Patient Education and Counseling 86 (2012) 354–359

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

Medical education

The skill of summary in clinician–patient communication: A case study

Sally Quilligan *, Jonathan Silverman

University of Cambridge, School of Clinical Medicine, Cambridge, UK

ARTICLE INFO

Article history:
Received 21 October 2010
Received in revised form 12 July 2011
Accepted 13 July 2011

Keywords:
Doctor–patient communication
Communication skills
Summary
Medical education
Medical-student
Standardised-patient
Micro-analysis

ABSTRACT

Objective: To investigate the use and impact of the micro-skill of summary in clinical encounters, a core skill that has little empirical investigation of its use and outcomes.
Methods: This exploratory study used a mixed method design. Video recordings of ten consultations between simulated patients and medical-students were analysed to identify types of summary used. Two contrasting cases were then micro-analysed and follow up interviews held with the 2 students and simulated patients, involved in the consultations, using the video recording as a trigger.
Results: Ninety-nine summaries were identified and grouped into six types: reflective, screening, clarifying, paraphrasing, interim and full. Summary appeared to aid accuracy. However, summaries about the patient's perspective were summarised less frequently than the biomedical perspective. When summaries were repeatedly incorrect they made the simulated patient feel they were not being listened to.
Conclusions: The use and effect of summary appears more complex than the medical literature suggests and may have both positive and negative attributes. Further research is needed to investigate whether these preliminary findings are replicated within doctor–patient consultations.
Practice implications: When teaching use of summary we need to address: type, purpose, accuracy, effect on patient and flexible use to suit the patient.

1. Introduction

The use of the micro-skill of summary is an important component of communication within the clinician/patient encounter [1], emphasised within the teaching and assessment of communication skills in medicine [2,3]. Silverman et al. [1] suggests that benefits of summary may include: aiding accuracy of information gathered, enabling the doctor to achieve a structure for the consultation, facilitating patients' responses and building the relationship. The author's review of 12 communication skills guides [1,4–14] found nine that identify summary as a skill recommended for use in medical interviewing (see Table 1).

However, only three of the 12 guides define what they mean by summary. Silverman et al. [1] describes summary as "the deliberate step of providing an explicit verbal summary to the patient of the information gathered so far". Cohen et al. [14] highlight the function of checking perceptions by identifying summary as "checking the story by periodically restating what the patient has said". The MAAS [9] places emphasis on checking and accuracy and suggests that there may be different qualities of summary. According to the MAAS, a good summary:

- Accurately reflects the content of what the patient has said.
- Rephrases the description rather than literally repeating.
- Seeks confirmation of the summary by asking the patient directly, either by using a questioning tone of voice or by following the summary with a pause that invites the patient's response.

Surprisingly little research has investigated the impact of using the skill of summarising on either the patient or the clinician. Indeed the use of summary may have disadvantages. Beach and Dixon [15] note that summaries are inevitably selective; they may gloss over and alter what has been reported. Two studies have specifically explored summarising in the medical interview using conversation analysis. Houtkoop-Steenstra [16] undertook a case-based study in general practice in Holland. Although dated, it challenges assumptions that summary is a useful, therapeutic device. Houtkoop-Steenstra [16] argues that when the doctor selectively chooses which information to highlight, that information gains greater focus. This analysis is important because it highlights the power of summary and suggests summary may not always be used in the patient's interests. Gafaranga and Britten [17] looked at consultations in general practice in the UK. They found that summaries were used at all points within the consultation and were orientated towards achieving mutual understanding.

Summarizing is therefore an under-researched topic in physician patient relations. Despite it being more or less taken for granted that summarizing is an effective skill, the empirical base

* Corresponding author. Tel.: +44 01223 769270; fax: +44 01223 769289.
E-mail address: saq23@medschl.cam.ac.uk (S. Quilligan).

0738-3991/$ – see front matter © 2011 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.pec.2011.07.009

Table 1
Tools reviewed.

Calgary Cambridge Observation guide (CCG) [1]
Arizona [4]
Bayer Institute for health care communication E4 Model [5]
Common ground [6]
Four habits [7]
Kalamazoo [8]
MAAS [9]
MACY [10]
MISCE [11]
Patient centred clinical method [12]
SEGUE framework for teaching and assessing communication skills [13]
The three function model [14]

Table 2
Transcription conventions.

t. . .o prolongation of the prior sound
↑ ↓ marked shifts in pitch
[. . .] indicates elapsed time in silence in seconds
Word stressed syllable
? rising intonation
°quieter°

for that assumption is weak. There has been little explicit exploration of what functions summaries perform and how the skill of summary is received and responded to by patients. Therefore, much of what we base our teaching on is anecdotal.

The purpose of this study is to conduct a study on how summaries are used in practice. The aim is to provide a rich description of the use of summary, extending the understanding of its effects on the consultation by exploring the impact of use of different types of summary and reasons for variance in outcomes. As a first step video-consultations between student-doctors and simulated patients were micro-analysed to study whether using summary is of value to either or both parties.

2. Methods

This exploratory study used a mixed methods design, drawing upon principles of discourse analysis [18] to develop a systematic approach to micro-analysis of summary. The recording of interaction was combined with observation and interviewing, allowing the researcher to work at the level of the whole encounter and at the micro level of detailed features of talk [18]. The study was approved by the University of Cambridge Psychology Research Ethics Committee. All participants gave informed consent and were aware that they could withdraw from the study at any time.

All 140 fourth-year medical-students in the 2008 cohort at the University of Cambridge undertook the standard initial sessions of the clinical communication skills curriculum consisting of six experiential sessions over six months. During the sessions, the skills of information gathering and relationship building including the use of summary were addressed. Over the following month each student video-recorded a 15 min consultation with one of five simulated patients (SPs). The students' task was to take a medical history from the patient (a standardised role of a 39 year old woman referred to outpatients with a history of rectal bleeding).

The study used a two-step approach: analysis of video-recordings and interviews. The corpus of consultations was purposively sampled to obtain ten consultations, one male and one female student from each of the five SPs. The ten recordings were repeatedly viewed to identify possible summaries and two contrasting consultations were selected for further analysis. Transcripts were prepared using detailed transcription notation [19] allowing for tiny details such as pauses, vocal inflection and interrupted speech to be recorded (see Table 2). These two cases were selected for in-depth analysis because they contained a high number of summaries and, when compared, showed different ways of using summary which appeared to elicit a different type and quality of information from the patient. The participants in these two contrasting consultations were interviewed, using video-recordings for simulated recall, to supplement findings of the video micro-analysis. The recording was stopped each time a summary was used and the interviewee was asked to comment on its purpose and the effect of the summary. The SPs were asked to contribute and respond to the discourse in their patient roles. The interviews allowed collection of data on the participants' perception of use of summary which would not have been available from videos alone.

For data analysis, Krippendorff's [20] framework of content analysis was adapted to provide systematic data analysis. This included five stages: unitising, sampling, coding, reducing and inferring. Unitising involved repeatedly listening to and viewing the ten recordings in order to distinguish segments of talk [19] making notes of the recordings content; and identifying units or summaries. Coding initially involved repeatedly viewing the two consultations in order to categorise the different kinds of summary within the data; producing transcriptions of the sections where summary was used in the remaining eight consultations and coding those summaries according to the categories defined. Reducing quantified the frequency and types of summary in the data. Inferring looked at the way the SPs and students responded to and interpreted particular incidents of summary use during the interview; and compared it with the recordings and specialised transcript once more.

The primary way in which rigour was established used a grounded theory approach [21]. By moving backwards and forwards from the recordings and transcripts it was possible to work and re-work with the codes until they could be applied consistently, and had clear definitions that could be repeatedly applied in the same way. SQ and JS then analysed the two cases to refine the coding and see that the descriptors were being used consistently and in the same way. The interviews with study participants provided an opportunity to follow up issues identified in the data. Furthermore, issues raised in the interview could be looked at again with the transcriptions and recordings. Finally the detailed transcriptions allow the reader to consider whether the description resonates with their own experiences.

3. Results

Within the ten consultations, 99 summaries were found and summary was used in every consultation with frequency of use varying from 2 to 20 times.

Four types of short summary and two kinds of long summary were identified as separate categories in the data by exploring how summary was introduced; words used; tone of voice; and particularly use of pauses and rising intonation, indicating a question. Types of short summaries included paraphrasing; clarifying; screening; and reflective (see Table 3).

- Paraphrasing summaries repeated back by re-phrasing information.
- A clarifying summary rephrased information and was immediately followed by a question related to that information just discussed.
- A screening summary rephrased information and was immediately followed by a check for any additional information.
- Reflective summaries were defined as any summary that used the patient's exact words; were longer than three words; and followed by a pause which invited the SP to add more detail.