Invite, Listen, and Summarize: A Patient-Centered Communication Technique
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Abstract

The need for physicians to have patient-centered communication skills is reflected in the educational objectives of numerous medical schools’ curricula and in the competencies required by groups such as the Accreditation Council for Graduate Medical Education. An innovative method for teaching communications skills has been developed at the University of Colorado School of Medicine as part of its three-year, longitudinal course focusing on basic clinical skills required of all physicians. The method emphasizes techniques of open-ended inquiry, empathy, and engagement to gather data. Students refer to the method as ILS, or Invite, Listen, and Summarize. ILS was developed to combat the high-physician-control interview techniques, characterized by a series of “yes” or “no” questions. The authors began teaching the ILS approach in 2001 as one basic exercise and have since developed a two-year longitudinal communications curriculum. ILS is easy to use and remember, and it emphasizes techniques that have been shown in other studies to achieve the three basic functions of the medical interview: creating rapport, collecting good data, and improving compliance. The skills are taught using standardized patients in a series of four small-group exercises. Videotaped standardized patient encounters are used to evaluate the students. Tutors come from a variety of disciplines and receive standardized training. The curriculum has been well received. Despite the fact that the formal curriculum only occurs in the first two years, there is some evidence that it is improving students’ interviewing skills at the end of their third year.


The need for physicians to have patient-centered communication skills is reflected in the educational objectives of numerous medical schools’ curricula and in the competencies required by groups such as the Accreditation Council for Graduate Medical Education. An innovative method for teaching communications skills has been developed at the University of Colorado School of Medicine as part of its three-year, longitudinal course focusing on basic clinical skills required of all physicians. Using this method, we teach a patient-centered and evidence-based method of interviewing. Patient-centeredness is a concept that refers both to a better understanding of the person of the patient and also to a more humane and respectful way of including the patient in the interview process.1,2

To provide the students with an adequate cluster of interview skills we emphasize three prime techniques, Invite, Listen, and Summarize (called “ILS” by the students). These skills are demonstrated in the following three-minute interview:

Medical Student (MS): Hi! I’m Billy Osler. I’m a medical student working with Dr. Dwinnell today.

Patient (Pt): Hi! How’re you doing? I’m Ralph Hart.

MS: Glad to meet you, Mr. Hart. Well, since we haven’t met before, maybe before we get to the medical stuff, you could tell me a little about yourself as a person.


MS: So you’re one of the guys who grows those great melons. I love ’em. The Pride of Colorado! Well, Mr. Hart, tell me what brings you in today.

Pt: OK. I’ve been having some chest pain and it’s getting me worried.

MS: So chest pain. Tell me more.

Pt: Well, I’ve been getting it for about six months. It’s not exactly a pain; more sort of a pressure or a heaviness in my chest here. I mainly get it when I’m doing stuff around the farm, especially walking up a hill on my property. Maybe it’s getting it a couple of times a week and more lately.

MS: I see. More a pressure. And getting more frequent. Anything else you can tell me?

Pt: Well, it usually lasts a couple minutes and then it goes away. But sometimes I break out in a sweat when I get it and even get short of breath.

MS: So pain for a couple of months, a pressure type feeling, and typically when you’re doing things. Sounds like it’s happening more and you’re getting short of breath and sweating with it sometimes. Is that it?

Pt: Yeah, you got it right, Doc. The big thing is that my wife has been very concerned about it and has been bugging me to come in.

MS: I see, you’re really here because of your wife.

Pt: Yeah, but I’m concerned too.

MS: I see. Anything else?

Pt: No, that’s about all.

MS: So what do you think it is?

Pt: Well, I’m a little concerned it’s my heart. My dad had something like this and they used to call it angina and he dropped dead when he was about my age.

MS: How do you feel about that?

Pt: I’m a little scared. I guess it’s not just my wife. I’m a little worried myself that it could be the same thing he had.
that color the patient’s story.6

observation of verbal and nonverbal clues allows the student to build empathy with conversation. Listening is a core skill that charting or computer use during the con-

avoiding distractions such as too much primally, maintaining eye contact, and interview include, “So you’re one of the things else?”; “What do you think this is?”, “Tell me what brings you in today”; “Tell me more”; “Anything else you can tell me?”; “Anything else?”; “What do you think this is?”; and “How do you feel about that?”

Although not visible in the script above, the student listens avidly, nodding appropriately, maintaining eye contact, and avoiding distractions such as too much charting or computer use during the conversation. Listening is a core skill that allows the student to build empathy with observation of verbal and nonverbal clues that color the patient’s story.6

Active (or reflective) listening requires some sort of response by the student to the patient’s story, a response that we designate as summarizing. Such use of summaries permit the student to review the story with the patient, allowing for correction or embellishment.7,8 The student regularly punctuates his listening with short summaries that in the above interview include, “So you’re one of the
guys who grows those great melons”; “So, chest pain”; “I see. More a pressure and getting more frequent”; and “I see, you’re really here because of your wife.”

Two additional summaries are more pro-
longed, “So, pain for a couple of months, a pressure type feeling in the chest and typically when you’re doing things. Sounds like it has been happening more and you’re short of breath and sweating. Is that it?” And “Let me see if I have this right. You’ve been having this chest pain that’s been going on for several months; it’s a pressure type sensation; sometimes when you get it you get out of breath and get sweaty and it seems to be happening more lately. Your father had something like this and you and your wife are concerned that this is a heart problem.”

Pt: Yeah. You got it right, Doc.

We find our students can apply the ILS technique to discover more about the patient as a person by making invitations such as the one found in the above inter-

view: “Well, since we haven’t met before, maybe before we get to the medical stuff, you could tell me a little about yourself as a person.” The ILS process itself human-
izes what can often be an inquisition rather than an inquiry.

The above interview also exemplifies se-
quential use of the ILS components. This sequence allows for open-ended inquiry and the development of adequate information collection and strong student–patient rapport. The invitations allow the patient to create his own story1,3 and avoid the hidden agenda trap that can lead to the “Oh, by the way, doctor” syndrome and the “full review of systems” syndrome.4,5 In this sample interview, the invitations to tell a story include “Tell me a little about yourself”; “Tell me what brings you in today”; “Tell me more”; “Anything else you can tell me?”; “Anything else?”; “What do you think this is?”; and “How do you feel about that?”

We have observed that students initially find the use of summaries the most diffi-
cult concept to accept and the hardest technique to learn, as it seems foreign to their everyday conversations. However, when they come to understand the high stakes nature of patient–provider commu-

nication, they realize how valuable the use of summaries can be. As supporting explanation, we emphasize the need to get the story right, the therapeutic value of a sense of being understood, and the chance to involve the patient in the develop-

ment of the story—hearing back what the student has gleaned allows the patient to correct and add to his or her own nar-

rative. The technique is easy to use, easy to remember, and enhances the three functions that Cole and Bird talked about in their seminal work on medical inter-

viewing.9 That is, it creates rapport, al-


ows good data collection, and improves compliance. In the end, summarizing helps students and patients develop an empathetic connection in an efficient fashion. The literature on medical inter-

viewing suggests that such improved con-

nection will to lead to better adherence.2 An unanticipated result has been that many students find that the use of sum-

maries reduces the need to take notes, thus enhancing their nonverbal skills.

Teaching the Techniques

To teach these communication tech-
niques, we use a small-group format that involves four students, four rotating stan-
dardized patients, and one facilitator working together during an afternoon. We are only able to accommodate ap-
proximately one fourth of the class on a given afternoon, and therefore we con-
duct exercises weekly for four straight weeks. The exercise takes approximately four hours. Use of standardized patients has become common in teaching medical communication10-12 and works well for us. Our stable of actors numbers about 200, and we use up to half of them during the year to portray a total of 20 roles. We emphasize the teaching of skills, believing that attitudes and knowledge will often follow skills acquisition.13-19

In these exercises we initially observed the frequent use of a closed-ended style of interviewing—a series of questions re-
quiring “yes” or “no” answers. These were asked in an effort to obtain a history as a sort of extended review of systems. This high-physician-control style has been well described by Byrne and Long20 and later by Platt and McMath.21 A high-
control, interruptive style tends to result in the oft-mentioned 18-second con-
straint that physicians put on a patient’s opening statement.22 Even though commu-
nication skills have been extensively studied and taught, a recent study showed similar early interruption of the patient’s narrative at an average of 23 seconds into the story.23 Although closed-ended questioning often revealed much of the patient’s story, it took a great deal of time, was destructive of student–pa-
tient rapport, and minimized any empa-
thetic connection between the two. It is to combat this behavior that we have come to emphasize the three interview skills described above.

Our faculty tutors are the key to the suc-
cess of this curriculum. We have trained over 80 faculty and currently involve 70 in this communications curriculum. Our tutors come from a variety of professions, including community and faculty physi-
cians, psychologists, attorneys, social workers, and educators. Within our phy-

sician tutor group we have many differ-
ent specialties represented, including pri-
mary care physicians, endocrinologists, rheumatologists, infectious disease spe-
cialists, cardiologists, psychiatrists, and general and orthopedic surgeons. We are also in the midst of a pilot project using primary care internal medicine residents as tutors. Our tutors participate in a full-
day training exercise prior to teaching, a one-hour review prior to each session,
and a brief debriefing after. Our faculty volunteers their time in teaching these groups. The faculty report that they find it personally rewarding and that their participation as a tutor leads them to use advanced interviewing techniques in their own professional lives.23

The ILS model dominates our longitudinal communications curriculum. We begin in the fall with our first-year students with the exercise that focuses on basic ILS skills. Subsequent exercises have an identical format, but we build on the basic ILS skills by adding complexity to the encounter. The second session, which occurs in the winter of the first year, emphasizes the empathic connection to patients who not only present a symptomatic story but also emphasize feelings, ideas, and values. The second-year curriculum starts in the fall with encounters that involve behavior modification issues, again approached with inquiry rather than heavy-handed efforts to change the patient’s behavior. Our final session in the winter of year two focuses on the difficult encounter. For this session we use four scenarios: an angry patient, a victim of domestic violence, an anxious, overly talkative patient, and a patient with reams of Internet material who has an incorrect self-diagnosis. All students are evaluated at the end of each year with two videotaped standardized patient encounters that are reviewed on a one-to-one basis with a faculty member. The videotape review is a powerful exercise that caps the program. Although the formal, longitudinal course communications curriculum is completed at the end of year two, three clinical clerkships now incorporate a standardized patient exercise that focuses on communications skills, building on the skills learned during the first two years of our curriculum.

Success of the Curriculum

Thus far, the curriculum has been very well received by our students. On a Likert scale with a range of 1–5, in 2003 the mean rating by the students of the communications curriculum was 4.4 (94% response rate). Students frequently report that these intense training sessions are “the best thing that has happened to me in medical school.” From clinical clerkship faculty we hear numerous anecdotal positive reports about the students’ communications skills. In addition, we measure communications skills at the end of their third year, when the students take a ten-station standardized patient exam. The standardized patients use checklists to score the students’ performances. They are then asked whether or not they would come back to see the student as a provider. The only parameter that correlates with a positive answer is the communications skill of the student. We note improvement in the communications scores from this exam since the expansion of our communications curriculum.

There are many acronyms used in medical interviewing. The Bayer Institute for Health Care Communication has promulgated a “4 E’s” model, consisting of Engagement, Empathy, Education, and Enlistment. Traditionally in medical school we are taught to find the patient problem and fix it. The use of the 4 E’s and the “find it fix it” skills lead to complete clinical care, according to Keller and Carol.24 The BATHE mnemonic (Background, Affect, Troubles, Handling of current situation, Empathic response) has been suggested as a path to understanding the patient’s view of illness.25 We do not view the ILS mnemonic as a replacement for more extensive communication devices. Instead, we began emphasizing this triad simply to decrease the use of high-control, narrowly focused inquiry. We have discovered that due to its simplicity, it is an easy-to-remember, efficient data collecting method that leads quickly to the use of empathy in the patient encounter.

Lessons Learned

There is a significant expense associated with using standardized patients; however, given the results we are seeing, the dean has been supportive of this effort. Although we have not do have clear outcomes data regarding the ILS method, the techniques taught are evidence-based skills; that is, they are based on techniques that have been shown in other studies to achieve the three basic functions of the medical interview: creating rapport, collecting good data, and improving compliance. There is some evidence that the curriculum does affect communication skills a year after its completion, but it is unclear whether there will be a lasting impact on our students. We are in the midst of expanding the communications skills taught during the third and fourth years of medical school. We will be tracking the data on student performance in our end-of-third year evaluation and we will have data from the National Board of Medical Examiners (NBME) Clinical Skills exam in the near future.

Finally, we have also come across a dilemma that in the same longitudinal course our students work with some preceptors who don’t always model the behaviors we are teaching. In an effort to address this, beginning this year we have partnered with the largest malpractice provider in the state of Colorado to provide an ILS workshop for our preceptors. For their participation the preceptors will receive points towards a reduced malpractice premium. Although the results of such efforts may be difficult to quantify, most of our managed care organizations do at least track patient satisfaction, which will be an interesting parameter to follow after this intervention.

References


