

## Introduction

Welcome to the Guide to Communication section of this portfolio. In this section we go through the various stages and activities of an optometric consultation and discuss their typical communication behaviours. We provide practical guides and points for reflection for practitioners. We also discuss common challenging communication scenarios.

### *What is in the Guide?*

In the Guide we present findings from our research project and illustrate them using specific examples from our data. These data examples are represented by transcripts and video still images.

We support our research with the findings of other studies on healthcare communication (key texts are listed in the resources section) and the results of our scoping exercise. Quotations from our scoping exercise are given in speech bubbles with the (anonymised) source given underneath.

Discussion of these various findings enables us to provide practical guidance and points for reflection for practitioners. We also link these to relevant GOC core competencies.

### **How to use the Guide**

We recommend that users decide for themselves how they wish to use the Guide. Some might choose to go through each part in order whilst others might prefer to focus on specific areas of interest or move freely between parts of the Guide and relevant Skills Development activities in the next section.

For *individual users* the Guide provides information to enhance knowledge about communication and promotes reflection on practice. *Pairs and small groups* might additionally find it helpful to use the information and reflection prompts as a basis for discussion. For *students and trainers* this Guide can reinforce key learning points and

connect to development activities – both within this portfolio and in external curricula.

### Transcripts

Our transcripts use the abbreviations 'Opt' (optometrist) and 'Pat' (patient) to indicate who is speaking the relevant line. Long transcripts may include line numbers so that particular turns can be referred to easily. These transcripts are a verbatim record so it is not unusual to observe incomplete sentences, syntactical/grammatical errors, hesitations and repetitions. Recording interaction in this level of detail helps us to produce an in-depth understanding of interaction. For this reason we also record the length of silences in seconds (line 11) and place one participant's speech directly underneath another's (rather than starting at the beginning of the new line) to indicate that the speaker is talking at the same time (e.g., in line 5 the patient begins talking as the optometrist says 'worse' in line 4). Relevant visible actions are noted in italics – e.g. (*shakes head*)

1. Opt: And distance vision
2.       looking at signs, do
3.       you think that's got
4.       any worse or better?
5. Pat:       That that's fine.
6.       That's that's not too bad
7.       at all. I mean I I
8.       can' - I can't focus very
9.       well and it may be
10.       be necessary to
11.       (0.3 secs) correct these
12.       now to better uh but now
13.       I mean I can generally
14.       see.

## List of topics

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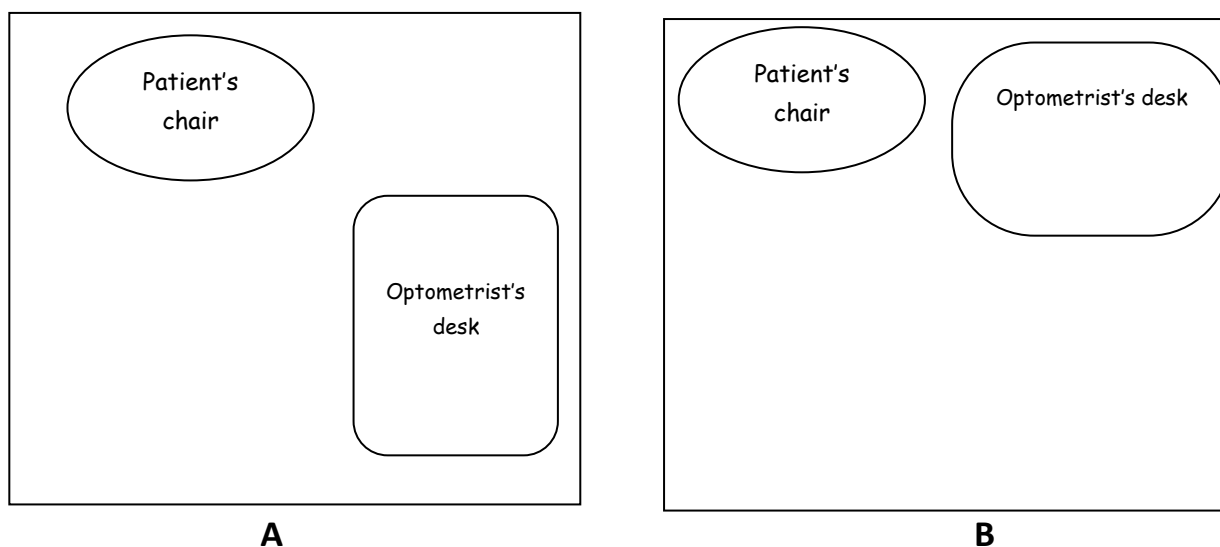
Topic 14: What is patient centred care?

## Topic 1: The layout of the consultation room

Consideration of communication in the consultation begins even before the patient enters the room. The physical layout of the consultation room, in particular seating arrangements and the layout of tools and equipment, can have a huge impact on interaction between practitioner and patient.

As discussed in Introduction and Background section, visible actions such as gaze and eye contact play an important role in communication. They are particularly important during phases of the consultation in which the optometrist is eliciting information from the patient (openings, follow up and history taking) and delivering information (findings and advice) to the patient. The relative seating positions of the optometrist and patient can alternatively reduce or enhance opportunities for eye contact.

Looking at these two diagrams: what consequences do the different room layouts shown have for communication?



In diagram A the optometrist's desk is at a right angle to the patient's chair. This layout can hinder eye contact as if the optometrist is writing or typing at the desk at the desk his/her back is turned to the patient (Image 1). An alternative is to sit facing the patient and use a clipboard to make notes (Image 2).



In diagram B the desk is adjacent to the patient's chair. This provides easier simpler opportunities for eye contact as the optometrist can sit turned towards the patient and reorient to the notes/computer screen without turning his/her back to the patient (Image 3).

## Topic 2: Beginning the consultation

### Relevant GOC core competencies

- Stage 1:** 1.1.1 Ability to communicate effectively with the patient...building a rapport  
1.3.2 Ability to interpret and respond appropriately to patient records and other relevant information
- Stage 2:** 1.1. Ability to communicate effectively with a diverse group of patients  
2.2.5 Interprets and responds to existing records.

Even before the consultation begins, it is possible to take steps to maximise the ease of communication.

### Layout and seating position in the consultation room

Eye contact between practitioner and patient is often crucial to the flow of communication in a healthcare consultation. This eye contact can be facilitated or hindered by the layout of the consultation room and physical positions of those within it. Whilst it may not be possible for optometrists to change the layout of the desk, equipment etc. in the room, it is possible – and worthwhile – to consider other physical arrangements.

- Do the seating positions of optometrist and patient maximise opportunities for eye contact during key activities such as soliciting patient concerns and delivering findings and advice?
- Is it possible for the optometrist to access the patient record (paper or electronic) without turning away or turning too far from the patient?
- Is it possible for the optometrist to read from or add to the patient record without turning away from the patient or dropping the head down completely?
- How easily can eye contact be renewed once it has been broken?

### Accessing available information

A few moments spent reviewing the patient record, completed patient questionnaires, information from Reception etc. enables the optometrist to:

- use the patient's name to ensure a personal, and possibly rapport building, greeting;
- draw on information about the patient's reason for visit to determine the wording of the opening question;
- draw on information about the patient's health status, previous experiences and so on to assess whether he/she needs assistance entering the room, is likely to be nervous etc.

### Greetings and small talk

The time during which the patient enters or is led into the consultation room is usually accompanied by greetings and 'small talk'. A personal greeting can help establish a positive atmosphere and small talk can allow the optometrist to observe whether the patient appears nervous or distressed. Optometrists sometimes complain that patients are overly keen on small talk and difficult to steer on to more relevant topics. Small talk can become particularly entrenched if the start of the consultation is taken up with the optometrist preparing record forms, tools etc. or dealing with notes from a previous encounter – because talk arises to fill silences. An advantage of having these materials prepared in advance of the consultation is therefore that it can reduce the opportunity for extended small talk and enable the consultation to get down to business quickly.

### Topic 3: Opening questions and patient responses

#### Relevant GOC core competencies

- Stage 1:** 1.1.1 Ability to communicate effectively with the patient.  
1.1.4 Ability to make a patient feel at ease and informed.
- Stage 2:** 1.1.2 Elicits the detail and relevance of any significant symptoms.  
1.1.3. Identifies and responds appropriately to patient's fears, anxieties and concerns about their visual welfare.

Opening questions get a consultation 'down to business'. After greetings and small talk the practitioner asks a question that seeks information about the patient's symptoms and/or reason for visit.

In optometry consultations, these questions usually refer specifically to the patient's eyes and are often tied to references to the timing of the patient's last visit.

"Right it's been another year since we saw you last time. Have there been any problems with your eyes since then?"

"Any particular problems this time round?"

#### Opening questions and responses are crucial to the conduct and outcome of the consultation:

- they set an agenda for the encounter – for instance as a 'new problem' or 'follow up' visit – and establish the clinical and communicative activities to follow.
- they can provide a rare opportunity for patients to talk at length and in their own terms about their concerns. They are central to the patient's experience of the encounter.

Finding the reason for the patient's visit is paramount to a successful outcome.

Optometrist, questionnaire response

#### The wording of opening questions

The wording of opening questions can set up different kinds of response from the patient. Example 1 below is a very open question. It seeks a response beyond a yes or no and encourages the patient to select whatever issues he/she feels to be relevant in regard to his/her eyes.

##### Example 1

So how do you find your eyes at the moment?

##### Example 2

Any problems with your eyes at all?

##### Example 3

Are you having any problems or is it just routine check-up today?

Examples 2 and 3 set up limited responses. Example 2 projects a yes/no response; this does not encourage the patient to talk at length – although it is actually likely in this context that any patient answering 'yes' will go on to give more information. From the practitioner's perspective these questions can efficiently direct the patient to relevant information and prevent overly long responses. Example 3 takes this further with two yes/no questions that direct the patient to key issues of relevance – the existence of problems and the purpose of the encounter. We observed this kind of 'either ... or' opening question quite frequently in our data and note that it can be problematic in a number of ways. Firstly, a 'yes' response to the first part of the question requires a 'no' response to the

second (and vice versa) so the patient needs to exercise some verbal dexterity to navigate the logic of the full question. Secondly, the question suggests that if a patient is coming for a routine check-up then he/she does not have any problems to report. It is possible however that a patient coming for a scheduled check also wants to report some concerns he/she has noticed between visits. By implying that having a routine check and having problems are mutually exclusive, the question risks the routine check patient selecting not to mention any new problems. Finally, as a closed yes/no question, it limits the content and length of the patient's response. This reduces the patient's opportunity to participate in this crucial part of the consultation.

**Example 4**

How've the eyes been? Have you noticed any problems?

**Example 5**

What sort of problems have you noticed then?

**Example 6**

Right so it's a re-check examination yeah?...Your last test was in February and you're saying that your distance and er reading is blurry?

In Example 4 the combination of an open and closed question suggests an extended but also directed response – an assessment of the eyes and a comment on the existence of problems. Examples 5 and 6 are opening questions which draw on existing information available – for instance from the record form, Practice reception etc – before the consultation begins. Drawing on this information can be a way to direct the patient to relevant issues immediately. In Example 5 this is done in an open way as it assumes that problems exist but invites the patient to describe what they are. Example 6 is more constraining, with the

optometrist reading out loud information the patient has previously given and asking him to confirm it.

**When selecting the wording of an opening question in the consultation it is necessary to balance the – sometimes competing – demands of:**

- **soliciting relevant information,**
- **encouraging patients to express themselves, and**
- **moving the consultation forwards efficiently.**

**Patient responses to opening questions**

In our research we frequently find that patients display difficulty answering the optometrist's opening question. We observe this difficulty in pauses before or during an answer, hesitations ('um' 'er' etc.), cut offs and restarts within sentences and the absence of a yes or no response to a closed question. We can see this in Examples 7 and 8.

**Example 7**

Opt: Any problems you're having or is it just a routine check for you today?

Pat: Erm well I notice that I'm squinting more when I'm out on the streets

**Example 8**

Opt: Do you feel that you are having any problems with the lenses?

(0.9 secs)

Pat: Erm (0.3) They do irritate me sometimes. I don't er don't keep them in for as long as I used to

In particular patients show equivocation over the existence of problems. The majority of opening questions we have observed include some kind of query about whether or not the patient has problems with their eyes but – as in Examples 7 and 8 - patients often respond without an explicit yes or no. They might also report something that sounds problematic but

then undermine it by referring to it as not serious (Example 9) or say they do not have any problems but later report something problematic (Example 10). This particularly occurs when patients attend for routinely scheduled check-ups.

**Example 9**

Opt: Any problems that you've had with your eyes or?

Pat: Er just where I had really bad hayfever with the eyes but (.) [shaking head] that was hayfever symptoms

**Example 10**

Opt: How've you been since the last time we saw you? Any problems?

Pat: No  
(0.2)

Pat: No  
(0.8)  
[Pat goes on to say she does not wear her glasses very often] And to be honest with you I can't wear them for any length of time without them making me feel sick

We suggest two interlinking reasons for these patient difficulties:

**1) Lack of knowledge**

Compared to other parts of the body many patients (in particular those without long term eye health conditions) know relatively little about the structures of the eye and the nature of eye disease. It can also be difficult to estimate the quality of our vision, notice gradual changes or distinguish between problematic changes and 'natural' deterioration that many of us expect to experience as we age. This lack of knowledge can make it difficult for patients to articulate their experience of their eyes.

**2) What constitutes a problem?**

Given this lack of knowledge it can be difficult for patients to gauge whether or not some change in their eyes constitutes a problem worth reporting right at the start of the consultation. As opening questions are so central to the consultation there is a kind of

pressure on patients to answer them in the 'right' way. If the patient describes something as a 'problem' but the examination tests later indicate that it is not, - and vice versa - then the patient risks losing 'face'. Equivocation during an opening question response can ameliorate this risk.

In addition, as part of a concern to 'do the right thing' (see Topic 6) patients may treat a check-up appointments as a consultation in which they are not *supposed* to have new problems to present (as they could/should have made an earlier appointment to discuss them) and provide corresponding responses that under-report an apparent problem or delay its report.

**It is helpful to consider ways to ease the difficulties patients display when answering opening questions:**

- **Asking patients what they 'notice' (Example 4) or 'feel' (Example 8) about their eyes acknowledges that the patient's experience may be subjective and limited in expertise. This can reduce pressure to produce a 'correct' answer.**
- **Avoiding the term 'problems' in the opening question – as in Example 1 or by asking instead about 'concerns' or 'changes' could bypass equivocation over what constitutes a problem.**
- **It is also helpful to avoid questions such as Example 7 which suggest that routine patients do not (should not) have any new problems to report.**
- **Finally, the tendency for patients to under-report or delay references to difficulties with their eyes indicates the important role of further history taking questions to solicit relevant information. Our data also show that silence can be a useful tool in prompting/enabling patients to speak further. Both features are discussed further in the next topic.**



## Topic 4: Follow-up questions and history taking

### Relevant GOC core competencies

- Stage 1:**
- 1.1.1 Ability to communicate effectively with the patient
  - 1.1.4 Ability to make a patient feel at ease and informed
  - 1.2.1 Ability to take a structured, efficient, accurate history and symptoms from patients with a range of ophthalmic problems and needs.
- Stage 2:**
- 1.1.1 Obtains relevant history and information relating to general health, medication, family history, work, lifestyle and personal requirements.
  - 1.1.2 Elicits the detail and relevance of any significant symptoms.
  - 1.1.3. Identifies and responds appropriately to patient's fears, anxieties and concerns about their visual welfare.

Follow-up questions and history taking after the opening question and response gather further information about patient concerns and broader information regarding the patient's vision and eye health status. This is a complex phase of the consultation, requiring the practitioner to make various decisions about what types of question to ask, how to word questions, and how to deal with patient answers. Here we discuss these important themes by using excerpts of data transcripts from four different consultations – A, B, C, and D. The full versions of these transcripts can be seen in the Resources Bank.

### Asking questions

#### Questions to solicit specific information

Whilst opening questions are often general in wording, most follow-up and history taking questions are more specific. They tend to ask about a named topic and may set up a yes/no answer:

#### Example 1: Consultation A

1. Opt: Right. It's been another year
2. since we saw er you last
3. time,
4. Pat: Yes.
5. Opt: Any problems that you've had
6. with your eyes since then?
7. Pat: No none. They've buh been
8. alright. Yes actually yes.
9. Opt: Great. Quite clear?
10. Pat: Yeah?
11. Opt: **Reading, seeing the TV's all**
12. **fairly clear?**

These kinds of question can usefully build on the information supplied by the patient's opening question response, whilst also enabling the optometrist to focus on relevant topics.

Even when yes/no questions are asked, it is quite common for patients to answer 'more than' the question.

#### Example 2: Consultation A

35. Opt: Okey dokey. **Any other**
36. **problems? Things like um**
37. **headaches, double vision,**
38. **any flashing lights?**
39. Pat: No I just had a
40. bit of internal dizziness in
41. the head er about a month ago,
42. which was put down to high
43. Opt: mmm.
44. Pat: blood pressure and er uh
45. (0.2 secs) problems with the
46. the family you know my father
47. in law died, (0.2 secs) having
48. to bear
49. Opt: Shame
50. Pat: everyone up through that

Here the patient says 'no' to the topic of other problems and then mentions other issues that have not been named by the optometrist but could feasibly be understood as 'other' problems. So at times, patients' answers treat optometrists' questions as *too* specific for their concerns.



### Questions for confirmation/clarification

The most specific kinds of question are those which solicit confirmation or clarification of something the patient has just said.

#### Example 3: Consultation B

49. Opt: **In sum it's a blur in the**  
50. **right eye only yeah?**  
51. Pat: Yes.

In addition to serving a useful clinical purpose these confirming/clarifying questions can display that the patient has been listened to and treats his/her responses as relevant to the consultation.

#### Question order

An opening question to gather general information followed by a series of specific enquiries and requests for confirmation/clarification can be a useful and logical order for the opening stages of the consultation. The patient has an opportunity to reveal his/her concerns and the optometrist is then able to solicit specific, relevant information. Very often the optometrist's questions follow the order of topics on the patient record form. Patients of course are unlikely to be familiar with the form and unlikely to frame their responses in reference to it. For instance they may answer with extra details relating to topics the optometrist has not yet asked about. We can see this in Example 4. In lines 48-49 the optometrist asks about distance vision but the patient's reply includes information about her reading vision.

In this kind of scenario when the patient answers 'more than the question' the practitioner might then: 1) stay with the patient's preferred topic and ask more (clarification) questions at this point then move back to the original topic later, 2) try to remember the information the patient has just given and come back to it later, or 3) ask

questions that steer the patient back to the original question (and record form order). In Example 4 the optometrist refers back to his original question before going on to clarify her concern about reading (lines 60-66). This movement between topics enables the optometrist to keep to his original order and the order of the record form; however this movement may be confusing to the patient and can perhaps also take up extra time.

#### Example 4: Consultation C

48. Opt: **How you getting on in terms**  
49. **of your distance vision?**  
50. (0.8 secs)  
51. Pat: Erm that's okay, (1.1 secs)  
52. I don't think erm (0.3secs)  
53. Chi: Long sighted. You long  
54. sighted?  
55. Pat: Yeah no it's just uh  
56. (0.2 secs) you know? I know  
57. I can even tell with these  
58. that I probably need them a  
59. bit stronger for reading.  
60. Opt: **Okay. Distance is okay**  
61. **though yeah?**  
62. Pat: Seems okay yeah I don't  
63. seem to have any problems,  
64. I mean no.  
65. Opt: **And reading you said**  
66. **slightly reduced or?**

#### Encouraging the patient to give further (specific) information

In Example 4 the optometrist moves very quickly to asking the patient specific questions and we can see that in response the patient treats the questions as *too* specific for what she wants to talk about. Compare this to Example 5. The patient produces a very long description of his current status and concerns. The optometrist acknowledges this description as it is produced and seeks clarification of some issues with closed questions but delays asking specific questions for a considerable time. Two particular features encourage the patient to continue talking:

- continuers such as 'Mmm.'
- silence and head nods

Accompanied by eye contact, these actions indicate that the patient is being listened to and can continue if he has more to say. At the same time they are also neutral, so avoid specifically agreeing (or disagreeing) with the patient's self-assessments, such as in Example 5 that he needs bifocals (line 17).

Delaying the start of more specific questions and encouraging the patient to continue can help the patient to feel involved in the consultation. Of course the information that the patient provides may or may not be relevant or given in a logical order.

#### Example 5: Consultation D

1. Pat: The other thing is I hadn't
2. realised that when you go
3. from being short sighted
4. to fairly long sighted, you
5. no longer take off your
6. glasses to to see things
7. close to, you have to put
8. glasses on to see
9. Opt: Yes
10. Pat: things close to.
11. Opt: It's irritating isn't it?
12. Pat: Umm. Well the other thing
13. is I suddenly realised that
14. possibly and with your
15. advice or otherwise uh
16. (0.3 secs) I need a pair
17. of bifocals
18. (1.3 secs)
19. Opt: Mmm.
20. (0.8 secs)
21. Pat: And that's going to have to
22. be the answer.
23. (0.9 secs)
24. Pat: Cos I'm constantly putting
25. on one pair to look at the
26. computer screen and (0.2
27. secs) the other one to uh
28. general
29. (0.5 secs)
30. Opt: Okay. First of all do they
31. still check the eyes at the
32. hospital?
33. Pat: They haven't done for some
34. time.
35. Opt: Mmm.
36. (0.2)
36. Pat: Uh there I was signed off,

**In the follow up and history taking phase of the consultation, it is useful for practitioners to consider:**

- **what type of question is being asked?**
- **what kind of response is required?**
- **what is a suitable question order?**
- **how might you deal with patients answering 'more than' the question?**

There are further issues to consider in relation to wording of questions in this phase:

#### Use of 'jargon'

##### Example 6: Consultation B

115. Opt: Do do you get any
116. headaches?
117. Pat: No.
118. (0.4 secs)
119. Opt: Double vision?
120. Pat: No
121. Opt: Flashes of light or
122. floaters?
123. Pat: No
124. (0.2 secs)
125. Pat: What are floaters?

Example 6 line 125 is a very rare instance of a patient admitting to not understanding some terminology or 'jargon' used in the consultation. More commonly patients do not refer (explicitly) to their own lack of understanding, which of course can have consequences for the outcomes of the encounter. It can be helpful to try to gauge how much knowledge a patient has and to design questions accordingly. For instance the patient in consultation B has referred early on (see full transcript in skills development section) to not having had an eye test since she was a child and this suggests she may be unfamiliar with terms such as 'floaters'. By contrast the patient in consultation D talks knowledgably about his own condition right from the start of the encounter and this indicates he will be able to understand certain

terminology – as indeed is the case in the full transcript as he later asks questions about the specific quality of his double vision.

Questions can be designed to avoid possible misunderstandings by including ‘familiar’ references. For instance, compare:

- ‘How is your distance vision?’
- ‘...seeing the TV’s... fairly clear?’
- ‘And distance vision looking at signs...?’

### Separated vs, connected questions

In example 6, and consultation B overall, the optometrist gathers information through a series of questions that appear as separate and not connected to each other, and that make no reference to the patient’s previous answers or personal circumstances. These questions and answers appear relatively quick and efficient but a little impersonal

#### Example 7: Consultation D

255. Opt: And d’you get many  
256. headaches?  
257. Pat: Erm I’ve woken up with  
258. headaches occasionally um  
259. that may be eye strain I  
260. don’t know.  
261. They’re not very bad, they  
262. go on for  
263. Opt: Mmm.  
264. Pat: I certainly don’t get them  
265. after be- after having used  
266. the computer (0.2 secs) not  
267. to the extent that, you  
268. know, it puts me off.  
269. Opt: Mmm. And how’s your general  
270. health, you quite well at  
271. the moment?

By contrast the questions in Example 7 are connected to each other. This is done simply, through ‘And’ at the start of the question (terms such as ‘So’ or ‘Okay and’ etc would also have the same effect). This gives the impression that the various questions are

building up to inform an overall picture of the patient’s status. In a more complex way, questions can build on the patient’s previous answer. For instance Example 1 lines 11-12 ‘Reading seeing the TV’s all fairly clear?’ after the patient says he has no problems with his eyes.

This connected style of questioning may take longer but is more conversational in tone. Making connections to the patient’s answers also provides an opportunity for the optometrist to comment on an answer in a way that displays empathy with the difficulties being reported: for instance Example 5 line 11 ‘It’s irritating isn’t it’ and Example 2 line 49 ‘Shame’.

### Using questions to assume an answer

The wording of a question can sometimes imply what the patient’s answer will, or even ‘should’, be. If a patient reports the absence of any problems, a follow-up of ‘So you’re reading glasses are okay?’ assumes a ‘yes’ in reply. This can appear unproblematic, as of course the question and assumption are based on information the patient has already provided. However we find that patients quite frequently report the absence of problems in response to an opening question but later go on to introduce some kind of concern.

For instance it may be that a patient is experiencing a reduction in near vision but as he/she expects this to occur ‘naturally’ with age this is not reported right at the start of the consultation. Follow up questions assuming a no problem response may make it more difficult for the patient to introduce this concern subsequently.

Questions can also imply a particular answer in more subtle ways. In example 6 the patient answers the question about flashes of light and floaters in the ‘expected’ way even

though – as she next states – she does not know what floaters are. The position of this question in a list of other questions that have received a ‘no’ response indicates that another ‘no’ is suitable here. In addition the question is grammatically incomplete but has the assumed form ‘*Do you get any flashes of light or floaters?*’ (a repetition from lines 115-116). The ‘any’ also projects a ‘no’ response. For example compare ‘*Do you get any headaches?*’, ‘*Do you get many headaches?*’ and ‘*Do you get some headaches?*’

**Questions that build connections to previous responses add a coherent and conversational tone to the interaction, and also provide opportunities to display empathy.**

**Questions that include jargon or imply a particular answer can be troublesome as the accuracy of the patient’s answer cannot be guaranteed. For this reason it is helpful for the practitioner to:**

- gauge how familiar the patient is likely to be with certain terminology;
- consider how to word questions to avoid misunderstandings;
- be aware of the assumptions built into questions and avoid expressing them when searching for key information from the patient;
- vary question formats in order to avoid chains of questions that prompt a similar answer.

### **The Skill of listening**

In addition to the delivery of questions, effective communication in this phase requires skilful listening by the optometrist. Actively listening to the answers that patients produce enables the optometrist to gather clinically relevant information as well as to gauge nuances such as whether the patient appears to be nervous, the patient’s level of

eye knowledge and any equivocation the patient has about the status of his/her eyes.

There are a number of ways to conduct active listening. Some practitioners select to ask a series of questions on specific topics which prompt the patient to deliver information in short segments that follow the order of the record form. This enables the information provided to be captured and entered into the form easily – although the process can be disrupted by the patient choosing to answer ‘more than’ the question and/or providing information out of order. Other practitioners use open questions and continuers (such as ‘mm’) to encourage the practitioner to speak at length and listen out for important details as they are delivered. Since practitioners might often produce irrelevant detail and talk in an order that does not correspond with the record form, this approach can require considerable skill.

A key complaint amongst patients – across all forms of healthcare – is that they do not feel listened to by their practitioners. So another aspect of active listening involves displaying to the patient that he/she is being listened to. This can be achieved through:

- making and maintaining eye contact;
- careful consideration of when is (and is not) an appropriate moment to write notes (and break eye contact);
- Repeating/reformulating patients’ words in questions for confirmation;
- adapting subsequent questions in response to information given by the patient.
- displays of empathy.

For further discussion of issues relating to listening, see Topics 5 and 6.

## Topic 5: Note taking during the consultation

### Relevant GOC core competencies

- |                 |   |
|-----------------|---|
| <b>Stage 1:</b> | 1.1.4 Ability to make a patient feel at ease and informed<br>1.2.2 Ability to produce comprehensive, legible and organised record keeping with appropriate detail and grading |
| <b>Stage 2:</b> | 1.1 The ability to communicate effectively with a diverse group of patients.<br>2.2.4 Creates and keeps full, clear, accurate and contemporaneous records.                    |

Writing or typing notes during the consultation is an unavoidable task but can have significant consequences for communication with the patient:

- **silences whilst writing/typing can break the flow of interaction and even feel 'awkward' if they are lengthy;**
- **spending significant time writing during the consultation can be detrimental to the patient's experience of the encounter.**

Making notes removes eye contact between practitioner and patient. Eye contact is fundamental to face to face communication; it helps conversation to flow and is a key way that we display we are listening to each other. A major source of complaint from patients across healthcare is that rather than paying attention to them, practitioners spend consultation time busying themselves with notes, prescriptions, computer systems etc. In particular, if patients do not receive eye contact whilst they are reporting their symptoms and concerns, they may feel as if they are not being listened. If there is no eye contact whilst being given a diagnosis and advice, they may feel as if they are being treated as unimportant.

For these reasons, it is helpful for optometrists to consider the following issues in relation to note-making and eye contact:

### Room layout and seating position

To what extent does the physical layout of the room require the optometrist to turn away

from the patient in order to make notes? (see images in Topic 1). Does the optometrist make notes in a hunched position that removes most opportunities for eye contact, or in a more upright one that means the optometrist can move his/her head easily to renew eye contact?

### When and how to make notes

Eye contact plays a particularly valuable role during openings, follow up and history taking as well as during the delivery of findings and advice. Consequently some practitioners choose to make no notes at all during these phases. Instead they write things up after the patient has left the room or wait for a 'natural break' in the conversation to occur before they turn away to begin writing/typing. In doing so they demonstrate that continued eye contact is important. Another alternative is to announce note making before it begins. Saying 'I'm just going to take a few moments to write this down' manages the patient's understanding of what is occurring and displays that any information they have given is being treated as important.

### Note making and time management

Time management is a major concern for many optometrists. As they are under pressure to complete the consultation within a particular period, they feel that it is necessary to make notes whilst talking with patient in order to save time. However our research indicates that the absence of eye contact resulting from note making can actually slow down communication. We

observe that patients often give short, perhaps single word answers when optometrists are not looking at them. This can lead to more questions and more time needed to gather information. We also frequently observe patient actions to encourage eye contact when it has been removed. Patients may stop talking entirely or eye contact through gestures and delaying the delivery of important information – as shown

in the example below. These behaviours can slow down communication. Therefore it may be that making notes whilst talking actually takes longer than maintaining eye contact and making notes later. For this reason we suggest that optometrists try maintaining eye contact whilst talking to the patient without making notes, and then assess whether it actually adds any time to the consultation.

Pat: I can't see with this eye



0.7 secs

Opt: Right, so

Pat: The left eye



*The patient has come to the practice for the first time. At the start of the consultation he is reporting some information about himself.*

*The optometrist is writing in the notes and is not making eye contact with the patient. The patient reveals a key piece of information – that he cannot see with one eye. He pats his left eye, indicating which eye this is, but says 'this eye'. By not saying 'left eye' this information is only understandable if the optometrist is looking at the patient. The patting of the eye and the withholding of 'left eye' both function to solicit the return of eye contact from the optometrist.*

*After 0.7 seconds and saying 'Right, so' the optometrist looks up and returns eye contact. At this point the patient completes the information by saying 'the left eye'. The patient appears to delay the full reporting of this key information whilst the optometrist is not looking at him. So the absence of eye contact slows down the communication between them.*

*In order to maintain the anonymity of our participants, the video stills from our data have been converted into drawings.*

**When writing notes during the consultation it is important for optometrists to be aware of the value of eye contact to communication and consider:**

- room layout and physical positioning;
- when to make notes
- how to prepare patients for the onset of note making;
- the possible slowing of communication due to the loss of eye contact.

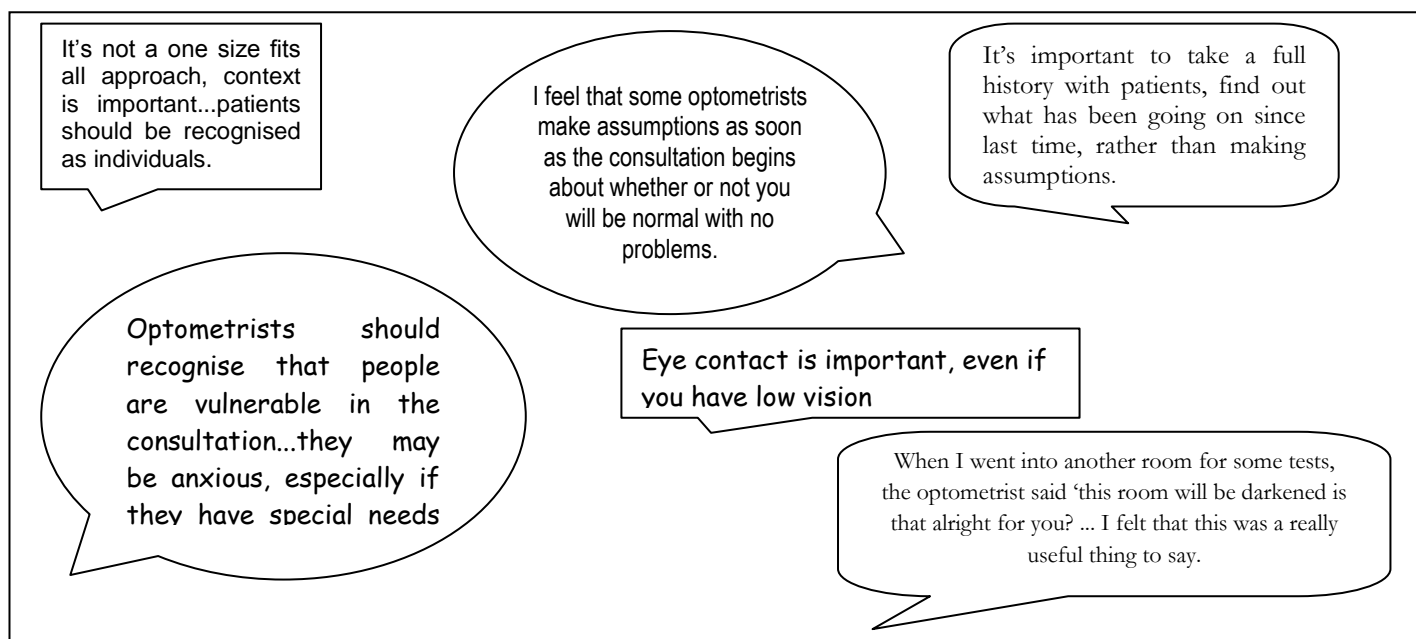


## Topic 6: Understanding patient concerns 1 – treating the patient as an individual

### Relevant GOC core competencies

- Stage 1:** 1.1.4 Ability to make a patient feel at ease and informed
- Stage 2:** 1.1 The ability to communicate effectively with a diverse group of patients.  
2.1.3. Shows respect for all patients.

During our scoping exercise we held a focus group with members of the Public and Patient Involvement (PPI) group at the College of Optometrists. Our participants felt very strongly that optometrists should acknowledge their patients as individuals and treat their histories and concerns as relevant to the consultation. The box below shows some comments from the session.



Participants reported personal experiences of not being treated as an individual. These related to occurrences such as: not being given opportunity to express themselves; being asked impersonal, 'standard' questions; optometrists not acknowledging their worries and anxieties; and optometrists talking to patient carers rather than patients themselves.

The group suggested that in order to treat patients as individuals optometrists should:

- **address patients by name;**

- **use information available in the record form to personalise conversation with the patient;**
- **encourage patients to express their concerns and experiences;**
- **practise active listening and acknowledge what patients say;**
- **tell patients what they will do to address their concerns;**
- **acknowledge and attend to patients' specific vulnerabilities and worries – including any special needs;**
- **take care to address the patient as much as possible when the patient attends with a carer.**



## Topic 7: Conducting tests

### Relevant GOC core competencies

- Stage 1:** 1.1.1 Ability to communicate effectively with the patient, taking into account his/her physical, emotional, intellectual and cultural background – building a rapport  
1.1.4 Ability to make a patient feel at ease and informed – understanding their fears, anxieties and concerns about their visual welfare in the eye examination and its outcome.
- Stage 2:** 1.1.2 Elicits the detail and relevance of any significant symptoms.  
1.1.3 Identifies and responds appropriately to patients' fears, anxieties and concerns about their visual welfare.

Undertaking the various tests that follow the history and symptoms can appear relatively unproblematic in communicative terms. Optometrists are adept at conducting these tests and frequently employ a standard set of instructions and questions to encourage the patient to participate as required. However there are a number of ways in which effective communication is central to the success and accuracy of the testing phase.

- **Patient performance in the test can relate directly to communication from the optometrist.** Patients, are often unfamiliar with examination tests and may not know or remember how they are expected to behave during them. Clear instructions and questions are essential to guide the patient through the various tests in this phase.

- **Communication from the optometrist can help the patient to feel at ease during the test phase.** Patients can feel uncomfortable or anxious during tests, as a consequence of lack of knowledge, physical discomfort, a concern to do 'well' (See Topic 8) and worries about hearing bad news. Instructions and questions can be delivered by the optometrist in ways that maximise patient comfort; helping the patient to feel comfortable is also likely to have the effect of helping the patient to perform with more accuracy.

For these reasons it is important for optometrists to focus on clarity and

maximising patient comfort during the test phase. Three particular areas are key: setting up the test, instructions and questions, and mid-test comments/assessments.

### Survey responses from optometrists

It is important for skills training to address instruction giving in tests as some patients can find the tests very challenging.

It helps to tell nervous patients that it's okay to say 'I can't tell the difference'. This helps them to relax.

### Setting up the test

Compare the transcripts on the next page. In Example 1 the optometrist moves from the history and symptoms phase of the consultation and onto the test phase, and then from one test to another without explaining or announcing what is about to happen. This is a fairly common scenario in our data – in particular where patients are attending for a routine appointment. Examples 2 and 3 are rather different. Here each optometrist gives some information to the patient about the upcoming test before giving instructions or asking the test question.

### Example 1.

*The optometrist has been looking at the patient's glasses at the end of history and symptoms. He passes the glasses back to her and uses a remote control to set up the Distance Vision Test screen.*

1. Opt: Can you see the top line there please?
2. Pat: T Z B F
3. Opt: Yeah. Can you see the top line there
4. please?
5. Pat: E V O T
6. Opt: Excellent. Looking at the O on the bottom
7. line there
8. (10 seconds)
9. Opt: That's fine. Looking at the paragraph here

### Example 2

1. Opt: Have a look straight ahead to where
2. the chart is at the end there just
3. to check your vision. So I'm going
4. to cover over this eye here

### Example 3

1. Opt: Okay. Now if you can keep looking at
2. the circles that are up there now,
3. and if you keep watching those I'll
4. just check how straight the eyes are

As mentioned above, patients – even those who are regular attendees can often be unfamiliar with the format, purpose and order of the test phase. Simple explanations or announcements of this kind can therefore be very helpful. They may relate to: the purpose of the test, physical arrangements for the test, and what the patient may expect to experience or feel (slight discomfort, difficulty etc.). Explaining its purpose can help the patient to understand and engage with the test. If the optometrist highlights a connection between the purpose of the test and the patient's earlier reported concerns, this can also help the patient to feel that his/her concerns are being attended to. Explaining physical arrangements can help the patient to feel more comfortable about what is going to happen. For instance, announcing that the lights will be switched off removes the possibility that it will take the patient by

surprise. Explaining what the patient may experience or feel can also pre-empt some typical concerns – for instance it can help an anxious patient to relax if told that a particular test is meant to be challenging that that it is 'okay' not to know the answer.

Maintaining eye contact during these announcements and explanations emphasises the importance of what is being said and also provides an opportunity for the optometrist to observe the patient for signs of nerves, lack of understanding etc. which can then be dealt with.

### Delivering instructions and questions

Test instructions about where to look, how to answer etc need to be delivered so that:

- the patient understands what to do,
- the patient feels comfortable to undertake the test.

Ensuring understanding involves a number of factors.

- 1) Using simple terms rather than jargon
- 2) Avoiding ambiguity by being specific.
- 3) Avoiding overly long or complex instructions/questions that may confuse the patient.

A useful example to demonstrate these points is the subjective refraction test. Test instructions rarely involved technical terms but patients frequently find it difficult to discern or articulate a difference between the vision scenarios they are presented. This difficulty can be compounded by the questions they are asked. Patients can find it difficult to respond to being asked about which vision condition is 'better' as 'better' can be a rather ambiguous term. Instead they are likely to find it easier to answer questions using more specific terms – such as asking about which condition is 'clearer' - or (follow up) questions that name alternatives for the patient to choose from – such as *'is it clearer or just smaller and blacker?'*

#### Example 4

1. Opt: Is it clearer do you
2. think with that lens
3. in front (0.3 secs) Is
4. it the same? (0.3 secs)
5. or better without?

Test instructions can also be confusing if they are too complex. In subjective refraction this can occur when patients are asked to compare more than two vision conditions; patients can find it difficult to understand or remember the different conditions named. To avoid this, instructions can be phrased and spoken in ways that ensure each part is clear and understandable. In Example 4 above, the optometrist asks the patient to select between three different conditions – better

with the lens, better without, or the same. The patients' ability to understand is enhanced by the pauses between the naming of each condition (which also correspond with the placing and removal of the lens in front of the patient's eye) combined with a 'continuing intonation' (her voice rises then falls) indicating that there is more of the question to follow.

#### Helping the patient to feel comfortable

In our data we frequently observe comments from patients that suggest that they feel some anxiety about an upcoming test or some discomfort during it. For instance:

- *"This one is my poorer eye"*
- *"I'm not doing as well as I should"*
- *"Oh my goodness"*

As noted above, optometrist explanations and announcements can help patients to feel more relaxed about an upcoming test – helping to overcome nerves or a lack of understanding on what the test is about. Further statements made during the test can also have a similar effect and comments such as 'I know it's difficult' can display empathy. In addition the wording of test instructions can help patients to feel more comfortable with the task ahead. A useful example here is the Distance Vision Test. Compare the following instructions/questions:

**A:** *What are the letters on the bottom line?*

**B:** *Read the top line for me*

**C:** *What's the smallest line you can read there?*

**D:** *Can you read anything on the bottom line?*

**E:** *Can you try the top line for me?*

**F:** *It's a bit of a challenge but can you read the top line?*

Statements A and B are straightforward instructions that 'expect' the patient to read the line indicated. Statement C enables the patient to select a line he/she feels most comfortable with. Statements D and E are requests that also indicate the patient might not be able to achieve the task and statement F explicitly refers to the difficulty of the task.

Statements such as C-F 'soften' test instructions/questions by enabling the patient to select for themselves how to answer (e.g., choosing a line) or by suggesting that 'succeeding' in the task is not necessarily possible or expected. These statements can therefore help to reduce patient concerns to 'do well', particularly if produced as the test gets harder and harder – for instance as letters get smaller and smaller.

#### **Comments and assessments during tests**

In our data we often observe optometrist comments such 'okay', 'good' etc when a test has been completed or when one eye has been checked and the other will be checked next. These comments mark the transition from one (part of the) test to another. They can also give an assessment of the patient's test performance. For instance 'that's excellent' or 'that's better on average on that eye' praise the patient whilst simultaneously marking the end of the test. Once again these kinds of positive comment can help the (anxious) patient to overcome concerns about doing 'well' in the test. Patients are often very sensitive to any indication that they have not done well or that they may receive bad news about their eyes. Therefore comments with a negative inference can cause anxiety. For

instance 'not as good on that eye' can be discouraging. Comments such as 'Oh no', or 'That's not supposed to happen' most likely refer to the functioning of test equipment etc.; however they may be interpreted by the patient as a possible indication of bad news and should therefore be avoided.

Finally, research has indicated that commenting on findings during the test phase can help to prepare the patient for forthcoming diagnosis and advice, and in particular can avoid patient resistance to it. This research (Heritage and Stivers, 1999 – see resource bank) was conducted in the context of parents attending with child patients and requesting antibiotics for sore throats, coughs etc where they were in fact not needed (a common problem in primary healthcare). Heritage and Stivers found that when practitioners made comments on their findings during the examination – 'the chest looks clear', 'I can see slight redness in the throat' etc – the parents were less likely to dispute a recommendation of no antibiotics needed than if the practitioner simply announced this after the examination was completed. This technique can also be helpful in optometry; for instance in cases where a patient attends and immediately claims he needs (new) glasses but the various tests indicate he does not. Making comments throughout the test phase has the effect of 'building up' evidence to support the eventual recommendation and may lead to the patient accepting the recommendation more easily.

## Topic 8: Understanding patient concerns – doing ‘the right thing’

### Relevant GOC core competencies

- |                 |   |
|-----------------|---|
| <b>Stage 1:</b> | 1.1.1 Ability to communicate effectively with the patient, taking into account his/her physical, emotional, intellectual and cultural background – building a rapport<br>1.1.4 Ability to make a patient feel at ease and informed – understanding their fears, anxieties and concerns about their visual welfare in the eye examination and its outcome. |
| <b>Stage 2:</b> | 1.1.3 Identifies and responds appropriately to patients’ fears, anxieties and concerns about their visual welfare.<br>2.1.3 Shows respect for all patients.   |

Optometrists often remark that their patients behave in ways that do not correspond with ‘textbook’ consultations. Instead of giving clear and concise answers patients sometimes give overly long descriptions, introduce details as an apparent afterthought or comment on their own test performance. These behaviours can appear irrelevant, time-consuming and even disruptive. So why do patients behave in these ways?

### Doing the ‘right’ thing

We can understand these behaviours by viewing them as actions through which patients display a concern to ‘do the right thing’. In Example 1 below the patient has been describing a worsening in her distance vision and in line 1 the optometrist says ‘*So driving’s got worse without glasses...*’ The patient confirms this and then goes on to say that she’s ‘*got*’ to wear glasses for driving and that she doesn’t want to drive without them. She makes clear that she now wears glasses for driving - information that was not requested by the optometrist. What might she be doing with this extended answer? Seeing whilst driving is a moral issue of appropriate behaviour in addition to a clinical issue of vision. Through her extra detail the patient positions herself as someone who is responsible, wears glasses when necessary and would not drive in a way that endangers others.

Patients frequently show that they conduct themselves in a socially appropriate manner. These displays relate to both being a ‘good’ person and being a ‘good’ patient.

### Being a ‘good’ patient

In Example 2 the patient has sought an appointment to present a new problem. He begins a description of this problem in line 1, presenting a large amount of detail. The patient appears to provide more detail than the optometrist needs, going on after the optometrist acknowledges the problem in line 6 and after he has answered a question about which eye it occurs in (in the omitted lines).

The patient is doing something specific in his description and we can trace this in his phrases ‘*what happened was*’, ‘*didn’t think too much of it*’ and ‘*but then I noticed*’. The patient is telling a *story* about how he came to realise he had a problem. A story or narrative is a way that patients can show they are providing all potentially relevant information to enable the practitioner to make a diagnosis. In healthcare it is the responsibility of a ‘good patient’ to recognise that he/she has a problem and to seek an appropriate expert to help with it. It is also important that the patient does not overestimate this problem and waste time with trivial complaints. The patient’s narrative enables him to demonstrate he is behaving appropriately since he noticed a change in his

### Example 1

1. Opt: Okay. So driving's got worse without  
2. glasses over the last few  
3. Pat: Without glasses yeah.  
4. Pat: So I've got to (0.4) wear them for  
5. driving now. I don't wanna drive  
6. a car without my without glasses.

### Example 2

1. Pat: **What happened was** I noticed um about  
2. two three months ago, I had a lamp  
3. at the side of me, and, so it's  
4. about seven o'clock at night and  
5. I noticed a flashing,  
6. Opt: Oh okay.  
7. Pat: about here  
(9 lines omitted in which Opt asks about which  
eye the flashing occurred in)  
8. Pat: **Didn't think too much of it**, and  
9. during the day it seems fine. I find  
10. it a little - it feels like uh there's  
11. an eyelash in it or something probably  
12. now. **But then I noticed** the following  
13. night when going out in the evening  
14. walking past street lights

### Example 3

1. Opt: Any problems you're having or is it just  
2. a routine check for you today?

### Example 4

15. Opt: What's the lowest line down that you can  
16. read up there now?  
17. (0.5)  
18. Pat: I can see the one underlined in red, which is  
19. R Z E P H  
20. (0.3)  
21. Pat: Can I go below? A B Y  
(Pat continues reading lines, then swaps over to the other  
eye. So far he has been unable to read the line indicated by  
Opt and has stopped to wipe his eye)  
8. Pat: I'm not doing as well as I should do. I  
9. should sail through that

### Example 5

1. Opt: Let's cover over this eye here  
2. Pat: That's my poorer eye.  
3. Opt: Not so good  
4. Anything on the top one?  
5. Pat: P A E N U  
6. Opt: Yes. Middle line at all?

eye (*'what happened was'*), didn't act on it whilst it appeared trivial (*'didn't think too much of it'*) but sought help when it occurred again (*'but then I noticed'*). Such extensive (but clinically irrelevant) detail can be very important to the patient.

These kinds of moral references occur in all kinds of healthcare setting and indeed as part of daily life we all frequently (unconsciously) use our talk to show that we are 'doing the right thing'. Because of this it is useful to be aware of ways in which things that we say may be (unintentionally) challenging to the moral status of others. The opening question in Example 3 - *'Any problems you're having or is it just a routine check for you today?'* - sets up the two consultation scenarios as mutually exclusive. It implies that patients with problems do and 'should' make a specific appointment to report them rather than waiting for a routine one. In the logic of the question, any patient who has noticed a problem but waited to report it has behaved inappropriately and this can make it difficult for the patient to provide an answer.

### **Doing 'well' in tests**

Another interesting area is patient behaviour during tests. It is common for patients to do 'more than' answer a test question, as we can see in examples 4 and 5 which both occur during the Distance Vision Test. The comments these patients make relate to the quality of their test performance. In example 4 the patient challenges himself to read further, *'Can I go below?'* and later, whilst experiencing difficulty, comments that he is *'not doing as well as'* he should. He displays that he has expectations about his performance and is disappointed not to meet them. Rather than treating tests as technical measurements of vision, patients often treat them as situations in which they should perform 'well' and as markers of their personal competence. This apparent concern

to perform well connects to survey research indicating that optometry patients often have a negative emotional experience of tests, encountering feelings of stress and anxiety. It is possible for optometrists to ameliorate these concerns? In example 5 the patient comments that the eye about to be tested is her *'poorer'* eye – once again providing 'more' talk than required and suggesting that she may have a negative experience of the test as she is unlikely to see well during it. We can compare the optometrist's subsequent questions to those in Example 4. Asking *'what'* the patient can read conveys an assumption that the patient will definitely be able read something on the line. In Example 5 the optometrist asks for *'anything'* *'at all'* from target rows on the chart. These questions encompass the possibility that the patient will be able to read nothing at all, accommodating 'failure' so that it possible for the patient to answer 'no' rather than reading any letters. For a patient who is anxious to do well this kind of approach may help alleviate concerns over performance and soften a negative experience of the test.

**It is helpful for optometrists to be aware of the ways in which patients display a concern to 'do the right thing', be 'good patients' and to perform 'well' in tests. This enables an understanding of why patients behave in particular ways, and why these behaviours may be important from the patient's perspective even though they may appear irrelevant to the consultation. It is also beneficial for practitioners to consider:**

- **what kinds of topic (such as driving) can be socially sensitive;**
- **how the wording of questions, instructions etc can threaten the patient's moral status;**
- **how practitioner actions during tests can shape the patient's (positive or negative) experience.**



## Topic 9: Delivering findings and advice

### Relevant GOC core competencies

- |                 |  |
|-----------------|--|
| <b>Stage 1:</b> | 1.1.1 Ability to communicate effectively with the patient, taking into account his/her physical, emotional, intellectual and cultural background – building a rapport<br>1.1.4 Ability to make a patient feel at ease and informed – understanding their fears, anxieties and concerns about their visual welfare in the eye examination and its outcome.<br>6.4.1. Ability to make an appropriate management plan, including the ability to make appropriate urgent referrals, for each patient and to involve the patient in the decision making process |
| <b>Stage 2:</b> | 1.2.1 Understands the patient’s expectations and aspirations and manages situations where these cannot be met.<br>1.2.3 Discusses with the patient the importance of systemic disease and its ocular impact, its treatment and the possible ocular side effects of medication.<br>1.2.4 Explains to the patient the implications of their pathological or physiological eye condition.<br>2.1.3 Shows respect for all patients   |

Once the test phase of the consultation is complete, it is necessary to deliver findings and advice to the patient. It is essential that this is done effectively. The patient must understand the information he/she has been given and in order to follow up on it as necessary – for instance by updating a lens prescription, changing hygiene procedures for contact lenses, seeing a General Practitioner etc. The delivery of findings and advice is an immensely complex activity. A number of reasons for this are:

- there is a wide variation in the content and volume of information that might need to be given to the patient;
- patients differ greatly in their capacity to understand and remember information they are given;
- there is a limit to how much new information people are able to understand and remember in one encounter. If patients are feeling anxious or upset after receiving bad news this limit can decrease further;
- in the clinical context it is sometimes necessary to give patients bad news – and this is a very delicate activity;

- patients are unlikely to volunteer that they do not understand information that they have been told or have some concerns about a recommended treatment.

Over the next three topics we discuss communication strategies that can help to overcome these challenges. Topic 10 looks at delivering bad news and Topic 11 describes some practices that can help to promote patient adherence to treatment recommendations. In this topic we focus on **the delivery of findings and advice to promote patient understanding and memory.**

Lack of patient understanding can have significant negative clinical consequences and may be a result of different factors:

- the patient is unable to follow the information given by the practitioner during the consultation;
- the patient can follow the information whilst it is given, but cannot (accurately) remember it after the consultation;
- the patient is able to follow the information in an abstract way but is

unable to understand how it relates to him/her personally.

There are a number of techniques which can avoid or overcome these barriers to understanding:

- **signposting;**
- **chunking;**
- **being clear and specific;**
- **relating information to the patient's own categories of understanding;**
- **seeking confirmation of understanding effectively.**

### **Signposting**

Signposting involves explicitly announcing the activity that is about to follow and/ or the type of information that is about to be given. For instance, *'That's all of the tests finished now, so let me tell you what I've found...'* This can be very helpful in preparing the patient for important information to follow and demonstrating the need to listen carefully. Signposting can also be effective when information delivery is separated into different stages in the consultation: for instance *'That's stage one – vision'* helps the patient to prepare to listen to information now whilst also making him/her aware that further information will be given at some later point. Optometry patients, in particular those who attend only for routine check-ups, can sometimes be unaware that both their vision and eye health are being tested, so this kind of signposting helps alert them to the different information they will receive.

Signposting is also a physical activity. Sitting upright, looking directly at the patient and maintaining eye contact whilst talking displays to the patient that the information being given is significant and needs to be paid attention to. It also demonstrates that the patient's needs are being taken seriously and so can assist with rapport and trust.

### **Chunking**

Large amounts of information can be delivered more clearly and remembered more easily when broken into small parts or 'chunks'. For example, delivering findings about vision and eye health at separate points in the consultation. This allows time for the patient to process and commit the information to memory before new details are given. Numbering information can also be helpful – *'There are two steps to take next'* *'There are two things I want to tell you about'* etc. Chunking can also involve the repetition of important details to the patient right at the end of the consultation plus the provision of resources to look at later, such as a leaflet or website etc. Where appropriate, the repetition of information may also require giving details to a relative or carer

### **Being clear and specific**

Example 1 comes from a routine consultation. The optometrist's information delivery is a good illustration of the common tendency to 'soften' bad news – that is to be implicit rather than explicit and to 'cloak' the negative. (see Topic 10). A consequence of this softening is that the news given becomes unspecific and unclear: what exactly is the problem this patient might have and why might it be important? When should the patient see her GP? Does she need to go soon or can she just wait until the next time she has an appointment for something else? Who should see talk about her results with and who will tell her if they are 'normal'? Why should she bother to have her blood pressure checked at all if it's *'just a very small thing'*?

In order to help the patient understand what the issue is and what he/she needs to do about it, findings and advice need to be clear and specific. So for instance in an assessment such as *'Everything is fine'* the optometrist needs to make clear whether this refers to vision, eye health or both. If the patient is

required to make a return appointment or see a GP he/she should be told how soon that appointment needs to be and what will happen during it. Visual aids such as pictures, diagrams, animations etc. can be particularly effective in keeping information specific as they can remove the need for overly long descriptions of the structure of the eye, the conduct of treatments etc. Modern technologies, such as computer tablets and animation programs, have made the use of such visual aids easier and their content more memorable. However it is important when using them that the optometrists take care to maintain some eye contact with the patient rather than looking entirely at the visual aid.

1. Opt: Um just one thing I  
2. wanted to ask you is  
3. if your blood pressure  
4. levels are okay at the  
5. moment? Have you had  
6. that checked out  
7. recently?  
8. Pat: Not recently no.  
9. Opt: It's just a very very  
10. small thing I'm  
11. picking up, it's just  
12. er um looking at the  
13. blood vessel  
14. appearance er just  
15. check it out just to  
16. make sure it's up to  
17. date and stable. Er  
18. I'm not, it's not  
19. anything sight  
20. threatening or  
21. anything you need to  
22. panic about. It's just  
23. a very small change.  
24. So just check it out  
25. and if it's normal  
26. then don't worry about  
27. it.

In addition the optometrist needs to determine whether it is necessary to use technical vocabulary to describe a condition

or treatment and if so, whether it is also necessary to provide a lay definition of the terminology alongside it (see Skills Development activity). Patients differ greatly in their knowledge of eyes and eye conditions so it is beneficial to reflect on the vocabulary they used when describing their status and symptoms at the start of the consultation and to pitch information delivery at the same level.

### **Relating information to the patient's own categories of understanding**

This highly illuminating quote comes from a min-interview with a very experienced optometrist.

It is important to be aware and make clear that this is about vision in the real world - it is not just about seeing letters on a chart, sitting in a chair; it has consequences for real life and this needs to be spelled out.

Patients are often better able to understand (and act on) information given to them when it is matched to their own categories of understanding and concern. Even if patients are able to follow references to refractive correction and prescription values, information presented in terms of whether they need to update their lenses and how often they need to wear their glasses etc. will be more meaningful to them as it relates to their day to day lives. Patients frequently exhibit concern over how changes in their eyes will affect their ability to drive, go to work, take other medications etc. so it benefits their understanding if the information given to them uses the same reference points. Once again it can be helpful to pay attention to the patient's descriptions at the start of the consultation and incorporate them into the delivery of findings

and advice. For instance, *'I can see why you say you have a lot of headaches because...'* or *'Although you've noticed some changes you don't need to wear glasses for reading at the moment'*. These references back to patient reports have the additional benefit of demonstrating that the patient has been listened to and that his/her concerns have been treated seriously and attended to.

### **Seeking confirmation of understanding**

In our data we often see optometrists ask questions such as *'Is that okay?'* or *'Alright?'* to check the patient's understanding of the information he/she has just been given. We also frequently see answers from the patient such as *'Yes'* and *'That's fine'*. The problem is that a 'yes' response is no guarantee the patient has actually understood. It is a common phenomenon across all kinds of settings, including healthcare ones, that yes/no questions to check understanding get 'yes' responses even if the respondent does not understand. This is because these questions exert a kind of 'pressure' to say yes because no-one likes to appear 'incompetent' or 'stupid'.

Because of this yes/no questions to check understanding have a very limited use in the optometry consultation and we recommend the use of alternatives. Questions such as

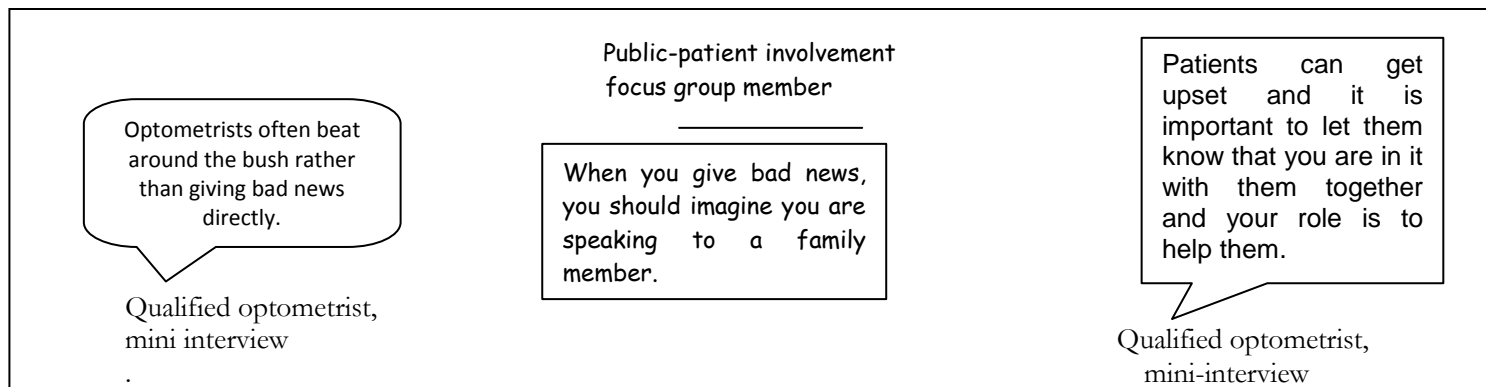
*'would you like to hear some more about this condition?'* or *'would you like to take a leaflet about this home with you?'* are much easier for the patient to answer as they do not require him/her to admit explicitly to any lack of understanding. Questions can also be asked to check how much the patient has understood. For instance in the kind of scenario seen in Example 1 above, the patient's answer to *'When do you think you will be able to see your GP to get your blood pressure checked?'* will reveal how far he/she has understood the seriousness (or otherwise) of the need to have the check done. It will also provide an opportunity for subtle correction if the patient displays any misunderstanding.

Finally, looking at the patient during the delivery of findings and advice can be a useful aid in assessing the patient's understanding. Although patients can be reluctant to admit to not understanding the information they have been given, they can sometimes reveal a lack of comprehension through their facial expressions, body language etc. When these are observed, the optometrist can then take steps to repeat information in a way the patient can understand.

## Topic 10: Delivering bad news

Delivering bad news to the patient – a serious diagnosis or unpromising prognosis etc. – is an extremely delicate task and one that optometrists tell us they frequently find challenging. The delivery of bad news has been studied extensively in communication training research, including in healthcare settings. In the US, Maynard and colleagues (see resource section) recommend that practitioners should be encouraged to:

- **become self-aware of their personal feelings and practices regarding good and bad news delivery and the challenges it presents;**
- **develop an awareness of patient needs regarding news delivery;**
- **further their understanding of the communication practices underpinning the delivery of good and bad news.**



### Good news is exposed immediately, bad news is cloaked

It is a consistent feature of communication that good news and bad news are delivered differently. Good news tends to be announced immediately and explicitly – for instance, *'We're having a baby!'* Bad news is often delayed, by pauses or via preceding phrases such as *'I'm not sure how to tell you this'* etc. Bad news is also often cloaked or hinted at- *'it didn't go as well as we wanted'* etc. This difference extends to healthcare settings, with good news exposed immediately – *'All your test results are fine'* – and, by comparison, bad news cloaked – *'Looking at your test results, one or two of them are a bit worrying'*. It is extremely valuable for practitioners to reflect on how this difference might affect their own practice. Is bad news delivered in a way that makes sufficiently clear what the issue is and how serious it is? If bad news has been cloaked when first delivered, is it necessary to restate it subsequently to ensure that the news is clear?

### Patient responses to news are an opportunity to display empathy

On hearing news about a diagnosis or prognosis, a patient's response might include a display of emotion - perhaps relief, happiness, shock or upset. This is an opportunity for practitioners to exercise empathy with the patient's emotional state. This may be done through an acknowledgement of the patient's likely feelings, giving the patient a few moments to compose him/herself before continuing the discussion, or offering support through comforting gestures, offering tissues etc.

### The value of reassurance

Once bad news has been delivered and responded to by the patient, it can be very valuable for the practitioner to offer some form of appropriate reassurance – for instance that a condition is easily treatable, a diagnosis is less severe than might have been expected, or that many people are able to adapt to and function well despite having a limiting condition. Maynard states that patients typically welcome this kind of reassurance and that it plays an important role in reaffirming a positive outlook in the consultation.

## Topic 11: Patient adherence to treatment

### Relevant GOC core competencies

<b>Stage 1:</b>	1.1.1 Ability to communicate effectively with the patient, taking into account his/her physical, emotional, intellectual and cultural background – building a rapport 1.1.4 Ability to make a patient feel at ease and informed – understanding their fears, anxieties and concerns about their visual welfare in the eye examination and its outcome.
<b>Stage 2:</b>	1.1.3 Identifies and responds appropriately to patients' fears, anxieties and concerns about their visual welfare. 1.2.3 Discusses with the patient the importance of systemic disease and its ocular impact, its treatment and possible side effects. 1.2.4 Explains to the patient the implications of their eye condition.

Patient adherence (or compliance) to treatment recommendations is a cause for concern across healthcare. It is found routinely (refs) that patients do not follow, or only partially follow, the advice they are given and this can have negative consequences for their clinical outcomes. The main causes of non-adherence to treatment recommendations are:

- **Complexity of treatment**
- **Cost of treatment**
- **Lack of understanding**
- **Side effects of treatment**
- **Lack of trust in practitioner**

Is it possible for effective communication to overcome these barriers and promote patient adherence? Paying attention to the following aspects of communication can certainly help to play a role.

### Explaining treatment

How practitioners explain treatments to their patients can have direct consequences for how patients understand the treatment, how complex they perceive it to be and how prepared they are to deal with possible side effects. So when presenting (new) treatments to the patient it is important to consider carefully:

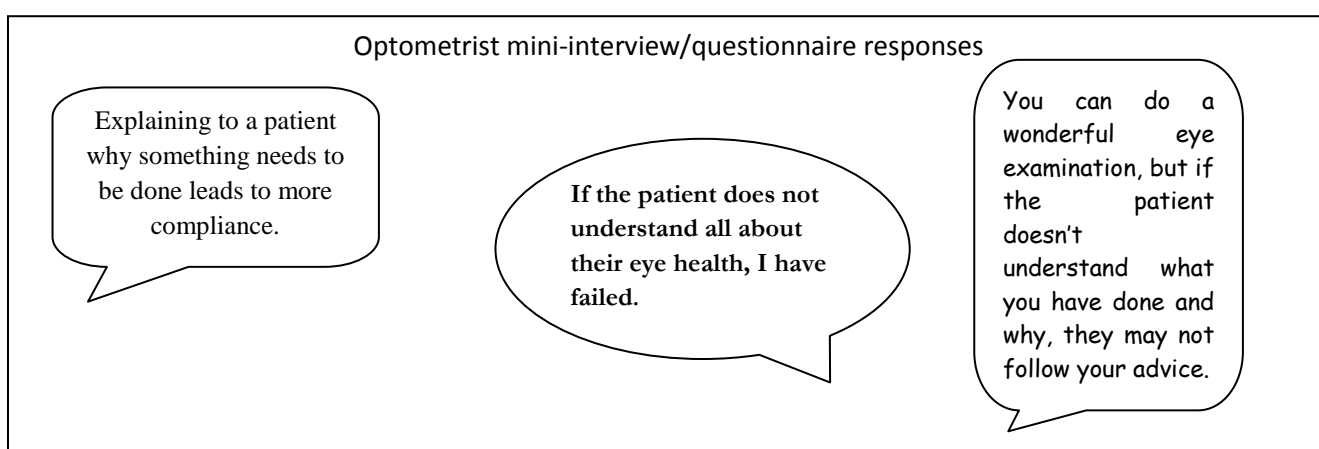
- at what point in the consultation is it best to describe the treatment?
- does key information need to be repeated and reinforced later in the encounter?
- what topics need to be covered? E.g., reason for the treatment; content of the treatment; expected length of treatment time; possible side effects; likely treatment outcomes; costs etc.
- how easily can the treatment explanation be understood? It may be necessary to modulate explanations to fit the level of knowledge the patient has displayed across the consultation.
- is it possible to avoid the use of 'jargon'; what key terminology needs to be explained?

### Encouraging patient involvement in treatment discussion

The more involved the patient is in the treatment discussion phase of the consultation, the more likely it is that barriers to adherence can be identified and addressed. This is for a number of reasons. Firstly, patients are unlikely to volunteer that they do not understand information they have been given and may be also be reluctant to ask questions unprompted. Encouraging patients to become involved in the discussion can help them feel more comfortable to ask questions or admit any lack of understanding.

Secondly, a discussion of the treatment (rather than the optometrist giving a monologue to explain it) can reveal potential barriers to adherence – such as patient concerns over cost or worries over dealing with side effects – which can then be dealt with in the ensuing conversation. Ways to encourage patient involvement in the treatment discussion include:

- relating the treatment explanation to the patient's own experience and understanding – for instance by connecting it symptoms and concerns reported at the start of the encounter.
- providing evidence to support the proposed treatment (see Topic 9)
- asking questions that can reveal the extent of the patient's understanding or make it easy for the patient to admit lack of understanding '*when do you think you will be able to go to the hospital for these tests?*' '*would you like to hear some more information about ...?*' etc.
- asking questions that invite the patient's perspective – '*How do feel about..?*' '*Do you feel that you would be able to deal with these kinds of side effects?*' etc.



### Providing further resources

It can be very difficult for patients to remember and understand all the details of a new treatment on the first occasion it is explained to them. Because of this it can be helpful to provide resources to help them learn more about their condition and treatment after the event. This may be in the form of written leaflets, useful internet sites and support groups etc. in addition to an encouragement to contact the practice for help, if necessary. Providing these kinds of resources can increase patient understanding, and this will make adherence more likely.

### Encouraging trust

Trust in the practitioner's (clinical, diagnostic etc.) ability is fundamental to patient adherence. The concept of trust is a very abstract one and may be composed of a wide variety of elements. In terms of communication, trust can be encouraged in a number of ways – most of which are discussed elsewhere in this portfolio:

- maintaining eye contact with the patient at key moments
- building a rapport with the patient
- displaying empathy with the patient
- encouraging the patient to express his/her concerns
- attending to patient nerves etc. during the conduct of tests
- explaining diagnoses and treatment recommendations
- inviting the patient to take part in treatment discussion



## Topic 12: Time management and the 'over talkative' patient

In our research optometrists often refer to time management demands as barrier to 'good' communication. They tell us that Practice requirements to complete a consultation in a set period prevents them taking time to verbally explore a patient's concerns in depth; they feel they cannot ask 'open' questions, which encourage respondents to speak at length and instead they use closed yes/no questions to move on to the examination tests quickly. For similar reasons they might also spend the time when a patient is talking to make notes rather than maintaining eye contact. Finally overly talkative patients can present a challenge as their long responses can put the consultation at risk of overrunning.

Many textbooks and communication guides – including those on patient-centred care (see Topic 14) – recommend that practitioners ask patients open questions and maintain eye contact with them whilst they answer them. This enables the patient to feel included in the encounter. For practitioners concerned about time management, it is helpful to reflect on the issues below to consider how to incorporate patient centred techniques whilst managing time in the consultation.

### **How much time is actually taken?**

It can be a useful exercise for practitioners to time their consultations to see if there is any difference between 1) asking open questions and maintaining eye contact during the responses and 2) asking closed questions and making notes whilst the patient is speaking. There are a number of reasons why these two approaches may not differ as significantly as optometrists often assume. Most simply, time can appear slower as a listener compared to a speaker, so a patient's extended talk may not last as long as assumed. Secondly, patients often treat the withdrawal of eye contact as problematic and can delay reporting important information until eye contact is renewed. So when practitioners withdraw eye contact to make notes etc., this kind of delay can counteract any time saved. Finally, closed questions can be highly constraining, and may prevent the patient revealing key information. This may mean it takes longer to reach an appropriate clinical outcome. In addition patients sometimes find later spaces to introduce information they feel is important and this can take longer to deal with than if it had been reported at a more appropriate place. The 'doorhandle remark' is a well-known phenomenon across healthcare: the practitioner is preparing to close the encounter when the patient introduces an important piece of information such as another symptom, which means a lot of further work, and time, needs to be taken. So, providing the patient with unconstrained time to speak could prevent these kinds of delays.

### **The skill of asking and listening**

In our scoping exercise some highly experienced practitioners told us that over time they have developed an ability to ask few questions whilst encouraging the patient to provide relevant detail in extended answers. When combined with active listening and skill at completing the record form, this enables information gathering in a time efficient way. It is helpful to reflect on what kinds of actions can promote this kind of efficient information delivery – perhaps for instance, carefully worded opening questions drawing on any available information and encouragements for the patient to continue talking. Recognition that patients are unlikely to frame their own talk according to the format of the record form, and an ability to respond to given answers – in terms both of further questions for confirmation/clarification and in completing the record form as necessary – are further features of this kind of skill.

### **What is the talkative patient doing?**

When patients talk at length are they delivering 'small talk' simply to fill a silence or are they reporting what might, to them, appear to be some relevant information? (See Topic 8). Patients may be less likely to treat the absence of eye contact or even interruptions as problematic when they are simply producing small talk. However, when they feel they are relating something significant they are more likely to treat eye contact and displays of listening as important – leading to the kinds of delay described above if these features are not present.

## Topic 13: Closing and handover

### Relevant GOC core competencies

- Stage 1:** 1.1.1 Ability to communicate effectively with the patient, taking into account his/her physical, emotional, intellectual and cultural background – building a rapport  
1.1.4 Ability to make a patient feel at ease and informed – understanding their fears, anxieties and concerns about their visual welfare in the eye examination and its outcome.
- Stage 2:** 1.1.3 Identifies and responds appropriately to patients' fears, anxieties and concerns about their visual welfare.  
2.1.3 Shows respect for all patients.

After the findings and advice have been delivered to and discussed with the patient, the consultation can come to a close. The closing of the consultation and handover to the Dispensing Optician etc. provides an opportunity to solicit further queries or questions from the patient and to emphasise the continuity of care the patient receives from the practice.

**Soliciting further patient queries or questions** At this stage of the consultation it is important to check that all the patient's questions or queries have been dealt with. This can be done through questions such as '*Would you like to ask me some questions?*' or '*Have I covered all your queries today?*' These questions provide a final opportunity to address any patient misunderstandings or concerns and demonstrate that the patient's (positive) experience of the consultation is regarded as important.

**Setting up the next visit** Setting up the next visit is a simple process of recommending when the patient should come back again next. In addition to being good business practice, this recommendation shows that the optometrist, and the practice more broadly, has a long-term interest in the patient's care. This emphasis on continuity of care can be an important feature in building up a relationship of trust and rapport with the patient.

**Patient handover** Taking the patient over to the practice reception or to see the Dispensing Optician can also be done with an emphasis on continuity of care. An impersonal 'sausage factory' approach suggests that the patient is not valued as an individual by the practice. Instead the handover can be done in a way that treats the patient's individual circumstances and continued care as important. For instance, walking the patient over personally, making introductions using people's names and repeating key details from the consultation are relatively simple actions that can significantly benefit the patient's experience.

**Eye contact and body movement** Once again eye contact and body movement can play a key role in communicating effectively in this stage of the encounter. Optometrists often appear busy writing in the patient's notes as the consultation comes to a close; this removes opportunities for eye contact and can create a hurried, impersonal feel to the end of the encounter. Alternatively, maintaining eye contact whilst soliciting further concerns emphasises that the patient's questions and queries are important and will be listened to. Furthermore, actions such as shaking hands and walking with the patient out of the room also treat the patient as important and as an individual.

## Topic 14: What is patient centred care?

The GOC's Stage two core competency 1.2.1 includes a performance indicator that optometrists should employ a 'patient centred approach'. The concept of patient centred care first arose through a study of doctor-patient interactions in primary care (Byrne and Long 1976) and since then has become central to communication training and guidance across healthcare fields. In the original study Byrne and Long audio recorded GP consultations and analysed them, categorising the communicative behaviours they observed. They made a distinction between two broad patterns: *doctor centred* behaviours which make use of the doctor's knowledge and skill and *patient centred* behaviours which make use of the patient's knowledge and experience. Patient centred behaviours have come to be preferred as they are viewed to acknowledge and respect the patient's role in the healthcare process and necessary decision making. Usefully, Byrne and Long categorise the kinds of action that can be seen as patient centred.

**Giving/seeking recognition of the patient**, e.g., by greeting him/her by name.

**Broad opening question** at the start of the consultation enables patients to choose what concerns to present and how to present them.

**Offering observations** e.g., "You look much better today", "You seem to be worried"

**Indirect/Concealed questions.** Statements can function as open questions, inviting patients to respond at length and in their own terms. E.g. "I expect you feel better after your holiday"

**Encouraging patients to talk more** – "Go on" "Mmm" etc.

**Reflecting** the patient's talk to enable him/her to speak further. "So you're worried about these new pains..." etc

**Exploring.** "Tell me more about that" or "Can you describe that in more detail" etc.

Using **silence** at key moments encourages patients to speak more, perhaps revealing deeper concerns they haven't yet expressed.

**Summarising to open up.** For instance summarising the patient's symptoms to invite his/her perspective on what a diagnosis may be, or summarising treatment progress so far to invite opinion on what could happen next.

**Answering patient questions**, for instance about their diagnoses.

**Indicating understanding** of what the patient has said.

**Treating patient ideas** – for example about treatment management – **as relevant** and adopting them into the discussion.

**Seeking, accepting and using patient ideas.** Accepting patient feelings - for example by acknowledging how patients might feel about their condition.

**Reassuring** the patient – for instance about the progress of his/her treatment

In their analysis of over 2500 consultations, Byrne and Long found that practitioners were highly consistent in communication style; they tended to adopt the same (doctor centred or patient centred) behaviours repeatedly, regardless of changes in patient. However they also found that training can encourage practitioners to change their behaviours. Byrne and Long conducted training sessions in which GPs discussed and reflected on recordings of their own consultations. The submissions of later recordings revealed that the sessions had successfully encouraged many participants to adopt more patient centred behaviours in their practice in the long term.