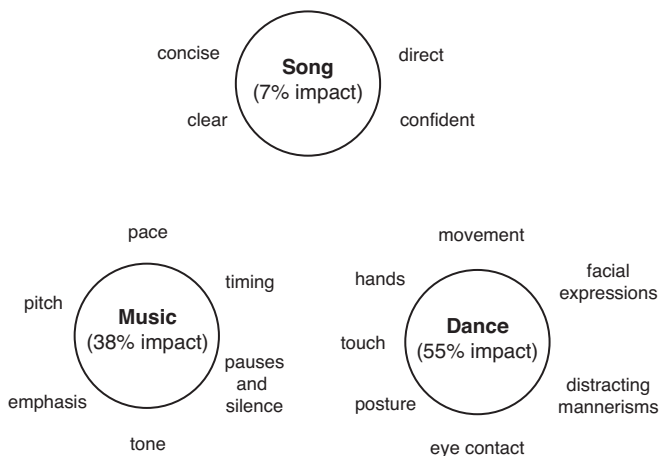


# Effective interpersonal communication skills

This chapter provides a range of tools and techniques to help you in face-to-face communications in a wide range of settings. They include: effective listening, giving feedback, breaking bad news, core interviewing skills, presentation skills, contributing to meetings and being interviewed. Dealing with anger and complaints is covered in Chapter 4 (section on ‘Dealing with anger’) and Chapter 6 (section on ‘Complaints’).

## Introduction: song, music and dance

We communicate with each other in order to give, seek and receive information; to inform, instruct, persuade, negotiate, motivate and encourage, to understand the opinions of others and so on. Interpersonal communication can be easy, happy and positive;



**FIGURE 3.1** Song, music and dance

it can be difficult, uncomfortable and challenging, or it can be somewhere in between.

Various commentators are agreed that the impact on the listener in face-to-face communication is made up of 7% words, 38% voice tone and emphasis, and 55% body language. This is sometimes referred to as song, music and dance (*see* Figure 3.1).

Consider the anaesthetist who is reassuring a patient during the few minutes before they are taken into theatre. The effect of the doctor's hand on the patient's forearm as they hear the words has a far greater positive impact on their feelings than the words themselves.

This is not to suggest that the words that you use in, say, making a case for more resources, are not important – they may catch you out if you do not do your research. It is the longer-term impact on the experience of the listener that is enhanced by the other, non-verbal signals they receive.

The General Medical Council (GMC 2006) and other medical professional bodies including the Academy of Royal Medical Colleges, the Royal College of General Practitioners and the Royal College of Physicians all stress the importance of doctors developing good communication skills.

The GMC stress that to communicate effectively you must do the following.

- Listen to patients, ask for and respect their views about their health and respond to their concerns and preferences.
- Share information with patients in a way they can understand without being patronising. Provide the information they want or need to know about their condition, its likely progression and the treatment options available to them, including associated risks and uncertainties.
- Respond to patients' questions and keep them informed about the progress of their care.
- Make sure that patients are informed about how information is shared within teams and among those who will be providing their care.
- Make sure, wherever practical, that arrangements are made to meet patients' language and communication needs.

Medical schools now provide communication skills training for medical students. The main subjects include breaking bad news, consulting patients and relatives, dealing with angry, difficult and reluctant patients, demonstrating empathy, and giving, explaining and receiving information. The skills are discussed mainly within this chapter, but like playing the piano or flying they cannot be mastered by reading how to do it, listening to a lecture or watching someone else do it. But this is often how doctors are expected to acquire their communication skills.

The GMC says there is an obligation on all doctors to review their skills as part of continuing professional development and take part in educational activities as a means of maintaining and further developing their competence (GMC 2006).

Doctors often face difficult situations, including bearing bad news, having to turn complex and often uncertain information into something that is understandable. They have to respond to the differing needs of a hugely diverse range of patients and their families, and do much of this when they are busy and under pressure. It is not

surprising, therefore, that problems with communication can occur.

NHS Quality Improvement Scotland (Scottish Executive 2003) identified communication with patients as an issue that continues to give rise to concern. Indeed they state that it is one of the most common reasons for complaints from patients and is an important factor in litigation.

So when doctors use communication skills effectively there are a number of benefits (Maguire and Pitceathly 2002).

- Patients' problems are identified more accurately.
- Patients are more satisfied with their care and can better understand their problems.
- Patients are more likely to comply with treatment or lifestyle advice.
- Patients' distress and the vulnerability to anxiety and depression are lessened.
- The overall quality of care is improved by ensuring that patients' views are taken into account.
- Doctors' own well-being is improved.
- Fewer clinical errors are made.
- Patients are less likely to complain.
- There is a reduced likelihood of doctors being sued.

However, different patients require different approaches. Some patients may want only the minimal detail about their illness while others may challenge the information provided by doctors. There can be language barriers, learning difficulties and physical problems.

So what are the necessary communication skills and how can you acquire them? Communication looks easy when it is done well. But it requires engagement, empathy, an ability to listen and respond and it requires time.

The problems of communicating effectively have been acknowledged in reports produced by the British Medical Association (BMA 2004), identifying both personal and organisational barriers to effective communication.

### **The personal barriers**

- Lack of skill and understanding – failure to understand the importance of using clear and simple language, giving structured explanations and listening to patients' views and encouraging two-way communication.
- Undervaluing the importance of communicating – for example, not appreciating the importance of keeping patients adequately informed.
- Negative attitudes by doctors towards communication and giving it a low priority due to their concern primarily to treat illness rather than focus on patients' other needs which may be psychological or related to social well-being.
- A lack of inclination to communicate – due to a lack of time, uncomfortable topics, lack of confidence and concerns relating to confidentiality.
- Human failings, such as tiredness and stress.
- Inconsistency of information. One of the biggest complaints from patients is of being given conflicting information by different healthcare professionals.
- Language difficulties – for some doctors who qualified in European countries who

are not required to take the English language test that is mandatory for other doctors from overseas.

### **The organisational barriers**

Organisational barriers are usually outside a doctor's direct control and include:

- lack of time
- pressure of work
- being subjected to interruptions.

The BMA report notes that doctors may be forced to devote less time to communicating with patients when the organisation they work for places an emphasis on increasing 'patient throughput' or similar initiatives.

### **Why it could be beneficial for you to enhance your communication skills**

The Scottish Report referred to above stresses that there are also important benefits for doctors in improving job satisfaction and reducing the risk of burnout. The ability to intervene positively to improve people's lives should make medicine one of the most rewarding careers. Instead it is marked by high rates of suicide, emotional exhaustion, depersonalisation (treating people in an unfeeling, impersonal way) and a sense of low personal accomplishment. Ramirez and colleagues (2006) found evidence of stress-related psychiatric morbidity in 27% of consultants. They found that burnout was also more prevalent among consultants who felt insufficiently trained in communication and management skills.

There are other reasons (summarised above) why doctors need highly sophisticated interpersonal skills. Technical and clinical competence is essential but these qualities are insufficient to meet the challenges of this changing environment. Doctors also need support to help them respond effectively to these changing conditions.

### ***Complaint handling***

A poll commissioned by the Scottish Executive (2000) found that 23% of NHS users either have or have wanted to make a complaint about the service they received, although only 5% went on to raise an issue or make a complaint. This reflects a major culture change within society where many patients and their families are prepared to challenge the way services are provided.

### ***Increasing litigation***

Just as more people are willing to complain, more people are prepared to sue. In England the NHS expects to pay out £5 billion over the next few years. Poor handling of complaints contributes to increasing litigation. A survey carried out by Action Against Medical Accidents (AVMA) shows that most patients want an explanation of what went wrong and an apology but many are forced to take legal action when this is not forthcoming (ICM 2002).

***Chronic disease management***

More patients and their families are becoming ‘experts’ in their chronic conditions. The long-term management of conditions such as asthma, diabetes and epilepsy is also shifting to a partnership model – between patients and their doctors and between professionals in different disciplines. This is a profound change in the traditional role of the doctor and their relationship with patients and other professionals.

***The appraisal process***

The appraisal process demands a sophisticated level of communication skills if it is to be successful. Many consultants will be both appraisers and appraisees. Each role requires significant preparation and skills in the art of giving feedback. In addition, appraisal includes an ‘assessment’ of the appraisee’s communication skills. This is therefore dealt with in more detail later in this chapter. The process of revalidation will require doctors to demonstrate effectiveness not only in what they do but how they do it, including how they interact and communicate with others.

***Communication of risk***

The awareness and quantification of risk is growing within the NHS and among the public. The delivery of healthcare is rarely risk free and trade-offs need be made between, for example, ease of access and safety. It is essential that clinicians are able to discuss risk with patients to help them make informed decisions.

***Listening and giving feedback***

Whether it is part of teaching, training, appraisal, mentoring, counselling or even taking a history, listening has to be effective. In addition in some situations you will need to give feedback, so it might be useful to consider these two skills in a little more detail.

**Effective listening**

Doctors, in common with others, are often in situations where they are supposed to be listening. It is easy to hear despite neither actively listening nor attending. Our minds can be distracted, a sign that can be noted by those on whom we should be concentrating. Effective (or active) listening is a developed skill and one worth acquiring. Effective listening obviously has many benefits, not least in a better understanding of what people say and feel. It can be hard work to acquire but can pay dividends. It will not come naturally to some people and may need practice to become proficient. There are a number of key elements to effective listening, as follows.

**Concentrate**

Try hard to concentrate on what is being said and do not allow yourself to think about something else, however important. Most individuals speak at the rate of 175 to 200 words per minute; however, research suggests that we are very capable of listening and processing words at the rate of 600 to 1000 words per minute. If possible, try to avoid distractions from visitors, phone calls, etc. Be silent, attentive and try hard to appear interested.

### **Show you are listening**

Non-verbal signals show that you are listening, such as maintaining eye contact, nodding, leaning forward. Do not fidget. Communication 'experts' suggest that non-verbal messages can be three times as powerful as verbal messages. Therefore, effective communication becomes difficult if you send non-verbal messages that you're not really listening. Reflect feelings to encourage the speaker to be open.

### **Don't interrupt**

Allow the speaker to finish and don't interrupt.

### **Don't jump to conclusions**

Avoid early judgements about what the speaker is saying or what you anticipate they might say next. As you can listen at a faster rate than most speakers talk, there is a tendency to evaluate too quickly and jump to conclusions. This is perhaps the greatest barrier to effective listening. It is doubly important when listening to a person with whom you disagree. When listeners begin to disagree with a sender's message, they tend to misinterpret the remaining information and distort its intended meaning so that it is consistent with their own beliefs. So maintain an open mind.

### **Avoid becoming defensive**

Don't take what is said personally when what is said is not meant to be personal. Don't become angry; effective listening does not mean that you will have to agree. Too much time spent explaining, elaborating and defending your decision or position is a sure sign that you are not listening because your role has changed from listening to convincing others they are wrong. If you disagree, simply respond with, 'I understand your point. We just disagree on this one.' Effective listeners listen calmly to another person even when that person is offering unjust criticism.

### **Clarify and summarise**

To clarify and summarise by paraphrasing is the art of putting into your own words what you thought you heard and reflecting it back to the sender. For example, a trainee might say: 'You have been unfair to rate me so low on my appraisal.' A paraphrased response might be: 'I can see that you are upset about your appraisal. You think it was unfair.' Paraphrasing is useful because you have to listen very carefully in order to accurately paraphrase and the paraphrasing response will clarify for the sender that their message was correctly received and encourage them to expand on what they are trying to communicate.

### **Listen to the whole message**

Observation is not solely about concentrating on the words being said, but also on the way they are being said. In other words, listen to the whole message. The way a speaker is sitting or standing, the tone of voice and inflection they are using, what the speaker is doing with their hands are all part of the message. A raised voice may be anger or frustration. Looking down while speaking could be embarrassment or shyness. People

who make eye contact and lean forward suggest confidence. Arguments may reflect worry. Inappropriate silence may be a sign of aggression.

### Check your understanding

Ask questions to make sure you have correctly understood the message being sent, to clarify points or to obtain additional information. Open-ended questions are best, as they require the speaker to convey more information. Frame questions in a way that suggests you have not yet drawn any conclusions. This assures the speaker that not only are you interested but you are looking to obtain more information. The more information that you as listener have, the better you can respond to the sender's communication.

### Other

- Takes notes where appropriate and with agreement if that seems necessary.
- Respect trust and confidences.

### Giving feedback

Feedback is part of education and training. Improving your feedback skills will help motivate and develop trainees' knowledge, skills and behaviour. It attempts to identify areas for improvement and actions to be taken to improve them.

It can be informal as in everyday sessions between seniors and trainees, or just between colleagues, or formal as part of written or clinical assessment. However, Ramsden (2003) says 'there is no sharp dividing line between assessment and teaching in the area of giving feedback on learning'. Feedback is part of the overall dialogue between a teacher and learner, not a one-way communication. If there is no feedback the trainee will assume everything is fine and no improvement is required. Many learning opportunities are wasted if they are not accompanied by feedback. Opportunities are also wasted if the learner cannot reflect honestly on their performance. Remember one of the main purposes of feedback is to encourage reflection.

So feedback is essential and the most effective is based on observable behaviours and is practical, timely and concrete. Feedback should be given with sensitivity. Begin by asking the trainee to tell you what they feel confident of doing well and what they would like to improve. Follow up with your observations on what was done well by being specific and then outline one or two points that could help the trainee to improve.

Giving and receiving feedback well requires a high level of skill and confidence that takes time to develop. The Johari window (*see* Chapter 1, section on 'Self-awareness') demonstrates that seeking feedback and disclosing information about ourselves in order to elicit feedback from others has the effect of enlarging the open quadrant. Typically, as I share something about myself (moving information from my hidden quadrant into the open), and if the other party is interested in getting to know me, they will reciprocate, by similarly disclosing information in their hidden quadrant. Thus, an interaction between two parties can be modelled dynamically as two active Johari

windows. It helps to choose someone you feel you can trust and whose response will give you some insight into yourself.

As your level of confidence develops, you may actively invite others to comment on your blind spots. You may already seek feedback from students on the quality of a particular lecture, with the desire of improving the presentation. The next stage is to invite comment on your ability to deal with more complex aspects of your role. Self-disclosure – giving the other person something about yourself that helps to build mutual confidence and trust – is an excellent way to start.

### Principles of giving effective feedback

Whether you are giving formal or informal feedback, there are a number of basic principles to keep in mind. Personal help can be useful, but sometimes people are hurt by the feedback they receive so be aware of the following.

- Be sensitive to the impact of your message.
- Give feedback only when asked to do so or if your offer to do so is accepted.
- Give feedback as soon after the event as possible.
- Focus on the positive.
- Do it privately wherever possible, especially negative feedback.
- Stay in the 'here and now'; don't bring up previous mistakes, unless this is to highlight a pattern of behaviour.
- Focus on behaviours that can be changed.
- Talk about specifics, giving examples where possible and do not evaluate or assume motives.
- Use 'I' and give your experience of the behaviour ('When you said . . ., I thought that you were . . .').
- When giving negative feedback, suggest alternative behaviours.
- Encourage reflection. This will require open questions such as:
  - What did you learn from this?
  - Did it go as you planned? If not, why not?
  - If you were doing it again, would you do it differently? Why?
  - How did you feel about it? How would you feel about doing it again?
  - How do you think the patient felt? What makes you think that?
- Do not overload; give only two or three key messages.

In Chapter 1 you will find a description of the Kolb learning-style inventory. Giving feedback can be seen as part of this four-stage cycle with feedback supporting the process of reflection.

A number of colleges and deaneries quote Pendleton's Rules, a more structured (and sometimes rigid) approach to providing feedback. After the observed event the following steps are utilised in order.

- 1 Ask the trainee: 'What do you believe went well?'
- 2 Offer what you think went well, e.g. 'This is what I think you did well . . .'
- 3 Ask: 'What would you do differently if you had the opportunity to do it again?'
- 4 Tell the trainee what you think they might do differently and discuss these points.

Some people point to limitations of these rules by the separation of 'what went well' and the 'what could be done differently', as they can seem artificial. It may appear quite structured and take a long time to identify the learner's needs. One approach is that essentially good feedback should centre on the fundamental principle that it is outcome-based. Therefore the fundamental questions are:

- What were you trying to achieve?
- What were you aiming for?
- What did you try to do to get there?
- What could you have done differently to help you get there?

A number of different models have been developed for giving feedback in a structured and positive way. These include reflecting observations in a chronological fashion; for example, replaying the events that occurred during the session back to the learner. This can be helpful for short feedback sessions, but you can become bogged down in detail during long sessions.

Another model is the 'feedback sandwich', which starts and ends with positive feedback.

When giving feedback to individuals or groups an interactive approach is deemed to be most helpful. This helps to develop a dialogue between the learner and the person giving feedback and builds on the learner's own self-assessment. It is collaborative and helps learners take responsibility for their own learning.

This is not the place to explore the subject fully, but Kurtz and colleagues (2005) devote a chapter in their book to analysing feedback in experiential teaching sessions and for those interested in the subject it is worth a look.

While on the subject of giving feedback, that given to unsuccessful candidates after selection interviews, often regarded as an essential part of the interview process, is discussed more fully later in this chapter in the section on 'Core interviewing skills' (p. 87).

### **Possible barriers to giving effective feedback**

Some are potential barriers and not a great problem if handled with sensitivity and skill, but they may include:

- a trainee who is resistant or defensive when receiving criticism; poor handling of this situation can result in all feedback being disregarded afterwards
- fear of upsetting the trainee
- reluctance to damage the trainee–doctor relationship
- fear of doing more harm than good
- feedback being too generalised and not related to specific facts or observations
- feedback without guidance on how to rectify behaviour
- inconsistent feedback from multiple sources
- a lack of respect for the source of feedback
- lack of sensitivity
- dependent and subordinate position of trainee to trainer (issue of organisational power and authority) and tensions around professional role boundaries and status

- differences in sex, age or educational and cultural background.

### **Negative feedback**

Negative feedback should also be specific and non-judgemental, possibly offering a suggestion: 'Have you thought of . . .?' Focus on some of the positive aspects before considering the areas for improvement.

- 'You maintained eye contact during the consultation. I feel this helped to reassure the patient.'
- 'You picked up most of the key points in the history, including A and B but you did not ask about C.'

Avoid giving negative feedback in front of other people, especially patients. Trainees should be encouraged to seek feedback themselves from others, as feedback actually works best when it is sought.

### **Giving formal feedback**

Perhaps following an appraisal an end of attachment assessment with formal feedback will occur. You may also be required to participate in formal clinical and non-clinical assessments which ideally should incorporate feedback. If feedback has been carried out regularly, the formal feedback sessions should not contain any surprises for the trainee. Feedback can be given on a one-to-one basis or in small groups. The structure for giving feedback needs to be agreed between you and the trainee(s), and may follow one of several models, some of which are described above. It is also important that both you and the subject(s) to whom you are giving feedback are fully prepared for the session.

#### ***Prior to a formal feedback session***

- Make sure the trainee is aware they are to receive feedback.
- Clearly define the purpose of the feedback session prior to or at the start of the session, collecting any information you need from other people.
- Summarise the feedback.
- Make sure you know the positive aspects and areas for improvement are listed (with supporting evidence).
- Make sure you know how the feedback relates to the learning programme and defined outcomes.

#### ***During the formal feedback session***

- Agree the purpose and duration of the feedback session.
- Clarify the structure of the session.
- Encourage the learner to self-assess their performance prior to giving feedback.
- Encourage a dialogue and rapport with the trainee.
- Reinforce good practice with specific examples.
- Identify, analyse and explore potential solutions for poor performance or deficits in practice.

**After the session**

- Complete any outstanding documentation.
- Make sure the learner has copies.
- Carry out any agreed follow-up activities or actions.
- Make sure that opportunities for remedial work or additional learning are arranged.
- Set a date for the next feedback session, if required.

**Difficulties with feedback**

Sometimes feedback is not received positively by learners and fear of this can inhibit trainers giving regular face-to-face feedback. People's responses to criticism, however constructively it is framed, can vary. Learners often discount their ability to take responsibility for their learning and their responses may present in negative ways, including anger, denial, blaming or rationalisation (King 1999).

When giving feedback, it is helpful to maintain an empathic yet consistent approach with a view to helping the learner take responsibility for development and improvement. It is also helpful to think in a structured way about how feedback might be received. You can help to prepare learners (and yourself) for receiving feedback by providing opportunities for them to practise the guidelines listed below. The aim of developing an open dialogue between the person giving feedback and the recipient is so that both parties are relaxed and able to focus on actively listening, engaging with the learning points and messages and developing these into action points for future development.

**Guidelines for receiving constructive feedback**

- Listen to the feedback rather than preparing your response/defence.
- Ask for it to be repeated if you did not understand it clearly.
- Assume it is constructive until proven otherwise; then consider and use those parts that are constructive.
- Stop and think before responding.
- Ask for clarification and examples if statements are unclear or unsupported.
- Accept it positively rather than dismissively.
- If not offered, ask for suggestions of ways you might modify or change your behaviour.
- Respect and thank the person giving feedback.

**Breaking bad news**

As explained above, the development of the skills of communication as a junior doctor is essential but often has to be learnt. Communication is a reciprocal process which enables the exchange of verbal and non-verbal messages between people to convey emotions, information, ideas and knowledge. It also connects the psychological, social and physical domains of patient care. Poor communication is one of the commonest causes of complaint in healthcare; MDU data shows that it is a feature in a large proportion of clinical negligence cases.

The use of such skills is particularly crucial when you have to be the bearer of bad news. It is an unfortunate consequence of working in healthcare that you will be called on from time to time to be the bearer of upsetting information. That news can include any information that changes a patient's, or their loved ones', view of the future in a negative way. In this context bad news can come in many forms for doctors. It may refer to:

- terminal illness
- diagnosis of a chronic illness (e.g. diabetes mellitus)
- disability or loss of function (e.g. impotence)
- a treatment plan that is burdensome or painful
- the death of a patient.

Bad news is defined as 'any information that produces a negative alteration to the person's expectations about their present and future' (Fallowfield and Jenkins 2004).

Hippocrates recommended that doctors be wary of breaking bad news because 'the patient may take a turn for the worse'. In *Medical Ethics* for 1803, Thomas Percival gave a similar warning, as did the American Medical Association in its first code of medical ethics in 1847.

In fact, withholding bad news from patients was commonly practised until quite recently. In 1961 a survey of 193 doctors revealed that 169 (88%) routinely withheld cancer diagnoses. Furthermore, they often used euphemisms such as 'growth' to describe cancer. The policy was to tell as little as possible in the most general terms consistent with maintaining co-operation and treatment. The same study revealed that most patients really wanted the truth about their diagnoses. In fact, many recent studies have found that most patients want to know the truth about their illness.

Therefore, a model that emphasizes patient autonomy and full disclosure has replaced a paternalistic model of care. Honest disclosure allows patients to make informed decisions. Withholding bad news diminishes patient autonomy. When a patient eventually realises the nature of their illness he or she may no longer trust the doctor. In fact, good practice now indicates that only under rare circumstances is nondisclosure of bad news ethical.

Breaking bad news can be a difficult task. How it is done may affect patient comprehension of, and acceptance of, the news, to say nothing of their relationship with their doctors. Some of the barriers to effective communication of bad news have been identified as follows:

- fear of being blamed by the patient
- not knowing all of the answers sought by the patient or relatives
- inflicting pain on the patient
- doctors' personal fears, even their own fear of illness and death
- little or no formal training in how to break bad news
- lack of time to give to the task
- cases with multiple doctors making it unclear who should break the bad news.

Breaking bad news requires expertise, knowledge and skill but also requires compassion.

You should give careful thought to your own perspective on the kinds of issues which will arise for the person receiving the bad news.

## The basic principles

### *Who*

The consultant is normally the lead person but does not necessarily need to be the person who does it. Make sure you are clear about what the person is to be told. Remember the recipient may like to have another person with them. This could be a relative or friend, or someone for support, such as a priest or social worker.

### *Where*

Ideally, a specially designated area should be used. In any event, it must be private. An office might suffice but ensure there are no interruptions from people entering, the telephone going or from your pager. Try to arrange for comfortable seating without the barrier of a desk.

### *How*

The use of a breaking bad news model is extremely useful, such as SPIKES, which is a six-step approach.

- Setting up the conversation – an appropriate environment, the provision of tissues, allowing the time and avoiding interruptions.
- Assessing the patient's **P**erception of their illness – 'What have you been told already?'
- **I**nviting the patient to disclose information – 'What do you know about your condition?'
- Giving **K**nowledge and information.
- Providing **E**mpathetic support for the emotional response of the patient.
- **S**ummarise and discuss the plans for the future.

Avoid medical jargon. Patients and families will be confused, so don't make it even worse. Be honest; if you do not know something, say so. But let them know if there is someone who does. Check their understanding and when you have finished, make sure there is someone to accompany them after your meeting.

Use appropriate eye contact, voice tone and body language. Remember the old saying: only 7% of the message is in the 'words', there is 55% in the 'dance' and 38% in the 'music'. Ensure that you know what the recipient wants to know and that the time is appropriate for them. All people being told are given the same information, with the same options, including an offer of a second opinion. The information should be factual. Give recipients an opportunity to return for further information or clarification.

Ensure that time is allocated not just to breaking the news but to supporting the recipient. In order to ensure that the patient's GP can deal effectively with them, make sure the GP is informed promptly of what the patient has been told. Your hospital will have a time scale for this, normally within two days. The medical record should be fully updated with notes of your consultation with the patient.

### The practicalities

The essentials in preparation are as follows.

- Check the case details thoroughly.
- Make sure you have all information and results to hand.
- Take the notes with you in case you need to refer to them for details.
- Remember that another member of staff present is helpful, not only for you, but to help and support the relative(s).

Your appearance and approach are important. If you wear scrubs, it should go without saying that you should make sure there are no bloodstains, particularly if it is a case of major trauma. Adoption of an appropriate mood can be difficult if one is pressed for time, stressed or unprepared. First check identities and relationships; it is not the time to get names and relationships wrong. Offer your own identity and status and that of anyone with you.

A brief neutral conversation to establish rapport may be beneficial, but do not delay getting on with the purpose of the meeting. You might explain why you have brought someone with you. The reason for meeting should be explained. It is helpful to find out what they already know or have been told; it cannot be assumed that they have previously been prepared for the possibility. Empathise, comfort where necessary, allow time for information to sink in, do not argue and allow relatives their expressions of anger without criticism. Check their understanding, invite questions and try to be practical.

Finally, offer to remain with them for a while in case they wish to ask questions perhaps, although they may wish to be alone. When finished summarise and check what the relatives wish to do immediately. They may wish to see the body. Give them the opportunity to attend to their appearance if they have been crying.

### Some further thoughts

There are countless articles and books on this subject and a review of nearly a hundred showed that there are few trials of strategies for breaking bad news. Most writing on the subject is opinion, albeit by experienced practitioners. It is said that the most important factors for individual patients when they receive bad news are the doctor's competence, honesty and attention, the time allowed for questions, a straightforward and understandable diagnosis and the use of clear language. Families rank privacy, the doctor's attitude, competence, clarity and time for questions as important. Knowing the doctor well and the doctor's use of physical contact (for example, by holding the patient's hand) rank lower.

You might sometimes need to get the patient's permission to share bad news, particularly for patients from some non-Western cultures in which autonomy of the individual may not be paramount and healthcare decisions frequently shared with others.

Also, informing patients about possible outcomes before ordering tests or procedures may help prepare patients for potential bad news. You can ask patients if they want only basic information or a detailed disclosure. Remember that although patients need enough information to make informed healthcare decisions, they need to

understand. So, for example, the word 'spread' should be used in place of 'metastasised'. Also it is helpful to check frequently that the patient understands, perhaps by asking 'Am I making sense?' or 'Can I clarify anything?' Undue bluntness and misleading optimism should be avoided.

An empathic doctor acknowledges a patient's emotional response to bad news by first identifying the emotion and then responding to it. 'I can see that you are upset by this news' is an empathic statement. Deliberate periods of silence allow patients to process bad news and vent emotions. After receiving bad news, a patient may experience a sense of isolation and uncertainty. Doctors can minimise the patient's anxiety by summarising the areas discussed, checking for comprehension and formulating a strategy and follow-up plan with the patient. Written materials such as hand-written notes, or prepared materials listing the diagnosis and treatment options, may be helpful.

The use of an empathic communication may improve the experience for you and reduce the patient's anxiety. Helpful phrases include:

- 'I wish I had better news' (as opposed to 'I'm sorry, I have bad news.')
- 'I admire your courage.'
- 'I will be here for you.'
- 'What gives you hope and strength?'

Unhelpful statements include:

- 'It could be worse.'
- 'We all die.'
- 'I understand how you feel.'
- 'Nothing more can be done.'

### **Suggested actions**

Ask if you can sit in with someone who is experienced and skilled at breaking bad news.

When you feel confident enough try doing it yourself, maybe with a more experienced person sitting in to help if things get difficult.

Afterwards reflect on what went well and what less well and ask for some feedback from the person who sat in to help.

Only when you feel confident, try doing these interviews on your own.

### **Complaints and anger**

Interpersonal skills are vital in dealing with complaints and these are dealt with in Chapter 6, 'Non-clinical involvement with patients'. Anger management is dealt with in Chapter 4, 'Managing day-to-day issues'.

### **Core interviewing skills**

A great deal of doctors' time is spent in one-to-one meetings, many of which might be described as an interview. They may not always be labelled as such, but each time we need to find out about a patient, the opinions of a colleague, recruit, appraise or

discipline a colleague, break bad news or deal with a complaint, we are using interviewing skills.

The most important skill related to interviewing is that of questioning. A clear understanding of the use of different types of question is essential. You should remember, however, that getting the words right is only one part of the process. Your manner, tone of voice, facial expression and posture all go together with the words to influence the interviewee's willingness to 'open up'.

### **Selection interviewing**

As with most things in life, interviews are usually much more effective if the panel has put in enough preparation time before the interview starts. Thought should be given to how a panel will work together, what the priorities are for the interviewers, what style of questioning will be used, how the seating should be arranged to put the candidate at ease, and so on. Panel members should have familiarised themselves with the paperwork and have a good idea about what approach they wish to take to questioning the candidates. The role of the chairperson is critical, particularly during the preparation stages that are aimed at getting the panel to work as a team, and then after the interview when the panel is concerned with making the right decision.

### **Types of questions and their uses**

The following approach to using questions to elicit useful information is framed in the context of selection interviewing. The basic approach is transferable to most other interview situations. It helps if you think of interviews as conversations with a purpose. The most effective interviews will generally feel fairly relaxed, if challenging for the interviewee. The aim should be to help them to feel relaxed and prepared to open up about things that perhaps they had not intended.

### ***Behavioural questions***

Traditional approaches to medical interviews tended to allow candidates to supply set-piece answers to well-signalled questions, such as 'What do you understand to be the purpose of clinical governance?', or hypothetical questions which only tell the questioner that the interviewee may have a theoretical understanding of the topic, which has probably already been assessed in an examination: 'What would you do if you were faced with . . . ?'

Questions that focus on the interviewee's past experience, their 'real life' events, are generally the most revealing. It is argued that we can understand more about a person's future behaviour by getting to know how they have behaved in the past – 'the best predictor of future behaviour is past behaviour'. This questioning technique requires skill to 'draw out' the interviewee. Questions might start with 'Tell me about your work in . . . ?', or 'Tell us about a situation in which you had to deal with . . .'. The answer is then probed in order to gain insight into the person's past behaviour patterns, motives, values, attitudes and personality. An approach which uses open questions, followed by probing and reflective questions, is most likely to succeed in allowing you to understand the person.

***Open questions***

Open-ended questions oblige the interviewee to respond with a full answer – they do not permit a ‘Yes’ or ‘No’ response. They are likely to start with ‘How’, ‘Why’, ‘When’ or ‘Where’ or ‘Can you tell me about . . . ?’ The aim is to get the interviewee to talk to you in their own words so that you can pick up hints that allow you to probe more deeply.

***Closed questions***

These are useful when checking facts. They are generally phrased to attract a ‘Yes’ or ‘No’ response. You may need to be absolutely sure you have the information you need: ‘Did you pass the examination?’ or ‘Was your paper published?’ Closed questions can be unhelpful in some cases. In history taking, they may lead patients to give answers that match the doctor’s assumptions rather than the patient’s real symptoms.

***Probing questions***

Use probing questions to explore in greater detail actions, experiences and associated opinions and feelings that have been hinted at in the answers to earlier open questions. The candidate will not normally mind gentle interruptions with short questions; for example, ‘How did the patient respond to that treatment?’, ‘How did you feel when they did that?’, or ‘What did you do then?’

Interruptions are usually acceptable if they are in the form of a probing or deflection question and the interviewer continues to show interest in the interviewee. This approach involves careful listening and some practice if it is to work well.

At the end of a response to an open question it can be effective to pause and allow the interviewee to give more detail or to expand on the last point made. A small gesture may be used, or you may merely add a comment such as: ‘And . . . ?’ Or ‘Go on.’

Silence can also be a very effective way of getting the candidate to open up in areas they had not intended to tell you about. We sometimes feel uncomfortable if a long silence occurs during a conversation. This can lead us to fill it, usually with an ill-thought out and often unhelpful contribution. Silence can have a positive effect in the interview. It can be used to put gentle pressure on the interviewee. This requires a discipline not always found in less experienced interviewers, who must stop themselves from talking while the seconds pass.

***Reflective questions***

These are for checking understanding, and also serve to elicit further explanation. They involve selecting a word, or a few words, from the interviewee’s most recent response and feeding them back as a question: ‘You felt unsure?’ or: ‘You took responsibility for the patient?’

These questions work well in counselling situations, but can also be powerful in getting interviewees in selection or appraisal interviews to go into greater depth regarding their motives and feelings.

***Scenario-based questions***

This style of questioning is increasingly used in medical interviews, particularly during selection for progression through training. Trainees' responses are graded against predetermined criteria according to how well they answer the question. Examples might include the following.

The surgical trainee candidate might be asked to explain how they would respond if faced with an Anaesthetic Registrar who refuses to anaesthetise a patient for an appendicectomy.

Positive responses might include questioning the Registrar, reflection on the possible reasons for the response such as co-morbidity, the timing during the day, and a review of the decision to operate. More probing questions might be used by the interviewers to elicit an awareness of the patient's need to know what is going on. On the other hand, responses that indicated insistence on proceeding, threatening a critical incident, going over the head of the Registrar and discussing the matter with a senior consultant, or accepting the Registrar's response without questioning it, would be likely to lead to a negative assessment of the candidate.

A clinical example of scenario-based questioning could be based in the A&E department – a 12-year-old boy has fallen off his bicycle. He has a broken arm (supra-condylar fracture) and is complaining of breathlessness. The candidate is first asked an open question, such as 'How would you respond to this situation?'

Successful responses would show an awareness of possible vascular injury to the arm; possible pneumothorax and the risk of associated intra-abdominal injury such as a ruptured spleen. The possibility of head injury might also be considered.

Negative assessment would result from responses which failed to take a history of the nature of the accident or the patient's history including possibility of asthma, failure to perform an examination including the trachea, sending patient for CXR without excluding tension pneumothorax, and failing to assess circulation in arm.

***Leading questions***

Interviewers sometimes try to help the candidate to understand the question by first setting the context for it. The effect is to give the interviewee the answer in the question. These are seldom, if ever, helpful to the interviewer. For example, the interviewer might say: 'We attach a great deal of importance to good teamwork. How do you find you get on in teams?'

It is far better to use the situational approach described above. Ask for the candidate's experience of particular types of work events (e.g. situations they have found stressful), and then try to probe to uncover any successes or problems that have arisen, in particular those that relate to working closely with colleagues.

**Feedback to unsuccessful candidates**

Giving feedback to unsuccessful candidates who have attended for interview is considered best practice in recruitment and selection. (More detailed discussion on feedback in general is given earlier in this chapter.) An appropriate member of the interview panel should be sought and agree to be responsible for providing feedback that can

be an uncomfortable process for the person giving the feedback. Alternatively, each candidate may be allocated a panel member who will if required to give feedback. It is helpful if this person is decided in advance as they can then make notes of helpful feedback points about the candidates during the interview.

Those giving feedback should bear in mind the psychological state of the failed candidates. Most will be upset at having failed to obtain the post so information for feedback should be based on this knowledge. They are likely to be sensitive to strongly adverse criticism. So feedback should be given based on the basis that the person:

- wants feedback
- understands it
- accepts it
- can do something about it.

This can be achieved in the following way.

- Check whether the candidate wants feedback; not everyone does!
- Focus on being constructive by starting with something positive, suggesting ways in which the candidate may improve skills and experience.
- Ensure that the feedback is based on an objective judgement relevant to the person specification.
- Ensure feedback is based on the notes taken during the interview.
- Deal only with a few (one or two) areas for action.
- Concentrate on the highs and lows during the interview by referring to specific behaviour.
- Concentrate on things within the individual's control.
- Do not overload the individual.
- Reference to any knowledge of the candidate that did not form part of the application or selection process must not be made.
- Feedback must be consistent with the decision of the selection panel, even if as provider of feedback you do not agree with the decision.
- Feedback must not be given to anyone except the candidate.
- Feedback must not involve discussion about other candidates.
- A record should be kept of any feedback given to candidates.

If a trainee's serious shortcomings come to light during a selection process, they need to be dealt with through the postgraduate dean or clinical tutor. It is probably not appropriate to bring up such issues at the end of the interview.

## **Presentation skills**

Effective communication of ideas is fundamental to the development of professional knowledge. Postgraduate professional development is partly dependent on doctors sharing research and knowledge with colleagues in regular meetings. Your ability to make effective presentations can also have a significant effect on your career opportunities, since self-presentation is a key factor in attracting attention to your potential.

For the purpose of this section, presentations are taken to mean any situation in which you are required to communicate information, ideas, propositions or a report to an audience of any size. These might include presenting an audit report to a department, reviewing a paper, or contributing to a presentation with others. Making an effective presentation means knowing how to present your ideas, your research and yourself confidently and to the best advantage.

Of course, you want to be able to do this without spending too long agonising over it. This section will help you make the most of your opportunities in making a good impression as a presenter in both formal and informal situations. It will do this by taking you through the processes involved in preparing a good presentation. That is, by:

- selecting relevant material
- organising that material
- delivering it to the best effect.

The first important thing to realise about presentation situations is that, although our basic medium of communication is words, they account for only a small part of the total message. It is generally accepted that less than 25% of what you communicate will be concerned with your words, and some 75% will be concerned with the way you use your voice and with body language, such as facial expression, posture and gestures. You cannot give a good presentation unless you have done the right kind of careful preparation. As part of your preparation you must have the answers to six fundamental questions.

- **Why** am I speaking? What is the purpose of the talk? Is it to inform, to teach, to make a proposition or to inspire and motivate? Defining your objective, preferably in a single sentence, will make preparation simpler and focus the talk.
- **Who** am I speaking to? The size, mix, level of understanding and attitudes of the audience must be taken into account during preparation. Levels of complexity and volume of information and ideas will depend on the likelihood that members of the audience can absorb them in the time available.
- **Where** am I speaking? Always try visiting the venue before your presentation. Check the equipment is working, decide where you will stand and whether your voice will carry without a microphone. Remember that the presence of an audience will deaden the impact and volume of your voice. Make sure the seating layout suits the kind of presentation you have in mind.
- **When** am I speaking? If your presentation is to be made at the end of the working day, you will need to take into account the energy level of members of the audience. The duration of the talk should affect its structure and level of detail. Avoid trying to pack in too much for the audience to absorb in the time available. Audiences will get restless if you run over your allotted time, so keep to your plan. It helps to note the time by which you must finish and to place a watch in front of you at the beginning of your presentation.
- **What** am I going to say? The content will be determined by the objective. Keep returning to your objective statement in order to avoid losing direction. The material is normally organised in one of the following ways:

- ▶ a generalisation followed by detailed explanation or illustration
- ▶ using a time, spatial or geographical sequence, or a sequence based on ascending or descending order of importance of each element
- ▶ contrasting one set of facts/ideas with another
- ▶ dividing a unit up into its component parts and saying a little about each.

Ask yourself which method will help you to present your material most effectively, then you are ready to write the first draft. Most good presentations are divided into an introduction, which sets the scene and prepares the audience for what is to come; a main body comprised of three or four main points; and a conclusion, which summarises and emphasises the theme.

- ▶ Write your opening and closing sentences in full and learn them ‘off by heart’.
- ▶ Capture the audience and tell them everything they need to know about the presentation in the opening.
- ▶ Make the conclusion really conclusive.

Remember that your presentation will be spoken. When you write your draft, write it in spoken English, not written English. This will help you to sound more natural, even when you are actually reading whole phrases or sentences from your cue cards (as most speakers do from time to time).

To help you achieve a clear, natural style, remember these tips.

- ▶ Use simple, familiar words that come to you naturally.
  - ▶ Only use technical jargon that your audience will understand.
  - ▶ Use short sentences.
- **How** am I going to say it? Most speakers use notes or prompt cards, but speak from brief notes to avoid reading word for word. The use of voice and gesture as well as audiovisual aids requires careful thought, practice and self-awareness. For speaking notes:
- ▶ use small cards rather than sheets of paper as they’re easier to hold and look more professional
  - ▶ write key sentences and key words on the cards
  - ▶ fasten the cards together, or at least number them in sequence in case you drop them.

### Effective delivery

Paying attention to articulation, pace, intonation and emphasis achieve effective delivery.

- Good articulation can be achieved by practising enunciation in front of a mirror. Many speakers are ‘lazy’ in the way they form their sounds, not moving their lips and tongue enough. Keep your head up. Don’t speak with your chin down in your collar.
- Pace should be varied to maintain interest. Nervous speakers always speak too quickly. Avoid racing! Pauses can be used for effect, but they also allow the listeners to absorb the points you are making and react to them.

- Intonation is the rhythm and inflection in the voice. Most people use only two or three tones of the musical scale when they speak. The Welsh and the Western Highlanders, on the other hand, use about an octave and a half. Get colour into your voice.
- Emphasis, often coupled with repetition, is a most useful speaking device. If your voice lacks colour, practise emphasising key words and phrases from your cue cards. Remember that you can also emphasise points by using appropriate (but not distracting) gestures.

In general, try to achieve the following.

- Speak as naturally and conversationally as possible.
- Stand in a comfortable position with your feet slightly apart.
- Smile and be friendly.
- Maintain good eye contact with the whole audience.
- Check whether you have any distracting mannerisms and work to get rid of them. These may include excessive use of certain phrases or sounds ('space fillers') such as 'you know', 'um', 'er' or 'You see'. Habits such as jingling keys or coins in a pocket, or pacing up and down like a caged tiger, can also be a barrier to effective communication with the audience.

### Visual aids

Good use of visual aids will improve your presentation by helping your audience to remember what you have said more easily than if you use words alone. Visual aids used badly or carelessly can be very distracting and even irritating, and are often worse than none at all. PowerPoint is normally regarded as the most professional way to present, but avoid overdoing it. Too many slides and too much use of special effects can be distracting and even irritating for an audience.

- Check that equipment is in the right place and working properly before you begin.
- Be sure that everything is large enough to be seen by everyone in the room.
- Don't read from visuals – you insult the audience's intelligence.
- Face the audience, not the screen. If you have one, place your laptop so that you can glance at it from time to time.
- Each picture should have only one main message. Complex slides confuse and bore.
- Minimise the words on each visual. A maximum of 20 is a good rule of thumb.
- Words should be in a clear, readable font (in roman not italic), and at least 20-point font size should be used.
- Always be prepared with back-up material, to cope if the machinery breaks down.

Handouts are sometimes used to support a presentation. It can sometimes be unhelpful to circulate them at the start of your presentation, as they may become a distraction. On the other hand, many people like to have a copy of the presentation so that they can add notes to it as you speak. You should adapt your approach to suit the audience.

**Taking questions**

- Decide whether you will take questions during or after your presentation and tell your audience your decision clearly in the introduction to your presentation.
- Listen carefully to the question and check that you've understood it.
- Repetition of the question also helps everyone in the room to know exactly what is being answered.
- Do not expect questions to come as soon as you stop talking. You are expecting the audience to go into a different mode, so be prepared to wait or 'plant' a question in the audience to get things going.
- Keep your answers short as you may bore the rest of the audience.

**Action**

Bearing in mind the above notes, describe in the space below what you see as your strengths and weaknesses as a presenter. If possible seek pointers from a colleague or friend who has seen you make presentations.

Strengths:

Weaknesses:

Now reflect on these, considering which of your weaknesses could be due to lack of experience or learning, and which are unchangeable. Seek to describe them in ways that help you to decide what improvements you need to make in your approach.

Now identify the types of situation in which you expect to make presentations over the next year or so.

At your next presentation, ask a couple of members of the audience (preferably friends who you can rely on to give you helpful feedback) to make notes about the way you make your presentation and tell you what they thought of it afterwards. You and they may find the checklist in Box 3.1 useful as a guide. Do not mention your perceived weaknesses to them beforehand, but quiz them about these aspects of your presentation when you get your feedback.  
Good luck!

**BOX 3.1** Presentation feedback sheet

**Content**

*Introduction*

- Was the purpose clear?
- Was a link made with the audience?
- Did the speaker make an impact within the first two minutes?

*Main body*

- Was the talk pitched at a level to suit the audience?
- Were there clear stages?
- Did it follow a logical sequence?

*Conclusions*

- Was there a summary of key points?
- (If relevant) was there an indication of action to be taken, and by whom?

**Voice**

- Volume too loud/soft?
- Tone varied to maintain interest?
- Pace too fast/slow?

**Timing**

- Started and finished on time?

**Stance**

- Relaxed posture, facing audience?

**Mannerisms**

- Free from distraction, such as pacing, verbal habits?

**Visual aids**

- Relevant/simple and clear/technically proficient?

## Contributing to meetings

There are many different kinds of meeting, including small group, support, events, clinical, staff, departmental, open or public, committees, workshops, learning sessions, conferences and so on. Meetings are a feature of professional life. They are a common event for clinicians representing colleagues, nurse managers and business managers.

They are also expensive and can waste time; for example, when there is no clear objective to the meeting, or a lack of effective leadership and control, or there are too many or the wrong participants. Time is often wasted on debate about 'Why?' rather than 'How?' In addition, a lack of clarity on outcomes produces unclear final decisions or even no decisions. Meetings that do not achieve results not only waste time but also often lead to more meetings.

## Aims, planning, teamwork

Every well-run meeting, whether formal or informal, should be based on three prerequisites:

- clear aims
- careful planning
- effective teamwork.

Clear aims should be related to the purpose of the meeting. A departmental meeting may be for talking, listening and sharing problems. A committee normally aims to make and agree decisions, whereas a learning session is about sharing ideas through teaching and learning.

Always go to meetings knowing what you want to achieve.

Advance preparation is vital, and that applies to all participants. How often have you been at a presentation of a new idea and when participants have been asked to comment, nearly everyone has suggestions for improvements? Yet no one was given the opportunity to study the proposal in advance, everyone was seeing it for the first time. Discussions are lengthy and suggestions numerous.

Other time-wasters include fighting losing or lost battles by discussing items decided elsewhere or that are not within the group's power to decide.

## Some reasons for meetings

Meetings can be called for all sorts of reasons other than reaching a decision, and these can be classified as follows:

- creating and developing ideas (e.g. brainstorming sessions)
- sharing out work and responsibility – usually valuable for small groups only
- delegation of work or authority within a group
- sharing responsibility for a difficult problem
- providing or receiving information – there may be better ways
- persuasion – best done before the meeting
- networking, which become 'talking shops'
- an alternative to preparing a short written report

- committees in the habit of meeting without a real purpose, even with lengthy agendas
- socialising – acceptable at the beginning of a meeting, but do keep it short
- perhaps as a substitute for work.

### **Decision making at meetings**

Decision making on tasks or issues may be a valid reason for calling a meeting, but you need to ask yourself if it is:

- consulting before a decision is made
- gathering information for a decision to be made elsewhere
- gaining agreement on a decision
- seeking a decision that requires the agreement of more than one group
- enhancing commitment to a decision
- making a decision.

### **Why go to a meeting?**

Any meeting you attend is your meeting too. Do you know why you're going? At every meeting you should have a personal objective(s).

### **Planning for a meeting**

Make sure you are fully prepared; otherwise you are failing to be an effective member. It may be the opportunity to put across a message. A seed sown today might be important for later. You can often turn someone else's question into a bridge for your own message. A question directed at you, in any situation, will always give you an opportunity to say what you want. Always answer the question and then make your point. If you are asked a question and you don't know the answer it is perfectly acceptable to say 'I don't know but I'll find out and let you know' and then go on to your statement, via a suitable link. You can also use the same technique in response to a statement, by agreeing with that statement, before linking to your own statement. Here the speaker becomes the leader and controls the meeting while speaking. This is observable at medical committees.

### **Seating arrangements**

Semicircles are good for problem-solving meetings and provide a good balance of control and sensitivity for the leader. Long tables are control mechanisms and inhibit brainstorming sessions. It is impossible to see others down the same side of the table, and discussions between participants are limited. The more eye contact and the more people it is made with, the more control you have.

To some extent where you sit will depend on your purpose. If you want to be uninvolved pick a position that permits that. If you are seeking to win a point or plan seizing control, pick a controlling position. At a long table this will be at either end. At a three-sided arrangement this will be either side of the chair or at either end. At a long table, an ally at the other end of the table will give you maximum support in handling a difficult meeting.

Next time you are at a meeting observe where people sit and see how it influences their roles. If you are going to be a competitor to the chair, sit as far away as possible. The ideal position is opposite, so that you can talk directly to the chair and include others as well.

## **General meeting techniques**

### ***Interruptions***

Knowing when to interrupt to gain control is a useful tool. Asking a question is a useful way of interrupting and changing the direction of the meeting. Always maintain a moderate tone and remember that the greatest impact you have will be through your non-verbal communication.

- 'Have you considered . . . ?'
- 'Could I add . . . ?' and continue speaking.
- Call the person by name, 'John, don't forget . . .', and continue speaking.
- Just start speaking and raise your voice above the level of the other person.

Do not wait for permission to be granted before you interrupt, but continue talking. It is often difficult to hang back while someone presents something that you consider inappropriate. But do think twice before making yourself vulnerable by interrupting the speaker, as your own point may not be quite as perfect as you thought.

If you want to prevent yourself being interrupted:

- insist on finishing by saying: 'Please, just let me finish . . .' and continue
- hold your hand up, palm outwards, and continue.

### ***Criticism***

If your suggestion should be the subject of criticism, ask the critic to present an analysis of your proposal with workable alternatives for the next meeting. Emotion can resist logic. When someone is emotionally aroused, your best ploy is to remain silent until their emotion peters out.

### ***Opposition***

When you are up against opposition your objective should always be to determine your opponent's objectives. There is nothing wrong with having a different objective. Ask yourself what your opponent wants and why they want it. Better still, ask them. Only when you know your opponent's priorities can you plan your own strategy.

### ***Confrontation***

If you are disagreeing with someone, try to provide your opponent with a way out, a way to save face. If you disagree, first state what you agree with, thus supporting their position as modified by your own. Make criticism less personal by claiming you are acting as the 'devil's advocate'.

***Contribute early***

Research indicates that when a person contributes early in a discussion, they are likely to exert a greater influence throughout the discussion. Asking questions for clarification or to challenge assumptions is a positive way to contribute at an early stage. This will help you to establish where others stand before committing yourself. This also obliges others to respond to you, but be prepared to come back into the discussion to combat opposing arguments.

**Conducting meetings**

If you hold the role of chairman or secretary to a regular meeting, you should ask yourself whether the meeting is necessary, and always question the value of minutes as compared with action points. The latter tend to be much easier and quicker to produce, are specific about who is responsible for actions and by which date they should be completed. They can normally be agreed at the end of the meeting. Keeping detailed minutes of meetings means that much time at the beginning of the following meeting is taken up in checking them for accuracy and discussing matters arising. This ritual often wastes time, as matters of real importance are normally dealt with in the meeting agenda. Of course, there are sometimes statutory reasons for maintaining detailed meetings. Occasionally, it is deemed necessary for clinical governance purposes. You should always be prepared to challenge the need for them, however.

A further point to consider is whether the discussion of 'any other business' serves a useful purpose. This item frequently allows those who are too lazy or disorganised to prepare properly for the meeting by submitting agenda items in advance to address their issues when everyone is anxious to leave. This can allow important matters to be inadequately addressed by the meeting. 'Any other business' can also be a golden opportunity for time-wasters to hold up progress on more important matters. Many meetings are conducted without redress to 'AOB' and are considered to be the better for it.

**Action**

There is an important difference between a stimulating discussion and a productive meeting. For the next meeting you attend, ask yourself the following questions.

- What is the purpose of this meeting?
- What should I achieve by the end?
- How will I distinguish my success from failure?

After the meeting ask the following.

- Was I correct about the task?
- Were the other participants clear about the task and objectives?
- Did I achieve the meeting's objective as stated in the agenda?
- Was the meeting a success or failure?
- If it was a failure, why?

- What could be done to improve the next meeting?
- What was done that should be discontinued?
- What could the chairperson do to improve the meeting?
- Could you have done without the meeting?
- If so, how?

## Being interviewed

Before considering interviews, it might be worth reflecting on the importance of your CV or application as a basis for, firstly, being short-listed and, secondly, for the panel to prepare questions. You should remember that at least some of the panel will never have met you, so their first impressions will be coloured by the quality of your application.

Modernising Medical Careers has introduced a more structured, centralised process of recruitment to the appointment of trainees. Deanery-based selection panels deal mostly with applications forms for specialist training posts, but many candidates for interview are still asked to bring copies of their CV to the interview. In some cases, though, application forms are the only source of information for the short-listing panels. CVs may still be required for trust posts or senior medical appointments. The MMC website carries updated information related to the selection process for the different training specialties. The selection process is structured around the person specification, with which you should be wholly familiar before the interview.

Selection interviews for specialist training posts are normally comprised of a number of interviews and assessments. These may involve attendance for at least half a day and may include a traditional interview, a scenario-based interview (*see above*, p. 90), an interview based on the trainee's portfolio and possibly competence tests such as patient simulation exercises.

Prepare everything the day before and allow plenty of time by arriving early and having all possible questions and your answers totally revised and memorised. You need to convince the panel that you will achieve your goals or, in the case of a consultant appointment, make a delightful colleague.

Apart from specialist training appointments, the size of appointment committees tends to grow in relation to the seniority of appointment, although there are guidelines and statutory regulations for the composition of selection committees. In the case of consultant interviews, it is not uncommon for the main interview process to be enhanced by a series of smaller interviews with small groups (say three or four persons) from the multidisciplinary team. These are used to help other future colleagues to have a say in who they will be working with, as well as giving you greater insight into the culture of the organisation. Apart from consultants within a specialty, members of the main selection committee will not all know one another. You can be reassured that even some of the panel members may feel in strange surroundings, and many panel members also confess privately to some nervousness.

As a general rule you should dress to reassure and fit the stereotype of the post for which you have applied. Go into the room positively, smiling and determined to enjoy it. It will not be as bad as a viva examination. Try to:

- be relaxed but business-like
- sit upright
- be friendly, smile with perhaps a degree of authority
- look initially at the chairperson, who should put you at your ease
- show enthusiasm for the job.

### Interview questions

Routine questions (usually from the chair) about your journey or finding the place help to 'break the ice' and are usually followed by some more routine questions to clarify any queries with your CV, such as unusual features or gaps. The questions then tend to move on to asking you your reasons for wanting the job or what attracted you to it. This is an opportunity to show that you have researched the hospital. Perhaps you have identified a significant challenge that the institution faces. Take care to avoid appearing critical of the trust or its management; they are unlikely to warm to someone who hardly knows them and who finds fault.

The next questions are likely to explore your future career direction. Be enthusiastic and do not give evasive answers. The questions are usually fairly straightforward, and simply aimed at getting you to talk about yourself. Do so with a mixture of confidence, enthusiasm, honesty and maturity as appropriate to the question (it is as easy as that!).

Always address your answer initially to the questioner but look around and try to engage all the panel members with your answer. Be neither monosyllabic nor loquacious; balance is important. Even if asked closed questions, avoid the temptation to give simple 'Yes' or 'No' answers. Try to expand the answer to allow the interviewer time to recover. You will gain no friends by making him or her feel uncomfortable.

The panel will normally have agreed in advance to split up questions into a number of areas, each covered by one panel member. You might be asked about your vision for the hospital and department, what you think of the hospital, or what you have to offer. Typical questions ask about research you have done or intend to do, your experience of clinical audit, government reports that affect you, and the NHS generally, as well as possible future plans and changes in the NHS.

There may be questions that seek to reveal 'what makes you tick'. These are usually about hobbies and outside interests. Avoid suggesting these might interfere with your work! Aptitudes and outside interests are a measure of whether you are a well-rounded personality.

### Talking about strengths and weaknesses

The interviewers may try to reveal your virtues and weaknesses, perhaps by asking about your mistakes or weakness directly, or your aptitudes and ambitions. Answers tend to reveal your personal values. Questions about weaknesses, mistakes, tasks that you could have done better, or opportunities missed gauge your self-awareness, intellectual honesty, maturity and dependability, and may relate indirectly to your team-membership characteristics.

There are no right answers to these questions, but it is worth thinking in advance about mistakes you have made, difficult situations you have been in, and times when

you have felt out of your depth and how you coped, and what you learned from these experiences.

Pressure questions about previous failed interviews may also give clues about your ability to cope with stress, your maturity and your emotional stability.

Questions about your greatest achievements, challenges or responsibilities are an attempt to obtain a record of your standards, your qualities of management and relationships, as well as your leadership style and ability, and whether you are a process- or people-oriented person. Questions about relationships are trying to assess relationships with colleagues by view of personality: social or self-contained; conforming or independent; extrovert or sensitive; phlegmatic or excitable.

### **Handling difficult panel members**

These are the ones who ask tricky questions that are intended to impress the committee with the questioner's skill. If you are asked that sort of question, stay calm, and if you find you are struggling remember that only better candidates get asked difficult questions to separate them, and that committee members usually have sympathy for candidates being given a difficult time by colleagues.

### **Handling silence**

If there is silence after your answer, you are being invited to continue. Do not be embarrassed by silence, even if you need time to think about your answer. Allow yourself time to think before answering, so that your replies are considered and logical. Do not be tempted to leap in and say something ill-considered.

You need not be embarrassed to have a question clarified if you are not clear what you are being asked, but do not waste time looking for hidden catches. Remember the interviewers are usually seeking reassurance. Do make sure you are answering the question asked. With multiple questions try to remember the individual questions or clarify before answering.

### **Conclusion**

Try to appear friendly, cheerful and smiling. Body language helps with a businesslike authoritative attitude, professional appearance and energetic approach. At the end of the interview you are generally invited by the chair to ask the panel any questions you might have. While it will not count against you to ask a question, it is acceptable and possibly desirable not to do so.

### **Panel presentations**

This is a developing method of helping to assess candidates for consultant appointments, and is thought to be a reasonable way of assessing the vision of candidates in relation to the future of a unit. Whether the candidate has grasped the problems of the unit in pre-interview visits and has a realistic expectation of what they are coming to will also be apparent. Some candidates like it as a way of being in control of the first part of the interview, whereas others feel uncomfortable making presentations, particularly as it will not usually be a part of their everyday work. It does illustrate the

importance of making sure you collect useful information from the clinical director, medical director, chief executive and chairperson when paying your pre-application visit.

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