obtained from patients was accurate and reflected key problems may have been due to their hurrying to complete their interviews within the allotted time.

The fact that the benefit of interview training with psychiatric patients extended to interviews with physically ill patients is encouraging and justifies the continuation of this training. It might be even more effective with both undergraduates and postgraduates if it were also given in other clinical departments, focused more on the weaker areas of performance, included practice with physically ill patients, and promoted discussion of the reasons for the reluctance to cover psychosocial problems and how to handle strong emotions and difficult questions.[6 17 18]

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II—Most young doctors are bad at giving information

Abstract

Forty young doctors, half of whom had had feedback training in interviewing as students, were assessed five years later. Each interviewed three patients and after being given results of examination, investigations, and diagnosis and prognosis returned to discuss them with each patient for 10 minutes. These discussions were filmed on videotape and evaluated. There was no difference between the scores of interview trained and control doctors. Though most gave simple information on diagnosis and treatment, few mentioned investigations, aetiology, or prognosis. Very few obtained and took any account of patients' views or expectations of these matters. Some young doctors do discover for themselves how best to give patients information and advice, but most remain extremely incompetent. This is presumably because they get no training as students in this important aspect of clinical practice. This deficiency should be corrected, and competence tested before qualification to practise.

Introduction

Teaching students in British medical schools about doctor-patient communication was until recently limited to history taking. Then interest broadened to teaching interviewing skills, emphasising the value of listening and responding as well as asking the right questions.[1] Despite the effectiveness of this teaching, it has seldom extended to teaching students how to handle the second part of a consultation, when a doctor explains and discusses his findings and his plans for investigation and treatment. Sir Ronald Bodley Scott commented on this omission 20 years ago when he stated that "this transaction is the doctor's quintessential function for it is a necessary preliminary to any treatment," and he observed, "We seldom discuss it with our students and never instruct them in its management."[2]

A study of the interviewing skills of recently qualified doctors gave us an opportunity to determine how skilled they had become in discussing their conclusions with patients, despite their lack of appropriate, formal training when they were students at Manchester Medical School.

Methods

We have already described how we obtained our sample of doctors and real and simulated patients. As we no longer needed to balance the design by type of problem, order of interview, and type of patient, we included four more doctors to increase the sample to 40, comprising 20 who had been given feedback training in interviewing as medical students and 20 who acted as controls.

Each doctor conducted three 15 minute interviews. A patient with a different illness (psychiatric, life threatening, or chronic disability) was seen on each occasion, and the doctor's first task was to determine the presenting problems. When this had been done the doctor was called out and given details of the results of physical examination and relevant investigations and was told the diagnosis. He was also given a treatment plan and a prognosis and asked to assimilate this information for five minutes. He then returned to the patient for 10 minutes to explain and discuss his findings, the diagnosis, and the proposed treatment. He was also told to mention the prognosis in appropriate terms. These discussions were recorded on videotape for later rating.

ASSESSMENT

Besides rating how well information was given to the patient the assessment was also based on the concept advanced by Tuckett *et al* and Pendleton *et al* that the doctor should tailor what he says about his findings and intentions according to the patient's own view of what is wrong and what treatment he expects and should also check that his diagnosis and advice have been accepted by the patient and understood.[3 4]

A rating scale was designed (see appendix) in which the handling of the main topics listed in table I was scored on a series of three point scales (where 0=no attempt, 1=moderate attempt, 2=good attempt) to indicate how well the doctor had handled and explained the topic. Moreover, two further three point scales assessed exploration of the patient's views and negotiation on an agreed conclusion in the light of these views. The first topic that the doctor mentioned was noted, and interviews were also rated on the extent to which the doctor used the methods thought by Ley to improve recollection of and compliance with advice and medication.[5]

Results

First topic mentioned—Over half the discussions (64, 54%) began with an explanation of the test results. Some began with an explanation of the

TABLE I—*Mean scores for handling main topics*

Topic	Mean total scores: Possible total	Trained doctors	Control doctors	All doctors (% of possible)	Mean scores excluding patients' views and negotiation: Possible	All doctors (%)
Previous tests	10	1·9	2·4	2·2 (22)	6	2·01 (34)
Diagnosis	8	2·9	3·1	3·0 (38)	4	2·39 (60)
Aetiology	8	2·1	2·1	2·1 (26)	4	2·58 (40)
Future tests	10	2·9	2·5	2·7 (27)	6	2·38 (40)
Treatment	10	5·8	5·1	5·5 (55)	6	3·72 (62)
Prognosis	8	1·6	1·5	1·6 (20)	4	1·21 (30)
Patients' views (all topics)	12	2·1	2·1	2·1 (18)		
Negotiation (all topics)	12	1·7	1·5	1·6 (13)		

TABLE II—*Distributions of scores on main topics. Values are numbers (and percentages)*

Topic	Poor score	Moderate score	Good score
Previous tests	86 (72)	33 (28)	1 (1)
Diagnosis	47 (39)	59 (49)	14 (12)
Aetiology	74 (62)	38 (32)	8 (6)
Future tests	78 (65)	31 (26)	11 (9)
Treatment	30 (25)	48 (40)	42 (35)
Prognosis	96 (80)	20 (17)	4 (3)
Patients' views	113 (94)	7 (6)	
Negotiation	115 (96)	5 (4)	

For items 2, 3, 6, maximum score 8, poor=0-2 (25%), moderate=3-5 (63%), good=≥6 (75%)
For items 1, 4, 5, maximum score=10, poor=0-3 (30%), moderate=4-6 (60%), good =≥7 (70%)
For items 7, 8, maximum score=12, poor=0-4 (33%), moderate=5-7 (58%), good =≥8 (75%)

Distribution of discussion scores—The mean scores shown in table I conceal that fact that there were some very good discussions, particularly in respect of treatment and, to a lesser extent, diagnosis (table II). For the other topics good discussions were rare: for most of them the performance was poor or they were often omitted altogether.

Obtaining patients' views and negotiating—Table II shows that there were no discussions in which good attempts were made to obtain patients' views or to negotiate in respect of all the topics. Table III, however, shows that when these aspects are considered for each topic separately patients' views were satisfactorily obtained about treatment in 24% of discussions, and good negotiation took place only slightly less often. In respect of the other topics these aspects of the discussions were usually omitted and were seldom handled well.

Ley's recommendations—In most discussions the doctors were proficient in avoiding medical jargon, using short words, answering questions, and giving

TABLE III—*Distribution of scores on obtaining patients' views and negotiating. Values are numbers (and percentages)*

Topic	Obtaining patients' views: 0 No attempt	1 Moderate attempt	2 Good attempt	Negotiating: 0 No attempt	1 Moderate attempt	2 Good attempt
Previous tests	114 (95)	4 (3)	2 (2)	118 (98)	1 (1)	1 (1)
Diagnosis	88 (73)	22 (18)	10 (9)	95 (79)	19 (16)	6 (5)
Aetiology	90 (75)	24 (20)	6 (5)	97 (81)	18 (15)	5 (4)
Future tests	102 (85)	14 (12)	4 (3)	108 (90)	7 (6)	5 (4)
Treatment	37 (31)	54 (45)	29 (24)	57 (47·5)	36 (30)	27 (22·5)
Prognosis	98 (82)	17 (14)	5 (4)	106 (88)	9 (8)	5 (4)

TABLE IV—*Use of methods recommended by Ley. Values are numbers (and percentages)*

	No attempt	Moderate attempt	Good attempt	Mean score
Avoided jargon	9 (8)	54 (45)	57 (48)	1·40 (70)
Used short words	7 (6)	59 (49)	54 (45)	1·39 (70)
Answered questions	34 (29)	29 (24)	57 (48)	1·19 (60)
Gave specific advice	26 (22)	41 (34)	53 (44)	1·23 (61)
Gave advice early	36 (30)	51 (43)	33 (28)	0·98 (49)
Repeated and reinforced information	76 (63)	23 (19)	21 (18)	0·54 (27)
Encouraged questions	84 (70)	17 (14)	19 (16)	0·45 (23)
Checked patients understanding	107 (89)	10 (8)	3 (3)	0·12 (6)
Categorised information	108 (90)	9 (8)	3 (3)	0·13 (7)

purpose of the interview (14, 12%), diagnosis (15, 12%), or recapitulation of the patient's key problems (12, 10%). Occasionally the patient's future plans (9, 7·5%) and the proposed treatment (3, 2·5%) were considered first. Only one interview began with an attempt to categorise the information to be given—for example, "I would like to start by telling you what I think is wrong."

Handling of topics—There was no difference between trained and untrained doctors in their mean scores for handling the six main topics (table I). Most scores were low, and treatment was the only topic with a mean score of over 50%.

Information giving—To see how well doctors just gave and explained information marks for obtaining patients' views and for negotiation were excluded from the analysis (table I). Scores on all topics except prognosis were then increased. Even so all except those for diagnosis (60%) and treatment (62%) were well below 50% of the possible maximum.

specific advice, especially early on in the exposition (table IV). They were less good at repeating or reinforcing advice and encouraging patients to ask questions. In only a few interviews was any attempt made to check whether a patient had understood what had been said or to categorise the information given.

Discussion

The fairly poor performance of the doctors is disturbing. Few used a systematic approach to giving information and advice, and most began with the data given to them rather than with a recapitulation of the problems they were about to treat or with an explanation of this second part of a consultation. Unfortunately, the

doctors were weakest on the techniques that have been found to increase patients' satisfaction and improve their compliance with medical advice and treatment.[6-8] These include discovering the patients' own views of their illnesses and their expectations of treatment and discussion of their consequent reactions to the information and advice they receive so as to help ensure their acceptance of it. It was, however, gratifying that in a quarter of the discussions the doctors did negotiate about treatment. Fewer than half of them used the techniques thought by Ley to improve compliance.[6] Their reluctance to discover the patients' views of their predicaments and to mention prognosis paralleled their tendency to avoid asking them about social and psychological aspects.

The poor performance of these doctors might have been due to the artificial nature of the consultations, but this is unlikely. They were used to being videorecorded, having participated in earlier studies with this method, and the group who had had feedback training in interviewing had no difficulty in doing this in the same conditions. Both control and trained doctors took their task seriously and did not appear to be distracted. When we discussed their performances with them after the recordings they said that they handled their own patients similarly. They agreed that their poor performance was due to lack of clear guidance about how to give information and advice to patients either while or since they were medical students.

We recognise that our sample was small and might be unrepresentative of young doctors in Britain. It was, however, typical of doctors produced by an established medical school that takes seriously the teaching of interviewing skills. Consequently, we believe that our findings represent true deficiencies in skills and indicate why doctors are so much less able to promote compliance with advice and treatment than would be expected. As these young doctors, most of them working in hospitals, will receive no further training in communication their performance may reflect that which is usual in hospital consultant practice.

The absence of any differences between trained and control students is noteworthy. It shows that the benefits of feedback training in interviewing skills do not help the communication of information and advice.

We conclude that a few doctors can present their conclusions and advice to their patients effectively, but most remain incompetent. The solution must lie in providing effective teaching of communication skills in medical schools and introducing the sort of assessments we have conducted to ensure competence before qualification. Now that medical treatments are potentially so effective it is essential that doctors should learn how to help patients understand and accept their advice and carry it out correctly. There is no doubt that when these young doctors were medical students they had not, in terms of the General Medical Council's recommendations, learnt "to communicate effectively and sensitively with patients."[9]

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Appendix

BASIS OF SCORING MAIN TOPICS ON THREE POINT SCALES (0-2)

Previous tests
Clearly described them
Explained the results
Explained their implications
Explored patients' views on this
Negotiated about it

Diagnosis
Gave a clear diagnosis
Explained it
Explored the patient's view on it
Negotiated about it

Aetiology
Clearly described causes of illness
Explained their effect
Explored patient's view of them
Negotiated about them

Future tests
Clearly described them
Explained them
Explained their implications
Explored patient's view on this
Negotiated about it

Treatment
Clearly described treatment and management
Explained them
Gave their purpose
Explored patient's view of them
Negotiated about them

Prognosis
Explained short term prognosis
Explained long term prognosis
Explored patient's view on this
Negotiated about it

The postdischarge treatment of patients who have had an intraocular lens implant seems to be pilocarpine drops 4% and maxitrol drops four times a day. What is the rationale for this treatment and for how long should it be given?

Among the earlier designs of intraocular lenses still widely used in Britain are those that are held in the pupil by the tone of the sphincter muscle (iris fixated lens). There is a risk of dislocation of these lenses, however, if the pupil dilates or is dilated. The lens may either dislocate backwards into the vitreous, in which case it is difficult and probably dangerous to the retina to attempt to replace it in the pupil, or forwards into the anterior chamber, where it will rub against and damage the corneal endothelium. The use of a parasympathomimetic drug such as pilocarpine drops exaggerates sphincter tone and stabilises the lens. The pilocarpine drops are continued twice or three times daily for up to six months after surgery. Often mild adhesions develop between the legs of the intraocular lens and the pupillary margin and the drops may safely be stopped.

Lens designs that span either the posterior or the anterior chamber are now frequently used and do not rely on the sphincter for their stability. Pilocarpine drops are therefore not required for this type of lens. Steroid drops are used to control the inflammatory response commonly seen after cataract surgery. Predsol drops are usually used but if the inflammation is severe a more powerful steroid such as dexamethasone is used and the frequency may be increased. Postoperative infection of the eye is a disastrous complication. The use of a broad spectrum topical antibiotic such as chloramphenicol or polymyxin reduces the frequency of severe ocular infection after cataract surgery.[1] Maxitrol drops—a combination preparation of dexamethasone and polymyxin—is a convenient way of delivering these drugs to the eye. In uncomplicated cases the antibiotic and steroid drops are usually used three or four times daily for the first six weeks after surgery and are tapered off and stopped soon after this.—BRUCE A NOBLE, consultant ophthalmologist, Leeds.

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