



Health Education Kent
Surrey and Sussex

TALKING WITH PATIENTS

A Consultation Handbook

Sixth Edition

Bill Bevington

We are the Local Education and Training Board for Kent Surrey and Sussex

*Developing people
for health and
healthcare*

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PREFACE TO THE 6TH EDITION

Welcome to the latest edition of Talking with Patients.

It is far too long, 8 years, since the 5th edition of this little booklet was released, and a lot has happened since that time. The focus of teaching and learning has inevitably moved on with the introduction of the Clinical Skills Assessment (CSA) component of the examination for membership of the Royal College of General Practitioners in 2008. The examination has become the licensing examination for entry into General Practice, and is therefore mandatory, with considerably bigger numbers of candidates than hitherto.

The population of the UK and the workforce in General Practice have continued to increase in size, and various shades of part-time working have become the norm. This has necessitated rapid increases in recruitment to General Practice, which in turn has opened the doors to doctors from home and overseas.

The CSA examination is itself more demanding than the RCGP's previous assessment of consultation skills by using the video, and so for many reasons the challenge to the huge number of doctors entering General Practice is harder and more widespread.

There is more written, on-line and recorded literature to help a doctor to understand the challenges of consultations in General Practice. In fact the more that there is out there the more difficult and even confusing it can be to know where to start.

This booklet, which has never aspired to be a textbook, hopefully still has a relevance as a brief introduction, guiding the reader through some of the established models and structures of thinking about consultations, and signposting the reader to consider reading more widely as and when required.

Talking with Patients has been warmly received by GP trainers and trainees, student nurses and health visitors in the past. Even a midwife once asked me for a copy! It is therefore with great pleasure that this new edition is now born.

I hope that it continues to give some useful help and guidance

Bill Bevington
June 2013

INTRODUCTION

The Challenge

Talking to patients can seem confusing. There seem to be so many ways of talking to our patients, all of them successful, that a newcomer can be left wondering where to start. Is one way better than another? The most revealing discussions sometimes seem to develop when the doctor strays from the history taking and talks to the patient about initially irrelevant non-medical matters. How does the doctor do this, make sense of it all, and still have time to record the consultation within the space of 10 minutes?

This booklet introduces doctors to the study of the Consultation and provides perspectives for looking at consultations in many different ways.

The Consultation in General Practice is the cornerstone of our work with our patients. In this booklet the ways of analysing consultations are laid out page by page. There is a brief accompanying description to clarify each list, but it is not intended to duplicate the text from which the summary has been drawn. References are given in each section, and a list of the consultation models is provided inside the back cover for easy reference and comparison.

In this latest 6th edition there is an extended section about the Hypothetico-deductive model, as I have come to consider that this is increasingly relevant for understanding the transition to consulting in a GP setting. In addition there is a new consultation model that has been devised with the help of many groups of GP trainees at CSA study days. There are new sections about the CSA examination and the COT, which has been developed to contain suggested 'training points', a chapter on Narrative Based Medicine and a section about how to help a newcomer to understand consultation models.

CONSULTATION MODELS

Consultation models are established lists of questions or areas to be explored, and provide a framework for a consultation. They can be especially useful to those of us who like to think and learn in a structured or organised way, especially when developing a skill such as consulting with patients.

There is no suggestion that any one model is better than another, they are all valid and useful in their different ways. There is duplication between them, after all they are models based on the same fundamental activity, but with different emphasis related to their origins. Models are not intended to direct the doctor to move slavishly through the model from beginning to end, the doctor can select and use a part of any model and as skills develop can weave components of two or more models into the same consultation, to create a personalised bespoke or eclectic model.

As competence and confidence grow the models can become superfluous; just as an experienced car driver no longer needs to say 'mirror-signal-manoeuve' at every obstacle. However, a study of this booklet may indicate new areas to explore, broadening our repertoire of consulting skills, and may help to answer questions about dysfunctional consultations.

There is always a lot of discussion about whether trainees should be using a model in their consultations, and that some candidates, often the struggling ones, are obviously following a formulaic model or structure in their consultations.

Personally I have a view that to do this when first learning how to conduct safe and effective consultations in General Practice is a positive and good thing. It gives the doctor a sense of orientation within the consultation, and will lead the novice through the important steps that need to be taken.

Equally there comes a time, perhaps part way into the ST3 year (although it will differ between individuals) when one would hope that the trainee has developed sufficient competence that they can conduct their consultations without a framework being evident. By this time the doctor should have developed a fluency which is what the CSA examination is hoping to see.

Broadly speaking the phases of acquiring consultation skills and using models can be spread between the 3 years of training.

Here is a summary:

- ST 1 The trainee learns to consult using the models, and constructs their own model to use in consulting and when watching video (see page 16). Reading basic texts on consultations.
- ST 2 The trainee adopts a broader range of consulting skills and reads more widely.
- ST 3 Higher levels of fluency and dexterity with components of various models. Established competence to the standard of independent practice and the CSA.

Hospital Consultation or Clerking Model

HPC	History of Present Complaint
PMH	Past Medical History
DRUGS	Medication
FH	Family History
SH	Social History
DQ	Direct Questions / systems
EXAM	Examination
IX	Investigation
D	Diagnosis

Reference:

Fraser RC : *Clinical Method - A General Practice Approach*
3rd edition Butterworth Heinemann ISBN: 9780750640053

Written by Robin Fraser, Professor of General Practice in Leicester. Well balanced, covering many aspects of the consultation, problem solving, communication, the diagnostic process, ethics, in addition to his useful re-working of the hospital model as the “inductive method”.

Hospital Consultation or Clerking Model or the Inductive Method

This first consultation model is a list of areas covered in classical hospital clerking or history taking. Derived from the list of questions with which we encountered our first patients as medical students it is intended to be comprehensive and takes us systematically through the whole medical history. The model concentrates on the **disease** and the final goal is the achievement of an accurate **diagnosis**.

This model is particularly helpful when first learning how to carry out consultations whether in hospital or a General Practice setting, and has therefore been renamed **the inductive method**. Unconstrained by time the student is trained by taking several histories in this way, developing the necessary communication and examination skills as experience grows.

In General Practice we have developed work patterns which usually necessitate much shorter consultations. We simply do not have the time to work systematically through such a comprehensive list of tasks during every consultation. The GP usually focuses on a selection of different aspects of the consultation which are often not disease-orientated as in the hospital model, but more often focused on **The Patient, The Illness, or The Problem**.

Pros: Thorough
May be helpful when stuck

Cons: Very time consuming
May be disease focussed
Exclusively doctor centred

Byrne & Long

1. The doctor establishes a relationship with the patient.
2. The doctor either attempts to discover or actually discovers the reason for the patient's attendance.
3. The doctor conducts a verbal or physical examination, or both.
4. The doctor, or the doctor and the patient or the patient (in that order of probability) consider the condition.
5. The doctor, and occasionally the patient, detail treatment or further investigation.
6. The consultation is terminated, usually by the doctor.

Reference:

Byrne, P.S. and Long, B.E.L. (1976). *Doctors Talking to Patients*, RCGP Publications, London. ISBN 0 11 320652 .6

A very detailed analysis. Not an easy read, but useful for us by providing this model. Illustrates the evolution of thinking about the consultation.

Byrne & Long

This model is derived from work by a GP and a Psychologist working 40 years ago! Pat Byrne and Phil Long studied audio tapes of hundreds of consultations in General Practice and compiled their list of six tasks or 'areas covered' from the consultations they had recorded. The list is short but includes for the first time in this series of consultation models the tasks of **introduction** and **finishing**, and in the task **considering the problem** the patient may be actively involved. Another distinction from the Hospital Model is that the Examination includes an examination of the patient's thoughts as well as a physical examination. Compared with the Hospital Model, Byrne and Long's model moves the focus of attention on to the **illness**. Illness is personal and unique, disease is impersonal and general.

Pros: Involving the patient

The notion of the 'Illness'

Cons: May lack suggestions about *how* we carry out the consultation

Stott & Davis

1. Management of Presenting problems
2. Modification of Help Seeking Behaviour
3. Management of Continuing Problems
4. Opportunistic Health Promotion

Reference:

N. Stott and R.H. Davis 1979

“The exceptional potential in each primary care consultation”

JRCGP 29.201-5

Stott & Davis

In 1979 Professor Nicholas Stott and RH Davis published a paper in the Journal of the RCGP entitled the ‘Exceptional Potential of each Primary Care consultation’. In it they described a simple model to help us think of 4 tasks that can take place in any consultation.

A. Management of Presenting Problems

This is the commonest task carried out in a consultation. An example would be a consultation for an intercurrent infection.

B. Modification of Help-Seeking Behaviour

An example might be to suggest that someone who repeatedly presents within 24 hours of the onset of a sore throat might initially consider self-medication for future episodes.

C. Management of Continuing Problems

After managing the presenting problem of the sore throat it can be a good opportunity to ask about pre-existing ongoing problems such as diabetes or depression.

D. Opportunistic Health Promotion

Every consultation creates an opportunity to ask about and record such information, for example about smoking, weight, cervical smears, immunisation etc.

Pros: Help seeking behaviour - a nice bit of novel lateral thinking

Cons: Again may be too brief to really guide the newcomer

Pendleton Et Al

1. Reason for Attending
 - Nature and history of problem
 - Aetiology
 - Patient's ideas, concerns, expectations
 - Effects of the problem
2. To Consider Other Problems
 - Continuing problems
 - At-risk factors
3. Doctor and patient choose an action for each problem
4. Sharing understanding
5. Involve patient in management, sharing appropriate responsibility
6. Use time and resources appropriately
7. Establish and maintain a positive relationship

References:

Pendleton, D. et al. *The Consultation, An Approach to teaching and learning*. Oxford Medical Publications. ISBN 0-19-261349-9

A comprehensive book, describing the history of thinking about consultations. Readable and useful. Worth investing.

And more recently an updated version is now available:

The New Consultation: Developing doctor-patient communication by the same authors

Pendleton Et Al

The third model was devised by David Pendleton, a psychologist working with a group of GP trainers from the Oxford region. In this model there are areas involving the patient's detailed thoughts and these assume an important role in this model.

The new tasks of identifying the patient's **ideas, anxieties and expectation** are specified, and identifying the **effects of the illness on the person** is incorporated as another new task. These four areas are often grouped together and called the **patient's agenda**. In this model the personal and psychological aspects of the illness and the importance of time management are further developed.

David Pendleton, perhaps more than anyone else, has made us think more energetically about the patient's thoughts and about working with them in a co-operative partnership, where we make real use of the patient's contribution in everyday consultations.

For me using this model makes more difference than any other.

Pros: The essence of patient-centredness

Cons: Not much!

Roger Neighbour

The Doctor's Two Heads

The Organiser

The Responder

The Five Activities

Connecting

Summarising

Handing Over

Safety Netting

Housekeeping

Reference:

Neighbour, R.H. (1987) *The Inner Consultation*

Lancaster: MTP Press

Roger Neighbour

An intellectually written book which I found rather long winded. It is clever and erudite but you need to make real time for this one. A classic but browse before you buy to see if it looks like a book for you.

The fourth model was constructed by Roger Neighbour, a GP from Watford, in 1987. Working with his local trainers' group, he has simplified the list of tasks and so we have a totally new list. The structure is described in his book 'The Inner Consultation'.

His model is brief and therefore easy to remember and use in real consultations. He suggests that doctors are working in two radically different ways while carrying out tasks in the consultation. These are called the **Organiser** and the **Responder**.

As the **Organiser** we are managing the organisation of the Consultation, timekeeping, selecting and asking questions, deciding to examine, making records, slowing and speeding consultations, negotiating and planning the patient's management.

The other role is as **Responder**. By Responder he means the attentive doctor, listening, thinking, processing, creating and testing ideas and being empathic. The doctor-centred nature of the organiser and patient-centred style of the responder are obviously completely different and mutually exclusive. While being an active organiser it is difficult to be responsive and vice versa. The skilled doctor needs to balance his own roles as organiser and responder while carrying out the five tasks in the Consultation.

An analogy of this Organiser/Responder idea might be driving a car while talking to a passenger. The organiser has to do the driving and the responder listens and talks to the passenger. If we are struggling with the route we have to stop listening and concentrate on the driving completely, and if the road is straight, wide and empty, with a minimum of distractions, we can concentrate as much as possible on our passenger, but without taking our eye off the road!

Roger Neighbour's five consultation tasks are as follows:

Connecting is established as an effective working relationship with a patient and obtaining information, developing empathy and rapport.

Summarising is drawing together the information gathered, making a diagnosis, checking it with the patient and formulating a plan for their care.

Handing over is returning the responsibility for some aspects of the disease and its management to the patient, agreeing a plan with explanation and reassurance.

Safety Netting is creating a contingency plan and procedures relevant to that patient, to ensure that the plan works out and that the patient is safe in any foreseen or unforeseen eventualities.

Housekeeping is keeping oneself, the doctor, well organised and in good condition, to be at ones most efficient and effective. It recognises the need to attend to fatigue, boredom, stress, lack of concentration, distraction and all the powerful emotions that can distract the doctor.

This model is different from all the previous ones because it seems to have moved on to include not only the clinical components of the previous models but now includes, for the first time, specific areas for safe doctoring (i.e. Safety Netting) and for being a healthy doctor (Housekeeping).

Pros: Erudite
Thought provoking
Re-defines the tasks

Cons: Complex
Not every trainee's cup of tea. Trainers beware!

A Training Consultation Model

A SEEKING A DIAGNOSIS

Listening

Open questions

Closed questions

Background

Context

Patient's thoughts

Examination

Diagnosis

Discussion about the diagnosis

B MANAGEMENT

The patient's prior management & expectation

The negotiation

Agreement

The future

Pros: It works well when working towards the C.S.A.
It was made in England

Cons: Everyone has made one of these

A Training Consultation Model

A: *SEEKING A DIAGNOSIS*

Listening

- The 'golden' minute, the opportunity to hear the patient's script, the well prepared story of their problem that every patient brings with them. Catalysis but not interrupting
- The doctor compiles a list of diagnostic hypotheses

Open questions

- Find out more about this person and their problems

Closed questions

- Clarifying and pivotal questions
- Rule-out questions, red flag questions

Background

- PMH, lifestyle

Context

- Psychosocial factors

Patient's thoughts

- Ideas and concerns (note expectations *not* explored here)

Examination

- A focussed physical and mental examination if indicated

Diagnosis

Discussion about the diagnosis

- Simple, honest, without jargon

B: *MANAGEMENT*

The patient's contribution

- What they have done or taken hitherto
- The 'E' of ICE

The negotiation

- Think of the shopkeeper with an array of options to consider and discuss, including the above

Agreement

- A mutually acceptable decision about the management, which may involve compromise and negotiation

The future

- Meeting again
- Safety netting
- Farewell

This 'new' model actually contains nothing new, but is a useful proven working model for training purposes. It is very much a list of Tasks. It must be understood that openness, patient centredness and empathy shall prevail throughout.

There are some minor innovations

- the patients views, their *idea and concerns*, are placed at the *end* of history taking, immediately before the examination
- The doctor elicits the patient's prior treatment and the expectation of future treatment – the E of ICE – *before* proposing any management suggestions of his or her own
- The negotiation of management is carried out rather like a shop keeper with an array of wares on offer. Each item on the counter is discussed in turn and a mutually agreeable decision is reached
- For a fuller description of the range of possible management options see the chapter on RAPRIOP on page 19

CALGARY-CAMBRIDGE MODEL

Structure & Framework

Initiating the Session

- establishing initial rapport
- identifying the reason(s) for the consultation

Gathering Information

- exploration of problems
- understanding the patient's perspective
- providing structure to the consultation

Building the Relationship

- developing rapport
- involving the patient

Explanation and Planning

- providing the correct amount and type of information
- aiding recall and understanding
- achieving a shared understanding - incorporating the patient's perspective
- planning: shared decision making

Closing the Session

References:

Kurtz, Silverman and Draper. *Teaching and Learning Communication Skills in Medicine*. Radcliffe Medical Press. ISBN 1 85775 273 2

and enhanced by a recent publication:

Kurtz S, Silverman J, Benson J, Draper J (2003) *Marrying Content and Process in Clinical Method Teaching: Enhancing the Calgary-Cambridge Guides Academic Medicine*;78(8):802-809

The Calgary-Cambridge Observation Guide To The Consultation

This useful tool combines a standard consultation model with a framework for studying how we use skills within a consultation. Increasingly, it is being used in teaching and improving consultation skills and is particularly suited to structuring analysis of video or role-played consultations.

The basic framework of the model is shown here. It reflects the changes in the later consultation models (Pendleton & Neighbour) with increasing emphasis on patient-centred communication. The main purpose of the model is in looking at the consultation skills that we use within each section of the framework. These are listed in more detail overleaf.

Initiating the session

Establishing Initial rapport

- Greets patient and obtains patient's name
- Introduces self and clarifies role
- Demonstrates interest and respect

Identifying the reason(s) for the consultation

- The opening question
- Listening to opening statement
- Screening

Gathering information

Exploration of problems

- Patient's narrative
- Question style
- Listens attentively
- Facilitative response
- Clarification
- Internal summary
- Language

Providing structure to the consultation

- Internal summary
- Sign-posting
- Sequencing
- Timing
- Agenda setting

Understanding the Patient's perspective

- Ideas and Concerns
- Effects
- Expectations
- Feeling and thoughts
- Cues

Building relationship

Developing rapport

- Non-verbal behaviour
- Use of notes
- Acceptance
- Empathy and support
- Sensitivity

Involving the Patient

- Sharing of thought
- Provides rationale
- Examination

Explanation and planning

Providing the correct amount & type of information

- Chunks and checks
- Assesses patient's starting point
- Asks patients
- Gives explanation at appropriate times

Achieving shared understanding

- Relates to patient's illness framework
- Encourages patient to contribute
- Picks up verbal & non-verbal cues
- Elicits patient's beliefs

Aiding accurate recall and understanding

- Organises explanation
- Uses explicit categorisation or signposting
- Uses repetition and summarising
- Language
- Uses visual methods of conveying information
- Checks patient's understanding of information or plans made

Planning: shared decision making

- Shares own thoughts
- Involves patient
- Encourages patient to contribute
- Negotiates
- Offers choices
- Checks with patient

Closing the session

- End summary
- Contracting
- Safety netting
- Final checking

So this is the daunting list of the 55 consultation skills that are contained within the sections of the consultation framework. Some are almost second nature, some are self-explanatory, some need further explanation. In general, you identify an issue in a consultation, for instance, 'achieving shared understanding', and then you examine the skills that you used, or could have used, within that section, to improve the consultation.

It is not so much a model or framework to help you through a consultation, more a totally comprehensive catalogue of the components of a consultation. It is at its most useful as a teaching tool, to help us to focus on particular aspects of a consultation, and in particular presents various alternative ways of approaching a difficulty within a consultation, when we get stuck.

Perhaps not so much a book for the learner, but an excellent teaching tool for the teacher.

Pros: A definitive catalogue of all that we need to know
A very useful teaching tool

Cons: Possibly too much to remember

CONSULTATION MODEL MAKING - A practical introduction

Few would argue that consultation models can be useful. However it does seem that trainees' experience of being introduced to models is rather variable, some having learnt all about them at medical school, and others working well into their ST3 year without a clue.

Over time and with the help of countless medical and nursing students I have devised a cunning plan that really seems to help the learner to understand consultation models. It is painless, simple, effective, and takes up a minimum of the trainers' time.

The essence of this is a prescriptive rapid teaching plan that can be completed in a couple of normal surgeries with the learner sitting in, often the *very first* or second session of sitting in with the trainer.

1. The trainee sits and watches 2 or 3 consultations, to get comfy and to observe the trainer's consultation skills
2. The trainee has a clipboard and A4 paper and while watching the next consultation jots down in the left hand margin the tasks that he sees or hears the trainer doing. On average there may be between 3 and 8 tasks listed. The best advice is to tell the trainee to repeatedly ask himself 'what are they talking about now ?' and to jot it down. An example of the list might be:
 - Story of painful elbow
 - Examination of arm and neck
 - Discussion about NSAIDs v pain killers
 - Talking about her mother's illness and the dog
3. The trainer does nothing at the end of this first consultation but simply gets on with the next one. The trainee is asked to watch the next 4 or 5 consultations and to *add* to the list on the paper, not to re-write a new list, thus accumulating a long list of tasks seen to be carried out by the doctor. Remember if tasks are seen repeatedly they are *not* added to the list. After say 6 or so consultations the trainer pauses between consultations, which have so far not been slowed down by this process. The trainer and trainee look at the list together and discuss it, *without pointing out any obvious omissions*. At this stage there may be on average a dozen tasks recorded.
4. The trainer then takes the sheet and underlines key words that could go to make up a generic list, such as:
 - a. History
 - b. Questions
 - c. Examination
 - d. Diagnosis
 - e. Prescription
 - f. Social circumstances
 - g. Worries
 - h. Other treatments
 - i. Self help

It is important to use the trainee's actual words noted down, e.g. 'worries' in the list above. Don't be tempted to write 'concerns'.

5. The trainer gets on with his surgery. Stoppage time 5-10 minutes max so far.
6. During the next consultation the trainee turns the page over, and holding it in landscape writes the list of tasks underlined by the trainer down the left hand margin of the page, and draws a grid with lines between the tasks and a dozen columns, leaving 3 or 4 blank rows below the bottom of the existing list.
7. The trainer checks this looks ok at the end of the consultation and explains that the trainee has just written his or her very own unique valid and totally understandable consultation model!
8. The trainee then watches the remainder of the surgery, ticking off rather than writing down what they see and hear happening. There will almost certainly be new tasks hitherto not seen which can be added to those vacant blank rows. An informed discussion can then take place, and new tasks added to the list at any time.
9. Total stoppage time 10 minutes plus time to chat.

In this way the trainee has demonstrated 3 important skills,

- A to observe
- B to record
- C to understand

It is a nice idea to type up the trainee's model on a blank grid, for them to use when watching video consultations that they will do. It gives a great sense of pride to feel that they have produced something that can be used just as well as one written by people that they have never met using words that they scarcely understand.

After a while it is then an easy step to suggest that on future occasions the trainee writes a similar grid using the tasks listed in the consultation models in this book, to help them to understand in greater depth what they contain and to appreciate the potential contained within them.

An example of a DIY consultation model created in this way might look like this:

Patient No	1	2	3	4	5	6	7
History of problem							
Questions							
Social circumstances							
Examination							
Diagnosis							
Medication							
Other treatments							
Follow up							
<i>Added at a later date :</i>							
Patient's worries							
Discussion re self help							
<i>More blank rows for more tasks</i>							

Remember that this is an iterative process and that while the table above may look woefully inadequate to you it has potential for additions and changes as new tasks are thought about, read about or even demonstrated by the trainer.

It is probably best to not take over and to suggest tasks that should be added to the list. That might disempower the trainee and inhibit creative thinking.

CONSULTATIONS SKILLS

On the previous pages we have looked at some of the established or seminal consultation models. These **Task Models** can be summarised as lists of areas to be covered, rather like stepping stones which one may choose to use, or not use, when making a journey across a stream. In the consultation they describe *what we do*.

Consultation Skills on the other hand do not tell us what to do but *how we do it*, i.e. how we get from one stepping stone to another. Skills in consultations are numerous and sometimes nebulous but acquiring and developing them does improve the consultation. Using these skills can help us to think more effectively and explore many different ways of understanding how our patients think and behave.

The following pages briefly describe some of the consultation skills.

THE HYPOTHETICO-DEDUCTIVE METHOD

Prior knowledge		from memory or records
Presenting information		from patient
Early Hypotheses	→	diagnostic possibilities
Pre-diagnostic interpretation		PDI
Pivotal questions	→	diagnostic probabilities
Examination		to support diagnosis
Investigation		to clarify diagnosis
Diagnosis confirmed		
Management decisions		

Reference: Robin Fraser *Clinical Method – a General Practice approach*
ISBN 075061448X

The Hypothetico-deductive method

'I believe that we do not know anything for certain, but everything probably'

[Christiaan Huygens](#)

' - a method of building up diagnostic hypotheses suggested by the answers to questions to the client, then testing each hypothesis as it arises by further questions or by clinical examination or laboratory test until a single diagnosis or a short list of diagnostic possibilities remains.'

Saunders Comprehensive Veterinary Dictionary _!

The **Hypothetico-deductive model** or **method**, first so-named by [William Whewell](#), is a description of [scientific method](#) which we apply to the process that we use, consciously or subconsciously, when working out what diagnosis the patient is presenting to us. According to the theory, scientific inquiry proceeds by formulating a [hypothesis](#). This hypothesis is then tested to see if the hypothesis is supported or refuted.

In a medical context this means that we think of diagnoses that might fit the patient's description of the problem. We then ask a series of carefully selected pivotal questions to promote or demote these diagnostic *possibilities*, which hopefully leaves us with a diagnostic *probability*.

This probability may then further be tested by carrying out a physical examination, and maybe still further tested by carrying out further investigations, although in truth

investigations are often expensive, time consuming and unrewarding, and do little more than to vaguely reassure the doctor.

This whole deductive process starts in our minds as soon as the patient comes in. As GPs we are tuned to instantly start wondering what the diagnosis might be. To a newcomer it feels worrying, to abandon the comfort blanket of a comprehensive hospital type history-taking, and in so doing we seem to be leaving many things out, which can initially feel like cutting corners and treading with uncertainty.

Hitherto GP trainees will have worked in hospitals where this kind of thinking and working would be wholly unacceptable. Hospital doctors are trained to be risk-averse, which may partly explain why it can be a very stressful time for some doctors who are new to General Practice, where working with uncertainty is often the norm.

As time goes on we become better and quicker at pattern recognition, and we then more frequently make accurate diagnoses more quickly and with less stress. There will however always continue to be patients who seem to pose un-diagnosable problems, and so we have to work hard in these cases and continue to handle uncertainty in our clinical decision making.

William Whewell (1840), *Philosophy of the Inductive Sciences*

DIAGNOSIS

Definition

“Achieving knowledge through symptoms” (Greek)

Achieving an accurate diagnosis is the primary fundamental task of a consultation. Without it we are working with uncertainty and our management and prognoses are built on sand.

The Inductive Method

In hospital the diagnosis is sought out ‘at all costs’ and no stone left unturned until the truth is established. To achieve a diagnosis in the hospital context we use the **Inductive Method** to guide our consultations. This has the advantage of being systematic and indiscriminative, but is expensive in time and resources.

The Triple Diagnosis or BioPsychoSocial approach

In General Practice the situation is totally different. For a start we seek diagnoses in any of the three areas:

- Physical
- Psychological
- Social

and there may be a working diagnosis or diagnoses in any one or more of these broad areas. Diagnoses are presented in ill defined, vague, non-medical ways, often in the early stages and often blurred by the presence of more than one diagnosis.

The illness is therefore often presented to a GP in a **‘disorganised’** form, compared to the **‘organised’** way in which we may refer a patient to a hospital with a clear description of a single problem or disease. It is this important role of ‘organising’ our patients problems and referring them appropriately to secondary care that defines another of our roles as GPs. It can be thought of as part of the ‘gate-keeper’ role, which really we may take for granted, but which comes sharply into focus when one journeys abroad and watches the nonsense that can result from self-referral into secondary care.

The Hypothetico-Deductive Method

See the previous section about this method on page 20

Further factors which influence the prioritising of diagnoses are:

- Probability
- Seriousness
- treat-ability
- novelty. Novelty implies that the doctor may have recently made a rare diagnosis and think of it frequently when drawing up the list of diagnostic possibilities.

Some practical tips for generating accurate diagnoses in a General Practice setting might be:

- to stay open minded i.e. be prepared to demote a diagnosis if questioning refutes it. This is difficult if you don't have an alternative diagnosis in mind.
- avoid the 'rule out syndrome' i.e. avoid reverting to the security of the Inductive Method which we sometimes do to avoid missing low probability diagnoses
- develop a Pre-Diagnostic Interpretation (PDI) i.e. the initial diagnostic favourite. Try to clarify this in your mind from what the patient is telling you before further questioning. E.g. 'It sounds like renal colic'
- If you are unable to think of a diagnosis do stick with the questions, including open questions, and ask the patients for their thoughts, before rushing to carry out investigations
- use clarifying questions about pivotal symptoms
- if stuck try using diagnostic checklists
- remember the triple diagnosis
- common things occur commonly
- diverse symptoms and signs are often caused by a single disease entity

PATIENT MANAGEMENT

RAPRIOP

Reassurance and Explanation
Advice
Prescription
Referral
Investigation
Observation
Prevention and Health Promotion

Reference:

Robin Fraser *Clinical Method 3rd edition*
ISBN: 9780750640053

An excellent book based squarely on all aspects of the consultation. Clear. Readable. Usable. .

Philip Meyerscough *Talking with Patients a basic clinical skill*
Oxford Medical Publications ISBN 0-19-261769-9

Having made a provisional diagnosis or diagnoses the main tasks in the Consultation can be collectively grouped under the title of patient management.

In this context management is a broad area including many activities. Several are inter-related as is everything that happens during a consultation and the boundaries of the different management activities are often blurred and overlap. For the sake of clarity the management tasks can be listed and considered separately. They are clearly described in Robin Fraser's book *Clinical Method* and make up the acronym RAPRIOP.

Reassurance and Explanation

The most commonly used patient management activity, **Reassurance** requires high levels of skill to be really effective. Working well reassurance can share or allay patient anxieties, using empathy and sympathy, and dispel false beliefs about diagnosis and outcomes. Patients often have wide ranging and worrying ideas about their own diagnosis and prognosis. Reassurance therefore needs to be based on firm factual evidence of a diagnosis that the patient understands and agrees. There is overlap here with David Pendleton's Consultation Tasks and the support intervention from the 6 IVC's.

There is evidence that good reassurance can influence Co-operation, Patient Satisfaction and even Health Outcomes.

Explanation

Explanation is linked to Reassurance in the model but needs separate consideration. To explain things well we need to use clear, jargon-free language which is appropriate for our patients' level of medical understanding and intelligence. Explanation works best if there is a good doctor/patient relationship in which the patient trusts and believes the doctor.

Advice

Advice can be considered, like diagnosis, in the three areas of Physical, Psychological and Social problems. It needs to be appropriate and the style tailored carefully to each patient. Some patients and some problems seem to need a counselling or patient-centred approach, exploring the options together and negotiating the way forward. On other occasions a different style is needed and the doctor needs to be more prescriptive, choosing the options for the patient and 'telling' them what must be done. The skill is to anticipate the most appropriate style for the particular patient or problem, and to develop a flexible range of skills.

Work on this skill. Too much advice paradoxically disempowers patients and leaves them confused. Too little advice leaves a patient in the dark, ignorant, and possibly dependent upon the doctor.

Prescription

In the context of this model Prescription means the prescribing of drugs. This chapter cannot include a full analysis of the wide range of factors related to prescribing but simply lists some key issues.

What are the aims?

- therapeutic e.g. to prevent, cure, relieve symptoms
- tactical e.g. to gain time, maintain contact, relieve doctor or patient anxiety

Will a drug really help? Is there evidence to support prescribing, often at great expense?

How effective will a drug be? Will there be risks or side effects?

Financial Cost Considerations

- generic v proprietary
- types or groups of drugs
e.g. ACE Inhibitors v Calcium Channel Blockers
NSAIDs v Analgesics

Contraindications and Interactions

Dosage and Duration - is our advice accurate and evidence based?

Compliance - so few prescriptions are dispensed (60%) or courses completed

Ongoing supervision - monitoring dosage etc.

Information about drugs - are patients informed or are they alarmed by the information they receive?

Referral

On average one in every ten consultations leads to a referral.

To whom do we refer:

- to Consultants
- to members of our PHC team
- to the attached team
- to ancillary healthcare workers
- complementary specialists
- Social Services

Why do we refer:

- for a second opinion
- for diagnosis
- for investigation
- for emergency, urgently or routinely
- to access specialist therapeutic equipment
- for specific therapy
- for social reasons
- in response to patient pressure

The GP has an extended role in supporting a patient before and after referral, especially for serious and multiple problems, helping the patient to interpret and understand what has been said and done, and in coming to terms with it all.

Investigation

Investigation is generally a blunt tool. On average only 1% of screening investigations such as routine chest X-rays or cervical smears reveal a diagnosis. Even when focused and carefully selected the chances of success are still only 10%.

Why do we investigate?

- to confirm a diagnosis
- to exclude a diagnosis
- to monitor any treatment
- to screen any asymptomatic patients
- to impress something upon our patients

We investigate approximately every ninth patient we see in surgery, often at considerable cost, so we need to think and discriminate carefully, and minimise box ticking. The Hypothetico-Deductive Method suggests that we should use investigation to *confirm* and not to *make* diagnoses.

Some questions that we might ask ourselves about investigations

- Why am I ordering this test?
- What am I going to look for in the result?

- If I find it will it affect my diagnosis?
- How will this affect my management?
- Will this ultimately benefit the patient?

Observation

In a General Practice context this means the long-term management and use of time to watch over a patient and their illness.

Most consultations are for self limiting conditions which simply do not require follow up. However about one quarter of our consultations involve the management of chronic illness and the key is to care, and not necessarily cure.

Caring

Caring can be summarised as two skills in which a doctor has to suppress his own emotional response to a patient's situation by displaying

Comfort, for the patient to talk

Acceptance of the patient's feelings and attitudes and two skills in which he has to react appropriately by showing

Responsiveness - recognising emotions and cues, and responding appropriately

Empathy, showing real understanding and recognition of a patient's feelings

Inadequate follow up results in anxiety and risks for the patient. Excessive care can erode a patient's independence and foster an inappropriate dependency on the doctor. Frequent follow up makes great time and energy demands on the doctor, possibly blunting his powers of observation, creating inconsistency and overwork.

The following factors can improve our observation of our patients:

- flexible appointment systems
- disease registers
- accessible doctors
- follow up clinics
- protocols and guidelines

Prevention

Anticipatory care is that part of our work which encourages Health Promotion and Disease Prevention.

The skill here is to think of it. We all know several basic ways in which people could lead healthier lives but we so often fail to promote these ideas in our surgeries.

The explanation is that the patient usually comes for a specific problem or problems directly unrelated to chronic disease or factors influencing health. To improve our performance in these areas we need to remember to address these areas, albeit briefly, in as many consultations as possible.

Having been trained in a disease-based problem-solving hospital environment it is not always second nature for GPs to promote health.

NARRATIVE BASED MEDICINE - THE ULTIMATE PATIENT-CENTRED APPROACH?

Narrative based medicine is a style of consulting in which there is emphasis on encouraging the patient to tell their story. So often we are preoccupied with the problem or the diagnosis that we might shut out the patient's story. It is only by hearing and responding to these stories that we are demonstrating a humanity that we would all regard as a virtue.

So often there is an agenda in our consultations that counteracts this style of working. The clock, the CSA, QOF, making time for record keeping, patients with multiple problems, there is no end to the list. However if we are to work in this way, and we as doctors and our patients would come to appreciate it, then we need to consider this challenge. At the heart of this is to focus on the patient's and our own narrative.

The patient's script, what they come to say to us, is wrapped up in a *narrative* or *story*. The story provides meaning, context and puts the problem into perspective. The *doctor's narrative* is all about how we react to all of this. What are our feelings about what we are hearing? Do we acknowledge our own feelings to ourselves, and do we show our emotions, in a positive accepting way that makes the patient feel that it is OK to be telling their story.

All of this encourages empathy and promotes understanding between the doctor and the patient. This in turn can have real benefits in the way in which a consultation will unfold. Where real empathy and understanding have been created the rest of the consultation will often be easier, enabling the patient to trust and cooperate in a way that might otherwise not happen.

John Launer at the Tavistock Clinic in London has written a lot about the value of Narrative Based Medicine in General Practice. He summarises the benefits succinctly into what he calls the 7 Cs

Here they are:

The Seven C's

"We have found that the most useful conceptual framework for communicating the essence of a narrative based approach is what we call the seven C's. These are seven core concepts that all have a background of substantial theory and discussion in psychology and the therapies:

1. Conversations

Conversations don't just describe reality, they create it. In primary care, they can be seen as interventions in their own right. We teach the skills for 'conversations inviting change': exploring connections, differences, new options, new realities. One of the great advantages of such conversations in family medicine is that they don't have to have beginnings or endings: 'ultra brief, ultra long therapy'.

2. **Curiosity**

This is the common factor that turns conversations from chatter into therapy. It should be friendly not nosy. Curiosity invites patients to reframe/reconstruct their stories. An essential aspect of curiosity is neutrality (to people, to blame, to interpretations, to facts.) Curiosity should also extend to yourself. How can you stop being bored, angry, impatient?

3. **Contexts**

This is what it is most effective to be curious about. Important contexts are families (geneograms), workplaces, history, geography, community, faith, belief systems, values. These are what people want to talk about and make conversations come alive. Attention to contexts also means thinking about your own, including the constraints of time, what patients expect of you and what medicine and society expect of you.

4. **Circularity**

Life seen as an endless and infinite dance of interactions. Think of the Krebs cycle, but in three dimensions and over time. A sense of circularity gets away from fixed ideas of cause and effect, unchangeable problems, over-concrete diagnoses. You can encourage this sense by (a) “circular questions” (b) following feedback (circling between yourself and patients) (c) tracking interactions (circling between patients and their family members).

5. **Co-construction**

What you are looking for is a better reality than the present one, which means a story (a form of words) that makes better sense for people of what they are going through. It may or may not incorporate a medical story, It may even change what they are going through.

6. **Caution**

Extend your skills and adventurousness but don't be unrealistic about your own resources, or cover up for the lack of others. Don't upset patients or get scared.

7. **Care**

Without which nothing else works.”

To try to summarise, think of your patients' stories. Listen, react, embrace those stories, and appreciate that sometimes the telling and sharing of these personal and even intimate stories can in itself be therapeutic. Empathy, warmth, and being real are the essence of all this. No-one is suggesting that this is a cure-all technique, but for our patients who repeatedly seem to need to talk this can throw new light on the potential of our consultations and on us as doctors.”

Reference:

www.gp-training.net/training/communication_skills/consultation

THE HEALTH BELIEF MODEL

Motivation about health

Perceived vulnerability

Perceived seriousness

Costs v Benefits

Cues to action

Locus of Control

- Internal Controller
- External Controller
- The Powerful Other

References:

Maiman LA, and Becker MH. *The health belief model: Origins and correlates in psychological theory*. Health Education Monographs 1974;2:336-353.

....where it all began

Tate, P. *The Doctors Communication Handbook*. 6th edition
Radcliffe Medical Press. ISBN 13:978 184619 392 7

For me Peter Tate's is the clearest and most readable book on the subject. In addition some excellent chapters on communications and consultations. .

Armstrong David *Outline of Sociology as applied to Medicine*
Butterworth Heinemann ISBN 0 7506 1929 5

A concise book about many aspects of health and illness in the broad sociological context.

Health Beliefs

This recently revived list is concerned with the beliefs that our patients have about illness and health.

The list is not in itself proposed as an alternative model or structure to carry us through a consultation, but it is a direct development of the ideas contained in the Pendleton list and it fits in appropriately in this series of consultation models. Health beliefs focus in increasing detail on the patient's thoughts, not simply about the consultation, but about the

patient's attitudes to illness in general and to themselves as patients. Asking ourselves and our patients about these issues can sometimes answer questions about the worried well, the hypochondriac, the non-compliant patient, the helpless and hopeless patient and the patient who repeatedly DNA's.

During the 1950's a group of American social psychologists tried to analyse the reasons why individuals failed to participate in a health promotion program, to identify and eradicate TB.

The theory they developed argues that an individual's likelihood of taking up such an offer depends on several factors:

1. Whether they think they are **susceptible** to a particular illness
2. Whether the consequences of the illness could be **serious**, physically or socially.
3. Whether the 'treatment' would confer **benefit**.
4. Whether there are barriers where the **costs** outweigh the benefits, in physical, social or financial terms.
5. **Internal factors** such as symptoms or worry about symptoms, and **external factors** such as media campaigns and advice from friends can act as the trigger that makes a patient seek help. These are called **cues to action**.
6. Patients vary enormously in the way they accept responsibility for their health. Some patients feel that they control their own health destiny, and see the doctor merely as an aid to achieving the treatment, prescriptions or referrals that they need. They have a very well developed and firm idea of their own diagnosis and equally definite expectations of what the doctor should do for them. These are the demanding Guardian-reading patients who would be said to have a powerful **internal controller**.

Another group, by contrast, feel that their likelihood of developing illness or staying healthy is completely out of their control and that nothing that they might ever do such as modifying their lifestyle will really ever make a difference. These fatalistic patients have an **external controller**.

Yet another group of patients feel that their health destiny rests externally to them, as in the last group, but rests specifically with one particular influential person, perhaps the GP or a close relative. They often misunderstand advice unless it is dispensed in a very clear and often dogmatic fashion, when they will often co-operative by "doing as they are told". Their locus of control rests with a **Powerful Other**.

COMMUNICATION

The Communication channels - ways in which we communicate

Verbal and cognitive level
Body sensation
Emotions
Sensory communication
Body movement

A list of some important aspects of communication - how we communicate

Observation	non verbal
Reception	
Listening/free attention	
Non verbal cues	
Silence	
Eye contact/lack of eye contact	
Questioning	
Reflection	
Confrontation	
Summarising	
Explaining	verbal

Communication

Communication is a skill which we sometimes take for granted. Some doctors are much better natural communicators than others and in trying to improve our consultation skills it is worthwhile thinking about all the different ways in which we communicate. It is useful to identify the different methods or 'channels' of communication so that we can think about them in turn in order to develop more insight and awareness about how we do and don't communicate effectively.

Here is a list of some of the different ways in which we communicate with our patients.

1. **Verbal/cognitive** - this includes how we speak, the words and language that we use, avoiding slang and jargon and includes the sense of meaning that we transmit and the understanding that we receive from our patients. Who is doing most of the talking, us, or the patient, or a well-meaning friend, relative or parent? Why?
2. **Body sensations** - if we focus our thinking upon our body we can think of all the following ways in which we ourselves 'feel' physically; hot, cold, dry, sweating, aching, pain, tension, comfort, butterflies, heart rate etc. We all have a blend or profile of body sensation and it can help to be aware of our own sensations, do they show, and what does it mean that we feel certain sensations during a consultation? Equally it is important to be observant for our patients body sensations, are they comfortable, do they look tense, are they in obvious pain, are they sweating etc? Can we spot how they are feeling, and what does that mean?

3. **Emotional communication** - this is sometimes self evident because of the other channels of communication which transmit emotions to us but we need to tune in to their mood and expression and to check out suspicions of sadness, depression, anger, anxiety, etc.
4. **Sensory channels** - touch, vision, hearing, smell, taste. Do our patients touch us a lot, do we touch our patients a lot? Can they see us clearly or is the window behind us? Is the light good for people with cataracts and impaired vision? Do they look at us at all, how much eye contact do we allow? None, enough, too much? Are they hearing us? Are we hearing them? Do we both try and talk at the same time? Are they deaf? Do we shout at foreigners? Do we smell OK? Do we react badly if our patients don't?
5. **Body movements** - in this channel we need to be aware of the concept of personal space. To understand the importance of posture and positioning of ourselves with respect to the patient, can we reach them and yet be at a safe distance for them, do we sit down to listen and do we understand postural echo? Do we allow our gaze to move around the desk, the computer screen or the room?

Do we sit still? Do children fidget excessively and why? Other important and useful aspects of non verbal communication involve mannerisms and the use of our hands and arms, and body posture. Are patients comfortable lying on our couch, comfortable enough to be able to talk and continue telling us important pieces of information? Important history taking doesn't stop when the patient undresses, it is sometimes just starting.

IMPROVING COMMUNICATION

Raise free attention

Clarify and reflect

Work on the relationship

Self disclosure

Improving Communication

How can we improve the way in which we give and receive information and improve the effectiveness of our consultations?

1. **Free Attention**

External Noise - Free attention describes our ability to concentrate on our patient. Our natural ability and motivation to pay attention can be diminished by distraction, which can be divided into physical distraction or noise such as the telephone, traffic, an uncomfortable chair, poor lighting. This is **external noise**, i.e. outside our head.

Internal Noise - The other area of distraction is inside our head. This consists of all the preoccupations that are on our minds while we are at work, inner voices that simply prevent us from concentrating totally on the patient in front of us, e.g. 'I must tax the car in the lunch hour', 'What shall I have for dinner tonight', or 'I do hope my Mum's hospital tests are OK'

One way we can improve our communication is by increasing our **free attention**.

Free Attention = Attentive energy minus internal and external noise.

2. **Clarify and Reflection** - We can communicate better if we check that our patients have understood what we have said and if we check with them that we have understood what they said. Spelling it out and demonstrating that there has been mutual understanding can be very helpful.

3. **Work on your relationship with your patient** - If a consultation seems like hard work then accept responsibility for trying to make it work more easily for both you and your patient. Try and ask more open questions such as 'tell me about ...' 'I would like to know more about ...' etc. If we feel inwardly fed-up or even hostile towards our patients, especially if they go silent, seem to avoid the subject, argue or get confused with what we say, try not to argue back. Try and stay on the same side as your patient and perhaps go back to safe easy ground and build up a picture of their problem all over again starting with easy unthreatening areas for discussion.

Try the following: 'Tell me something you think I may not have understood about you.' 'What do you need from me at this moment?' Remember too that most disgruntled patients have crossed transactions or an unfulfilled patient's agenda. Think therefore of the *Pendleton Consultation Task List* and in particular the *Patient's Ideas, Anxieties and Expectations and the Effects of the Illness* upon the patient. Exploring these four areas one by one will often expose the reason why patients seems to be disgruntled and may help you to achieve a better outcome for the patient.

4. **Self disclosure** - This means being totally honest and open with our patients. Tell them how difficult and frustrating you find some problems that they present in the consulting room. Be honest and tell them if you don't know the answer to their questions. Sharing your reality as it happens can often increase a patient's comfort and not make matters worse.
5. **Body Language** A lot has been written elsewhere about body language. It is interesting, important, real, and helps us to improve our communication and rapport with our patients.

SOLER

A delightfully simple list to improve our awareness of our own body language is SOLER, which was shown to me by Kate Elsworthy, when working in our surgery. We don't know where it came from!

- S** Sit - straight, square and still
- O** Open posture
- L** Lean, (meaning postural echo)
- E** Eye contact
- R** Relax

In conclusion, it is often valuable to concentrate for a while upon one's ability to communicate. It is often difficult to sit down and do this on one's own but the video can be useful here, or inviting a trusted friend to sit in can often enable one to identify what is going on and in which "channel" of communication we are working, whether it is effective, and whether we might make any changes.

THE SIX INTERVENTION CATEGORIES

Doctor Centred:

Prescriptive
Informative
Confrontational

Patient Centred:

Cathartic
Catalytic
Supportive

Reference:

Heron J. *Helping the client – a creative practical guide*
Sage Publications ISBN 0-8039-8291-7

Heron, J. *Six Category Intervention Analysis*.
Human Potential Resource Group. University of Surrey.
ISBN 1-85237-045-9.

This small but specialised book is the definitive handbook on the 6 IVC's. Many useful ideas which will remain evergreen.

The Six Intervention Categories

This title sounds complicated and full of jargon but is in fact quite simple and can be a very useful model for helping us to think about how we talk to our patients.

The Six Intervention Categories, or IVC's as they are known, are well established and are relevant wherever two people meet in a negotiating or advisory context, such as business, selling, the professions and counselling.

For the purpose of their use in General Practice the IVCs were developed by a psychologist, John Heron, working at the University of Surrey in Guildford in the 1970s, in conjunction with the GPVTS day release course organisers.

As an analogy the doctor's discussion with the patient can be thought of as a brief spell when the doctor accompanies and influences the patient on his or her journey through life. The IVC's are literally interventions by the doctor in which he is influencing the future course or direction of the patients' journey.

The IVC's are divided into doctor-centred and patient-centred interventions depending upon where the energy lies in the interaction, in other words, is the doctor actively trying to

modify the patient's thinking or behaviour, or is the doctor suggesting ways in which the patient may actively choose to behave or think differently?

The Doctor Centred Interventions:

Prescriptive - in this intervention the doctor makes an explicit recommendation, that the patient should do something at the doctor's suggestion. He may or may not have involved the patient in choosing and discussing the suggestion but the essential component of this intervention is that the patient is given specific advice about what to do, what to take, or perhaps what to think!

Informative - this intervention is involved with the doctor imparting knowledge or information. How relevant it might be in the patient's opinion is obviously important. Lack of information leaves a patient dependent upon the doctor, excess information can create anxiety and inhibit the patient from finding out things for him/herself. Is it understandable, is it relevant, is it too simple or too complicated?

Confrontation - in this intervention the patient is confronted by the doctor. In the analogy of the journey the direction that the patient is taking is challenged by the doctor and so his thoughts or actions are being questioned. To help the patient find a better direction in his illness or in his life, confrontation can at first cause upset and be uncomfortable. It therefore needs to be appropriate, caring, sensitive, well timed, and followed up!

Patient Centred Interventions:

Catharsis - in this intervention the doctor helps the patient to explore and express emotions. Many emotions are so powerful that they actually disable patients and prevent them from getting on with their lives as effectively and positively as possible. For example, suppressed fear can produce shaking, suppressed anger can produce shouting, suppressed sadness produces tears. To help a patient to bring out and expose these emotions can therefore release them from the strain of unresolved negative emotions and help them move forward.

Catalysis - means moving a patient on, encouraging them, and helping them to say more. The ways of achieving catalysis are often subtle and gentle and are often non-verbal. For example, creating the right atmosphere, a quiet environment, a sense of trust and security, listening well, and genuine interest. This can encourage patients to continue to reveal thoughts and feelings which may be sensitive and which they have perhaps never shared with anyone.

To maximise our ability to catalyse our patients we therefore need to look systematically at all these various areas which together can make or break a catalytic intervention. There are also some specific catalytic phrases which can be most useful such as *reflecting* or repeating the last word of a patient's sentence, and asking *open questions* which invite the patient to contribute more to the discussion.

Support - the intervention of support sounds elementary and is indeed exactly what it says. It means helping and encouraging the patient to cope with the stress of illness and life crises. It is an *enabling* intervention meaning that it is the opposite to "leaving it to the doctor" and is an expression of actual or intended help offered to the patient so that he or she can cope more effectively with their problem. Supportive interventions affirm the worth

and value of the patient, their qualities, their attitudes and their actions. They are making the best of what the patient has and encouraging positive thinking at a time when patients might naturally be gloomy or lose sight of their strengths.

Successful and Perverse Interventions

Using the strategies contained in this list of interventions can help patients to move on in their journey from sickness towards health, where they previously became stuck or ended up not achieving health because they went down the wrong path. It is necessary to identify the necessary required intervention, carry it out and know when to stop.

Choosing the wrong intervention, performing it ineptly or persevering inappropriately is called **perverse intervention** and can undo the good that has gone before. There are obviously millions of ways of getting interventions slightly wrong but don't worry, you will soon sense, verbally or non-verbally, when you are on the wrong track. A simple example would be to be very prescriptive and do a lot of 'telling' and 'instructing' a patient who does not want to be told, e.g. counselling a hardened drinker by 'telling' him to stop will not usually work unless he is first of all motivated to stop.

PATIENT-CENTRED CONSULTATION STYLE

Doctor Centred

Patient Centred

Task focus

Doctors agenda

Patient's agenda

What is the Diagnosis?

What is the Problem?

Thinking convergent
on the diagnosis

Thinking divergently about illness,
problems and context

Patient's Ideas
Anxieties
Expectations

How do the problems affect the patient?

Interventions

Prescriptive
Informative
Confrontational

Catalysis
Catharsis
Support

Techniques

Closed questions

Open questions

Time

Controlling time

Allowing time to explore unknown
aspects of problems

Control

Doctor centred

'recommending' or

'suggesting' management decisions

Deciding *for* the patient

Patient centred

Discussing options *with*
The patient which the
patient may or may not
take up, i.e. a counselling style

Decisions *with or by* the patient

Patient-centred Consultation Style

Generally regarded as a 'good thing' this style consists of a general approach and specific skills that result in the focus of attention concentrating on the patient, and in particular what the patient thinks and feels about all aspects of all the problems which they bring to the doctor.

The Doctor-centred, or Paternalistic style, in contrast, is more concerned with the doctor's need to organise the process of the consultation, trying to confirm the diagnosis with carefully chosen specific questions - closed questions. As a rule it is easy to spot closed questions, they can be answered with 'yes', 'no', or one word answers.

For example the question 'Do you feel tense or stressed these days?' can too easily be answered with a simple yes or no, which tells the doctor so little.

The Doctor-centred doctor is working to time, deciding what to discuss and what to say and do, and is in control. Working like this can be efficient, punctual, and least stressful for the doctor, but can sometimes leave problems unexplored and anxieties unresolved for the patient.

Patient-centred consultations, by contrast, allow the patient time to explore matters more fully. The diagnosis or diagnoses may be considered in the physical, psychological, and social realms. From the patient's point of view they are often thought of as 'problems' rather than 'diagnoses'. For example a hypertensive patient may be much more preoccupied by the malaise and impotence of hypertension and its treatment, than the precise BP readings which so worry the doctor. To the doctor it can seem like a serious diagnosis, to the patient it is a hell of a problem which may affect every aspect of his life.

So how do we conduct patient-centred consultations to successfully explore these important problems and thereby help our patients more effectively.

- **Time**

Allow time to explore and listen. Switch off the 'speed up' driver in your head when appropriate. Switch it on again later or you will never get home!

- **Triple Diagnosis**

Remember that patient's problems may be social or socially triggered, and that social and seemingly minor psychological problems may be perfectly adequate justification to the patient to come to see you. Not every patient will have a dominant physical problem.

- **Interventions**

Try to develop your skills in catalysis, catharsis and support. These skills take up time and can be embarrassing and tricky to develop, but are the way into the patient's mind

- **Patient's Agenda**

Ask specifically about each of the components of the patient's agenda, especially if you are stuck not knowing what to make of the patient's symptoms.

Patient's Idea: Ask 'What do you think is the cause of your problem?'

Patients Concern: Ask 'What is it about this problem that worries you most?'

Pt Expectations: Ask 'What did you think I should do about your problem today?'

Effects of the Problem: Ask 'How is this problem affecting your life at the moment?'

Not every one of these questions will always be rewarded with an illuminating answer, but often they do create a flash of insight or understanding, enabling the consultation to move forward.

- **Open Questioning**

Open questions demand an 'open' or descriptive reply. So instead of 'Do you feel tense or stressed these days?' consider as an alternative 'You seem to have a lot going on. What is the most stressful aspect of your life at the moment?' This kind of question might be stone walled with a monosyllabic 'nothing', but will usually encourage a helpful descriptive reply. So try questions which begin with the words

‘ What is the most difficult/worrying/depressing.....

‘ Tell me about.....

‘ What is it like

It is important to stress that a patient-centred consultation style is not necessarily better than a doctor-centred style. Exclusively patient-centred consultations last longer, create more work, and are consistently more stressful for the doctor. They do however help the doctor to develop a greater understanding of his patients and their problems.

The ultimate skill is to be able to move gently from one style to the other, and back, the doctor gaining control of time and task in the one, allowing and making time to discuss and explore the patient's problems in the other.

MICHAEL BALINT

Summary

1. Nearly all problems presented to the doctor have a psychological element to them and this needs exploring.
2. The doctor has feelings in a consultation. These need to be recognised and can be used to the benefit of the patient.
3. The general practitioner has a positive therapeutic role in all consultations, not only those with a defined disease process.

Reference:

Balint, M. (1957) *The doctor, his Patient and the illness*. Tavistock Publications, London. ISBN 0.272 79206 3.

Michael Balint

Michael Balint (pronounced Bar-lint) was a Hungarian psychologist who worked in London with a group of GP's in the 1950's and 1960's. The group met regularly for many years and discussed the doctors, patients and their consultations. They developed three philosophies which are particularly relevant in General Practice.

1. It became evident that many patients who presented with minor **physical complaints** also had a **psychological problem**. Focusing on the psychological problem, which may be a 'stand alone' problem, or a problem directly related to or caused by physical illness often achieved greater success than working on the physical problem alone.
2. Michael Balint's second philosophy was that doctors have feelings and that these feelings can have an important influence on the Consultation. They need to be identified and used in the consultation. By highlighting the real importance of the doctors feelings and using them consistently in a consultation the term '**the doctor as the drug**' was coined. This meant that a doctor can have a powerful ability to influence the patients' thinking and ultimately their total health, without necessarily writing a prescription.
3. The third philosophy drawn from Michael Balint's work was that **doctors can develop the necessary skills to work effectively with psychological problems** that patients present. Previously the concept had been that the doctor's skills were dependent upon the doctor's personality, and that the personality dictated the likelihood of the doctor exploring the patient's psychological problems. Balint suggested that such success often simply depended on asking appropriate questions about psychological problems, and that doctors could therefore be taught to ask these questions and become more successful.

The Flash Technique

The Balint approach established that doctors have an active and not passive role in consultations. He showed that the doctor's feelings need to be identified and used within the consultation. Subsequent work by Balint and his wife Enid Balint described the **flash technique** where doctors become aware of their feelings in the consultation and sometimes interpret the feelings back in a way that can give the patient some insight into the problems that are presented. For example, if a patient angers the doctor it may be that other people will also be made angry by the patient and it might be appropriate to ask the patient about this.

TRANSACTIONAL ANALYSIS

Transactional analysis (TA) helps us to look at consultations - often difficult ones or consultations with unsatisfactory outcomes - by concentrating on the state of mind, or ego state, of the patient and the doctor, and how they interact.

Ego States

The theory, described by Eric Berne, is based on the concept of the Ego States. At any one time all of us are said to be in one or other of three ego states which are described as:

Parent ego state (P)
Adult ego state (A)
Child ego state (C)

The **Parent** ego state is the part of us which is preoccupied with parental thoughts and speech and can often be identified by containing the words 'should, ought, or must'. It is imprinted on us as children, by our own parents and other authority figures such as teachers, doctors, older siblings, police, and those in authority.

There are two different components of the Parent ego state. One is the **Nurturing Parent**:

e.g. 'You shouldn't go near the fire or it will burn you'

and the other is the **Critical Parent**:

e.g. 'You simply must stop smoking *now* !

The **Adult** ego state is principally concerned with thoughts and speech that are logical and factual.

e.g. 'If you go near the fire it will burn you'
'If you smoke your asthma will probably become worse'

Note the logic in these statements and the lack of parental content expressed within them. They are often problem solving, looking for sensible and constructive compromise whilst still allowing the recipient to retain individual autonomy, i.e. making the patients responsible for their actions.

The third ego state is the **Child** ego state which is the part of ourselves that is concerned with the expression of our feelings. This is the first to develop when we are very little and in many ways it controls the subsequent development of the whole person. As we grow we acquire a basket full of feelings as a direct result of our earliest experiences. Some of these feelings will be resolved, or fulfilled, but others will be unresolved and can continue to affect us throughout the whole of our lives.

The child ego state is also divided into two parts, the free child and the adapted child.

The **Free Child** is the healthy uninhibited part of us that is involved in having fun, being creative, experimenting, playing and loving.

The **Adapted Child** lacks natural spontaneity. The thinking and behaviour is adapted or inhibited in response to other people's expectations or difficult circumstances. An Adapted Child ego state can result in unnatural or manipulative behaviour such as petulant or sulky behaviour, for example.

Examples

At any one time each of us can be said to be using one or other of our ego states which determines how we think and feel and behave. This influences the way others will view us, and dictate 'what we are like'. To illustrate this point one could think of a patient who is ill and simply needs to know the diagnosis and to be cured. This is factual logical thinking and they could therefore be said to be 'in' their **Adult** ego state when they come to see us.

e.g. 'Doctor, I have got a sore throat. I think it may be tonsillitis.
Can you advise me what to do?'

By contrast, some patients are always demanding, nothing is ever right and they seem to have a perpetual axe to grind. They could be described as being in their **Parental** ego state.

e.g. 'Tell the doctor my throat is very sore and he must visit me today.'

Again by contrast, some patients seem to always be emotional and unable to be logical or take responsibility for their illness. The helpless and hopelessly 'chronic sick' and 'worried well' could fit into this category and can be described as being in the **Adapted Child** ego state. They have adapted their behaviour in order to stand a good chance of eliciting a certain 'nice' response from the doctor, perhaps sympathy, comfort, a prescription, or a certificate.

e.g. 'Oh dear, doctor, my asthma is so bad I don't know what to do.
I am so worried about it. I have been completely unable to stop
smoking like you said I should.'

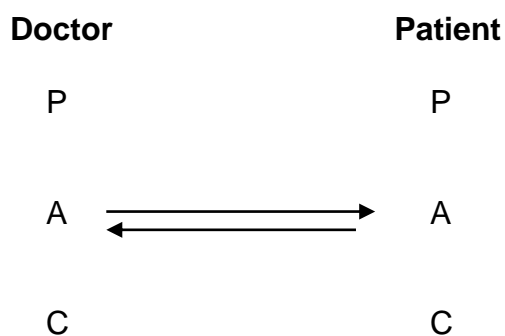
The key to understanding TA is to identify which ego state your patient is 'in' or is 'using' and to be aware how appropriate or inappropriate it might be in the circumstances. Is each person content with their own and the other's ego state, and is that ego state the most appropriate to enable a person to make the best possible progress as a patient?

INTERACTIONS OR 'TRANSACTIONS'

The doctor and patient can interact in many ways. In most successful consultations they will both display **Adult** behaviour, or sometimes a **Parent** doctor can work effectively with a **Child** patient. Providing they are happy with each other's ego state the consultation will probably succeed and they will be satisfied:

Doctor	Patient
How is your asthma?	My asthma is still bad, I haven't stopped smoking yet.
Do try and stop smoking, it really will help.	OK

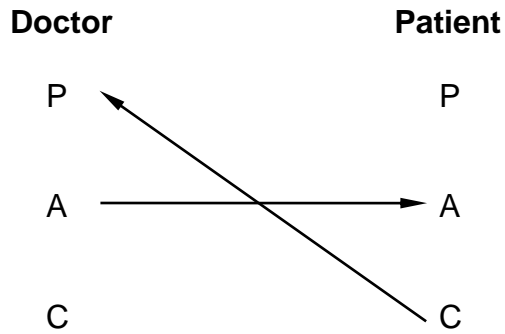
All of this brief interaction is straightforward, factual stuff. The doctor's **Adult** ego state has been communicating with the patient's **Adult** ego state, i.e. a parallel, or **complementary transaction** that will probably be constructive and effective:



Crossed Transactions

Sometimes however the transaction can be **crossed**, for example the logical **Adult** doctor trying to reason with a drinker who is dependent on alcohol. The patient (**Child** ego state) feels the doctor is making unreasonable demands and being critical, and the patient will no longer 'work' with that doctor.

Doctor	Patient
Your liver enzymes are quite high. We need to look at how much you are drinking.	You are always criticising my Drinking, just like my father did.



A crossed transaction, the consultation going nowhere.

Summary

Generally individual patients tend to have a certain repertoire of thinking and behaviour. If, as doctors, we can recognise our patient's difficult or unproductive behaviour by using this model we can sometimes help them to develop insight and help themselves.

There are very many ways in which patients and doctors behave and interact. The many interactions and crossed interactions are described as 'games' and can be read about in the references given below.

References:

Eric Berne. *Games People Play*.

Penguin Books

The man who devised and defined TA. Written in 1964.

Thomas Harris. *I'm OK - You're OK*

Pan Books. ISBN 0-330-23543-5

Resumé of TA., developing themes about TA.

Thomas Harris. *'Staying OK'*

Pan Books, ISBN 0-330-29136-X

And more. Includes excellent chapters on personal management, including time management.

Ian Stewart and Vann Joines. *TA Today*.

Lifespan Books, ISBN 1-870244-00-1

An up-to-date book about TA and its modern use, including life scripts, drivers, rackets, stamps and games! .

WORKING QUICKLY

Fast or Slow by nature
 by nurture

Time Efficiency

- Minimise distractions
- Get organised
- Start on time
- Listen carefully
- Prioritise
- Quick-fire Patient's agenda
- Examine the patients
- Delegate and refer

Perhaps the greatest paradox of all is the challenge of time management when learning about consultations.

The acquisition of so many complex skills, learnt for the great majority of time while carrying out real consultations, so often seems to slow us down, in order to fit everything in. Quite the opposite effect to what we really need, to learn to work comprehensively *and* quickly, to be able to cope with the relatively faster and more pressurised pace of life as a working GP. In fact time pressure during consultations is one of the commonest sources of disillusionment and early burn-out, feeling that we 'don't have the time to do the job properly', or 'didn't come into practice to have to cut corners and work like this'.

So it seems that time management is seriously important, and I would like to try to tease out some of the issues, and look for some suggestions to prevent or overcome the problem.

We all have a regulating metronome within us. For some of us it works more quickly than average, for others more slowly. To a certain degree we can control it, and wind up our natural rate, but can we sustain working at an unnaturally faster pace, and what effect might that have on us ?

What are the parameters of our natural work-rate?

Nature

Some of us just seem to *be* faster than others. T4, genetics, I don't know.

Nurture or Drivers

We all adopt a profile of behaviour and thinking during our early life, which for some of us results in a life-long compulsion to behave in a particular driven way in adult life. Examples of Drivers are to 'Please people', 'Be perfect', and 'Hurry up'. If we carry a 'Hurry up' driver with us, then we will seem to those around us to get things done awfully quickly, the corollary being that the rest of us can be left feeling rather slow. So some people just seem to be *naturally* quick.

What are some of the other more changeable factors which impinge on our work-rate, and what can we do to gain control?

Training

There is a theory that if we train at a skill we will master it and become better at it. Well, that's the whole hard-to-prove theory behind GP training, and yet so many young principals seem to struggle with this issue of working to time despite attending a training scheme and conquering the twin peaks of Summative Assessment and the M.R.C.G.P. exam. Time Management may be taught, but may not be learnt.

The challenge here is to analyse one's 'time behaviour profile', and work at each component, in order to speed up effectively. So I would suggest that we *can* learn or be trained to work more quickly, but maybe not using the tools that have so far been provided by GP Training Schemes.

Experience

There can be no doubt that old lags of GPs do eventually seem to improve their own time management but are they sacrificing some aspects of quality within their consultations in so doing? We can't all simply wait to grow old, we need to manage time effectively now. By learning 'on our patients' there can be no doubt that young principals *do* continue to learn new consultation skills, but experience alone is not quick or reliable enough for GPs in training. Effective time management needs to be effectively learnt!

Motivation

We all have the ability to speed up if it is absolutely essential, to get to a cinema after work, for example. But we can't and wouldn't want to sustain the kind of corner-cutting that may be needed. The cost to us is a sense of skimming over problems superficially, avoiding cues, denying our patients, and unseemly rush, all resulting in a sense of a 'job not well done'.

On other occasions we almost do the opposite, languishing on problems, considering everything, and virtually ignoring the time. The net result here is equally stressful for some of us. Our receptionists and partners will share the stress, even if the patients love it.

The happy medium must be to control time, literally watching a clock (preferably placed discretely on the wall in our direct line-of-sight over the patients shoulder) and to think carefully about the question 'Do I actually *want* to work more quickly?' There is good evidence that one *can* change one's style to work more quickly without compromising the content and value of consultations from the patient's point of view.

Distraction

We all spend some of our time being distracted by issues outside the consulting room that have absolutely nothing to do with the consultation. We are not day-dreaming, we are simply distracted. To a certain extent we are all distracted all the time, but to varying degrees. The aim here is to acknowledge those distractions, sort them, discuss them, or leave them metaphorically outside the room, and try to concentrate as best as one can for the surgery session. Often easier said than done, but to enable this to happen some partnerships make a point of meeting briefly *before* surgery, to offload briefly, as well as later over coffee, for example. See also 'Free attention' on page 35.

Disorganisation

You can't have failed to notice what a huge variation there can be in people's kitchens. Some are a real pickle, but homely, while others look really sterile and empty, just like the ones in kitchen shop showrooms. The food coming out of the ovens may be equally wonderful, but it's harder to be organised and efficient and whip up a good recipe when the place (and maybe the mind) is full of clutter. Dishing up 15 to 20 imaginative well served recipes in the space of 2-3 hours requires an organised workplace, whether it's a kitchen or your consulting room.

So the message here is to

- get the surfaces clear,
- have a dictaphone to hand,
- dictate *between* patients,
- have the printer and stationery at the ready,
- and watch your own time-management

TIME MANAGEMENT

Starting on time

Unless we can consistently catch up within the first 2 or 3 consultations, starting 10 minutes late for a surgery session means that every patient will wait an average of 10 extra minutes. This represents 150 minutes of *patient-waiting-time* per session on average, which will strain the receptionists, waiting room, car park, and ultimately the doctor. Starting consistently late is arrogant unprofessional time-management suicide!

Listening

More than 90% of diagnoses are evident within the first minute of a patient's history. The average doctor interrupts the average patient's history after 17 seconds. There may therefore be great value in listening really carefully for *longer* rather than shorter than usual, if you want to maximise your diagnostic precision.

Prioritising

Many patients bring a list of more than one problem. It is simply not logical to try to address 3 or more problems in the time allotted for one problem, so try suggesting that the patient comes back another day. Most will be flattered that you are so interested in their many problems. It can sometimes be difficult to know which of many problems may be the most important. The patient's and your priorities may differ, so share your thoughts on that and try to agree to address the chosen major problem only. How we would choose to handle this type of situation divides us into procrastinators and non-procrastinators. Both styles are imperfect, but doctors who like to 'finish the job' in the first consultation inevitably take longer and consistently make more stress for themselves.

What to leave in and what not to leave out

John Howie wrote an interesting article in 1991 contrasting slow and fast consulters. I recommend it to you. In his study he found that doctors who did longer consultations fitted in more psychological care, more care of ongoing problems, and more health promotion. No surprises there, but he went on to show that providing that the *patient's agenda** was explored and addressed properly then the patient was happy at the end of shorter consultations. The message here then is simply to run through the agenda, however quickly, when trying to speed up to do shorter yet effective consultations.

If consulting quickly another crucial and rather obvious step to take is to *keep examining the patients*. It is terribly easy to speed up and gloss over even a brief focussed examination. The history taking can continue virtually throughout, and the extra net time taken can be minimal.

Finally it is imperative to *record* every encounter, however brief, whether it took place in the surgery or over the phone. Note-keeping is often an early casualty when the doctor speeds up. The temptation to put off note-keeping and dictating to the end of a surgery session is counter-productive and invites inaccuracy.

(*see David Pendleton's model on Page 7)

Delegate

Some doctors are naturally very self-reliant and it is almost alien for them to delegate. This may be a trait of older doctors who have learnt their craft without a team of primary care staff around them. Some of these doctors are today's trainers, however, so we need to encourage the best use of our primary care teams, to spread the load and use the special skills that they bring to our practices. This is not a negative issue, but a very positive one, very much in the patient's and the doctor's best interests.

And to conclude.....

- Be efficient, remember the kitchen stripped and ready for action.
- Minimise interruptions , from staff at the door and on the phone
- Handle paper only once. Just don't pick it up if you are not *immediately* able to do whatever might be necessary. So before reading your post or going into battle with your in-tray get a Dictaphone, filing cabinet, bin, stationary, computer, telephone, patients' computer records all at your fingertips.

These many suggestions are really quite basic, for which I make no apology. Time management should after all be really simple, and it's perhaps because on paper it looks simple, and yet we don't master it, that it becomes so stressful. Without successful time management our work time can erode personal time, and that can start a whole new spectrum of potential problems.

You will have favourite tips of your own, to help you conquer time, so do please send them to me, and I will look forward to enclosing them in the next edition of this booklet.

As with most skill-based activities the best plan is often to try practising the various suggestions listed here, one at a time, during ordinary surgery sessions, to see if they work for you.

Reference: Howie J G R et al *Long to Short consultation ratio, a proxy measure of quality of care for General Practice* BJGP 1991, 41, p48-54

THE PATIENTS WHO COME IN TWO BY TWO...

Patients often come in with another person. Usually the presence of the other person is totally apparent and appropriate. For example a parent with a child, a daughter with an elderly parent, a patient with an interpreter, or simply a couple who 'do everything together'.

All of this is natural and elementary, but consultations with 2 people in the room can become complex, and sometimes seem to end unsatisfactorily. How can we understand and overcome this problem?

It is often helpful in these situations to think of the patient and their companion as two distinctly individual people, each with their own distinctly individual agenda. Leading directly from David Pendleton's clarification of the patient's agenda, on page 14, it can be very helpful to consider the *ideas, concerns* and *expectations* of both parties separately. Although these may fundamentally be related to the same problem, i.e. the presenting patient's illness, they can sometimes be worlds apart. Trying to identify and handle one common agenda will sometimes fail to resolve or answer one or more aspects of the two diagnostic ideas, two areas of concern, and two sets of expectations that the two people bring to the consultation.

It is sometimes precisely because these agendas are both important that the companion comes too. So when patients arrive in pairs think 'Aha, what's so important that brings you *both* here today?' The answer may be simply clarified by first addressing the patient's agenda, and then turning to the companion and asking specifically for their own agenda. All this sounds time-consuming, but with practice one can run through an agenda in one minute, and giving time and value to the companion's contribution can often be time very well spent.

MEDICAL RECORDS

Recording the events that take place in consultations is a complex skill.

Why do we make a record?

For the patient who has a right to access the information in the notes.

For yourself **a. during the consultation** - to record information we may otherwise instantly forget, e.g. blood pressure readings or symptoms;

b. at the end of the consultation - when summarising and planning the management;

c. after the consultation - when writing a referral or reviewing previous consultations.

For our Partners to find out what has been happening in each other's consultations.

For administration internally - e.g. recording cervical smears, immunisation and Read codes, for data and target purposes.

For Medico-legal Reasons

The decisions about what to record and what *not* to record are difficult ones. The challenge is to abbreviate a hospital record keeping style (average hospital outpatient record = 87 lines of A4 per consultation) to a General Practice record style (average = 11 lines of computer entry per consultation) without omission of important data and without recording worthless facts. This is, of course, an impossible task and by such vicious brevity we are risking omission and all the attendant dangers.

A study of GP records invariably shows a smattering of all kinds of data, but almost invariably the information most often 'missing', which is often most useful retrospectively, is a record of diagnosis. Even if it is a 'soft' unsubstantiated diagnosis it is valuable to record, with question marks if desired.

There are many proposed models for record keeping. One that is quite a useful 'starting' model is known as 'SOAP', where one records something - even if only one word - in each of the four following categories:

S (Subjective) = Symptoms e.g. c/o sore throat 7/7

O (Objective) = Findings o/e tonsillitis with exudates, glands +++

A (Assessment) = Diagnosis Tonsillitis? Glandular Fever,

P (Plan) = Management Rx PenV 250 qds 7/7. For IM Screen 10/7

As one becomes more experienced the content will develop and different skills and recording methods will evolve.

Other factors to consider are:

- Abbreviations
- Disease Management pages - on the computer
- Disease Management charts - held by the patient
- Standardisation of recording
- Summarising
- What to keep and scan and what to discard
- Access to records
- Recording home visits, emergencies, and telephone consultations
- Using the computer in an unobtrusive manner during consultations

Computerisation

Just about every consultation is now recorded on a computer. The computer presents us with some new challenges of confidentiality, speed, size, flexibility, and general intrusion. All these problems are diminishing. In the meantime, the modern doctor needs to be increasingly computer literate and keyboard skilled, which is more of a challenge for trainers than for our trainees.

Medical Records and the GMC

Curious perhaps, to find the GMC's presence here. The truth is quite interesting, and at the same time perplexing. The GMC have a major role in protecting patients. In so doing they have developed an assessment program which is wheeled into action when a doctor is suspected to be under-performing, or , operating 'at the trailing edge' of the profession. One of their assessment tools is designed to measure the quality of medical records. Medical records have been a common area for the setting of standards for GPs..

So here is their model of 'required record keeping' that they use. It is based on a survey of 50 computer records selected at random,.

GMC Performance Procedures – Medical Record Keeping

1. Last entry by the doctor Present and dated
 Legible
 Understandable
 Appropriate
2. Records over the past 2 years – The doctors records are understandable without reliance on the entries of others
3. The doctor's records show evidence of clinical reasoning and appropriate continuing care

Although not a required component of GP training this does give us a good lateral insight into what is required in medical record keeping, especially with respect to showing 'evidence of clinical reasoning'.

A GUIDE TO AUDIT

Definition

An audit is a measurement of the quality of clinical care or organisational performance.

Medical Audit has been a component of quality assurance in General Practice for decades. It has been defined and re-defined, and examples written and re-written over the years. The fundamental activity of audit in a medical context hasn't changed a jot, so you could think of this as a 'generic' example of audit.

It is important to be aware of the difference between a survey and an audit.

A survey is a data collection exercise in which activity is observed and may be measured.

An audit also measures activity, but compares the results or standards achieved with an initial target standard which is set before data collection commences.

Some advice about audit

1. Keep it simple
2. Audit 1 or 2 criteria or 3 at the most. Smaller *is* more beautiful.
3. Re-audit., ~~and~~ but do not change the criteria, or you will not be comparing like with like. Carefully explain any changes to the denominator of your audit numbers.
4. A **criterion** is the *aspect of care* which one uses to measure quality. It should be clear, and evidence – based where possible. e.g. “all diabetic patients should have...”
5. A **standard** is the *actual measured level of care*. It will be expressed in numerical terms, as a number and if possible as a percentage. e.g. “63 patients (51%) attended the clinic....”
6. The initial **standard set** should be realistic bearing in mind local circumstances *and* the ideal world.
7. **Standards achieved** are those that have been achieved by counting, measuring, or auditing the care under scrutiny
8. Beware setting standards of 100%. Standards should be realistic, and perfection can be hard.
9. Don't worry if your results seem to be poor or are even deteriorating. Try to work out why, be prepared to explain the results, and outline your plans for future improvement.
10. One side of A4 *may* be sufficient. 2 or 3 may be better!
11. Keep it simple!

The naming of parts

An audit must contain the following elements:

- a. Title
- b. Aim and reason for choice of audit
- c. Criteria
- d. Initial Standard Set, where possible
- e. Preparation and Planning
- f. Data Collection
- g. Standard achieved (1)
- h. Analysis & Changes made
- i. Data Collection
- j. Standard Achieved (2)
- k. Conclusions

This brief example is intended to outline the structure of an audit. It is not comprehensive, and is very brief, to clarify the necessary steps. A typical written audit will require more descriptive text.

An example: To illustrate the components of an audit

Title An audit of the care of patients with Type II Diabetes Mellitus

Aim To measure:

- a) The compliance of patients attending a diabetic clinic
- b) The overall quality of diabetic care

Criteria

- a) All patients should attend the diabetic clinic annually
- b) All patients should have an HbA1C of 48mmol/mmol or less

Reference NICE (May 2008). The management of type 2 diabetes

Initial Standards set

- a) 95%
- b) 70%

Preparation and Planning

Diabetic patients were identified from computer-based searches of Read codes for Diabetes, and of medication. We also checked the old register of patients attending the diabetic clinic, and searched on a list of pathology results of HbA1C tests.

The data was gathered by conducting computer searches of population size, recorded attendance at our diabetic clinic, and for the date and level of the latest HbA1C test results.

Data Collection (1):

The Diabetic register identified 320 type II diabetics
During the year 01/01/10 - 01/01/11

- a. 243 (76%) patients attended to clinic
- b. 158 (49%) patients had HbA1C < 48 mmol/mmol

Standards achieved (1)

- a. 76%
- b. 49%

Analysis, Discussion and Changes made:

The results were disappointing. We decided to:

1. Increase the number of clinical appointments available
2. Arrange a meeting with the local diabetic specialist
3. Adopt a more aggressive approach to blood sugar control
4. The partner who had led our Diabetic Clinic had left the practice 2 years ago and perhaps the drive to maintain standards had lapsed. We decided to ask another partner to take over the clinic.

Data Collection (2):

During the year 01/01/11 – 01/01/12

- 289 (91%) patients attended clinics
- 172 (54%) patients had an HbA1C < 48mmol/mmol

Standard Achieved (2):

- a. 91%
- b. 54%

Summary of findings:

Title: An Audit of Diabetic Care			
Criterion A: All patients should attend the Diabetic Clinic at least Annually			
Standard Set	Standard Achieved (1)	Standard Achieved (2)	
01/01/10 95%	01/01/11 76%	01/01/12 91%	
Criterion B: All patients should have an HbA1C of < 48mmol/mmol			
Standard Set	Standard Achieved (1)	Standard achieved (2)	
01/01/10 70%	01/01/11 49%	01/01/12 54%	

Conclusions:

- It is easier to encourage people to attend a clinic than to control their diabetes
- We will need to work energetically to achieve the new stringent national targets for the care of our diabetic patients.

VIDEO RECORDING CONSULTATIONS, VIDEO CONSULTATION ASSESSMENT AND THE RCGP CONSULTATION OBSERVATION TOOL: COT

Introduction

If some of us are touchy about looking at photos of ourselves and hearing ourselves on tape, then it is hardly surprising that watching video of ourselves at work can at best be uncomfortable and at worst embarrassing. It can therefore never be a foregone conclusion that video will be user friendly.

However, as the Consultation Observation Tool or COT is now a mandatory component for practice workplace-based assessment and the resulting commentary has a place in the trainee's eportfolio there is no hiding place.

The video had formerly been the medium for the assessment of clinical performance in the MRCGP examination but with the coming of the Clinical Skills Assessment or CSA the video continues to be an invaluable means of teaching and learning about consulting skills. The COT is a direct descendant of the RCGP video examination, using the same criteria.

The COT is a list of tasks, not unlike a consultation model, that are used to assess the virtues of a video recorded consultation. In order to maximise the learning opportunity in this way it is essential that all trainees at all times in a GP attachment have constant access to a video camera. Perhaps one of the main points to stress about the video is for the trainee to use it early, frequently (but not necessarily for too long at a time, an hour at a time is plenty), with 24/7 access, and to have sufficient protected time to watch and learn from the recordings.

Here is the R.C.G.P.'s Consultation Observation Tool. I have added some 'training points' as a way of focussing on how a trainee might maximise the learning from it. These are the parts of the tool which sometimes create a considerable challenge for the trainee, and which benefit from focussed thought and rehearsal.

Rehearsal is an invaluable method of learning for a trainee, and there is huge benefit in practising 'unusual' or 'difficult' consultations with fellow trainees.

THE R.C.G.P CONSULTATION OBSERVATION TOOL OR C.O.T.

A Detailed Guide to the Performance Criteria with Training Points for skills development

Introduction

The C.O.T. is a useful mechanism for developing consulting skills. It can be used for recording the content and calibre of consultations that are either watched live or on video.

Despite a great deal of time and effort the messages contained in this document can sometimes be difficult for trainees to understand, internalise and demonstrate.

I have therefore suggested some new 'training points' to try to help to bridge the gap between understanding and performing these skills. Frequently they involve rehearsal, i.e. practising with a friend or in a group, to explore ways and to find the words to make these skills come alive. It is only by practising that we all find the words with which we are comfortable.

Other skills require insight, and some are just difficult, and need practice and experience to develop to the required level.

PC1: The doctor is seen to encourage the patient's contribution at appropriate points in the consultation.

This PC is particularly looking for evidence of a doctor's active listening skills, the ability to use open questions, to avoid unnecessary interruptions, and the use of non-verbal skills, in exploring and clarifying the patient's symptoms.

Remember to think of the competences as active ones. In many consultations there is little need to encourage; the patient comes in and states what is the matter, and the doctor may not necessarily be given credit for that. You should seek for evidence that the doctor can encourage a contribution from a patient when encouragement is needed.

Training points

- *Concept of the golden minute*
- *Check phatic communication i.e. the OKs, rights, I see, yes words that we utter to show that we are listening*
- *Avoid steering the history*

PC2: The doctor is seen to respond to signals (cues) that lead to a deeper understanding of the problem

The competence is to respond appropriately to important, significant (in terms of what emerges afterwards) cues.

Take account of non-verbal cues, if these are evident. However, the doctor's response to a non-verbal cue may either be verbal (commenting that a patient seems upset, worried etc), non-verbal (use of silence) or active (a change in body posture, a touch to the patient, offering the patient a tissue). It is important that you are alert for these responses.

This PC certainly incorporates “**showing empathy**”, and if you notice an empathic response, consider whether it represents a response to a cue (i.e. the “cue” may be explicit, but the emotional significance that is being responded to may be quite subtle).

Training points

- Rehearse the words to respond to cues
e.g. Earlier on you said that...
I noticed that
You seem would that be true
- Remember that cues are pretty rare
- Tears, naked emotion, sullenness, raised voices and anger can all be cues.
- Throw away lines – ‘mustn’t grumble’ ‘lots of problems no one died of’, etc can be cues

PC3: The doctor uses appropriate psychological and social information to place the complaint(s) in context.

We expect candidates to consider relevant psychological, social including occupational aspects of the problem: these may be known beforehand, or offered spontaneously by the patient, or elicited. The competence is to **use** the information in exploring the problem e.g. “how does your backache affect your life as a builder”.

Training points:

- Rehearse the words used to check out the psychological context
How much has your illness been getting you down ?
How have you been recently?
Have you been stressed, or anxious, or depressed at all?
- Rehearse the words used to explore the social circumstances
How are things at home and at work?
Has your illness been making things difficult in any way?
- Think in terms of the bio-psycho-social context of patients’ problems, especially if there is no obvious significant physical problem (that you can identify ...)
- Think of the ‘context’ as painting in the background picture behind every patient

PC4: The doctor explores the patient’s health understanding.

This PC incorporates exploring the patients “ideas, concerns and expectations”, in the context of the Unit - “**Discover the reasons for the patient’s attendance**”. The competence is the curiosity to find out what the patient really thinks - a cursory “what do you think?” without any response to the answer will not do. But questions like “what did you think was going on.....what would be your worst fear with these symptoms.....were you concerned this was serious.....what were you hoping I would do for this condition are much more likely to get a valuable response.

Training points:

- Site these questions carefully, avoiding distorting the patient's thinking.
- Timing : perhaps 'I' and 'C' at the end of information gathering, just before examination, and 'E' when about to set out the management options
- Rehearse the questions as above.
- Move beyond the 'You're the doctor, you tell me' response, and ask again. A lot of patients still hesitate to venture an opinion
- Be aware of the health belief model that talks about 'perceived seriousness, perceived vulnerability, costs v. benefits, cues to action etc

PC5: The doctor obtains sufficient information to include or exclude likely relevant significant conditions.

Doctors demonstrate this competence by asking questions around relevant hypotheses. It is important to remember the context of General Practice, and especially that registrars are not (usually) specialist-generalists in any field.

This is the medical safety PC, which addresses the focused enquiry that commonly occurs during the consultation, not necessarily at a particular stage: it may happen during an examination, or later, during the explanation, or even as an afterthought.

This is an occasion when closed questions may be the most efficient method of obtaining the information, for example to determine whether or not a patient with headaches might have a serious illness such as raised intracranial pressure. It does not mean that the doctor has to go into every conceivable detail or chase rare diagnoses. Remember that it is part of the element **obtain sufficient information about symptoms and details of medical history** which in turn is part of **defining the clinical problem(s)**. It is about taking a history in the degree of detail which is compatible with safety but which takes account of the epidemiological realities of General Practice.

Training points:

- *Initially a new trainee will need to ask a lot of questions, to feel that serious and uncertain diagnoses have been ruled out.*
- *The last paragraph above here is a bit trite. It is a difficult decision for a trainee to know how much to ask and how much to leave out, especially when new to a GP consulting setting*
- *Be aware of the Hypothetico-deductive method (HDM)*

PC6: The physical/mental examination chosen is likely to confirm or disprove hypotheses that could reasonably have been formed, OR is designed to address a patient's concern.

The competence will usually be the choice of examination, not the way it is done (because the video may not be the best place for that to be assessed- however it may generate discussion in this area). A mental state examination would be appropriate in a number of cases. Intimate examination should not be recorded!

Training points:

- *Explain what you need to examine and why, and ask consent. Get into a habit of doing this*
- *Remember that examinations in General Practice need to be focussed*
- *It is reasonable to talk your way through the exam procedure, to confirm to the examiner what you are endeavouring to do and what you are finding*

PC7: The doctor appears to make a clinically appropriate working diagnosis

Whilst this is included in the consultation summary form there should be evidence on the video of a clinically appropriate diagnosis or hypothesis having been made.

Training point:

- *In the CSA there will very rarely be two diagnoses*
- *This does not mean that there will not be psychological diagnoses and social issues that the doctor must consider, as well as the physical diagnosis*

PC8: The doctor explains the problem or diagnosis in appropriate language.

*There must be evidence of an **explanation** of the patient's problem. The element states that the findings should be shared with the patient. As educational supervisors we need to judge the quality of the explanation. A short explanation may be enough but it must be relevant, understandable and appropriate. It is essential for an adequate explanation.*

Competent registrars will incorporate some or all of the patients' health beliefs - in other words, one that responds to the health beliefs considered in PC4. It is unlikely that this PC could be demonstrated in the absence of PC4. However, on occasion, the patient will volunteer their health belief without prompting.

Essentially it requires a reference back to patient-held ideas during the explanation of the problem/diagnosis.

Training points:

- *Rehearse the words such as :*

“ I know you were concerned that these headaches might be a brain tumour, but having listened carefully and examined you that seems very unlikely to me. I think that your headaches are far more probably due to migraine, which in turn is related to all the stress going on for you at work at the moment.....”

It is good to rehearse with friends explaining the nature of various conditions, making them brief, informative, and un-scary

PC9: The doctor specifically seeks to confirm the patient's understanding of the diagnosis

This competence implies a quite discrete process: a digression after the explanation, to check how well it has been understood. A cursory "Is that OK?" or the patient simply nodding is not enough. It must be an active seeking out of the patient's understanding. Questions such as "Tell me what you understand by that" or "What does the term angina mean to you?" and a dialogue between patient and doctor ensuring that the explanation is understood and accepted, are essential.

Training points:

- *Doctors are naturally bashful about practising this as it is asking the patient to do something quite challenging, i.e. to have heard, understood and remembered what has been said. We are all aware that it can embarrass a patient, and so we hesitate.*
- *Try 'So that I can be sure that I have made this clear (implying the doctor's possible failing) could you tell me what you now understand by angina etc....'*
- *This is another good intervention to practise in a group*

PC10: The management plan (including any prescription) is appropriate for the working diagnosis, reflecting a good understanding of modern accepted medical practice.

*It is important that the management plan relates directly to the working diagnosis and **must** represent good current medical practice. Please remember, however, that in the UK there are large differences, due to local guidelines or resources, in the availability of investigations in primary care, such as PSA tests, access to ultrasound and echocardiography. Management must be a safe plan even though it may not be what you would do. Investigations and referral should be reasonable. The prescribed medication (if any) should be safe and reasonable, even if not your preferred choice!*

Training points:

- *This skill depends entirely on a blend of a good level of medical knowledge and the skill to spot something when it is sitting in front of us. Experience is crucial, and this is one area that can make sitting the exam too early in a training year a high risk – and expensive – strategy*

PC11: The patient is given the opportunity to be involved in significant management decisions.

*This was formerly "sharing management options" - the new version seeks to reward the underlying competence of doctor and patient engaging in **shared decision making**. Included in this competence is establishing the conditions for shared decision-making, such as the patient's willingness to be involved (at least a third are unwilling), their ability to take decisions (some are not able), and the evidence-base on which any decisions are being made. The registrar should be rewarded for addressing any of these aspects of the competence: they do not need to take the patient right through to a decision.*

Training points :

- Remember the analogy of the shop keeper discussing the pros and cons of what is on the counter and coming to a mutually acceptable decision
- Be aware that not all consultations can have management options that the patient can choose, sometimes only the doctor knows best !
- The doctor can however seek the patient's understanding and agreement with the proposed plan
- Rehearse the words to do this

PC12: Makes effective use of resources

This criterion relates to the doctor using resources effectively e.g. effective use of time

Training points:

- Time yes, but also referrals and investigations, i.e. avoiding too many.

PC13: The doctor specifies the conditions and interval for follow-up or review

This criterion within the unit make effective use of the consultation **should be straightforward. It should be interpreted broadly**, so that any reference to returning (“next week”, “when the tablets run out”, “if not better in a few days”, “see the nurse for a BP check in 1 month”, etc.) may be rewarded.

Training points:

- This is simple but the problem is that if a consultation runs over time then the skill simply cannot be demonstrated before the buzzer goes
- Some doctors consistently run late. Look not at the end of the consultation to explain this problem, but look instead at managing time, managing lists, negotiating follow up consultations, door handle situations, confronting skills – to interrupt unhelpful chatter, and the organisation of appointment times.
- Watching the time is crucial – a computer clock is generally too small, but a desk alarm clock sized clock can be ok, and a wall clock hung directly in the line of sight as the doctor looks over the patients shoulder can minimise the distraction of checking the time. The desk clock is probably best.

Reference:

www.rcgp.org.uk/gp-training-and-exams/mrcgp-workplace-based-assessmentwpba/cotfor-mrcgp-workplace-based-assessment.aspx

A SAMPLE CONSENT FORMS FOR USE IN CONJUNCTION WITH VIDEO RECORDING

A simple form, requiring the patient to *opt out*. For 90% of consultations this will enable you to keep the camera running between consultations, so minimising the intrusion and distraction that consent forms and fiddling with the camera can cause.

<p style="text-align: center;">Video consultation consent form</p> <p style="text-align: center;">_____</p> <p>We would like to video-record your consultation with the doctor today.</p> <p>This is for educational purposes. The recording will be studied by the doctors in this practice and will then be erased.</p> <p>If you are happy for your consultation to be recorded you need do nothing.</p> <p>If you would prefer not to be recorded then please tell the doctor at the beginning of your consultation.</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Thank you.</p>
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THE R.C.G.P. CLINICAL SKILLS ASSESSMENT

Introduction

The ~~new~~ latest form of the MRCGP examination has been with us since 2008.

Like lots of great things it comes in three parts. It consists of Workplace Based Assessment carried out in the surgery, the Applied Knowledge Test which does what it says on the tin, and the Clinical Skills Assessment which is the assessment of communication skills.

The RCGP has an excellent website with which everyone will be familiar, and is a sine qua non as far as understanding everything about the exam and the CSA in particular, and for prospective candidates there is a plethora of essential good advice and information.

There are aspects of the CSA which cause concern and confusion however, so we might look at some aspects of it all in this chapter.

First of all let's look at **The RCGP's description of the exam** – *the words in italics are mine*

“Each candidate is allocated a consulting room and has 13 consultations, each of 10 minutes, all of which are assessed. Patients are played by Role Players who have been trained and calibrated to perform their role in a consistent manner. Each of the thirteen cases is marked by a trained Examiner using a pre-set marking schedule which is specific to the case. The Examiner marks each case on three domains or areas - Data Gathering, Clinical Management and Interpersonal Skills. This creates an overall numerical mark for the case. Each domain carries the same number of marks. The marks for each case are added to create a final mark.

The cases are extremely carefully developed by the case-writing group, who are themselves active examiners. They are blueprinted for realism, accuracy, appropriateness, level of challenge, and the case mix on any one day of the exam is carefully assembled to create a consistent overall challenge. At the beginning of every day of the exam the cases are re-calibrated by the three actors and three examiners, who take it in turns to role play the doctor. Throughout the day an interact facilitator sits in on the consultations in turn, to ensure that the actors are giving consistent performances of the case

The three **domains** on which you will be marked are:

- **DATA-GATHERING, TECHNICAL & ASSESSMENT SKILLS:** *Gathering & using data for clinical judgement, choice of examination, investigations & their interpretation. Demonstrating proficiency in performing physical examinations & using diagnostic and therapeutic instruments*
- **CLINICAL MANAGEMENT SKILLS:** *Recognition & management of common medical conditions in primary care. Demonstrating a structured & flexible approach*

to decision-making. Demonstrating the ability to deal with multiple complaints and co-morbidity. Demonstrating the ability to promote a positive approach to health

- **INTERPERSONAL SKILLS:** *Demonstrating the use of recognised communication techniques to gain understanding of the patient's illness experience and develop a shared approach to managing problems. Practising ethically with respect for equality & diversity issues, in line with the accepted codes of professional conduct.*

The **grades** will be on a four point scale:

Clear Pass	scores 3
Pass	scores 2
Fail	scores 1
Clear Fail	scores 0

All 13 cases count, and so if we do the maths the max score is 13 cases x 3 domains x a max score of 3/domain = 117. The usual average pass rate is 75% overall, slightly higher for first time candidates. The actual pass mark varies by one or two marks to account for the inevitable slight variation in the degree of challenge set by the cases from day to day.

Feedback:

Results are provided in the form of an overall score and a comparative passing score for that day. Areas of performance which have been identified as deficient by two or more Examiners will be flagged the feedback which is in turn relayed to the candidate's ePortfolio. This is recorded by the Examiner using a specific set of **16 Feedback Statements** as detailed below:

Global:

1. Disorganised/unstructured consultation.
2. Does not recognise the issues or priorities in the consultation (for example, the patient's problem, ethical dilemma etc).
3. Shows poor time management.

Data Gathering:

4. Does not identify abnormal findings or results or fails to recognise their implications.
5. Does not undertake physical examination competently, or use instruments proficiently.

Clinical management:

6. Does not make the correct working diagnosis or identify an appropriate range of differential possibilities.
7. Does not develop a management plan (including prescribing and referral) reflecting knowledge of current best practice.
8. Does not show appropriate use of resources, including aspects of budgetary governance.
9. Does not make adequate arrangements for follow-up and safety netting.
10. Does not demonstrate an awareness of management of risk or make the patient aware of relative risks of different options.
11. Does not attempt to promote good health at opportune times in the consultation.

Interpersonal skills:

12. Does not appear to develop rapport or show awareness of patient's agenda, health beliefs and preferences.
13. Poor active listening skills and use of cues. Consulting may appear formulaic (slavishly following a model and/or unresponsive to the patient), and lacks fluency.
14. Does not identify or use appropriate psychological or social information to place the problem in context.
15. Does not develop a shared management plan, demonstrating an ability to work in partnership with the patient.
16. Does not use language and/or explanations that are relevant and understandable to the patient.

This list of 16 feedback statements has quite a potential as a teaching and learning tool for the CSA. One of the problems about preparation for the CSA is that unlike the Video Exam which preceded it the CSA has a somewhat complex set of generic indicators or skills that need to be demonstrated. It is long and detailed, and not the sort of thing that I could carry in my head, even though I understand the sense of what is required. There are 33 of them!

However each case has a case-specific marking schedule written alongside the case description, so that when sitting and marking a live case the examiner has a nice list of those things that should be shown by the doctor – to pass, or a list of cardinal omissions – that would swing the scales the other way. This is fine for the examiner in the CSA, but in a teaching and learning situation, without a lot of careful thought and preparation, we will launch into role-plays without a pre-made marking schedule, which makes the process of assessing more difficult and can leave the trainee unsure about whether a consultation has passed muster.

This is not to pour scorn over role-play. It has been and continues to be one of the all-time useful methods of learning these new skills, but might prompt one to consider creating a 'map' of what would be looked for, before starting the role play.

This is a useful résumé of the process of the exam and the marking procedure and can be found at

www.rcgp.org.uk/gp-training-and-exams/mrcgp-exam-overview/mrcgp-clinical-skills-assessment

There is also a very useful section on the RCGP website specifically about 'using feedback' which enlarges on the above and contributes to the plethora of advice available. I do recommend looking at this.

Here is the web address:

www.rcgp.org.uk/gp-training-and-exams/mrcgp-exam-overview/~/_media/Files/GP-training-and-exams/MRCGP-Clinical-Skills-Assessment-Jan-2012.ashx

Preparing for the CSA

Trainees often seem to think that preparing for the C.S.A. is preparing for something that is different to real life consultations, which is patently not so. The wisdom and lessons contained within the RCGP's website description of the exam are conceived and are required reading for trainers and candidates alike.

So what additional practical advice can we give for preparing for the C.S.A.

1. See lots of patients. The more the merrier.
2. Use the video for self assessment. Regularly.
3. When using the video allow sufficient time to watch and analyse the recordings.
4. Use a consultation model or map to assess your performance objectively. Don't just gaze at the screen and come to an overall view about how wonderful you are.
5. Ask your trainer or another doctor to watch with you, to ensure that you are calibrating your own powers of observation accurately.
6. Practise challenging consultations that one normally sees infrequently by role playing with a friend. For example anger, breaking bad news, manipulative patients, external locus patients (see page 54) consultations about sexuality and sex.
7. Ensure that you get really good levels of practice seeing patients who don't often come to see you, for example patients who in your practice may normally go to a clinic such as diabetes, asthma, well woman, cervical smear, patients with mental illness, well babies, immunisations etc.
8. Similarly ensure that you become competent at consultations that would normally be done by doctors of the opposite sex. So the male doctors need to see lots of gynae patients, breast checks, smear, HRT, Pill checks, while the female doctors need to see patients with prostatism and erectile problems. This is often tricky to arrange, as patients and nurses may be more comfortable keeping the male doctors out of the gynae clinic for example, and this is a problem that trainers owe it to their trainees to try to resolve.
9. There is a certain range of knowledge and skills that are special to the CSA. Although it is not primarily a knowledge test it is inevitable that a sound level of knowledge is required and I have compiled a list of things that often come up and need to be learnt. *See page 74.*
10. Try to develop a sixth sense about time. You really need a clock on the desk. A travel clock is best.
In Euston the rooms have nice big clocks on the wall right in front of the doctor's desk.
11. Practice describing ordinary illnesses in lay terms, without jargon.
12. Listen out carefully for cues and for the patient's diagnostic ideas and concerns. If they are mentioned in the history – and they often are – don't go asking again by 'ICEing' the patient. It makes it seem as if you have not been listening, is formulaic and wastes time.
13. Get good at handling a situation where you don't know what the diagnosis is. This is hard, but there are ways and means. Honesty, asking the patient what they think, discussing your uncertainty, think of the triple diagnosis possibility i.e. bio-psycho-social presentation etc.
14. Remember that failing to finish within the 10 minutes in the exam doesn't mean that the case was a 'failure'. The scoring is awarded throughout the consultation and you will have scored points for what you *did* do.

15. Try to develop a warmth about the way you come across to your patients. Good listening, reacting to what you hear and see, understanding what it must be like for your patient in their circumstances, and showing that you understand, i.e. being empathic, and being real in your responses and language. This is a tricky skill to acquire, but is a component of the College's motto, *Scientia cum Caritas*. Caritas is Latin for the virtue charity, which in this context really means 'love for our neighbour'. Well I'm not suggesting we love all our patients, but being caring and kind and compassionate will do nicely.

And finally:

There is always a lot of discussion about whether trainees should be using a model in their consultations, and that some candidates, often the struggling ones, are obviously following a model or structure in their consultations.

Personally I have a view that to do this when first learning how to conduct safe and effective consultations in General Practice is a positive and good thing. It gives the doctor a sense of orientation within the consultation, and will lead the novice through the important steps that need to be taken.

Equally I feel that there comes a time, perhaps part way into the ST3 year (although it will differ between individuals) when one would hope that the trainee has developed sufficient competence that they can conduct their consultations without a framework being evident. By this time the doctor should have developed a fluency which is what the CSA examination is hoping to see.

The CSA & International Medical Graduates - IMGs

There is no doubt that the C.S.A. examination has been a major struggle for many doctors for whom English is not their first language. This has been highlighted with the introduction of the CSA primarily because the exam demands high levels of linguistic skill.

There are many different aspects of why it is especially difficult to pass this exam when working in one's second or even third language. Let me say straight away that if I was told I had to go and work in, say, France I would do extremely badly, even though French is my second language. I therefore have the greatest respect and admiration for those doctors who put themselves and their families through so much upheaval to come and apply to work here to support our NHS. They meet huge challenges every step of the way.

However there is more to this than simply language. International medical graduates (IMGs) bring with them a range of cultural behaviours and thinking that make it especially difficult to practise in an empathic and patient centred way. These are virtually in-born issues which cannot be un-learnt in a year or two.

IMGs do less well in the CSA exam. They have a significantly lower pass rate than UK graduates. In fact the pass rate only levels out if doctors have come to this country and started speaking English as children from the age of 11.

The challenge facing the IMG candidates and their trainers is huge. There needs to be a very real understanding of all these issues and there needs to be education around these issues for our trainer workforce.

I cannot in this short booklet list all the aspects of this subject, but can refer you to an excellent systematic review paper that comes from New South Wales, where they have had similar challenges with helping IMGs. The paper is excellent, because it pulls together several aspects of the difficulties, and suggests what needs to be done, by doctor and trainer alike, to help conquer these challenges.

Here are some key themes and messages coming from this paper :

Issues for clinicians training IMGs , a systematic review

Pilotto et al

Key themes

Emerging from a review of 18 significant articles were:

- The need for IMGs to adjust to a change in status
- The need for clinicians to understand the high level of English language proficiency required by IMGs;
- The need for clinicians to develop IMGs' skills in communicating with patients (skills that include subtle and pragmatic aspects of language interaction);
- The need for clinicians to understand IMGs' expectations about teaching and learning;
- The need for IMGs to interact effectively with a range of people.

In summary: Clinicians

- Need to understand the language and communication problems associated with learning and patient care and recognise the associated concerns for IMGs and should explore IMGs' understanding of cultural boundaries;
- Teach the use of open-ended questions;
- Encourage reflective listening skills; and
- Develop IMGs' ability to explore psychosocial issues.
- Understand the impact that the teaching system from which IMGs come has on the communication process;
- Differentiate IMG cultural silence from lack of interest or under confidence;
- Deal with IMGs' expectation of didactic teaching;
- Recognise the unspoken requirements of IMGs; and
- Guard against negative feedback being perceived as criticism.

In summary, IMGs need:

- The ability to deal with an equitable doctor–patient relationship
- The ability to maintain a positive image of themselves as professionals
- The ability to communicate with a range of people;

- The ability to choose the appropriate terminology, register, and amount of information for different audiences;
- An element of empathy;
- The skills to interact with nursing staff, and a clear understanding of the role of support staff in clinical care;
- An understanding of practice protocols, with ongoing monitoring of whether information is being interpreted accurately.

These lists need the background text from this excellent article to make complete sense. See the reference below.

A long and daunting list of academic and personal challenges all round, but it may help us to develop new educational plans to resolve some of these issues for the future generation of IMGs.

Reference: *Issues for clinicians training international medical graduates: a systematic review* Louis S Pilotto, Geraldine F Duncan and Jane Anderson-Wurf MJA 2007; 187: 225–228

Richard Wakeford, is psychometrician to the RCGP, has written a clear and helpful article describing this issue from a statistical viewpoint. He draws some useful conclusions and I would recommend looking at his paper

Reference: *IMG's relative underperformance in the MRCGP AKT and CSA examinations* Education for Primary Care (2012) **23** : 148-152

PRACTICAL KNOWLEDGE AND SKILLS FOR THE CSA

Although the CSA is predominantly assessing communication skills there is inevitably an element of examining the doctor's knowledge within the cases. There are a number of things which seem to be frequently asked of candidates in this sense. Some of them are pure knowledge, some are really skills and procedures. I thought that it might be helpful to include a list here. It is not exhaustive, and I am sure everyone could add to it, but it may be a start.

ALLERGY

Anaphylaxis Drugs

CVS

Medication for Ht Failure
Hypertension
Acute PE

Taking BP

Cardio-risk calculation using the BNF

CNS

Dementia screening MMSE
Depression screening PHQ9
Tuning fork testing
Cerebellar function
Cranial nerve testing

Migraine / cluster headache
Epilepsy and driving regulations

DIABETES

4 priorities i.e. Sugar / BP / Lipids / Renal
Insulins
Oral hypoglycaemics
Interpreting blood test results

ANDROLOGY

Impotence & erectile dysfunction
Prostatism
Presentation of Ca Bladder
Prostatism
Retention

OPHTHALMOLOGY

Snellen's chart
Intra-ocular pressure
Visual field testing
Use of ophthalmoscope

INFECTIONS

Antibiotic guidelines
HIV Blood test results

IMMUNISATIONS

Childhood imms programme
Adult imms programme
SEs of imms

MUSCULOSKELETAL

Examining joints:
Neck(whiplash)/shoulder/elbow/wrist/spine/
Hip/knee/ankle
DMARDs

OBSTETRICS & GYNAECOLOGY

Menstrual 'formula'
Infertility
Dysmen / Menorrhagia / Polymen / Amen
HRT , < 50yr, > 50yr, risks
Starting & stopping contraception
Missed pills
Depot contraception
Emergency contraception
OCP , POP, IUCDs
Use of gestational calculator
LARCS
Drugs in pregnancy and breastfeeding

RESPIRATORY

Asthma
Step-wise treatment
Inhaler technique
Peak flow & interpretation

ENT

Tuning fork tests Rinne / Weber
Use of otoscope

GUIDELINES

Breast disorders and ca screening
Hypertension NICE
JBS 2
Lipid modification NICE
CKD NICE
LARC NICE
DM NICE Type 2
DVLA Medical fitness to drive
IBS NICE
Asthma SIGN
COPD NICE

ADDITIONAL AREAS

Analgesic pain ladder + policy on benzodiazepines
and hypnotics
Smoking cessation
Interpretation of blood test results
Flagging the BNF for quick access e.g. cardiorisk, HRT risk, etc
Driving regulations and serious illness and operations
Telephone advice
Genetic counselling for simple conditions

SOURCES OF HELP AND ADVICE FOR CSA

There is a great deal written to support candidates and to give information and advice

1. First and foremost is the R.C.G.P. website which has a great deal information. This is a must.
www.rcgp.org.uk
2. The R.C.G.P. and the Wessex Faculty have produced a series of 3 DVDs entitled "A guide to the Clinical Skills Assessment". This is a useful package, with a good introduction, demonstrating a variety of cases in an exam setting, accompanied by an explanatory workbook that covers many aspects of the exam.

This is an excellent package and really sets the scene for the examination

Wessex Faculty Head Office 01264 355 013

Wessex@rcgp.org.uk

3. Dr Peter Tate has produced a set of 2 DVDs that are entitled “Effective Consulting”. The first describes 5 Key Consultation Tasks and the second looks at 4 common challenges encountered by GPs. The package not only helps in the preparation for the C.S.A. but is an invaluable teaching tool for developing interpersonal skills.

The 5 key tasks actually closely mirror the 5 main areas of the COT.

This is available on Amazon.

This set of DVDs is brilliant. Well conceived with clear important messages, interactive and in my view essential viewing for a trainee, and everyone else...

Preparation Courses for the C.S.A.

There are predictably many courses available. Generally GP Departments of postgraduate section of Health Education provide suitable courses which will be usually run by current examiners.

Beware of commercial non-college and non-deanery run courses. They often do not have examiners running them, and there is a world of difference between these and courses run by examiners. They often add nothing to what is available locally..

AKNOWLEDGEMENTS

This booklet was originally written during the GPVTS day release course in Guildford. It was developed from the Consultation Handbook written by Peter Jenkins and Mary Davis in 1985, when they were programme directors on the Guildford and Chertsey vocational training scheme.

Most of the content is drawn directly from the texts of some of the most enduring writings on the subject. The chapter about the Calgary Cambridge Inventory has been written by Dr Richard de Ferrers from Frimley Green in West Surrey. This booklet naturally appears on his practice website ! www.fgmc.org.uk

The remainder of the booklet has been drawn from a wide range of sources. Educational meetings, workshops, colleagues and my patients have produced endless ideas and stimulation that is interwoven within these pages. To everyone involved I am very grateful.

This booklet is now in its sixth edition. Each edition has been modified, hopefully to reflect the changes and developments which evolve in the many aspects of teaching and learning about consultations. The feedback that I have received has been invaluable, and has helped to influence the development of the text. I very much welcome any comments and suggestions, to help improve future editions.

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Godalming 2013
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ABOUT THE AUTHOR

Bill Bevington went to Epsom College and the Middlesex Hospital Medical School. After a very brief flirtation with orthopaedic surgery he sensibly found his way into General Practice. Pre-dating vocational training. Bill cut his teeth in a lovely rural practice in South Norfolk. Education for the established GP scarcely existed, in a way fuelling a lifelong interest in the vaguely academic aspects of medicine.

With the support of the local Deanery and the Royal College of General Practitioners an interesting career ensued with many roles with the former and an inspiring time with the latter.

Bill moved back to Surrey in mid-career and became particularly interested in consultations, mainly because no one had ever taught him anything about them. Hence this small booklet.

He has been a trainer, programme director and associate GP dean, worked with under-performing doctors, and been a lecturer in General Practice and specialty subjects at St Georges Hospital Medical School in London, and for the University of Surrey at home and abroad. He has worked with the RCGP on Fellowship by Assessment, Membership by Assessment, and as an RCGP Video and CSA examiner.

Bill is now retired from General Practice and spends his time pottering about making things, sailing, and enjoying being a grandfather.