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WEB PAPER

Improving general practitioners' interviewing skills in managing patients with depression and anxiety: a randomized controlled clinical trial

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Abstract

Background: Studies regarding the effectiveness of CME programmes on physicians' behaviour and communication skills showed inconsistent results. Few randomized controlled trials have been conducted in Asia.

Methods: To evaluate the effectiveness of a 4 2-hour education programme to improve GP interviewing behaviours, 16 general practitioners were randomized to the intervention and control groups, respectively. Physicians assigned to the intervention group received 8 hours of training emphasizing interviewing behaviours in the diagnosis and treatment of depression and generalized anxiety disorders (GDS). Those assigned to the control group did not receive any training until the completion of study. Standardized patients were used to evaluate the performance of physicians. Two consultations before and after enrolling in the education programme were videotaped. Independent evaluations of consultations were made by a trained clinical psychologist and a social worker blinded to the study status of physicians. The rating schedule for the videotapes was based on the tasks listed on the Calgary Cambridge Observation Guide.

Results: The change of score between the intervention and control physicians was significantly different in 'active listening and facilitating patients' response' ($p=0.011$) with the intervention physicians having improvement of score. For 'non-verbals', 'understanding patient's perspective' and 'negotiating mutual plan of action', positive change of score in the intervention physicians were seen when compared to that of the control, although the difference did not reach statistical significance ($p=0.06$, $p=0.05$, $p=0.06$, respectively). However, for 'opening', 'structuring the consultation', 'explanation and planning' and 'closure', there were no statistical significant differences between control and intervention group.

Conclusions: Our results showed that only certain communication skills, such as active listening and facilitating patient's response, can be taught in the management of depression and generalized anxiety disorder (GAD) in Chinese primary care physicians.

Introduction

Previous studies conducted in the West showed that training could increase the sensitivity of primary care physicians to mental health problems (Roter et al. 1995; Lin et al. 1997). Others showed that communication skills can be effectively taught, leading to greater patient disclosure of sensitive psychosocial information (Gask et al. 1978; Bensing & Sluijs 1985; Levinson & Roter 1993; Maguire & Pitceathly 2002) and better detection of emotional distress by physicians (Levinson & Roter 1993), although not all studies showed positive results (Marks et al. 1979). In one of the studies, two four-hour interactive workshops were shown to be effective in changing primary care physicians' behaviour and communication skills in diagnosing and managing depression (Gerrity et al. 1999). In a similar study, Roter et al. (1995) showed that eight hours of continued medical education (CME) of communication skills training could make significant changes in physicians'

Practice points

- Educational intervention helps physicians to acquire only certain communication skills to care for patients with depression and anxiety disorders.

communication skills and could result in reduction of patients' emotional distress for as long as 6 months.

These studies are important because although 60% of mental health care is provided in primary care settings, primary care practitioners fail to recognize up to two thirds of the emotional disorders manifested by their patients (Von Korff et al. 1987; Kessler et al. 1999). Many studies (Borus et al. 1988; Young et al. 2001) showed that practitioners often lack the skills to detect or deal with psychosocial problems in primary care when patients clearly

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considered their primary care physicians to be their primary source of mental health care (Ustun & Von Korff 1995). As a result, there is a need to provide more training for primary care physicians to improve their skills in managing these patients (Von Korff et al. 1987; Simpson et al. 1991; Kessler et al. 1999).

Although studies conducted in the West have demonstrated the effectiveness of CME courses in improving doctors' consultation skills, few randomized controlled trials have been conducted in Asia. Therefore, this study was conducted to evaluate the effectiveness of a CME course in improving doctors' consultation skills in relation to diagnosing and managing patients with depression and generalized anxiety in primary care.

Methods

Subjects

Primary care physicians in Hong Kong were recruited from a mailing list that a PR company utilised to contact primary care physicians for medical events and conferences. Information regarding the study was posted to all 2260 primary care physicians on the mailing list with an aim to recruit 40 general practitioners to participate in the study. The first 40 general practitioners who replied and fulfilled the study criteria were recruited. Inclusion criteria included, (1) being able to attend all 4 2-hour sessions of the workshop, (2) agree to see two standardized patients with depression/anxiety at the University Family Medicine Clinic at baseline and after attending the education programs and (3) agree to have the two consultations videotaped and be reviewed by two health care professionals independently. Physicians who have enrolled in a CME program or courses on psychiatric care within the past year were excluded.

Half of the physicians were randomized into the control and half into the intervention group. All physicians in the intervention group received 8 hours of CME training emphasizing the detection, diagnosis and treatment of major depression and generalized anxiety disorders. They were taught the essential interviewing skills to care for patients with psychosocial problems. Physicians randomized to the control group did not receive any training until completion of the study (wait-list control).

Intervention

The Depression and Anxiety Education Program consisted of 4 2-hour sessions given at lunch time hour for 2 days in a week for 2 consecutive weeks. The program covers 8 communication skills and 2 knowledge objectives (Appendix 1) based on Rogerian model of emotion handling skills (Roter et al. 1995) and the 'Depression and Anxiety' chapters from 'Behavioural Medicine in Primary Care' (Feldman & Christensen 2003). The first 2 hours of the first session consisted of (1) a 20 min presentation on the rationale for the CME program (2) a 100-minute interactive presentation by a liaison psychiatrist on common DSM-IV-defined disorders (1994) (anxiety and depression), the modes of presentation

of these disorders in primary care, and on treatment strategies of these disorders, with discussion of 10 cases.

For the 2 hours of the second session, communication skills that included supportive counselling skills were taught using the viewing of videotapes. These included viewing four videotapes with poor to good consultation of a physician interviewing standardized patients who presented with depression and generalized anxiety disorders. At various points during the video viewing, the skills and deficit in skills demonstrated by the physician were noted and discussed. Discussion with physicians was also made to identify individual problem encountered in caring for patients with psychiatric diseases. For the entire 4 hours of the third and fourth sessions, the physicians were divided into two groups led by two preceptors. They were asked to role-play scenarios and give suggestions in the management of patients presented with major depression and generalized anxiety disorder. Constructive feedbacks were given by the preceptors to individual physician. The preceptors consisted of academic family physicians who were also teachers of post-graduate programmes (Diploma and Master of Family Medicine) in family medicine.

Assessments

For the intervention physicians, two consultations before (1st and 2nd) and two consultations (3rd and 4th) after enrolling in the Education Programme were videotaped. The 3rd and 4th consultations for control physicians were videotaped at the same time as those of the intervention physicians who completed the education programme. Standardized patients (SPs) were used to role play patients with psychological problems and were seen by all participating physicians at baseline (before intervention) and 1 month after the education programme at the University Family Medicine clinic. The videotaped consultations were analysed and evaluated using standardized checklists. Investigators performing the analyses and evaluation were blinded to the assignment status of the physicians.

Standardized patients instead of real patients were used to evaluate the performance of physicians. Standardized patients have been used previously to assess physician performance (Colliver & Swartz 1997; McLeod et al. 1997; Ramsey et al. 1998), including physician's communication skills (Finlay et al. 1995; Ramsey et al. 1998). The accuracy and reliability of this methodology has been demonstrated in several studies (Badger et al. 1995; Cohen et al. 1996; De Champlain et al. 1997) and one study supports the reliability of such method for portraying patients with major depression in particular (Badger et al. 1995).

The standardized patients were patients who presented with the two scenarios [one with depression (CW and MY) and one with generalized anxiety disorder (UC and CW) in both pre (CW, US) and post (CW, MY) intervention cases] to tap into the broad domain of depression and generalized anxiety in primary care settings. Individuals who had experience as standardized patients played the roles. The standardized patients had a scripted presentation and medical and social history. The SPs were coached regarding the case histories,

affect, and behaviours. Coaching were focused on maintaining a natural dialogue with the physician in which questions were answered directly but diagnostic information was not offered unless explicitly elicited by the physician. If the physicians mentioned depression or generalized anxiety disorder, the SPs were instructed to be surprised and be hesitant in accepting the diagnosis. If the SPs felt the physician had developed good rapport and adequately explained the diagnosis, they were told to reluctantly agree with the treatment plan. If the physicians had not done these things, the SPs were told to resist the diagnosis and treatment plan except for returning for a follow-up visit. To ensure that the SPs play her/his role reliably, she or he was videotaped being interviewed by the principal investigator (SW) as part of their training. In addition, the interview was reviewed and feedbacks were given to improve their performance.

Instruments and standardization

The rating schedule for the videotapes was based on the tasks listed in the Calgary Cambridge Observation Guide (Kurtz & Silverman 1996) (Appendix 2). Eight major categories of skills were included. Two of these, 'active listening and facilitating patient's response' and 'negotiating mutual plan of action' were weighed double as they were considered very important by patients but often neglected in busy general practice with a doctor-centred approach. Each major skill was rated on a 6-point scale. An additional item on a global assessment of the physician's consultation skills was also included with separate scoring of 1–5 in the assessments. Moreover, a separate checklist consisted of presence or absence of various tasks in diagnosing and managing major depression and generalized anxiety disorders was also included as an additional assessment tool (Appendix 2). One registered clinical psychologist (AL) who works in private practice and is an adjunct assistant professor at the Department of Psychology of the University and one social worker (NC) who works as a private counsellors rated all of the videotapes after briefing on how to rate the videotape using the Calgary Cambridge Observation Guide. Both raters have more than 10 year clinical experience in dealing with patients presenting with psychiatric problems. One standardization meeting was held between the principal investigator, the clinical psychologist (AL), the social worker (NC) and the research assistant (KC) before any rating of videotapes occurred. After the meeting, ten randomly selected tapes were independently rated, and differences in scores were discussed during a second standardization meeting until agreement was reached after which both raters continued with the rating.

Sample size

To our knowledge, no randomized controlled trial has been performed using the Calgary Cambridge Observation Guide as the rating scales for measuring physicians' interviewing performance. As a result, the proportion of general practitioners who demonstrated desired behaviour (e.g. assessment of suicidal ideation and assessment of more than 5 criteria for major depression) was used as outcome

measures when the sample size was calculated. Finding from a previous randomized controlled clinical trial by Gerrity et al. (1999) was used for this purpose. According to the study, significant difference ($p < 0.05$ by chi-square test) in the proportion of general practitioners who demonstrated the desired interviewing behaviour (e.g. assessment of suicidal ideation and assessment of more than 5 criteria for major depression) was observed in 22 general practitioners who enrolled in a 4 2-hour intervention programme for depression when compared to that of 26 controls. We estimated that we would need 38 subjects (20 per group), assuming a 2-sided type I error of 5% for the study to have 80% power to detect a difference in the proportion of general practitioners who demonstrated the desired behaviour when compared to that of the control. To assume a drop-out rate of 5%, 40 subjects were recruited.

Data analysis

Data were analysed using the SPSS package for Windows (Windows XP version; SPSS Inc., Chicago, US) following the intention to treat principle. Scores from the two raters were averaged and the change of scores between the two groups was compared using the Student *t*-tests. To compare the presence of desired interviewing behaviours (e.g. assessment of suicidal ideation and assessment of more than 5 criteria for major depression) in diagnosing and managing major depression and generalized anxiety disorders between the intervention and control groups, chi-square tests were used for both pre-intervention and post-intervention consultations. Associations of scores with years and place of graduation were not included as covariates in analysis as no baseline differences in these categories were found. All tests were 2-tailed using an alpha of 0.05.

Results

Out of the 40 general practitioners who agreed to participate, 5 dropped out before videotaping (2 were unable to come for the education sessions; 1 had no time to be videotaped and 2 could not be contacted for videotaping) and 2 dropped out before post-intervention videotaping took place (both were unable to come for the time assigned for post-intervention videotaping). One physician's videotaping was not included in the analysis after discussion among investigators to avoid bias as he was found to know the standardized patients. Overall, 33 physicians completed the study and results from 32 (80%) physicians were included in the analysis.

The demographic data for the 32 participants were shown in Table 1. No statistically significant difference was seen (chi-square test > 0.05) in the demographics of physicians in the intervention and control groups. Overall, 70% of physicians were in the age range of 40–60. Forty percent of participants were females, 84% of participants worked in private practice and 56% were local graduates.

All tapes were rated by the trained clinical psychologist and social worker. The correlation between the ratings was satisfactory for physicians' scores rated using the Calgary Cambridge Observation Guides (Total score: Pearson $r = 0.53$,

Table 1. Demographic characteristics of doctors.

	Intervention (<i>n</i> = 16)	Control (<i>n</i> = 16)	<i>p</i> -value
Gender			
Male	9 (56.3%)	10 (62.5%)	0.719 ^{NS}
Female	7 (43.8%)	6 (37.5%)	
Age			
<30	0 (0.0%)	1 (6.3%)	0.824 ^{NS}
30–40	3 (18.8%)	3 (18.8%)	
40–50	6 (37.5%)	5 (31.3%)	
50–60	5 (31.3%)	6 (37.5%)	
>60	2 (12.5%)	1 (6.3%)	
Postgraduate training			
Yes	7 (43.8%)	7 (46.7%)	0.870 ^{NS}
No	9 (56.3%)	8 (53.3%)	
Undergraduate training			
Hong Kong	8 (50.0%)	10 (62.5%)	0.476 ^{NS}
Overseas	8 (50.0%)	6 (37.5%)	∅

**Notes: NS - Statistically insignificant ($p > 0.05$).

Table 2. Inter-rater agreement.

Case	Total scores (Pearson correlation)	Global ratings (Spearman correlation)
Pre-Case 1	0.598** <i>n</i> = 32	0.077 ^{NS} <i>n</i> = 32
Pre-Case 2	0.488** <i>n</i> = 32	0.262 ^{NS} <i>n</i> = 32
Post-Case 1	0.632** <i>n</i> = 32	0.543** <i>n</i> = 32
Post-Case 2	0.617** <i>n</i> = 32	0.676** <i>n</i> = 32
Overall agreement	0.527**	0.322**
∅	<i>n</i> = 128	<i>n</i> = 128

Notes: Statically significant at 0.01 level. NS-Statistically insignificant.

$p < 0.01$) and was shown in Table 2 (Pearson pre: r 0.49–0.60, $p < 0.01$; post: r 0.62–0.63, $p < 0.01$).

The change of score between the intervention and control physicians was significantly different in ‘active listening and facilitating patients’ response’ ($p = 0.011$) with the intervention physicians having improvement of score. The change in the overall score was also different between the intervention and

control physicians with the intervention physicians having improvement of scores ($p = 0.03$) (Table 2). For ‘non-verbals’, ‘understanding patient’s perspective’ and ‘negotiating mutual plan of action’, positive change of score in the intervention physicians were seen when compared to that of the control, although the difference did not reach statistical significance ($p = 0.06$, $p = 0.05$, $p = 0.06$, respectively). For the global rating, there was a trend towards differences between the two groups although the difference did not reach statistical significance ($p = 0.05$). There was no difference in change between the two groups in their scores on ‘opening’, ‘structuring the consultation’, ‘explanation and planning’ and ‘closure’.

For the assessment of desired behaviours (i.e. suicidal ideation, stresses at home etc), no significant differences were seen between the intervention physicians and the control physicians.

Summary of main findings

To our knowledge, this is one of the few randomized controlled clinical trials conducted in Asian countries that investigated the effectiveness of an educational programme for general practitioners. The educational intervention in our study was shown to be effective training methods for helping doctors acquire some communication skills such as ‘active listening and facilitating patients’ response’ and ‘understanding patient’s perspective’ that have been used in both undergraduate and postgraduate teaching (Kurtz et al. 1998; Aspegren 1999; Maguire & Pitceathly 2002). However, other skills such as ‘initiating a session’ or ‘closure’ were not shown to be better with participation in the intervention group. As a result, these findings suggested that only certain interviewing skills can be taught.

One explanation for the lack of differences in the presence of desired interviewing behaviour in the assessment and management of major depression and anxiety between the intervention and control physicians could be due to good knowledge of the participated physicians before enrolment. These physicians who had an interest in treating psychiatric diseases could already had a good amount of knowledge regarding what to ask in these consultations even before intervention. For example, for the major depression case, over 55% of physicians had already asked about suicidal ideation and almost 100% asked about stresses at home/work in the GAD case before intervention took place. As a result, it would be hard to have improvement over the already good baseline performance. Another explanation is our small sample size due to drop-outs. Due to inadequate sample size, the power for the study to detect differences between intervention physicians in the presence of desired interviewing behaviour is reduced.

Comparison with existing literature

The results of this study were less encouraging than results from other randomized controlled studies conducted in the West (Roter et al. 1995; Roter et al. 1998; Gerrity 1999), which suggested that Continuing Medical Programme can improve

Table 3. Change in interviewing skills between the control and intervention groups.

Task	Description	Intervention			Control			p-value
		Pre	Post	Change	Pre	Post	Change	
1	Initiating the session/opening	3.55	3.33	-0.22	3.58	3.20	-0.38	0.499
2	Non-verbals	3.13	3.19	0.06	3.30	2.92	-0.38	0.062
3	Active listening and facilitating patient's response	3.13	3.16	0.03	3.28	2.83	-0.45	0.011*
4	Understanding patient's perspective	2.72	2.86	0.14	2.89	2.61	-0.28	0.054
5	Structuring the consultation	3.03	3.14	0.11	3.03	2.98	-0.05	0.396
6	Negotiating mutual plan of action	2.69	2.94	0.25	2.84	2.67	-0.17	0.063
7	Explanation and planning	2.70	3.00	0.30	2.75	2.66	-0.09	0.124
8	Closure	2.64	2.78	0.14	2.73	2.45	-0.28	0.157
Total score		29.39	30.48	1.09	30.53	27.83	-2.70	0.030*
Global rating		2.88	2.94	0.06	3.03	2.69	-0.34	0.052

*Statistically significant at 0.05 level. Maximum score out of 5 for tasks 1 to 8 and global rating. Maximum score out of 50 for total score.

Table 4. Doctors' performance in desired interviewing behaviour in pre and post-intervention consultations.

	Intervention			Control		
	Number (%)			Number (%)		
Doctors' performance in desired interviewing behavior	(n = 16)	(n = 16)	p	(n = 16)	(n = 16)	p
PRE	Case 1 (CW)			Case 2 (US)		
Assessed						
Major depression criteria	8 (50.0)	9 (56.3)	0.723	7 (43.8)	4 (25.0)	0.264
GAD criteria	1 (6.3)	0 (0.0)	0.310	2 (12.5)	3 (18.8)	0.626
Suicidal ideation	10 (62.5)	9 (56.3)	0.719	10 (62.5)	8 (50.0)	0.476
Stresses at home/work	15 (93.8)	14 (87.5)	0.544	15 (93.8)	16 (100.0)	0.310
Discussed possibility of depression/GAD	11 (68.8)	9 (56.3)	0.465	8 (50.0)	10 (62.5)	0.476
Prescribed or suggested use of antidepressants	10 (62.5)	8 (50.0)	0.476	10 (62.5)	11 (68.8)	0.710
Scheduled follow up arrangement	5 (31.3)	4 (25.0)	0.694	7 (43.8)	7 (43.8)	1.000
POST	Case 3 (CW)			Case 4 (MY)		
Assessed						
Major depression criteria	4 (25.0)	2 (12.5)	0.365	12 (75.0)	8 (50.0)	0.144
GAD criteria	7 (43.8)	3 (18.8)	0.127	1 (6.3)	0 (0.0)	0.310
Suicidal ideation	4 (25.0)	4 (25.0)	1.000	12 (75.0)	12 (75.0)	1.000
Stresses at home/work	16 (100.0)	15 (93.8)	0.310	14 (87.5)	16 (100.0)	0.144
Discussed possibility of depression/GAD	10 (62.5)	6 (37.5)	0.157	10 (62.5)	12 (75.0)	0.446
Prescribed or suggested use of antidepressants	10 (62.5)	8 (50.0)	0.476	11 (68.8)	11 (68.8)	1.000
Scheduled follow up arrangement	6 (37.5)	4 (25.0)	0.446	8 (50.0)	5 (31.3)	0.280

a number of physicians' communication skills towards patients who have common presentations of depression and anxiety.

Our findings were also less encouraging than results from a previous study (using pre and post intervention design) conducted in Hong Kong (Chan et al. 2003), where the same

scale for assessing physician's consultation skills was used. Chan et al. (2003) showed that communication skills such as 'active listening', 'understanding patient's perspective' and 'non-verbals' were among the most teachable skills out of all skills observed in the Calgary Cambridge Observation Guide

while other skills could also be taught. However, as there were a trend for improvement in other communication skills such as 'understanding patient's perspective' and 'non-verbals' in our study, it is hard to know if our negative results in other areas of consultation skills were due to lack of effect or the small sample size.

Strengths and limitations of the study

As our standardized patients presented with different scenarios at the pre and post intervention consultations, the difference of pre and post intervention scores between the two groups were used to compare the performance of physicians between the intervention and control physicians. The use of standardized patients and the inclusion of a control group and the study design are the strengths of the study. However, as the sample size was reduced during the study, the power of this study was reduced which might have affected the study findings.

Other limitations include the possibility of a self-selection bias that may limit the generalizability of the findings, as do all studies with volunteer participants. Physicians who participated in our study were likely to be those with an interest in treating patients with common psychiatric diseases and probably have had a greater interest in improving their care of patients with anxiety or depression when compared to primary care physicians in general. However, we showed that our workshop could improve some communication skills in these physicians who presumably had good communication skills before enrolment. Thus, we may argue that these workshops might have even a greater impact for those with more deficient communication skills at baseline.

Implications for future policy and clinical practice

We showed that educational intervention may be useful in improving certain areas of consultation skills that include 'active listening and facilitating response', 'understanding patient's perspective', 'non-verbals' and 'negotiating mutual plan of action'. However, there is unlikely any benefits to other consultation skill areas such as 'explanation and planning', 'opening' and 'closure'. As a result, educators should be aware of the limitations in the teaching of consultation skills in primary care. Further research with a larger sample size and longer duration may be helpful to determine the impact of the programme on patient outcomes and to evaluate the durability of the skills learned or improved.

Ethical Approval

The study was approved by Joint The Chinese University of Hong Kong – New Territories East Cluster Clinical Research Ethics Committee.

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Appendix 1

Objectives for the Depression and Anxiety Education Program

Knowledge

- Diagnose major depression and generalized anxiety disorder.
- Describe management strategies for major depression and generalized anxiety disorder.

Communication skills

Signaling receptivity by:

- Asking patients about their feelings.

- Listening without interruption.
- Following up on signs of patients' emotional distress.

Showing positive regard by

- Complementing patient efforts.
- Making statements of validation (explicitly stating that patients' feelings/views are normal or understandable).

Expressing empathy by

- Accurately acknowledging an emotion expressed by the patient.
- Making explicit statements of partnership or support.
- Providing appropriate reassurance.

Appendix 2. Calgary Cambridge Observation Guide.

Task	Description of task	Global Rating(0–5)#	Comments
I. Initiating the session/Opening	1. GREETs patient by name 2. INTRODUCES SELF (and clarifies role) 3. DEMONSTRATES INTEREST AND RESPECT (attends to physical comfort, here and throughout interview) 4. IDENTIFIES AND CONFIRMS PATIENT'S PROBLEM LIST or issues, e.g. "So headache, fever-anything else you'd like to talk about?" 5. NEGOTIATES AGENDA, taking both patient's and doctor's perspective into account		
II. Non-verbal of doctor & patient	1. DEMONSTRATES APPROPRIATE NON-VERBAL BEHAVIOUR: 1a. eye contact, facial expression, 1b. posture and position, 2. FACILITATE PATIENT'S RESPONSES NON-VERBALLY, movement, tone and pace of voice 3. APPEARS CONFIDENT and reasonably relaxed 4. PICKS UP NON-VERBAL CLUES, i.e. body language, speech, facial expression, affect. CHECKS OUT and acknowledges as appropriate		
III. Active listening and facilitating patient's response	1. ENCOURAGES PATIENT TO TELL STORY of problem(s), FACILITATES PATIENT'S RESPONSES VERBALLY (use of encouragement, silence, repetition, paraphrasing, interpretation, reflective statements). 2. Uses open and closed questioning techniques. APPROPRIATELY MOVES FROM OPEN TO CLOSED. 3. LISTENS ATTENTIVELY, allows patient to complete statements without interruption and leaves space for patient to think before answering or go on after pausing. 4. CLARIFIES PATIENT'S STATEMENTS which are vague or need amplification, e.g. "Could you explain what you mean by lightheaded?" 5. EMPATHIZES AND SUPPORTS PATIENT, e.g. expresses concern, understanding, willingness to help, acknowledges coping efforts and appropriate self-care.		
IV. Understanding patient's perspective	1. DETERMINES AND ACKNOWLEDGES PATIENT'S IDEAS, i.e. beliefs regarding cause. 2. EXPLORES CONCERNS (including worries, effects on lifestyle) regarding each problem. 3. DETERMINES PATIENT'S EXPECTATIONS regarding each problem. 4. ENCOURAGES EXPRESSION OF FEELINGS AND THOUGHTS 5. PICKS UP VERBAL AND NON-VERBAL CUES, e.g. patient's need to contribute information or ask questions, information overload, distress.		
V. Structuring the consultation	1. SUMMARIZES AT END OF A SPECIFIC LINE OF INQUIRY (present Hx, past Hx) to verify own interpretation of what patient has said, to ensure no important data were omitted 2. PROGRESSES from one section to another USING TRANSITIONAL STATEMENTS; includes rationale for next section 3. STRUCTURES interview in LOGICAL SEQUENCE 4. ATTENDS TO TIMING and keeping interview on task 5. OVERALL ORGANIZATION		

VI. Negotiating mutual plan of action (Collaborative attitude rather than authoritarian style) VII. Explanation & planning VIII. Closure	1. INVOLVES PATIENT by making suggestions rather than directives and ENCOURAGES PATIENT TO CONTRIBUTE their IDEAS, suggestions, preferences, beliefs. 2. DISCUSS OPTIONS & NEGOTIATES A MUTUALLY ACCEPTABLE PLAN 3. REVEALS RATIONALE for opinion 4. ELICITS PATIENT'S UNDERSTANDING, REACTIONS AND CONCERNS about plans and treatments, including acceptability and OBTAINS PATIENT'S VIEW OF NEED for action, PERCEIVED BENEFITS, BARRIERS, MOTIVATION; accepts and advocates alternative viewpoint as necessary. 5. ENCOURAGES PATIENT to be involved in implementing plans, TO TAKE RESPONSIBILITY and be self-reliant. 1. GIVES EXPLANATION AT APPROPRIATE TIMES (avoids giving advice, information, opinions prematurely) 2. GIVES INFORMATION IN CLEAR, WELL-ORGANIZED, complete fashion without overloading patient; avoids or explains jargon. 3. RELATES EXPLANATIONS TO PATIENT'S ILLNESS FRAMEWORK: to previously elicited beliefs, concerns and expectations. 4. CHECKS PATIENT'S UNDERSTANDING AND ACCEPTANCE of explanation and plans; ensures that concerns have been addressed 5. ASKS ABOUT PATIENT SUPPORT SYSTEMS, discusses other support available *Bonus: Use of diagrams or aids and pamphlets 1. SUMMARIZES session briefly, may ask patient to summarize. 2. CONTRACTS WITH PATIENT regarding next steps for patient and physician. 3. CHECK THAT PATIENT AGREES and is comfortable with plan and ASKS IF ANY CORRECTION, QUESTIONS or other items to discuss 4. ENCOURAGES PATIENT TO DISCUSS ANY ADDITIONAL POINTS and provides him/her with opportunity to do so, e.g. "Are there any questions you'd like to ask or anything at all you'd like to discuss further?" 5. SAFETY NETS APPROPRIATELY, what to do if plan is not working, when and how to seek help.
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Total Score = I + II + 2 x III + IV + V + 2 x VI + VII + VIII = 50 maximum. Comment if any fatal mistakes: e.g. ethical problem- broke patient confidentiality.

Global Rating: Please rate the doctor's performance globally from 0–5

0	1	2	3	4	5
Very poor	Poor	Inadequate	Adequate	Good	Impressive performance
Task in diagnosing and managing major depression and GAD					Yes or No?
Assessment of suicidal ideation					
Assessment of stresses at home/work					
Discussed possibility of depression/GAD					
Prescribed or suggested the use of antidepressants (benzo. for GAD)					
Scheduled follow up arrangements					