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MEDICAL EDUCATION MYTHOLOGY

A critical look at ideas, concerns and expectations in clinical communication

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Abstract

Background: For medical students and doctors, capturing the patient's perspective is critical if the consultation is to be meaningful for both parties. Medical students are taught the import of this in their communication skills training aided by inquiring into the patient's ideas, concerns and expectations (ICE) during the consultation. Ensuring the effectiveness of those inquiries can be a challenge for different reasons. Yet apart from a handful of papers on the subject, there is little guidance on the efficacy of ICE as a communication technique and specifically how to successfully blend questions about ICE within the interaction between doctor and patient.

Proposal: This paper takes a closer look at this communication technique and explores some of the interactional features of inquiries into ICE. First, the background to ICE and its emergence within the field of medical education is considered. Next the argument considers some of the contextual and pedagogical issues that inquiries into ICE gives rise to. The discussion then goes on to explore some conceptual underpinnings drawing on findings from Conversation Analysis, which provide some direction in approaching questions about what the patient thinks. Finally, the implications of the argument presented are considered in relation to the teaching and assessment of medical students with a short proposal for next steps.

Conclusion: Capturing the patient's perspective through an exploration of their ideas, concerns and expectations remains a valuable approach in communication skills training in medical education. It is important, however, that ICE type inquiries are used carefully and responsively if they are to be used to improve communication with patients.

1 | INTRODUCTION

A central part of the communication skills teaching medical students receive involves two fundamental requirements: to elicit relevant medical information and to capture the patient's perspective about their situation. These two sources of data need to be integrated so that each 'version' of the problem (the doctor's and the patient's) is comprehensive and meaningful for both parties[1,2] Both sources of data are not mutually exclusive. Gathering information on the medical signs and symptoms is clearly important. Nevertheless, without knowledge of the patient's perspective and what matters to them most, the consultation is, at best, suboptimal, at worst, wasteful.[1]

Effectively capturing that perspective by finding out and incorporating what the patient thinks is also integral to the delivery of

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patient-centred care,[3,4] often providing the relevant context for discussions of medically relevant topics.[1] Such topics might include the patient's experience of their symptoms, how they see things and other more substantive information on specific topics such as Family History and Social History. Typically, the task of eliciting medical information is relatively straightforward. Difficulties can arise, however, when trying to find out about the patient's perspective.[1] A practical solution to help with this problem, and something that is taught widely in medical schools as part of communication skills training, is to inquire into the patient's ideas, concerns and expectations or ICE as it is more commonly referred to.

The introduction of ICE as a key element of the consultation emerged out of extensive examination of GP consultations conducted by David Pendleton, Peter Tate et al.[5] back in the 1980s. In the examination of these consultations, Pendleton et al. identified a small number of GPs who were taking a different approach to their interactions with patients. They noted that these GPs were much more focused on finding out about the patient's experience of their illness rather than simply pursuing a diagnostic investigation. This focus on the patient's experience was characterised around eliciting the patient's ideas, their concerns and expectations and the difference between this subgroup and the rest of the group was quite stark.[5] 'Not only did this equip them to make more nuanced and holistic diagnostic formulations, they were also able to tailor their explanations and advice to the person in front of them'. (Whitaker 2021: 1).

The practical import of inquiries into ICE as part of a patient-centred approach soon began to gain empirical momentum on both sides of the Atlantic. In the United States, research started to highlight the importance of inquiring into the patient's wider social context and the relation of this to health outcomes.[6] In the United Kingdom, studies on this topic revealed the importance of eliciting the patient's concerns and the relation of this to levels of patient understanding and patient adherence.[7,8] The use of ICE, as a communication technique, slowly spread from the GP consulting room to the lecture theatres of medical schools as part of the formalisation of programmes of communication skills teaching.

Addressing a patient's ICE is now an integral part of the standards expected of new medical graduates when interacting with patients as part of a patient-centred approach.[9] In a very important sense, ICE type inquiries and what they represent has helped shape a paradigmatic shift in medical practice not simply one connected to professional etiquette but one that tangibly acknowledges the importance of the patient's perspective as integral to the transaction of medical care.

However, evidence to support the importance of inquiries into ICE within the consultation is not necessarily supporting evidence for how to implement this technique effectively. Nevertheless, it is with effectively implementing this technique, where difficulties often arise. The primary driver of these difficulties is the treatment (albeit unintended) of inquiries into ICE as a technical device to fix a communication problem, namely, capturing the patient's perspective. When utilised as a 'technical fix' attention is diverted away from the communication process[10] and, consequently, how inquiries into ICE can be used in practice in a more patient centred way.[3]

This paper attempts to clarify and address the interactional difficulties students or practitioners may find themselves in when inquiring into a patient's ideas, concerns and expectations. A synergy between practical and theoretical knowledge is proposed to address this matter. Findings from Conversation Analytical studies of ordinary and doctor–patient interaction are used to inform approaches to eliciting the patient's perspective in less formulaic ways. Finally, the implications of the argument presented are considered in relation to the teaching and assessment of communication skills for medical students.

2 | DIFFICULTIES WITH IDEAS, CONCERNS AND EXPECTATIONS

There are clear potentialities to incorporating the patient's ICE within the consultation. Engaging with the patient's ICE has been shown to positively shape levels of prescribing,[11,12] shared decision making,[13] history taking and patient understanding.[7] Moreover, each component part can hold specific implications within the consultation. For example, inquiries into a patient's ideas and expectations have been more closely associated with partnership building than with exploration and understanding of the illness experience.[8] Given its value within the consultation, knowledge of how to implement this technique effectively is clearly critical, but this is where some of the difficulties begin. Elwyn et al.[13] provide some guidance on how to effectively implement this technique. They suggest that by 'being open to the patient's contributions … by using mitigated phrases, deploying pauses, and becoming sensitive to both verbal and non-verbal signals, it is possible to explore these issues without causing the impression that the enquiries are rhetorical' (Elwyn et al., 2000: 894). Although offering some closer scrutiny of ICE type inquiries, this guidance is a little opaque. It is unclear, for example, what these 'mitigated phrases' look like or indeed how one avoids the impression of being rhetorical.

Several clinical communication skills texts are also short on specific guidance. Some texts imply that inquiries into the patient's ICE should be made early on in the consultation following the history of the presenting complaint.[14] Some texts provide example questions and phrases as they address building a connection with the patient.[15] Others, although they cover the topic quite extensively, do not really provide any explicit guidance on when these topics should be addressed within the consultation.[16]

Given the import of capturing the patient's perspective within the consultation, accurate and detailed guidance is key if only for the fact that medical students learn but are also assessed on their competence with communication skills. ICE is, and is typically learned as, an acronym. All other acronyms in medicine tend to be checklist in nature, e.g. SBAR or SOCRATES, both of which serve the purpose of guiding either the delivery or collection of information in the sequential order of the acronym. One unintended consequence of this is that ICE tends to get fixed in the mind of the student as a checklist reinforcing its

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'technical fix' status. The problem here is that checklists are not typically designed to build rapport, and when inquiries into ICE are introduced in checklist form into the interaction, it is likely to resonate negatively with the patient.[10,17] When this 'technical fix' status passes over into the assessment environment, it is all too readily used to demonstrate competence and pass the history taking stations of clinical examinations.[3] Consequently, without detailed and accurate guidance on communication behaviours, students start to view inquiries into ICE as a 'formulaic piece of behaviour they have to squeeze into every consultation in order to pass' (Neighbour, 2022: 66). This can result in a learned 'inattentional deafness'[18] where questions about the patient's perspective do not always fit the sequence of talk, for want of 'squeezing' them in. On occasion this 'squeezing in' may not even make sense to the patient.[10,17] particularly when these questions are disconnected from a loose 'off the cuff' remark by the patient or something the patient mentions 'unprompted in their opening remarks,'[5] The result is that critical communication behaviours, which can drive the success of inquiries into ICE, typically get lost from view along with a fuller picture of the patient's perspective.

3 | POTENTIAL SOLUTIONS: TYPES OF QUESTION

When treated as a 'technical fix', all too often the mechanisms driving inquiries into ICE (types of question and the positioning of those questions) are not really attended to. To address this issue, thought needs to be given to providing students/trainees with some direction in thinking about the phraseology, positioning and execution of those questions to ensure they are put to good work in a way that will encourage a more meaningful view of the patient's perspective. In relation to these matters, important direction is provided by research studies using Conversation Analysis (CA). A brief account of this method is presented here, but a fuller and more detailed account can be found elsewhere.[19] CA is a method used to provide detailed and nuanced insights into the dynamics of social interaction as a sequentially organised phenomenon. Detailed transcription and analysis of instances of social interaction by its practitioners has identified structural and sequential aspects of social interaction in different contexts,[20] including the doctor-patient encounter,[21,22] which hold relevance for the argument presented here.

Question–answer sequences are a core unit of analysis for Conversation Analysts whose studies reveal that questions embody specific interactional constraints.[23,24] Questions set agendas, i.e. the topic to which the answer should be addressed.[25] They also embody presuppositions that can influence and shape the recipient's response.[26] Consider the most basic question concerning the patient's ideas, 'Do you have any ideas as to what might be causing this'? This question is a polar type of question, which narrows the parameters of the recipient's response.[25] This is because the polar type of question sets up the frame for a 'yes'/'no' response in which either 'yes' or 'no' should occur as the first part of the response.[23,27]

So already the design of this question has a potentially limiting impact on the opportunity for the patient to present their perspective. The danger here is that even if the patient has a vague idea, the question design leaves open the possibility for them to answer 'no', thus limiting the quality of information the student is attempting to elicit. The possibility of a 'no' is reinforced by the fact that patients typically see the student/doctor as the knowledgeable expert and are acutely aware of the knowledge differential[28,29] when responding to questions. Similar problems remain when concerns and expectations are inquired into in the same way. Although these are all valid questions in the right direction of travel, their design creates a potentially limiting effect capturing the patient's perspective.

Replacing the question 'Do you have any ideas what might be causing this?' with, for example, the question 'What thoughts have you had about this/What are your thoughts on this?' is likely to be more effective. One of the reasons for this is that this question belongs to a category of questions that have been identified as 'telling questions'.[30] The design of telling questions (many of which are 'wh'-prefaced) usually follow the closure of a sequence of interaction (e.g. the patient describing their symptoms) and work to encourage a particular focus on a topic of talk.[31] The telling question 'what thoughts have you had' as with the 'do you have' question sets the topical agenda (the patient's thoughts) but the parameters are now wider.[26] This is because the presuppositional content of the question, that the patient *has* had thoughts about what has been happening, eliminates the possibility of a 'yes'/'no' answer and strongly indicates that the patient's thoughts are of value, thus providing more interactional scope for capturing the patient's perspective and building partnership.[8]

Technically the 'wh' type of question may involve leading the patient, something which is generally frowned upon within communication skills training. However, this leading has benign rather than malign implications. The principles behind this parallel what Pomerantz[32] has identified as 'offering a candidate answer'. This refers to the practice of providing a possible answer, which is built into the question. It is a strategy that can be used to elicit information whilst at the same time provide the recipient with some guidance as to the information that is required. In the example above 'What thoughts have you had' guides the patient to providing information on what they think about the situation. In this regard offering a candidate answer is 'both responsive to, and helps shape, the nature of the situation' (Pomerantz 1988: 366) in a way that is more collaborative. These basic findings could also be utilised to re-design questions about concerns and expectations as well, for example, 'What worries you about these symptoms' 'What do you hope to get from the consultation?'

4 | POSITIONING AND SEQUENCING

In the effort to avoid students falling into a 'technical fix' mode, cultivating an awareness of the wording of questions is important.

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However, the goal should always be to integrate ICE inquiries in such a way that reflects a 'responsive mode' or 'adaptive expertise'.[33,34] ICE inquiries should almost fly under the radar in a more subtle indirect way as opposed to more explicit direct inquiries. They should be sequentially connected to the interaction in a meaningful way. This requires reflection on the positioning of these questions as well as the importance of cultivating a natural curiosity in finding things out. CA offers important guidance here also where analyses of the relation between verbal and non-verbal communication reveal important insights[35,36] but there are other less technical and just as effective approaches. Roger Neighbour,[3] for example, refers to the technique of 'turning a receipt', which is simply linking your question to something the patient has already told you. This is an effective way of ensuring the ICE type or 'perspective seeking' question, flies under the radar whilst at the same time encouraging the patient to tell you what they think. For example, 'you mentioned your mother's heart problems (Receipt), what thoughts have you had about that?' (Turn).

Notwithstanding attention to question design, sequencing and positioning and the implications for how the recipient responds, there is always an element of negotiability when questions are asked.[37] If, for example, the use of 'wh' type questions are used without attending to the possibility of the patient resisting the question (e.g. 'What do you mean?') or without attending to verbal or non-verbal cues or what the patient has already disclosed, then the risk of 'inattentional deafness' still remains.[1] The point is, however, that the design of the 'wh' type of question makes this less likely since it creates more possibility for dialogue between student and patient encouraging a higher level of responsiveness from the student. Ultimately, however, attending to question type and the positioning and sequencing of questions is already getting the student to pay much more attention to the patient and the interaction overall, which in itself is critical to capturing the patient's perspective.

5 | CURIOSITY

Approaching inquiries into ICE in the way described above should not only improve the effectiveness of these types of inquiries but also help students/clinicians cultivate an awareness of their natural curiosity[34] where questions are asked simply because the student really wants to know the answer[3] not because they want to demonstrate a basic competence. Encouraging the use of the student's curiosity[34] to find out what the patient thinks, will not only assist the interaction but will also encourage a deepened sense of self-reflection and situational awareness, both key attributes for the demands of modern medical practice. Encouraging this curiosity needn't be viewed as an aspirational objective but can be developed very early on by drawing the student's attention to listening to the patient[38] where listening involves actively monitoring acknowledging, responding and engaging, with behavioural, verbal and non-verbal cues emitted by the patient. This in turn will provide the basis for a greater degree of empathic responsiveness, also key to capturing the patient's perspective.

[1]I am grateful to the Deputy Editor for drawing my attention to this in an earlier version of this manuscript.

6 | EQUALITY, DIVERSITY AND INCLUSION

The basic structure of question–answer sequences particularly polar type questions is relatively stable across cultures,[39] and adjustments to the presuppositional content of questions (of the kind described here) has also been found in doctor patient encounters in other cultures.[40] However, cultural differences can potentially be a real factor shaping students' abilities to grasp these approaches. Ultimately, the ideas presented in this paper are driven by the notion of patient centredness, which itself is an ethnocentric concept and, potentially, an exclusionary one at that for those students from different cultural backgrounds. Consequently, the requirement to grasp and explore the patient's perspective may prove to be a bigger challenge to some groups of students than others, a challenge that may require extra support within medical school curricula.[41]

7 | CONCLUSION

From the point of view of both teaching and assessment, inquiries into ICE should not be seen as a discrete part of the interview, but rather as something that is woven through the patient's interaction with the student/clinician by effectively listening to the patient,[10,17] a listening shaped by a genuine interest in wanting to find out what the patient thinks.[3] As mentioned earlier, ICE represented a paradigmatic shift in medical practice not simply one connected to professional etiquette but, one that tangibly acknowledged the importance of the patient's perspective as integral to the transaction of medical care. Like many aspects of good communication, teaching students how to capture the patient's perspective takes greater effect if the learning is underpinned by conceptual and behavioural understandings.[34]

Taking this more in-depth approach will firstly cultivate an appreciation of the sequential relevance of capturing the patient's perspective within the flow of the consultation. Secondly, it will provide students with more scope to exercise adaptive expertise, a skill which is invaluable for both basic and more complex communication challenges.[33] This is possible and medical educators can (and most likely do) focus on developing a more 'responsive mode' of communication characterised by sensitivity to context, sequencing and positioning within the interaction, types of question and a natural curiosity. However, if this re-thinking of capturing the patient's perspective is not reflected and reinforced in practical examinations where all too often communication is assessed under a general banner of 'professionalism', this small but significant attempt at culture change will be difficult to attain.

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CONFLICT OF INTEREST

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This is a sole authored paper and the author meets conditions 1, 2, 3 and 4.

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