The telephone interview

The telephone interview is now becoming a common mode of doctor–patient communication. Triaging, managing minor or administrative problems and follow-up for both acute and chronic conditions can all be effectively achieved

on the telephone (Pinnock *et al.* 2003). The review by Car and Sheikh (2003) of telephone consultations has shown that the level of patient satisfaction with this mode of consulting is high. Patients value speed and improvement of access, reduced travel time and costs, as well as the possibility of increased frequency of contact. However, there has been little study of the skills needed to consult effectively on the telephone, or of the training that doctors need to enable them to use this medium with skill and confidence, which is vital if quality and safety are to be ensured (Toon 2002).

Although the core skills for communication with patients pertain to consulting on the telephone, there are some important differences, and here again some skills need to be used with greater depth and accuracy, particularly if the patient lacks confidence on the telephone.

Understanding can be compromised because visual non-verbal cues that are normally important for sending and interpreting messages are unavailable to both physician and patient. In emergency work, it is common for someone else to telephone on behalf of an ill or elderly patient, so that communication may have to be conducted through a third party. Careful active listening, frequent checking for understanding and an interested response are paramount if the telephone interview is to be effective. Encouraging the patient to speak requires the use of verbal rather than non-verbal facilitation: '*mm . . . mm . . . , aha . . . yep . . .*', or the clearer '*I see . . . go on . . . tell me a bit more . . . yes . . . yes . . .*'. Discovering the patient's concerns, ideas and hopes for the consultation is vital. If patients are ill at ease with telephone consultations, this is often due to previous experience of difficulties with telephone communication, which have not always been in a medical context (Hopton *et al.* 1996). Overtly picking up the patient's cues enables the doctor to enter this arena in an efficient and empathic manner. '*It sounds as if you are very concerned . . . I can hear from your voice that you are anxious about . . .*'. Sometimes a careful challenge needs to be made: '*You don't sound satisfied with what I've just said*'. Hearing-impaired individuals may find telephone interactions difficult.

Paradoxically, consultations on the telephone may be no shorter than face-to-face consultations because of the necessity for clarifying beyond doubt both the disease and illness content of the interview. It is easy to cut corners and fail to clarify specific parts of the patient's story and miss an important diagnosis. Asking what the patient can see or feel ('*What does the rash look like?*' or '*How alert is your baby?*') may allow the clinician to manage the problem safely without seeing the patient. Information giving needs to be clear and simple, with chunking and checking throughout. Repetition and summarising the management plan more than once are useful. Asking the patient to reiterate important details back to the doctor is a particularly useful form of repetition here. Offering options often enables the patient and the doctor to move towards mutually understood common ground (*see* Chapter 6), and allows negotiation to proceed more smoothly. Closing the consultation will be difficult if the patient feels that their needs have not been met, especially if follow-up plans are unclear or the patient has not agreed to the doctor's suggestions. Accurate recording of the interview is crucial.

Out-of-hours consultations in primary care practice where the doctor does not know the patient may present special problems. A qualitative study by Males (1998) of UK family doctors' experiences of giving telephone advice is helpful here.

Key skills of the Calgary–Cambridge Guides which need to be applied with greater depth, intention and intensity

Skills from the Calgary–Cambridge Guides	Applying these skills with greater depth, intention and intensity
Initiation	
Preparation	Answer the telephone or return calls promptly. When you are initiating the call, check that you have all of the relevant information in front of you before you pick up the telephone.
Make introductions	Check that you are talking to the correct patient – you may not recognise the patient's voice, even if you know him or her well.
Develop rapport	Use tone of voice and supporting statements early in order to develop rapport.
Gathering information	
Listen actively	Give verbal encouragement to continue, rather than listening in silence.
Gauge the patient's emotional state	Pick up cues and respond clearly and verbally to them.
Clarify	Carefully clarify the clinical story, using appropriate direct questions.
Discover the patient's framework	Clarify that the patient's ideas, concerns and expectations have been obtained before proceeding to explanation and planning.
Building the relationship	
Demonstrate empathy, acceptance and sensitivity Provide support	These need to be demonstrated verbally and repeatedly.
Structuring the interview	
Use internal summary Signpost	Use these two skills in tandem more frequently when you cannot see the patient in order to clarify transitions between open and closed questions, the disease and illness frameworks and explanation and planning.
Explanation and planning	
Chunk and check	Check understanding and agreement verbally rather than by using a nod of the head, for example.
Use clear language that is free from jargon, and moderate pace	This is particularly important if the telephone connection is of poor quality. Giving some ideas about the prognosis is particularly helpful early in an illness, especially if the doctor and the patient have decided that a face-to-face consultation is not necessary.
Offer options	Do this before trying to agree a management plan.

Continued

Skills from the Calgary–Cambridge Guides	Applying these skills with greater depth, intention and intensity
Negotiate a management plan	Check that the management plan is acceptable. This is more likely to reassure the patient who has agreed that they do not need to see a doctor on this occasion. Encourage the patient to repeat the advice that you have given. Ask whether there are any outstanding questions or concerns.
Closing	
Summarise and check Safety net	These three skills need particular attention on the telephone, in order to be clinically safe and to maintain rapport and the patient's confidence.

Hidden depression and psychosis

Interviewing patients with mental illness demonstrates the importance of the core skills of gathering information (especially of taking an accurate clinical history) and building the relationship.

Uncovering hidden depression and assessing suicidal risk

Depression is a frequently occurring psychiatric disorder that is easily missed in medical practice. Accurate diagnosis depends on the skill of the doctor. Here the process skills need to be highlighted, not only to help the patient to tell their story more easily and discover their perspective, but also in order to elicit the all-important content of this specific psychiatric interview, namely how depressed the patient is and whether they are suicidal or not.

The psychiatric interview differs from all other medical interviews in that the mental health examination is an integral part of the interviewing process – the interview is the 'history' and the 'examination' at one and the same time. Using the process skills of the guides accurately and compassionately in order to cover the content of the psychiatric interview is one of the most demanding and difficult tasks in medicine. The interviewer not only has to establish initial rapport and discover the patient's story as far as possible but also has to make a formal assessment of the patient's mental state.

Many depressed patients feel that they do not deserve to take up the doctor's time. It is often a characteristic of their illness that they feel that it is not possible for physicians to listen to and fully understand them. As a result they may receive less effective care than they need and deserve (Gask *et al.* 2003). Focusing on building the relationship from the very beginning of the interview will encourage the patient to 'open up' and tell their story in their own words as well as share their feelings about the situation in which they find themselves – an important part of the therapeutic approach. Building rapport, expressing empathy and support and asking difficult questions sensitively should help the physician to elicit key facts such as whether the depressed patient has a severe and sustained disturbance of mood accompanied by feelings of worthlessness, loss of interest and morbid guilt, together with changes in appetite, weight and sleep pattern. It is essential to discover whether patients who are thought to be at suicidal risk have thoughts of hopelessness, self-harm or suicide. Both open questions and precision