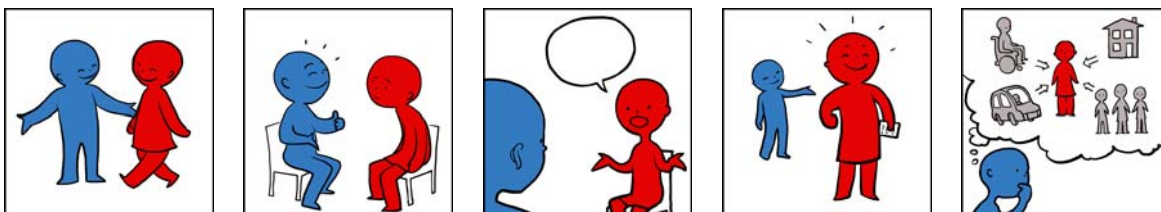


The CARE Approach



A learning tool for
healthcare professionals

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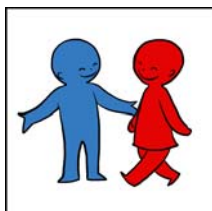
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THE CARE APPROACH WORKSHEET

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INTRODUCTION



Welcome to the CARE Approach

Conversations between patients and practitioners lie at the very heart of healthcare. Such conversations happen day in and day out in the NHS, when patients consult their GP, or attend an out-patient appointment, or see their physiotherapist, or visit their practice nurse for a minor illness or chronic disease management. The list of opportunities for healthcare conversations is almost endless given the wide-range of staff working in the NHS and the different ways in which encounters can happen. In the course of a career, a healthcare professional is likely to have hundreds of thousands of clinical encounters.

Although these encounters may at times be quite straight forward, the days when the healthcare professional simply imparted technical expertise and knowledge to a receptive and passive patient are long gone. In today's world, patients and carers expect to be engaged in a partnership with practitioners in their healthcare and wish to be informed and be involved in decisions. The encounter can be a complex phenomenon, where both parties bring expertise and knowledge, and engage in a conversation about a certain problem or set of problems. The hallmark of high quality healthcare is responding effectively to the needs of every individual patient, and good communication between practitioner and patient is a key part of this.

Research has shown that patients consistently rate empathy and the human aspects of care as top priorities (Mercer & Reynolds, 2002; Mercer et al., 2004, 2007). To be an effective healthcare practitioner requires mastery of not only the technical aspects of care but also of the human aspects. The CARE Approach focuses on the human aspects of care and on how the words used and the non-verbal cues and responses are vitally important in creating encounters that are satisfying and enabling. The CARE Approach aims to assist you in developing, practising and reflecting on empathic, person-centred communication. This manual is a practical tool to help you develop and enhance this. We hope the CARE Approach will inspire and support you in the encounters you have with the people you care for in your work – that is, your patients. However, you may even find the CARE Approach helps with interactions with colleagues and friends!

What is the CARE Approach?

The CARE Approach is an overarching framework for empathic, person-centred encounters in healthcare interactions. It is derived from the CARE Measure [see [Appendix 1](#)] which is a widely used patient-rated measure of the clinical encounter. Whereas the CARE Measure is used to measure patients' experiences of the interpersonal aspects of clinical encounters,

the CARE Approach has been specifically developed to help practitioners reflect on, practice, maintain, and improve their communication skills and to use these skills effectively in helping empower and enable the patient. This learning resource has been developed for use by a wide range of healthcare practitioners across the NHS in Scotland. It can be used by individuals, groups, or organisations. It is available free of charge within the NHS. The CARE Approach can be used in combination with the CARE Measure, or can be used as a stand alone learning tool.

The CARE Measure (and thus the CARE Approach) is based on a broad definition of relational empathy in the clinical context, defined as the ability:

1. To understand the patient's situation, perspective and feelings (and their attached meanings).
2. To communicate that understanding and check its accuracy; and
3. To act on that understanding with the patient in a helpful (therapeutic) way (Reynolds, 2000; Mercer & Reynolds, 2002).

The CARE Approach has four interacting components:

Connecting Assessing Responding Empowering

The ways in which the CARE Approach components broadly map on to the (ten) items that make up the CARE Measure is shown in [Table 1](#). The table also outlines aspects of the practitioners' interpersonal skills that relate most to each of the CARE Approach components. The key principle underlying the CARE Approach is flexibility. Each encounter is unique – it has never happened before and it will never happen again - and thus it requires awareness, sensitivity, an unconditional acceptance of the patient and of his or her needs, and an ability to be present and respond in the moment. It is also influenced by context. What may be helpful and appropriate in an in-depth psychiatric assessment may be very different from the exchange between a healthcare assistant and a patient attending to have a blood sample taken. As such, the CARE Approach is not intended to be a rigid set of rules to be applied in the same way in every encounter, but rather a broad set of guiding principles to be applied flexibly depending on the situation and circumstance.

Structure of the learning tool

The CARE Approach web-based learning tool consists of six modules, with each one building on the module before.

- [Module one](#) is about what you (as a person) bring to the encounter in terms of attitudes, beliefs and values.
- Modules [two](#), [three](#), [four](#), and [five](#) describe the four components of

the CARE Approach. These modules describe the key aspects of each component and explain how each component operates and can be applied and developed in practice.

- [Module six](#) is about 'putting all the components together' and demonstrating the CARE Approach in action. It is about the spirit of the CARE Approach.

For ease of explanation and understanding the CARE Approach components are separated and presented in sequence. However, it will quickly become apparent that 'connecting' for example, is not necessarily an exclusive domain of the start of an encounter, and the practitioner and patient can connect and reconnect (perhaps deepening the connection) many times during a single or through successive encounters.

Throughout the modules suggested exercises, audio recordings and clips of patient-practitioner encounters are included to illustrate certain points, to facilitate learning and reflection, and to help you respond in relation to your own working environment. The clips of the encounters are simulated and show interactions between actor- patients and real healthcare practitioners. A [worksheet](#) is provided as a Word document to record your answers.

Please note that during the course of this manual we refer to the patient interchangeably as either he or she.

Acknowledgements

The following actors and practitioners featured in the clips:

- | | |
|---------------------|------------------|
| ■ Paddy Bonner | ■ Phil Cotton |
| ■ Alicia Devince | ■ Fiona McNeney |
| ■ Pene Herman-Smith | ■ Stewart Mercer |
| ■ Sarah McCardie | ■ Karen Pirie |

The clips were made at the Media Production Unit at the University of Glasgow. The development of the CARE Approach was sponsored by the Self Management Programme of the Long Term Conditions Unit, the Scottish Government.

Formatting of this document for web usage was undertaken by Jane Goodfellow, General Practice and Primary Care, University of Glasgow.

Cartoon images are reproduced courtesy of Adam Murphy.

About the authors

The CARE Approach was developed by Professor Stewart Mercer, Professor Phil Cotton and their team at the University of Glasgow.

- **Stewart Mercer** is a general practitioner and professor of primary care research at the University of Glasgow and is internationally

recognised for his research on the clinical encounter. A full list of Stewart's publication and current research can be found [here](#).

- **Phil Cotton** is a general practitioner, and professor of learning and teaching at the University of Glasgow, where he is also deputy head of the undergraduate medical school.
- **Annemieke Bikker** is a research assistant at the University of Glasgow, General Practice and Primary Care and has previously researched practitioner-patient interactions, verbal and non-verbal communication and their links to health outcomes.
- **Maria Higgins** is also research assistant at the University of Glasgow, General Practice and Primary Care and has also researched practitioner-patient interactions, and healthcare needs of asylum seekers.

Additional information

1. [The development of the CARE Approach](#)
2. [Frequently asked questions](#)

Table 1 Overview of the CARE Approach components in relation to the CARE Measure

CARE Approach component	Description of component in relation to the practitioners' interpersonal skills	CARE Measure items that CARE Approach component maps on (patient rating)
Connecting	Actively engaging with the patient in order to create or deepen rapport and to facilitate open communication within a safe 'environment'.	1. Making you feel at ease 2. Letting you tell your story
Assessing	Listening and taking a holistic approach in order to fully understand the patient's situation, perspective and feelings (and their attached meanings).	3. Really listening 4. Being interested in you as a whole-person 5. Fully understanding your concerns
Responding	Communicating your understanding (and checking its accuracy) in a caring and compassionate way, responding positively with clear explanations if appropriate	6. Showing care and compassion 7. Being positive 8. Explaining things clearly
Empowering	Helping patients to feel more in control according to their abilities, preferences and values, and planning their treatment in partnership with them	9. Helping you take control 10. Making a plan of action with you

MODULES

MODULE 1 What you bring to the encounter

This module explores

1. What caring means to you
2. The difference between patient-orientated and disease/task-orientated encounters
3. The importance of both verbal and non-verbal communication
4. The ways in which your attitudes, beliefs and values influence the encounter

Caring

‘Caring’ is an emotive term and people interpret the word in different ways.

Exercise 1.1

Answer the following questions. You can write or type your answers on the accompanying worksheet.

1. What is your response when you hear or read the word “caring”? What thoughts come to mind? What feelings do you associate with the word?

Possible answers...

2. What are the aspects of your job that make it possible for you to practice in ways that you consider to be caring?

Patient-orientated encounter versus disease- or task-orientated encounters

In a patient-orientated encounter the healthcare professional creates opportunities for the patient to express his views, concerns, beliefs, and priorities regarding his care, and to participate as fully as he wishes to in the decision-making process. To put it another way, it is about realising that the patient is at the centre of care, and as healthcare professionals our task is to work effectively in partnership with the person, and at times, his family members and carers.

In contrast, in a task-orientated encounter the healthcare professional completes a series of tasks that ‘need to be done to the patient’ in the time given where the agenda is driven by the structures and processes of the healthcare system. The tasks are relevant to the patient, but the patients’ views, concerns, beliefs, and priorities are set aside by the need to ‘get the job done’. In this case, it is the practitioner’s (or the system’s) needs which take priority and are reflected in his behaviour, attitude, and verbal and non-verbal communication. Similarly, a disease-oriented encounter focuses on the disease rather than the whole person. We see the patient as the

'diabetic in bed 3' rather than the person in bed 3 who has diabetes (and the disease might not be the major concern to the person at that time).

If we are used to a task or disease-oriented approach in the patient-practitioner encounter we may be used to 'telling' a patient what to do without making sure that the patient has understood the advice, whether he is motivated to follow the advice, and what worries he has. The task-orientated approach may reflect how we have been trained, what we have learned from others, and the structures and processes within the workplace. In task-orientated encounters we drive the interaction with the patient and can choose to cover only those things we feel we have time for or ability to deal with.

Exercise 1.2

The following exercise is designed to raise our own awareness of whether we communicate in a patient-orientated or in a disease- or task-orientated manner

1. What features best characterise you when interacting with a patient, e.g. tend to reassure, listen well, take control?
2. Consider the types of patient interactions you have. List situations when you are most likely to be patient-orientated and when are you most likely to be task- or disease-orientated.
3. For each of the situations you list above, describe whether you are aiming to meet your own needs or the patient's needs.

Moving to a more patient-orientated approach may involve going beyond the way we conduct our encounters with patients. This may sound daunting and, depending on the context, can often be achieved through small changes, such as making appropriate eye contact, smiling, listening more and talking less, checking that you have understood the patient's concerns, and sharing decisions with the patient about the plan of action ahead. In a nutshell, it is about paying attention to the patient as an individual who has come to you for help, and responding in a helpful and non-patronising way.

Exercise 1.3

1. Think of yourself as a patient. What qualities would the ideal doctor or nurse have? Record your answers on the worksheet.
[Possible answers...](#)
2. In what ways are these qualities important?
[Possible answers...](#)

Communication

Communication is central to the CARE Approach. The way we express ourselves has a direct effect on those around us. Effective communication needs good verbal and non-verbal skills. In broad terms, verbal communication skills relate to what is said and non-verbal communication refers to how it is said. Non-verbal communication includes the tone and speed of speech, and also body language, like eye contact, facial expressions, and posture. We tend to be less aware of our own non-verbal behaviour than our verbal communication, as it happens subconsciously yet it powerfully 'speaks' to the other person conveying our attitudes and feelings. Our non-verbal behaviour plays a much bigger part in overall communication than we realise and can facilitate or hinder the effectiveness of what we are saying. When *what* is said contradicts *how* it is said, people tend to believe the non-verbal message. For example, a patient is less likely to be convinced that you are really listening to them, even if you say so, if you persist in looking at the computer screen. Therefore, in order for our message to be effective and credible it is important that we match what we say and how we say it.

Values and beliefs

Values relate to beliefs about what is right and wrong, what you consider important, and what you think ought to be done in certain circumstances. Values relate to how we view and understand the world and they give meaning to what we do in life. They underpin our attitudes (assumptions, expectations and judgements), behaviour, and the way we communicate. Therefore, it is important to be aware of the values, beliefs, and attitudes that we hold, and thus what we bring (consciously or not) to the encounter.

We are not born with values and beliefs. We develop them as we grow and mature, through our parenting, our education, and our interactions with others. Like all things in life they can change. Conflicts can arise when our values and behaviour do not correspond, or when we are working in an environment that is at odds with our values or does not allow us to express them. Our values may also 'leak' through our communication in a way that patients find unhelpful, prejudicial, judgemental, and confusing.

Exercise 1.4

This exercise is called the "respected figures" exercise. The exercise is also on the worksheet.

- In the first column please write down at least two and up to five people who you deeply respect for the way they have led their lives. You do not have to respect everything about them, but in one or more significant ways you admire how they have lived. These people could be living or dead, famous or not famous,

known to you personally or simply heard about.

- Then in the second column, write down the qualities they have or had that you respected. What was it about them that you admired? Then look for qualities or clusters of qualities that stand out. They may stand out simply because you know inside that this quality is of great importance to you, or the quality may stand out because it is repeated – possibly with slightly different descriptions – for a number of the people who you respect.
- Write down up to three such qualities in the third column. If you are not being overly idealistic, these qualities are likely to represent *Root* values which are crucially important for you to try to live by.

Who do you deeply respect for the way they have led their life?	What are the qualities this person has that you particularly respect?	What are the three key qualities this person has that you particularly respect?
1.		
2.		
3.		
4.		
5.		

From Dr J. Hawkins

<http://www.goodmedicine.org.uk/goodknowledge/wellbeing-time-management-self-determination>

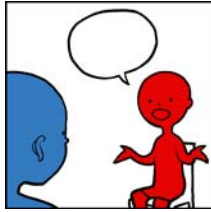
Do you live your values?

Consider the values you have identified in the respected figures exercise above. Do you live these values yourself? In what ways do you try to live these values in your personal and professional life? What are the things

that help you bring these values into your everyday life? What are the things that prevent this from happening?

Exercise 1.5

Make a list of your top 3 root values, and consider the above questions. Can you make any changes in your work or personal life that would allow you to live your values more fully?



CARE

MODULE 2 Connecting

This module explores

- The importance of 'connecting' in the encounter
- How to enhance your rapport with your patients
- How to make effective use of non-verbal communication
- How to encourage the 'patient narrative' as part of connecting

'Connecting' is what happens when you 'click' with someone. It often occurs naturally and spontaneously between two people when they first meet and very quickly like each other. As this occurs at a sub-conscious level, it can be difficult to describe exactly why it has happened. When it happens, we just know it and it feels good! We can also sense its absence when it does not happen (and it can create a mutual feeling of unease). You probably have examples in which you remember feeling how easily you connected with someone, without being able to put into words why.

Of course, connecting is a two-way process and as such it cannot be forced or faked. However, in the CARE Approach, we are suggesting that connecting is a key component of the patient encounter and thus in your professional role you may need to work at maximising the chances of 'connecting' with your patient. Fortunately you can learn to optimise connecting, which for the healthcare professional is an active process that requires both conscious effort and willingness (Neighbour, 1987).

Within the context of the CARE Approach, connecting refers to the start of the process of actively engaging with the patient. In order for patients to share their views and concerns with us, we need to do our best to ensure that they feel comfortable and at ease to do so. Connecting covers four features that are part of empathic, person-centred communication. These are:

1. Establishing rapport
2. Accepting the patient as a person
3. Effective non-verbal communication
4. Allowing the patient to tell her 'story'.

Establishing rapport

The process of establishing rapport involves creating a trusting atmosphere in which the patient feels comfortable to share personal information (Arnold & Boggs, 2003). Establishing rapport starts at the very beginning of the encounter, for example, in the way we greet the patient in the waiting room and invite her to join us in the consulting room, or in the way we approach her at the bedside.

First impressions are important. The way we introduce ourselves (verbally and non-verbally) and our opening words and sentences form an essential part of connecting.

Exercise 2.1

Watch the clips that show different approaches and answer the following question:

In what ways do the health care practitioners create a good first impression with the patients?

Clip 1



Clip 2



Clip 3



Possible answers...

Accepting the patient as a person

We may not necessarily condone or approve of everything that the patient tells us but accepting patients without prejudice is fundamental to an empathic approach. It demonstrates our respect for them and this facilitates connecting.

Although it may sound straightforward, interacting with people without making prejudicial judgements and treating them in a way that is equal and fair can be a challenge, because we do have tendencies to prefer certain

types of people more than others. Raising an eyebrow, making less eye contact or beginning to talk a touch more loudly are types of nonverbal behaviour that may be perceived as 'frosty' and may suggest that we are being critical (Davis, 2006).

Exercise 2.2

1. How easy or difficult would it be for you to be accepting and not judge the following people? Tick the box that most closely reflects your viewpoint

		Very easy	Easy	Difficult	Very difficult	Impossible
1	A mother who does not control her disruptive child whose behaviour prevents you from understanding the mother's story.					
2	A man who does not follow your advice and complains about the same issues over and over again.					
3	A patient who blames you for her troubles.					
4	A woman who refuses to take any responsibility for her health and wants you to tell her exactly what to do.					
5	A patient who demands your help in an aggressive manner.					
6	A patient who talks and talks, but not about his health.					
7	A woman who keeps taking over the conversation and does not listen to you.					

Exercise 2.2 continued

2. Look at the ones you ticked as 'difficult', 'very difficult' or 'impossible'. What are some of the reasons for these answers?
3. In what healthcare situations have you had to set aside personal biases, values and judgements?

Exercise 2.3

Read the following remarks made by patients who took part in a study on quality in general practice consultations in Glasgow (Mercer et al, 2007). Reflect on what you think the patients reacted to.

- A. "Some of them make you feel inadequate, you know you're getting old and you're getting senile and you're not able to take things in, I mean sometimes you feel that way, you feel as if och I'll just lift my bag and jacket and go."
- B. "I've got Dr X and Dr Y and the two of them have got totally different attitudes when it comes to talking to you, Dr X will take the time and listen to you."
- C. "You feel as if you're taking up his [the doctor's] time...that makes you feel under pressure."
- D. "When I go to see my doctor, I want him to see me, the person, not a bottle of methadone, I'm not that, I'm a person that 's got needs and everything like every body else, because I'm on methadone, I just don't get treated properly."

Possible answers...

Effective non-verbal communication

By now it should be clear that our non-verbal communication plays a big part in connecting with patients. It determines how we come across in our introduction and hence how approachable, trustworthy, accepting and interested we are perceived to be (Cole & Bird, 2000). Our non-verbal behaviour is especially important in communicating that we are listening. Here are a few simple pointers on non-verbal forms of communication that will aid the process of connecting:

- ***Eye contact.*** Appropriate eye contact is crucial. Prolonged eye contact may come across as 'staring' and patients may feel embarrassed or intimidated. Conversely, too little eye contact may come across as rather cold and patients may feel that you are not interested in what they are saying. If possible, it is important to be at the same eye level as the patient for example, by having a chair that

is the same height as the patient's chair.

- *Posture.* For very good reasons, the patient's chair is normally stable with four legs while the practitioner's chair is often a swivel seat on wheels. The practitioner has to complete various tasks and has to face the patient and the computer at different times in the encounter. Patients are more likely to perceive that the healthcare practitioner is interested and listening if they are sitting upright and leaning slightly forwards than if the practitioner is slouching back in the chair. If we sit with our legs uncrossed and our arms unfolded patients may be more likely to feel we are listening to them than if we sit with our legs crossed and our arms folded.
- *Signalling.* Getting a balance between facing the patient and performing the tasks necessary to record information is important. Some practitioners find it useful to tell the patient what they are typing into the computer as they do this: "Right, let me record this in your notes...you have had this pain for four weeks now..." and "I am typing a note here to say that you should come back in two weeks if this doesn't clear up". Practitioners also confirm that they are listening by using occasional grunts such as "Uh-uh" while using the computer.
- *Gestures and expressions.* Our gestures, like our seated posture, can make the difference between a patient feeling that she is being listened to or not. Our arm and hand movements and our facial expressions must match the content of what we say and what we hear. This is sometimes termed 'congruence'.
- *Voice inflection.* We can use the sound, speed and volume of our voice to communicate interest and warmth. Inappropriate use of our voice can (unintentionally) convey distance and coldness.

Exercise 2.4

Watch the clips. These versions of the clips have the sound removed. Watch these silent versions and answer the question underneath.

Clip 1 (without sound)



Clip 2 (without sound)



In what ways are the practitioners' non-verbal approaches to the patients different?

If you wish, you can watch the clips again with sound.

Clip 1 (with sound)



Clip 2 (with sound)



[Possible answers...](#)

Allowing the patient to tell his 'story'

People need time and space, and our attention, to fully describe their illness and concerns in their own way. Giving time and attention shows respect and interest. Ultimately, we want to obtain an understanding of what is on the person's mind and how he feels. After opening the encounter and inviting the patient to tell his story, we can encourage and facilitate story-telling by looking at the patient, nodding, and by verbal utterances such as, "*Uh-uh*", "*OK*", and "*really*".

There are many different reasons for encounters for example, to monitor an illness or disease, to undergo a test, and because there is a new symptom. However, it may be important to give patients the opportunity to tell us whatever they feel they need to, whatever their reason for coming to see us. Neutral, open, inviting questions are best. Here are a few examples of ways to invite patients to tell their story:

- “How are you today?”
- “What has happened since we last met?”
- “Can you tell me a wee bit about the story about your back? Like when it started and how you ended up at physiotherapy today.”

Exercise 2.5

Watch the clip and answer the following question.



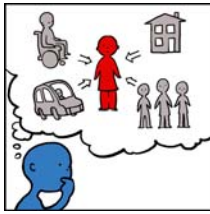
In what ways are the different aspects of connecting demonstrated in the clip? The four aspects are: establishing rapport, accepting the patient as a person, effective non-verbal communication, allowing the patients to tell their ‘story’.

[Possible answers...](#)

A final word on connecting

Connecting is a thread that runs through the whole encounter and is not confined to the first few minutes. Opportunities for connecting may develop and deepen over time, either within a single encounter or over a series of encounters. In some branches of healthcare, such as primary care, general practice, mental health, and care of the elderly, continuity of care is both possible and desirable, and allows you and the patients to work together over a period of time. The more we connect with a patient, and re-establish and reinforce the connection, the stronger the therapeutic relationship will be. Here are some examples of ways to make connections over time:

- “I remember you telling me about...”
- “How is your daughter these days?”
- “You mentioned that a while back, tell me more...”
- “Is this the same as the one you told me about last month?”



MODULE 3 Assessing

This module explores

- How to strengthen the connection through the process of assessing
- The importance of attending and how to use it in practice
- How to develop a sensitivity to patients' cues
- How to use a holistic approach
- How to identify and apply different kinds of questions in order to gather further information and strengthen the connection

In 'assessing' we aim to understand the patient's situation, perspective and feelings (and their attached meanings), and to place a patient's symptom and medical problems within the context of her life as a whole. This requires us to take a bio-psycho-social perspective. In making a holistic assessment, we need to listen to, and ask the patient directly, about how her symptoms or medical problems are influencing and being influenced by her life; about stress, emotions, and psychological issues, family, work, and other important life-roles and relationships, and about how the illness is affecting her as an individual. For example, a recent life-threatening illness, such as a heart attack, may result in anxiety and stress, interfere with the patient's ability to work, raise concerns about intimacy and sexual activity, and challenge the person's view of themselves as strong and healthy, and raise existential or spiritual questions about life and death.

In assessing we need to understand what the patient finds important and values in their life and how she makes sense of what is happening to her (McCormack, 2010). Core questions are "What are the issues and concerns from the *patient's* perspective?", and "What does the patient want to achieve in relation to her health?" (Davis, 2006). Only by listening carefully and asking the right questions can we obtain insight into these issues.

Within the CARE Approach, there are four components of assessing:

1. Attending
2. Sensitivity to patients' cues
3. Understanding the 'whole person'
4. Asking questions

Attending

In order to fully understand the patient and be able to respond meaningfully, we need to pay close attention to the content of the patient's story, the words that he uses to describe his experiences and how he

makes sense of his story. This process is called attending. Attending goes beyond listening as we need to be fully present in the moment and wholly aware of what the person is communicating verbally and non-verbally. We need to resist reacting to what the patient is telling us and answering immediately in order to 'fix' his problem. We need to be aware of, but resist getting sidetracked by, our own thoughts, feelings and agenda, as the patient's story unfolds. By listening carefully and accurately, we need to be able to 'hold' and 'stay with' the emotions that we feel.

The aim of assessing is to get to the heart of the matter – to understand how the patient sees her situation and obtain a picture of the patient's world, including his emotional state and the issues he is facing. We need to be sure that our own 'take' on the story does not distort the way we are listening and what we are hearing. Are we making judgements about the patient (based on partial evidence) or accepting him as he is and allowing his story to continue to unfold in its own way? (McCabe & Timmins, 2006; Arnold & Boggs, 2007). Listening in this way is not easy. It requires practise, reflection, and experience before we can give our complete attention to our patients and for it to become a natural way of interacting. Through attending we demonstrate that we are focussed on the patient and communicate that we care about his wellbeing.

Exercise 3.1

Watch the two clips and answer the following question.

Clip 1



Clip 2



In what ways do the health care practitioners show that they are attending/ listening?

[Possible answers...](#)

Attending is a powerful way to show that we respect and value the patient. However, if the patient feels that we are not paying close attention, do not give our time or are making assumptions or judgements about him, then he may feel that his concerns are being ignored or not taken seriously. In this situation he may disconnect, become less open about his concerns and may show signs of withdrawing from us. This is unlikely to be an empowering experience for the person.

Exercise 3.2

Twelve common barriers to listening are outlined below (McKay, et al., 2009). In what ways and under what circumstances might these barriers interfere with your listening?

- *Comparing* – Comparing interferes with listening because you are constantly assessing which of you, for example, knows best. While a patient is talking, you are thinking “If you think that is hard, let me tell you how hard it actually can be.”
- *Mind-reading* – Mind-reading pushes you to look for hidden meanings rather than to listen to what is actually being said. You might not completely trust that the patient is being open or honest about what they really want, so you shift your focus to possible hidden meanings through changes in intonation or facial expressions.
- *Rehearsing* – Rehearsing means trying to look interested while you are planning and rehearsing your response.
- *Filtering* – You listen to some things and not others often to avoid problems. For example, if you are afraid of confrontations then you will pay attention to what mood the patient is in. If you perceive no “angry” signs then you stop listening.
- *Judging* – Judging is often done so quickly that you often do not realise that you have done it. However, when you subconsciously label someone as being unintelligent or lazy, you tend to pay less attention to what they are saying.
- *Dreaming* – The patient’s words trigger your own associations and you go off in a day dream. When you continue to listen, the patient is talking about something else, leaving you with a gap in their story.
- *Identifying* – Whatever the other person says can trigger memories of similar experiences and before you know it, you have interrupted the other person’s flow in order to tell your story or started to think about your own experiences. Meanwhile you stop paying attention to the other person’s story.
- *Advising* – You are keen to fix the patient’s problems and are ready with advice, reassurance and suggestions after only hearing a few sentences. You like to start your reply with “If I were you, I would...” However, whilst searching for advice you

could be missing what the real problem is.

- *Sparring* – Regardless what the other person says you start to look for issues to disagree and argue about. A common example is to make sarcastic comments to dismiss the patient's point of view (the so-called put-down).
- *Being right* – You will go to great lengths in order to try to prove that you are right, thereby using tactics such as making up excuses, talking over the other person in a loud voice or twisting the facts.
- *Derailing* – As soon as you feel out of your comfort zone or bored you change the topic of the conversation, make a joke or banter in order to prevent any further discomfort. Meanwhile you stopped paying attention to the other person's story.
- *Placating* – You want to please and be nice regardless of the situation. You use words like, "of course you are", "absolutely", "really", and find yourself unwittingly agreeing with everything they say.

Sensitivity to patient's cues

In the course of a conversation people will make throw-away comments or smile through gritted teeth when describing someone else. Sometimes a relative or carer will raise an eyebrow when the patient tells you that she can manage at home alone. These are all examples of cues. There are verbal and non-verbal elements that you may wish to pick up on and explore in the encounter. You might say something like: "I get the impression that you don't find X an easy person to care for".

Sometimes a patient will directly reveal a concern e.g. "I am really worried", but often such concerns are hidden and revealed only as cues. Cues range in degree of subtlety and can be easily missed or deliberately ignored. All cues are hints (consciously or unconsciously) that there is more on the person's mind than he has articulated. It is probably best to assume that the patient is looking for a response from us. The extent to which patients feel able to discuss their emotions depends on many factors, such as the intensity of the feelings they are experiencing, how well they are coping, as well as their personality. However, as the healthcare professional, your own ability, willingness, and sensitivity to detecting and exploring cues are crucial to the patient having the opportunity to express what he is feeling.

Being open to patient's cues can be described as carefully listening to the emotions behind the facts. From the patient's point of view, the way she feels is as important to her as the factual side of her medical condition. In one way or another during the encounter the patient will show us how she is feeling and how much she is able to make sense of what is going on in her life.

Cues are opportunities to gain a better insight into what the patient is experiencing. By explicitly acknowledging them we can enhance our assessment and deepen our connection with the patient. If a cue is ignored or missed, especially when the patient has repeated it several times, the encounter is likely to be unsatisfactory for the patient and any subsequent responses and attempts to empower are likely to be unsuccessful.

Exercise 3.3

Watch the following clips that show a mixture of verbal and non-verbal cues made by the patients and answer the following questions.

Clip 1



Clip 2



Clip 3



1. What verbal and non-verbal cues do the patients give? What are the feelings that are revealed in the patients' voices or expressions?

[Possible answers...](#)

2. Which cues do the practitioners pick up and which ones do they miss?

[Possible answers...](#)

3. In what ways would you have dealt with the cue differently?

Understanding the ‘whole person’

Understanding the ‘whole person’ means not characterising the patient only by his illness or one facet of his life. Taking other factors like gender, age, culture and life experiences into account in our interaction with patients is known as working holistically.

In order to be able to understand the patient's experience of his illness, it may be important to learn about his work, family, home circumstances, support, or personality (Brown et al, 2001; Stewart et al, 2003). The extent of this will of course depend on the context and nature of the encounter. However, it is often possible to take account of other aspects of a person's life whether you are taking a full history or seeing someone in a minor illness clinic - “Who is at home with you?” is a question that might help here.

Understanding the whole person does not mean knowing his entire life story. It means being able to understand where the patient is ‘coming from’ in the current encounter. To be able to put his experiences of his illness in context is invariably helpful to both patient and practitioner.

If done in a non-intrusive and respectful manner, holistic assessment demonstrates that we are interested in the person with the illness. This helps in our assessment of the person and strengthens the connection with him (Platt & Gordon, 1999). Additionally, knowing about the relevant details of the patient's life will help us to give a more tailored response and increase our understanding of the patient's reactions to his health and illness (Stewart et al, 2003).

Exercise 3.4

The following clips are examples of different styles used by the same practitioner to obtain understanding of the ‘whole’ person. Watch the clips and observe how the health care practitioner demonstrates a holistic approach. On the worksheet there is space to record your observations if you wish to do so.

Clip 1



Clip 2



Clip 3



Possible answers...

Asking questions

Patients sometimes leave encounters with a question about what was said - "I wonder why the nurse asked me that?" The questions that either you or the patient ask are an important aspect of the interaction, because they are a means of exploring and gathering relevant information. By being aware of different ways of asking questions we can gather information without coming across as being intrusive or superficial. If the patient considers questions to be intrusive, they may feel uncomfortable. However, too few or superficial questions may be interpreted as lack of interest. The number and type of questions depend to some extent on the patient's problems and how much information we need.

Certain questions used at appropriate times in an encounter can be particularly productive in yielding information. Six types of questions are described below (Vocational Studies year 1):

1. *Open-ended questions* are general questions and encourage the patient to respond with more than one or two words. It is up to the patient how much information she gives. These questions often start with: how, what, when or can. For example "What can I do for you today?", "From your point of view what are the key things that are affecting your health?"
2. *Focussed questions* define the area of enquiry more precisely but allow some scope in answering. For example "You said that you were feeling tense. What do you mean by that?"
3. *Closed questions* are the ones that can only be answered with specific responses, like yes or no. Continual closed questioning constrains the responses that the patient can give and prevents the patient from giving personal meaning of their experiences (Mead &

Bower, 2000). Often, they start with: do, is or are. For example “Do you sleep well?”, “What is your name?”, “How many children do you have?”

4. *Indirect questions* are rhetorical statements that imply that a response is expected, without grammatically being an actual question. These questions can be used as a way of gathering information without making the patient feel that she is being questioned and they give the patient the chance to volunteer information. For example “In these situations some people find it difficult to get off to sleep.”

It is best to avoid the following two types of questions.

1. *Leading questions* imply specific answers, which are based on our assumption of what we think the patient should be experiencing. The most likely response is that the patient will agree passively with us. For example “You don’t sleep well, do you?”
2. *Compound or double questions* mean that we ask more than one question at a time. The result is that we sent a mixed message and often the answer is incomplete or confused. For example “Do you need to take sleeping pills to help you sleep, and do you still feel tired in the morning?”

Exercise 3.5

Watch the clip and answer the following question.



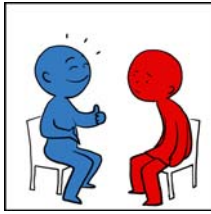
In what ways are the different aspects of assessing demonstrated in the clip? The four aspects are: attending, sensitivity to patients’ cues, understanding the ‘whole person’, and asking questions.

[Possible answers...](#)

A final word on assessing

Assessing is the combination of gathering information regarding a patient’s concerns, beliefs, views and expectations *and* holding and sifting that information in order to decide how best to respond and empower that individual. Thus assessing in the CARE Approach is done on the basis of gathering the information that is unique to that individual and reflecting on this, with the patient (or internally with yourself) as you begin to plan how best to respond. In many cases, as with connecting, this happens quickly

and intuitively, without any need to reflect, think, or plan. However, in many encounters such intuitive and accurate responses may not be forthcoming, thus requiring reflection and planning on the best ways forward in the next phase of the encounter or even after the encounter, in thinking ahead to future meetings with the same patient.



MODULE 4 Responding

This module explores

- How responding interacts with connecting and assessing.
- Different ways to communicate that we understand the patient's story
- Why showing care and compassion are important
- Why being honest and positive is important.
- How to feel more confident in explaining things clearly and answering questions sensitively.

In the previous chapters on connecting and assessing we looked at ways of obtaining a picture of what the important issues are for the patient through attending, using a holistic approach and picking up on the patient's verbal and non-verbal cues. Also, we saw that by building rapport and by paying close attention to what the patient tells us, we enhance and deepen the therapeutic relationship.

Responding to the patient happens throughout the encounter. We do this verbally and non-verbally. In the process of responding we follow up and act upon the findings of our assessment, from which we obtained an accurate picture of what the important issues are for the patient. In responding we continue to pay attention to the patient's verbal and non-verbal cues in order to observe how he reacts to us. Being able to pitch our response to the patient's level of concern, emotion and understanding as well as his state of mind, whilst addressing the issues that are important to him, will facilitate the patient's understanding and involvement in the encounter.

Within the CARE Approach, responding means directly 'replying' to the issues identified in assessing, and communicating and checking that we have accurately understood the patient's concerns and act on that understanding in a way that will help the patient. There are four aspects to responding:

1. Demonstrating understanding
2. Showing care and compassion
3. Being positive
4. Giving relevant information and clear explanations

Demonstrating understanding

When we are listening to a patient, it is important to periodically check that we have understood correctly the meaning of the story for the patient and

not inadvertently overlooked or dismissed something that the patient regards as important. The task is to clarify various aspects of the story as sensitively as we can. If we can do this properly, we can communicate to the patient that we are taking her views and concerns seriously and that we respect them. By hearing back what she has said the patients can see it in a slightly different light or it may help her articulate what she is trying to say. At times this means that we need to interrupt the patient's story. Helpful ways of demonstrating our listening and understanding are:

- *Paraphrasing or summarising* the key points of the patient's story.
For example "So what you are saying is that you are confused about the different tablets and that you stopped taking them."
- *Repeating key words and phrases* that the patient says.
For example "so...you...have...no...energy?" or "...really tired..."
- *Seeking clarification or checking out* the patient's statements that sound (slightly) confusing to us.
For example "Can I just check with you that what you are saying is...?" or "Am I right in picking up that you...?"

Through feeding back to the patient what is said and our understanding of it, we give the patient the opportunity to check and correct our understanding. Feeding back demonstrates that we are paying attention and communicates that we care. In making this explicit, the chances are that the patient feels understood and appreciated, and we create more opportunities to increase rapport and trust and thus strengthen the connection made at the start of the encounter, thereby encouraging the patient to express themselves more freely.

Showing care and compassion

Responding to the patient in a way that conveys our care and compassion is a key aspect of the CARE Approach. Showing care and compassion is a way to express our core values as healthcare professionals. Most of us went into and remain in healthcare because we want to help people. Responding to our patients in caring and compassionate ways allows us to directly practice in the way we value, and in the way we would like others to respond to us. Responding gives voice to our values, beliefs, and attitudes. When we feel compassion we find it easier to listen deeply, understand more fully, and demonstrate empathy. As a result, we are able to show concern that is both genuine and heartfelt.

One way of showing our involvement with the patient is through an empathic comment that reflects on the feelings of the patient. A reflection goes beyond the content of the patient's story (unlike paraphrasing or summarising) as it takes also into account the patient's non-verbal behaviour, the context of what the patient has said and the words used.

For example "It sounds like your back pain is affecting really quite a lot of areas in your life. It is affecting your mood as well, because you are struggling to do all the activities that you were used to be able to do. Is that right would you say?"

Another way of conveying that we are with the patient on a human level is through validating the patient's reactions to her experiences as normal and understandable. A validation shows the patient that her reaction is "appropriate" and "acceptable" considering her experiences.

For example, in response to a patient who is crying and excusing herself, a practitioner says: "No that is fine. It is very normal and understandable. It is a long time that you have suffered the pain."

Empathic comments, like reflections or validations demonstrate that we attempt to understand the meaning behind the patients' words, value their perspective of the situation and support them.

Exercise 4.1

1. Think about how you would communicate that you care and compassionately relate to a patient.

[Possible answers...](#)

2. Watch the following clips. In what ways do the practitioners show care and compassion?

[Possible answers...](#)

Clip 1



Clip 2



Being positive

Having a positive attitude requires us to be honest and, at times frank, but never negative about a patient's problem. In all situations in healthcare we should strive to offer hope and to empower. We need to be aware at all times that our approach and attitudes can have powerful effects on our patients, especially when they feel vulnerable and anxious.

We should not be insincere or dishonest for the patient would quickly detect this. Remaining positive in our approach and attitude is perhaps the most important thing we can do to encourage our patients to see a clear way ahead of them. Indeed, research on the importance of different aspects of patient-centred care has shown that patients get better quicker when their doctors respond to their problems in a positive way (Little et al 2001).

Exercise 4.2

Watch the clips and answer the following question.

Clip 1



Clip 2



In what ways do the practitioners communicate that they are being positive?

[Possible answers...](#)

Giving relevant information and clear explanations

Two important aspects of responding to patients' concerns are giving factual information and explaining things. Explaining things clearly and tailored to the patient, means that we give information and explanations in ways that take into account and are consistent with the patient's understanding, needs, values and beliefs. In addition, we observe the patient's reactions in order to check if we need to refine our explanations. When we communicate effectively and give clear information, we enable the patient to take more control and responsibility over his life.

Exercise 4.3

The following clips are two examples of giving information to the patient. Watch the clips and answer the following questions for each one.

Clip 1



Clip 2



1. In what ways are the practitioners' approaches to giving information and explanations different?

[Possible answers...](#)

2. In what ways do the patients react differently in response to the practitioners' explanations?

[Possible answers...](#)

The situation of giving information without taking into account a patient's understanding and needs is not uncommon within healthcare and it indicates that consciously or unconsciously we are following our own agenda. For example, we give him too much information, because it is an interesting topic to us or we follow a set of tick-boxes or script in our head that we feel we have to complete without interruption or taking into account what effect this has on the patient. In this case our communication is less effective and can lead to misunderstanding and worry for the patient. Consequently, what we say may be ignored or misinterpreted.

In order to match the amount and type of information to the patient's needs and preferences, we need to find out what and how much he wants to know. For example, is it the diagnosis, coping techniques or support available, the causes of the illness or side effects of treatment (or even just some aspects of these) that the patient is keen to learn more about? Asking and checking with the patient as we impart information is one way to match our information-giving to the patient's needs. For example, "I don't

know how much you know about high blood pressure already?” or “Can you say a little bit more about how you think it works?”

We need to be aware of certain terms that may be so familiar to us that we assume patients share the same understanding. Words, like ‘migraine’, ‘virus’, and ‘depression’ are part of every day speech and most people are comfortable using them. This is true too of stories and explanations which we ‘trot out’ without thinking. While these accounts have become refined and honed over a life of interacting with patients, there is a danger that they lose meaning. Medical words that are widely used will carry different meaning to different people and the meaning can be different from medical usage. Often it is useful to check the patient’s understanding of a particular technical term, because it is possible that he will hear the technical term again (Consulting: Communication skills for GPs in training, 2005).

Exercise 4.4

Can you think of different reasons why you might use medical jargon?

[Possible answers...](#)

Jargon does not only refer to words found in the index of textbooks, but to words used by practitioners when communicating with one another. Being aware that we use certain jargon terms and appreciating why we do so, will help us to become more aware of the way we interact with our patients.

Exercise 4.5

Watch the clip and answer the following question.



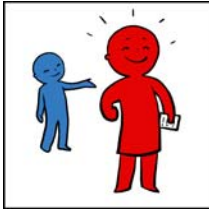
In what ways are the different aspects of responding demonstrated in the clip? The four aspects are: demonstrating understanding, showing care and compassion, being positive, and giving relevant information and clear explanations.

[Possible answers....](#)

A final word on responding

Responding builds on connecting and assessing, by requiring us to ‘reply’ to the persons’ concerns. Responding involves both verbal and non-verbal aspects, as demonstrating understanding, showing care and compassion, being positive, and giving information and explanations is not just about what we say when we respond, but also how we say it.

Whether the way we are responding is effective depends on the context in which it is used. The patient’s reaction to how we are responding is one way of gauging how we are being perceived. For example, a patient who smiles or visibly relaxes, and opens up a bit more following your response implies you have responded in an “appropriate” way. Keeping the focus on the patient, paying attention to cues and asking for feedback, if appropriate, will help us to keep the focus on the patient and maintain a person-centred approach.



MODULE 5 Empowering

This module explores

- How empowering interacts with connecting, assessing and responding
- What appreciating the bigger picture means
- How to help patients to take control and build their capabilities
- How to make a plan of action with the patient and confirm his understanding
- How to use empowering to build the patient's confidence

Empowering patients is a concept that is difficult to define. It is sometimes described as sharing power with the patient or even surrendering power to the patient. It is a term that is widely used within the context of healthcare, and is widely regarded as impacting positively on patient satisfaction and even some health outcomes.

Exercise 5.1

Answer the following two questions.

1. What does empowerment mean to you?

[Possible answers...](#)

2. In what ways can you empower patients?

[Possible answers...](#)

Looking back at connecting, assessing and responding, you may already have noticed that empowering is a thread running throughout the CARE Approach. In the context of the CARE Approach, empowering refers to helping patients to feel more in control of their health and healthcare. The focus of empowering in the CARE Approach relates to the following four aspects:

1. Appreciating the bigger picture
2. Helping patients to gain control
3. Action planning and confirming understanding
4. Confidence-building

Appreciating the bigger picture

We have already discussed the need for a 'whole-person approach' as part of assessing, but appreciating how a person's life and circumstances are affecting his health is so fundamental to empowering that we feel it is important to re-visit some of this again here.

In trying to empower, we need to have a good understanding of the context of the illness or condition against the backdrop of the patients' life. We need to know not only how the illness is affecting the patients' life, but how life is affecting the illness. Appreciating the bigger picture means using our knowledge and judgement sensitively to imagine how this person's conditions might be influenced by his life circumstances. We can also indicate our understanding directly with the patient, and check its accuracy.

For example, many of us will have an appreciation of the geographic areas that our patients come from – of the housing type, the feelings of safety within the community, the public transport links and the access to supermarkets and other services. The patient's address, recorded in the case notes, may give an indication of certain aspects of a patient's life - though the real danger here is that we make assumptions and pigeon-hole people. Knowing that a patient with COPD lives in a high-rise block might tell us nothing more than the restrictions on his social life when the lifts break down (which they might do on a frequent basis). Knowledge of the local area may help us to understand why some patients are late for appointments, and why our advice about healthy living never seems to be taken up. Although we can make a real difference to the way that patients feel within the encounter, the effect might not endure after the interaction when patients return to their daily lives. Trying to understand people's lives helps us to appreciate why our best efforts might not always have the effect we hope for and why people struggle to make sense of the advice we sometimes give.

It might be useful to use open questions like "What is life like for you?" and "Who is at home with you?" and to respond to statements like "It's difficult you know" with "Tell me about that..."

It is helpful to find out about what restricts patients in their daily lives as people might feel disempowered in their domestic lives or work places. Patients may talk about flights of stairs, an unsympathetic boss, or a challenging family member. Connecting with people in terms of this bigger picture and trying to appreciate and understand the complexities of their lives can not only enhance our relationship with patients, but also help in goal-setting and tailoring treatment, and in helping patients to make realistic and appropriate decisions about care.

Patients will respond very differently to a healthcare practitioner who is trying to understand them and their lives than to a practitioner who gives advice and instructions that do not fit with the challenges of daily living. As healthcare professionals we need to appreciate how the patient feels about pushing himself to take control and what failure might mean for him e.g.

confirmation in his own mind of repeated failure, or ridicule by friends, family and others.

A patient may have an informal role as a carer which means that he does not have much time for his own health, and awareness of this might lead to the patient being able to access entitlements and other assistance.

Helping patients to gain control

As healthcare professionals we often give patients information about their condition and how to manage it, services to support them, and health promotion literature.

In some cases we teach patients how to undertake tasks such as checking their peak flow and administering injections. Giving information and teaching skills of self-management can be empowering. However, some of this information is complex and some of these skills are quite technical and it is seldom sufficient to give her the information and to show her the skills without supporting her and reinforcing the instruction.

It can be useful to identify a patient's strengths and her prior accomplishments. In addition, it can be helpful to explore with the patient what she feels she can do to improve her situation.

Taking control of your condition can be frightening particularly if you fear being left to get on with it on your own. However, helping patients to take control is about them taking responsibility for more self-care and not about them taking responsibility for all care. It may be better to think of it as gaining more control rather than taking absolute control.

This usually involves exploring with the patient what she can do to improve her health or situation. So our role becomes that of coach and mentor - nurturing, involving, demonstrating, and positively reinforcing. By being involved as active partners in their care, patients are encouraged to take more control and responsibility, based on their strengths and capabilities.

Some treatment options may require an adjustment in lifestyle, behaviour and associated coping skills in order to meet certain health goals. Information about treatment options may be hard to take on board and may require a simple structured pace. The patient needs to feel comfortable in order to be able to discuss health goals or treatment options, and we need to be sensitive to how the patient is responding as we give information and check understanding.

Fundamental to shared decision-making of any kind is that the patient understands her situation up to the point that she feels able to make choices that she is comfortable with. Making their own choices will help patients gain a sense of control and independence. Access to information and support from others with the same condition, e.g. self-help groups, can be useful for some patients.

Gaining control is having the self-belief that you can achieve something as much as having success in mastering certain skills or finding the motivation to change something in your life.

Exercise 5.2

1. What does self-management mean to you?
2. Listen to the recording in which a healthcare professional talks about self-management. How do your answers relate to the practitioner's view? In [Appendix 5](#) you can read the transcript of the recording on self-management.

AUDIO CLIP



Action-planning and confirming understanding

Making a plan of action with the patient relates to defining options on how to proceed. Options can involve agreeing health goals and making choices about treatment options. We should resist making assumptions about how much a patient wants to be involved in his care and we need to find out how much and in what ways a patient wants to engage in care. A shared plan of action needs to be realistic in terms of what is achievable in order for it to be effective.

A patient cannot really exercise choices unless we facilitate a shared understanding of the problem or illness, which needs to be defined in a clear manner that both agree. Having a holistic approach by focussing on the patient's feelings, needs, experiences and life-style will help making the problem concrete and relevant.

An action plan sets out management of a condition and within this plan there may be specific goals. It is helpful to make a distinction between long- and short-term goals. A long-term goal for a young person with asthma might be to play a whole game of football without having to come off because of shortness of breath. A short-term goal might be to control wheeze on minimal exertion through optimal inhaler use over the next few weeks. The time-frame defines whether a goal is short or long-term, but so does the likelihood of the goal being achievable, and this has to be negotiated. Achieving goals, whether short- or long-term is about helping people become much more confident in their ability to cope with and manage their illness.

Exercise 5.3

The following clips show different styles regarding exploring with the patients what they can do to improve their situation, identifying choices that are realistic for the patients and actively seeking their preferences.

Clip 1



Clip 2



In what ways do the practitioners differ in their approaches?

[Possible answers...](#)

In clip 2 above, the physiotherapist and the patient talk about goal setting. In the following recording the physiotherapist explains in more depth what she means by goal setting.

You can find the transcript of the recording on goal setting in [Appendix 5](#).

An important aspect of making a plan of action with the patient is to check frequently that the patient understands the information you give and that he is clear on what the course of action you both have decided on. Having a clear understanding enhances the patient's ownership of his health and enables him to manage her situation better (*Consulting: Communication skills for GPs in training*, 2005).

To check whether our communication has been effective we can ask the patient to feed back to us what has been agreed during the encounter. For example, we can say: "I want to be sure that I explained X properly, because it can be confusing. Can you tell me what we agreed?" or "Just so that I am clear, what are the kind of things we agreed on? Just to make sure we both know."

Another way is to give the patient ample opportunity to ask questions or to clarify things. For example, by asking "Does that sound alright to you?" or

“Is this what you expected from your visit today?” or “Is there something else that you would like to talk about or ask me?”

Confidence-building

People are more likely to attempt something when they believe they can do it and if they think they have the ability to do it. Self-esteem and self-efficacy are two concepts that can help us to make sense of confidence-building. Self-esteem is the belief that people have regarding their self worth, respect and value, while self-efficacy is described as a person's beliefs in his capabilities and competences in order to cope with and feel in control over his life (Bandura, 1982).

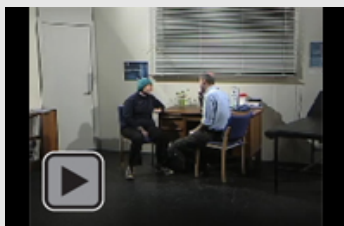
Recognising and nurturing the strengths and competencies of a patient is an important feature of helping him to gain a sense of control over his care and health. Empowering, in the sense of fostering the patient's beliefs in his own capabilities and competences, (Ashcroft, 1987) can take many different forms.

We can confidence-build through an appropriate frequency of follow-up. At these regular encounters we can empower patients by endorsing, confirming, praising, affirming and congratulating patients. We may also need to help patients to refine techniques and we may need to offer instruction. Patients want us to be honest and to show appropriate levels of support and follow-up. We can reduce a patient's feelings of vulnerability and increase his security by using strategies such as “if you don't feel he is better bring him back tomorrow morning.”

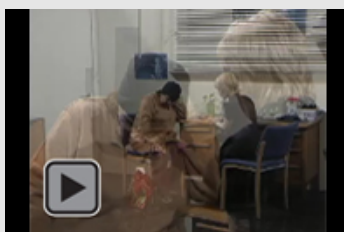
Exercise 5.4

Watch the following clips and answer the following question.

Clip 1



Clip 2



Clip 3



In what ways do the healthcare practitioners foster the patients' beliefs in their own capabilities and competences?

[Possible answers...](#)

As insightful practitioners we will appreciate our patients' successes no matter how large or small, acknowledge these successes and use them as milestones in a patient's journey. Gaining confidence brings hope and a determination that goals can be achieved and that successful plans or pathways can be made to achieve goals.

Exercise 5.5

Watch the following clip and answer the following question.

Clip 1



In what ways are the different aspects of empowering demonstrated in the clip? The four aspects are: appreciating the bigger picture, helping patients to gain control, action planning and confirming understanding, and confidence-building.

[Possible answers...](#)

A final word on empowering

Throughout the description of each component of the CARE Approach it has become clear that they cannot be seen as isolated parts. This module on empowering has been no exception.

The potential empowering outcomes of the CARE Approach are highlighted throughout the manual. These are that patients feel, understood, valued and respected; involved in their care in a way they feel comfortable with; able to self manage; and that the interaction supports their overall well-being. The next section of the manual will put all the four components together and show them in action.

Overview of the CARE Approach

Connecting	Assessing
<ol style="list-style-type: none"> 1. Establishing rapport 2. Accepting the patient as a person 3. Effective non-verbal communication 4. Allowing the patients to tell their 'story' 	<ol style="list-style-type: none"> 1. Attending 2. Sensitivity to patients' cues 3. Understanding the 'whole person' 4. Asking questions
Responding	Empowering
<ol style="list-style-type: none"> 1. Demonstrating understanding 2. Showing care and compassion 3. Being positive 4. Giving relevant information and clear explanations 	<ol style="list-style-type: none"> 1. Appreciating the bigger picture 2. Helping patients to gain control 3. Action planning and confirming understanding 4. Confidence-building

MODULE 6 Putting it all together

This module explores

- How the CARE Approach components interact and work together
- That the CARE Approach is a two-way process
- The spirit of the CARE Approach
- Ways of supporting yourself in the CARE Approach

The integration of the CARE Approach components

Although in learning about the CARE Approach we have presented these as individual components in the previous modules (2-5), you have probably realised by now that the four domains of the CARE Approach do not necessarily follow this simple linear order of 'connecting – assessing – responding – empowering'. Indeed in everyday practice most encounters will have a varying combination of the four components going on, in a varying order.

Exercise 6.1

Watch the following clips and answer the questions.

1. Write down what components of the CARE Approach you think are happening when over the course of the encounter. You can use the blank graph below to 'map' this out by placing a cross against the component you think is going on as the interaction moves along the time scale.

Clip 1



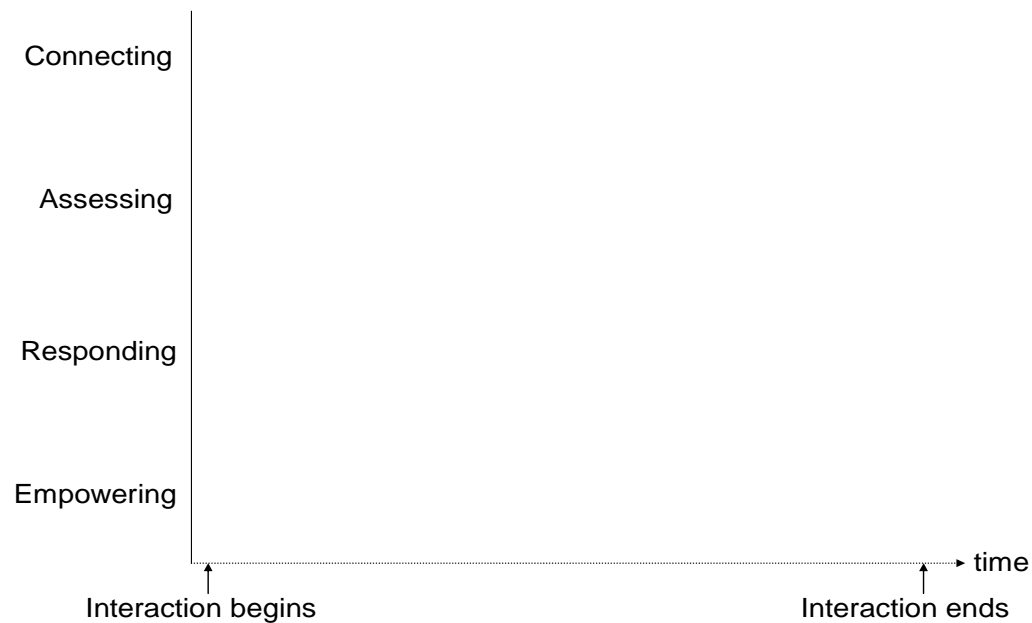
Clip 2



Clip 3



[Possible answers...](#)



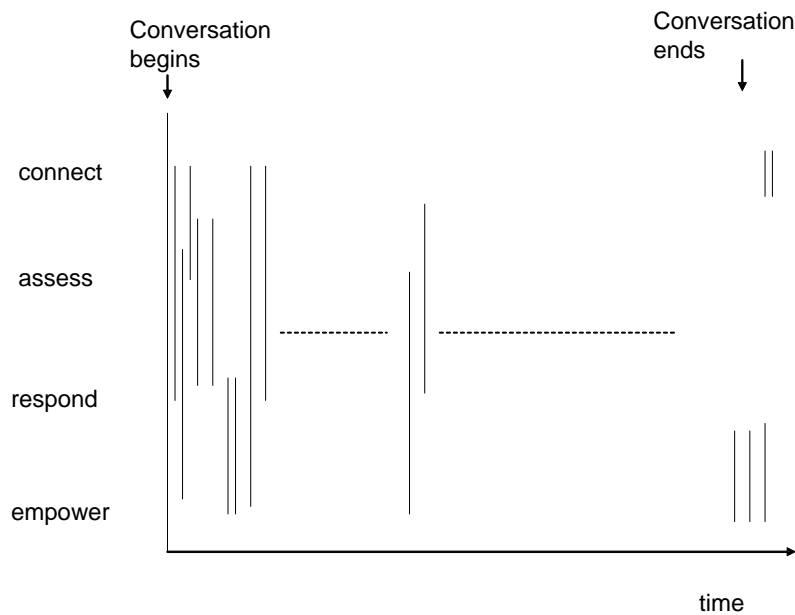
Exercise 6.1 continued

2. In what ways are the different components of the CARE Approach demonstrated in each clip?

[Possible answers...](#)

Clearly there are many ways in which the CARE Approach components can come into play in an encounter. Some encounters may be mainly about connecting with some assessing, and the response may simply be to set a date for the next consultation. Some encounters may have repeated cycles of differing combinations of C-A-R-E, or indeed experienced practitioners may be combining the different components at the same time. Figure 1 illustrates how a skilled practitioner might combine and move between the domains of CARE during an encounter.

Figure 1



In this hypothetical encounter (figure 1), the practitioner is both connecting and assessing at the same time at the start of the consultation (for example by making the patient feel at ease by a polite and warm introduction and assessing the patient's non-verbal behaviour); if the patients seems anxious or ill at ease, the practitioner may then rapidly respond to this by offering a smile, or slightly changing his head position, or body position. This may then help the patient relax a little, and the practitioner then continues connecting, letting the patient tell her story, and again assessing by listening and looking for non-verbal and verbal cues, and responding to these as they arise. Thus during the course of an encounter there are an infinite number of possible ways to enact the CARE Approach. If we are highly skilled communicators, and are fully engaged in the encounter, such responses occur naturally, based on our insight and awareness. Under such conditions, the encounter is almost like an impromptu piece of jazz music performed by expert musicians.

The CARE Approach is a two-way process

What is no doubt also obvious to you by now is that the CARE Approach is not something that you 'do' to the patient; it is a two-way process that is all about the interaction with the patient. If you are with a patient that you get on with very easily, then it is likely that you have both connected at the first glance of the encounter (perhaps when you have gone to call the patient in the waiting room and have made eye contact); this may be because you already know each other well from previous encounters or it may just be that somehow you instantly 'click' as discussed earlier.

The connecting-assessing-responding-empowering (in whatever order and combination they occur) may well then simply run 'automatically' without any effort on your part. Such encounters are of course a joy (unless they

involve breaking bad news or the suchlike) and make the job of being a healthcare professional seem very easy and satisfying.

However, as we all know, not all encounters follow such an easy, smooth course. Perhaps in most consultations, especially if we do not know the patient well, there is an element of 'feeling our way' in the encounter. What is very likely though is that the patient is also going through a similar process and making an active effort to connect with us, is assessing us (verbally and non-verbally) and is responding in active ways. The patient may even go to great lengths to try to empower us in our difficult work.

Exercise 6.2

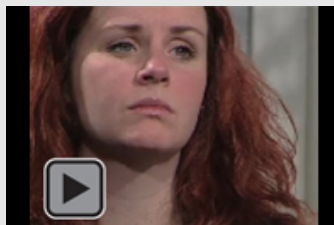
Watch the clips and answer the following question.

In what ways can the CARE Approach be applied to the way the patient is interacting with the healthcare professional?

Clip 1



Clip 2



Clip 3



[Possible answers...](#)

We may meet a patient that we feel a dislike for (and we may not even know why) or that, despite all our best efforts, a patient may be clearly not responding to what we are saying or suggesting. Under such

circumstances it may be tempting to plough on with the consultation regardless, and bring it to a speedy close! However, a better way might be to slow down, take a deep breath, and take a moment to notice what is actually going on. Notice how you are feeling in your mind and body. You may be feeling tense, irritated, angry, or frustrated. You might notice a slight tightness in your throat or abdomen, or that your heart is racing. Just noticing how you are feeling may be enough to allow you to slightly relax, to acknowledge and let go of these feelings, or to simply let them be there without acting on them. You may be surprised to find that this may be enough to also help the patient feel less tense, as you begin to tune in to what the patient is actually feeling and the possible reasons why. It is never too late in a conversation that has somehow got off on the wrong foot to turn things around (or to at least try). Perhaps you need to ask the patient how she is feeling about what you have been saying, or to offer a simple apology if you have clearly picked up the wrong end of the stick. If you are sincerely motivated to help the patient, most difficulties and misunderstanding can be worked through at an early stage, to the mutual satisfaction of both patient and practitioner.

Exercise 6.3

In what way does the practitioner address the situation in the following clip?



[Possible answers...](#)

The spirit of the CARE Approach

So far then we have discussed the individual components of the CARE Approach, how these can interact in a cyclical, non-linear way, and how the encounter with the patient is an active interaction on both sides, not simply the health professional carrying out a detached, objective clinical procedure.

This then brings us to what actually lies at the core of the CARE Approach, to the thing that comprises its essence or spirit. In our view, the heart of the CARE Approach is a combination of empathy and awareness: awareness of ourselves, awareness of the patient, and awareness of the interaction between us, moment by moment.

Such awareness, and our capacity for this, determines the authenticity, depth and presence inherent in our interactions with patients.

Ways of nurturing and supporting yourself and others in the CARE Approach

This section will look at some ways to successfully nurture and develop awareness in the context of the blend of skills, techniques and attitudes which we have covered so far in the manual in describing the CARE Approach.

The first point to make is the need to look after ourselves. Healthcare can be a stressful and demanding profession. It is important that you maintain a healthy work-life balance and promote self-care for yourself just as you do for your patients. If you are feeling stressed or burnt-out, or are suffering from other problems that are affecting your well-being, then it is unlikely that you be performing at work to your full potential. At worst, your own poor well-being may be actively limiting your ability to deliver high quality care to your patients. If you have significant concerns in this area, you need to discuss this with your line manager, or occupational health service, or GP.

Looking after your own health means paying attention to the things that affect your health and that only you can do something about – that is lifestyle factors such as exercise, healthy diet, drinking alcohol within safe limits, stopping smoking, and so on. Looking after your body also has major benefits for your mind – exercise for example is an excellent treatment for stress or mild depression. Other ways of looking after your well-being involves spending time with loved ones and close friends, doing hobbies you enjoy, having regular breaks or holidays, and so on.

For some people religious or spiritual beliefs and practices are an important way of developing awareness and fostering well-being. The cultivation of mindfulness for example has a long history in eastern spiritual traditions such as Buddhism. However, mindfulness can be taught as a set of skills independent of any religious belief system. A popular form of accessible, secular mindfulness training is the mindfulness-based stress reduction (MBSR) educational programme devised by Jon Kabat Zinn. This is run over 8 sessions and involves training in mindfulness meditation, integrated with teaching on psychological understanding and models of stress.

There is increasing empirical evidence of benefit of MBSR to healthcare professionals (Irving et al., 2009) and may therefore be helpful in developing the interpersonal and self awareness that is core to the CARE Approach. Indeed, the self-development behaviours and competences identified by the Knowledge and Skills Framework as essential for delivering patient-centred care can be closely aligned with the proposed objectives of mindfulness training. This includes developing reflective self-awareness and developing strategies to manage emotional and physical impact of work, maintaining personal wellbeing and managing stress (Core Dimension 2: personal and people development).

A final word on the CARE Approach

We hope that you have found the CARE Approach stimulating and useful to your work as a healthcare professional. To develop a more empathic, person-centred way of interacting takes practice, and is both challenging and exciting. A journey of a thousand miles starts with a single step, so any small changes you make to your interactions with patients based on the CARE Approach may lead to surprisingly large benefits to them.

Remember that the CARE Approach is not a one-way street, and that the people we call patients are generally also trying their best to interact with us in a fruitful way. In healthcare encounters a win-win situation in terms of productive and effective human interactions is what everyone is striving for.

It may seem daunting in a busy NHS, and you may at times feel overwhelmed. You are a professional doing an important job, and you want to do it to the best of your abilities. However, you do need to stay within your professional boundaries and if you feel that you are out of your comfort zone you need to seek the support of your team members and your line manager. As discussed in this module, you also need to look after your own wellbeing, in the workplace and outside of work.

Thank you very much for taking the time to study and reflect on the CARE Approach. We wish you continuing success in your important work.

References

- Arnold E, Boggs K (2003) *Interpersonal Relationships: professional communication skills for nurses*, 4th ed., W.B. Saunders: Philadelphia
- Brown JB, Stewart MA, Ryan BL. *Assessing communication between patients and physicians: the measure of patient-centered communication (MPCC) working paper series*. Paper no. 95-2, 2nd ed. London, Ontario, Canada: Thames Valley Family Practice Research Unit and Centre for Studies in Family Medicine, 2001
- Cole SA, Bird J (2000) *The medical interview: The three-function approach*, 2nd ed., Mosby: Int.
- Consulting: *Communication skills for GPs in training*. 2005 [DVD] by Martyn Hull. RCGP Midland Faculty (DVD)
- Davis CM (2006) *Patient practitioner interaction: An experiential manual for developing the art of health care*, 4th ed. SLACK: Int.
- Gaun Yersel' - *The Self Management Strategy for Scotland* (2008) by LTCAS and the Scottish Government
<http://www.ltcas.org.uk/resources/library/search/Gaun+yersel/>
- Hawkins J.
<http://www.goodmedicine.org.uk/goodknowledge/wellbeing-time-management-self-determination>
- Irving JA, Dobkin PL, Park J Cultivating Mindfulness in health care professionals: A review of empirical studies of mindfulness-based stress reduction (MBSR) *Complementary Therapies in Clinical Practice* 2009; **15**:60-68
- Kabat-Zinn J (2004) *Full Catastrophe Living* (15th ed). Piatkus: London
- Little P, Everitt H, Williamson I, Warner G, Moore M, Gould C, Ferrier K, Payne S (2001) Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations. *BMJ*, **323**: 908-911
- McCabe C, Timmins F (2006) *Communication skills for nursing practice*, Palgrave MacMillan: London
- McCormack B, McCance T (2010) *Person-Centred Nursing: Theory and Practice*, Wiley-Blackwell: Oxford
- M^cKay M, Davis M, Fanning P (2009) *Messages: The communication skills book* (3rd), New Harbinger Publications Inc.: Oakland
- Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature (2000). *Soc Sc & Med*, **51**: 1087-1110
- Mercer SW, Reynolds WJ. Empathy and quality of care. *Br J Gen Pract* 2002; **52**: S9-S12
- Mercer SW, Maxwell M, Heaney D, Watt GCM (2004) The consultation and relational empathy (CARE) measure: development

and preliminary validation and reliability of an empathy-based consultation process measure. *Family Practice*, **21**(6): 699-705

- Mercer SW, Cawston PG, Bikker AP. Quality in general practice consultations; a qualitative study of the views of patients living in an area of high socio-economic deprivation in Scotland. *BMC Family Practice* 2007; **8**:22
- Neighbour R (1987) *The inner consultation*. Kluwer Academic Publishers: Int.
- Pearcey P. 'Caring? It's the little things we are not supposed to do anymore'. *International Journal of Nursing Practice* 2010; **16**: 51-56
- Platt FW, Gordon GH (1999) *Field guide to the difficult patient interview*, Lippincott Williams & Wilkins: Int.
- Reynolds W (2000) *The measurement and development of empathy in nursing*. Aldershot (UK): Ashgate Publishing Ltd.
- Rungapadiachy Dev M (2008) *Self awareness in health care*. Palgrave MacMillan: Int.
- Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR (2003) *Patient-centered medicine: transforming the clinical method*, 2nd ed. Radcliffe Medical Press: Oxon
- The Scottish Government. *The Healthcare Quality Strategy for NHSScotland*. 2010. Edinburgh, The Scottish Government.
www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf
- *Vocational Studies year 1: Handbook for tutors*. University of Glasgow, College of Medical, Veterinary and Life Sciences, General Practice and Primary Care

APPENDICES AND ADDITIONAL INFORMATION

APPENDIX 1 The CARE Measure

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Please rate the following statements about today's consultation Please tick one box for each statement and <u>answer every statement</u>						
	Poor	Fair	Good	Very good	Excellent	Does not apply
How was the doctor at...						
Making you feel at ease <i>Being friendly and warm towards you, treating you with respect; not cold or abrupt</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Letting you tell your "story" <i>Giving you time to fully describe your illness in your own words; not interrupting or diverting you</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Really listening <i>Paying close attention to what you were saying; not looking at the notes or computer as you were talking</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being interested in you as a whole person <i>Asking/knowing relevant details about your life, your situation; not treating you as "just a number"</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fully understanding your concerns <i>Communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Showing care and compassion <i>Seeming genuinely concerned, connecting with you on a human level; not being indifferent or "detached"</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being positive <i>Having a positive approach and a positive attitude; being honest but not negative about your problems</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explaining things clearly <i>Fully answering your questions, explaining clearly, giving adequate information; not being vague</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helping you to take control <i>Exploring with you what you can do to improve your health yourself; encouraging rather than "lecturing" you</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making a plan of action with you <i>Discussing the options, involving you in decisions as much as you want to be involved, not ignoring your views</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Information

The Consultation and Relational Empathy (CARE) Measure is a consultation process measure that has been developed by Dr Stewart Mercer and colleagues in the Departments of General Practice at Glasgow University and Edinburgh University. It is based on a broad definition of empathy in context of a therapeutic relationship within the consultation. The wording reflects a desire to produce a holistic, patient-centred measure that is meaningful to patients irrespective of their social class, and has been developed and applied in over 3,000 general practice consultations in areas of high and low deprivation in the west of Scotland.

The scoring system for each item is 'poor'=1, 'fair' = 2, 'good' = 3, 'very good' = 4, and 'excellent'= 5. All ten items are then added, giving a maximum possible score of 50, and a minimum of 10. Up to two 'Not Applicable' responses or missing values are allowable, and are replaced with the average score for the remaining items. Questionnaires with more than two missing values or 'Not Applicable' responses are removed from the analysis.

The theoretical background and validation of the CARE measure can be found in:

- Mercer SW, McConnachie A, Maxwell M, Heaney DH, and Watt GCM. Relevance and performance of the Consultation and Relational Empathy (CARE) Measure in general practice. *Family Practice* 2005, **22** (3), 328-334
- Mercer SW, Watt, GCM, Maxwell M, and Heaney DH. The development and preliminary validation of the Consultation and Relational Empathy (CARE) Measure: an empathy-based consultation process measure. *Family Practice* 2004, **21** (6), 699-705
- Mercer SW and Reynolds W J. Empathy and quality of care. *BJGP* 2002, **52** (Supplement); S9-S12.

The CARE measure can be used free of charge. The Intellectual Property rights rest with the Scottish Executive. The measure may not be used on a commercial basis without the consent of the author and the Chief Scientist Office of the Scottish Executive Health Department, on behalf of the Scottish Ministers. If you would like more information, please contact;

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For further information, and to download the measure please visit;

<http://www.gla.ac.uk/departments/generalpractice/caremeasure.htm>

APPENDIX 2 Person-centredness

Person-centredness is becoming a popular term. In healthcare literature and policy documents the term is often used interchangeably with patient-centred, client-centred or relationship-centred. Although there is no consensus on the definition of person-centredness, in general it is used to describe healthcare delivery that places the patient in terms of their human experience and respect for their values at its core. The focus is on the process of interaction and it is recognised that this process is influenced by the qualities and attitude of the health practitioner (McCormack & McCance 2010; Mead & Bower 2000).

In recent policy documents, such as the Self Management Strategy for Long Term Conditions in Scotland, the focus is on the needs of *people* and not *patients*. Although we support this word-use throughout the CARE Approach, we use person-centred when referring to the overall approach but use the term patient (instead of person, client or service-user) when it seems appropriate in the context of individual encounters.

APPENDIX 3 Background to film scenarios

PLEASE NOTE when the filming of the simulated encounters between the actor-patients and practitioners took place, only the actor-patients knew the scenarios. The practitioners were largely unaware of the kind of issues the actor-patients would address during the interaction.

Robert Farlane



Mr Farlane is a 49 year old plumber who seeks treatment for chronic right knee pain. He lives with his wife and two teenage children. His wife does not work and his fourteen year old son was born with cerebral palsy which mainly affects his physical capabilities. Mr Farlane is worried about the impact that this pain will have to work and support his family and care for his disabled son. In this encounter he talks with the physiotherapist.

Mrs McDonald



Mrs McDonald is a 65 year old woman who has noticed that her big toe nail is a bit discoloured. She is retired and lives with her husband in a first floor tenement flat. She has a history of Type 2 diabetes (for 20 years or so). Based on the stories she has heard from other people, she is worried that her toenail could lead to other more serious things like losing her leg. She discusses her issues with the podiatrist.

Rhona Leslie



Rhona is 38 and unmarried. She lives with her elderly mother and works as a cashier in a firm of accounts. She is a nervous person and recently this has been getting worse. She has now episodes of “palpitations” where her heart seems to beat very rapidly. Last week was the first time she passed out and this made her frightened. She came to the GP for advice.

Mrs Boyle



Mrs Boyle is a 47 year old woman who seeks treatment from the physiotherapist for chronic low back pain. The pain started many years ago for no apparent reason and has gradually worsened to the current levels. As a result she has been off work and put on weight. She lives her husband who has a demanding job. At times she feels she is not contributing to the home and she limits her social activities due to the fear that the pain will be aggravated. She is worried that something is seriously wrong and that nothing can be done to help.

Billy Anderson



Billy is dependent upon a variety of drugs that he obtains regularly from (unsuspecting) GPs. He does not consider himself an addict as he just needs these things to help him sleep and to control pain. Poor sleep has been a constant problem for him. He used to be a surveyor. He is divorced with two children who he is not in contact with. In the encounter he aims to persuade the doctor to issue drugs (Temazepam).

Mrs Dalrymple (1)



Mrs Dalrymple is an elderly woman who has multiple conditions. Upon the death of her sister Rosie, she helps looking after her sister's grandchildren as well as after her own. She lives with her husband who quite recently has been made redundant. Due to her circumstances she has not paid much attention to her health. She is worried about her feet. She has a good relationship with the GP who knows her relatively well through previous visits in the clinic.

Mrs Dalrymple (2)



Another visit by Mrs Dalrymple to the GP.

Mrs Jeanie Hall (initial visit)



Jeanie Hall has been a widow for about a year. She finds life difficult. She suffers from multiple conditions (including diabetes and heart problems). She no longer works and is socially becoming more and more isolated. The GP has asked her to come to the practice to discuss her circumstances. Mrs Hall was not sure what to expect of the visit.

Mrs Jeanie Hall (follow up visit)



Jeanie Hall returns to the clinic for her second visit to discuss with the GP how she got on after the initial visit within which they had made a plan of action. She is more at ease as she knows what to expect of the interaction. She feels that she has made progress and discusses openly her reunion with her daughter and a long lost friend.

APPENDIX 4 Background of the CARE Approach

The background of the CARE Approach relates to two developments. In May 2010, the Scottish Government published the *Healthcare Quality Strategy for NHS Scotland*. The strategy focuses on person-centredness and on communicating in an empathic manner. A core priority is to deliver “*caring and compassionate staff and services*” (page 1). The drive towards care that focuses on the patient’s needs, the relationship between the practitioner and the patient, is collaborative and holistic is not isolated to Scotland, but is consistent with policy developments at international level.

Moreover, in the Healthcare Quality Strategy for NHS Scotland the [Consultation and Relational Empathy \(CARE\) Measure](#) is recommended for use across the whole of the NHS in Scotland as one of the ways to obtain patient feedback regarding the provision of person-centred care. The CARE Measure was developed and validated by Professor Mercer and colleagues in the Universities of Glasgow and Edinburgh almost ten years ago and is now widely used in Scotland, the UK, and internationally. This patient-rated experience measure (PREM) assesses the quality of healthcare interaction in terms of the ‘human’ aspects of the encounter from the patients’ perspective. The measure can be used to give direct feedback to the practitioners on their strengths and weaknesses in terms of empathy as experienced by the patients (Mercer et al. 2004). The CARE Measure is also being used in General Practitioner appraisals, and in the assessment of GPs in training across the UK as part of the new MRCGP workplace-based assessment. Although initially developed and validated in general practice, the measure has also been validated in secondary care settings and is currently being used in nursing and allied health professions (AHPs) as well as in medical specialities. A major formal validation of the measure in nursing and AHPs in Scotland is being carried out by Stirling University and is near completion.

The CARE Approach manual is designed to translate the key aspects of this vision of person-centred, empathic encounters at policy level into a resource for practice. Additionally, the CARE Approach supports the use of the CARE Measure. The CARE Approach can be used in conjunction with the CARE Measure, but the approach can also be used as a stand-alone tool.

The development

The CARE Approach was developed by Professor Stewart Mercer, Professor Phil Cotton and their team at the University of Glasgow and in collaboration with the Scottish Government. The starting point of the development of the CARE Approach was the ten items of the CARE Measure. The manual makes the link between the ten items of the Measure and the four aspects of the Approach. Through researching a wide scope of health and communication literature, drawing on shared experience of teaching communication skills at undergraduate and postgraduate levels in multidisciplinary settings, discussing this approach with healthcare

practitioners and through meetings with the Scottish Government the manual is in its first edition.

What the CARE Approach is not

The CARE Approach is *not*

- a new theory (with definitions) of person-centredness. The CARE Approach acts more like an umbrella and provides a general understanding of the concept. An existing range of multidisciplinary of healthcare literature is incorporated in the manual.
- a method purely about clinical assessments. It goes beyond that and addresses the human (including the emotional) aspects that are part of the encounter.
- a tick box exercise that promotes a right / wrong way approach to care.
- a rigid model. Instead it is a general framework that recognises that each encounter is unique, dependent on the context and requires a flexible approach.
- a linear model that maps exactly onto the beginning, middle and ending stages of an encounter. The four components are an integrated cyclical process and each component can occur at any moment during the interaction.

APPENDIX 5 Transcripts of audio recordings from exercises

Self-management

“Self-management is really trying to get the patient to take some responsibility for managing their symptoms, especially with chronic conditions, where some people are looking for something external to fix them and sometimes that is just not possible. So, self-management is trying to encourage and empower the patient to find different tools and techniques, which work for them on a day-to-day basis, which will help them to manage their symptoms and their life better, so that they have a better and improved quality of life, whilst possibly having some help from external support, but that is not the long term answer. They have to find within themselves the different tools and techniques which work for them on a day-to-day basis, which will help improve their life”.

[Back to Exercise 5.2...](#)

Goal setting

“In relation to the clip, we mention medium to long term goal setting with the patient, specifying work as a goal. So that is something that we would sit down and we would agree. We would look at the short term goals again liaising with the SMART acronym and ensuring that everything was Specific, Measurable, Achievable, Realistic and Timely. Work on the short term goals initially, so that she can see that she is actually achieving something, which will boost the confidence, self-esteem and motivation to continue with following the goals. Potentially, after an assessment if the work was not an immediate achievable goal then discussing with the patient and hopefully agreeing that that potentially would be a medium to longer term goal. But focussing on the small, achievable ones initially to give them that inner strength and confidence and self esteem”.

[Back to Exercise 5.3...](#)

APPENDIX 6 Additional bibliography

In addition to the references referred to in the text, the following materials also influenced the development of the CARE Approach manual.

Books and articles

- Alexander MF, Fawcett JN, Runciman PJ (Eds.) (2006) *Nursing Practice: Hospital and Home: The Adult*, 3rd ed., Churchill Livingstone: Edinburgh
- Brooker C, Waugh A (2007) *Foundations of Nursing Practice: Fundamentals of Holistic Care*. Elsevier: London
- Bunt L, Harris M (2009) The Human Factor: How transforming healthcare to involve the public can save money and save lives (discussion paper). NESTA: London
<http://www.nesta.org.uk/library/documents/the-human-factor.pdf>
- Chant S, Jenkinson T, Randle J, Russell G, Webb C. Communication skills training in healthcare: a review of the literature. *Nurse Education Today* 2002; **22**:189-202
- Crane R (2009) *Mindfulness based Cognitive therapy*. Routledge
- Docherty C, McCallum J (2009) (Eds.) *Foundation Clinical Nursing Skills*. Oxford University Press: UK
- Firth-Cozens J, Cornwell J (2009) *The Point of Care: Enabling compassionate care in acute hospital settings*. The Kings Fund: London
- Goodrich J and Cornwell J (2008) *Seeing the Person in the Patient, the Point of Care* Review Paper. The Kings Fund: London
- Howie JGR, Heaney DJ, Maxwell M, Walker JJ, Freeman GK & Harbinder R. Quality at general practice consultations: cross sectional survey. *BMJ* 1999; **319**:738-743
- Hutchinson TA, Dobkin PL. Mindful medical practice: just another fad? *Canadian Family Physician* 2009; **55**(8):778-779
- Knobloch Coetzee S Kloppe H. Compassion fatigue within nursing practice- A concept analysis. *Nursing and Health Sciences* 2010; **12**:235-243
- Krasner M et al. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA* 23/30, 2009; **302**(12):1284-1293
- Lloyd M, Bor R (2004) *Communication skills for medicine*, 2nd ed., Harcourt: London
- McCabe C. Nurse-patient communication: an exploration of patients' experiences. *Journal of Clinical Nursing* 2004; **13**:41-49
- Morse JM, Bottorff J, Anderson G, O'Brien B, Solberg S. Beyond empathy: expanding expressions of caring. *Journal of Advanced Nursing* 2006; **53**(1):75-90

- Neuman M, Bensing J, Mercer S, Ernstmann N, Ommen O, Holger P. Analysing the “nature” and “specific effectiveness” of clinical empathy: A theoretical overview and contribution towards a theory-based research agenda. *Patient Education and Counseling* 2009; **74**(3):339-46
- Nuland, van M, Thijs G, Royen, van P, Noortgate, van den W, Goedhuys J. Vocational trainees' views and experiences regarding the learning and teaching of communication skills in general practice. *Patient Education and Counseling* 2010; **78**(1):65-71
- Perry B. Conveying compassion through attention to the essential ordinary. *Nursing older people* 2009; **21**(6):14-21
- Sanders P (2002) *First steps in counselling: A student's companion for basic introductory courses*, 3rd ed., PCCS Books: Ross-on-Wye
- Sanders P, Frankland A, Wilkins P (2009) *Next steps in counselling practice*, 2nd ed., PCCS: Ross-on-Wye
- Schreiner K (2009) *Medical assisting made incredibly easy: Therapeutic communications*. Lippincott Williams & Wilkins, Wolter Kluwer Health: Int.
- Silverman J, Kurtz S, Draper J (2005) *Skills for communicating with patients*, 2nd ed., Radcliffe Publishing
- Skelton J. 2008 *Language and clinical communication: this bright Babylon*. Radcliffe Medical Press
- Stewart M. Towards a global definition of patient centred care, *BMJ* 2001; 322:444-445
- Stilgoe J, Farook F (2008) *The talking cure: why conversations is the future of healthcare*. Demos: London
<http://www.demos.co.uk/files/Talking%20cure%20final-web.pdf?1240939425>
- Sully P, Dallas J (2005) *Essential Communication Skills for Nursing*. Elsevier Mosby: London
- Thomas KB. General practice consultations: is there any point in being positive? *BMJ* 1987; **294**:1200-1202
- Van der Cingel M. Compassion and professional care: exploring the domain. *Nursing Philosophy* 2009; **10**:124-136
- Walsh M (2002) (Ed.) *Watson's Clinical Nursing and Related Sciences*, 6th ed. Bailliere Tindall: Edinburgh
- Wright KB, Sparks L, H Dan O'Hair (2008) *Health communication in the 21st century*. Blackwell Publishing
- Perkins DD, Zimmerman MA. Empowerment Theory, Research and Application. *American Journal of Community Psychology* 1995; **23**(5):569-579

DVDs

- *Communicating with children in hospital*. An ask doctor Clarke

production for the RCPCH (2008)

- *Communication and human relationships in long term conditions.* By Medic Angels
- *Confident to ask: ready to respond.* By NHS Greater Glasgow and Clyde (Equalities in health)
- *Managing your medicines: Communication and safety of medicines.* By Self Management Programme, Long Term Conditions Unit. The Scottish Government
- *Walk the talk. Youth voices: Issues and solutions for health service.* By NHS Health Scotland (2009)

Frequently asked questions

Is it possible to use the CARE Approach when you feel under time-pressure?

Yes. The CARE Approach can be applied in situations where we feel under pressure. It is a guide on how to put person-centredness into practice regardless of the workload. The focus is on our 'attitude' and communication and how these can be incorporated into our lives and routinely used in practice without creating more work. Research conducted within primary care indicates that an empathic attitude of the practitioner (as perceived by patients) led to better outcomes and enablement, regardless of consultation length.

Is it difficult to learn the CARE Approach?

Developing skilful communication habits takes practice. Often we have developed a way of interacting on 'automatic pilot' with patients without questioning whether that is the best way or not. The CARE Approach manual is a supportive tool to review and reflect on the impact of your own communication skills. It is not about changing your personality, but about adopting your approach and responses in healthcare encounters in order to communicate in a person-centred manner. Therefore, as long as you are willing to be open to a way of approaching people that may or may not be familiar to you and (gradually) become aware of how you can put the approach into practice, you will be on the right track. Sometimes the CARE Approach may seem too difficult (or far fetched) to put into practice and in these cases we tend to go back to the ways we are used to in dealing with patients. This is a natural process. Learning to deal with patients in a person-centred way needs commitment and can be a continuous process.

Does this manual not just describe what we are already doing in practice?

Some of you may already be working in a way that is person-centred and the manual will just remind you of what you are doing. However, others may identify new insights and discover a different way of working that builds the tasks around the patient, rather than the other way around.

What about the patient side of the encounters?

It is important that communication in healthcare is a two-way process. Just as we are assessing and responding, so is the patient. That is why communication can be such a challenge! The CARE Approach provides a tool for you to feel better equipped to interact with your patients. It cannot predict the patients' reactions to the way you interact nor to the content of what you say. However, the manual describes

how to pay attention to patients' emotional cues and level of understanding and highlight the importance of checking with the patient what you are picking up from them.

Does the CARE Approach help me with patients who seem to want me to tell them exactly what to do?

Patients sometimes ask “what do you think I should do?” and say things like “you just tell me and I’ll do it”. The CARE Approach can help us to think about how we respond to these questions and statements. Creating time to explore why a patient feels like this can be fruitful. It will also be consistent with the CARE approach that we use with patients at other times. At times, we may need to give direct instructions to patients, and the ways in which we share these and agree on them are key elements of the CARE Approach.

Further reading

The following books are only a handful from the many useful books on the subject of communication, empathy and person centred-ness.

- Davis CM (2006) *Patient practitioner interaction: An experiential manual for developing the art of health care*, 4th ed. Slack
This is a very accessible book on self-awareness, human behaviour and skills for communicating effectively with patients. At the end of each chapter is a series of exercises.
- McCabe C, Timmins F (2006) *Communication skills for nursing practice*, Palgrave MacMillan: London
This is a good introductory book to communication from a patient-centred and therapeutic perspective. It includes information on different models of communication and exercises.
- McCormack B, McCance T (2010) *Person-Centred Nursing: Theory and Practice*, Wiley-Blackwell: Oxford
This book brings together a variety of resources on person-centredness and caring. It has a practical approach to developing ways of caring in a person-centred manner.
- McKay M, Davis M, Fanning P (2009) *Messages: The communication skills book* (3rd), New Harbinger Publications Inc.: Oakland
This book covers extensively different types of communication and includes exercises. Its techniques can be applied personally as well as professionally.
- Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR (2003) *Patient-centered medicine: transforming the clinical method*, 2nd ed. Radcliffe Medical Press: Oxon
This is a practical book introducing the patient-centred model of medicine. It is illustrated with real case examples. It has a section focussing on research on patient-centred care.

THE CARE APPROACH WORKSHEET

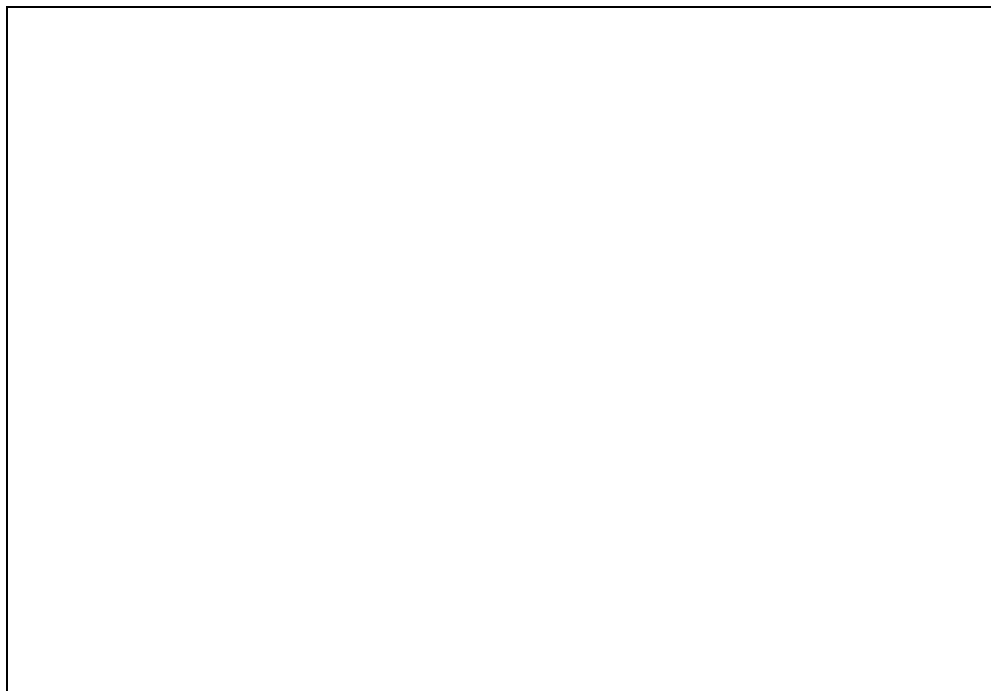
MODULE 1 What you bring to the encounter

Exercise 1.1

1. What is your response when you hear or read the word 'caring'? What thoughts come to mind? What feelings do you associate with the word?



2. What are the aspects of your job that make it possible for you to practice in ways that you consider to be caring?



Exercise 1.2

1. What features best characterise you when interacting with a patient e.g. tend to reassure, listen well, take control?

2. Consider the types of patient interactions you have. List situations when you are most likely to be patient-orientated and when are you most likely to be task- or disease orientated?

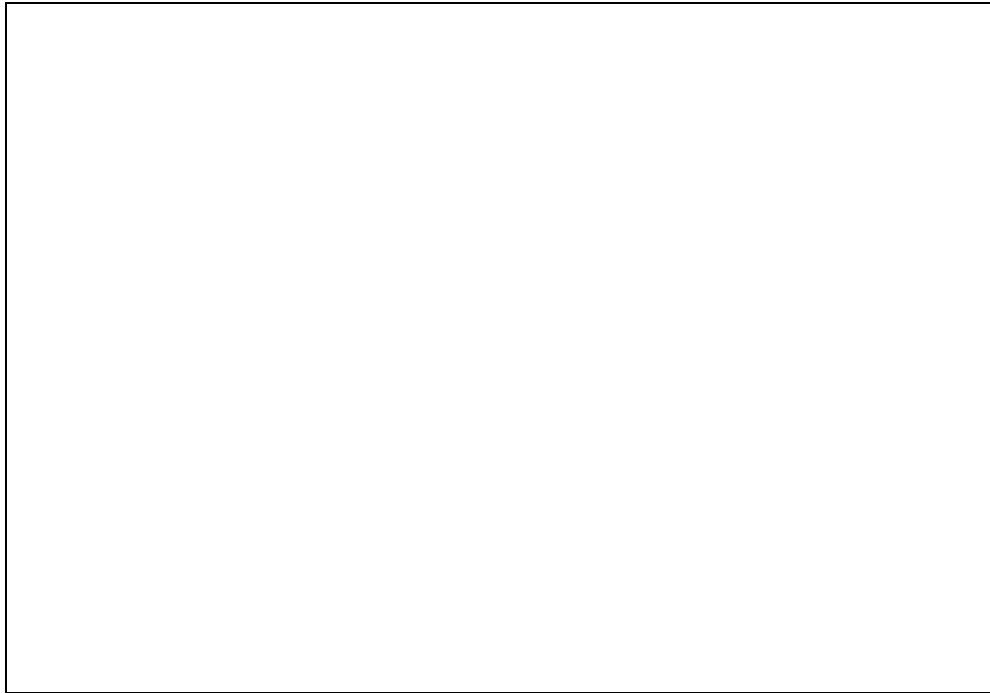
Patient-oriented

Task- or disease-oriented

3. For each of the situations you list above, describe whether you are aiming to meet your own needs or the patient's needs:

Exercise 1.3

1. Think of yourself as a patient. What qualities would the ideal doctor or nurse have? Record these in the box below.



2. In what ways are these qualities important?



Exercise 1.4

This exercise is called the respected figures exercise. In the first column please write down at least two and up to five people who you deeply respect for the way they have led their lives. You do not have to respect everything about them, but in one or more significant ways you admire how they have lived. These people could be living or dead, famous or not famous, known to you personally or simply heard about. Then in the second column, write down the qualities they have or had that you respected. What was it about them that you admired? Then look for qualities or clusters of qualities that stand out. They may stand out simply because you know inside that this quality is of great importance to you, or the quality may stand out because it is repeated – possibly with slightly different descriptions – for a number of the people who you respect. Write down up to three such qualities in the third column. If you're not being overly idealistic, these qualities are likely to represent *Root* values which are crucially important for you to try to live by.

Who do you deeply respect for the way they have led their life?	What are the qualities this person has that you particularly respect?	What are the three key qualities this person has that you particularly respect?
1.		
2.		
3.		
4.		
5.		

(Dr Hawkins: <http://www.goodmedicine.org.uk/goodknowledge/wellbeing-time-management-self-determination>)

Exercise 1.5

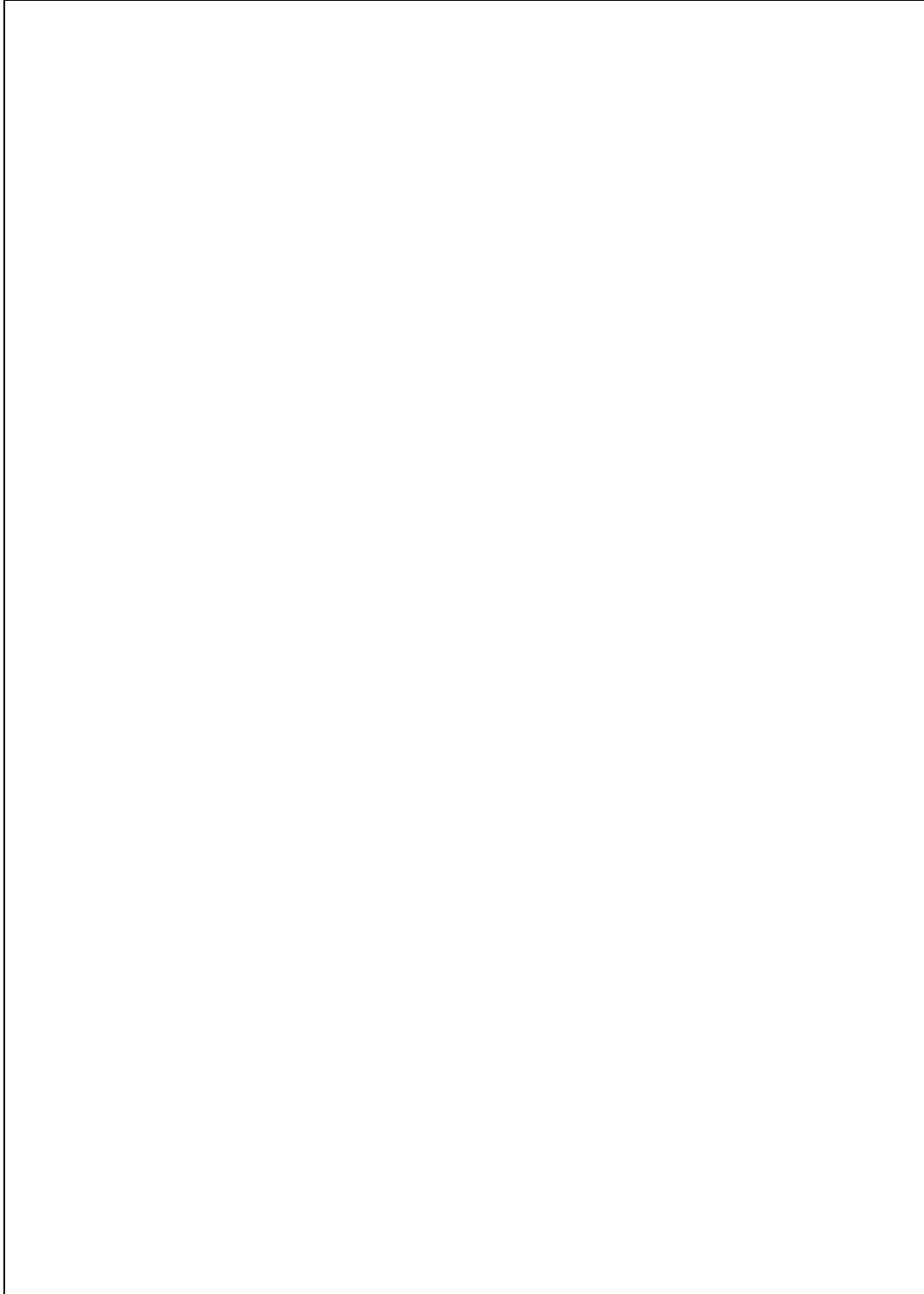
Consider the values you have identified in the respected figures exercise above. Do you live these values yourself? In what ways do you try to live these values in your personal and professional life? What are the things that help you bring these values into your everyday life? What are the things that prevent this from happening?

Make a list of your top 3 root values, and consider the above questions. Can you make any changes in your work or personal life that would allow you to live your values more fully?

MODULE 2 Connecting

Exercise 2.1

Watch the clips that show different approaches. In what ways do the healthcare practitioners create a good first impression with the patients?



Exercise 2.2

- How easy or difficult would it be for you to be accepting and not judge the following people? Tick the box that most closely reflects your viewpoint.

	Very easy	Easy	Difficult	Very difficult	Impossible
1. A mother who does not control her disruptive child whose behaviour prevents you from understanding the mother's story.					
2. A man who does not follow your advice and complains about the same issues over and over again.					
3. A patient who blames you for her troubles.					
4. A woman who refuses to take any responsibility for her health and wants you to tell her exactly what to do.					
5. A patient who demands your help in an aggressive manner.					
6. A patient who talks and talks, but not about his health.					
7. A woman who keeps taking over the conversation and does not listen to you.					

- Look at the ones you ticked as 'difficult', 'very difficult' or 'impossible'. What are some of the reasons for these answers?

- In what healthcare situations have you had to set aside personal biases, values and judgements?

Exercise 2.3

Read the following remarks made by patients who took part in a study on quality in general practice consultations in Glasgow (Mercer et al., 2007). Reflect on what you think the patients reacted to.

- (A) *“Some of them make you feel inadequate, you know you’re getting old and you’re getting senile and you’re not able to take things in, I mean sometimes you feel that way, you feel as if och I’ll just lift my bag and jacket and go.”*

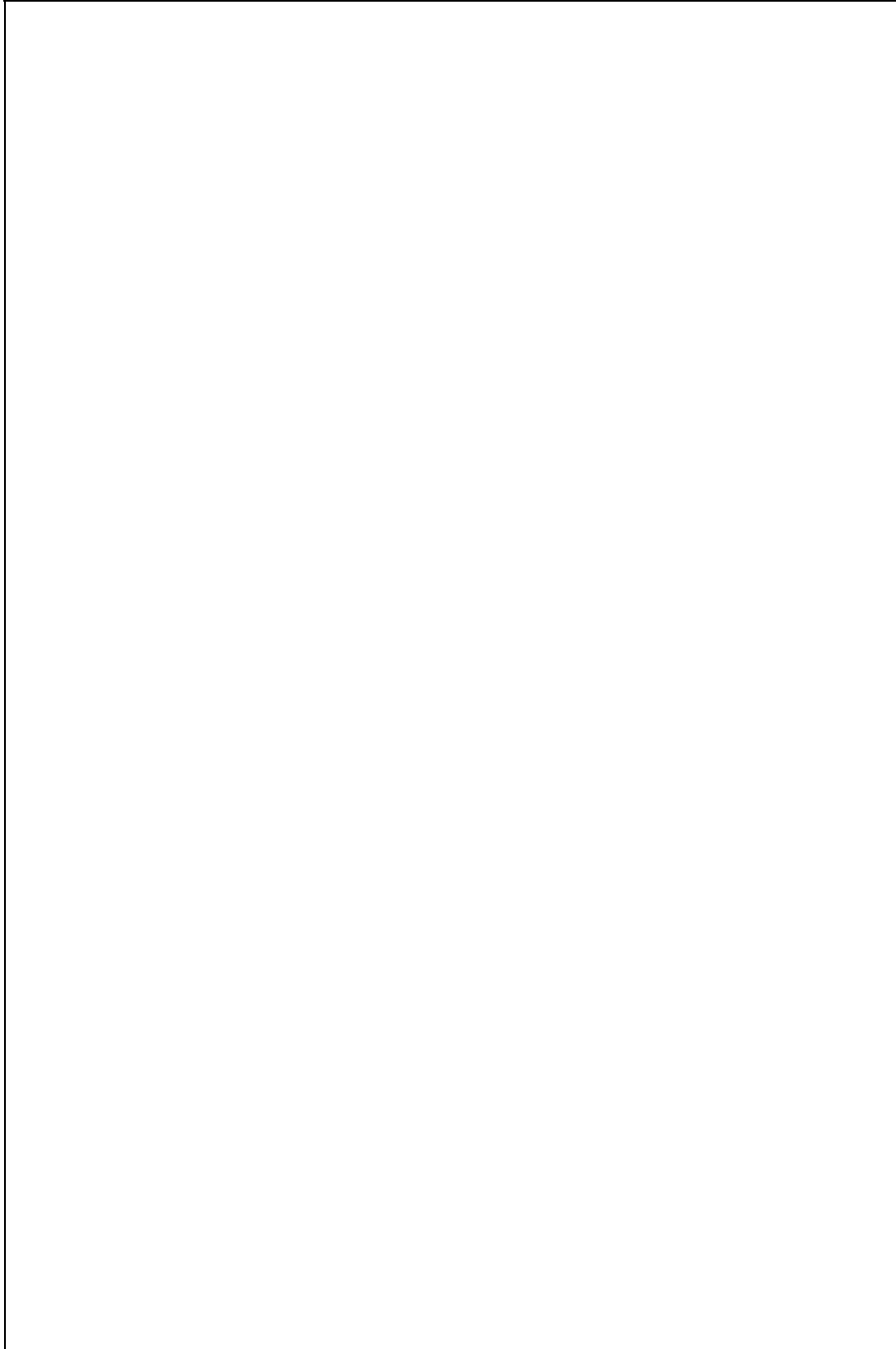
- (B) *“I’ve got Dr X and Dr Y and the two of them have got totally different attitudes when it comes to talking to you, Dr X will take the time and listen to you.”*

- (C) *“You feel as if you’re taking up his [the doctor’s] time...that makes you feel under pressure.”*

- (D) *“When I go to see my doctor, I want him to see me, the person, not a bottle of methadone, I’m not that, I’m a person that ’s got needs and everything like every body else, because I’m on methadone, I just don’t get treated properly.”*

Exercise 2.4

Watch the clips. These versions of the clips have the sound removed. In what ways are the practitioners' non-verbal approaches to the patients different?



Exercise 2.5

In what ways are the different aspects of connecting demonstrated in the clip? The four aspects are: establishing rapport, accepting the patient as a person, effective non-verbal communication, allowing the patients to tell their 'story'.

MODULE 3 Assessing

Exercise 3.1

Watch the clips and answer the following question.

In what ways do the health care practitioners show that they are attending/
listening?

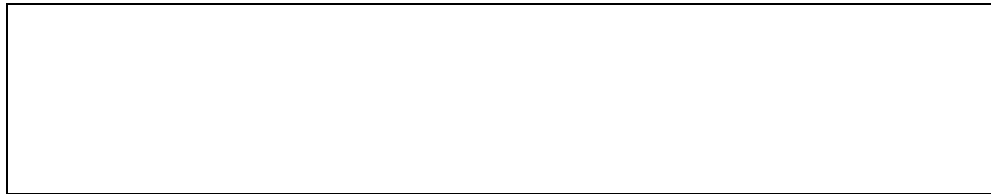
Exercise 3.2

Twelve common barriers to listening are outlined below (McKay, et al., 2009). In what ways and under what circumstances might these barriers interfere with your listening?

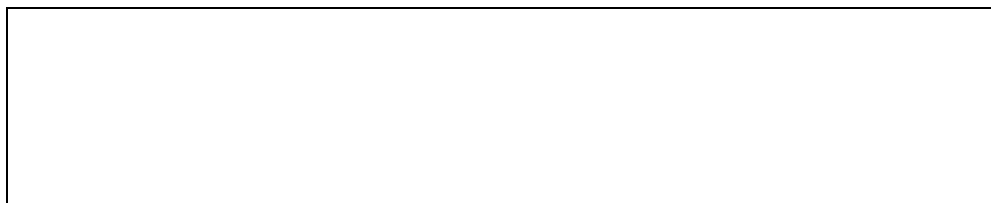
- *Comparing* – Comparing interferes with listening because you are constantly assessing which of you, for example, knows best. While a patient is talking, you are thinking “If you think that is hard, let me tell you how hard it actually can be.”

- *Mind-reading* – Mind-reading pushes you to look for hidden meanings rather than to listen to what is actually being said. You might not completely trust that the patient is being open or honest about what they really want, so you shift your focus to possible hidden meanings through changes in intonation or facial expressions.


- *Rehearsing* – Rehearsing means trying to look interested while you are planning and rehearsing your response.



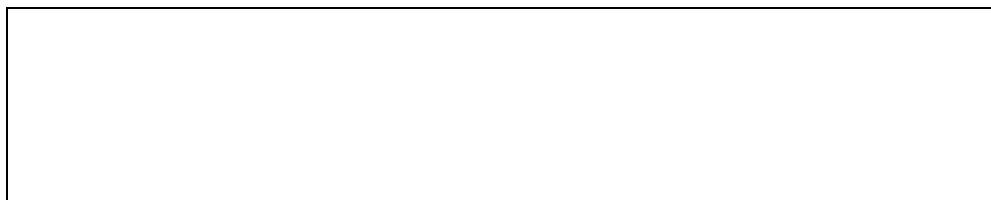
- *Filtering* – You listen to some things and not others often to avoid problems. For example, if you are afraid of confrontations then you will pay attention to what mood the patient is in. If you perceive no “angry” signs then you stop listening.



- *Judging* – Judging is often done so quickly that you often do not realise that you have done it. However, when you subconsciously label someone as being unintelligent or lazy, you tend to pay less attention to what they are saying.



- *Dreaming* – The patient’s words trigger your own associations and you go off in a day dream. When you continue to listen, the patient is talking about something else, leaving you with a gap in their story.



- *Identifying* - Whatever the other person says can trigger memories of similar experiences and before you know it, you have interrupted the other person's flow in order to tell your story or started to think about your own experiences. Meanwhile you stop paying attention to the other person's story.

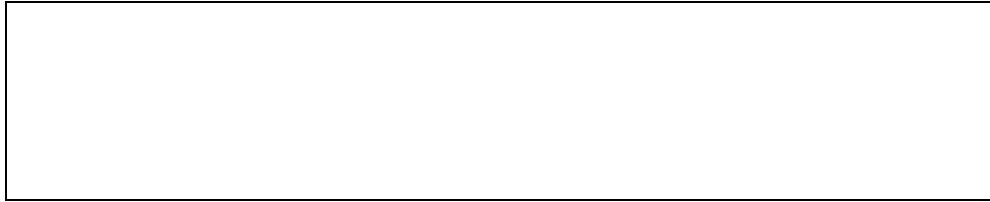
- *Advising* – You are keen to fix the patient's problems and are ready with advice, reassurance and suggestions after only hearing a few sentences. You like to start your reply with "If I were you, I would..." However, whilst searching for advice you could be missing what the real problem is.

- *Sparring* – Regardless what the other person says you start to look for issues to disagree and argue about. A common example is to make sarcastic comments to dismiss the patient's point of view (the so-called put-down).

- *Being right* – You will go to great lengths in order to try to prove that you are right, thereby using tactics such as making up excuses, talking over the other person in a loud voice or twisting the facts.

- *Derailing* - As soon as you feel out of your comfort zone or bored you change the topic of the conversation, make a joke or banter in order to prevent any further discomfort. Meanwhile you stopped paying attention to the other person's story.

- *Placating* – You want to please and be nice regardless of the situation. You use words like, “of course you are”, “absolutely”, “really”, and find yourself unwittingly agreeing with everything they say.



Exercise 3.3

Watch the clips that show a mixture of verbal and non-verbal cues made by the patients and answer the following questions.

1. What verbal and non-verbal cues do the patients give? What are the feelings that are revealed in the patients' voices or expressions?

2. Which cues do the practitioners pick up and which ones do they miss?

3. In what ways would you have dealt with the cue differently?

Exercise 3.4

The following clips are examples of different styles used by the same practitioner to obtain understanding of the 'whole' person. Watch the clips and observe how the health care practitioners demonstrate a holistic approach. Underneath is space to record your observations if you wish to do so.


Exercise 3.5

In what ways are the different aspects of assessing demonstrated in the clip? The four aspects are: attending, sensitivity to patients' cues, understanding the 'whole person', and asking questions.

MODULE 4 Responding

Exercise 4.1

1. Think about how you would communicate that you care and compassionately relate to a patient.



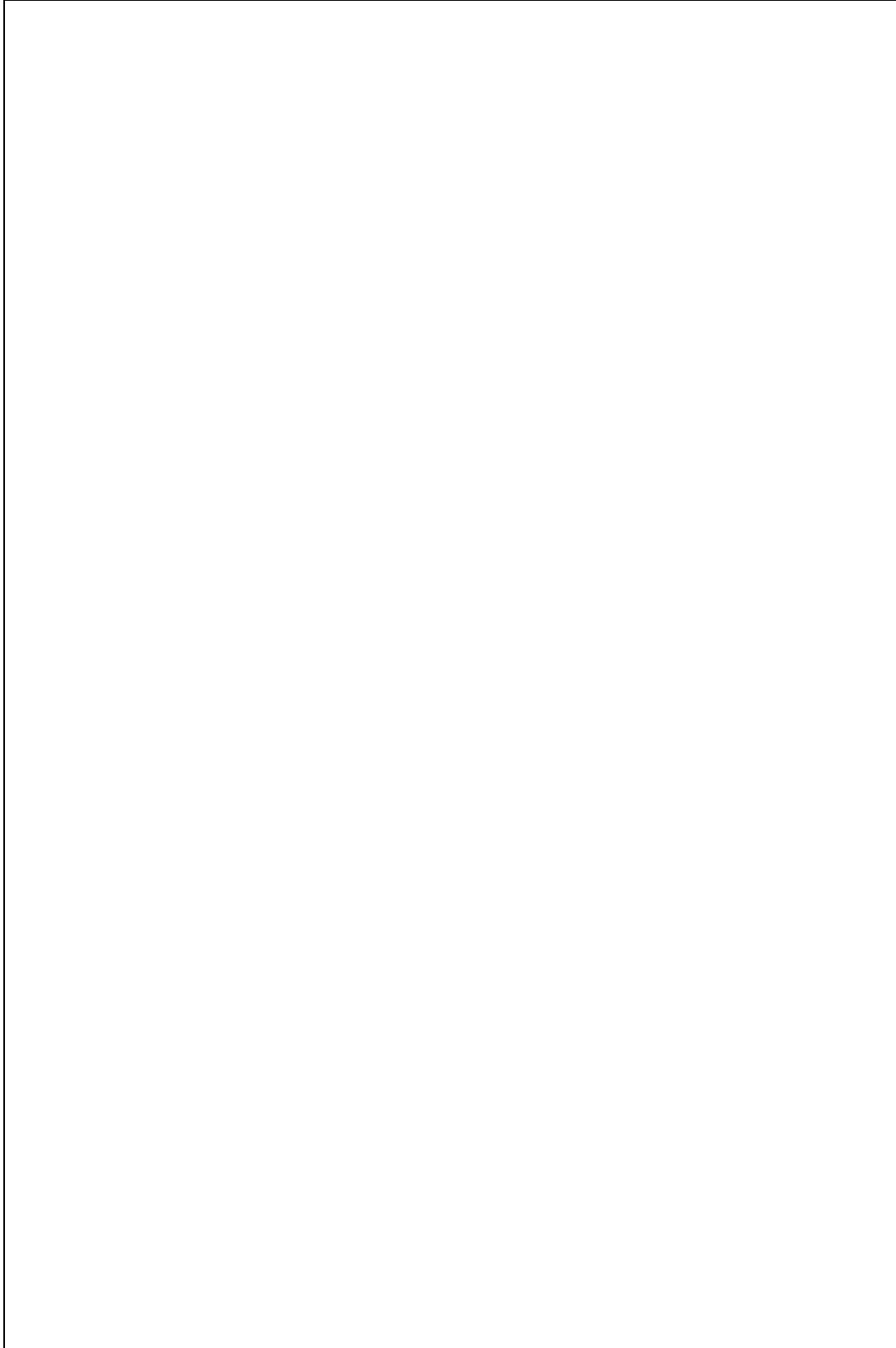
2. Watch the following clips. In what ways do the practitioners show care and compassion?



Exercise 4.2

Watch the following clips.

In what ways do the practitioners communicate that they are being positive?



Exercise 4.3

The following clips are two examples of giving information to the patient. Watch the clips and answer the following questions for each one.

1. In what ways are the practitioners' approaches to giving information and explanations different?

2. In what ways do the patients react differently in response to the practitioners' explanations?

Exercise 4.4

Can you think of different reasons why you might use medical jargon?

Exercise 4.5

In what ways are the different aspects of responding demonstrated in the clip? The four aspects are: demonstrating understanding, showing care and compassion, being positive, and giving relevant information and clear explanations.

MODULE 5 Empowering

Exercise 5.1

3. What does empowerment mean to you?



4. In what ways can you empower patients?



Exercise 5.2

1. What does self-management mean to you?

2. Listen to the recording in which a healthcare professional talks about self-management. How do your answers relate to the practitioner's view? In [Appendix 4](#), you can read the transcript of the recording on self-management.

Exercise 5.3

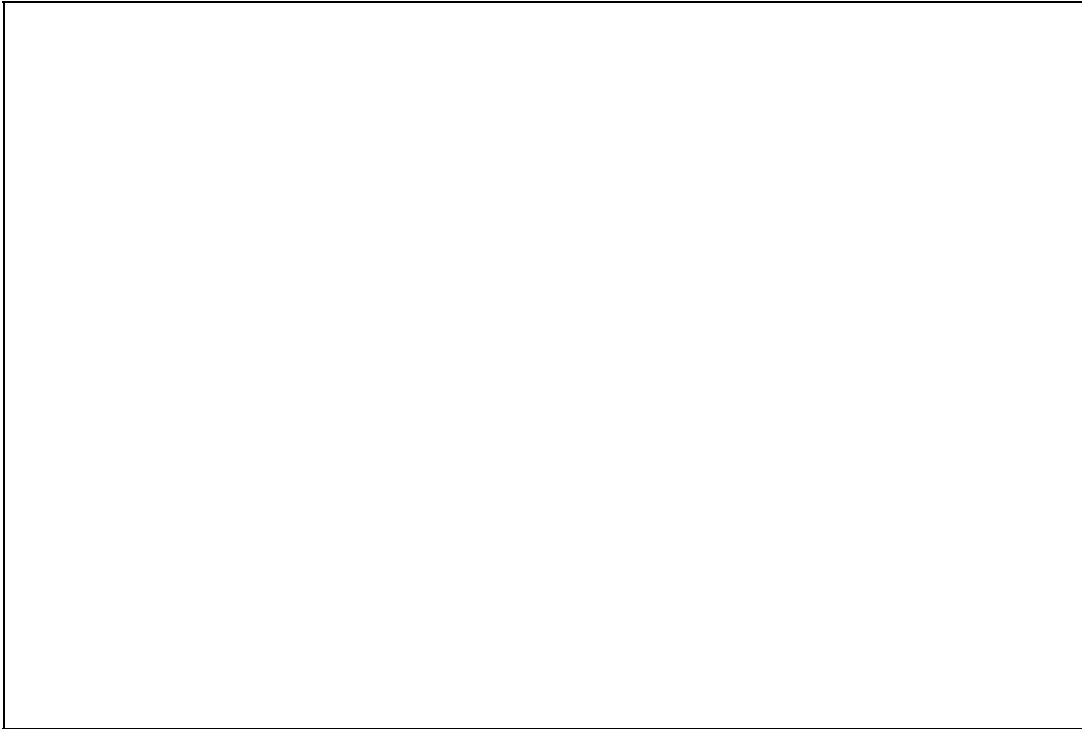
The clips show different styles regarding exploring with the patients what they can do to improve their situation, identifying choices that are realistic for the patients and actively seeking their preferences. In what ways do the practitioners differ in their approaches?

Exercise 5.4

In what ways do the healthcare practitioners foster the patients' beliefs in their own capabilities and competences?

Exercise 5.5

In what ways are the different aspects of empowering demonstrated in the clip? The four aspects are: appreciating the bigger picture, helping patients to gain control, action planning and confirming understanding, and confidence-building.

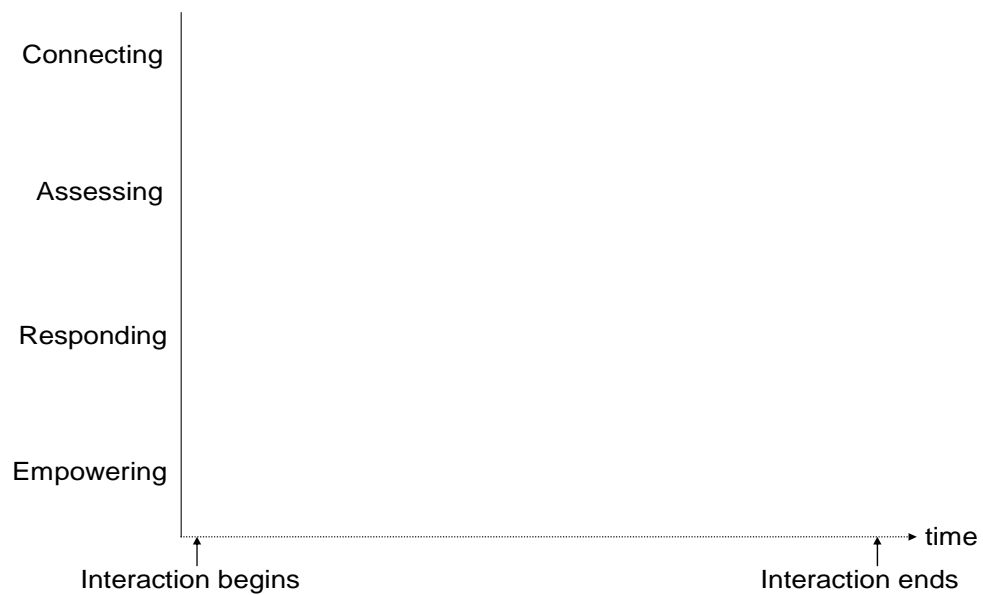


MODULE 6 Putting it all together

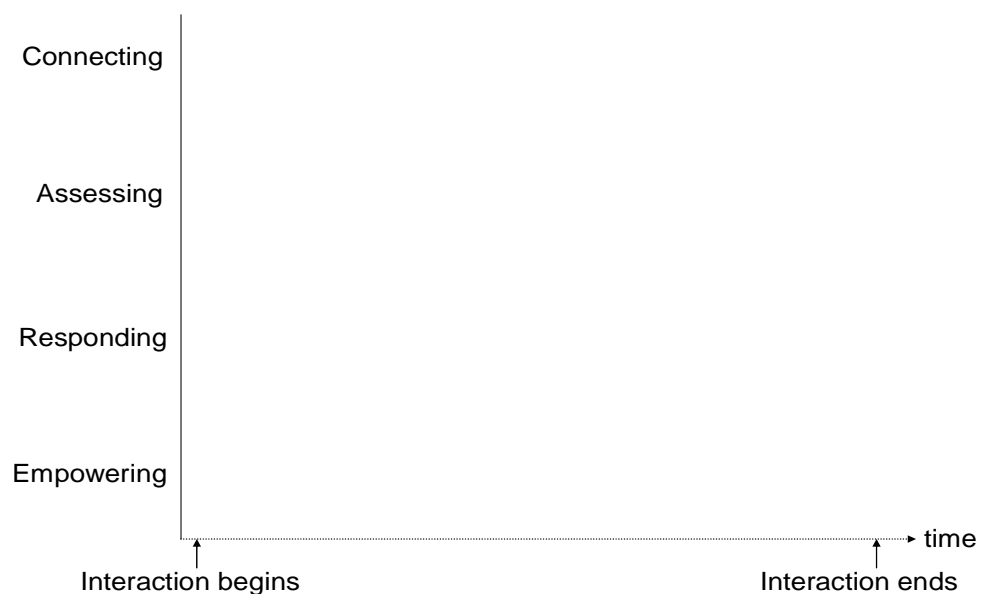
Exercise 6.1

1. Write down what components of the CARE Approach you think are happening when over the course of the encounter. You can use the blank graph below to 'map' this out by placing a cross against the component you think is going on as the interaction moves along the time scale.

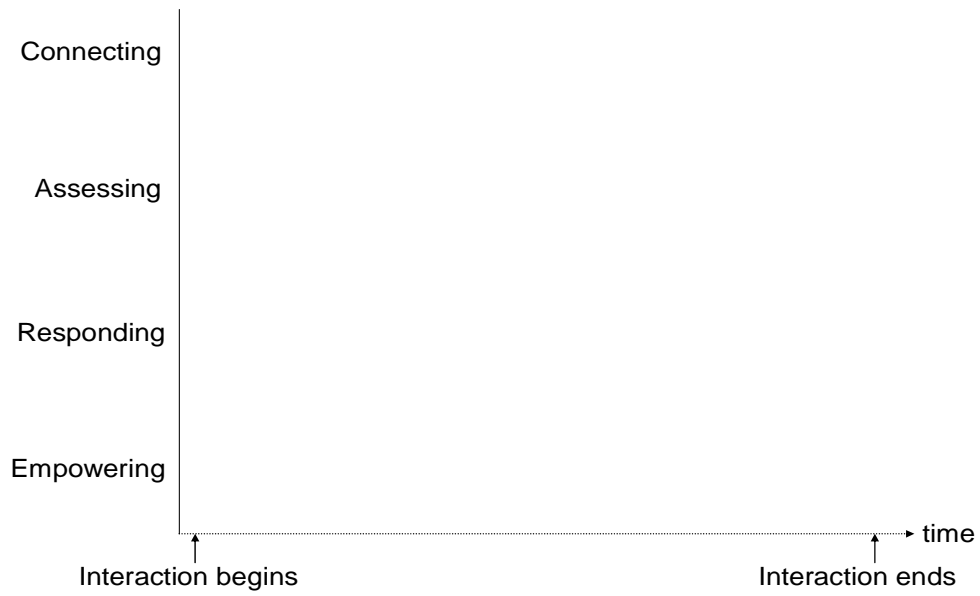
Clip1



Clip 2



Clip 3



2. In what ways are the different components of the CARE Approach demonstrated in each clip?

Exercise 6.2

Watch the clips and answer the following question. In what ways can the CARE Approach be applied to the way the patient is interacting with the healthcare professionals?

POSSIBLE ANSWERS

MODULE 1 What you bring to the encounter

Exercise 1.1

Possible answers

Looking after someone, providing a service, showing respect, a way of relating to someone, a feeling, being emotionally involved.

In a recently published study (Pearcey, 2010) on people's views on caring a group of nurses gave the following replies:

- *"I think caring is about the way you are to people and the way you feel about people."*
- *"Caring is actually bothering to find out more about people and their problems – it's the bit that can make a difference."*
- *"Caring? It is the little things that we are not supposed to do any more."*

[Back to Exercise 1.1...](#)

Exercise 1.3

1. Possible answers

You may have thought of things like: make time for me; focus on me; be respectful; being technically very competent; act in a way that shows I am in the right hands, being present and available to me; be interested in me as a person; not judge me; be sympathetic; friendly and approachable; empathic; trustworthy;; intuitive or explain how they can help me.

2. Possible answers

If they know and understand me they are more likely to get my management right; wanting the best technical care possible; common courtesy; respect, signal that we see them as a person in their own right and not simply as another patient.

[Back to Exercise 1.3...](#)

MODULE 2 Connecting

Exercise 2.1

Possible answers

NON-VERBALLY All practitioners are focussed on the patient and are not doing anything else that could indicate that they are distracted. They are facing the patient, lean slightly forward and maintain good eye contact. This creates the impression of openness and being interested.

VERBALLY In clip 1 the practitioner introduces herself by name and role and does not assume that the patient knows who she is. She checks how patient would like to be addressed and offers to be called by first name as well. This may add a personal touch that can help to connect and put the patient at ease.

In clip 2 the practitioner welcomes the patient by name and asks how she is. She responds in a friendly manner to the remark about the weather.

In clip 3 the practitioner thanks the patient for coming to the clinic. He addresses the patient by her first name and introduces himself as Dr Cotton.

[Back to Exercise 2.1...](#)

Exercise 2.3

Possible answers

- A. *this remark relates to feelings of not feeling supported or involved in the encounter, because the GP does not take on board the patient's level of understanding*
- B. *this is a remark on how being approached differently in terms of being given time and feeling listened to can make a difference.*
- C. *this is a reaction to the GP's rushed attitude and how that relates to feelings of pressure.*
- D. *this response relates to the perception of being judged by the GP and to feeling disrespected as a result.*

[Back to Exercise 2.3...](#)

Exercise 2.4

Possible answers

In clip 1 the practitioner is orientated towards and looks at the patient. She makes supportive gesticulations, nods to encourage the patient to talk and seems generally calm and relaxed. The patient is clearly in distress and the practitioner comes across as approachable.

In clip 2 the practitioner (GP) is slightly orientated towards the desk at the start. He shakes hands with the patients. He is focused on the patient. At the end of the clip he has his hand over his mouth and later on folds his arm. This change in body language could create a distance between him and the patient..

[Back to Exercise 2.4...](#)

Exercise 2.5

Possible answers

Establishing rapport: The practitioner thanks the patient for coming along. She introduces herself by name and role and does not assume that the patient knows who she is (and thereby prevents that the patient may feel uncomfortable). She clarifies with the patient how she would like to be addressed and offers to be called by her first name as well. This may add a personal touch that can help to connect and put the patient at ease. Her approach seems engaging and a good start for building rapport and trust.

Accepting the patient as a person: She comes across as approachable and gives the impression that she is genuinely interested in the patient.

Effective non-verbal communication: Her body language of facing the patient, maintaining good eye contact and leaning towards the patient signals that her focus is on the patient. She has a relaxed and friendly manner and her voice matches the verbal content.

Allowing the patient to tell her 'story': She lets the patient tell her story without interrupting her and she shows signs of encouragement through her non-verbal communication (like nodding)..

[Back to Exercise 2.5...](#)

MODULE 3 Assessing

Exercise 3.1

Possible answers

In clip 1 the practitioner shows that he pays attention to the patient through his eye contact, the way in which he sits in his chair and by leaning forward. He does not rush the patient. Instead he gives the impression that the time is hers. He has an open and interested or non-judgemental expression on his face. He nods to encourage her to continue talking. He does not interrupt her, allows for silence and does not seem to feel the need to fill it. It looks like he pays close attention to her words as well as to her body language. His facial expressions match the content of her story.

In clip 2 the practitioner conveys that she is listening and paying attention by maintaining good eye contact. She nods to encourage the patient to keep talking and does not interrupt the patient. Her facial expressions match the content of the patient's story..

[Back to Exercise 3.1...](#)

Exercise 3.3

1. Possible answers

In clip 1 the patient's facial expressions show that she is worried. Although she was told that everything was fine [with her toe] in the past, she is not convinced this is the case.

In clip 2 the patient looks down, her speech is broken, and she speaks quietly. She gives the impression that she is down and in a low mood.

In clip 3 the patient looks and verbalises that she is anxious and worried. Her facial expressions show that she is in distress.

2. Possible answers

In clip 1 the practitioner appears to miss the patient's cue of being anxious about her toe and changes the topic.

In clip 2 the practitioner picks up on the patient's cue and asks her about her thoughts and feelings. Through this question the patient is encouraged to open up about her experiences. By picking up on the cue the patient can feel that the practitioner is genuinely interested and wanting to understand her story.

In clip 3 the practitioner does not address the patient's low mood or explore what the patient is anxious about. Instead she appears to change the topic of the conversation to investigations and to an activity that the patient would like to be able to do again.

[Back to Exercise 3.3...](#)

Exercise 3.4

Possible answers

In clip 1 the practitioner places the sleeping problem in a wider context.

In clip 2 the practitioner explores the home situation of the patient.

In clip 3 the practitioner picks up that the patient looks tired. This leads the conversation to explore various aspects of the patient's life that contribute to the patient feeling exhausted. It is clear that the practitioner knows this patient quite well.

[Back to Exercise 3.4...](#)

Exercise 3.5

Possible answers

Attending: *The practitioner faces the patient, leans slightly forward, had good eye contact and is not doing anything else other than focussing on the patient.*

Sensitivity to patients' cues: *The patient is clearly in distress. The practitioner acknowledges the patient's feelings through an understanding attitude and allowing for silence.*

Understanding the 'whole person' and Asking questions: *In this clip the practitioner explores whether she has anyone to talk to and he asks about the patient's daughter..*

[Back to Exercise 3.5...](#)

MODULE 4 Responding

Exercise 4.1

1. Possible answers

You may have thought of things like: a sympathetic look, a touch or a silence, providing supportive responses in tune with the patient's state of mind.

2. Possible answers

In clip 1 the practitioner makes empathic comments and normalises her experiences of grief.

In clip 2 the practitioner makes reflective comments and validates the patient's experiences.

[Back to Exercise 4.1...](#)

Exercise 4.2

Possible answers

In clip 1 the practitioner summarises his understanding of the patient's story and feeds that back to her. Then he gives it a positive turn and talks about the possibility to change the situation. He uses words like "working together" and "reversing things in the right direction." His gestures and voice inflection matches his verbal communication.

In clip 2 the practitioner is honest with the patient and offers alternatives to improve her situation.

[Back to Exercise 4.2...](#)

Exercise 4.3

1. Possible answers

In clip 1 the practitioner tailors his response carefully to the patient's level of understanding. His speech is precise and measured. He uses his non-verbal behaviour to engage with the patient.

In clip 2 the practitioner gives a detailed explanation about the patient's problem.

2. Possible answers

In clip 1 the facial expressions of the patient and responses given by her indicate that she feels involved in the interaction. This enhances the process of connecting.

In clip 2 it is not possible to tell how much the patient feels involved in the interaction.

[Back to Exercise 4.3...](#)

Exercise 4.4

Possible answers

Familiarity with jargon; not knowing other words; feeling intimidated by certain patients; being certain that patients know what you mean or being unaware that patients may not know the meaning; to validate yourself; lack of confidence or trying to impress; preventing patients to get involved in order to save time; and trying to hide that you do not know the answer to a patient's question.

[Back to Exercise 4.4...](#)

Exercise 4.5

Possible answers

Demonstrating understanding: *the practitioner puts the patient's experiences of tiredness in the wider context of her life.*

Showing care and compassion: *he gives supportive non-verbal responses in tune with the patient's state of mind.*

Giving relevant information and clear explanations: *he explains about the interaction of the tablets*

[Back to Exercise 4.5...](#)

MODULE 5 Empowering

Exercise 5.1

1. Possible answers

Gaining control or mastery of something, being actively involved, enhanced self-esteem, respect, enabling, to validate, making things possible, giving someone hope,, feeling better, more able to cope, increased confidence or independence.

2. Possible answers

Listening, giving tailored advice, enabling, helping people move on, making people feel better about themselves.

[Back to Exercise 5.1...](#)

Exercise 5.3

Possible answers

In clip 1 the patient says that she would like to go out more. The practitioner picks up on this asks the patient whether she has any ideas regarding improving her situation.

In clip 2 the practitioner explains how she can facilitate the process of the patient's self-management through goal setting.

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Exercise 5.4

Possible answers

In clip 1 he reinforces the need to lose weight and is positive and congratulatory.

In clip 2 the practitioner points out that the patient 'knows' and is doing well.

In clip 3 he congratulates the patient and points out the need to take time.

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Exercise 5.5

Possible answers

Appreciating people's lives: *He talks about the work situation and how that impacts on her life.*

Helping patients to gain control: *He has a positive attitude and they agree together to do something about her situation..*

Action planning and confirming understanding: *In a calm and clear manner he talks about next steps. He also checks if she would like to talk about anything else.*

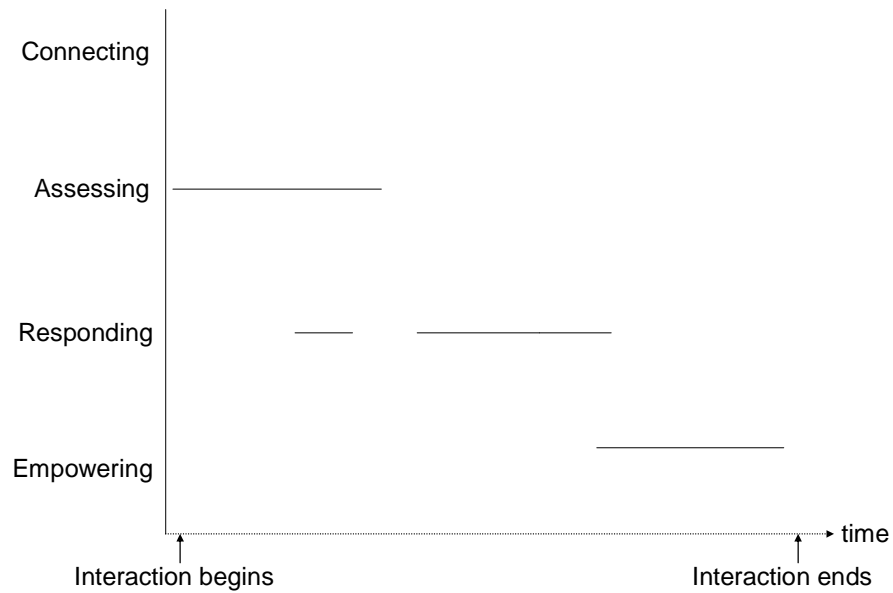
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MODULE 6 Putting it all together

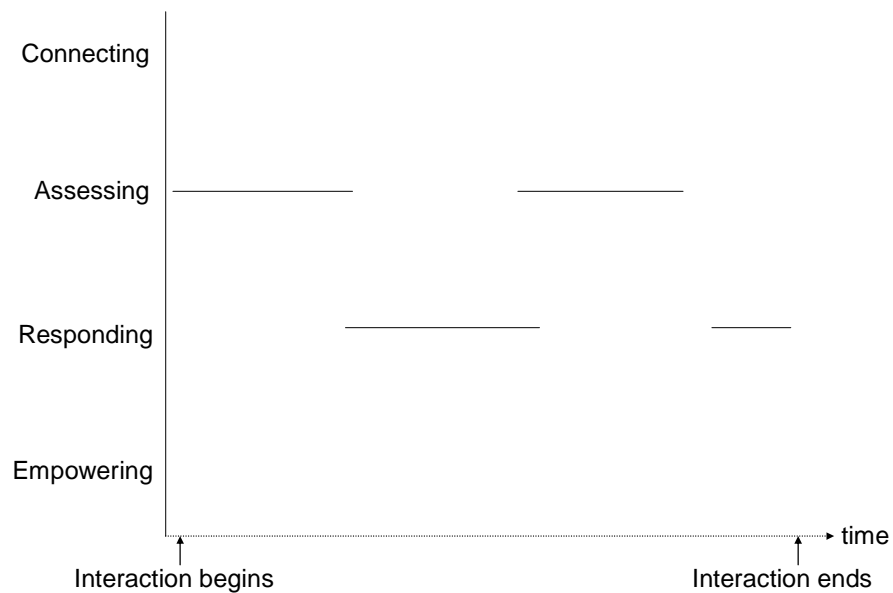
Exercise 6.1

1. Possible answers

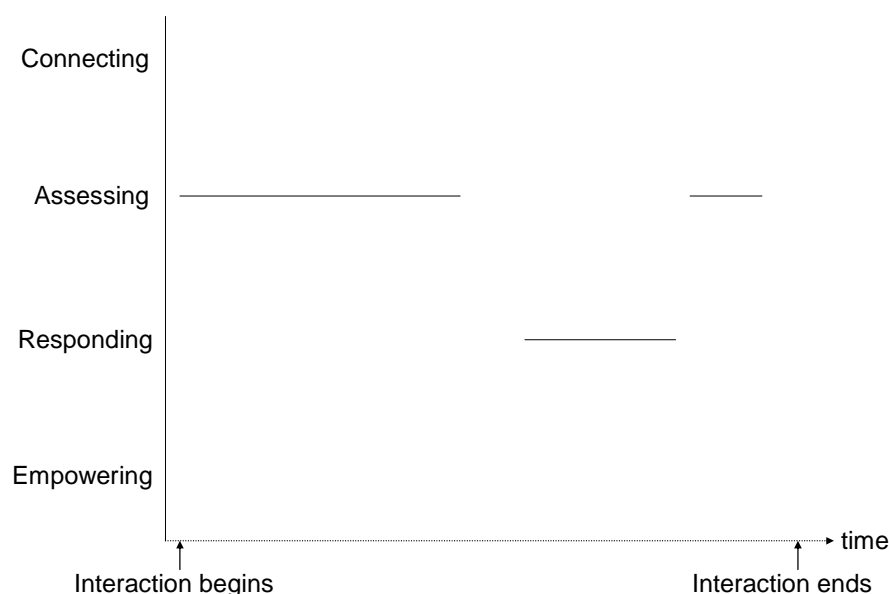
Clip 1



Clip 2



Clip 3



2. Possible answers

In clip 1 the practitioner starts with assessing, he is attending and he asks the patient about her sister (understanding the 'whole person'). He is responding, takes into account the patient's circumstances and is being positive. At the end of the encounter he is empowering and is moving towards action planning. Throughout the interaction connecting seems to be going on. The practitioner's non-verbal communication matches the flow of the interaction and he approaches the patient in an accepting and non-intimidating manner.

Clip 2 starts with assessing and then moves in and out of responding when the practitioner feeds back her understanding of the story. Also she shows her involvement by reflecting back that she can see that it means a lot to the patient to go swimming with his son. Connecting seems part of the interaction. The practitioner has a friendly manner and allows the patient to tell his story.

In clip 3 the practitioner is mainly assessing. He listens and encourages the patient to tell his story (connecting). In a non-intrusive manner he asks whether the patient has received tablets from his friends (understanding the 'whole person'). Then he moves into responding by briefly demonstrating his understanding of the story. At the end he continues with assessing by asking a question. The practitioner seems accepting of the patient (connecting) throughout the encounter.

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Exercise 6.2

Possible answers

Clip 1

Connecting: *the patient focuses on the practitioner and moves slightly forward, he has a friendly manner, greets and asks her how she is doing.*

Assessing: *he looks at the physiotherapist and gives the impression that he concentrates on what she says.*

Clip 2

Connecting/Assessing: *the patient focuses on the practitioner when he speaks, her facial expressions and verbal utterances show that she is listening and in agreement with what the practitioner communicates.*

Responding: *she seems very open and genuine in her response.*

Clip 3

Responding: *the patient gives the impression that she is open and genuine in her response. There seems to be good rapport with the practitioner.*

[Back to Exercise 6.2...](#)

Exercise 6.3

Possible answers

The practitioner reflects back to the patient his understanding of what is happening in their interaction. He acknowledges both viewpoints in a non-judgemental and non-intimidating manner.

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