ Empathy
- ◆ Reflection (repetition)
- ◆ Support
- ◆ Statement of reassurance

Skills — Techniques

Framing Statement

The purpose of framing the encounter is to establish a comfortable atmosphere for the patient to disclose emotional material, fear, worries and concerns.

Ask two participants to role play the beginning of an encounter: “Welcome patient and frame the encounter”

Ask participant to give examples of a personalized framing statement. Share statements with group.

Appropriate Non-verbal Communication

Discuss/list non-verbal behaviors. Analyze appropriateness. Ask each provider to select **3** non-verbal behaviors that would improve his/her communication: (demonstrate active listening; avoid distractions; maintain eye contact; facilitate conversation by sitting and facing each other, avoid being separated by a table...)

Trainer’s Notes

Be sure that role-players welcome patient. Frame the encounter, such as: “*I am Dr. _____, How are you today? What can I do to help you?...*”

Use verbal and non-verbal communication behaviors. Talk about what was done during the first part of the training. Ask participants to save their chosen non-verbal behaviors to write them on their “job aid” at the end of the session.

Skills — Techniques

With the help of a transparency (*tr. #8*), and with participants' comments, the trainer presents the remaining 7 skills to the participants. The main objective of this part of the encounter is that the provider will do his/her best to understand and share common feelings with the client by applying the following:

Ask for feelings

It is important to respond to a client's feelings, so that he/she sees that the provider is attentive and interested.

Compliment patient efforts

These statements make the client feel respected, valued or approved of.

Legitimation

Reassure the client that his/her feelings and reactions are normal and to be expected.

Empathy

One experiences empathy when one can feel another's feelings or understand problems from another perspective than his/her own. Provider should let client know that he/she accepts the client's emotions.

Reflection (repetition)

Reflection refers to an intervention by the doctor that simply puts into words the client's emotions that the provider observes.

Support

Explicit statements of support can solidify the client's relationship with the provider. It emphasizes the provider's personal commitment to help the client. This support is often better expressed through the tone of the voice than the specific words used.

Statement of Reassurance

Many clients seek reassurance from their providers. However, it is important not to reassure too soon, until diagnosis is confirmed.

Trainer's Notes

"How did you feel about this?"

"What worries you most about it?"

"How does your spouse feel about that?"

"I am pleased to see that you came back for your appointment as planned."

"You did the best for your child, ..."

"Most people react to your situation in just the same way."

"You should know that your reactions are entirely normal under the circumstances".

"I am sorry that this has happened to you..."

"I feel bad for you"

"You seem to be having a lot of pain (worry, stress, etc.)..."

"I can tell that this is upsetting for you"

"Let me know what I can do for you"

"Please do come back if you need further help"

"Your condition is not so serious; if you follow my instructions you have an excellent chance of getting better."

Exercise: Practice of IPC Skills (1 hour)

Participants (1) listen to the audiotape of the local encounter(s); (2) with transcript of encounters taped in the country (see annex #7), participants work in groups and look at ways of improving the encounters including the (new) skills just reviewed (just the socio-emotional ones at this time). Group presentation in plenary, discussion and conclusion (1h).

DAY 2

It's good to start the day reviewing the skills that the participants practiced the day before. Let the participants discuss among them, and exchange ideas and feelings. Ask for example which ones they believe are the most useful.

B. Problem Solving Skills: Gathering Data to Understand the Clients' Situation and Problems (1 hour, 30 min.)

The trainer presents to the participants the problem solving skills (*transparency #9*). He/she introduces the topic by saying that an accurate diagnosis depends largely on the provider's ability to obtain the necessary information from a patient. Most providers are quite skilled in processes related to gathering data to understand patients' problems. However, some problems may exist in the communication style, for example by interrupting the patient and by jumping too quickly to conclusions. By using data-gathering skills in a more systematic manner, the providers can become more efficient and effective interviewers.

Transparency 9

Problem Solving Skills

- ◆ Effective listening, or attentive/active listening
- ◆ Encourage dialogue
- ◆ Avoid interruption
- ◆ Avoid premature diagnosis
- ◆ Resist immediate follow-up probing
- ◆ Probe for more information
- ◆ Ask patient what seems to cause the problems.

Skills—Techniques

Effective listening, or attentive/active listening, is a technique of unspoken communication that helps to put patients at ease. The provider shows interest by being patient, does not interrupt.

Encourage dialogue.

Dialogue is encouraged by asking questions that require the patient to generate an answer more complete than simply “yes” or “no”. They offer the patient an opportunity to disclose problems more

Trainer's Notes

Active listening can be complemented by some “verbal” intervention which encourages the patient to continue talking. Use both verbal and non-verbal communication skills: “*uh-huh, I see, tell me more,*” etc., head nod, eye contact...

“Open-ended questions” about patient's complaint: “*Describe when you noticed your first symptoms of discomfort.*” “*Describe when your child started to eat less.*”

Skills—Techniques

freely. These are the “open-ended” questions vs. the “close-ended questions”. Once the patient has provided a history of the problem, the provider can gradually narrow the focus to investigate a specific diagnosis and finish the dialogue by a few close-ended questions.

Avoid Interruption. The provider lets the patient explain his/her problems.

Avoid premature diagnosis. (=Resist immediate follow-up) The provider avoids jumping to conclusions when the patient elicits a problem.

Probe for more information. The provider questions the patient (open-ended) to be sure that (s)he had the chance to explain all the concerns. By probing, the provider examines, explores all possibilities.

Ask patient: what seems to cause the problems, what are the difficulties, any other worries?

Trainer’s Notes

A study conducted in 1984 in the US by Beckman & Frankel on the effect of physician’s behavior on the collection of data found that most patients were interrupted within 18 seconds of their initial presentation of complaints, as the physician directed questions toward a specific concern. The implication of this finding is that physicians probably spend time on problems that may not be the most significant to the patient. The same researchers found that no patient used more than 150 seconds to complete an entire opening statement.

Listen well before recommending a solution or treatment. DO NOT: “*For the headache you mentioned, just take an aspirin each time it hurts.*”

“*Do you have any other concerns that you would like to tell me about?*”

“*Tell me more about your child’s loss of appetite?*”

“*Tell me how you feel when you wake up in the morning?*”

The provider will use “open-ended” questions to investigate the causes of the problem and make a diagnosis: “*Why do you think....Are there any problems at home?*” The questions might become close-ended to help to focus.

Exercise: Practice of IPC Skills (1 hour)

Participants form pairs “A and B” to role play a scenario. (Refer to annex #8). The script instructs the patients (“participants A”) to only tell the doctor what he asks for. The providers (“Participants B”) are to find out all they can using new skills in 5 minutes. Then the members of the pair switch roles with a new script (annex #9). Discuss experience and relate it to actual practice.

Attention: When giving the instructions (Guide for Simulation) DO NOT give the entire Annex 8, then 9 to all participants; first cut the annex: half for participants A, the other half for participants B, as they are not supposed to know the patients’ problems.

C. Counseling and Information/Education Giving (1 hour, 30 min.)

Participants brainstorm on “What is counseling?” and come up with their definition. Show transparency #10.

The techniques for better counseling and information giving are introduced by showing a video to the participants, or by a role play of a counseling session (*see annex # 10*). Participants work in group, or in plenary, discussing which skills they noticed. Participants should then look for appropriateness in their own settings. Ask them how they would adapt, or how they would counsel clients. Each participant will work on a “mental rehearsal”: describe a client and diagnosis (*see annex # 11*). Each participant imagines giving the counseling. The participants record the ways they approached the counseling session. Share in plenary (30 min.). Show the list of skills that will help the health provider to conduct good counseling (*transparency # 11*). Each skill is discussed, and concrete examples are given for each one.

Transparency 10

Definition of Counseling

A person-to-person interaction in which the provider gives adequate information which will enable a client to make an informed decision about his/her health. Counseling helps the client to understand his/her feelings and deal with his/her specific, personal concerns. Effective counseling empowers a client to make his/her own decisions.

Transparency 11

Counseling and Information/ Education Giving

- ◆ Explore client’s understanding of illness
- ◆ Correct misconception of facts
- ◆ Use appropriate vocabulary
- ◆ Present/explain what clients needs to know/do to get better (in blocks)
- ◆ Check client’s understanding of illness, correct misconceptions
- ◆ Discuss/give concrete behavioral changes that client can accomplish
- ◆ Repeat, summarize key information
- ◆ Convince or motivate client
- ◆ Check on acceptability/mutuality of decision making
- ◆ Closing.

Skills — Techniques

Explore client's understanding of illness.

Before the patient hears the provider's diagnosis, the provider will find it useful to listen to the client's own thoughts on the cause of the illness. Clients may reveal information and emotions that can help providers determine the clinical diagnosis, or give the patients better understanding of their discomfort.

Correct misconception of facts and provide information and education about important related issues.

Use appropriate vocabulary and assess the patient's level of understanding before choosing the way to explain the diagnosis.

Present/explain what clients needs to know/do to get better (in blocks).

Use short sentences that will be remembered easily. Pause frequently and repeat the key details.

Check client's understanding of illness, correct misconceptions.

When the provider is satisfied with the scope and depth of information presented, (s)he should check the patient's understanding. Only the client can confirm what is understood. This is best done with open-ended questions.

Discuss/give concrete behavioral changes that client can accomplish.

The provider does not ask the client to do something that (s)he finds impossible to accomplish.

Trainer's Notes

*"Tell me what you know about your condition?"
"What causes it?" "How can it be cured?"*

"From what we know about diarrhea, it is likely that it was caused by drinking contaminated water, or by eating contaminated food..."

"When you get home, give one small spoon of the medication to your child, and again another one tonight before bedtime. Tomorrow morning, be sure that he does not eat anything before going to the laboratory for the blood test. Come back to see me for your appointment this coming Monday at 9:00am. I'll have the laboratory results."

"I would like to make sure that I have made everything clear. Would you tell me how and when you are going to give the medicine to your child?" "What are the most important things that you will do when you get back home..." (participants can practice with annexes #8 and 9).

"According to what we discussed, you will go for a walk for 20 minutes each day." (DO NOT say: "Please try to exercise every day"). Or, "Present to your child the dinner you prepared for the family." (NOT: "Your child should eat more everyday.") But, "You said your child likes bananas, so you are going to give him one every day."

Skills — Techniques

Trainer's Notes

Repeat, summarize key information.

The provider makes sure that the main points are clear to the client.

“I'd like to remind you about 3 things that we talked about”: (1)..., (2)..., (3)...

Convince or motivate client.

The provider convinces the client that if (s)he does what they both decided, the situation will get better soon.

“You will progress rapidly if you follow these instructions”.

Checking on acceptability/mutuality of decision making.

The provider makes sure that the client understood the decisions taken and agreed.

“We will work together to make sure you (your child) get well.”

Closing.

Provider asks client if there is anything else (s)he would like to know. Provider praises and thanks the client for coming. The provider makes clear with the client when to come back.

“Is there anything else you would like to know? I'll see you next ...; thank you for coming”.

3. Orientation to the Practicum *(time depends on option)*

A. If Tape Recording Has Been Done Prior to the Session

(1) In groups, participants practice the [new] skills and techniques just revised by listening to the tape recording of health providers and clients' encounters. (2) Volunteers who are going to tape during their afternoon practice must have a tape recorder, know how to record, and have a tape to do the recording. If possible, volunteers tape two encounters; then listen to the tapes. (3) They should come back for “Day 3” with comments of their own performance.

B. If Tape Recording Has Not Been Possible

Participants form groups and practice the [new] skills and techniques. Use the transcripts of encounter (*an-nex#7*), this time focusing on the skills for gathering of the data, and counseling/information giving skills. Each group presents in plenary its findings. Finish the day by asking who, amongst the participants, is willing to tape one or two encounters. Volunteers who are going to tape must have a tape recorder, know how to record and have a tape to do the recording. Volunteers should come back for “Day 3” with comments of their own performance.

If participants have taped their encounters, start “Day 3” by listening to the tapes. The performer talks first about his/her experience. In plenary, review the skills. Trainer emphasizes the positive.

DAY 3

Interpersonal Communication Skills Between Health Providers *(4 hours)*

Contents

- ◆ Issues causing difficulties in working environment
- ◆ The role of IPC skills in working environment
- ◆ Participant's evaluation of course (10 minutes)
- ◆ Recommendations about future IPC training in Egypt in plenary (15 minutes)
- ◆ Closing Session (certificates, 10 minutes).

Introduction

The objectives of this day are to realize that IPC skills are playing an important role in our daily working environment and are closely linked with the different issues involved in our work.

The central principle of this day is that the participants do not need to be given a lot of new information to learn; rather they need an opportunity to exchange ideas, feelings, and experiences. This day will be designed principally by the participants who will, after brainstorming and group exercises, decide which issue, or problem, the participants want to focus their efforts on.

Subject — Activities

This day is introduced by asking the participants if they believe that the IPC skills revised during the past two days can be applied to their daily working relations with colleagues.

Issues causing difficulties in work environment.

Ask participants to work in groups on the different issues/dimensions that they perceive as being the cause of some difficulties in their work environment. Identify the problem(s). Each group presents its work. The overall work is outlined on the board.

Trainer's Notes

The answer is yes. Let participants brainstorm their ideas.

Possible answers

- ◆ poor leadership,
- ◆ poor (or lack of) supervision,
- ◆ lack of group dynamics,
- ◆ poor (or no) structure,
- ◆ lack of supplies,
- ◆ poor (or no) training,
- ◆ no feedback.

Subject — Activities

The role of IPC skills in work environment.

Basic principles and possible variables for each dimension are revised through mini case studies (prepared in Egypt and based on existing situation). For each one, participants are asked to present (1) the basic principles or characteristics of each dimension/area that they present; (2) IPC skills or variables that will improve the situation.

Once the problems have been discussed, have each group focus on one issue. The groups work on the problems identified and look for solutions: How can we “fix” these problems using the interpersonal communication skills just revised?

Evaluation

Each participant receives an evaluation form (annex 13, 10 minutes).

Recommendations

In plenary, the facilitator asks the participants to “brainstorm” on future similar training in Egypt: Do they think it’s necessary? To whom should it be given? Should the groups be mixed (medical doctors, nurses, midwives)?

Closing Session

- ◆ Each participant receives a certificate.
- ◆ Closing remarks by the facilitators.

Trainer’s Notes

Attention: If the answers are based on lack of supply, poor structure, lack of personnel, point out to the participants that IPC can do little about it. Ask them to concentrate in areas where IPC can play a positive role. Ask participants to work on groups with annex 11: Mini case studies: group dynamics, leadership, supervision.

Articles and supplementary readings are encouraged. They should cover the following topics:

- ◆ Issues in group process and decision making
- ◆ Synergistic team work
- ◆ Leadership
- ◆ How to be an effective supervisor.

List of Transparencies

<i>Transparency # 1</i>	Objectives of the Interpersonal Communication (IPC) Training
<i>Transparency # 2</i>	List of values— Group's results
<i>Transparency # 3</i>	Language efficiency— the use of simple language
<i>Transparency # 4</i>	Definition of Interpersonal Communication (IPC)
<i>Transparency # 5</i>	Objectives of the training
<i>Transparency # 6</i>	Interpersonal Communication Skills
<i>Transparency # 7</i>	Definition of socio-emotional communication
<i>Transparency # 8</i>	Behaviors that reinforce the interpersonal contact between the client and the provider
<i>Transparency # 9</i>	Problem Solving Skills
<i>Transparency # 10</i>	Definition of Counseling
<i>Transparency # 11</i>	Counseling and Information/Education giving

List of Annexes

<i>Annex # 1</i>	List of Values (Participant)
<i>Annex # 1 bis</i>	List of Values (Co-facilitator)
<i>Annex # 2</i>	Self-Evaluation of Listening Skills
<i>Annex # 3</i>	Translation— Language Efficiency
<i>Annex # 4</i>	Give Clients Clear Information in a Way They Understand
<i>Annex # 5</i>	Levels of Communication
<i>Annex # 6</i>	Job Aid (provided twice)
<i>Annex # 7</i>	Transcripts of an Encounter (from country)
<i>Annex # 8</i>	Problem Solving Skills: gathering data to understand the clients situation and problems (Simulation)
<i>Annex # 9</i>	Problem Solving Skills: gathering data to understand the clients situation and problems (Simulation)
<i>Annex # 10</i>	Role Play: A Good Counseling
<i>Annex # 11</i>	Counseling and Information/Education Giving - “mental rehearsal”
<i>Annex # 12</i>	Mini-case Studies
<i>Annex # 13</i>	Evaluation of the Course

ANNEX # 1 — Participant List

List of Values

INSTRUCTIONS:

Clarify the following words by order of importance: 1 - 14.

Give rate 1 to the most important to you and rate 14 to the least important.

_____ Good physical health

_____ Financial security

_____ Intelligence

_____ Education

_____ Cleanliness

_____ Marriage

_____ Children

_____ Success in performance

_____ Happiness

_____ Religion

_____ Friends

_____ Family reputation

_____ Citizenship

_____ Taking care of one's family

ANNEX # 1 bis — List for the Co-facilitator

List of Values

GROUP'S RESULTS: (List for the co-facilitator: coding. Write the results on a transparency (tr#2) made off this list of values. Show it in plenary when the results have been compiled. Explain results to the group)

	TOTAL	MEAN RATE	CLARIFICATION OF THE GROUP
Good physical health	_____	_____	_____
Financial security	_____	_____	_____
Intelligence	_____	_____	_____
Education	_____	_____	_____
Cleanliness	_____	_____	_____
Marriage	_____	_____	_____
Children	_____	_____	_____
Success in performance	_____	_____	_____
Happiness	_____	_____	_____
Religion	_____	_____	_____
Friends	_____	_____	_____
Family reputation	_____	_____	_____
Citizenship	_____	_____	_____
Taking care of one's family	_____	_____	_____

ANNEX # 2

Self Evaluation of Listening Skills

Please evaluate yourself:

Mark your levels of involvement (does it happen?) for each of the following statements:

Listening Habits	Levels of involvement			
	Always	Sometimes	Rarely	Never
Busy with something, i.e. writing while someone is talking	_____	_____	_____	_____
Pretends to be attentive to speaker, while thinking about something else	_____	_____	_____	_____
Cares only of about what to say next; does not listen	_____	_____	_____	_____
Not concentrating (day-dreaming) when someone else talks	_____	_____	_____	_____
Interrupts the other speaker	_____	_____	_____	_____
Looks for mistakes (details) by other speakers (does not concentrate)	_____	_____	_____	_____

Language Efficiency

“Translate” the Medical Information

Read the following examples of medical terminology and give examples of the way health workers should communicate the information to the client:

A. The clinical spectrum of cholera is broad, ranging from inapparent infection to severe cholera gravis, which may be fatal in a short time period. After an incubation period of 6 to 48 hours, there is an abrupt onset of watery diarrhea. Vomiting often follows in the early stages of the illness. Signs of severity include cyanosis, tachycardia, hypotension, and tachypnea. The symptoms and signs of cholera are entirely due to the loss of large volumes of isotonic fluid and resultant depletion of intravascular and extracellular fluid, metabolic acidosis, and hypokalemia.

(A)

B. The medical notes related to pregnancy are more important with adolescents, that is women under 20. Of concern are premature babies with inadequate weight at birth, maternal and infant mortality, anaemia and vascular-renal syndrome of pregnancy.

(B)

C. Other medical explanations you've heard or read:

(C)

D. How could you rephrase your medical example in words that the average client would understand?

(D)

ANNEX # 4

Give Clients Clear Information in a Way They Understand

The information you give clients must be correct and clear.

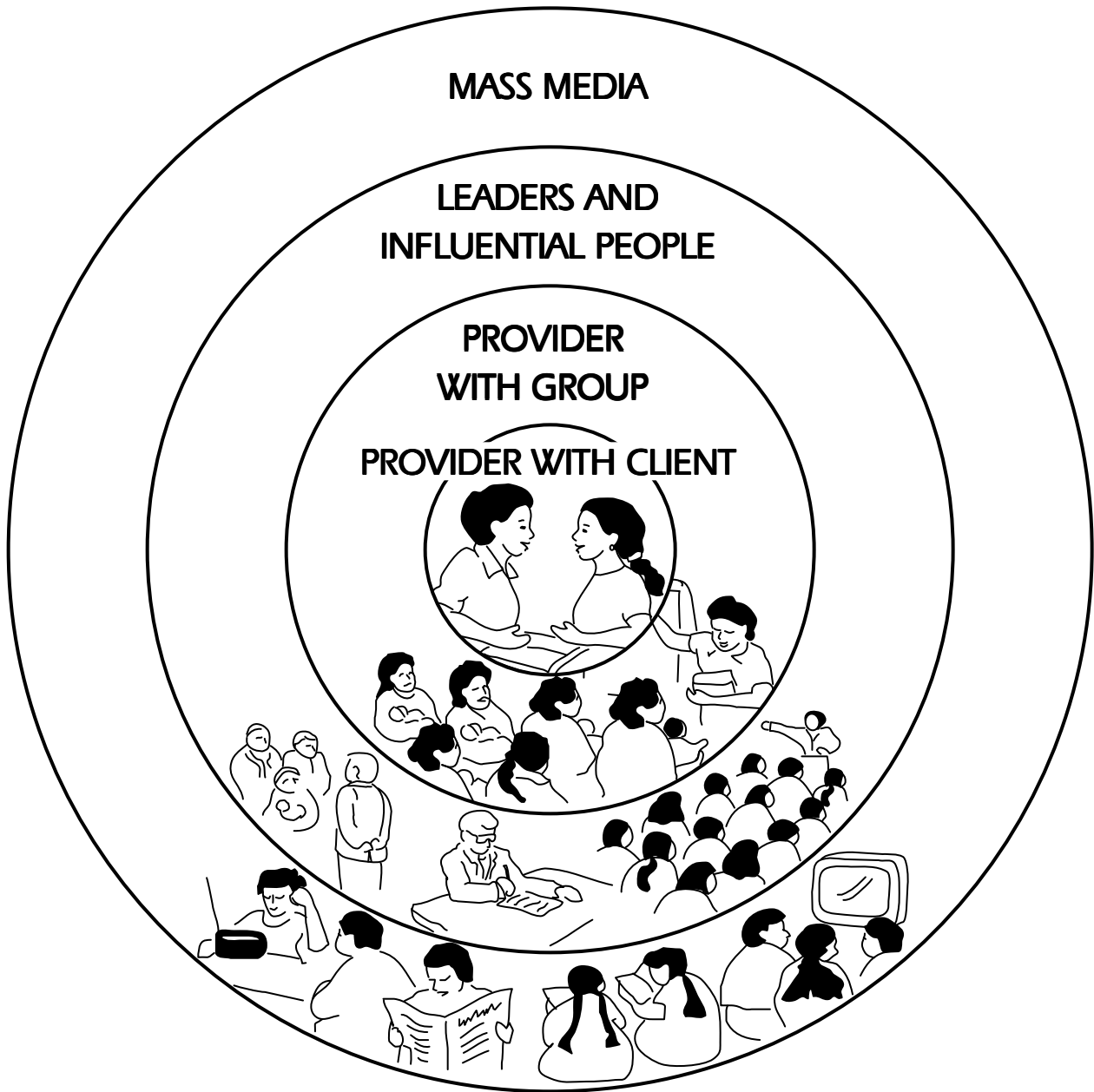
To make sure your information is clear:

- ◆ use short words and short sentences;
- ◆ use words that your clients understand;
- ◆ use pictures and print materials, if available;
- ◆ stop from time to time and ask clients if they understand;
- ◆ ask if they have questions;
- ◆ when you mention a part of the body, point to it;
- ◆ repeat instructions;
- ◆ ask clients to repeat instructions.

from: JHU/Popline, 1987, Population Reports, Series J., No. 36

ANNEX # 5

Levels of Communication



Source: JHU/Popline, Population Reports, Series J, No.36, Dec. 1987 "Why Counseling counts!"

The following job aid can be cut out, folded and used as a pocket guide (provided twice)

ANNEX # 6

Job Aid



Part A - Outside

Counseling— Education Giving

- ◆ Find out how client perceives illness
- ◆ Correct misconception of facts
- ◆ Use appropriate vocabulary
- ◆ Explain in an organized way what needs to be known/done next (in blocks)
- ◆ Check client's understanding about illness
- ◆ Recommend concrete behaviors to client
- ◆ Motivate client to follow treatment
- ◆ Make sure client accepts the treatment

Closing

- ◆ Make sure client knows when to come back
- ◆ Ask patient if there is anything else he/she would like to know

Skills Needed for Effective Interpersonal Communication

Self-Assessment Check List

Overall Socio-Emotional Communication

- ◆ Welcome patient
- ◆ Use verbal and non-verbal communication behaviors

CHS/QAP, JHU, AED, 1993



Part A - Outside

Counseling— Education Giving

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- ◆ Correct misconception of facts
- ◆ Use appropriate vocabulary
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Skills Needed for Effective Interpersonal Communication

Self-Assessment Check List

Overall Socio-Emotional Communication

- ◆ Welcome patient
- ◆ Use verbal and non-verbal communication behaviors

CHS/QAP, JHU, AED, 1993

Job Aid



Part B - Inside

Guidelines To Talk With Patient — Dialogue

- ◆ Ask for feelings
- ◆ Compliment patient efforts
- ◆ Reinforce feelings that are normal and understandable
- ◆ Reflect the patient's emotions
 - repeat what patient said
 - invite him/her to speak more
- ◆ Show empathy
- ◆ Show support/partnership
- ◆ Help patient not to worry

Problem Solving Skills — Gathering Data

- ◆ Listen effectively
- ◆ Encourage dialogue: ask open-ended questions
- ◆ Avoid interruption
- ◆ Avoid premature diagnosis
- ◆ Resist immediate follow-up
- ◆ Probe (explore) for more information
- ◆ Ask about causes, difficulties and worries related to the problem



Part B - Inside

Guidelines To Talk With Patient — Dialogue

- ◆ Ask for feelings
- ◆ Compliment patient efforts
- ◆ Reinforce feelings that are normal and understandable
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- ◆ Avoid interruption
- ◆ Avoid premature diagnosis
- ◆ Resist immediate follow-up
- ◆ Probe (explore) for more information
- ◆ Ask about causes, difficulties and worries related to the problem

ANNEX # 7

Transcripts of an Encounter

(To be done in country: Tape anonymously an encounter or two, and transcribe it as it is.)

ANNEX # 8

Problem Solving Skills: gathering data to understand the clients' situation and problems

Guide for a simulation

Instructions: To participant "A" (the client)

Please read the following. Answer ONLY what the health provider asks you (5 minutes of simulation)

You are sick, with a strong headache; you feel tired, and weak; you sweat, urinate a lot, and your urine is discolored. You eat well and you are always thirsty, but you notice that you are losing weight. Your mother and her brother have diabetes. You take aspirin for your headache, but it does not help! You don't know what to eat; your friend told you that you should drink orange juice and eat bananas.



Instructions: To participant "B" (the health provider)

You are the medical doctor (or the health provider). The person in front of you is here for a medical visit. Using the skills in interpersonal communication that we reviewed today, try to make a diagnosis in 5 minutes of what the woman (or man) has, and see what the next steps (laboratory tests, diet, drugs, changes of behavior) should be.

ANNEX # 9

Problem Solving Skills: gathering data to understand the clients' situation and problems

Guide for a simulation

Instructions: To participant "A" (the client)

Please read the following. Answer ONLY what the health provider asks you (5 minutes of simulation)

Two weeks ago you started giving supplementary food to your four month old baby because you believe that you don't have enough milk. Unfortunately, for a week your baby has not slept well because he got a cold (runny nose). He does not seem to like the food you are giving him, and since yesterday he has had diarrhea. You are very nervous and you don't know what to do. You know that your milk is diminishing. You do not work, and your mother is at home with you.



Instructions: To participant "B" (the health provider)

You are the medical doctor (or the health provider). The mother in front of you is here for a medical visit. Using the skills in interpersonal communication that we reviewed today, try to make a diagnosis in 5 minutes of what the woman has, and see what the next steps (laboratory tests, diet, drugs, changes of behavior) should be.

Role Play: A Good Counseling

(To be given ahead of time to two participants, so that they can get ready for it)

HEALTH SKETCH

A good example of counseling: place = center

Characters: nurse of the center
Mary (client)

Mary [enters in the center—the nurse smiles]

Nurse: Hello—please come in and have a seat.

Mary: I have four children. I want to be able to feed them and by the grace of God, send them to secondary school. The eldest is only six. My husband complains that they are too noisy. I am tired.

Nurse: Your husband and you are tired because your children are young. You would like to be able to take care of them, you don't want another baby. Are you thinking about using a contraceptive method?

Mary: Yes, I would like to take pills, but I'm afraid people say that it weakens you and that you can get pregnant even when using it.

Nurse: So, you are afraid that the pill is not an efficient method and that it will make you feel tired.

Mary: Yes.

Nurse: What else have you heard about pills?

Mary: They also say that it can give you cancer, but I'm not sure.

Nurse: Many people have the same fears. These fears are however not justified by any medical reason. The pill is one of the most efficient methods we have. If you take your pill everyday, you cannot get pregnant. Sometimes people forget to take it, or they take it only when necessary, not everyday. Of course they can get pregnant. Also, sometimes, women on pills can be tired for other reasons (they have too many children), but they don't think of the real reason of their fatigue and they put the blame on the pills. Moreover, the pill doesn't give cancer—it can even protect you against some cancers. But we also have other methods apart from pills that I can explain. Why do you want to try pills?

Mary: Well, I've heard about IUD, but I was told that it had to be put inside your body and that it could move from your stomach to your heart, so I'm afraid.

Nurse: I'm glad that you heard about the IUD, so you know that the pill is not the only choice—you are right when you say that it is put inside the body [shows one to her] but I can assure

you that where it is put, it's completely closed. The IUD cannot move, it is impossible. (Nurse shows her a diagram of the female reproductive system indicating the uterus and the position of the IUD.)

Mary: [nods]

Nurse: Have you heard about any other methods?

Mary: No, only those.

Nurse: We have several other methods that I'll explain to you. But since all the methods are not suitable for all women, I will ask you some questions to help you choose the one most suitable for you. [Nurse shows the client different methods: the condom, the foaming tablets, implants, injectables, etc. Nurse also explains the voluntary surgical sterilization procedures: tubal ligation and vasectomy].

Mary: I would like to have the voluntary surgical contraception. Many women simply call it TL.

Nurse: Yes. TL is the shortened form of Tubal Ligation which means tying the fallopian tubes to prevent the egg traveling from the ovary through the fallopian tubes to meet the male sperm in the uterus. If no egg meets the sperm, conception does not take place.

Mary: [nods agreement]

Nurse: Why would you like the TL? I thought you indicated earlier you wanted the pill...

Mary: Because we do not want any more children. Frankly speaking, my husband and I cannot afford a larger family. We have to prevent any risk of pregnancy in future.

Nurse: I am glad you say 'my husband and I'. This is a joint decision. You might wish to consult your husband and get his views and support before confirming your decision.

Mary: I know you're right and I am confident of my husband's support in the matter.

Nurse: Now that you have chosen this method, let me explain to you how it works. [Nurse explains with the use of a diagram how the procedure is conducted, how it prevents conception].

Mary: Thank you—the more you explain, the more I am determined it's the best one for me.

Nurse: Please remember to talk to your husband. I shall give you condoms to use with your husband before both of you reach a decision. May I meet with both of you a week from now...Thursday next week at 2:00 pm, shall we say?

Mary: That'll be fine. Thank you and good-bye.

Nurse: Good-bye, Mary.

Note: This counselling session follows the GATHER pattern of JHU/PCS, Population Report, Series A, No. 8, May 1990.

Counseling and Information/Education Giving— “Mental Rehearsal”

Guide for simulation:

Read the following script, and imagine that you have to give counseling and information to the patient. Please write how you would use the revised counseling skills.

A young woman arrives, quite nervous, at the hospital with a 4 year old little boy. She said that, since yesterday, he has had a fever of 39.5C, his throat hurts, and he vomited twice and does not want to eat anymore. When you examine the child, you notice that he has a red throat with white spots, the respiratory sounds are normal, although the child has some light respiratory difficulty (30 breathing frequency). The young mother is agitated; she said that her husband is also sick, and she does not know what to do when he cries at night.

Read the following script, and imagine that you have to give counseling and information to the patient. Please write how you would use the revised counseling skills.

After three days, and a long conversation with her BINT CHAAL, Um Ashraf, a 25 year old Baladi woman decided to bring her 10 month old baby to a physician at his private clinic in her Baladi Cairo neighborhood. The baby has a fever, and a cough, and does not breathe properly. For three days he has had a cold. At home, Um Ashraf gave her baby tea and some medicine that she does not remember the name of. The baby gets worse, the woman says, because he breathes very rapidly. After examining the child, you find that he does not have any severe symptoms (cyanosis, groaning), and his respiratory frequency is 38/minute, but he is agitated and has a fever of 38.7C.

ANNEX # 12

Mini-Case Studies

The following mini-case studies have been written in Egypt, based on actual problems. They are presented just for information.

Please read each mini-case-study. Identify for each one, ONE major type of problem, such as poor leadership, lack of IPC training, lack of supervision, poor or no group dynamics (team work), lack of feedback...). Then each group works with ONE case study, and looks for interpersonal communication solutions that can (partially) resolve the problems:

Mini-Case Study # 1:

Dr. Ahmed is the director of the Shobra Hospital in Cairo. He wants all problems to be reported only by his executive director, Dr. Mohamed, and decisions are to be only made by him, whatever the problems are. One day, Dr. Mohamed reports to Dr. Ahmed that the night staff of the Intensive Care Unit (ICU) leaves early in the morning before even taking the time to report to the morning staff, leaving much confusion during the day. Dr. Ahmed decides to deduct 15 days of salary for each member of both staff, day and night.

Mini-Case Study # 2:

The main hospital in Alexandria is in restoration, therefore the pediatrics department is temporarily closed. The pediatrics unit is divided within the four floors. Since that happened, the members of the team do not see each other. Some of them just learned that their chief of unit, Dr. Salam is on vacation. Nurse Ms. Mona, who was assigned floor 3 with two other nurses, is quite discouraged. She feels that she is the only one working in the afternoon. She never sees any pediatrician. She is ready to resign. She tells this to one of the nurses that she meets every day at lunch time in the cafeteria.

Mini-Case Study # 3:

The delivery of drug supply is done by the new pharmacist, Mohammed Raouf at Maady Hospital in Cairo. Mohamed was told by his chief, Mrs. Al Azhar to be sure that each patient knows exactly how to take his/her medication and know when to come back to the center. After one month with Mohammed working there, Mrs. Al Azhar realizes that many patients did not come back to the hospital as they were supposed to. She calls Mohamed, who is very surprised. He shows her that, according to his records, all the patients said that they knew when to come back and said that they knew when to take their medication.

Mini-Case Study # 4:

Going to work today, Dr. Sami Shalaan is nervous and afraid. His supervisor, Dr. H. Makhoulouf is visiting his department of the hospital. Last time Dr. Makhoulouf visited the health center, it was terrible. According to Dr. Makhoulouf, Dr. Shalaan was going to be fired! Dr. Makhoulouf criticized Dr. Shalaan's work, and called attention to the poor care of the few materials available. Sami Shalaan wanted to say that two staff members had left the center, and that he felt the need to receive some updated training after fifteen years of working at that center. But Shalaan could not say one word, so Dr. Makhoulouf left! This time, Sami prepared a list of things he wants to tell his supervisor.

Group A: Mini case study # 1 (Poor leadership)

Group B: Mini case study # 2 (Poor group dynamics)

Group C: Mini case study # 3 (Poor interpersonal communication skills)

Group D: Mini case study # 4 (Poor supervision)

Evaluation of the Interpersonal Communication Workshop

Cairo, Egypt

July 1994

The following questions will help evaluate the workshop that you attended. Please respond to each question. This evaluation is anonymous.

1. Please indicate what you liked most during this workshop, and why.

2. Please indicate what you liked least during this workshop, and why.

3. Please grade each session according to the degree you liked it: 5 =liked at lot; 1 =did not like it at all.

- ___ basic concepts of Interpersonal communication (IPC)
- ___ use of (non) verbal communication
- ___ guidelines to talk with client
- ___ increasing dialogue
- ___ counseling/information giving

4. Please grade each method used according to the degree you liked it: 5 =liked a lot; 1 =did not like it at all.

- ___ role-play/simulation exercises
- ___ taping practice
- ___ exercise with transcripts of encounter
- ___ video use
- ___ slides presentation
- ___ group discussion in plenary
- ___ small group work

5. Would you recommend this workshop to your colleagues? Why or why not?

Yes ____

No: ____

6. Please grade each skill according to the degree you believe will be of greater use in the future:

very useful = 5; not at all useful = 1.

- ____ welcoming patient
- ____ compliment client's effort
- ____ use of non verbal communication
- ____ reflect/repeat what client said
- ____ listening skills
- ____ show empathy
- ____ encourage dialogue (open-ended questions)
- ____ avoid interruption
- ____ avoid premature diagnosis
- ____ resist immediate follow-up
- ____ explore for more information
- ____ find out how client perceives illness
- ____ correct misconception of facts
- ____ use appropriate vocabulary
- ____ explain information in organized way
- ____ check client's understanding about illness
- ____ make sure client knows when to come back
- ____ recommend concrete behaviors to client
- ____ motivate client to follow treatment

7. Do you believe that the same training course should be given to more people, such as: nurses, midwives, social workers, others (specify)?

8. Please comment or give suggestions on how we could increase the quality of this workshop. (be specific)

9. Any other comments? (use other side if necessary)

Training Manual for IPC

TRINIDAD AND TOBAGO



Training Manual

**Interpersonal Communication (IPC)
Skills for Primary Health
Care Providers**

Trinidad and Tobago

1995



Quality Assurance Project

Center for Human Services

in collaboration with

The Academy for Educational Development

and

The Johns Hopkins University

USAID Contract No. DPE-5992-A-00-0050-00

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This activity would not have been possible without the collaboration of Dr. Pooran Ramlal (Director of Community Medical Services, Ministry of Health), Dr. Maynard (Permanent Secretary of Health), and Drs. Harry Singh, Krishna S. Kumar and Violet Duke (County Medical Officers of Health, Counties of Caroni, St. Georges West and Victoria, respectively). Field work, analysis and training were assisted by the technical expertise of Diane Renaud (JHU) and a committed field and coding team, both in the U.S. and Trinidad. Lastly, the many doctors participating in the study and training activities contributed to the strength of the activity and lessons learned.

Abbreviation List

AED	The Academy for Education Development
CHS	Center for Human Services
IEC	Information Education Communication
IPC	Interpersonal Communication
JHU	Johns Hopkins University
QAP	Quality Assurance Project
USAID	United States Agency for International Development

INTERPERSONAL COMMUNICATION (IPC) SKILLS FOR PRIMARY CARE PROVIDERS

Introduction

The curriculum for improved interpersonal communication skills has been developed by the Quality Assurance Project of the Center for Human Services (CHS) in collaboration with The Johns Hopkins University (JHU) and The Academy for Educational Development (AED) to be adapted and applied to the needs of the Trinidadian health system. The principal training objective is to enhance the communication skills of health providers and improve their interpersonal interactions with patients, so that health outcomes will improve. The training is designed so that Trinidadian training experts can easily replicate the course throughout the country as appropriate.

The training activity will employ a variety of training methods to ensure that participants develop new skills, enhance their sense of self-efficacy and apply state-of-the-art interpersonal communication methods, building on their existing skills and strengths. The methods to be used will include:

- ◆ Participatory plenary sessions that employ brainstorming and question and answer sessions so that participants can “discover” the new skills for themselves. Skills are discussed in terms of importance, changeability, current level of skill, and ideal level of skill.
- ◆ Dynamic role plays which will demonstrate the various communication strategies and allow participants to practice these methods.
- ◆ Videotapes will be used as instructional tools as appropriate.
- ◆ Mental rehearsal techniques will also be used to allow participants to explore what aspects of the new interpersonal communication skills will be most easy or difficult for them, and how they as individuals will overcome these difficulties.
- ◆ Transcripts and analysis of actual Trinidadian medical visits will be used to reinforce and demonstrate IPC skills.

Objectives of the Training

- ◆ To enhance the communication skills of health providers and improve their interpersonal interactions with patients, so that patient's satisfaction, compliance, and health outcomes will improve.
- ◆ To enhance the communication skills of health providers and improve their interpersonal interactions with patients, so that their own satisfaction, efficiency, and efficacy will improve.
- ◆ To focus on the interpersonal communication skills that are recognized by the Trinidadian health providers as the most useful within the Trinidadian context.
- ◆ To enable Trinidadian training experts to replicate the course throughout the country as appropriate.

Agenda of the Course

DAY 1: Interpersonal Communication (IPC) Skills

I. Introduction

- A. Introductions of trainer and participants (*30 min.*)
- B. Orientation to IPC training: overview of the research (*30 min.*) and teaching literature linking IPC training and patient outcomes
- C. Trinidad Baseline Study: Lessons learned at home (*30 min.*)
- D. The three-function model of medical interviewing: (*30 min.*)
(A) Data Gathering (B) Responding to Emotions (C) Educating and Motivating Patients

Coffee Break—30 Minutes

II. Skills Needed for Effective Communication: Skills Practice (transcripts, role-play, mini-case studies)

- A. Data Gathering (*1 hour, 15 min.*)
 - ◆ Effective listening, or attentive/active listening
 - ◆ Encourage dialogue with open-ended questions
 - ◆ Avoid interruption
 - ◆ Resist immediate follow-up
 - ◆ Probing/checking information
 - ◆ Ask patient what seems to cause the problems.
- B. Responding to Emotions (*1 hour, 15 min.*)
 - ◆ Appropriate non-verbal communication
 - ◆ Compliment patient efforts
 - ◆ Legitimation
 - ◆ Empathy
 - ◆ Reflection
 - ◆ Support
 - ◆ Statement of reassurance.

Break for Lunch

Home Practice: Audiotape a Medical Encounter and Listen to it!

DAY 2: Interpersonal Communication (IPC) Skills

II. Skills Needed for Effective Communication, continued

C. Educating and Motivating Patients

- 1. Educating the patient about illness (1 hour)
 - ◆ Explore client's perception of the illness
 - ◆ Provide a basic diagnosis
 - ◆ Use appropriate vocabulary
 - ◆ Determine patient's prior knowledge about illness

-
- ◆ Provide details of diagnosis
 - ◆ Check client's understanding—correct misconceptions
 - ◆ Present/explain what client needs to know/do to get better
 - ◆ Repeat, summarize key information.
2. Negotiating and maintaining the treatment plan (*1 hour*)
- ◆ Check baseline information about treatment
 - ◆ Describe treatment plans and goals
 - ◆ Check patient's understanding
 - ◆ Elicit patient's preferences
 - ◆ Negotiate a treatment plan together.

Coffee Break—30 Minutes

3. Probing for patient compliance (*1 hour*)
- ◆ Detecting and improving low rates of compliance.
4. Motivating for patient compliance (*1 hour*)
- ◆ Respond to emotions
 - ◆ Discuss/give concrete behavioral changes that client can accomplish
 - ◆ Elicit statement of commitment
 - ◆ Negotiate solutions.

How to keep alive these skills—Job aid use (*15 min.*)

Participants' evaluation of course and recommendations about future IPC training in Trinidad.

Training Content

DAY 1

This first day of the course is divided into four parts:

- (1) A plenary session including: (a) introduction of trainers and participants, (b) an overview of the basic research regarding Interpersonal Communication and both patient and physician outcomes
- (2) Presentation of Trinidad Baseline Study Results
- (3) Description of the Three-Function Model of Medical Interviewing
- (4) A skill-building and practice session targeting effective communication behaviors. Participants will work by pairs or be divided into small groups of 4-5. The groups will be guided by the trainer(s).

Flip charts or transparencies, slides, and video films will be used. Skills will be learned through role plays and simulation carried by participants and/or trainers. Findings/comments will be presented in plenary.

NOTE: We encourage participants to use their manual as a living document, adding their personal notes and comments on the right side of each page.

I. Orientation and Overview (1 hour)

1. Introductions
 - A. Participants and trainer(s) introduce themselves.
 - B. Participants' expectations: Participants are asked to list/state their expectations and goals for the course.
 - C. Trainer presents training objectives (annex #1). Objectives participants have stated are summarized and integrated.
2. Research literature relating Interpersonal Communications (IPC) and patient outcomes of satisfaction, recall understanding, compliance, and functional status
3. Presentation of Trinidad Baseline Study results based on questionnaire and audiotape analysis
 - A. Brainstorming with participants on the importance and changeability of IPC behaviors (verbal and non-verbal) integrating research and training results and behaviors identified by participants.
4. The Three-Function Model of Medical Interviewing

II. Specific Skills for Effective Communication

- A. Gathering Data to Understand the Client's Situation and Problems (1 hour, 15 min.)

An accurate diagnosis depends largely on the provider's ability to obtain the necessary information from a patient. While most providers are very skilled in processes related to gathering data, interrupting the patient and jumping too quickly to diagnostic conclusions based on the first presented symptom are common. By using data-gathering skills in a more systematic manner, the providers can become more efficient and effective interviewers.

Skills—Techniques

Notes

Active listening entails both verbal and non-verbal communication that helps put patients at ease. The provider shows interest by appearing attentive and not interrupting the patient.

Active listening is demonstrated both verbally and through body language. Verbal skills include use of encouragers such as “mm-hmm, I see, go on, tell me more.” Non-verbally, body language such as head nods, forward body lean, smiles, eye contact communicates interest and openness.

Open-Ended Questions

Dialogue is encouraged by asking open-ended questions that require more than simply “yes” or “no”. They offer the patient an opportunity to disclose problems more freely. Open-ended questions as opposed to the much more common close-ended questions allow the patient to set the agenda and take the initiative in describing symptoms and relevant history. Once the patient has provided a history of the problem, the provider can gradually narrow the focus to investigate a specific diagnosis and finish the dialogue by a few close-ended questions.

Open-ended questions about patient complaint: “What can you tell when you noticed your first symptoms of discomfort?” “What can you tell me about when your child started to eat less?” as opposed to closed-ended questions “When did the symptoms start?”

The provider will use “open-ended” questions to investigate the causes of the problem and make a diagnosis: “Why do you think....Are there any problems at home?...” The questions might become close-ended to help to focus after the patient has been the opportunity to tell their story.

Many physicians fear that asking open-ended questions takes too much time. However, when used correctly, it can save time and improve efficiency of diagnosis by uncovering important information early in the history process.

Surveying Patient Problems
(Resist immediate follow-up)**Notes**

Specialists in the medical interview consider the most important question to be “What else is bothering you?”.

A study conducted in 1984 in the US by Beckman & Frankel on the effect of physician behavior on the collection of data found that most patients were interrupted within 18 seconds of their initial presentation of complaints, as the physician directed questions toward the first presented concern. These complaints, however, were not necessarily the most significant to the patient nor the most clinically significant. The same researchers found that no patient used more than 150 seconds to complete an entire opening statement.

A study by Levinson, White, and Roter (1994) found that 20% of medical visits had a new medical complaint presented at the close of the visit. These complaints are much less likely to arise if the patient’s full list of concerns were discussed early in the visit.

Exercise

Participants form pairs “A and B” to role play a scenario. The script instructs the patients (“participants A”) to only tell the doctor what he asks for. The providers (“participants B”) are to find out all they can using new skills in 5 minutes. Then the members of the pair switch roles with a new script. In plenary the participants discuss their experience and relate it to their actual practice. The principal skills are listed once more on the board. Participants write on their notebook their preferred examples.

B. Building Rapport and Responding to Patients' Emotions (1 hour, 15 min.)

The following behaviors will help the health provider to achieve this goal, reinforcing the interpersonal contact between him/her and the patient.

Skills—Techniques

Notes

Appropriate Non-verbal Communication

Participants discuss/list non-verbal behaviors, including eye contact, facial expressions, body lean, seating position. Non-verbal behaviors and body postures communicate interest, concern, attentiveness, and conscientiousness.

Reflection and empathy

One experiences empathy when one can feel another's feelings or understand problems from a perspective other than his/her own. Provider should let clients know that he/she accepts the client's emotions. Empathy is demonstrated by putting into words the patient's emotions that the physician observes. For instance, "I can tell that this is upsetting for you"... "I can see you are worried (unhappy, concerned) by all of this".

An expression of empathy in a simple, non-judgmental way helps assure the patient that his/her feelings have been communicated and accepted.

It is important to respond to a patient's feelings as soon as they are displayed and not to overstate the depth or extent of the patient's emotions: It is better to say "You seem a bit upset with this" as opposed to "I can see this makes you very angry".

Legitimation

Reassure the client that his/her feelings and reactions are normal and to be expected. Legitimation validates and normalizes the patient's experience: "This would be difficult for anyone." "Under these circumstances, anyone would be upset."

Personal Support

Explicit statements of support can solidify the client's relationship with the provider. It emphasizes the provider's personal commitment to help the client and uses the word "I". For example, "I want to help you however I can".

Partnership

Patients react more positively and are more successful in cooperating with treatment when they feel that something is being done “with” them, rather than “to” them. When patients do not feel involved with their treatment, they may be skeptical or lax in following the doctor’s plan. For example: “Let’s see what we can come up with together,” “Let’s talk about what treatment choices there are and what you think would work for you”.

Respect and Compliment

These statements make the client feel respected, valued or approved of. Compliments approving of patient efforts to cope with illness or conscientiousness in following a plan are appreciated by patients and signal regard. There is often some aspect of patient behavior which can be complimented, even if it is simply keeping the appointment. For example “I’m impressed by how hard you’re working on your diet,” “You are doing a great job juggling all the pressures you are under”.

Exercise

Each participant selects 3 behaviors that would improve his/her communication and interpretation of emotions. This might include active listening, avoiding distractions, maintaining eye contact, sitting forward, avoiding separation by a table, use of facial expressions, etc. It should also include the use of rapport-building verbal skills.

Simulation: Participants form pairs and identify themselves as A and B. All A’s talk for 2 minutes; B’s pay attention to what is said by A’s and respond only non-verbally. The exercise is repeated with both verbal and non-verbal responses. After 2 minutes, switch, now B’s will talk and A’s will complete the exercise.

Discuss the simulation from different participants points of view: cultural aspects of communication—differences related to gender, age, ethnicity, educational level.

Homework Assignment: Tape record yourself with a patient and listen to the tape. Identify a 5-minute segment in which targeted skills were used.

DAY 2

3. Educating the Patient

Explore client's understanding of illness.

Before the patient hears the provider's diagnosis, the provider will find it useful to listen to the client's own thoughts on the cause of the illness. Clients may reveal information and emotions that can help providers determine the clinical diagnosis, or give the patients better understanding of their discomfort. For example, "Tell me what you know about your condition?" "What do you think causes it?" "How do you think it can be cured?"

Notes

Provide a basic diagnosis.

Diagnoses can be complicated and confusing for the patient when unfamiliar terms are used. Diagnosis should be delivered in short, easily grasped messages. For example: "You have a sexually transmitted disease. It's called gonorrhea. It is a curable disease and there are things you can do to prevent this from happening again". You will want to provide more details regarding the diagnosis after you determine the patient's prior knowledge and correct misconceptions.

Exercise: Language Efficiency

Exercise: translation—the use of simple language. Too often we complicate language, using words that people do not understand. This exercise will help us to "translate" difficult terminology by simple words that our clients will understand. Show transparency example of language too difficult, and its "translation." Participants propose a simple text.

Language efficiency: "Translate the medical information." Individual work (5 min). Volunteers read their "translation."

Determine the patient's prior knowledge about the illness.

Physicians can save valuable time by accurately gauging what patients already know about their illness. Time is saved by addressing knowledge gaps rather than covering material patients already know.

For example “Before we get into how this can affect you and how we can treat it, I’d like to know what you already know about sexually transmitted diseases.”

Correct misconception of facts and provide information, education about important related issues. “From what we know about diarrhea, it is not likely that it was caused by running too fast, more likely it was...”

Check client’s understanding of illness

When the provider is satisfied with the scope and depth of information presented, (s)he should check the patient’s understanding. Only the client can confirm what is understood. This is best done with open-ended questions. For example: “I would like to make sure that I have made everything clear. Would you tell me what are the most important things that you will do when you get back home...”

Patient Education Strategies

Recall can be improved by the use of:

- Summarize and ask for feedback
- Organize information in blocks
- Use short sentences
- Pause frequently
- Repeat key details.

Since only some proportion of all information given to the patient will be remembered, it is important to:

- Present information early rather than late in the visit
- Disclose the most important information first.

4. Negotiating and Maintaining the Treatment Plan

Negotiate a treatment plan cooperatively.

A physician may offer a prescription or recommend a lifestyle change, but that does not ensure that the patient will follow through with it. Only the patient has the power to change his/her behavior. The treatment plan is more likely to work if the physician first discovers the patient’s true desires and intentions.

“You really need to begin to exercise,” “What ideas do you have about how you can work this into a regular routine?” “You need to cut down on salt and fats.. let’s try to think through what you eat and what you’re willing to give up.”

Discuss/give concrete behavioral changes that client can accomplish

The provider does not ask the client to do something that (s)he finds impossible to accomplish. For example: “I want you to go for a walk for 20 minutes each day.” (NOT: “Please try to exercise every day.”)

It’s important to follow the steps outlined earlier in educating the patient, including checking the patient’s baseline information, correcting misconceptions, and verifying accurate recall.

Use Patient Education Strategies! For example: “When you get home, give one small spoon of the medication to your child, and again, another one tonight before bedtime. Tomorrow be sure that he does not eat anything before going to the laboratory for the blood test. Come back to see me for your appointment on Monday at 9:00am.”

Elicit patient’s intent

Having the patient make a commitment to the plan you have negotiated greatly enhances the likelihood that they will stick to it. For example “We’ve talked about ways for you to start regular exercise. Can you tell me what you think you will do?”

Planning to prevent relapses

A good plan is still only a plan and the patient needs to follow through. Making the treatment regimen as simple and easy to follow will improve compliance. Research indicates that most patients do not comply with all aspects of a complicated regimen—they are likely to select those aspects that are the least difficult. Patient compliance is inversely related to the complexity of the drug regimen—fewer drugs are complied with better than many drugs. Changes in health habits and lifestyle behaviors are the hardest aspect of a treatment regimen to follow.

5. Probing for Patient Compliance

Detecting and improving low rates of compliance is absolutely critical for effective treatment. It is estimated that almost half of the patients in care do not fully benefit from prescribed regimens. Most doctors, however, cannot identify which of their patients are not complying. It is absolutely necessary to probe patient compliance on an ongoing basis. How compliance questions are asked are critical to truthful answers. Use of open-ended, nonjudgmental questions are most likely to produce an honest and open answer. Researchers have found that compliance probes are most effective when prefaced with a statement such as “Many patients have trouble always remembering to take their medication at the right time. What kind of problems have you been having?”

6. Motivating for Patient Compliance

When compliance problems are uncovered, it is necessary to renegotiate the treatment plan and to engage in problem solving.

**“How can these problems be best handled?
What do you think would work?”**

Notes

**Discuss/give concrete behavioral changes
that client can accomplish.**

It is preferable to start with small incremental steps that are more likely to lead to success than an overly ambitious goal. It is better to aim at a 2 pound weekly weight loss for 10 weeks than a to simply set a 20 pound goal.

Participant's Evaluation of Course (10 minutes)

Recommendations about Future IPC Training in Trinidad

Closing Session

Evaluation

Each participant completes an evaluation.

Discussion and Feedback

List of Annexes

<i>Annex # 1</i>	Objectives of the Training
<i>Annex # 2</i>	Learner Needs Assessment
<i>Annex # 3</i>	The Three Function Model of Medical Interviewing
<i>Annex # 4</i>	Language Efficiency – “Translate” the Medical Information
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NNEX # 1

Objectives of the Training

- ◆ To enhance the communication skills of health providers and improve their interpersonal interactions with patients, so that patient's satisfaction, compliance, and health outcomes will improve
- ◆ To enhance the communication skills of health providers and improve their interpersonal interactions with patients, so that their own satisfaction, efficiency, and efficacy will improve
- ◆ To focus on the interpersonal communication skills that are recognized by the Trinidadian health providers as the most useful within the Trinidadian context
- ◆ To enable Trinidadian training experts to replicate the course throughout the country as appropriate.

ANNEX #2

Learner Needs Assessment

Individual Skill Assessment

Please list 10 communication behaviors used in patient care on the far left of the form. For each skill, rate its importance to patient outcomes on a scale of 1 to 5 (1 is least important and 5 most important). Again using a scale of 1 to 5 (1 is lowest skill level and 5 highest skill level) please rate your current level of skill and your ideal level of skill for each of the behaviors listed.

Communication Behaviors	Importance	Current Level of Skill
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		

The Three Function Model of Medical Interviewing

(A) Data Gathering

(B) Responding to Emotions

(C) Educating and Motivating Patients

Language Efficiency

“Translate” the Medical Information

Read the following examples of medical terminology and write against each phrase the way health workers should communicate the information to the client:

A. The most serious side effects related to the use of oral contraceptives are: cardiovascular problems (high blood pressure, blood clot, strokes). These can occur with women suffering from a disease and to which pills are contraindicated.

(A)

B. The medical notes related to pregnancy are more important with adolescents, that is women under 20. Of concern are premature babies with inadequate weight at birth, maternal and infant mortality, anaemia and vascular-renal syndrome of pregnancy.

(B)

C. Other medical explanations you've heard or read:

(C)

D. How could you rephrase your medical example in words that the average client would understand?

(D)

NNEX #5

Give Clients Clear Information in a Way They Understand

Organize information in blocks;

Use short words and short sentences;

Use words that your clients understand;

Use pictures and print materials, if available;

Pause frequently;

Stop from time to time to summarize;

Stop from time to time to ask if client understands and if they have questions;

When you mention a part of the body, point to it;

Repeat instructions and key details;

Ask clients to repeat instructions;

Present important information early rather than late in the visit;

Present the most important information first.

ANNEX # 6

Guide for a Simulation

Problem Solving Skills: Gathering Data to Understand the Client's Situation and Problems

Please read the following. Answer ONLY what the health provider asks you (5 minutes of simulation)

Instructions: To participant "A" (the client)

You are sick, with a terrible headache; you feel tired, and weak; you sweat, urinate a lot, and your urine is discolored. You eat well and you are always thirsty, but you notice that you are losing weight. You take aspirin for your headache, but it does not help! You don't know what to eat; your friend told you that you should drink orange juice and eat bananas. Your mother and her brother have diabetes, but since they are both overweight and you are not, you don't think that is your problem. You have heard that symptoms like the ones you are experiencing are sometimes associated with cancer.



Instructions: To participant "B" (the health provider)

You are the medical doctor (or the health provider). They have never seen this patient before. Using the skills in interpersonal communication that we reviewed today, try to gather a complete medical history and respond to the patient's emotions.

ANNEX # 7

Guide for a Simulation

Problem Solving Skills: Gathering Data to Understand the Client's Situation and Problems

Please read the following. Answer ONLY what the health provider asks you (5 minutes of simulation)

Instructions: To participant "A" (the client)

Two weeks ago you started giving supplementary food to your four month old baby because you believe that you don't have enough milk. Unfortunately, for a week your baby has not slept well because he got a cold (runny nose). He does not seem to like the food you are giving him, and since yesterday he has had diarrhea. You are very nervous and you don't know what to do. You know that your milk is diminishing. You do not work, and your mother is at home with you.



Instructions: To participant "B" (the health provider)

You are the medical doctor (or the health provider). Using the skills in interpersonal communication that we reviewed today, gather as much information you can about the patient and respond to her emotions.

NNEX # 8

Guide for a Simulation

Counseling and Information/Education Giving “Mental Rehearsal”

Read the following script, and imagine that you have to give counseling and information to the patient. Please write how you would use the revised counseling skills.

A young woman arrives, quite nervous, at the hospital with a 4 year old little boy. She said that, since yesterday, he has had a fever of 39.5C, his throat hurts, and he vomited twice and does not want to eat anymore. When you examine the child, you notice that he has a red throat with white spots, the respiratory sounds are normal, although the child has some light respiratory difficulty (30 breathing frequency). The young mother is agitated; she said that her husband is also sick, and she does not know what to do when the baby cries at night.

Guide for a Simulation: Patient-Centered Interviewing Skills

To Enhance Patient Compliance

OBJECTIVE

KEY STRATEGY

The patient's perspective should be considered and respected.

Have a diagnostic and treatment rationale and provide it to the patient using simple, direct language.

negotiate a plan and anticipate problems. Discuss any concerns or reservations the patient may have concerning the plan, including their ability to follow through—physically, emotionally, and financially.

Check the patient's knowledge, beliefs, and expectations about treatment so that misunderstandings and misinformation may be discussed.

Respond to the patient's emotions and provide emotional support, partnership and respect.

Have the patient make a commitment to following the treatment regimen.

If the patient shows any reluctance to commit to the plan, negotiate treatment options and modifications until you are both comfortable with a workable solution to which the patient can make a commitment.

Check understanding of the treatment plan and goals by asking the patient to repeat it back to you in their

“Patients often have ideas about their condition. What do you think caused your problem? What do you think would help?”

“Your blood pressure continues to be very high. In cases like this anti-hypertensive drugs can help. I want you to start taking medication right away and be sure to continue on your weight reduction and salt restricted diet”.

“Does this make sense to you? Do you have any questions or concerns about following these recommendations?”

“Tell me what you know about your condition and treatment.”

“Let's work it out together. I know how difficult this can be. I'm here for you.”

“I need to know if you can live with what we discussed? Do you think you will have any trouble with anything we talked about—anything at all?”

“What do you think would work for you? Any ideas? What else could we try?”

“Let me make sure you have it right. Tell me what you are going to do.”

“Most people have trouble remembering to take their medicine ...”

“How can these problems be best handled? What do you think would work?”

wn words and the close of the visit.

Probe for nonadherence at every visit, using a nonjudgemental open approach.

Renegotiate the plan and problem solve.

ANNEX # 10

Evaluation Form of the Interpersonal Communication Workshop — Trinidad

The following questions will help us evaluate the workshop that you attended. Please respond to each question. This evaluation is anonymous.

1. Please indicate what you liked most during this workshop, and why.

2. Please indicate what you liked least during this workshop, and why.

3. Please grade the individual aspects of training as to the degree you believe the skills will be used in your routine practice, using a 5-point scale (1= not at all to 5 = a great deal).

1	2	3	4	5	Overview and basic concepts of Interpersonal communication (IPC)
---	---	---	---	---	--

1	2	3	4	5	Data gathering
---	---	---	---	---	----------------

1	2	3	4	5	Responding to emotions
---	---	---	---	---	------------------------

1	2	3	4	5	Educating the patient
---	---	---	---	---	-----------------------

1 2 3 4 5 Negotiating and maintaining the treatment plan

1 2 3 4 5 Probing for patient compliance

1 2 3 4 5 Motivating for patient compliance

4. Please grade each method used according to the degree you felt it contributed to effective learning on a 5-point scale (1= not at all to 5 =helped a great deal).

1 2 3 4 5 Training manual

1 2 3 4 5 Job aid

1 2 3 4 5 Role-play/simulation exercises

1 2 3 4 5 Video use

1 2 3 4 5 Exercise with transcripts of encounter

1 2 3 4 5 Taping practice

1 2 3 4 5 Slides/overhead presentation

1 2 3 4 5 Group discussion in plenary

1 2 3 4 5 Small group work

5. Would you recommend this workshop to your colleagues? Why or why not? Yes: ___ No: ___

6. Please grade each skill according to the degree you believe you will use in the future: (1) for not at all (only rarely); (2) sometimes (as before training); (3) sometimes (but more than before training); (4) often (as before training); (5) often (but more than before training).

1 2 3 4 5 Welcome patient

1 2 3 4 5 Compliment client's effort

1 2 3 4 5 Use of non-verbal communication

1 2 3 4 5 Reflect/repeat what client said

1 2 3 4 5 Listening skills

1	2	3	4	5	Show empathy
1	2	3	4	5	Listen effectively
1	2	3	4	5	Encourage dialogue (open questions)
1	2	3	4	5	Avoid interruption
1	2	3	4	5	Avoid premature diagnosis
1	2	3	4	5	Resist immediate follow-up
1	2	3	4	5	Explore for more information
1	2	3	4	5	Find out how client perceives illness
1	2	3	4	5	Correct misconception of facts
1	2	3	4	5	Use appropriate vocabulary
1	2	3	4	5	Explain information in organized way
1	2	3	4	5	Check client's understanding about illness
1	2	3	4	5	Make sure client knows when to come back
1	2	3	4	5	Recommend concrete behaviors to client
1	2	3	4	5	Motivate client to follow treatment

7. Do you believe that the same training course should be given to more people, such as: nurses, midwives, social workers, others (specify)?

Yes: ___ No: ___

8. Please comment or give suggestions on how we could increase the quality of this workshop (be specific).

9. Any other comments?

Tape Transcriptions of Patient-Provider Encounters *Trinidad, August 1994*

Tape 1

D: Spell your surname.
P: [Spells out name]
D: How old are you?
P: 77
D: How you feeling?
P: Well, I not feeling so bad today...but see if I lie down and get up... a giddiness...yeh. If I bend down... a giddiness.
D: Hm mmm. So you get a giddiness when you change your position from lying down to standing and that sort of thing.
P: Yes. Right.
D: How long this started? You always had them?
P: It's a few weeks now. [Interruption here; someone enters and says Good morning; doctor responds "Good morning, son"]
D: Let me just listen to your chest.... Let me see your tongue... all right... You suffer from blood pressure. You are taking your pressure tablets all the time?
P: No, doctor.
D: So what do you do? You are taking any tablets right now?
P: No, I have to take two a day; to make to stretch I have to take one to make it last.
D: You'd like to change your tablet? Or you'd want to continue with the same tablets?

P: If I can get it I'll continue with the same tablet.
D: I can letdoctor says...they can get it here...that depends on the supply... hmm... but you have to take it...because...
P: I'll have to try and buy it.
D: All right. We might get some sometime on Monday ...that is the problem. Sometimes if they don't have it. Ah...so I'll stop changing your tablets then.
P: No I will try and buy...
D: Well you get possibly some, you know.
P: All right. I'll try and buy it.
D: Now your pressure is not so bad. OK but you have to cut down on salt very well much. No salty foods and continue the tablets the same way...you taking twice a day?
P: Twice a day, morning and evening.
D: I will recommend a blood test..I will recommend a blood test as you are feeling giddiness from time to time...I will recommend a blood test to see if there is any other problem. So the next time when you come you ask for the blood test from the clerk so that before you come to the doctor you will have the blood test results.
P: Right, yes.
D: Remember avoid the salty food, eh.
P: Yeh.
D: When you go for the test you tell the clerk you have a blood test to do so you have to talk to the Head Nurse.
P: Yes, I'll tell her.
D: All right. OK have a nice day.
P: OK thanks bye.

Tape 2

D: We're gonna be on the air honey. Yes, Mrs. Morn-

ing. Well Miss. OK, weight remaining constant, BP 140 over 90, that's fine. Your urine is OK for the moment. You're complaining of what...rash?

P: Yes, yes, rash.

D: [Reading] In the hip? Which appears after...after what?

P: I used some... I had an itch and I put some Limacol on it.

D: Hmmm

P: ..but ahm...I had pain on this leg...and it leave....so a friend gave me this...so I took some of it and he tell me to bring it and show you.

D: No, well, this is for arthritis. You took Olfem.

P: ..so I don't know if it is that.

D: Nah P: ...He say to bring it and show you and then a set of...

D: But that helped you with the pain, right?

P: Yes... a set of buttons here...

D: You getting any itching or scratching in the passage?

P: No, nothing like that.

D: Appetite all right?

P: Yes...Urine going out OK.

D: You following your diet all right?

P: Yes...excuse me, are you Dr. ___?

D: No..I'm Dr. ____

P: OK because I was telling my son what a nice doctor the last doctor here... He tell me probably it's ___ from St. Mary's College with him and it's a Chinese...so I say let me come....

D: No well you didn't meet me the last time. Who you met the last time was Dr. _____

P: Oh oh.

D: ...another Chinese doctor. So you're quite satisfied with how you're taking the sugar tablets and how they're working?

P: Everything, yes. Everything OK.

D: OK, right..and the Brenerdin for the BP?

P: Yes, alright...but ahm...

D: You sleeping all right?

P: Yes, well that...

D: I want to see the rash.

P: Yes, doctor, when I tell you....

D: You want to lie down for me to see the rash?

P: ...all over here hurting me...all here...

D: OK sweetheart you just lie down let me have a look. [a long pause]

P: Here..it turned red here.

D: Now this rash if you notice, watch me, if you notice carefully the rash is only on one side of your body

P: Yes.

D: ...and it's a kind of blistry kind of rash...

P: Yes.

D: ..that is what they call....er...shingles

P: Oh ho...

D: ...you must have heard of shingles

P: Oh yes...

D: It has nothing to do with the medicine. It's related to chicken pox.

P: Oh.

D: ...but it's what they call shingles. It's alright and we'll give you medication.

P: I hear if that goes around you, you dead.

D: ...You can get up. It's nothing to worry about. There's no cure for it but it's nothing to worry about...It will be itching you so I'll give you some Piriton, OK? I don't think we have Piriton at the moment, OK, so what I'll do I'll give you a prescription to buy some in the drugstore and ..er...when the heads come off you can always put a little cream on it...you know... a little petroleum jelly or zinc and castor oil and some painkillers because it does pain...

P: I got something...Jergen's Cream...

D: Jergen's cream? You could afford expensive cream, sweetheart.

P: No someone gave me as a present.

D: I only making joke with you, love. Don't go yet...don't go yet..That is shingles [writing] S H I N G L E S right? Now I'm also going to give you..... 91.5 it's the same as the last time. _____, DNL once a day, Brenerdin once a day two months. So we'll see you in two months, eh

love? Have a good day.

P: OK thanks. What is the weight there, please.

D: Same weight as last time, 91.5 kg and your BP is 140 over 90 and the name of the thing in case you want to tell your son is shingles.

P: Thank you. Have a nice day. God bless you. And I'll pray for you.

D: All right. Have a nice day.

Tape 3

D: Look how your pressure high

P: I can't understand it. I can't understand how the pressure so high.

D: Yes, Miss _____. Why is your pressure so high today—240 over 110. You want me to take it again. No, well, I don't have a blood pressure machine in here but the nurse wouldn't ..er... make a mistake like that.

P: I find it strange.

D: Yes, 240 over 110 is very high because that is not your kind of figure at all, at all.

P: No. That is why I say she make a mistake.

D: Have you been eating a lot of salt recently?

P: No.

D: Have you been under stress recently? Anything bothering you?

P: Yes. My niece dead and is I alone home.

D: You alone home. You have to cook and everything for yourself?

P: Yes, everything.

D: And then you not so young again. What about the appetite?

P: The appetite is alright.

D: How the bowels going off?

P: Good.

D: I see you have a corn on the toe. Let me see it.

P: Yes.

D: You still have on all these stocking and thing.

You'll have to take it off for me, please.

P: Is that what bring me because I don't understand it.

D: Aaaargh [Pulling off something?]

P: Oooh oooh [cry of pain]

D:you?

P: Yes.

D: Yes, well it dropping off, it dropping off. Alright, alright, _____Your bowels go off alright?

P: Yes.

D: You passing water alright?

P: Yes.

D: Are you sleeping alright?

P: Well not so alright. Cause when I turn at night I have a long time to catch back my sleep.

D: Yes, well you know ..er..the young people when they turn in the night they can't go back to sleep. What I'll do, I'll give you a little bit of ..er.. a little bit of Valium to take. You'll only take it like for a few nights in a row, just to settle yourself, you know.

P: Yes.

D: And then you'll try to sleep normally for yourself. If after three nights you say, [setups] God, I can't sleep normally again, then you'll try it for a few more nights again. I don't want you to take it as a vice every night.

P: No, no.

D: OK, now I'm also going to give you a tablet to drop your blood pressure a little bit and I want you to come back next Monday. Next Monday shouldn't be for your regular visit.

P: No, no.

D: ...but I want you to come back next Monday because I want to check your blood pressure and see how it is.

P: Yes.

D: If it goes down we'll say OK. If it doesn't we'll have to find out why. OK? Brenerdin.. one per day [writing] let's say for 2 weeks because I'm not accustomed to use as a pressure case. I'll give

you some Panadol for the pain in the corn. Try not to wear anything too tight on that corn, eh. So it will get a chance to heal. And the Valium only at nights.

P: This is what I put on the corn.

D: Colamine. That's very good. OK, honey, have a good day. Don't forget I want to see you next week Monday. Alright. Here you are darling, give them back this.

P: OK thanks.

Tape 4

D: Hello, good morning

P: Morning

D: Sit down. Alright, how you feeling this morning?

P: Don't feel too bad. I find...about five weeks ago when I go to urinate, the urine like when I want to urinate together with stool the same time as urine ...

D: Hmm mmm

P: But no stool ain't coming, for at least 8 days I can't go off. So I had to go to Casualty...and then they didn't have anything there so then they give me a prescription to go by the drugstore to get some fine little tablets....

D: Fine yellow tablets?

P: Yes, reddish-like...

D: Hm mmmm

P: Wednesday I went up by St. George there he tell me when I come to see if I could get a paper from you to get a X-ray to see if it's anything developing there.

D: Yes, but are you taking your tablets?

P: Yes, I take the tablets regularly.

D: And what about the sugar tablets, are you taking that regularly?

P: Yes, I taking the sugar tablets.

D: How much are you taking?

P: Taking two.

D: Two every day. You didn't see the dietician yet?

P: Yes, I see the dietician and I have to go..... the weekend.

D: You start to see her? You start to see the dieti-

cian?

P: Yeh.

D: Oh. So you are on the diet?

P: Yeh, well you ..er.. know how the thing is, sometimes you have to eat a little rice...you can't...

D: The sugar in the urine still reading high this morning, you know.

P: Yes, well...

D: So how many sugar tablets you taking? Two?

P: Yes.

D: Well, what you have to do is stay on the diet, take these two and I'll add on another for you to take for the sugar and the pressure reading normal so you could continue with the same pressure tablets. One a day.. OK? So...and the constipation problem, you still having it? Right now?

P: No, well still to go off, it takes me some days before I go off.

D: No vomiting, no diarrhoea?

P: No, it's only when I did take the ... I had the diarrhoea.

D: No belly pain?

P: No.

D: What about eating an' thing, you eating OK?

P: Yes, the eating is OK.

D: You eating all right. OK. Well what you got to do is take these tablets and see how you feel with this. The sugar is a little high and the pressure is reading normal so you increase the sugar tablets and stay on the diet, OK.

P: Yes.

D: I gave you something for the constipation also... OK. Alright.

Tape 5

D: Morning Mr. _____

P: Morning, morning.

D: How things with you today?

P: Doc, things gone worse with me. The whole belly for the whole week ...but last night in the morning now is pains till the evening time.

D: Mmmm...

P: So when I go to eat....but now the whole chest start to bust and the belly, well you know...last year they sent me to the hospital well the same thing happen now. Well last night was the worse night now.

D: But what happened when you went to the hospital?

P: Well, I remain for three days...the same tablet you give me here they gave me that there and they send me home.

D: Hmm mmm...

P: But the night they ask me...well the whole night I wake out the first night

D: Hmm mm

P: The second night I sleep but when I get up I get up with pain but when they ask me the next day "How you feel?" I say, " Well slight little pain". They sound me, all kinda things, they take X-ray, do everything...well did make one or two visits you know they call me back. Well the same thing happening now and what happening now is a kind of rash coming out on my body and a set of lota and I watching some... look here have a scratching when I bathing.

D: Hmm mmm...

P: ...plaks plaks all over my skin and as soon as I perspire it come back... a set of lota. So I don't know...I say I'll use some wild senna some bush medicine, I shoulda use that before.

D: Well the lotal don't worry too much about that, that we could give you some medicine for that. Now your diabetes. I see the urine is down. You following the diet and taking the tablets and thing?

P: Well let me explain to you. Twice I was here the last time I didn't get most of the tablets. Next time I come back they didn't have I went and buy some. But I went Chaguanas I get some there and some gas tablets. I buy gas tablets.

D: All right...

P: and I buy the ...how they call it...the ... for the....

D: Trental...

P: Me eh working nowhere.

D: But I want to know when you say you buying the tablets you taking them everyday at the dosage we tell you to take it or you taking it now and then?

P: No, no just how you say it..

D: You taking it everyday...

P: Yes, well it have certain medicine if I not have pain they tell me to take half....

D: Yes, the aspirin is half, the GTN an' thing is when necessary.

P: Yes.

D: Yes, but all the other ones is to take regularly.

P: Like the sugar tablet.

D: Regular, every day.

P: Every morning I take it.

D: You ain't miss out no day at all?

P: No, I miss out the two days I was outside

D: But most days you take it.

P: Yes.

D: And the Isodil everyday?

P: Everyday

D: You ain't miss out no days at all?

P: Yes I tell you two days.

D: Those two days but otherwise you taking them straight?

P: Yes.

D: Alright. So the problem here now is this belly pain.

P: Is the belly pain right on the

D: So the sugar seems to be well controlled, the BP is reasonably well controlled...

P: the sugar now.. let me tell you...if I eat a little sugar cane now...

D: What you doing that for?

P: Well I just telling younext I eat a piece of dasheen and check the sugar it right up... [bits missed here]..it check normal you understand everything what I saying...I observe that...

D: Only when you go off the diet...

P: I eh working nowhere, doc, and now things hard and 4 children to mind and my wife....

D: Well it's not so much to buy anything different, you know. It's the same things you eating...it's just to eat the right amount and well, you don't put in the sugar...you cut down the starch an'

- thing little bit...
- P: Me eh have nothing...when I was..
- D: But you know for yourself the things that does raise it up and does help keep it down.
- P: Yeh.
- D: Alright...
- P: This pain, this pain...
- D: Alright, the sugar you have nothing to worry about. Now the heart seems to be going alright too. How often you have to put the tablet below the tongue?
- P: Well not so often eh doc, but when I get all this pain I does try and put it...
- D: Umm mmmWell when you get that pain and you put it below you tongue what does happen?
- P: Nothing. Same thing.
- D: It don't change that pain at all?
- P: No change, no, no, no. I put in two tablets. A family say put two.
- D: But it don't change that one there at all?
- P: No change.
- D: So you get the X-rays and thing in the hospital for that now?
- P: Yes, I get everything.
- D: So what is the last thing the hospital tell you about this now?
- P: I tell them instead of paying passage I coming back here. They say it's alright.
- D: Yes but you see the problem I have with you and this pain is i am not sure what is causing it.
- P: Yes, look it's a whole year...Yesterday morning I get the pain about 5 o'clock it take me but not so heavy..
- D: So you're not going back to their clinic, then?
- P: No, well...I come here. I mean if you have to go back...it's the passage.
- D: Well you see the thing with you and this pain is I don't know what causing the pain, you know that. Now we not sure what is really happening in there.
- P: Now I saying is gas...now I want to explain you something. When this pain take me I take some Andrews...the peppermint kind. Two drops and you know the ..two drops...and I start to belch and thing...the pain pass out. I go and take some Andrews and Milk of Magnesia and you know and I get a l'il operation...pain pass. But then after all it's not everyday I'll use that. But this whole week I have only a slight l'il pain. But I saying is a gas. I mean between me and you, eh.
- D: Well, you shouldn't really get severe pain like that with gas, you know. I mean it'll come now and then and go away.
- P: But it still going and coming. Same thing happening when I come and see you...the tablets you gave me the same tablets the hospital gave me...
- D: But one time before when I saw you outside I gave you some very expensive tablets to buy, remember? Prepulsin...to take three times a day half hour before you eat...That one didn't help you at all with this thing?
- P: All the tablets you gave me...I buy all, I take all...no help. I come back here...and no help. I go in the hospital. I think the only thing help me is the Magnesia and Andrews, understand, everything to operate the belly. A little help...and you know when I sleeping in the night what the help is? [bits missing here] about one, two when I gas up and food coming up you know when you [bits missing here] like if you drink a rum? Coming out your nose?
- D: What is the [reading] the stomach thing running back up in the tube up here? All right. Hold on to this...this is the prescription for your sugar tablets and your heart tablets. This is for the circulation, right?
- P: I don't think they have the circulation tablets at all.
- D: Well they may have some now. I think they got new stocks there right.
- P: For the whole year I ain't get nothing.
- D: I am going to give you an additional prescription now. I want you to go to the pharmacy and buy some of these ones right and try these for the next week. Come in next week and tell me what happened. Well you won't come for the regular medicine you'll just come to tell me what happened to this pain. But if this is helping you, you'll want to continue it for a little while, right? [pause, writing prescription] OK, here we go...So

everything clear with you there now?

P: The cramps, the cramps....

D: No, I gave you the one there for that...

P: You know long time I could walk and do this...at home I going to cutlass some land there...after 15 minutes I can't stand up, my waist and feet hurting me.

D: What is happening there you see this diabetes and thing over the years it damages the veins and the circulation in the foot so the veins after you move a li'l bit enough blood can't come to supply the thing...so that tablet that you taking there if you take it regularly all the time it will improve it...it would not go away completely but you'll find you could do a little more before you start to get the cramps.

P: Cause I want to cutlass around the house or go get an axe to bust some wood...I feel my chest start to pain me a little bit..

D: You can't do these things again..

P: Well...I just.. my wife call me...

D: Well, you know the heart circulation not good...

P: So I say well I must perspire.

D: Yes, alright...Let me tell you the way you do...you could do a little work and thing but the minute you start to feel a short breath or feel anything you stop. Don't try to push yourself beyond that, right?

P: Well sometimes I am sharpening a saw and while I sharpening I start [bits missed out here] I get a kind of nervous ...You just sit down...

D: You have to stop. You have to stop, you can't do those things too much. Take your time; li'l bit, li'l bit.

P: So I'll be steady sitting and pushing a file.... I mean I used to work hard. It used to take me 20 minutes to walk from the junction to here and it take hours now.

D: Well the systems not working like how they were working before.

P: [mutter, mutter]

D: Alright, well next week you'll let me know how it's going, nah.

P: Alright.

Tape 6

D: Yes, _____, How are you today?

P: I'm well but at night I wheeze.

D: You have your tablets?

P: No, I have no tablets.

D: No tablets? How often you getting the attacks now?

P: Partly every night but when...

D: Every night? Even when you take the medication?

P: No, when I take the medication...

D: It's alright...

P: I feel alright and when I get up in the morning I get a slight wheeze again I take the medication again and I'm OK for the day.

D: And you're alright. OK. And you'll continue with your Ventolin.

P: I'd like to get some Panadol, please.

D: [writing]...inhaler

P: I'm getting some Panadol?

D: Yes, I've put it here. OK, dear.

Tape 7

D: Hello, good morning.

P: Morning.

D: What's your name?

P: _____

D: _____. How old are you?

P: 65

D: How are you doing today?

P: Well, I am getting a lot of pain here.

D: A lot of pain?

P: Yes

D: Where you getting the pain?

P: Getting it in the back here.

D: Backache? How many days this backache started?

P: The whole week now.

D: OK. Let me have a look at your back. It's here?

P: Yes

D: Umm. It's hurting when I'm pressing?
P: Yes.
D: let me listen to your chest. Can you open your mouth let me have a look at your tongue? OK. The legs are not swollen, eh? Your sugar is reading very high today, you know?
P: Yes, so they say.
D: Why you think so? Are you taking your tablets every day or it finished?
P: Taking. ...buy some.
D: You bought some tablets?
P: Yes.
D: Umm. But you are taking it every day?
P: Every day.
D: Because your sugar is reading very high. Did you take any sweet food?
P: No.
D: OK. Then I have to change your tablet and see...
P: Change the tablets?
D: Yeh. See how the sugar is...the sugar is reading very high today. I don't know why...I will recommend a blood test, eh? [raises voice] I will recommend a blood test..
P: A blood test?
D: Yes. Go back to the nurse and find out when to come for the blood test.
P: OK. [a long pause]
D: The pressure tablet you are taking every day?
P: Yeh.
D: So this time we'll see you in 6 weeks' time, right? Because your sugar is reading a little high. So we'll check back earlier than before. Usually we see you every 3 months but this time we'll see you in 6 weeks' time. But before that you get the blood test done.
P: OK.
D: Yes, you have some pain tablets, two times a day. One tablet two times a day for 10 days.
P: Thanks
D: That will help the backache, OK. Have a nice day.
P: Thanks very much.

Tape 8

D: How you going?
P: OK.
D: Dear, what's happening with your sugar today?
P: Well the sugar a little high this morning.
D: Not a little high; it's very high.
P: Very high. I don't know what is the cause.
D: Have you run out of tablets?
P: Not really, I have tablets.
D: So you have been taking it every day?
P: Yes, every day.
D: This morning?
P: No I didn't take it this morning.
D: Why?
P: Because I was hurry to come down here. But as soon as I go home I will take it.
D: You took it yesterday?
P: Yes.
D: Did you test the sugar at home?
P: No I didn't test it this morning.
D: Normally do you test it?
P: Yes, I test it.
D: Everyday?
P: Not everyday.
D: How often?
P: Like two days, three days..
D: Hmm. And what has it been doing recently?
P: Well sometimes the colour change to different colours.
D: What are you using?
P: The er...
D: The stick?
P: Yeh.
D: And when you say it changes to different colours, how high it gets?
P: Well that is where I don't know...I don't know about reading it..
D: Oh ho
P: I ain't know about reading.
D: Have you ever brought it here for the nurses to explain to you?

P: No.

D: Well what I think you should do is for them for you to come here, bring it here and let them explain what is high and what is low and what you should be doing alright.. Because just looking at it and you....

P: Yes, I ain't know...

D: Don't know what it's doing. But most of the time it's what colour? Like, OK, you know it'll have the colour that it starts off with..

P: yes, I know.

D: Right? And then it has different colours as it goes down?

P: yes, on the bottle....

D: It stays the same colour most of the time? Or it doesn't change? Or it changes most of the time?

P: No sometimes it is the same colour that the bottle have. Sometimes it remain like that. And sometimes again it change like a little like different colours you know.

D: Well, you'll have to ..er.. bring it in and let them explain it to you....what it is. OK. Well we really will have no idea of what is going on here with this.

P: Oh oh...yes.

D: Alright you're taking one sugar tablet... two sugar tablets and a pressure tablet in the morning.

P: Take two sugar tablets? Or...

D: You're taking....how many sugar tablets you taking in the morning?

P: One.

D: just one?

P: Yes.

D: What happened to the glucophate?

P: I take....

D: Aren't you getting two sets of sugar tablets?

P: One. A little white one.

D: When was the last time you came here? You haven't been here for a while?

P: Yes, like every three months, then they call me.

D: Alright...So you just taking one sugar tablet in the morning now?

P: Yes.

D: Right. What about the pressure tablets?

P: These days they ain't giving me no pressure tablets but my neck does hurt me a lot.

D: Who's not giving you any?

P: Well er..the nurse didn't give me any this last time?

D: The nurse or the pharmacist or the doctor.

P: Well if it ain't mark there the pharmacy don't give you. But if it mark they give it to you.

D: And suppose the pharmacy doesn't have it?

P: Well if they don't have it you have to get it, you have to buy it.

D: So when was the last time you took any pressure tablets?

P: Well, about tow or three weeks I ain't take none.

D: Well alright we'll have to bring you in for some blood test as well, OK?

P: OK.

D: To see what is happening with your sugar. Have you .erm..ever seen the dietician here?

P: No the nurse tell me next month the 20th I have to come in to see the

D: Dietician.

P: Yes.

D: How old are you now?

P: I is 62, 15th November.

D: You have an idea of what you're supposed to be eating?

P: Yes. I eat like...sometimes I eat like wheat bread or wheat flour roti, a little rice, sometimes...

D: How much sugar you eat for the day?

P: Sugar, no. I don't eat no sugar for the day.

D: You don't sweeten anything?

P: Yes, sometimes you know, like the body want a little bit of sweet tea or something.

D: How you know the body wants it?

P: 'Cause I can't do without it. Yes, sometimes I can't do without it.

D: How do you know that? I am asking you.

P: Sometimes I feel as if I am losing something.

D: Hmmm. How you mean?

P: Like if I don't drink anything sweet I feel I like if I getting mad and when I drink a little sweet I feel good. The body like it need it.

D: How often does that happen?
P: Well, that always happen to me. Yes, I have to drink a little sweet. If I can't drink sweet I feel like I can't like. True. Must drink a little sweet.
D: Well more than likely then you wouldn't. 'Cause it doesn't make sense giving you these tablets if you drinking that..
P: Yes, I know.
D: You know and you still do it...
P: Yes, the officer....
D: That is for the Welfare People. You think...this thing about drinking sweet stuff...
P: Yes, I don't always drink it, you know. I know it's not good for the body. I know that....
D: OK [sighs]
P: I know it's not good for the body.
D: As long as you say you know that I hope you will decide to continue..
P: OK
D: And you will see the dietician, OK?
P: All right.

Tape 9

D: Good afternoon. How you keeping today?
P: Not too bad.
D: All right. I had recommended some tonic for you to get the last time.
P: Well, I really didn't...
D: You didn't bother...your appetite came back?
P: Yes
D: All right. Good.
P: Get some[a lot very unclear here]
D: You just never used it? OK.
P: You could see from the prescription if there's any....
D: If there's any that you can get it? OK? Let me just check your pulse make sure it's OK? [pause] OK, your pulse is nice and steady today. You ever feel it bothering you? The heart beat...you ever feel it bothering you?

P: No, if I do anything..
D: ..Strenuous...
P: Strenuous...
D: Well, it's just a matter of keeping you on the tablet Digoxin until....[laughs a little] OK this is your prescription...And you'll get your new appointment at the desk outside. Alright?
P: [Mumble] OK.

Tape 10

D: Now what's your name?
P: ..
D: How old are you?
P: 45.
D: How you feeling this afternoon?
P: I'm feeling a little sick.
D: A little sick.
P: Yes.
D: You're using your medication?
P: Yes.
D: Cut down on your salt?
P: Yes.
D: you're doing your little exercise and so?
P: Well sometimes I does can't keep up with the exercise. When I start to take the exercise I feel a pain in the chest and back. My whole back does pain me.
D: Anytime you do this exercise you get pain?
P: If I do anything.... for two, three days I does feel sick.
D: Any short breath?
P: Well erm..when I get a pain I get short breath...if I do anything...if I clean the house I have to go and rest a li'l bit. After I rest I have to go and do something else and continue like that for the whole day.
D: So if you keep on doing something you still get the pain?
P: Yes.
D: Does the pain come up to the shoulder?
P: Yes, right through on the shoulder right here.

D: Uh huh. All there too. What about the side of the arm?

P: Yes, but I does have the pain on this side. Sometimes I does feel a kind of numbness all round here so. Sometimes if I doing anything I does can't hold the knife for too long or any object for too long...

D: Uh huh.

P: I does can't do it.

D: All right. Anybody in your family has a history of heart problem or high blood pressure?

P: Well my mother in law say she have heart problem but I really don't know because she never go by a doctor.

D: What about your mother, father, brother, sisters?

P: My father he does suffer from heart.

D: Uh huh...All right...OK.. Well in April your pressure was fairly high...in May it came down a bit, it had improved a bit. Today it has gone up again. What happened, eh?

P: Well, this...[unclear]

D: What you mean?

P: I was having a little problem.

D: What, neighbours?

P: It's not neighbours...is my husband's brother and sister.

D: What. You're having a little domestic problem?

P: Yes.

D: So this is worrying you a bit.

P: Well I was frightened to leave home and come out because one of his brothers wanted to chop my daughter...this one wanted to chop her.

D: And you are still frightened a bit.

P: Yes.

D: You know this little problem could carry up the pressure somewhat. And probably this is what is happening.

P: Right.

D: It's a little high— 140 over 100.

P: I using a special tablet really more than the one you recommend me.

D: Which one have you been using than the one I recommend?

P: I wanted to bring the tablet. The first time I

came here I showed the doctor the tablet what _____ recommend me...

D: Oh.

P: And that is the tablet that does help me a lot, eh.

D: Yes, in the past you've been using one called Isotopin and Vasoretic.

P: Yes.

D: Well this is very expensive and we don't have them here.

P: Yes it is expensive.

D: Can you afford to buy them? I mean they are very good if you can afford them but if you cannot...

P: I don't always have the money to buy because my husband is an alcoholic.

D: Oh I am sorry to hear that. So how you feel when you use the pink one—the Brenerdin—I've been giving you.

P: It don't help me at all. I don't feel well with it.

D: Do you want to try something else that we have?

P: Yes...well.

D: You could probably try another one. But I want you to do your exercise as usual. I want you to cut down on the salt, cut down on the heavy spices.

P: When you have people...I have to say... my husband is an alcoholic...If I cook something with no salt and his mother say "This thing have less salt". He says he will eat just how I eating but when he drink he will say "this thing have less salt".

D: But you must explain to him what is happening. He can always take more salt after you cook.

P: Well, he makes that a problem.

D: And where is he working?

P: He working WASA...for a while.

D: You ever talk to him about attending AA meetings?

P: I talk to him but...

D: He has friends who in the meeting who can advise him or encourage him?

P: Nobody can advise him...because I talk to him so much and he don't want to listen.

D: Well a lot of them have this problem—they don't like to listen.

P: He just don't want to listen.

D: Alright {interrupted by nurse} What I'll do I'll put you on another tablet, eh, one twice a day. Cut down on your salt, do your exercise as usual, OK. You're resting well?

P: Well you know when you have problems sometimes you wake up you can't sleep sometimes in the day you go to take a rest and with the problem when you wake up you can't sleep.

D: Alright. This tablet you take one in the morning and one after your dinner. This will also help you rest. And I hope the next time you return we get a normal reading. [pause. writes prescription] All right. You go back to the Clerk, you get your next appointment, you use your medication as recommended. We'll see you again, OK.

P: Thanks.

D: Right.

Training Manual for IPC

HONDURAS



Manual de Capacitación

**Destrezas de Comunicación Interpersonal
(CIP) Para Proveedores de
Atención de Salud**

Honduras

Enero 1994



El Proyecto de Garantía de Calidad

El Centro de Servicios Humanos

en colaboración con

La Universidad Johns Hopkins

La Academia para el Desarrollo Educativo

y

El Ministerio de Salud de Honduras

USAID Contract No. DPE-5992-A-00-0050-00

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Reconocimientos

El presente manual de capacitación fue realizado por el Proyecto de Garantía de Calidad (QAP) del Centro de Servicios Humanos (CHS) en colaboración con la Universidad Johns Hopkins (JHU) y la Academia para el Desarrollo Educativo (AED) en estrecha colaboración con expertos del Ministerio de Salud Pública de Honduras (MSPH), y con fondos proporcionados por la Agencia de los Estados Unidos para el Desarrollo Internacional (U.S. Agency for International Development - USAID). El contenido de este documento está basado sobre un trabajo conjunto del QAP/CHS/JHU/AED, y adaptado parcialmente del material “Communication Strategies in the Medical Interview”, Pfizer Inc., 1993.

Lista de Abreviaciones

AED	Academy for Educational Development (La Academia para el Desarrollo Educativo)
CHS	Center for Human Services (Centro de Servicios Humanos)
CIP	Comunicación Interpersonal (Interpersonal Communication)
IPC	Interpersonal Communication (Comunicación Interpersonal)
JHU	Johns Hopkins University (Universidad de Johns Hopkins)
QAP	Quality Assurance Project (El Proyecto de Garantía de Calidad)
MSPH	Ministerio de Salud Pública de Honduras
USAID	U.S. Agency for International Development (Agencia de los Estados Unidos para el Desarrollo Internacional)

Destrezas de Comunicación Interpersonal (CIP) Para Proveedores de Atención de Salud

Introducción

El presente manual de capacitación para mejorar las destrezas de comunicación interpersonal ha sido elaborado por el Proyecto de Garantía de Calidad del Centro de Servicios Humanos en colaboración con la Universidad Johns Hopkins y la Academia para el Desarrollo Educativo a fin de adaptarlo y aplicarlo a las necesidades del sistema de salud de Honduras. La propia capacitación se realizará en estrecha colaboración con expertos del Ministerio de Salud Pública de Honduras. El Ministerio de Salud de Honduras tiene experiencias en llevar a cabo diferentes tipos de capacitaciones. Una de las estrategias del Ministerio es mejorar la calidad de los servicios no solamente en el aspecto humano pero también en el aspecto técnico y físico. El principal objetivo de la capacitación consiste en contribuir a mejorar las destrezas de comunicación de los proveedores de salud y en contribuir a mejorar sus interacciones personales con los pacientes a fin de que mejore el estado de salud de los pacientes. También se ha concebido de forma que los expertos hondureños en capacitación puedan reproducir fácilmente el curso en todo el país, según proceda. Las actividades de capacitación se realizan en combinación con un estudio de evaluación que validará los comportamientos recomendados aquí y determinará la eficacia de la propia capacitación. Así, pues, un objetivo adicional consiste en concentrarse en las mismas destrezas que son el tema del estudio de investigación, a fin de que la capacitación cumpla los objetivos de los participantes así como el estudio de investigación. Prevemos que esta actividad tendrá múltiples beneficios para los proveedores de salud, los instructores y gerentes del Ministerio de Salud y la comunidad internacional de salud pública.

Los proveedores de salud que participen en el estudio aumentarán la eficacia de su ejercicio médico. Estamos convencidos de que estas nuevas destrezas surtirán un efecto en estos proveedores durante todas sus vidas profesionales. Inicialmente, se impartirá capacitación a 35 proveedores y también se capacitará a un grupo testigo de 35 proveedores adicionales después de que se lleve a cabo la evaluación. Por tanto, esta actividad en pequeña escala beneficiará a 70 proveedores de salud y a sus pacientes. Además, el plan de capacitación se ha concebido de forma que los coinstructores hondureños puedan reproducir fácilmente el curso en todo el país. Estos profesionales asumirán un papel en la capacitación desde el principio, por lo que, después de concluida la capacitación, se sentirán confiados en administrar el curso sin ayuda de expertos internacionales. La actividad también brinda beneficios a los proveedores de salud en toda la América Latina y en el mundo en desarrollo. Mediante la colaboración con los profesionales hondureños de salud en todos los niveles, esperamos adaptar los modelos que han resultado eficaces en los Estados Unidos de forma que sean apropiados e igualmente eficaces en el marco de los países en desarrollo.

La actividad de capacitación empleará una serie de métodos docentes para asegurar que los participantes adquieren nuevas destrezas, realcen su sentido de eficacia propia y apliquen métodos modernos de comunicación interpersonal, utilizando como base las destrezas y habilidades que poseen. Entre los métodos que se emplearán figuran los siguientes:

- ◆ Breves presentaciones acerca de destrezas específicas de comunicación que incluyen ejemplos concretos de que “hacer” y “no hacer”.
- ◆ Sesiones plenarias participativas que emplean ofrecimiento espontáneo de ideas, y preguntas y respuestas a fin de que los participantes pueden “descubrir” las nuevas destrezas por sí mismos.
- ◆ Dramatizaciones dinámicas que demuestren las distintas estrategias de comunicación y permitan a los participantes practicar estos métodos.
- ◆ Videocintas que se utilizarán como herramientas de instrucción, según proceda. (Si videocintas no están disponibles, dramatizaciones dinámicas las pueden reemplazar.)
- ◆ Técnicas de ensayo mental que permitirán a los participantes explorar los aspectos de las nuevas destrezas de comunicación interpersonal que serán más fáciles y más difíciles para ellos, y la forma en que estas personas superarán estas dificultades.
- ◆ También formará parte del curso una práctica real de los conocimientos adquiridos. Cada participante grabará en cinta algunos encuentros reales con pacientes. Las cintas se analizarán y criticarán en el grupo a fin de que cada proveedor pueda obtener reacciones específicas y sugerencias sobre cómo mejorar su actuación.

Declaración de Confidencialidad de los Participantes

Los participantes han sido seleccionados al azar para participar en un curso de capacitación y estudio sobre comunicación interpersonal. Les damos las gracias por haber accedido a participar en el estudio y esperamos que se sientan en libertad de hacer cualesquiera preguntas acerca del estudio. He aquí algunos aspectos generales muy importantes de la actividad de capacitación y su evaluación que debería usted conocer:

- ◆ Usted puede esperar que la participación en este curso y estudio mejore sus destrezas de comunicación interpersonal a fin de que pueda ayudar a sus pacientes a lograr resultados sanitarios óptimos. Usted puede utilizar estas destrezas en el ejercicio tanto público como privado de la profesión médica durante toda su vida profesional. En la actualidad, no existe amplia disponibilidad de cursos como éste debido a que las destrezas se están descubriendo y perfeccionando aún, razón por la cual usted formará parte de un grupo selecto de proveedores que tienen experiencia en este área.
- ◆ Recibirá un certificado como prueba de haber concluido con éxito el curso.
- ◆ El estudio no evalúa el desempeño de los participantes sino más bien el sistema en su conjunto. En realidad, prevemos que la comunicación interpersonal será un área débil ya que no se hace hincapié en ella en el modelo de educación médica. El estudio se concentra en mejorar el futuro, no en indicar errores del pasado. Además el fin principal al registrar las interacciones y analizar el desempeño del proveedor consiste en debatir qué comportamientos por parte de los proveedores surten el efecto más eficaz sobre el cumplimiento y el estado de salud del paciente. Estos resultados ayudarán a determinar qué aspectos deberán subrayarse en actividades futuras de capacitación.
- ◆ Ud. forma parte del grupo control del estudio, es decir que grabamos sólo una vez uno de sus encuentros, mientras otro grupo (experimental) fue grabado dos veces, la segunda vez después de haber recibido la capacitación en comunicación interpersonal.
- ◆ Su identidad se mantendrá anónima durante todo el estudio. La información acerca de su actuación individual no se comunicará a su supervisor ni a ninguna otra persona en el sistema de salud. El sistema de identificación se establece de forma que ni los investigadores ni los participantes puedan determinar qué información corresponde a proveedores de salud específicos. Al analizar o interpretar los datos, los funcionarios del Ministerio de Salud no tendrán acceso a los nombres de participantes específicos en el estudio.

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- ◆ De igual forma, no se pretende evaluar a ningún UPS participante en el estudio. Lo que importa es que comportamientos generan mayor satisfacción en el paciente motivándolo según las recomendaciones médicas. En ningún momento se pretende que un grupo de profesionales asociados a una unidad de servicio se compare con sus colegas que trabajan en otra unidad.

Objetivos

- ◆ Contribuir a mejorar las destrezas de comunicación de los proveedores de salud y contribuir a mejorar sus interacciones interpersonales con los pacientes, de forma que mejoren la satisfacción del paciente y el cumplimiento del paciente en beneficio de su salud.
- ◆ Permitir a los expertos hondureños en capacitación reproducir el curso en todo el país, según proceda.
- ◆ Centrarse en las destrezas de comunicación interpersonal de los proveedores de atención médica a fin de que se cumplan los objetivos del estudio procurando en todo momento que los mismos sean congruentes con los de los participantes.

Curso de Comunicación Interpersonal: Agenda

I. DIA 1

Destrezas de Comunicación Interpersonal (CIP)

1. Introducción: (2H00)
 - ◆ orientación sobre el estudio de CIP
 - ◆ conceptos básicos de CIP
2. Destrezas requeridas para una comunicación eficaz (*primera parte*, 2H30)

II. DIA 2

Destrezas de Comunicación Interpersonal (CIP), (segunda parte), y Práctica.

1. Destrezas requeridas para una comunicación eficaz (*segunda parte*, 3H00)
2. Orientación a la práctica (30')
3. Práctica (30' - 2H00—*a completar al trabajo*)
 - ◆ grabación de dos encuentros
 - ◆ análisis de transcritos de encuentros

Los participantes harán una grabación en cassette de sus encuentros con pacientes en los que pusieron en práctica las nuevas destrezas. Los que no pueden grabar, trabajarán con transcritos.

III. DIA 3

Destrezas de CIP: Análisis de la práctica

1. Estudio en grupo y análisis de las cintas grabadas de los participantes, o de los transcritos (los equipos de participantes identifican los puntos fuertes y las debilidades, formulan recomendaciones) (2H00)
2. Práctica de destrezas (dramatización) (1H30)
3. Evaluación del curso por parte de los participantes y recomendaciones para una futura capacitación en CIP en Honduras (debate en grupos pequeños) (20')

Clausura de la sesión (10')

Contenido de la Capacitación

Día 1

La primera parte de este curso se divide principalmente en dos partes:

- (1) Una sesión plenaria de 2 horas para una introducción: presentación de los capacitadores y de los participantes, orientación sobre el estudio de CIP y revisión de los conceptos básicos de comunicación interpersonal.
- (2) Una sesión de 5 horas para estudiar las destrezas necesarias para una comunicación eficaz. Esta sesión será presentada en dos partes. Los participantes se dividirán en grupos pequeños de 4-5 personas. A cada grupo de trabajo se le asignará un cocapacitador. Se utilizarán rotafolios o transparencias. Se aprenderán las destrezas mediante dramatizaciones y simulación realizadas por los participantes o los capacitadores. Los resultados y comentarios se presentarán en la sesión plenaria.

1. Introducción

Los cocapacitadores se presentan y los participantes pasan al ejercicio “romper el hielo”.

El capacitador principal presenta los objetivos de la capacitación. (Transparencia #1)

A. Orientación al estudio de comunicación interpersonal

El investigador principal explica a los participantes las etapas del estudio en Comunicación Interpersonal (15 minutos).

Objetivos del Curso

- ◆ Contribuir a mejorar las destrezas de comunicación e interacciones interpersonales de los proveedores de salud con los pacientes, de forma que mejoren la satisfacción y el cumplimiento del paciente en beneficio de su salud.
- ◆ Permitir a los expertos hondureños en capacitación reproducir el curso a nivel nacional, según proceda.
- ◆ Centrarse en las destrezas de comunicación interpersonal de los proveedores de atención médica a fin de que se cumplan los objetivos del estudio procurando en todo momento que los mismos sean congruentes con los de los participantes.

[Transparencia 1]

B. Conceptos Básicos de Comunicación Interpersonal *(una hora y media)*

Aclaración de valores

El capacitador presenta la sesión con un ejercicio sobre valores. Distribuya la hoja de ejercicios titulada “Lista de valores” (véase el anexo 1).

La codificación la realizará más tarde un cofacilitador/cocapacitador. La conclusión sobre la aclaración de valores se presentará una vez que se conozcan los resultados (véase el anexo 1 p:2; a presentar en transparencia #2.)

Distintas características de la comunicación interpersonal (CIP)

Los participantes ofrecen ideas espontáneas acerca de las características de la CIP (verbal y no verbal). Pueden trabajar en grupos y en plenaria; exponga su trabajo.

Comunicación no verbal

Expresión corporal: Los miembros del grupo se turnan para tratar de expresar varias emociones con su cuerpo/rostro. Otros participantes tratan de adivinar los sentimientos que aquéllos expresan.

Simulación: Los participantes forman pares y se identifican como A y B. Todos los A hablan durante 3 minutos; los B no pueden interrumpir ni decir nada, sino sólo prestar atención a lo que dicen los participantes A. Después de 3 minutos, cambian, ahora los B hablarán y los A escucharán.

En plenaria, los participantes hablan acerca de sus sentimientos.

Comunicación de mensajes negativos. En especial, mensajes no verbales. ¿Qué mensajes?

Se termina de hablar con los participantes acerca de los distintos aspectos de la comunicación intercultural y de la importancia de interpretar con precisión la comunicación no verbal, con la importancia de escuchar (vease anexo #2). Después discutir en plenaria.

Notas

Lista de Valores

Resultados del grupo

Utilice el anexo 1 p: 2, llenándolo con los resultados del grupo.

[Transparencia 2]

Por ejemplo, expresiones faciales: temor, ira, aburrimiento, felicidad, mirada, etc.

Respuestas posibles: primero, pida comunicación no verbal (comportamientos): expresión corporal, contacto visual, sentimientos (mal estar); pida que sean específicos en cuanto a las expresiones corporales: comodidad, entendimiento, ayuda.

Respuestas posibles: distracción por teléfono, interrupciones: alguien que se aproxima, expresión facial, mirada al reloj, mirada a papeles, no hay silla para el cliente, oficina sucia.

Comunicación verbal— Eficacia del lenguaje

Ejercicio: traducción—el uso de lenguaje sencillo.

Muy a menudo complicamos el lenguaje utilizando palabras que la gente no entiende. Este ejercicio nos ayudará a “traducir” terminología difícil con palabras sencillas que nuestros clientes comprenderán (Transparencia #3).

Distribución de la hoja: “Eficiencia en el lenguaje: ‘Traducción’ de la información médica” y trabajo individual (anexo 3). Voluntarios leen su “traducción” (5 min).

Discuta por qué es importante usar palabras sencillas y directas (anexo 4).

Definición de comunicación interpersonal (CIP)

Lleve a los participantes a que debaten sobre la definición de CIP. (Transparencia #4)

Notas

El Uso de Lenguaje Sencillo

Texto de lenguaje complicado

Los problemas de salud debido a embarazos en las adolescentes son más graves en las mujeres menores de 20 años. Los problemas más frecuentes son el nacimiento prematuro o el bajo peso de los recién nacidos, así como la mortalidad materno-infantil y la anemia.

Ejemplo de su traducción a lenguaje sencillo

Las mujeres menores de 20 años pueden sufrir de mayores problemas de salud durante el embarazo. Es posible también que el bebe nasca antes del tiempo y con muy poco peso.

[Transparencia 3]

Respuestas posibles: evitar malos entendidos, evitar crear mitos.

Introducción a la CIP

Notas

Existen distintos niveles de comunicación: uso de carteles, espacios de radio y televisión; encuentro entre dos personas; distintos niveles de comunicación; CIP: verbal y no verbal, actitudes, expresiones, apariencia exterior (presentación de 12 diapositivas de PCS/JHU). Una de las diapositivas muestra los distintos niveles de comunicación. El nivel de comunicación interpersonal se encuentra en el punto central. Cada nivel tiene un papel y distintas modalidades de comunicación (anexo 5).

Definición de la comunicación interpersonal

“La comunicación interpersonal es el intercambio cara a cara de información o sentimientos, verbal y no verbal entre individuos o grupos.

[Transparencia 4]

2. Destrezas Requeridas Para una Comunicación Eficaz (5 horas)

El capacitador explica que las destrezas que se presentan a continuación no son nuevas. Se omiten a veces debido a otras obligaciones o al hecho de que no se consideran importantes.

El objetivo de esta capacitación es doble: (1) brindar técnicas para reforzar las destrezas de Comunicación Interpersonal, (2) ver cómo integrarlas en los encuentros realizados hoy en día por los médicos hondureños (transparencia #5).

Objetivos de la Capacitación

- (1) Brindar técnicas para reforzar las destrezas de Comunicación Interpersonal, y
- (2) ver cómo integrarlas en los encuentros realizados hoy en día por los médicos hondureños.

[Transparencia 5]

Al dominar las técnicas presentadas, el personal clínico no sólo adquiere más destrezas sino, también, un marco para su aplicación. Las destrezas se presentan en tres partes: (1) Destrezas Generales de Comunicación Socioemocional: Lineamientos para hablar con los pacientes, (2) Destrezas de Resolución de Problemas, (3) Destrezas de Asesoramiento, Información y Educación (transparencia # 6). Sin embargo, en la vida real, un encuentro no siempre ocurre en la misma secuencia. Lo que es importante es que las destrezas de comunicación interpersonal ocurran durante el encuentro. Al comienzo de la sesión, los participantes reciben una “guía portátil práctica” (véase anexo 6). Cada uno puede completarlo con los ejemplos preferidos.

Notas

Destrezas de Comunicación Interpersonal

- Destrezas Generales de Comunicación Socioemocional: Lineamientos para hablar con los pacientes
- Destrezas de Resolución de Problemas
- Destrezas de Asesoramiento, Información y Educación.

[Transparencia 6]

A. Comunicación General Socioemocional: Establecimiento de un Contacto y Respuesta a las Emociones de los Clientes— Lineamientos Para Hablar con los Pacientes (1h30)

I. Definición de comunicación socioemocional

El proveedor establece y mantiene un contacto positivo con el cliente durante todo el encuentro (transparencia # 7).

Definición de Comunicación Socioemocional

El proveedor establece y mantiene un contacto positivo con el cliente durante todo el encuentro.

[Transparencia 7]

2. Los siguientes comportamientos ayudarán al proveedor a lograr esta meta (transparencia # 8).

**Comportamientos Reforzando el Contacto Interpersonal
Entre el Cliente y el Proveedor**

- ◆ Marco de referencia/creación de un ambiente propicio
- ◆ Comunicación no verbal apropiada
- ◆ Pregunta a los participantes cuáles son sus sentimientos
- ◆ Felicitación al paciente por sus esfuerzos
- ◆ Legitimación
- ◆ Empatía
- ◆ Reflejo
- ◆ Dar apoyo
- ◆ Declaración tranquilizadora

[Transparencia 8]

Destrezas—Técnicas

Marco de referencia / creación de ambiente propicio

El objetivo del “Marco de referencia” es de establecer un ambiente cómodo para que el paciente se sienta bien y que pueda hablar de sus emociones sin pena.

Iniciar un encuentro: Dar la bienvenida al paciente y establecer un ambiente cómodo desde el primer momento y durante toda la entrevista.

Dar ejemplos utilizando un marco de referencia.

Comunicación no verbal apropiada

Dar una lista de comportamientos no verbales. Analizar si son apropiados. Pedir a cada proveedor que seleccione tres comportamientos no verbales que mejorarían su comunicación (demostrar capacidad activa de escuchar: evitar distracciones; mantener contacto ocular; facilitar la conversación sentándose y colocándose frente al paciente.)

Asegúrese de que los participantes que desempeñen los papeles den la bienvenida al paciente, establezcan la creación de ambiente propicio, tal como: *“Soy el Dr._____. ¿Cómo está hoy?...¿En qué le puedo ayudar?”*

Utilice comportamientos de comunicación verbal y no verbal. Hable acerca de qué se hizo durante la primera parte de la capacitación. Pida a los participantes que guarden los comportamientos no verbales que han seleccionado para escribirlos en su “guía práctica portátil” al final de la sesión.

El proveedor hará todo lo posible por comprender y compartir sentimientos mutuos con el cliente. Esto se hace a través de lo siguiente:

Pregunta a los pacientes cuáles son sus (pre)sentimientos

Es importante responder a los (pre)sentimientos del cliente para que éste vea que el proveedor es atento y se interesa por él.

Felicitación al paciente por sus esfuerzos

Estas declaraciones hacen que el paciente vea que se le respeta, valora o aprueba.

Legitimación

Tranquilice al cliente diciéndole que sus sentimientos y reacciones son normales.

Empatía

Uno experimenta empatía cuando puede percibir los sentimientos de otro o comprender los problemas desde una perspectiva distinta de la suya; casi identificarse con la otra persona. El proveedor deberá informar al cliente que acepta las emociones de este.

Reflejo

Por reflejo se entiende una intervención del médico que simplemente interpreta y traduce a palabras las emociones del cliente observadas por el.

Dar apoyo

Dar apoyo puede solidificar la relación del cliente con el proveedor. Subraya el compromiso personal del proveedor para ayudar al cliente. A menudo este apoyo se expresa mejor mediante el tono de voz que con las palabras específicas empleadas.

Declaración tranquilizadora

Muchos clientes buscan que sus proveedores los tranquilicen. Sin embargo, es importante no hacerlo prematuramente (no dar seguridades demasiado pronto cuando no existen bases para ello). Espere que tenga el diagnóstico confirmado.

“¿Cuál es su impresión acerca de esto?”...“¿Qué le preocupa más acerca de esto?”...“¿Qué piensa su cónyuge acerca de esto?”

“Me complace ver que volvió para su cita según proyectamos”.

“Hizo usted lo mejor por su hijo, ...”

“La mayoría de la gente reacciona a su situación de la misma forma”.

“Usted debería saber que sus reacciones son totalmente normales en las circunstancias”.

“Siento que le haya ocurrido esto..”

“Me entristece lo que le ha ocurrido”.

“Parece estar teniendo mucho dolor (preocupación, estrés, etc.)...”

“Puedo ver que esto le preocupa”.

“Dígame qué puedo hacer por usted”.

“Vuelva, por favor, si necesita mi ayuda nuevamente”.

“Su condición no es tan grave; si sigue mis instrucciones, tiene una posibilidad excelente de mejorar”.

Trabajo en grupos:

Con la transcripción de los encuentros grabados en cinta en Honduras, los participantes mejoran los encuentros incluyendo las destrezas nuevas. Cada grupo efectúa su presentación en la plenaria. Sigue un debate general (1 hora, anexo 7).

B. Destrezas Para Resolver Problemas: Recopilación de Datos Para Comprender la Situación y los Problemas del Cliente (1h30)

Al segundo día, el capacitador empieza el día dando a los participantes todo el tiempo necesario (30-45 minutos) para discutir, dar sus impresiones, hacer preguntas acerca de lo que se aprendió el día anterior. Luego se revisan las destrezas mostrando la película “comunicación no verbal” (casetta del Ministerio de Salud de Honduras).

La exactitud de un diagnóstico depende en gran medida de la capacidad que tiene el proveedor del servicio para obtener la información necesaria de un paciente. La mayor parte de los proveedores son bastante hábiles en cuanto a los procesos relacionados con la recopilación de datos encaminados a entender los problemas de los pacientes. Sin embargo, pueden existir algunos problemas en el estilo de comunicación, por ejemplo, interrumpiendo al paciente o llegando demasiado rápido a conclusiones. Mediante el empleo de destrezas de recopilación de datos de forma más sistemática, los proveedores pueden convertirse en entrevistadores más eficaces y productivos.

Los siguientes comportamientos ayudarán al proveedor a lograr a resolver problemas (transparencia # 9).

Destrezas Para Resolver Problemas

- ◆ Escuchar eficazmente o con atención y de forma activa
- ◆ Promover el diálogo
- ◆ Evitar interrupciones
- ◆ Resistir a un seguimiento inmediato
- ◆ Indagar
- ◆ Preguntar al paciente cuál parece ser la causa de los problemas

[Transparencia 9]

Destrezas—Técnicas

Escuchar eficazmente o escuchar con atención y de forma activa

Escuchar eficazmente es una técnica de la comunicación no verbal que le ayuda a tranquilizar a los pacientes. El proveedor muestra interés teniendo paciencia, no interrumpiendo. El escuchar activamente puede complementarse con alguna intervención “verbal” que anime al paciente a seguir hablando.

Promover el diálogo

El diálogo se promueve haciendo preguntas que requieran que el paciente genere una respuesta más completa que el simple “sí” o “no”. Ofrecen al paciente una oportunidad para notificar problemas con mayor libertad. Son las preguntas “abiertas” frente a las preguntas “cerradas”. Una vez que el paciente ha proporcionado un historial del problema, el proveedor puede concentrarse paulatinamente en investigar un diagnóstico específico y concluir el diálogo con unas cuantas preguntas cerradas.

Evitar interrupciones

El proveedor deja que el paciente explique sus problemas.

Resistir a un seguimiento inmediato

El proveedor evita sacar conclusiones inmediatas cuando el paciente causa un problema.

Notas

Los participantes utilizan las destrezas de comunicación tanto verbal como no verbal: ajá, ya veo, continúe, etc., asentimiento con la cabeza, contacto ocular...

“Preguntas abiertas” acerca de una queja del paciente: “*Me puede decir cuándo advirtió usted los primeros síntomas de malestar?*”... “*¿Me puede decir cuándo comenzó su hijo a comer menos?*”

A través de un estudio realizado en 1984 en Estados Unidos por Beckman y Frankel sobre el efecto del comportamiento de los médicos en la recopilación de datos constató que la mayoría de los pacientes eran interrumpidos dentro de los primeros 18 segundos de su presentación inicial de problemas, por culpa del médico quien dirigía las preguntas a una preocupación específica. La repercusión de este resultado es la de que los médicos probablemente emplean tiempo en problemas que no son los más significativos para el paciente. Los mismos investigadores hallaron que ningún paciente utilizó más de 150 segundos para concluir toda una declaración de apertura.

Escuche bien antes de recomendar una solución o tratamiento. NO diga: ... “*Para la jaqueca que mencionó, límtese a tomar aspirina cada vez que le duela la cabeza.*”

Indagar—Explorar

El proveedor interroga al paciente (preguntas abiertas) para asegurarse de que tiene la posibilidad de explicar todas las preocupaciones. Al indagar, el proveedor examina, explora todas las posibilidades.

Preguntar al paciente cuál parece ser la causa de los problemas, cuáles son las dificultades, ¿alguna otra preocupación?

Notas

“¿Tiene alguna otra preocupación que quisiera comunicarme?”...“Hábleme más acerca de la pérdida de apetito de su hijo.”...“Dígame cómo se siente cuando se despierta por la mañana”.

El proveedor utiliza preguntas abiertas para investigar las causas del problema y hacer un diagnóstico: *“¿Por qué piensa usted...?”...“¿Cuales son los problemas en su casa?”* Las preguntas podrían hacerse cerradas para ayudar a concentrar las respuestas.

Los participantes constituyen pares A y B para la dramatización de una escena. Trabajar con los guiones (anexo 8 y 8 bis). En la plenaria, los participantes debaten la experiencia y la relacionan con su práctica real. Se incluyen una vez más en la pizarra las destrezas principales.

C. Asesoramiento e Información/Educación (1h30)

Las técnicas para proporcionar un mejor asesoramiento/información se presentan por medio de un video a los participantes o mediante la representación de una sesión de asesoramiento (15 minutos). Los participantes en grupo o en la plenaria debaten qué destrezas advirtieron. Los participantes deberán considerar entonces si el estilo de las técnicas en sus sitios de trabajo es apropiado y cómo lo adaptarían o qué aconsejarían a los clientes. Cada participante trabajará con un “ensayo mental”: describa a un cliente y un diagnóstico (anexo 9). Cada participante se imagina dando asesoramiento. Cada participante escribe las formas en que abordaron la sesión de asesoramiento. Comparta en la plenaria (30 minutos). El capacitador ilustra las destrezas con la transparencia # 10.

El video “A través el espejo”, AIDSCOM, AED, 1991 se muestra. Solo la parte “Clara” y su conclusión. Se puede mostrar el video antes o después de la presentación de las nuevas destrezas.

**Asesoramiento e
Información/Educación**

- ◆ Explorar la comprensión de la enfermedad por parte del cliente/paciente.
- ◆ Corregir malos entendidos acerca de los hechos
- ◆ Utilizar vocabulario apropiado
- ◆ Presentar/explicar qué necesita saber/hacer el cliente para mejorar (en bloques)
- ◆ Comprobar la comprensión de la enfermedad por parte del cliente, corregir malos entendidos
- ◆ Sugerir cambios concretos de comportamiento que el cliente puede efectuar
- ◆ Repetir/resumir información clave
- ◆ Convencer o motivar al cliente
- ◆ Comprobar la aceptabilidad/mutualidad de la toma de decisiones
- ◆ Concluir

[Transparencia 10]

Destrezas—Técnicas

Explorar la comprensión de la enfermedad por parte del cliente/paciente. Antes de que el paciente escuche el diagnóstico del proveedor, el proveedor hallará útil escuchar las propias ideas del cliente sobre la causa de la enfermedad. Los pacientes pueden revelar información y emociones que pueden ayudar a los proveedores a determinar el diagnóstico clínico o dar a los pacientes una mejor comprensión de su molestia.

Corregir los malos entendidos acerca de los hechos y proporcionar información/educación acerca de temas afines importantes.

“Dígame qué sabe acerca de su condición.”... “¿Qué la ocasiona?”... “¿Cómo puede curarla?”... “¿Qué le preocupa más acerca de esto?”

(Esta destreza es la misma que la tercera que vimos en la primera parte “socio-emocional”).

“Sobre lo que se sabe acerca de la diarrea, es probable que fuese ocasionada por agua contaminada,...”

Utilizar vocabulario apropiado y determinar el nivel de comprensión del paciente antes de decidir la forma de explicar el diagnóstico. El proveedor usa vocabulario popular para establecer una mejor comunicación con los pacientes.

Presentar/explicar qué necesita saber/hacer el cliente para mejorar (en bloques). Utilice frases cortas que se recuerden con facilidad. Haga pausas frecuentes y repita los detalles principales.

Comprobar la comprensión de la enfermedad por parte del cliente, corregir los malos entendidos. Cuando el proveedor queda satisfecho con el alcance y profundidad de la información presentada, deberá comprobar la comprensión del paciente. Sólo el cliente puede confirmar lo que comprende. Esto se sabe óptimamente con preguntas abiertas.

Sugerir cambios concretos de comportamiento que el cliente puede efectuar. El proveedor no pide al cliente que haga algo que encuentra imposible de hacer.

Repetir/resumir información clave

El proveedor se asegura de que los puntos principales le quedan claros al cliente.

Convencer o motivar al cliente

El proveedor motiva al cliente convenciéndole de que si hace lo que ambos han decidido, la situación mejorará pronto.

Comprobar la aceptabilidad/mutualidad de la toma de decisiones

El proveedor se asegura de que el cliente comprendió las decisiones adoptadas y convenidas.

Concluir

Pregunte al cliente si hay algo más que le gustaría saber. El proveedor felicita al cliente y le da las gracias por venir. Si es el caso, el proveedor se asegura de que al cliente le queda claro cuándo ha de regresar.

“Quisiera asegurarme de que he explicado todo claramente.”...“¿Me puede decir cómo y cuándo dará la medicina a su hijo?”...“¿Cuáles son las cosas más importantes que hará cuando regrese al hogar...?”

“Quiero que dé un paseo de 20 minutos cada día.” (NO diga: “Trate de hacer ejercicios diarios.”... “Lávese las manos cada vez antes de preparar la sopa para su hijo.” NO diga: “Tenga más higiene antes de preparar la comida para su familia”.)

“Quisiera recordarle tres cosas de las que hablamos...”

“Usted progresará rápidamente si sigue estas instrucciones”.

“Trabajaremos juntos para asegurarnos que usted (su hijo) mejora”.

3. Orientación a la Práctica (30 minutos)

Explicación cómo practicar las [nuevas] destrezas y técnicas que acaba de revisar.

El capacitador se asegura de que los participantes tienen una grabadora, que saben cómo efectuar la grabación y que disponen de una cinta para grabar. Se requiere que los participantes graben dos de sus encuentros y escuchen las cintas. A los que no tienen grabadora, el capacitador distribuye dos transcritos que tendrán que mejorar. Deberán regresar el día siguiente, con comentarios escritos de su propio desempeño. El instructor trata con los participantes las preocupaciones y responde a las preguntas.

Día 3: Destrezas de Comunicación Interpersonal

Análisis de la práctica (4 horas de instrucción)

- ◆ Repaso y análisis de las cintas de audio de los participantes. Los participantes pueden trabajar con un colega (pares) o con un grupo pequeño para formar equipos. Juntos, identifican los puntos fuertes, las debilidades y recomendaciones para mejorar el encuentro. Utilizarán la guía práctica portátil para comprobar la exactitud (2 horas). También se utilizará la grabación hecha en diciembre en Tegucigalpa como práctica de las destrezas aprendidas (anexo 7 para los transcritos).
- ◆ Práctica de destrezas adicionales en la plenaria mediante dramatización (1 hora, 30 minutos).
- ◆ Evaluación del curso por los participantes (véase anexo 10, el formulario de evaluación, 10 minutos).
- ◆ Recomendaciones acerca de la capacitación de comunicación interpersonal (CIP) futura en Honduras (debate en grupos pequeños o en la plenaria) (10 minutos).
- ◆ Sesión de clausura - entrega de diplomas (10 minutos).

Lista de las Transparencias

- Transparencia # 1* Objetivos de la capacitación
- Transparencia # 2* Lista de valores— resultados del grupo
- Transparencia # 3* El uso de lenguaje sencillo
- Transparencia # 4* Definición de la comunicación interpersonal
- Transparencia # 5* Objetivos de la capacitación
- Transparencia # 6* Destrezas de comunicación interpersonal
- Transparencia # 7* Definición de comunicación socioemocional
- Transparencia # 8* Comportamientos reforzando el contacto interpersonal
entre el cliente y el proveedor
- Transparencia # 9* Destrezas para resolver problemas
- Transparencia # 10* Asesoramiento e información/educación

Lista de los Anexos

- Anexo 1:* Lista de valores — Participante
- Anexo 1: p.2* Lista de valores — Cofacilitador
- Anexo 2:* Evaluación de su propia destreza de escuchar
- Anexo 3:* Eficiencia en el lenguaje
- Anexo 4:* Dé información clara a los clientes en una manera que entiendan
- Anexo 5:* Niveles de comunicación
- Anexo 6:* Guía de ayuda (presentada dos veces)
- Anexo 7:* Encuentro a mejorar con destrezas de comunicaciones interpersonales (CIP)
- Anexo 8 & 8 bis:* Guiones de destrezas para resolver problemas
- Anexo 9:* Guión de asesoramiento/información — «Ensayo mental»
- Anexo 10:* Evaluación

Anexo 1

Lista del Participante

Lista de Valores

Instrucciones: Aclarar las siguientes palabras en orden de importancia: 1 - 14. Dé una calificación de 1 a la palabra que, según usted, es más importante y de 14 a la menos importante.

- _____ Buena salud física
- _____ Seguridad financiera
- _____ Inteligencia
- _____ Educación
- _____ Limpieza
- _____ Matrimonio
- _____ Hijos
- _____ Exito en el desempeño profesional
- _____ Felicidad
- _____ Religión
- _____ Amigos
- _____ Reputación familiar
- _____ Ciudadanía
- _____ Cuidado de su propia familia

Lista para el Cofacilitador

Lista de Valores

Resultados del grupo: (Lista para el cofacilitador: codificación. Escriba los resultados en esta transparencia y expóngala en sesión plenaria cuando los resultados se hayan compilado. Explique los resultados al grupo, demostrando que las opiniones varían de acuerdo a los valores de cada uno.

Lista de Valores

	Total	Tasa Media	Orden de Opinión del Grupo
Buena salud física	_____	_____	_____
Seguridad financiera	_____	_____	_____
Inteligencia	_____	_____	_____
Educación	_____	_____	_____
Limpieza	_____	_____	_____
Matrimonio	_____	_____	_____
Hijos	_____	_____	_____
Éxito en el desempeño	_____	_____	_____
Felicidad	_____	_____	_____
Religión	_____	_____	_____
Amigos	_____	_____	_____
Reputación familiar	_____	_____	_____
Ciudadanía	_____	_____	_____
Cuidado de su propia familia	_____	_____	_____

Anexo 2

Evaluación de su Propia Destreza de Escuchar

Por favor, evalúese a sí mismo: Marcar sus niveles de involucramiento para cada una de las siguientes declaraciones:

Hábitos de Escuchar	Niveles de involucramiento			
	Siempre	De vez en cuando	Raramente	Nunca
Ocupado con algo, por ejemplo, escribiendo mientras que otra persona está hablando				
Aparenta estar atento al orador mientras que piense en otra cosa				
Sólo piensa en lo que va a decir después; no escucha				
No se concentra (sueña despierto) mientras que alguien habla				
Interrumpe al otro orador				
Busca errores (detalles) en lo que el orador dice <i>(no se concentra)</i>				

Anexo 3

Eficiencia en el Lenguaje

Por favor, escriba en términos sencillos lo siguiente, para que la madre entienda lo que Ud. dice:

Señora, su hijo está afectado de una infección respiratoria aguda, la cual infecta el aparato respiratorio de localización baja; la infección es de origen viral. La incubación es de corto período cuya evolución es de 2 semanas como máximo. Estas infecciones afectan a niños menores de 5 años. Protega a sus bebés.

¿Dígame señora, dónde ha notado Ud. los tirajes que tiene su hija? ¿Eran principalmente tirajes supraclaviculares, intercostales o subcostales?

¿Ha notado Ud. si el niño está cianótico y escuchó si tenía respiración jadeante?

¿Tiene antecedentes de alguna enfermedad seria? ¿Y la familia de su esposo tiene antecedentes de enfermedades hereditarias o alérgicas, como epilepsia?

Anexo 4

Dé Información Clara a los Clientes en una Manera que Entiendan

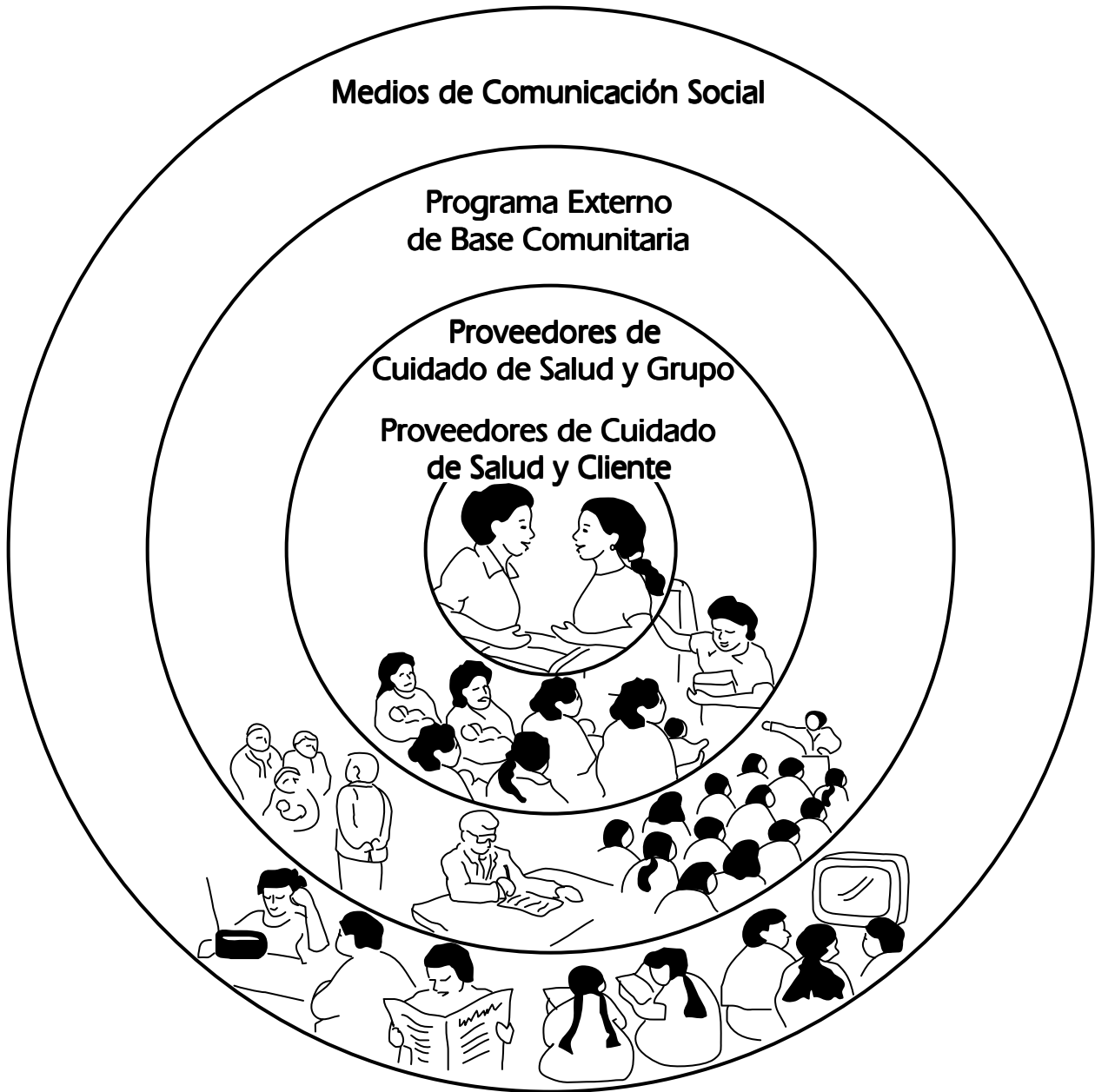
La información que les dé a los clientes debe ser correcta y clara.

Para asegurar que la información sea clara

- ◆ utilice palabras y frases cortas;
- ◆ utilice palabras que sus clientes entienden;
- ◆ utilice fotos y empresas, si son disponibles;
- ◆ de vez en cuando párese y pregúnteles a los clientes si entienden;
- ◆ averigüe si tienen algunas preguntas;
- ◆ cuando mencione partes del cuerpo, indíquelos;
- ◆ repita instrucciones;
- ◆ pida que los clientes repitan las instrucciones.

de: JHU/PopLine:Population Reports, Series J., No. 36 Dec. 1987 «Why Counseling Counts!»

Niveles de Comunicación



de: JHU/PopLine: Population Reports, Series J, # 36, Dec. 1987 "Why Counseling Counts!"



Anexo 6

Guía de Ayuda

(exterior)

Asesoría/Información/Educación

- ◆ Descubra cómo percibe la enfermedad el cliente
- ◆ Corrija las ideas equivocadas de los hechos
- ◆ Utilice el vocabulario adecuado
- ◆ Explique de forma organizada lo que se necesita saber/hacer a continuación (en bloques)
- ◆ Compruebe la comprensión que tiene el cliente acerca de la enfermedad
- ◆ Recomienda al cliente comportamientos concretos
- ◆ Incite al cliente a que continúe el tratamiento
- ◆ Asegúrese de que el cliente acepte el tratamiento

Cierre

- ◆ Asegúrese de que el cliente sabe cuándo volver
- ◆ Pregunte al cliente si desea saber algo más

GUIA PRACTICA PORTATIL

Destrezas Requeridas para una Comunicación Interpersonal Eficaz

Para los Proveedores de Salud Hondureños

Comunicación Socioemocional General

- ◆ Dé la bienvenida al paciente
- ◆ Recorra a comportamientos de comunicación verbal y no verbal

CHS/QAP, JHU, AED, 1994

(exterior)

Asesoría/Información/Educación

- ◆ Descubra cómo percibe la enfermedad el cliente
- ◆ Corrija las ideas equivocadas de los hechos
- ◆ Utilice el vocabulario adecuado
- ◆ Explique de forma organizada lo que se necesita saber/hacer a continuación (en bloques)
- ◆ Compruebe la comprensión que tiene el cliente acerca de la enfermedad
- ◆ Recomienda al cliente comportamientos concretos
- ◆ Incite al cliente a que continúe el tratamiento
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Cierre

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- ◆ Dé la bienvenida al paciente
- ◆ Recorra a comportamientos de comunicación verbal y no verbal

CHS/QAP, JHU, AED, 1994

Guía de Ayuda



(interior)

Pautas para Hablar con el Cliente – Diálogo

- ◆ Averigüe qué siente el paciente
- ◆ Felicite al paciente por sus esfuerzos
- ◆ Refuerce los sentimientos normales y comprensibles
- ◆ Refleje lo que el paciente dice
 - repita lo que dice el paciente
 - invítele a hablar más
- ◆ Demuestre empatía
- ◆ Demuestre apoyo/camaradería
- ◆ Ayude al paciente a no preocuparse

Destrezas para Resolver Problemas— Recopilación de Datos

- ◆ Escuche con eficacia
- ◆ Aliente el diálogo: haga preguntas abiertas
- ◆ Evite la interrupción
- ◆ Evite el diagnóstico prematuro
- ◆ Resista el seguimiento inmediato
- ◆ Indague (explore) para obtener mayor información
- ◆ Averigüe las causas, dificultades y temores relacionados con el problema



(interior)

Pautas para Hablar con el Cliente – Diálogo

- ◆ Averigüe qué siente el paciente
- ◆ Felicite al paciente por sus esfuerzos
- ◆ Refuerce los sentimientos normales y comprensibles
- ◆ Refleje lo que el paciente dice
 - repita lo que dice el paciente
 - invítele a hablar más
- ◆ Demuestre empatía
- ◆ Demuestre apoyo/camaradería
- ◆ Ayude al paciente a no preocuparse

Destrezas para Resolver Problemas— Recopilación de Datos

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- ◆ Evite la interrupción
- ◆ Evite el diagnóstico prematuro
- ◆ Resista el seguimiento inmediato
- ◆ Indague (explore) para obtener mayor información
- ◆ Averigüe las causas, dificultades y temores relacionados con el problema

Encuentro a Mejorar con Destrezas de Comunicación Interpersonal

Caso # 1

Px. Buenos días

Dr. Buenos días, que le pasa a la niña?

Px. Fíjese que tiene unas grandes fiebres que no..

Dr. No le dio aspirinas?

Px. Le di, Doctor.

Dr. Qué más tiene la niña?

Px. Hace tres días estuvo obrando con sangre.....diarrea, también...

Dr. Cuando comenzó la diarrea? Ayer o hace más tiempo?

Px. Hace más tiempo.

Dr. Sea, por favor, más precisa, Señora. Comenzó desde el lunes o el martes?

Px. El lunes.

Dr. A qué horas, por la mañana, en la tarde?

Px. En la tarde, en la tarde, por la tarde.

Dr. Y antes de comenzar la diarrea la niña comenzó a mostrar algún malestar, dolor de abdomen, dolor de barriga o algún vómito, apareció asientos?

Px. Sí

Dr. Y cómo son las características de estos asientos, son líquidos, blandos?

Px. Pero no son líquidos, pura diarrea, también hace ...

Dr. De qué color?

Px. A veces lo hace verde, amarillo, hay días que lo hace bien negro, cuando come..., bien negro.

Dr. Tiene dolor?

Px. Sí, como come a veces lo hace bien negro, bien feo.

Dr. ... la cantidad de sangre que lleva es poca, o solo son manchas?

Px. No, solo son gotitas (estrías), sí.

Dr. Cuántos asientos hace al día?

Px. Mire estuvo haciendo casi como 8 veces en el día.

Dr. Ayer miércoles?

Px. Ayer miércoles, ya no, fíjese ayer ya no estuvo haciendo, ayer ya solo hizo en la noche.

Dr. Cuántos asientos hizo al día? Cuántos?

Px. 2 veces ahora en la mañana, y dos veces en la madrugada.

Dr. Pero siempre de color verde, sí, y con estrías, siempre con manchitas de sangre, y siempre con olor y siempre con dolor?

Px. No, no siempre, de vez en cuando....

Dr. vómito?

Px. No, solo la fiebre.

Dr. Y la fiebre, como le empezó?

Px. La fiebre, la fiebre, la tiene, mire la fiebre siempre la ha padecido ella, y la lleve a una clínica y me dijeron que era infección aquí, al pecho, pero resulta que me le pusieron de esta.... Penicilina procainica pero no me le ha llegado la fiebre no me se le quita; en la noche tiene más, de fiebre, creo que tiene come 3 días ya,...

Dr. Tiene tos? sí, la tos, secreción de nariz?

Px. Sí la tos, desde ayer la tiene.

Dr. Le escuche si tiene sibilancia?

Px. Siento ruidos en el pecho, bien feo, mire bien cansada, se siente...mire.

Dr. Bueno ahora me va a dar información sobre estos otros datos de aspecto general, verdad?

Px. Sí

Dr. ...piso...agua potable...ventilada la casa....servicios sanitarios....la estufa...patio...los cuartos..ventilados,....humedad...mucho polvo...// embarazo...complicación...donde...

Dr. Y le hicieron episiotomía y puntos?

Px. Epitomia? ...no...creo, puntos... sí creo.

Dr. Cuánto pesó la niña al nacer?

Px. Mire que no sé

Dr. No recuerda?

Px. No me lo dijeron ahí

Dr. No midieron ni pesaron a la niña al nacer?
Px. No, no recuerdo
Dr. Ud. no se le ocurrió...
Px. Yo lo que escuché es que la numeración que a mi me dijeron , yo no le entendí, Yo le pregunté a la muchacha y me dijo que como ocho y medio había pesado la niña.
Dr. Pero no tiene seguridad?
Px. No tengo seguridad
Dr. Pero la niña nació sin ninguna complicación?
Px. Sí
Dr. No hubo necesidad de que le aplicaran oxígeno?
Px. No.
Dr. No resucitador? La tuvieron en incubadora?
Px. No
Dr. El mismo día a las horas después del parto la llevaron a su cama a que le pusiera el pecho?
Px. Sí
Dr. Cuántos días estuvieron internas?
Px. No, solo al siguiente día me vieron otra vez.
Dr. De alta?
Px. Sí
Dr. Ningún problema?
Px. Ningún problema
Dr. Ud. y la niña salieron en buenas condiciones?
Px. Sí
Dr. A la niña,... la ha tenido ya interna en hospitales alguna vez?
Px. Sí, la tuve en el seguro, allá en San Pedro Sula.
Dr. Qué enfermedad le diagnosticaron?
Px. No, solo era la fiebre, doctor.
Dr. Pero le dijeron alguna...nada?
Px. No, no me dijeron que era, me dijeron que era infección nada más.
Dr. Infección en dónde?
Px. Aquí, ve.
Dr. Infección en la garganta.... Solamente esa vez ha estado interna la niña?
Px. Sólo esa vez.
Dr. Y ella posteriormente no ha padecido de otras enfermedades? Asma?

Px. No, solo...
Dr. Bronquitis?
Px. No
Dr. Neumonía, bronconeumonía?
Px. No
Dr. Sarampión. Nunca ha tenido anteriormente diarrea con sangre? Sólo son las fiebres que me le han pasado?
Dr. Qué edad tiene Ud?
Px. 23 años voy a cumplir ahorita.
Dr. Casada, soltera o unión libre?
Px. Soltera.
Dr. Está sin marido entonces?
Px. Vivo con mi mamá.
Dr. Cuántos hijos tiene?
Px. Dos.
Dr. Y el otro hijo qué tiene... qué edad....?
Px. Tiene cuatro años.
Dr. Varón?
Px. Hembra también.
Dr. Hembra también.... Ha tenido abortos Ud?
Px. Ninguno
Dr. Ambos embarazos y los dos partos han sido normales?
Px. Sí
Dr. Bien, ahora me va a referir en relación a las enfermedades de su familia....antecedentes familiares...eh su familia tuvo o tiene parientes que padezcan de diabetes o azúcar en la sangre?
Px. No
Dr. De una enfermedad en los pulmones que se llama tuberculosis ha padecido algún pariente en su familia?
Px. Lo único que han padecido es de unos poquitos, que padece de asma.
Dr. quién?
Px. Un sobrino, nada más.
Dr. Pero Ud. no ha padecido?
Px. No
Dr. Algún hermano o por parte de su marido, su esposo o algún cuñado, cuñada?

Px. No
Dr. eh....convulsiones y epilepsia padece algún el la familia?
Px. No, tampoco
Dr. Su marido, qué edad tiene el papa de la niña?
Px. 23, 24 años.
Dr. Convive con él?
Px. No
Dr. Están separados?
Px. Sí
Dr. Pero, él es sano?
Px. Sí
Dr. No tiene antecedentes de ninguna enfermedad seria?
Px. No, No
Dr. Y la familia también de su marido no tiene antecedentes de enfermedades hereditarias o alérgicas?
Px. No
Dr. Por ejemplo, epilepsia, convulsiones?
Px. Este,...epilep...epe...convulsiones le pegó a una sobrinita de él, pero sé que fue por una caída, nada más, pero ya no padece más de eso.
Dr. Y su niña qué tipo de comida le da?
Px. Yo le doy comida de la que yo como.
Dr. Y le da pecho?
Px. Leche y pepe.
Dr. Y, ...lactancia de su pecho?
Px. Sí, también
Dr. La combina con leche artificial?
Dr. Ud. trabaja?
Px. No, ahorita no.
Dr. Por qué le da leche artificial a la niña?
Px. No me abundaba mucho la leche.
Dr. A los 10 meses, cómo le prepara los pepes, qué cantidad de agua le pone?
Px. No se bebe un pepe todavía.
Dr. En cuanto a sus alimentos, qué clase de alimentos le da?
Px. Bueno, yo le doy...
Dr. Bueno, ya le hace tres tiempos desayuno, almuerzo y cena, y qué le da?

Px. Bueno, yo le doy papa, tortilla desechita con frijoles y arroz.
Dr. Le da pan, tortilla?
Px. Sí
Dr. Frutas?
Px. Sí
Dr. Bueno, ahora pasamos al examen físico, sosténgame y ayúdeme por favor.
Dr. Bueno.... le puede....hidratación al niño, le ha iniciado Ud. en su casa Litrosol?
Px. No, no le he dado Litrosol.
Dr. Pero no va a saber Ud. que existe el Litrosol o sí?
Px. Sí
Dr. Están sucias las manos, verdad hay que mantener aseada a la niña, verdad, con mucho cuidado...mantener las manitas lavadas siempre verdad con agua y jabón... acostumbra darle Ud. el agua hervida o casi pura, como la trae.
Px. Así pura como la traen.
Dr. ¡Ay Señoral y qué le pasa entonces se ha mantenido Ud. alejada del Centro de Salud, no ha recibido instrucción de cómo llevar el manejo de la higiene de su niña? (llanto de niño) Entonces de ahora en adelante tiene que venir seguido, Ud. a sus citas de crecimiento y desarrollo....para que no siga sufriendo esta desinformación en la que Ud. está; venga acá a recibir instrucciones acerca de las diferentes enfermedades que hayen el ambiente, para que así sepa en su casa Ud. proporcionarle cualquier medida...verdad....de emergencia auxiliar antes de traerla a un centro de salud, allí le enseñan el manejo de la fiebre, el manejo de la hidratación en el período en que el niño vomita y diarrea así como en el aseo personal de los niños, sea en la higiene dental y en el control de sus vacunas....tiene su carnet de vacunación?
Px. Sí
Dr. Bueno, hasta ahora las vacunas van correctas verdad....Bien entonces su niña tiene que darle hidratación, no es una diarrea severa, podrá ser un síndrome diarreico agudo, probablemente la característica es viral, con instalación aguda verdad...las características de hidratación más

sin embargo, se le recomienda que le haga un examen de heces, verdad, acá en el laboratorio para determinar si hay además de esta infección viral, además si hay asociados algunos parásitos intestinales, verdad....la va a hidratar., oralmente con Litrosol. Es necesario que lo conozca y lo sepa manejar, verdad que se le van a dar instrucciones acerca del manejo del Litrosol y Ud.

en su casa las medidas higiénicas, verdad...darle agua hervida, verdad...su alimentación normal y su pecho, verdad....no le suspenda ninguna dieta únicamente durante este período diarreico no le dé alimentos fuertes con fibras gruesas como carne de res y cerdo , verdad, déle dieta suave, proteica,y ...estará mejor, verdad?

Anexo 8

Guión: Destrezas Para Resolver Problemas— Recopilación de Datos Para Comprender la Situación y los Problemas del Cliente

Lea lo siguiente, PERO solo diga al proveedor de salud lo que él le pida. (5 minutos de dramatización)

Instrucciones: Para los participantes "A" (los pacientes)

Ud. está enfermo, sufre de dolor de cabeza, se siente cansado, muy débil, transpira, orina mucho y las orinas son casi incoloras. Ud. tiene bastante apetito y sed, pero está notando que pierde peso. . . Su mamá tiene diabetes, también el hermano de su mamá. Ud. toma aspirinas para el dolor de cabeza pero no le ayuda. No sabe qué comer, su amiga le dijo que tomara jugo de naranja y comiera bananas.



Guión: Destrezas Para Resolver Problemas— Recopilación de Datos Para Comprender la Situación y los Problemas del Cliente

Instrucciones: Para los participantes "B" (los proveedores)

Ud. es un proveedor de salud. Le llega una señora (o señor). Con todas las destrezas revisadas hoy, trate de diagnosticar en 5 minutos lo que tiene, y vea lo que hay que hacer en el futuro (laboratorio, régimen, medicamentos, cambiar actitudes. . .)

Guión: Destrezas Para Resolver Problemas— Recopilación de Datos Para Comprender la Situación y los Problemas del Cliente

Lea lo siguiente, PERO solo diga al proveedor de salud lo que él le pida. (5 minutos de dramatización)

Instrucciones: Para los participantes "A" (los pacientes)

Hace dos semanas que Ud. está dando a su bebé de 4 meses alimentos adicionales porque se queja Ud. de no tener suficiente leche. Desafortunadamente hace una semana que su bebé no duerme bien porque tiene un resfrío, no le gusta la comida que le da, y desde ayer tiene diarrea y fiebre. Ud. está muy nerviosa, no sabe qué hacer, parece que su leche está disminuyendo. Ud. no trabaja, es su primer hijo y vive con su mamá.



Guión: Destrezas Para Resolver Problemas— Recopilación de Datos Para Comprender la Situación y los Problemas del Cliente

Instrucciones: Para los participantes "B" (los proveedores)

Ud. es un proveedor de salud. Le llega una señora. Con todas las destrezas revisadas hoy, trate de diagnosticar en 5 minutos lo que tiene, y vea lo que hay que hacer en el futuro (laboratorio, régimen, medicamentos, cambiar actitudes. . .)

Anexo 9

Guión de Asesoramiento/Información - “Ensayo Mental”

A continuación se le presenta un ejercicio, léalo e imagínese dando asesoramiento. Escriba luego las formas en que abordan la sesión de asesoramiento.

Imagínese dando asesoramiento/información al cliente:

El padre de un niño de 4 años consulta porque éste tiene fiebre de 39.5 C, dolor de garganta, ha vomitado 2 veces y no tiene apetito. Al examinarlo Ud. observa que tiene la garganta enrojecida con puntos blancos, los ruidos pulmonares son normales pero tiene algunos signos de dificultad respiratoria. El padre está muy nervioso, principalmente porque su esposa también está enferma y porque dice que no sabe qué hacer con el niño que llora mucho cada noche.

A continuación se le presenta un ejercicio, léalo y imagínese dando asesoramiento. Escriba luego las formas en que abordan la sesión de asesoramiento.

Imagínese dando asesoramiento/información al cliente:

A la consulta del Centro de Salud Jutiapa acude un padre con su niño de 10 meses de edad; manifiesta que éste tiene fiebre, tos y no respira bien y desde hace cuatro días presentó resfrío. Refiere además que el tratamiento que le dieron en la casa fue: té de manzanilla y panadol; sin embargo, a pesar del tratamiento el niño no mejoró; luego desde hace un día empezó a respirar muy rápido y se nota bastante inquieto. Al realizar el examen físico, Ud. encuentra que no tiene tiraje, no tiene cianosis, no tiene estridor, pero está inquieto y además tiene temperatura de 38.7C.

Anexo 10

Evaluación de la Capacitación: Destrezas de Comunicación Interpersonal Para Proveedores de Atención Primaria de Salud

HONDURAS - 8 - 10 DICIEMBRE 1993

Las siguientes preguntas sirven para evaluar la presente capacitación. Agradecemos de antemano su valiosa contribución por responder a cada una de ellas. Esta evaluación será anónima; mucho le agradeceríamos que contestara a todas las preguntas lo más sinceramente posible.

1. ¿Favor de indicar qué más le gustó durante esos tres días? ¿y por qué?

2. Favor de indicar en qué grado le gustó la capacitación colocando un círculo alrededor del número que mejor describa su agrado dentro de la escala abajo indicada.

Escala		
no me gustó	→	me gustó mucho
1 2 3 4 5 6 7 8 9 10		· los conceptos básicos de Comunicación Interpersonal (CIP)
1 2 3 4 5 6 7 8 9 10		· el intercambio de ideas entre colegas
1 2 3 4 5 6 7 8 9 10		· las simulaciones para percibir mejor las destrezas
1 2 3 4 5 6 7 8 9 10		· el ejercicio con el transcrito del encuentro
1 2 3 4 5 6 7 8 9 10		· el video en consejería
1 2 3 4 5 6 7 8 9 10		· la práctica, con la grabación, con el transcrito
1 2 3 4 5 6 7 8 9 10		· el análisis de la práctica

3. ¿Cuál es el tema que le gustó más? ¿y por qué?

¿Cuál es el tema que le gustó menos? ¿y por qué?

4. ¿Cuáles piensa Ud. que serán los temas de más utilidad en su trabajo?

¿Y los de menos utilidad?

5. Le agradeceríamos que nos hiciera saber sus comentarios y sugerencias para mejorar la calidad de la capacitación.

6. Otros comentarios.

Data Collection Tools



Instruments Used to Evaluate the Interpersonal Communication (IPC) Training Course



Quality Assurance Project

Center for Human Services

in collaboration with

The Academy for Educational Development

and

The Johns Hopkins University

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Introduction

Coding Communication Behaviors

In each of the three case studies, a method of observation was used. In both Trinidad and Honduras, an audiotape was made of the medical visits and analyzed using a well established method of interaction analysis. The system codes each phrase or complete thought in the visit by either the patient or physician into one of 34 mutually exclusive and exhaustive categories. Coding is done directly from audiotapes, with adequate inter-coder reliability. Reliability coefficients for physician categories average .76 (range .58-.90) and for patient categories average .81 (range .71-.99), based on double coding of a random example of 10% of audiotapes.

For simplicity, the large number of individual coding categories are reduced to meaningful composites falling within three the functional groupings of interaction related to the visit's content, affect, and process. Instrument 1, presents the content composites, the individual code categories included within the composites, and category examples of dialogue.

In Egypt, audiotape analysis was not feasible, so an alternative method of observation method was developed through the use of a check list. It was done with the help of a predetermined form ("hands on" observation check list) with coded behavioral habits that we wanted to see happening during an encounter between a health provider and a patient. These coded observed behaviors reflect the interpersonal communication (IPC) skills introduced to the medical doctors when they received the training.

Physician Questionnaire

Self-administered questionnaires for physicians were included in the case studies. They included open and close-ended questions providing a pre-training needs assessment and physicians' ratings of the course methods and content. The questionnaires were given just after the physicians met with their patients.

Patient Exit Interview

Each of the three case studies used similar questionnaires, however each was modified according to local needs. The same questionnaire was used in Trinidad and in Egypt with only a few changes in the order of the questions. In Honduras the questionnaire was similarly structured, however, the selection of items for scales was different, reflecting different response patterns of the subjects. In all settings we included a 1-item global satisfaction measure. The exit interviews were carried out by the same person who observed the clinical encounter or by another trained professional such as a doctor or nurse who had received IPC training.

These differences had implications for subsequent analysis. In Honduras, our satisfaction measures reflected three quite independent aspects of satisfaction and produced three subscales: satisfaction with informative behaviors, positive behaviors and negative behaviors. In Trinidad, however, a similar set of items showed less variation and we were able to derive only one 9-item subscale of general satisfaction.

INSTRUMENT 1
The Roter Interaction Analysis System (RIAS)

Functional Grouping	Communication Behavior	Examples
Content Categories	Question-Asking (re: medical condition, therapeutic regimen, psychosocial topics)	
	(Open-ended)	What can you tell me about the pain? How have you responded to the pills? What's happening with your son?
	(Close-ended)	Does it hurt when you bend? Did the shot help? Are you sleeping any better?
	Biomedical Information (re: medical condition, therapeutic regimen)	The pills may make you drowsy. You'll need to take the antibiotics every day for 10 days.
Affective Categories	Psychosocial Exchange (re: problems of daily living, issues re social relations, and feelings and emotions)	It is important to get out and do something daily. The Senior Center is a great place for company and they'll give you lunch, too.
	Positive Talk (agreements, approvals, laughter/jokes)	You look fantastic. You're doing great!
	Negative Talk (disagreements, disapproval)	I think you're wrong. You weren't being careful.
	Social Talk (nonmedical chitchat)	How about that baseball game last night?
Process Categories	Emotional Talk (concern, reassurance, empathy, support)	I know you're worried about your heart. We'll take care of it—it will be OK.
	Facilitation (asking for patient opinion, patient understanding, paraphrase)	What do you think it is? Do you follow? Let me make sure I've got it right—you said the pain is less than before, but still bad.
	Orientation (directions/instructions)	Get up on the table, take a deep breath.

Tape Summary Form

Interview code _____ Sex of provider _____
Date of coding _____ Sex of patient _____
Coder ID _____

1. Global Affect Ratings (for complete interview)

	Provider	Patient
Anger/Irritation (LO)	1 2 3 4 5 6	1 2 3 4 5 6
Anxiety/Nervousness	1 2 3 4 5 6	1 2 3 4 5 6
Dominance/Assertiveness	1 2 3 4 5 6	1 2 3 4 5 6
Interest/Concern	1 2 3 4 5 6	1 2 3 4 5 6
Friendliness/Concern	1 2 3 4 5 6	1 2 3 4 5 6
Responsiveness	1 2 3 4 5 6	1 2 3 4 5 6
Sympathetic/Empathetic	1 2 3 4 5 6	1 2 3 4 5 6
Depression	1 2 3 4 5 6	1 2 3 4 5 6
Emotional distress	1 2 3 4 5 6	1 2 3 4 5 6

2. Counter #s Beginning _____ End _____

3. Any interruptions?

- Third party interruption
- Telephone
- Dr./Patient leaves room
- Clinic staff participates

4. Overall tape quality

- Good
- Fair (somewhat difficult to understand)
- Contains inaudible sections
- Poor (explain)

5. Treatment regimen discussed on tape (check all that apply):

- Prescriptions
- Diet
- _____ Ongoing
- Exercise
- _____ Changed
- Stress
- _____ New
- Over-the-counter drugs or remedies

	DRUG	DIET	EXERCISE	TEST
I. Assessment-Inquiry				
a. Indirect or rhetorical (e.g., no problems?)	_____	_____	_____	_____
b. Simple direct (e.g., have you been taking your pills following your diet, etc?)	_____	_____	_____	_____
c. Information seeking—intensive—Detailed (e.g., when did you take it last? How many tablets did you take?)	_____	_____	_____	_____
d. No assessment.				

II. Problem identification re compliance (established a compliance problem and understands its dimensions, e.g., cost of medication, side effects, lack of understanding of dosage)

	DRUG	DIET	EXERCISE	TEST
a. No compliance problem identified, all OK	_____	_____	_____	_____
b. Partial compliance problem identification (implies only partial closure)	_____	_____	_____	_____
c. Full problem identification (implies closure of discussion)	_____	_____	_____	_____
d. Problem implied but not made explicit	_____	_____	_____	_____
e. Availability problem	_____	_____	_____	_____

III. Resolution

a. Full or passive acceptance (both types of compliance)	_____	_____	_____	_____
b. Rejected (of either)	_____	_____	_____	_____
c. Implied conflict, suggested noncompliance (personal)	_____	_____	_____	_____
d. Mid-compromise, making deals or negotiation — availability issue	_____	_____	_____	_____
e. No problem resolution discussed (both)	_____	_____	_____	_____

INSTRUMENT 1: The Roter Interaction Analysis (RIAS)

(Honduras and Trinidad)

Interview code _____ Date of coding _____ Coder ID _____

Length of interview _____

PROVIDER	PATIENT
personal	personal
laughs	laughs
approve	approve
comp	comp
agree	agree
BC	
check	check
empathy	empathy
concern	concern
R/O	R/O
legit	legit
partner	
self-dis	
disapprove	disapprove
crit	crit
?reassure	?reassure
trans	trans
orient	orient
?bid	?bid
?understand	?understand
?opinion	
(?)med	?med
(?)thera	?thera
(?)tls	?tls
(?)l/s	?l/s
(?)p/s-f	?p/s-f
(?)other	?other
?med	
?thera	
?tls	
?l/s	gives-med
?p/s-f	
?other	gives-thera
gives-med	
	gives-tls
gives-thera	
gives-tls	gives-ls
gives-ls	gives-p/s-f
gives-other	gives-other
C-med/thera	
C-mt;ls	
C-l/s,p/s	?service
unintell	unintell

INSTRUMENT 2
Health Provider's Observation Check List

QUALITY ASSURANCE PROJECT

Cairo, Egypt

November 1994 - January 1995

The following check list is used to record the observation made during an encounter between a medical doctor (health provider) and a patient.

Date _____

Name of Interviewer/Number _____ # _____

Hospital Name/Number _____ # _____

Health provider ID number _____ # _____

Trained in IPC skills [] yes

[] no

Sex of patient [] female

[] male

The following behaviors are presented in a specific order, and divided within three dimensions. This was the order and the way the training was presented to the participants.

NOTE THAT THE ENCOUNTER MAY FOLLOW A TOTALLY DIFFERENT ORDER, IT'S FINE, WE ARE LOOKING FOR THE BEHAVIORS TO HAPPEN AT ANY MOMENT OF THE ENCOUNTER. THE SEQUENCE DOES NOT MATTER.

Check List for Analysis of Health Provider's Observation

SKILL	YES (frequency)	NO	COMMENT (intensity)
A. Socio— Emotional			
Welcome patient			
Use positive non verbal communication			
Repeat what patient said			
Show empathy			
B. Problem Solving			
Encourage dialogue (open-ended questions)			
Ask what causes problem			
Avoid premature dialogue			
Explore more information			
Listen effectively			
C. Counseling Information Given			
Present info in block			
Use appropriate vocabulary			
Give specific behavioral recommendation			
Check acceptability of treatment			

Overall Comments

Time recorded for the encounter: _____ minutes.

INSTRUMENT 3
Physician Questionnaire

QUALITY ASSURANCE PROJECT

Cairo, Egypt

November 1994 - January 1995

The following questionnaire is addressed to the physicians of the May 15 Hospital in Cairo who participated in the observation check list exercise. This questionnaire goes along with the exit interview addressed to the patient who will be interviewed when leaving the doctor.

Date _____

Hospital Name/Number _____ # _____

Health provider ID number _____ # _____

Trained in IPC skills [] yes [] no

◆ What makes it most difficult to communicate with your patients?

◆ What three things would help you do your job better?

◆ What makes it difficult for patients to comply with the treatment you prescribe?

HERE THE QUESTIONNAIRE STOPS FOR THE MEDICAL DOCTORS WHO DID NOT ATTEND THE IPC COURSE LAST JULY.

Over please (for the IPC trained MDs).

◆ What are the most useful skills of the Interpersonal Communication (IPC) course that you received last July that you apply when having the encounter with patient?

(1) _____

(2) _____

(3) _____

◆ Do you use the "job aid"/pocket guide that you used during the course?

Yes [] No []

If yes, is it useful? Yes [] No []

Why?

◆ Tell us why (or why NOT) you would recommend an IPC course to colleagues?

Additional comments:

THANK YOU.

INSTRUMENT 4
Patient Exit Interview
QUALITY ASSURANCE PROJECT

Name of Interviewer/Number _____ # _____

Hospital Name/Number _____ # _____

1. Health Provider ID Number _____ # _____

2. Date ____ / ____ / ____
day mo year

3. Sex of Patient []¹ Male
[]² Female

We'd like to ask you some questions about your visit with the doctor today. There are no right or wrong answers; we just want your opinion. No one at the hospital will ever know how you answered these questions.

4. What illness brought you to the hospital today?

5. Was today the first time you have been treated by this doctor?

[]¹ Yes
[]² No

6. **Overall, how satisfied** are you with the way the doctor treated you today? Would you say you are very satisfied, somewhat satisfied, slightly satisfied or not at all satisfied?

[]¹ very much
[]² somewhat
[]³ slightly
[]⁴ not at all
[]⁹ don't know

7. How **interested** in your health problem was the doctor who treated you today—very much, somewhat, slightly or not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

8. How **respectfully** were you treated today by the doctor—very, somewhat, slightly, not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

9. How **caring** was the doctor today—very, somewhat, slightly, not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

10. How **rushed or hurried** would you say the doctor was today—very, somewhat, slightly, not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

11. How much did the doctor **bouff** you today—very much, somewhat, slightly, or not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

12. How **welcoming** was the doctor in greeting you today—very much, somewhat, slightly, or not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

13. How much did the doctor **make you feel small** today—would you say very much, somewhat, slightly or not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

14. How **attentively** do you think the doctor listened during the consultation—very, somewhat, slightly or not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

15. How much were you **interrupted** during your consultation—very much, somewhat, slightly or not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

16. During your visit, **who do you think spoke more**, you or the doctor?

-]¹ doctor
-]² patient
-]³ about the same
-]⁹ don't know

17. How much do you feel the doctor **cut you short** while you were speaking —very much, somewhat, slightly or not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

18. How much do you feel the doctor **appreciated what you do** to take care of yourself—very much, somewhat, slightly or not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

19. What did the doctor **tell you to do**/to care for yourself/?

[DON'T READ ANSWERS, MORE THAN ONE ANSWER OK]

-]¹ medicine
-]² dietary
-]³ exercise/fitness (reduce or increase)
-]⁴ stress reduction
-]⁵ work reduction
-]⁶ other _____ (specify)
-]⁹ don't know

20. How much do you feel the doctor **encouraged you to follow-through** with your treatment plan—very much, somewhat, slightly or not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

21. How much would you say you **trust** the doctor who treated you today — very much, somewhat, slightly, or not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

22. How important do you think it is that you and the doctor **decide together** on a treatment plan—very much, somewhat, slightly or not at all?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

23. How important is it that the doctor **show interest in what you have to say?**

- ¹ very much
- ² somewhat
- ³ slightly
- ⁴ not at all
- ⁹ don't know

24. How important is it to you that the doctor ask about **all** your health problems, complaints, and concerns—very much, somewhat, slightly, not at all?

- ¹ very much
- ² somewhat
- ³ slightly
- ⁴ not at all
- ⁹ don't know

25. How important is it to you that the doctor **notice your feelings**, especially any sad or worried feelings you might have had?

- ¹ very much
- ² somewhat
- ³ slightly
- ⁴ not at all
- ⁹ don't know

26. How important is it to you that you **understand** all that the doctor tell you—very much, somewhat, slightly, not at all?

- ¹ very much
- ² somewhat
- ³ slightly
- ⁴ not at all
- ⁹ don't know

27. How important is it to you that the doctor gives **you as much time as is necessary** to speak about health problem—very much, somewhat, slightly or not at all?

- ¹ very much
- ² somewhat
- ³ slightly
- ⁴ not at all
- ⁹ don't know

28. How important is it to have **privacy** while you are with your doctor—very, somewhat, slightly, or not at all?

- ¹ very much
- ² somewhat
- ³ slightly
- ⁴ not at all
- ⁹ don't know

29. How much do you feel the doctor **considered your previous medical problems** when treating you today — very much, somewhat, slightly or not at all?

- ¹ very much
- ² somewhat
- ³ slightly
- ⁴ not at all
- ⁹ don't know

30. How many things were you **not able to discuss** with your doctor today, that you would have hoped to address? Would you say many, some, a few, or none at all?

- ¹ many
- ² some
- ³ few
- ⁴ none at all
- ⁹ don't know

31. How easy was it for you to understand the words your doctor used?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

32. Did the doctor you saw today ask if you had any questions about the recommended treatment?

-]¹ Yes
-]² No
-]⁹ don't know

33. Did the doctor explain to you what you didn't understand?

-]¹ Yes
-]² No
-]⁹ don't know

34. Did the doctor ask if you feel able to complete his/her recommended treatment?

-]¹ Yes
-]² No
-]⁹ don't know

35. Did the doctor go over the steps you need to take to follow his/her recommendations and treatment?

-]¹ Yes
-]² No
-]⁹ don't know

36. How much privacy would you say you had in today's visit?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

37. Did you receive a prescription for any medicine?

-]¹ Yes
-]² No ————— > SKIP TO QUESTION 44

38. People sometimes have difficulty following doctors' orders as prescribed. Do you think you will be able to follow your doctor's suggested treatment?

-]¹ very much
-]² somewhat
-]³ slightly
-]⁴ not at all
-]⁹ don't know

39. Where do you think you will get your medicines?

[DON'T READ ANSWERS]

-]¹ Hospital Pharmacy
-]² Will return to hospital when there is a new supply
-]³ Go to another health center pharmacy
-]⁴ Go to a private pharmacy
-]⁵ Won't get them/can't afford to buy/will "wait"
-]⁶ Other _____
-]⁹ Don't know

40. It is likely or unlikely that you will buy the medicine that the doctor prescribed?

- ¹ Likely
- ² Unlikely
- ⁹ Neither/Don't know

41. Is it likely or unlikely that you would stop your treatment if you were feeling **better**?

- ¹ Likely
- ² Unlikely
- ⁹ Neither/Don't know

Thank you very much for all your time. We appreciate your help.

INSTRUMENT 5

Cuestionario Para Entrevista al Salir de Consulta

Proyecto de Garantía de Calidad

Actividad en Honduras

Version 30 de Noviembre, 1993

ENCUESTADOR: CUANDO HAYAN ESPACIOS PROVISTOS, ESCRIBA LAS RESPUESTAS EN ESOS ESPACIOS. EN TODOS LOS OTROS CASOS DEBEN HABER LISTADOS DE RESPUESTAS ASOCIADAS A CADA PREGUNTA. USE ESOS LISTADOS PARA CODIFICAR LAS RESPUESTAS. ENCIERRE EN UN CIRCULO LA RESPUESTA QUE DEN LOS ENTREVISTADOS.

No. Identificación de la encuesta _____

Medición

1. Pre test 2. Post test

Grupo

1. Experimental 2. Control

Fecha de encuesta _____
(Día) (Mes) (Año)

Hora de Realización de la Encuesta _____
(Hora) (Minutos)

1. Nombre del Encuestador: _____

1. Dr. Lilian Dominguez 3. Dr. Alicia Rivera
2. Dr. Lisandro Guillen 4. Dr. Josefina Borjas

2. UPS donde se encuesta

- | | | | |
|---------------------|-----------------------|----------------------|--------------------|
| 1. San Felipe | 6. El Chile | 11. Villa Adela | 16. La Cuesta |
| 2. Hospital Escuela | 7. Brisas del Picacho | 12. Flor del Campo | 17. Mateo |
| 3. Alonso Suazo | 8. 3 de Mayo | 13. El Bosque | 18. IHSS/La Granja |
| 4. Monterrey | 9. San Francisco | 14. Pedregal | 19. Monte Redondo |
| 5. El Manchen | 10. Las Crucitas | 15. San Benito Pinos | 20. Alemania |

3. Número de Identificación del Prestatario de Servicio

(E: *ESCRIBIR DIRECTAMENTE EL NUMERO*) _____

Hospital Escuela

005 Gustavo Vallejo
007 Hugo Castro Sierra
010 Raul Marengo
015 Wilfredo Argueta
016 Servio Tulio Mateo

San Felipe

026 Rebeca Soriano
034 Ana Andino
037 Ruben Juarez
039 Dennis Velasquez
044 Selvin Omar Perez
046 Guillermo Perez
053 Suyapa Barcenas
054 Jose Mancía Herrera
055 Juan Benavides
058 Marco A Rodriguez
059 Fausto Varela
066 Bernanardo Bulnes
062 Blanca Serrano

Las Crucitas

118 Zudora Berlioz
120 Marta Rubi
178 Maylin Chong Pineda

Brisas del Picacho

084 Carlos Mead

Alonso Suazo

069 Jose Mario Rivera
070 Maria A. Oyuela
071 Liberato Aleman
151 Lilian Banegas

El Manchen

073 Alejandro Gonzalez
075 Marta Urquia Banegas

El Chile

080 Ruth Medina
081 Iris Milagro Tejeda

3 de Mayo

094 Alberto Pineda
097 Milton Castellanos

Monte Redondo

156 Mirella Pavon

El Bosque

136 Rosa Cabrera
150 Lorenza Martinez

San Francisco

110 Jovita Ponce

IHSS

183 Reina Yadira Galvez
184 Carlos Pinto
185 Anibal Benitez
186 Ricardo Corrales
187 Anibal Villatoro
188 Franklin Rodriguez
189 Quintin Hernandez
190 Roberto Castillo
191 Hiram Coello
192 Marcio Sarmiento
193 Marco A Sarmiento
194 Mario Valdez
195 Silvia Ondina Bueso
196 Telma Bonilla
197 Maria Felix Ferrera
198 Obdulio Rodezno
199 Nohemi Salguero
200 Mario Erazo
201 Lorena Medina

Monterrey

103 Ruben Dario Rodriguez
104 Sagrario Guevara
102 Nerza Paz
105 Alejandro Oviedo

La Cuesta

163 Edman Maradiaga

Flor del Campo

113 Luis Medina

145 Alba Lidia Sanchez

Los Pinos

179 Lizet Mendoza

180 Jesus Barrientos

181 Marcio Zelaya

El Pedregal

099 Maira Salgado

La Alemania

139 Virginia Palma

Mateo

174 Rene Enamorado

4. Sexo del Prestatario

1. Masculino. 2. Femenino.

5. Número Completo de Colegiación del Prestatario

BUENOS DIAS/BUENAS TARDES. QUISIERA QUE ME DIERA UNOS 10 MINUTOS PARA PLATICAR SOBRE LA MANERA EN QUE SE LE ATENDIO EN ESTA CONSULTA. SE DESEA MEJORAR ALGUNAS DE LAS COSAS QUE HACE EL MINISTERIO/EL SEGURO. LOS DATOS QUE AQUI VAMOS A RECABAR SON PARA FINES DE INVESTIGACION Y SON ENTERAMENTE PRIVADAS.

6. ¿Es usted el enfermo?

1. Sí.
 2. No. (E: PASE A LA PREGUNTA 8).

7. ¿Qué es usted del enfermo? _____

1. Mama. 4. Hermano/hermana.
2. Papa. 5. Amigo.
3. Abuelo/abuela. 6. Otro. Especifique.

8. ¿Es niño o niña? (E: SI ES EVIDENTE SOLO ANOTE LA RESPUESTA SEGUN LO QUE OBSERVE).

1. Masculino.
 2. Femenino.

9. ¿Cuántos años cumplidos tiene (el paciente)? Años _____ Meses _____

(E: ESCRIBIR DIRECTAMENTE LA EDAD. ESCRIBA MESES SOLO PARA LOS MENORES DE UN AÑO. PARA LOS MAYORES DE UN AÑO, REDONDEE LA EDAD.)

10. ¿Por qué tipo de enfermedad trajo al paciente a consulta? _____

(E: CODIFIQUE TODAS LAS PATOLOGIAS QUE SE MENCIONEN.)

- | | | |
|-------------|------------------|------------------------|
| 1. Diarrea. | 3. Hipertensión. | 5. Otra. Indique cual. |
| 2. IRAs. | 4. Diabetes. | |

11. *(SI ES PACIENTE ADULTO)* ¿Entró a la consulta acompañado o solo?

1. Acompañado.
2. Solo.

12. ¿Qué le pareció la manera en que lo atendió el médico/la enfermera en la consulta? Por ejemplo, se quedó muy satisfecho, satisfecho, un poco satisfecho o insatisfecho?

0. No sabe, no contesta.
1. Muy satisfecho.
2. Satisfecho.
3. Poco satisfecho.
4. Insatisfecho.

13. Por que razón quedó (in)satisfecho? _____

(E: SENALE TODAS LAS RESPUESTAS QUE SE DEN. EL ENTREVISTADO PUEDE HABER SENALADO MAS DE UNA RAZON.)

RAZONES DE SATISFACCION.

1. Buen trato.
2. Me escuchó atentamente.
3. Competencia técnica.
4. Es el médico de siempre.
5. Me atendió rápido.
6. Me dió medicamentos.
7. Vio todos los enfermos que traje
8. Otras razones. Indique cuál.

RAZONES DE INSATISFACCION

1. Mal trato.
2. No ponía atención.
3. Incompetencia técnica.
4. Médico nunca visto antes.
5. Se tardó en atenderme.
6. No me dió medicamentos.
7. Traje 2 enfermos y vio uno.
8. Otras razones. Indique cuál.

14. ¿Cuanta confianza como médico/enfermera le tiene a la persona que lo/la atendió? Por ejemplo, muchísima, mucha, poca o ninguna?

- 0. No sabe, no contesta.
- 1. Muchísima.
- 2. Mucha.
- 3. Poca.
- 4. Ninguna.

15. ¿Porqué (no) le tiene confianza como profesional al doctor/enfermera que lo/la atendió?

RAZONES DE CONFIANZA

- 1. Buen trato.
- 2. Examinó como esperaba.
- 3. Explica indicaciones.
- 4. Es el médico de siempre.
- 5. Me atendió rápido.
- 6. Me dió medicamentos.
- 7. Vió todos los enfermos que traje
- 8. Otras razones. Indique cuál.

RAZONES DE DESCONFIANZA

- 1. Mal trato.
- 2. No examinó como esperaba.
- 3. No explica indicaciones.
- 4. Médico nunca visto antes.
- 5. Se tardó en atenderme.
- 6. No me dió medicamentos.
- 7. Se limitó a ver pocos enfermos.
- 8. Otras razones. Indique cuál.

16. ¿Se interesó en su caso la persona que lo atendió?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucho o poco/poco o nada?

- 0. No se aplica.
- 1. Mucho.
- 2. Poco/nada.

17. ¿Fué orgullosa la persona que la atendió?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucho o poco/poco o nada?

- 0. No se aplica.
- 1. Mucho.
- 2. Poco/nada.

18. ¿Fué amable durante la consulta?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucho o poco/poco o nada?

- 0. No se aplica.
- 1. Mucho.
- 2. Poco/nada.

19. ¿Le pusó atención cuando usted le contaba su enfermedad?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucho o poco/poco o nada?

- 0. No se aplica.
- 1. Mucho.
- 2. Poco/nada.

20. ¿Estaba haciendo otras cosas mientras lo atendía?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucho o poco/poco o nada?

- 0. No se aplica.
- 1. Mucho.
- 2. Poco/nada.

21. ¿Dejó el doctor que estuvieran entrando y saliendo otras personas del consultorio?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucho o poco/poco o nada?

- 0. No se aplica.
- 1. Mucho.
- 2. Poco/nada.

22. ¿Le molestaron esas interrupciones?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucho o poco/poco o nada?

- 0. No se aplica.
- 1. Mucho.
- 2. Poco/nada.

23. ¿Lo dejó hablar con libertad sobre su enfermedad?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucho o poco/poco o nada?

- 0. No se aplica.
- 1. Mucho.
- 2. Poco/nada.

24. ¿Fue comprensiva con usted la persona que lo atendió mientras le explicaba su enfermedad?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucho o poco/poco o nada?

- 0. No se aplica.
- 1. Mucho.
- 2. Poco/nada.

25. ¿La facilitó la persona que lo atendió por tratar de aliviarse/alivar a su niño?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

26. ¿Lo regañó la persona que lo atendió por algo?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Muchas o pocas veces/pocas veces o nunca?

- 0. No se aplica.
- 1. Mucha.
- 2. Pocas/nuncas.

27. ¿Le dió apoyo la persona que lo atendió para que trate de aliviarse/aliviar a su niño?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucho o poco/poco o nada?

- 0. No se aplica.
- 1. Mucho.
- 2. Poco/nada.

28. ¿Se interesó la persona que lo atendió por saber como afecta esta enfermedad su vida diaria?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucho o poco/poco o nada?

- 0. No se aplica.
- 1. Mucho.
- 2. Poco/nada.

29. Le preguntó la persona que lo atendió sobre todos los males que tiene (el niño)?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

30. ¿Se le quedó algo que no pudo decirle a la persona que lo atendió?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Muchas cosas o pocas/pocas o ninguna?

- 0. No se aplica.
- 1. Muchas.
- 2. Pocas/ninguna.

31. ¿Le pudo decir a la persona que lo atendió porque cree usted que cayó enfermo?

- 0. No sabe, no contesta.
- 1. Sí,
- 2. No.

32. ¿Se interesó por saber si usted podía cumplir el tratamiento?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucho o poco/poco o nada?

- 0. No se aplica.
- 1. Mucho.
- 2. Poco/nada.

33. ¿Le quedaron dudas sobre el tratamiento?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No. *(E: PASE A LA PREGUNTA 35.)*

34. ¿Se las aclaró la persona que lo atendió?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

35. ¿Las palabras que usó la persona que lo atendió para explicarle el tratamiento fueron fáciles o difíciles de entender?

- 0. No sabe, no contesta.
- 1. Fáciles.
- 2. Dífíciles.

36. ¿La persona que lo atendió le explicó paso a paso las cosas que tiene que hacer?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

37. ¿Le dió ánimo para que trate de seguir las indicaciones que le dió?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucho o poco/poco o nada?

- 0. No se aplica.
- 1. Mucho.
- 2. Poco/nada.

38. ¿Durante la consulta, le explicó con claridad las cosas que usted no entendía?

- 0. No sabe, no contesta.
- 1. Sí.
- 2. No.

¿Mucha claridad o poca/poco claridad o ninguna?

- 0. No se aplica.
- 1. Mucha.
- 2. Poca/ninguna.

39. ¿Qué le dijo el doctor que tiene (su hijo)?

40. ¿Le recetó alguna medicina?

- 0. No sabe, contesta.
- 1. Sí.
- 2. No.

41. ¿Cómo se lo va a tomar/cómo se lo va a dar?

42. ¿Por cuántos días?

(E: ESCRIBIR DIRECTAMENTE LA CANTIDAD DE DIAS. SI NO SABE, ESCRIBA NO SABE.)

43. ¿Le dieron otras indicaciones?

- 0. No sabe, no contesta.
- 1. Si.
- 2. No.

44. ¿Qué otras indicaciones le dieron?

45. ¿Le dieron aquí las medicinas que le recetaron?

- 0. No le recetaron nada.
- 1. Algunas.
- 2. Todas. *(E: PASE A LA PREGUNTA 47).*

46. ¿Donde piensa conseguir las?

- 0. No se aplica.
- 1. Comprándolas en la farmacia.
- 2. Volviendo aquí cuando haya surtido.
- 3. Ir a otro centro a ver si allí tienen.
- 4. Con un amigo que es visitador/medico.
- 5. No piensa conseguir las.
- 6. Otras formas. Especifique cuales.

47. ¿Qué piensa hacer para mejorarse?

(E: CODIFIQUE TODAS LAS RESPUESTAS QUE SE DEN.)

- 0. No sabe, no contesta.
- 1. Tomar los medicamentos.
- 2. Seguir las indicaciones que le dieron en consulta.
- 3. Seguir tomando/dando lo que se consume actualmente.
- 4. Ir donde otro prestatario.
- 5. Otras maneras. Especifique cuales.

48. ¿Había ya venido donde este doctor/enfermera antes?

- 1. Si.
- 2. No.

¿Volvería usted donde este doctor/enfermera?

- 0. No contesta.
- 1. Si.
- 2. No.

49. ¿A qué horas llegó al hospital/centro? _____

Hora

Minutos

50. ¿Hasta qué grado cursó en la escuela?

(E:ESCRIBIR EL NUMERO DE ANOS DE ESCOLARIZACION.)

51. ¿Por qué nombre lo conocen a usted?

52. ¿Quién es la persona más conocida en su barrio que puede dar razón de donde usted vive?

53. ¿Cual es la dirección exacta donde vive usted actualmente y permanecerá hasta finales de febrero?

Dibuje un croquis si es necesario:

Annotated Bibliography



Working Group on Counseling and Health Communication

Annotated Bibliography



Quality Assurance Project

Center for Human Services

in collaboration with

The Academy for Educational Development

and

The Johns Hopkins University

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Annotated Bibliography

I. Empirically Validated Studies

J01 — Anderson, J.L. 1979. "Patients' recall of information and its relation to the nature of the consultation." In **D.J. Osborne, M.M. Gruneberg and J.R. Eiser (Eds.) Research in Psychology and Medicine, 2. London: Academic Press.**

A study of patients' recall of information in a rheumatology out-patient clinic found overall recall to be 40 percent. More information was recalled about treatment than diagnosis. Recall varied according to the patient's age, anxiety and the amount of information given. The patients' opinions about the doctors and their consultations were elicited. Consultations were classified according to the patient's level of participation. These factors were not related to the level of recall.

Key words: patient recall; patient participation; rheumatic patients.

J02 — Anderson, L.A.; B.M. DeVellis and R.F. DeVellis. 1987. "Effects of modeling on patient communication, satisfaction and knowledge." **Medical Care 25(11): 1044-56.**

This experimental study investigated the efficacy of two modeling procedures on enhancing patient communication. A pretreatment interview assessed knowledge, assertiveness and other concomitant variables. A total of 150 subjects were randomly assigned to one of three treatment conditions. The two modeling conditions were videotaped presentations of a health educator interacting with a patient (i.e. model) who either asked questions or revealed problems. The control videotape in-

cluded only the educator's presentation; no patient was shown. A subsequent standardized face-to-face patient education session was used to assess the impact of the intervention on patient communicative behaviors. A post-treatment interview assessed knowledge and satisfaction. Subjects who viewed a modeling videotape spoke more than subjects who viewed a control videotape. The bulk of our findings indicated that a question-asking model was generally more effective than a disclosive model in eliciting communicative behaviors. Knowledge scores were found to increase after the intervention, regardless of subjects' verbal participation.

Key words: modeling; intervention; patient question-asking; disclosing problems; knowledge; satisfaction.

J03 — Bain, D.J.G. 1977. "Patient knowledge and the content of the consultation in general practice." **Medical Education 11:347-350.**

The relationship between verbal exchange in doctor-patient consultations and patient comprehension has been measured by means of audiotape recordings. The results provide objective evidence of differences in outcomes for similar presenting illnesses in different social groups, and these results tend to support the hypothesis that people from lower socio-economic classes may not derive as much benefit from medical advice as do those of middle and upper classes. The author identified deficiencies in clinical relationship which if corrected will improve doctor-patient communication in consultations in general practice. If patient comprehension and compliance are viewed as

essential, communicative as well as clinical skills have to be accepted as part of the general practitioner's training.

Key words: patient comprehension; socio-demographic characteristics.

J04 — Bartlett, Edward et al. 1984. "The effects of physician communications skills on patient satisfaction, recall and adherence." *Journal of Chronic Disease* 37(9/10): 755-764.

This study examined the effects of physician interpersonal skills and teaching on patient satisfaction, recall and adherence to the regimen. We studied the ambulatory visits of 63 patients to five medical residents at a teaching hospital in Baltimore.

It was found that quality of interpersonal skills influenced patient outcomes more than quantity of teaching and instruction. Secondary analyses found that all the effects of physician communication skills on patient adherence are mediated by patient satisfaction and recall.

Key words: patient recall; satisfaction; adherence; interpersonal skills.

J05 — Beisecker, A. and T. Beisecker. 1990. "Patient information-seeking behaviors when communicating with doctors." *Medical Care* 28(1): 19-28.

In order to better understand patient differences in question-asking and other information-seeking behaviors when communicating with doctors, 106 rehabilitation medicine patients were studied. Socio-demographic data, attitude measures, interview data and tape-recordings of encounters revealed that patients desired information about a wide range of medical topics but did not engage in many information-seeking behaviors when communicating with doctors. While desiring information, patients regarded doctors as the appropriate

persons to make medical decisions. Regression analyses indicated that patient information-seeking behaviors were more directly associated with situational variables (length of interaction, diagnosis, reason for visit) than with patient attitudes or socio-demographic characteristics. Patient attitudes influenced patient information-seeking behaviors only for patients with interactions lasting at least 19 minutes, indicating that a longer interaction may be necessary for patient attitudes regarding desire for information and participation in medical decisions to manifest themselves in information-seeking communication behavior.

Key words: doctor-patient communication; patient information-seeking; medical encounters; question-asking; consumerism; patient role; rehabilitation clinics.

J06 — Bensing, Jozien. 1991. "Doctor-patient communication and the quality of care." *Social Science and Medicine* 32(11): 1301-1310. [Study 1 only]

In this article a comparison is made between three independent sources of assessment of medical consultations. A panel of 12 experienced general practitioners rated 103 consultations with hypertensive patients on the quality of psycho-social care. There was a high consensus between the judges, resulting in a high reliability score. Two contrasting groups were formed: consultations that were rated high and those rated low in quality of psycho-social care. A comparison was made between this general assessment of the quality of psycho-social care and a more detailed assessment of the same consultations on nine much used communication variables made by trained psychologists. Knowledge about doctor-patient communication proved to predict very well as to which quality group the consultations belonged. A very high percentage was predicted accurately, solely on the basis of these nine communication variables. Affective behavior, and especially non-verbal affective behavior had the strongest predictive power. In the last part of the study a third

source of assessment, i.e. patients' satisfaction was compared with both other sources. Much lower relationships were found, although most were in the predicted direction. Affective behavior seems to be the most important in determining patient's satisfaction.

Key words: quality of care assessment; psychosocial care; patient satisfaction; hypertensive patients.

J07 — Bertakis, K.; D. Roter and S. Putnam. 1991. "The relationship of physician medical interview style to patient satisfaction." *The Journal of Family Practice* 32(2): 175-181.

The present collaborative study of medical interviewing provided an opportunity to collect interviews from 550 return visits to 127 different physicians at 11 sites across the country. Tape-recordings were analyzed using the Roter Interaction Analysis System, and post-visit satisfaction questionnaires were administered to patients.

Physician question-asking about biomedical topics (both open and closed ended questions) was negatively related to patient satisfaction; however, physician question-asking about psychosocial topics was positively related. Physician counseling for psychosocial issues was also positively related to patient satisfaction. Similarly, patient talk about biomedical topics was negatively related to satisfaction, while patient talk regarding psychosocial topics was positively related. Patients were less satisfied when physicians dominated the interview by talking more or when the emotional tone was characterized by physician dominance.

Key words: patient satisfaction; physician question-asking; physician talk; patient talk.

J08 — Bertakis, Klea. 1977. "The communication of information from physician to patient: A method for increasing patient retention and satisfaction." *The Journal*

of Family Practice 5(2): 217-222.

Patients are more satisfied with their physicians when they are given and retain more information about their illnesses. When an experimental group of patients was asked to restate what they had been told, followed by physician feedback, retention of the information was 83.5 percent compared to 60.8 percent in a control group in which this technique was not used. Patient satisfaction was also higher in the experimental group.

Key words: patient satisfaction; retention; physician feedback.

J10 — Boreham, Paul and Diane Gibson. 1973. "The informative process in private medical consultations: A preliminary investigation." *Social Science and Medicine* 12: 409-416.

This paper reports on a preliminary investigation of the informative elements of doctor-patient interaction. The research methods employed in this study provided for an examination of both patients' views and expectations about the provision of information concerning their illnesses as well as their behavior toward seeking such information during their actual consultation.

Our interview data indicated that patients exhibited a surprising lack of knowledge concerning their illnesses even though they attached considerable importance to gaining such information. Moreover, our observations of the doctor-patient interviews revealed that patients- largely because of their own passivity-gained little additional information during the course of their consultation.

Key words: patient expectations; information gain.

J11 — Carter, William et al. 1982. "Outcome-based doctor-patient interaction analysis: Identifying effective provider and patient behavior." *Medical Care* 20(6): 550- .

Three interactional analysis (IA) systems (Bales', Roter's modified Bales and Stiles' "Verbal response modes") were used to characterize behavioral elements of provider-patient dialogues of 101 new patient visits in a general medical clinic. Specific provider and patient behaviors within segments of the encounter (introduction-history, physical exam and conclusion), which were shown to be related to encounter outcomes of knowledge, satisfaction and compliance were examined.

Key words: Interaction Analysis Systems; patient knowledge; satisfaction; compliance; general practice.

J12 — Comstock, Loretto et al. 1982.

"Physician behaviors that correlate with patient satisfaction." *Journal of Medical Education* 57: 105-112.

The behavior of 15 internal medicine residents, each with 10 patients, was observed through a one-way mirror. Ratings by the patients of satisfaction with their physicians were also obtained. Patient satisfaction correlated strongly with ratings for physician courtesy and information-giving. Non-verbal behaviors such as eye contact, bodily positioning and physical contact did not correlate with patient satisfaction. The correlations between physician behavior and patient satisfaction did not hold for the four women physicians studied.

Key words: patient satisfaction; physician behavior; internal medicine.

J13 — Davis, Milton. 1971. "Variation in patients' compliance with doctors' orders: Medical practice and doctor-patient interaction." *Psychiatry in Medicine* 2: 31-54.

Doctor-patient interactions were tape-recorded and coded according to a modified system of Interaction Process Analysis. These data, combined with a series of patient interviews and a self-administered questionnaire completed by physicians, were analyzed to determine the extent of patient compliance with doctors' orders and how variations in compliance are influenced by some se-

lected patient characteristics and by the structure and process of doctor-patient relationship.

None of the demographic characteristics of patients investigated here was associated with compliance. However, the ways in which doctors and patients initially fit their activity into the presumably institutionalized patterns of behavior appropriate for doctor-patient interaction and the way they deviate over time from the institutionalized role expectations was found to be related to variations in patient compliance.

Key words: patient compliance; role expectations.

J14 — Davis, Milton. 1968. "Variations in patients' compliance with doctors' advice: An empirical analysis of patterns of communication." *American Journal of Public Health* 58(2): 274-288.

This paper is concerned with the ways in which dimensions of doctor-patient interaction relate to patient compliance. The study group consisted of 154 new patients seen by 76 junior and 78 senior (attending) physicians. Data were collected by means of tape-recording of encounters, patient interviews, self-administered questionnaires completed by doctors, and content analysis of patients' medical records.

Thirty-seven percent of the patients did not adhere to their doctors' instructions. Interaction in the primary doctor visit was not associated with later compliance. However, revisits between an authoritative patient and a physician who passively accepts such patient participation were associated with patient noncompliance. Effective communication is impeded when doctors and patients evidence tension in their relationship. Unless this tension is released, noncompliance will result regardless of the doctor's efforts to achieve solidarity.

Key words: patient participation; compliance.

A01 — John P. Elder, Terry Louis, Omaj Sutisnaputra, Neni Surani Sulaeiman, Lisa Ware, Willard Shaw, Carl de Moor, and Judy Graeff, "The Use of Counseling Cards for Community Health Volunteer Training in the Management of Diarrhea in West Java, Indonesia."

The Indonesian Ministry of Health relies greatly on a network of over a million kader (community health volunteers) to bring primary health care to the village level. The West Java Department of Health's Control of Diarrheal Disease (CDD) Program recently carried out an extensive research and development effort to produce effective job aids for the kader in CDD and a training program to teach their use. A set of counseling cards were produced to provide kader with a tool to diagnose and treat diarrhea and teach the proper use of ORS. Researchers conducted a controlled evaluation in which they measured the cards' effectiveness through observations of kader performance and interviews with mothers they had counseled. In the intervention group, 15 kader underwent two days of training to use the cards when diagnosing and advising treatment for cases of diarrhea in their villages. The 16 control kader received comparable CDD training without the cards. Each group of kader was also given a list of local mothers to counsel. Follow-up interviews were held with those mothers to test their level of knowledge on CDD and to observe their ability to mix ORS properly. Significant performance differences between the intervention kader and mothers, and the control kader were consistently more accurate in their diagnoses and recommendations for treatment. Mothers counseled by the intervention kader also prepared ORS significantly better than the mothers counseled by the control kader.

J15 — Francis, V.; B. Korsch, and M. Morris. 1969. "Gaps in doctor-patient communication: Patients' response to medical advice." *The New England Journal of Medicine* 280(10): 535-540.

Study of 800 outpatient visits to Children's Hospi-

tal of Los Angeles to explore the effect of the verbal interaction between doctor and patient on patient satisfaction and follow-through on medical advice showed 24 percent of patients to be grossly dissatisfied, 38 percent moderately compliant and 11 percent non-compliant. The extent to which patients' expectations from the medical visit were left unmet, lack of warmth in the doctor-patient relation, and failure to receive an explanation of diagnosis and cause of the child's illness were key factors in noncompliance. Complexity of the medical regimen and other practical obstacles also interfered with compliance. There was a significant relation between patient satisfaction and compliance. There was no significant relation between the demographic variables tested and satisfaction or compliance.

Key words: patient satisfaction; compliance; patient expectations; pediatric visits.

J16 — Freemon, Barbara et al. 1971. "Gaps in doctor-patient communication: Doctor-patient interaction analysis." *Pediatric Research* 5: 298-311.

258 visits to a pediatric walk-in clinic were scrutinized using an expanded version of Bales' Interaction Process Analysis. Data analysis consisted of individual case studies and computer programs for descriptive summaries of cases and index scores.

As hypothesized, a distinctive behavior pattern emerged for doctor, parent and child. Doctors were found to talk more but show less emotion than mothers. Almost two-thirds of the mother's communication related to medical history, while the doctor discussed history and treatment but gave little attention to cause, prognosis, and seriousness. In general, outcome of the medical consultation was found to be favorably influenced by having a physician who was friendly, expressed solidarity, took some time to discuss nonmedical, social subjects and gave impression of offering

information freely without the patients having to request it or feeling excessively questioned.

Key words: patient compliance; pediatric visits.

J17 — Greenfield, Sheldon et al. 1988. “Patients’ participation in medical care: Effects on blood sugar control and quality of life.” *Journal of General Internal Medicine* 3:448-457.

The authors developed an intervention designed to increase the involvement of patients in medical decision-making. In a 20-minute session just before the regular visit to a physician, a clinic assistant reviewed the medical record of each experimental patient with him/her, guided by a diabetes algorithm. Using systematic prompts, the assistant encouraged patients to use the information gained to negotiate medical decisions with the doctor. The mean pre-intervention glycosylated hemoglobin values were 10.6% for 33 experimental patients and 9.1% for 26 controls. After the intervention the mean levels were 9.1% in the experimental group ($p < 0.01$) and 10.6% for controls. Analysis of audiotapes of the visit to the physician showed the experimental patients were twice as effective as controls in eliciting information from the physician. Experimental patients reported fewer function limitations.

Key words: intervention; patient involvement; treatment outcomes.

J18 — Greenfield, S.; S. Kaplan and J. Ware. 1985. “Expanding patient involvement in care: Effects on patient outcomes.” *Annals of Internal Medicine* 102: 520-528.

An intervention was developed to increase patient involvement in care. Using a treatment algorithm as a guide, patients were helped to read their medical record and coached to ask questions and negotiate medical decisions with their physicians during a 20-minute session before their regularly

scheduled visit. Six to eight weeks after the trial, patients in the experimental group reported fewer limitations in physical and role-related activities ($p < 0.05$), preferred a more active role in medical decision-making and were as satisfied with their care as the control group. Analysis of the audiotapes of physician-patient interactions showed that patients in the experimental group were twice as effective as control patients in obtaining information from physicians ($p < 0.05$).

Key words: intervention; patient involvement; treatment outcomes.

J19 — Hall, J.; D. Roter and C. Rand. 1981. “Communication of affect between physician and patient.” *Journal of Health and Social Behavior* 22(March):18-30.

The purpose of this research was to identify patterns of patient-provider communication, in particular combinations of verbal and nonverbal (vocal) expression during the medical visit, that are associated with patient contentment with the visit and appointment-keeping. The data used in the analysis were tape-recordings of 50 patient-physician interactions during routine medical visits for chronic disease. The interactions, which were rated by 144 judges, were assessed in three conditions: electronically filtered speech (voice only), original speech (voice and words) and transcripts (words only). Among the affective aspects rated were anger, anxiety, dominance, sympathy, assertiveness and businesslike manner.

Findings indicate that patients’ contentment with the medical visit is related to the ratings of the physician’s communication, but that the relationship for the physician’s verbal communication is opposite that for the physician’s nonverbal communication. The patient’s return for subsequent appointments is also associated with the physician’s expression and anxiety in original (unfiltered) speech. Since affect, in this study, appears to be reciprocated, we suggest that negative physician affect expressed in voice tone with positive affect communicated through words is

interpreted by patients in an overall positive manner, as probably reflecting perceived seriousness and concern on the part of the physician.

Key words: non-verbal communication; patient contentment; appointment-keeping.

J20 — Henbest, R.J. and M. Stewart. 1990. "Patient-centeredness in the consultation. 2: Does it really make a difference?" Family Practice 7(1): 28-33.

The major purpose of this study was to test the hypothesis that patient-centeredness in the consultation was associated with improved patient outcomes. Patient-centred care was defined as care in which the doctor responded to the patient in such a way as to allow the patient to express all of his or her reasons for coming, including: symptoms, thoughts, feelings and expectations. The study took place in the offices of six family doctors. All consultations were audio-taped and the patients completed a questionnaire and two structured interviews with the investigator: one immediately following the consultation and the other two weeks later. Patient-centeredness was found to be associated with the doctor having ascertained the patient's reasons for coming and with the resolution of the patient's concerns. It was also associated with the patient's feeling understood and resolution of the patient's symptoms until confounding variables were controlled. The results of the multivariate analysis suggested that the impact of a patient-centred approach may be part of a package of care, consisting of a doctor whose overall practice allows for the development of personal relationships with patients over time through continuity of care.

Key words: patient centeredness; treatment outcomes; patient satisfaction.

J21 — Heszen-Klemens, I. and E. Lapinska. 1984. "Doctor-patient interaction, patients' health behavior and effects of treatment." Social Science and Medicine 19(1): 9-13.

The purpose of this study was to explore the whole range of patients' health behavior, its connection with doctor-patient interaction (as an independent variable) and with treatment results (as a dependent variable). The direct effect of doctor-patient relationship on the outcome of treatment was also examined. The subjects were 62 outpatients. Two visits of every patient to his physician were tape-recorded and analyzed. Also, two interviews were made with every patient in order to obtain data concerning health behavior. Treatment results were evaluated by physicians. Doctors' directiveness, their emotional attitude towards the patient, patients' activity and patient partnership status were found to have an effect on patients' health behavior (compliance and spontaneous health activity).

Key words: health behavior; health outcomes.

J22 — Howell-Koren, P. and B. Tinsley. 1990. "The relationships among maternal health locus of control beliefs and expectations, pediatrician-mother communication and maternal satisfaction with well infant care." Health Communication 2(4): 233-253.

The objective of this study was to assess the relationship among mothers' perceptions of control over the health of their children, mothers' expectations about and satisfaction with their infants' pediatric well-child care visit, and selected attributes of pediatrician mother interaction during these well-care visits. Results suggest that pediatrician-mother interaction during well-child visits is responsive to mothers' locus of control beliefs with regard to their children's health and expectations regarding physician interactive behavior. Moreover, pediatrician-mother interaction was predictive of maternal overall satisfaction. These results are discussed both theoretically and within an applied perspective.

Key words: locus of control; patient's expectations; patient satisfaction; pediatric visits.

J23 — Inui, Thomas et al. 1982. “Outcome-based doctor-patient interaction analysis: Comparison of techniques.” *Medical Care* 20(6): 535-549.

Interaction analysis (IA) systems have been devised and applied to doctor-patient dialogues to describe encounters and to relate process to outcomes. Prior work in this area has been typified by the use of single taxonomy for classifying verbal behaviors and limited outcomes (compliance and/or satisfaction). We applied three different IA systems (Bale's, Roter's and Stiles') to 101 new-patient visits to a general medical clinic for which multiple outcomes had been determined: several measures of patient knowledge of problems at conclusion of visit; patient compliance with drugs (over the ensuing three months); and patient satisfaction with the visit (perceived technical, interpersonal and communication quality). Within IA systems, cross tabulations and multiple regressions were performed to relate encounter events to outcomes. Across IA systems, multiple regression R2 and R2 adjusted for the number of independent variables entering were used to characterize strength of relationships. Roter's IA system showed stronger relationships to outcomes of knowledge and compliance than did Bales' or Stiles' systems. R2 for patient satisfaction was identical for Bales and Roter and greater than R2 for Stiles. We conclude that choice of IA system for research or teaching purposes should be based on behaviors and outcomes of particular interest and importance to the user. Based on audio-review of tapes, Roter's approach is less time-consuming and may perform as well as more complex systems requiring transcript analysis.

Key words: Interaction Analysis Systems; patient compliance; satisfaction; general practice.

J24 — Joyce, C.R.B. et al. 1969. “Quantitative study of doctor-patient communication.” *Quarterly Journal of Medicine* 38, 150, 183-194.

Fifty-four encounters between patients with rheumatic complaints and two physicians were tape-

recorded. Patients were then interviewed immediately after, one week or two weeks after the initial clinical encounter in order to assess their retention of information provided during the encounter. No patient remembered all that he/she been told during the encounter. Patient remembered about one-half of the ten things they were told. Most of the forgetting appeared to take place immediately. Statements related to diagnosis and explanation of treatment were most likely to be forgotten. There was no connection between the loss of information and time elapsed between clinical encounter and interview. Also, there was no association between degree of improvement in clinical condition and the amount of information imparted or recalled.

Key words: rheumatic patients; patient recall.

J25 — Kaplan, S.; S. Greenfield and J. Ware. 1989. “Assessing the effects of physician-patient interactions on the outcomes of chronic disease.” *Medical Care* 27(3):S110-S127. [Study 1]

Data are presented for four clinical trials conducted in varied practice settings among chronically ill patients differing markedly in socio-demographic characteristics. These trials demonstrated that “better health” measured physiologically (blood pressure or blood sugar), behaviorally (functional status), or more subjectively (evaluations of overall health status) was consistently related to specific aspects of physician-patient communication.

Key words: physician, interaction with patient; patient, interaction with physician; chronic disease; health outcomes; satisfaction, patient; compliance, patient; intervention.

A02 — Kim, Young-Mi, Jose Rimón, Kim Winnard, Carol Kazi Stella Babalola and Dale Huntington, “Improving Quality of Service Delivery and Client Compliance in Nigeria.” *Manuscript Submitted to Studies in Family Planning* (04-01-91).

This study evaluates the effect of a nurse training program in family planning counseling skills on the quality of service delivery at the clinic level, as well as its impact on the clients' compliance with prearranged appointments. The study used a quasi-experimental design to compare certified nurses who received six weeks of family planning technical training with certified nurses who received, in addition to the six-week technical training, a three-day course in counseling skills. Data was collected through client exit interviews, expert observation and inspection of medical record abstracts. The results indicated that the quality of interpersonal relations, information giving, counseling and follow-up mechanisms can be improved by short-term intensive counseling training. Clients' compliance for attending follow-up visits can also be enhanced.

J26 — Korsch, B.; E. Gozzi and V. Francis. 1968. "Gaps in doctor-patient communication: Doctor-patient interaction and patient satisfaction." *Pediatrics* 42(5): 855-871.

Eight-hundred patient visits to the walk-in clinic of the Children's Hospital of Los Angeles were studied by means of tape-recording the doctor-patient interaction and by follow-up interview. Seventy-six percent of the patient visits resulted in satisfaction on the part of the patient's mother; in 24 percent there was dissatisfaction. The following factors were found to contribute to patient dissatisfaction: notably lack of warmth and friendliness on the part of the doctor, failure to take into account the patient's concerns and expectations from the medical visit, lack of clearcut explanation concerning diagnosis and causation of illness and finally excessive use of medical jargon.

Key words: patient satisfaction; patient expectations; pediatric visits.

J27 — Lane, Shelly. 1983. "Compliance, satisfaction and physician-patient commu-

nication." In R.N. Bostrom (Ed.) *Communication Yearbook* volume 7. Beverly Hills: Sage.

The study examined the different compliance-gaining strategies used by physicians in outpatient clinics and the impact of those strategies on patient satisfaction and compliance. A total of 16 physicians and 121 patients were observed and audio-taped communicating in actual clinical podiatric examinations. The compliance-gaining tactics physicians employed in order to facilitate adherence were coded in terms of 3 strategy coding scheme based on task/informational, personal and threatening clusters. Immediately after the doctor-patient encounter, patients were asked to rate how satisfied they were with their doctor's communication, and they were phoned two weeks after their encounter to determine their level of compliance with treatment instructions.

Statistical analysis revealed that physicians used threatening tactics least when compared to task/informational and personal compliance-gaining tactics. Multiple regression analysis indicated that 34 percent of medical communication satisfaction and 72 percent of stated levels of adherence could be explained by a variety of compliance-gaining strategies used in doctor-patient interaction. The analyses suggest that although patients may be satisfied when their doctors avoid threatening type tactics, adherence results when their doctors use threatening tactics along with personal compliance-gaining tactics.

Key words: compliance-gaining strategies; patient satisfaction; adherence; podiatric examinations.

J28 — Larsen, Katheryn and Charles K. Smith. 1981. "Assessment of non-verbal communication in the patient-physician interview." *The Journal of Family Practice* 12(3): 481-488.

The interview portion of 34 patient-physician visits at a family medical center was videotaped.

Videotapes were screened by two judges in two major nonverbal categories, immediacy and relaxation. Physician and patient were scored separately at 40-second intervals for 11 component parameters of the two major categories. These scores were correlated with patient satisfaction and understanding, ascertained by post-interview questionnaire. For analytical purposes, patients were assigned to low or high satisfaction groups and low or high understanding groups.

Statistically significant differences between low and high satisfaction groups were demonstrated with respect to overall physician immediacy; five individual physician nonverbal parameters; and two individual patient nonverbal parameters. Similar statistical results were obtained for understanding groups.

The preliminary investigation suggests that nonverbal behavior of the physician in the patient-physician interview is important in determining patient satisfaction and understanding.

Key words: non-verbal communication; patient satisfaction; understanding.

J29 — Lau, Richard et al. 1982. "Psychosocial problems in chronically ill children: Physician concern, parent satisfaction and the validity of medical records." *Journal of Community Health* 7(4): 250-261.

This study concerns the psychosocial aspects of treatment for chronically ill children. The English-speaking parents of 44 children 5-13 years of age being seen at five specialty clinics at a large county hospital in Los Angeles, and their attending physicians were the subjects in this study. The parents were interviewed concerning their expectations for the current visit, and the doctor-patient interaction was tape-recorded. Identical categories of information were abstracted from the tape-recording and from a chart review of patients' medical records. Although parents expected 76%

of the psychosocial aspects of care to be covered by the doctor, only one-fourth were actually discussed in the visit. These unfulfilled expectations were associated with lower satisfaction with medical care received ($r=.47$, $p<0.01$). Finally, while doctors recorded about 80% of discussions of symptoms and physical examinations in the patient's medical record, they recorded only 25% of discussion of psychosocial problems.

Key words: psychosocial aspects; patient expectations; patient satisfaction; pediatric visits.

J30 — Lewis, Catherine et al. 1986. "Parent satisfaction with children's medical care: Development, field test and validation of a questionnaire." *Medical Care* 24(3): 209-215. [Study 2 only]

The authors developed a questionnaire to measure parent satisfaction with children's medical encounters, administered it to 104 parents of pediatric patients (field trial 1), and revised it. The revised Parent Medical Interview Satisfaction Scale (P-MISS) was then tested on a new sample of parents whose medical visits were videotaped (field trial 2). On field trial 2, the P-MISS showed a high alpha reliability (.95). The four factor-based subscales identified by field trial 1 showed high alpha reliabilities on field trial 2: physician communication with the parent (.81), physician communication with the child (.93); distress relief (.85) and adherence intent (.86). With the exception of the distress relief subscale, the subscales appear to measure distinct dimensions of satisfaction. Objective ratings of physicians' interpersonal skills to parents during medical interviews correlated significantly with parents' total satisfaction scores as well as with all four satisfaction subscale scores, providing preliminary evidence of the construct validity of P-MISS.

Key words: satisfaction, pediatric visits, physician-patient communication, physician-parent communication, adherence.

J31 — Ley, Philip et al. 1973. “A method for increasing patients’ recall of information presented by doctors.” *Psychological Medicine* 3: 217-220.

Within minutes of leaving the consulting room, patients are frequently unable to recall what their doctor has told them. This paper describes a simple, practical method for increasing recall by the organization of medical information into labelled categories. The success of this technique was demonstrated first in a laboratory experiment with volunteer subjects and then in a naturalistic setting with general practice patients.

Key words: patient recall; family practice.

J32 — Ley, P. and M.S. Spelman. 1965. “Communications in an out-patient setting.” *British Journal of Social and Clinical Psychology* 4: 116-118.

A sample of 47 new attendees at a medical out-patient clinic were interviewed shortly after they had been seen by the consultant to see how much they remembered of what the consultant had told them. Patients’ accounts were taken down and compared with the verbatim record made by the consultant at the time when he interviewed the patient. Patients retained proportionately less of the information the more they were told. Older patients tended to remember more of what they were told than younger patients. Recall was related to the nature of the information given. Of all statements made by doctors instructions are the most likely to be forgotten.

Key words: Information retention.

A03 — Ministry of Health and Eduardo Mondlane University Faculty of Medicine, Mozambique, “Evaluating the management of diarrhoea in health centres in Mozambique.” *Journal of Tropical Medicine and Hygiene*. 91: 61-66.

An evaluation of the health centre management of pediatric cases of diarrhoea, comprising observa-

tion of the consultation, interview of the guardian immediately afterwards and home follow-up was performed in one rural and three urban areas of Mozambique. Oral Rehydration Therapy was advised for 83% of patients, of whom 71% received ORS packets. Eighty-seven per cent of mothers followed up stated that they had given ORT, but only 37% had a solution present at the time of interview. The main weakness in case management was the lack of health education, especially about the quantity of fluid to give, which was reflected in the mothers’ belief that ORT is a medicine to ‘stop the diarrhoea’ and their consequent administration of it like a syrup, one teaspoonful three times a day. The results of the evaluation have facilitated the design of more appropriate health education and health worker training materials and methods.

C01 — PRICOR. October 1989. “Preliminary Findings from Growth Monitoring/Promotion Systems Analysis.” *PRICOR Child Survival Report: Results From Systems Analysis.*

This study examined counseling at Child Nutrition Centers (CNIs) in Togo. Observations of both clinic sessions and feeding and caring practices in the home attempted to demonstrate a relationship between certain provider behavior during counseling and maternal behavior in the home. Additional information was collected through interviews and focus groups to substantiate observations and to test maternal recall. Conclusions were made regarding staff and client behaviors in general. Mothers were able to recall recent key messages but did not demonstrate the incorporation of these messages into their practices at home.

C02 — PRICOR. April 1990. “Operations Research Improves Home Treatment of Malaria in Children.” *PRICOR Child Survival Report: Results from Systems Analysis. [Study 1 only]*

Two problems existed relative to the treatment of malaria with chloroquine in Zaire. One problem was that only 30-50% of mothers used chloroquine when it was necessary and the other is that over half of those who used it did so in a dose too low to be effective. In order to strengthen the capacity of the health center nurses to educate mothers regarding malaria treatment, the nurses were trained in treatment and in health education techniques. Educational materials and messages were developed. Pre- and post-test information was used to determine the extent of mothers' proper treatment of malaria and their knowledge of the correct dosage.

C03 — PRICOR. June 1990. "Using Operations Research to Increase the Effectiveness of Growth Monitoring at Preschool Clinics." PRICOR Child Survival Report: Results from Operations Research.

Staff of a child health project in Zaire realized that very little time was available for clinic nurses to educate mothers as to their children's nutritional status. This study shows how clinics involved in the project experimented with a triage system designed to extend counseling time as much as possible. Counseling time was compared to attendance and mothers' knowledge, both of which were shown to increase when the triage system was put into place.

J33 — Putnam, Samuel et al. 1985. "Patient exposition and physician explanation in initial medical interviews and outcomes of clinic visits." Medical Care 23(1): 74-83.

102 visits to a medicine walk-in clinic were tape-recorded, transcribed, and coded according to the Verbal Response Mode (VRM) system. Questionnaires given before and after the clinic visit and telephone interviews one week and four weeks after the visit were used to measure patient satisfaction, compliance, and change in symptoms. Two verbal exchanges were examined: in the

medical history, the Patient Exposition exchange, which was measured as the frequency with which patients make statements about their illnesses in their own words, and in the conclusion, the Physician Explanation exchange, which was measured as the percentage of physician statements that are factual. These verbal indexes showed correlations with patient satisfaction, but no correlations with patient compliance.

Key words: patient exposition; physician explanation; medical interviews; clinic visits; compliance; satisfaction; health outcomes.

J34 — Rimer, Barbara et al. 1984. "Informed consent: A crucial step in cancer patient education." Health Education Quarterly 17 (supplement): 30-42.

Informed consent is an issue of major importance for cancer patients and for the practitioners who treat them. In this paper we present an overview of informed consent and describe a study of informed consent to cancer treatment conducted at the Fox Chase Cancer Center in which the consultation between the patient and the physician (and/or other health professional) was observed and patients were interviewed. On the average patients recalled less than 40 percent of what they were told. Patients who were told more items recalled more; however, they recalled a smaller proportion of what they were told. Several implications for health education were drawn from the study results.

Key words: cancer patients; informed consent; patient recall.

J35 — Robinson, E.J. and M.J. Whitfield. 1985. "Improving the efficiency of patients' comprehension monitoring: A way of increasing patients' participation in general practice consultations." Social Science and Medicine 21(8): 915-919.

The aim of the investigations reported was to

examine the effects of helping patients to check their understanding of instructions and advice given during their consultations with general practitioners. Three groups of patients were both tape-recorded during their consultation and interviewed immediately afterwards. The groups differed in the written information they were given prior to their consultations. The "Normal" group were informed only that the researcher was interested in how well doctors and patients understand each other. The "Permission" group was explicitly invited to raise queries with the doctor during their consultation. The "Guidance" group was asked to use two specified strategies to check their understanding of instructions and advice given by the doctor. We coded the frequency of questions and comments about treatment which patients produced during their consultations and the accuracy and completeness of their subsequent accounts of the recommended treatment. The "Normal" and "Permission" groups did not differ in either respect. The "Guidance" group produced significantly more questions and comments than the "Normal" group and gave more complete and accurate accounts of the recommended treatment. A partial replication in a different practice produced consistent results.

Key words: patient comprehension; general practice; patient question-asking.

J36 — Robinson, E.J. and M.J. Whitfield. 1988. "Contributions of patients to general practitioner consultations in relation to their understanding of doctor's instructions and advice." *Social Science and Medicine* 27(9): 895-900.

126 patients of 6 general practitioners were tape recorded in consultation with their doctor and interviewed immediately afterwards, and 81 of the patients were interviewed again 2 days later. We related the accuracy of patients' accounts of the instructions and advice they were offered to two characteristics of patient's participation during their consultation: (i) the frequency of spontane-

ous comments or queries about diagnosis, cause, consequences or treatment of the problem presented, and (ii) the frequency of comments and queries which sought to clarify something said by the doctor. The incidence of the latter was unrelated to accuracy of patients' subsequent accounts. However, people who made errors or omissions in both immediate and home interviews in their accounts of instructions and advice offered, were more likely than those who gave accurate accounts to have produced spontaneous comments or queries during their consultation. Whether the doctor accepted, rejected or ignored these ideas was irrelevant to the incidence of post-consultation errors and omissions.

Key words: doctor-patient communication; general practice; consultations.

J37 — Ross, Catherine and Raymond Duff. 1982. "Returning to the doctor: The effects of client characteristics, type of practice, and experiences with care." *Journal of Health and Social Behavior* 23(June): 119-131.

Although a number of policy-makers have suggested that previous experiences with medical care affect subsequent use of physician services, few researchers have examined the issue empirically. We divide the determinants of revisiting the doctor in pediatric practice into three categories: client characteristics, organizational characteristics and characteristics of the doctor-patient interaction; and we develop a causal model. Although, income and education have no direct effects on the frequency of returning to the doctor, they have indirect effects through the organization of health care and experiences within the health care system. Clients who are poorly educated tend to have consistently negative experiences with the health care delivery system. These experiences affect subsequent use of services. Positive experiences with the interpersonal, psychosocial aspects of the doctor-client interaction increase a client's proclivity to return to the doctor while negative doctor-client

interactions decrease the probability of returning to the doctor.

Key words: pediatric visits; psychosocial aspects; patient return.

J38 — Rost, K.; W. Carter and T. Inui. 1989. "Introduction of information during the initial medical visit: Consequences for patient follow-through with physician recommendations for medication." *Social Science and Medicine* 28(4): 315-321.

In this research we tested how the introduction of information reflecting both the patient's and physician's perspective is related to the patient's adherence to physician recommendations for medication. Introduction of information was defined as bi-directional if patients independently offered information or behavior as frequently as they provided the information or exhibited behavior that physicians requested. Thirty random samples of audio-taped dialogue were used to construct estimates of introduction of information during the history, examination and consultation phases of initial ambulatory care visits of 45 older male patients. The data demonstrate that bi-directional introduction of information during the examination segment explains more than half of the variance in patient adherence to physician recommendations for new medication. These findings support the idea that physician willingness to allow patients to contribute input may contribute to partnership's arrival at treatment decisions that have meaning for both.

Key words: negotiation; compliance; medical interview; patient participation; ambulatory care.

J39 — Roter, Debra et al. 1990. "An evaluation of residency training in interviewing skills and the psychosocial domain of medical practice." *Journal of General Internal Medicine* 5: 347-354.

Competent use of interviewing skills is important

for the care of all patients but is especially critical, and frequently deficient in meeting the needs of patients experiencing emotional distress. This study presents an evaluation of a curriculum in communication and psychosocial skills taught to first-year medical residents. A randomized experimental design compared trained and untrained residents' (n=48) performances with a simulated patient presenting with atypical chest pain and psychosocial distress. Evaluation was based on analysis of videotapes, simulated patient report of residents' behaviors and chart notation. Trained compared with untrained residents asked more open-ended questions and fewer leading questions, summarized main points more frequently, did more psychosocial counseling, and were rated as having better communication skills by the simulated patient. The use of more focused and psychosocially directed questions and fewer leading and grab-bag questions was associated with more accurate diagnoses and management recorded in the medical chart. However, no significant difference was found in the charting practices of trained versus untrained residents.

Key words: interviews; psychological; education; medical; internship and residence; internal medicine; psychiatry; primary health care; psychosocial skills; simulated patients.

J40 — Roter, D. and J. Hall. 1987. "Physicians' interviewing styles and medical information obtained from patients." *Journal of General Internal Medicine* 2: 325-329.

This paper investigates the association between physicians' interviewing styles and medical information obtained during simulated patient encounters. The sources of data are audiotapes and transcripts of two standardized patient cases presented by trained patient simulators to 43 primary care practitioners. Transcripts were scored for physician proficiency using expert generated criteria and were content-analyzed to assess the process of communication and information con-

tent. Relevant patient disclosure was also scored from the transcripts based on expert generated criteria. Findings were: (1) On the whole physicians elicited only slightly more than 50 percent of the medical information considered important according to expert consensus. (2) Both open and closed questions were substantially related to patient disclosure of medical information to the physician, but open questions were substantially more so. (3) Patient education, particularly information regarding prognosis, cause, and prevention, was substantially related to patient disclosure of medical information to the physician. (4) Finally, clinical expertise was only weakly associated with patient disclosure of medical information to the physician.

Key words: physician interviewing style; patient information-giving; patient disclosure; simulated patients; primary care.

J41 — Roter, D.; J. Hall and N. Katz. 1987. "Relations between physicians' behaviors and analogue patients' satisfaction, recall and impressions." *Medical Care* 25(5): 437-451.

This paper investigates associations between physicians' task-oriented and socio-emotional behaviors on the one hand and analogue patients' satisfaction, recall of information and global impressions. The study is based on role playing subjects' responses to interactions between physicians and simulated patients. Audiocassettes of two standardized patient cases presented by trained patient simulators to 43 primary care physicians were rated by role-playing patients (N=258) and electronically filtered excerpts from the encounters were rated for vocal affect by 37 independent judges. Content analysis was made of the visits' transcripts to assess interaction process and to identify all medical information communicated. Findings revealed that role-playing patients clearly distinguished task from socioemotional behaviors of the physicians. Within the task domain, patient centred skills (i.e. giving information and counsel-

ing) were consistently related to patient effects in a positive direction whereas physician-centered behaviors (i.e. giving directions and asking questions) demonstrated the opposite relationship. A negative pattern of association was also evident between physicians' socioemotional behaviors and patient effects.

Key words: physician-patient communication, physician task behavior, physician socio-emotional behavior, patient satisfaction, patient recall, analogue study, simulated patients, physician performance.

J42 — Roter, Debra. 1984. "Patient question-asking in physician-patient interaction." *Health Psychology* 3(5): 395-409.

Presented is an analysis of data gathered as part of an experimental intervention designed to increase patient question-asking during routine medical visits. Audiocassette recordings of two physicians in 123 medical visits were content-analyzed to identify the number, content and form of patient questions, as well as a variety of other interaction variables. These measures were then related to patient satisfaction with care. Findings indicate that the experimental intervention had significant effect on increasing the number of direct questions asked and that these were asked outside of their usual interaction pattern. Further, the relationship between question-asking and satisfaction differed in the two groups.

Key words: intervention; patient question-asking; patient satisfaction.

J43 — Roter, Debra. 1977. "Patient participation in the patient-provider interaction: The effects of patient question-asking on the quality of interaction, satisfaction and compliance." *Health Education Monographs* 5(4): 281-311.

The purpose of this study was to investigate the effectiveness, dynamics, and consequences of a

health education intervention designed to increase patient question-asking during the patient's medical visit.

Data were collected at a Baltimore family and community health center. A total of 294 patients and 3 providers took part in the study. The study design included random assignment of patients to experimental and placebo groups with two non-equivalent (non-randomized) control groups.

Findings included: (1) the experimental group patients asked more direct questions and fewer indirect questions than did placebo group patients, (2) The experimental group patient-provider interaction was characterized by negative affect, anxiety, and anger, while the placebo group patient-provider interaction was characterized as mutually sympathetic, (3) The experimental group patients were less satisfied with care received in the clinic on the day of their visit than were placebo patients, (4) The experimental group patients demonstrated higher appointment-keeping ratios during a four month prospective monitoring period.

Key words: intervention; patient question-asking; patient satisfaction; appointment-keeping.

J44 — Siminoff, L.A.; J.H. Fetting and M.D. Abeloff. 1989. "Doctor-patient communication about breast cancer adjuvant therapy." *Journal of Clinical Oncology* 7(9): 1192-1200.

We studied 100 consecutive patient-physician encounters about adjuvant therapy to determine how well we informed patients about benefits and risks and how clearly we recommended treatment. Evaluation included observation and audio-recording of encounters, patient and physician-completed questionnaires and patient interviews. Patient-physician agreement on the benefits and risks of adjuvant therapy were poor. Poor agreement was partially explained by the observation that patients and physicians exchanged little spe-

cific information. Furthermore, decision-making was compressed. Although this was the first meeting with a medical oncologist for 79 patients (79 percent), 82 (82 percent) made final decisions about treatment by the end of the meeting.

Physicians clearly identified their recommended treatment. Patients generally followed the physician's recommendation except when clinical trials were recommended. Physician recommendations of clinical trials were not as effectively communicated as non-trial treatments.

Key words: cancer patients; patient-physician agreement; decision-making.

J45 — Smith, K.; E. Polis and R. Hadac. 1981. "Characteristics of the initial medical interview associated with patient satisfaction." *The Journal of Family Practice* 12(2): 283-288.

This study examines the relationship between selected interview characteristics, particularly physicians' verbal behaviors, and levels of patient satisfaction and understanding. Twenty-nine initial patient interviews by 11 physicians were videotaped and rated using a modified Bales' technique. Questionnaires provided measures of patient satisfaction and understanding. Results of correlational analysis indicate that higher patient satisfaction was associated with greater interview length, increases in the proportional time spent by the physician in presenting information and discussing prevention, and shorter chart review times. Increased patient understanding was associated with increases in the proportional time spent presenting both information and opinions, close physical proximity, and reduced chart review time.

Key words: patient satisfaction; understanding.

J46 — Snyder, Diehl; J. Lynch and L. Gruss. 1976. "Doctor-Patient communications in a private family practice." *The Journal of Family Practice* 3(3): 271-276.

One-hundred fifty-five randomly selected patients in a private family physician's office were interviewed immediately before and immediately after their visit with the doctor in an attempt to assess the degree of misunderstanding that occurs in doctor-patient communications. Fifty-four percent of these patients either forgot to mention all their medical problems to the physician or they confused or forgot certain instructions concerning their diagnosis or treatment. A X² analysis failed to reveal any significant sex or age differences in the proportions of misunderstandings. There was also no correlation between the number of misunderstandings, the amount of time the doctor spent with the patients, the patients' rating of their own health on a scale of one to ten and the patients' complaints or praises about their medical treatment. The number of years of formal education completed by the patient showed a direct relationship to the number of misunderstandings. Patients on their first three visits to this office tended to misunderstand more of their medical instructions. Furthermore, the study suggested that patients with chronic internal diseases and those who express excessive trust in their physician might have an increased number of misunderstandings.

Key words: patient misunderstanding; family practice.

J49 — Stewart, Moira. 1984. "What is successful doctor-patient interview? A study of interactions and outcomes." *Social Science and Medicine* 19(2): 167-175.

The present exploratory study was undertaken to assess whether patient-centred interviews are related to positive outcomes. The study was conducted in 24 family physicians' offices where 140 doctor-patient interactions were audio-taped. The taped interactions were analyzed using Bales Interaction Process Analysis. Ten days after the audio-

taped visit the patients were interviewed in their home in order to assess their satisfaction with care, their reported compliance and to conduct a pill count.

Bivariate analysis indicated that interviews in which physicians demonstrated a high frequency of patient-centred behavior were related to significantly higher reported compliance and close to significantly better pill counts and satisfaction. Furthermore, in most instances, when the patient and physician scores were considered in combination, there was evidence that the physician's behavior, particularly that sort of behavior which initiated a discussion such as an explicit request for the patient's opinion, had more impact upon outcome than did the patient behavior.

Key words: patient-centeredness; patient satisfaction; compliance; family practice.

J50 — Stiles, William et al. 1979. "Interaction exchange structure and patient satisfaction with medical interviews." *Medical Care* 17(6): 667-681.

The verbal interaction between patients and physicians in 52 initial interviews in a university hospital screening clinic was studied using a new discourse coding system. Factor analysis of category frequencies showed that each interview segment, medical history, physical examination, and conclusion consisted mainly of two or three types of verbal exchange. Patient satisfaction with the interviews, assessed with a questionnaire that yields separate scores for satisfaction with cognitive and affective aspects, was found to be associated with exchanges involving the transmission of information in particular interview segments. Affective satisfaction was associated with transmission of information from patient to physician in "exposition" exchanges, during the medical history, in which patients told their story in their own words. Cognitive satisfaction was associated with transmission of information from physician to patient in "feedback" exchanges during the

conclusion segment, in which physicians gave patients information about illness and treatment.

Key words: affective satisfaction; cognitive satisfaction; patient exposition.

J51 — Svarstad, Bonnie. 1976. "Physician-patient communication and patient conformity with medical care." In Mechanic, D. (Ed.) *The Growth of Bureaucratic Medicine: An Inquiry into the Dynamics of Patient Behavior and the Organization of Medical Care*. New York: John Wiley & Sons.

The purpose of the study was to answer the question, "Why do physicians sometimes fail to achieve the patients' conformity with medication advice?" The design of the study, which began in 1969, included systematic observation of physician-patient interaction, review of medical records and pharmacy files, follow-up interviews with the patients about a week after their clinic visits, and validation of the patients' reported behavior by means of a "bottle check." The study found that the physicians frequently did not discuss their expectations in an explicit manner. Of the 347 drugs prescribed or proscribed, 60 were never discussed during the observed visits. The physicians gave explicit, verbal advice about how long to take the drug in only 10 percent of the 347 drug cases. How regularly the drug should be used was made explicit in about 17 percent of the cases. Of the 131 patients studied, 68 made at least one error in describing what the physician expected. Patients who had a completely accurate perception of what the physician expected were more likely to conform with the physician's expectations. Whereas 60 percent of patients who had a completely accurate perception of what the physician expected conformed with the physician's treatment plan only 17 percent of those who made at least one error did.

Key words: patient conformity; physician expectations.

J52 — Tabak, Ellen. 1988. "Encouraging patient question-asking: A clinical trial." *Patient Education and Counseling* 12: 37-49.

In this pilot study, a printed intervention was tested as an inexpensive alternative with potential for wider dissemination. Sixty-seven family medicine patients were assigned randomly to one of two educational conditions just prior to their medical visit: a treatment booklet stressing the importance of recognizing information needs and encouraging patients to ask questions; or a placebo education booklet similar in format but not in content. The patient-physician interactions were audiotaped to determine the number of questions patients asked, and a questionnaire was administered after each encounter to assess patient satisfaction with care. The mean numbers of questions asked in the experimental and control groups were 7.46 and 5.63 respectively; the mean difference of 1.83 questions was statistically nonsignificant ($p>0.05$). Question-asking did not correlate with reported satisfaction.

Key words: intervention; patient question-asking; patient satisfaction.

J53 — Thompson, S.; C. Nanni and L. Schwankovsky. 1990. "Patient-oriented interventions to improve communication in a medical office visit." *Health Psychology* 9(4): 390-404. [Study 1]

This paper reports on two interventions to improve patients' contribution to communication in a medical office visit. In the first study, women awaiting a medical appointment were randomly assigned to a group that was asked to list three questions to ask their physician or to a control group. Women who listed questions asked more questions in the visit and reported being less anxious. In the second study, a third group that received a message from their physician encouraging question-asking was added. Both of the experimental groups asked more of the questions they had wished to, had greater feelings of control, and were more satisfied with the visit in general

and with the information they received. The two experimental groups did not differ significantly, suggesting that the effect may be attributed either to thinking one's questions out ahead of time or to the perception that one's physician is open to questions.

Key words: intervention; patient question-asking; patient satisfaction.

J54 — Treadway, Judith. 1983. "Patient satisfaction and the content of general practice consultations." *Journal of the Royal College of General Practitioners* 33: 769-771.

Patient satisfaction was measured in interviews with 81 patients after their initial visits to trainee general practitioners. Increased satisfaction was found to be associated with the patient feeling understood, with the patient actually telling the doctor what he or she wanted (verbalizing the request) and with increasing age of the patient. Satisfaction was not associated with patients feeling improvement in their illness. The main conclusion of this general practice study was that encouragement of patients to express requests to their doctor will result in more effective doctor-patient communication and in improvement of the doctor's understanding of the patient's needs.

Key words: patient satisfaction; general practice.

J55 — Wasserman, R.C. et al. 1984. "Pediatric clinicians' support for parents makes a difference: An outcome-based analysis of clinician-parent interaction." *Pediatrics* 74(6): 1047-1053.

Supportive clinician behaviors were studied to determine their impact on parents. Forty initial health supervision visits to a pediatric clinic were videotaped through a one-way mirror. Mothers were interviewed immediately before and one week after the visits to ascertain changes in concerns, opinions of clinicians, perceptions of in-

fants and self-confidence. Mothers also completed a post-visit satisfaction questionnaire. Analyses compared visit outcomes according to high and low levels of maternal exposure to clinician support. Mothers exposed to high levels of encouragement had significant improvement in their opinions of clinicians and higher satisfaction ($p=.02$). Mothers exposed to high levels of empathy had higher satisfaction and greater reduction in concerns ($p<.05$). No significant differences in outcome were found for exposure to reassurance.

Key words: communications, doctor-patient relationship, maternal concerns, satisfaction; clinician-parent interactions; pediatric visits; clinician support.

J56 — Weinberger, M.; J. Greene and J. Mamlin. 1981. "The impact of clinical encounter events on patient and physician satisfaction." *Social Science and Medicine* 15E: 239-244.

Eighty-eight encounters were observed over a one-week period at an outpatient clinic of a university affiliated hospital. Participants were interviewed subsequent to each interaction. Multiple discriminant analysis showed encounters viewed by patients as unsatisfactory to be characterized by greater distance between parties during information gathering, increased amounts of feedback, highly active physicians, and physicians who are on call. Satisfied patients had encounters marked by increased physician use of (1) nonverbal encouragement, (2) questions about family and social situations, and (3) expressions of continuity from previous visits. Physicians were less satisfied in encounters in which they were active, felt pressed to other medical commitments and were on call. The most positive physician assessments occurred when patients were seen as compliant and where humor and nonverbal encouragement were used during the interaction.

Key words: patient satisfaction; physician satisfaction.

J57 — Willson, Pamela and J. Regis McNamara. 1982. "How perceptions of a simulated physician-patient interaction influence intended satisfaction and compliance." *Social Science and Medicine* 16: 1699-1704.

The present study investigated the extent to which competence and courtesy influenced enacted patient perceptions of medical care; as well as how these perceptions related to satisfaction and compliance with the care delivered. Small groups of undergraduates viewed one of four video-tapes on which were depicted a physician-patient interaction for a sore throat problem. Differential levels of competence and courtesy were displayed in the various tapes. While watching the videotape, subjects were asked to assume the role of the sore throat patient. Univariate ANOVAs indicated that the courtesy manipulation influenced the perception of courtesy and general medical satisfaction, while the competence manipulation influenced not only perceived competence but perceived courtesy, general medical satisfaction, and compliance as well. Subjects were able to accurately discriminate the extremes of good and poor physician behavior.

Key words: patient satisfaction; compliance; simulated patient.

J58 — Wolraich, Mark et al. 1986. "Medical communication behavior system: An interactional analysis system for medical interactions." *Medical Care* 24(10): 891-903.

The study assessed the psychometric properties of the Medical Communication Behavior System. This observation system records time spent by the physicians and patients on specific behaviors in the categories of informational, relational, and negative situation behaviors by using hand-held electronic devices. The study included observations of 101 genetic counseling sessions and also assessed the outcome measures of patient knowledge and satisfaction. In addition, 41 of the sessions were rated using the Roter Interactional Analysis System and 20 additional control subjects completed the post

counseling information without being observed to examine the effects of recording the session. Results showed good interobserver reliability and evidence of concurrent, construct and predictive validity. No differences were found between the observed and unobserved groups of any of the outcome measures.

Key words: physician-patient interaction; communication skills; MCBS vs RIAS; patient knowledge; satisfaction; genetic counseling.

J59 — Thompson, S.; C. Nanni and L. Schwankovsky. 1990. "Patient-oriented interventions to improve communication in a medical office visit." *Health Psychology* 9(4): 390-404. [Study 2]

(See abstract above, J53)

J60 — Kaplan, S.; S. Greenfield and J. Ware. 1989. "Assessing the effects of physician-patient interactions on the outcomes of chronic disease." *Medical Care* 27(3):S110-S127. [Study 2]

(See abstract above, J25)

J61 — Kaplan, S.; S. Greenfield and J. Ware. 1989. "Assessing the effects of physician-patient interactions on the outcomes of chronic disease." *Medical Care* 27(3):S110-S127. [Study 3]

(See abstract above, J25)

J62 — Kaplan, S.; S. Greenfield and J. Ware. 1989. "Assessing the effects of physician-patient interactions on the outcomes of chronic disease." *Medical Care* 27(3):S110-S127. [Study 4]

(See abstract above, J25)

II. Dissertations

Appleyard, JoAnn. 1989. "Decisional Control in the Client-Provider Relationship: An Exploratory Investigation in a Primary Care Setting." PH.D. dissertation, University of Illinois at Chicago, Health Sciences Center.

Decision Control, an element in Interaction Model of Client Health Behavior, was examined with adult clients interacting with physicians and nurse practitioners in a primary care setting. The study described client behaviors in achieving decisional control and the relationships among client demographic variables, preferences toward decisional control, actual control behaviors, and the health care outcome variables of compliance and satisfaction with provider behavior.

Written questionnaires were used to measure client preferences toward decisional control, perceptions of provider encouragement of decisional control, and satisfaction. Client behavior regarding decisional control was measured by analyzing transcripts of tape-recorded encounters between clients and providers (60), while data on compliance and a second measure of satisfaction were collected by telephone questionnaire.

The findings did not confirm the hypothesized relationships among the variables. That is, clients who preferred decisional control and who actively participated in the interaction were hypothesized to be more satisfied and to comply than clients who preferred control but did not participate actively. However, the independent variables did contribute significantly to discriminant models for satisfaction and compliance, and there were significant relationships among several of the variables.

Key words: decision-making; patient satisfaction, compliance; primary care.

Curtin, Roberta B. 1987. "Patient-Provider Interaction: Strategies for Patient Compliance." PH.D. dissertation, University of Wisconsin.

Pharmacy students and volunteer patient subjects were enlisted to stage simulated medical consultations in which prescription instructions were communicated. Three classes of variables were considered as they related to the specified outcomes: (1) pharmacy student background characteristics which included both past role socialization experiences and a preconsultation exposure to one of three randomly assigned communication strategies; (2) patient background characteristics, including past experience with the health care system; and (3) the process and content of the interaction that occurred between these two participants in the medical consultation.

The most important finding to emerge from this study was the fact that it is the interaction process and content, specifically with regard to the nature, quality and quantity of the information which is disclosed in the consultation, which is most significantly related to the outcomes of patient satisfaction and patient comprehension and recall of medical instructions.

Key words: information-giving; patient recall; comprehension; satisfaction; compliance.

Curtin, Stephen F. 1985. "World View and the Biopsychosocial Model of Medicine: Medical Resident Behavior and Patient Satisfaction." PH.D. dissertation, Saybrook Institute.

The purpose of this study was to determine if the ability of physicians to apply the biopsychosocial model of medicine_ attend to patients as persons and to strengthen affective bonds_ is linked to the preference of those physicians for organicism as it is measured by the World Hypothesis Scale. Audiotapes were made of nine family-practice residents while they cared for 40 outpatients, and the data acquired was evaluated by means of The

Medical Inquiry Scale. At the same time, each patient completed the Medical Interview Satisfaction Scale and each of the residents answered an exit questionnaire after each patient encounter.

It was hypothesized that patients of residents who prefer the organic world view would be more likely to report high affective satisfaction with the medical encounter than patients of low-preference residents.

The results of the study showed that the affective scores favored the high preference residents ($p < .01$). It is clear from the study that the world view of the resident impacts medical behavior, the physician-patient relationship and patient reports of satisfaction.

Key words: biopsychosocial model; patient satisfaction; family practice.

DeLauro, James P. 1981. "Health Risk Feedback in Physician-Patient Interaction." PH.D. dissertation, University of Pennsylvania.

In this study, feedback about the personal health risk of patients was used to assess the effect of information control on physician-patient relationships, and on patients' subsequent awareness of personal health risk indicators.

Forty-five patients with a primary diagnosis of hypertension, diabetes or obesity were assigned to one of five experimental conditions in which health risk information was either given or withheld from physicians and patients in various combinations. Every patient completed a pre and post test questionnaire designed to assess personal health risk. Feedback was given several days before regularly scheduled office visits which were tape-recorded and analyzed using Bale's Interaction Process Analysis Scale, and a system of content categories developed for this study.

Physicians and patients were found to differ in the primary objectives of their most frequent communications. Physicians' comments were most commonly task-oriented, while patients showed greater concern for the social aspects of the interaction.

Access to health risk feedback had no effect on patients' awareness of personal risk indicators. The control variable of pretest knowledge was significant in explaining post-test knowledge in eight of the ten summary variables analyzed. Observations of the interaction tended to confirm that patient's pre-study attitudes were intensified by the health risk information provided.

Key words: feedback; patient knowledge; hypertension; diabetes; obesity.

Kishi, Keiko I. 1981. "Communication Pattern between Health-Care Provider and Client and Recall of Health Information." D.N.S. dissertation, University of Pennsylvania School of Nursing.

Communication patterns between health care provider and client were analyzed according to Flanders Interaction Analysis System, and the relationship between the communication patterns of the health care providers and the client recall of health information was studied.

Sixty-eight mothers from the lower socio-economic classes were interviewed.

There was a statistically significant relationship between the ratio of client-talk to health-care provider talk and the recall ratio of the client. When clients participated more actively in health teaching sessions, more health information items were recalled by the client. The recall ratio of the client had a significant relationship with the clients race and with repetition of information by the health-care provider.

There was a significant inverse relationship between health-care provider questioning and the recall ratio of the clients. There was a significant inverse relationship between the length of the teaching session and client recall ratio.

Key words: patient participation; patient recall; provider question-asking.

Lober, Rosalie. 1982. "The Relationship of Patient-Practitioner Verbal Interaction to Patient Satisfaction Modified by Patient Psychological Differentiation and Time." PH.D. Dissertation, New York University.

Verbal communication and its effect on patient satisfaction was investigated for 58 pregnant women in four private obstetrical settings. A group of 28 patients, utilizing physicians and a group of 30 patients utilizing midwives were compared on measures of the verbal interaction, patient satisfaction, and the relationship between them. Measures of patient psychological differentiation and time were also measured and compared for patient groups.

Key words: verbal interaction; patient satisfaction; Ob/Gyn.

Moser, Daniel L. 1982. "Physician-Patient Consultations: Communications and Patient Outcomes." PH.D. dissertation, University of Virginia.

This study tested whether the use of the "illness" model in dealing with medical care has any measurable effects on patients as compared to the more traditional "disease" orientation.

Using 13 private and clinic primary care physicians, this study recorded and analyzed visits with the physicians for 139 patients, averaging more than 10 for each physician, in order to ascertain the relative use of the "disease" or "illness" approach to patient problems by the physicians and the physician's and patient's interaction. Patient's

compliance and remembrance of the physician's instructions and descriptions of the patient's medical problems two weeks after the recorded visit were also collected.

A positive relationship between increased addressing of psychosocial dimensions of patients' problems by the physician and patients' compliance and remembrance of instructions was found for lower income patients. Further significant differences were found between the physician's addressing of psychosocial dimensions of the patient's problems and the race and socioeconomic status of patients; there was higher psychosocial addressing of problems by physicians for white middle-class patients.

Key words: biopsychosocial model; patient recall; compliance; primary care.

Rivera, Tovar A.D. 1989. "Patient Values and Satisfaction with a Medical Interview." PH.D. dissertation, University of Pittsburgh.

The present study sought to examine how physician behavior influenced the satisfaction of patients with different value preferences. The acute care visits of 87 patients with one of three physicians at a university student health center were audiotape and physicians verbal behaviors were classified using Roter System of Interaction Analysis. The relative importance patients placed on affective, information-giving, and technical physician behaviors were assessed prior to the medical interview with a self-report measure. Participants completed a satisfaction questionnaire following their visit.

It was hypothesized that physicians' affective, information-giving, and technical behaviors would influence satisfaction, and that greater satisfaction would result when physician communication style matched patients' value preferences. Results did not support the hypotheses that physician behaviors or conformity to patient values predicts satis-

faction. Physicians' positive affect (as perceived by coders) predicted satisfaction, however, accounting for 17 percent of variance. Patients reported more satisfaction when physicians were seen as warm, caring and not angry; physician humor also contributes to that perception.

Key words: value preferences; patient satisfaction; acute care.

Romano, Samuel E. 1982. "An Evaluation of Active Patient Role Orientation Training." PH.D. dissertation, State University of New York at Buffalo.

This research project was designed to evaluate the effects of active patient role orientation (APRO) training on the behavior of ambulatory care patients. At a primary care medical center, 54 adult female patients were randomly assigned to one of three treatment groups. Each group was exposed to one of the following experimental conditions: (1) APRO training, consisting of didactic information and modeling film components which presented active role behaviors; (2) neutral training, consisting of didactic information and modeling film components which presented information about nutrition; and (3) no training.

The major hypothesis of the study was not supported by the results of the data analyses. There was no significant differences found among the treatment groups in the amount and type of responses made by the patients within the initial medical visit; in the patients' level of expressed satisfaction; in the degree of patient compliance recorded; and in the patients return rates for follow-up appointments. Additionally, physicians of the study patients did not significantly differ in their levels of expressed satisfaction across the three treatment groups.

Key words: intervention; patient participation; satisfaction; compliance; appointment-keeping.

Rost, Kathryn M. 1985. "Patient and Physician Anxiety in the Medical Interview: Consequences for Patient Satisfaction and Compliance." PH.D. dissertation, The Johns Hopkins University.

The participants in the study were 87 male patients with multiple chronic medical problems seeing residents and staff physicians for the first visit at a VA general medicine clinic. Compliance measures were available for the 47 patients who received prescription refills or new medications during the visit. Anxiety was unobtrusively measured from audiotapes of medical visits at the beginning, middle and end of consultations by determining the rate of patient and physician "non-ah" speech disturbances. Patient satisfaction was measured by a self-administered scale, and patient compliance was measured by refill obtaining behavior for three months after the visit, a measure previously correlated with physiological changes expected from prescribed medication.

Patients who were less anxious at the beginning and in the middle of the visit were more likely to comply with new medication regimens. Physician responsiveness buffers the detrimental effects of patient anxiety on compliance. More educated patients had a higher probability of compliance if their anxiety increased over the course of the visit. Anxiety reduction had a small influence on patient satisfaction in more educated, anxious patients.

Physician anxiety at the end of the visit had a positive relationship to subsequent patient compliance, although potential mechanisms of influence probably differed between higher and lower educated patients.

Key words: patient anxiety; physician anxiety; patient compliance; chronic diseases.

Stearns, Thomas W. 1980. "The Physician-Patient Relationship: An intervention to Improve Provider-Patient Interaction and Patient Compliance." PH.D. dissertation,

Florida State University.

The effectiveness of a brief workshop tutorial was evaluated by comparing four family-practice residents who received the intervention with four non-tutored control residents. The content of the tutorial reflected previous research implicating a relationship between interactional behaviors of physicians towards their patients and patient compliance. Didactic, videotape modeling and role-play procedures were included in the four-hour tutorial. Assessments were made of both physician and patient interaction behavior, patient compliance and patient satisfaction.

Results suggest that the tutorial workshop was effective in increasing relevant physician interaction behaviors. These behaviors remained stable throughout a six-month period of assessment. However, relationships between these physician behaviors and patient satisfaction were not supported by the present results.

Key words: intervention; patient satisfaction; compliance; family physicians.

III. Unvalidated Studies/No Outcome

Dauber, B. M. Zalar and P.J. Goldstein. "Abortion counseling and behavior change." Family Planning Perspectives 4(2): 23-27.

Between the first week of 1971 and October 15, 1971, 360 women were counseled for abortions at San Francisco General Hospital. A control group (Group 1) of 99 women who had received abortions prior to the institution of pre-abortion counseling program and whose only counseling had consisted of a 10 minute contraception lecture were compared with 99 women (Group 2) who met with a counselor usually 2 weeks prior, 2 times the day before the abortion, just before and after the abortion and just prior to the discharge from the hospital. Evaluation of the two approaches showed that 60 women in Group 1 accepted contraception whereas in Group 2 89 women did.

Key words: counseling; abortion; evaluation.

Dodge, J.A. and D. Oakley. 1989. "Analyzing nurse-client interactions in family planning clinics." Journal of Community Health Nursing 6(1): 37-44.

The nurse-client interactions of 12 taped interviews in 2 family planning clinics were analyzed using 5 client self-care themes and 9 provider responses and the results discussed in terms of Orem's Self-Care Theory. The taped sessions took place at a planned parenthood and a health department clinic. Content analysis was verified by outside raters trained in the methods selected. Client responses emphasized past practice and knowledge, over current intent to practice self care and decision processing. The nurses responded most often by asking questions and providing information, and less often by restatement, directives, support or suggestions. This pattern was found regardless of the nurse's education. The emphasis by nurses on providing information is likely a result of the agency's focus on ensuring that the client makes an informed and voluntary choice. Research has shown however that contraceptive continuation among adolescents was correlated with support and even authoritative guidance given by the provider.

Key words: family planning; self-care; nurse behavior.

Huntington, D.; C. Lettenmaier and I. Obeng-Quaidoo. 1990. "User's perspective of counseling training in Ghana: The mystery client trial." Studies in Family Planning 21(3): 171-177.

This report describes an evaluation method that combines clinic observation with an exit interview methodology. Eighteen women posing as clients were requested to visit three clinics with trained and three clinics with untrained family planning counselors. These clients (called mystery clients in Ghana) were later interviewed to uncover any perceived differences between the consultations.

The effect of training was evident. Trained counselors consistently provided more complete information about all available contraceptives. However, both trained and untrained counselors often treated younger clients with disrespect or refused to give them the information they requested. This behavior indicated the need to strengthen the values clarification section of the counselors' training sessions.

Key words: evaluation; counseling; mystery client; family planning; Ghana.

Kopp, Z.; K. Cox and P. Marangoni. 1989. "Implementing a counseling training program to enhance quality of care in family planning programs in Ecuador." Unpublished paper.

During 1988 and 1989, a counseling training program was developed for all staff member of APROFE. The program was jointly developed by International Planned Parenthood Federation/Western Hemisphere region, (IPPF/WHR), and APROFE which is an Ecuadorian Family Planning Organization affiliated with IPPF/WHR. A baseline client survey was carried out to determine levels of client satisfaction and contraceptive knowledge at 6 clinic sites. Additionally, the quality of client-provider interaction was assessed by direct observation. Seven training workshops were provided for over 100 staff members of APROFE who interact with clients: secretaries, receptionists, physicians, nurses, motivators, educators, counselors, and nurse-midwives. The impact of the program was assessed by pre- and post-workshop Knowledge, Attitude, and Practice tests and by subsequent observations of client-provider interactions.

Key words: evaluation; counseling; family planning; Ecuador.

Marcus, R.J. 1979. "Evaluating abortion counseling." Dimensions in Health Service 56(3): 16-18.

The impact of counseling on women who requested abortions at the Vancouver general Hospital in Canada was assessed in a follow-up study of 401 of the women who received counseling and 404 of the women who did not receive counseling. No significant differences were found between the counseled and non-counseled groups in respect to the proportion of women who 1) subsequently practiced contraception; 2) returned for repeat abortion during the next 12 months; 3) returned for medical check-ups following the abortion; and 4) were willing to consider alternatives to abortion. The counseled did experience fewer negative feelings prior to and immediately following the abortion; however, these differences disappeared six months later. The group which received counseling reported more satisfaction with their level of contraceptive knowledge.

Key words: counseling; abortion; satisfaction.

Reynolds, V; M.H. Puck and A. Robinson. "Genetic counseling: An appraisal." Clinical Genetics 5(3): 177-187.

To assess the impact of genetic counseling interviews with former recipients of the counseling (consultands) in the Genetic Counseling Clinic of the University of Colorado were conducted. The majority of consultands retained the information over extended periods of time. Over one half of the consultands found the counseling helpful. A positive correlation was found between degree of satisfaction and level of understanding. 41 couples were influenced in their family planning by the genetic counseling. Genetic counseling was of limited value when the counselor was unable to satisfy the expectations of the consultand for enlightenment about the cause of the problem, particularly those of unknown etiology.

Key words: genetic counseling; client expectations; satisfaction.

Schuler, Sidney et al. 1985. "Barriers to effective family planning in Nepal." *Studies in Family Planning* 16(5): 260-270.

To investigate why family planning (FP) services in Kathmandu Valley of Nepal are underused, a study was initiated under the auspices of the Nepal Family Planning/Maternal Child Health Project. The study was intended to provide a user perspective, by examining interactions between FP clinic staff and their clientele. "Simulated" clients were sent to 16 FP clinics in Kathmandu to request information and advice. The study revealed that in the impersonal setting of a family planning clinic, clients and staff fall into traditional, hierarchical modes of interaction. In the process, the client's "modern" goal of limiting her family size is subverted by the service system that was created to support this goal. Particularly when status differences are greatest, that is, with lower class and low caste clients, transmission of information is inhibited.

Key words: family planning; mystery client; user's perspective; Nepal.

Simmons, R.; L. Baqee; M. Koenig and J. Phillips. 1988. "Beyond supply: The importance of female family planning workers in rural Bangladesh." *Studies in Family Planning* 19(1): 29-33.

Using participant observation data on worker-client exchanges from Bangladesh, this article examines the interface between a government family planning program and the rural women it serves. Case material focuses first on the program function typically identified in the literature: meeting unmet demand for contraception by providing convenient supply. Functions that have been less recognized are then illustrated: (1) the worker's role in reducing fear of contraceptive technology; (2) her efforts to address religious barriers, child mortality risks, and high fertility preferences; and (3) her role in mobilizing male support. The range of functions performed by the female family planning worker in the cases discussed here dem-

onstrates that her role transcends the boundaries of what is conventionally implied by the concept of supply. She acts as an agent of change whose presence helps to shift reproductive decision-making away from passivity, exposing women long secluded by the tradition of purdah to the modern notion of deliberate choice.

Key words: family planning; community health workers; participant observation; Bangladesh.

Walton, S. M.; H. Gregory and G. Cosbie-Ross. 1988. "Family planning counseling in an antenatal clinic." *British Journal of Family Planning* 13(4): 136-9.

Family planning counseling relies on opportunism of the service, maximal provision, and adequate retention of information by patients. These aspects were studied in an evaluation of counseling in an antenatal clinic in Cleveland. They were found to be more appropriate than the traditional post-natal counseling. A significant proportion of women felt the advice was helpful in determining their eventual method of contraception. This was more noticeable in the under 20 age group.

Key words: family planning; antenatal clinics; evaluation; counseling.