Development and face validation of strategies for improving consultation skills

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Abstract

Context: While formative workplace based assessment can improve learners' skills, it often does not because the procedures used do not facilitate feedback which is sufficiently specific to scaffold improvement. Provision of pre-formulated strategies to address predicted learning needs has potential to improve the quality and automate the provision of written feedback.

Objectives: To systematically develop, validate and maximise the utility of a comprehensive list of strategies for improvement of consultation skills through a process involving both medical students and their clinical primary and secondary care tutors.

Methods: Modified Delphi study with tutors, modified nominal group study with students with moderation of outputs by consensus round table discussion by the authors.

Results: 35 hospital and 21 GP tutors participated in the Delphi study and contributed 153 new or modified strategies. After review of these and the 205 original strategies, 265 strategies entered the nominal group study to which 46 year 4 and 5 students contributed, resulting in the final list of 249 validated strategies.

Conclusions: We have developed a valid and comprehensive set of strategies which are considered useful by medical students. This list can be immediately applied by any school which uses the Calgary Cambridge Framework to inform the content of formative feedback on consultation skills. We consider that the list could also be mapped to alternative skills frameworks and so be utilised by schools which do not use the Calgary Cambridge Framework.
Key words:
Assessment of clinical performance
Clinical education
Clinical skills
Communication skills
Consultation skills
Instructional materials
Feedback

Paper

Introduction and need for this study

A key set of skills for all medical practitioners is being able to talk to patients who present with medical concerns, examine them, decide on the likely diagnosis and negotiate an agreed plan of investigation and treatment: in short, being able to conduct a 'consultation' with a patient. We usually teach these skills separately but expect learners to hone and integrate them by conducting multiple consultations in the workplace. To learn from this activity learners need to reflect on their performance and receive external feedback upon it. Both of these tasks, self-reflection and external feedback, can be helped by a comprehensive conceptual framework or scaffold which encompasses the tasks required so long as they can be readily understood and held in mind by both learners and tutors. Having an accepted scaffold for consultation skills allows much more specific reflection and advice regarding how elements of the tasks can be achieved.

It is clear that assessment of workplace-based activity can improve a learner's consultation skills[1] and improvement is predominantly mediated by discussion between learner and tutor.[2] Whether this discussion is called feed-forward or feedback, its goal should be to provide the learner with "specific information about the comparison between the learner's observed performance and a standard, given with the intent to improve the learner's performance."[3] Feedback needs to provide the learner with guidance which is specific enough to enable the learner to enhance achievement.[4] At its simplest, feedback provides verification as to whether an observed performance was optimal or not. However, if tutors wish to help learners to improve their performance, learners will require further explanation as to why the observed performances were or were not optimal. Furthermore, explanation is insufficient on its own: additional structure or scaffolding is needed to support learners to make use of feedback by providing more explicit instructions and strategies to remediate the sub-optimal performances. This often requires that tasks are deconstructed to make them more achievable[5] and to set specific goals. In addition, tutors need to set their learners an appropriate and realistic level of challenge.[6] By doing so, the gap between observed and intended performance can be narrowed.

In practice, current workplace assessments can result in a greater focus on assessment than feedback with the design of the forms often contributing to limited feedback.[1 1] Learners who perceive that they have passed an assessment may feel little incentive to make use of feedback that is available.[7] There is often a failure to set specific learning goals.[8] Tutors often have different concepts of the standard required and therefore are likely to have different notions of the level of challenge that should be set by a learning goal.[9] We have observed that while tutors can readily identify what was done well and what learners need to improve, the feedback given is often non-specific and does not assist learners to address the deficit between the observed and desired performance.[10]

Tutors are often discouraged from providing appropriate feedback because of time constraints.[8] One way to reduce time pressure is to assist tutors to scaffold learners' learning when sub-optimal performances have been observed. This can be done by providing pre-written strategies for use in the event of various possible predicted sub-optimal performances. This has potential additional benefits such as acquainting tutors with the standard required; the use of terms familiar to the learners from their curriculum; and helping tutors to set appropriate challenges for their learners. We now report a study in which we aimed to systematically develop, validate and maximise the utility of a comprehensive list of strategies for improvement through a process involving both medical students and their clinical tutors from primary and secondary care.

Methodology

Context: Serial workplace-based assessment is a key component of the consultation skills development programme for students at Keele University School of Medicine. This is an integrated spiral programme in primary and secondary care running from year 3 to year 5. This uses the **Ge**neric **Co**nsultation **S**kills (GeCoS)[11] assessment tool which was designed to support the formative and summative assessment of consultation skills in various settings. GeCoS has been developed by a group of clinical tutors in Keele from the Leicester Assessment Package (LAP),[12;13] the Calgary Cambridge Guide to the Medical Interview[14] and Tomorrow's Doctors 2009,[15] and validated by a panel drawn from hospital and GP tutors, half from Keele and half from seven other UK medical schools.[11] It can be seen in Appendix 1.

Given the problem of lack of specificity of the content of feedback,[10] we had developed support materials for tutors and students using GeCoS. This contained up to eight pre-formulated strategies for improvement for each GeCoS competency to help tutors scaffold learning through specific feedback. Our intention was to enhance the educational potential of the feedback by:

a) Addressing the 'specificity gap' in feedback by providing the tutor who has identified a need for improvement with a set of specific strategies (or scaffolding) for improvement from which the tutor can suggest those s/he feels will help the learner.[10]

b) Saving time as the tutor doesn't need to "re-invent the wheel".

c) Offering the potential to 'automate' the production of written feedback. After the discussion of how to improve, the selected strategies plus any other tutor comment can be recorded for the learner. To save the tutor time writing, the strategies for improvement have been included in an online version of the workplace-based assessment feedback form with text boxes for additional comment. This online workplace-based assessment tool generates an email to both the tutor and the learner containing a written summary of the discussion between them. We call this email the "educational prescription".

d) Enabling learners who have self-identified a need to improve a particular competency with suitable strategies to do so.

We developed the current set of strategies from the LAP strategies,[16] amendments and additions being informed by our course materials which were based on the Calgary-Cambridge model[14]. An example of a competency and its corresponding strategies for improvement is shown in figure 1.

Table 1 maps the number of strategies originally developed for each domain of consultation skills. Although GeCoS had been validated, the set of strategies for improvement had not and we considered that they needed improvement and validation by both teachers and students.

Operational definitions: We defined a valid strategy as one which if both understood and then adopted by students, should result in improvement in the relevant competence. We defined comprehensiveness as including all distinct strategies suggested by teachers and students during this study and during the workplace-based assessment of students in the first years of its use.

Basis of judgements: The judgement of whether adopting the competence should enhance performance would be made by hospital and general practice tutors (because the support materials would be used in both hospitals and general practices) and by students (who would be asked to adopt them). The judgement of whether strategies were understandable would be made by students who have to be able to understand them to adopt them. The judgement of whether strategies were distinct was made by the author group which included hospital and general practice tutors and a student.

We therefore had to access the views of a broad range of experienced general practice and hospital tutors and of medical students. We judged that a single methodology would not suffice. We used a modified Delphi study[17] questionnaire administered by a commercial survey web site (SurveyMonkey™) to access the views of a broad cross section of teachers; methods which the authors[11;13;18] and others have used previously.[11;19-21] We considered that an electronic survey would not adequately access the views of students: we wished to access not only their candid views on the usefulness of the strategies but also why they thought those which were not useful were not and how they could be improved. We therefore used a modified nominal group technique[22] which allowed us to assess the discussion between students about the strategies but modified voting by maintaining anonymity using an audience response system which reflects aspects of Dephi methods.[17] We also considered that student participants would be more able to contribute if they had experience of workplace-based assessment and receiving written summaries containing a mix of the original and novel strategies. We therefore recruited students from years 4 and 5 of our undergraduate course as they had this experience.

Methods

Delphi study of tutors: Tutors were asked to express their opinions of the usefulness of each of the original strategies for formative feedback following workplace-based assessment of an undergraduate medical student. The questionnaire used a four point Likert response scale anchored by "Useful" (1) and "Not useful" (4). As well as alternative wordings, they were also asked to offer any additional strategies for improvement they had found helpful. The instructions to the respondents are reproduced in Figure 2.

Because of the number of strategies (205, see table 1), we developed nine online surveys, one for each GeCoS domain. Participants were asked to complete two surveys but were also sent the web addresses for the other seven so that they could respond to those in which they were interested. The panel of participants was drawn from hospital and general practice clinical tutors and examiners in order to include experts in all types of consultations. We continued to recruit participant tutors until we had 10 responses for each domain, aiming for half GP and half hospital tutors.

Data capture, analysis and synthesis: All categorical and free text data from the tutor Delphi were downloaded. To this we added rewordings and distinct new strategies from the written summaries of actual workplace-based assessments ("educational prescriptions") of the cohort of year 3 students from May 2010 through to the end of their 4th year in June 2011.

Analysis was by a round table group of the authors. Each meeting consisted of at least two hospital doctors and at least two GPs to bring both perspectives to the data.

All suggestions for rewording and new strategies were reviewed using previously described methods[11] to decide whether:

- Reworded strategies were an improvement on the original strategy.
- Suggested new strategies were indeed new rather than being rephrased existing strategies.

The usefulness ratings of each strategy provided the researchers with an indication of how important it was to seek an improved wording. The working protocol was that a rewording was sought for any strategy with a "Usefulness" rating of more than 2.0 in the Delphi study (2.5 is the mid-point of the "Useful" to "Not useful" 1 to 4 scale). The rewording was informed by the suggestions of the surveyed tutors and those identified from educational prescriptions as mentioned above.

We were also careful in preparing the list of strategies for validation by the student participants to ensure comprehensiveness. To this end we were mindful of the need to present a variety of unique suggestions for every GeCoS competence.

Modified nominal group study with students: The outcome of the tutor study was a new (expanded) list of strategies which entered the student study for validation. Both the original and reworded versions were presented to the student group.

Student participants were recruited by AT (a year 4 medical student). To accommodate the number of strategies, multiple groups were run. The methodology combined elements of Delphi consensus[17] and nominal group technique. The groups were facilitated by AT and the discussions were recorded, either by a 'scribe' or by digital tape recorder, and transcribed. Each group session lasted 90 minutes during which approximately 30 strategies were considered.

Group process: Each strategy was presented for validation to one student group only, but if any changes were made it was then presented to a second group after revision.

The strategy was presented using a PowerPoint presentation with the following wording:

> "If you need to improve on competency <<*Selected GeCoS competency*>>
>
> Would the following be a useful strategy for you?
>
> <<*Selected strategy for improvement of that competency*>>"

The student facilitator first checked "Do you understand the competency?" to enable clarification if necessary. The group then voted on the utility of the strategy for improvement using electronic keypad devices.

Each individual voted "Useful" or "Not useful" before discussion of each strategy. "Useful" was defined as the strategy being both clear (the student could understand what was suggested) and relevant (the student could envisage themselves or others improving by doing what was suggested).

The definitions of student consensus were:

- If 70% or more responded "Useful" then the item was "Validated".
- If more than 30% and less than 70% responded "Useful" the item was "Not validated".

- If fewer than 30% responded “Useful” the item was “Rejected”.

Students who responded “Not useful” were asked whether it was because the strategy lacked relevance or clarity and why they considered this to be the case. These reasons were captured and transcribed to inform the rewording of the competence by the subsequent “round table” of the authors.

Following the vote on the usefulness of each original strategy, any possible rewordings from the tutor study were shown on a second slide. The student group then voted on which was the preferred wording.

The round table of the authors (including AT to ensure that the students’ comments were represented) met to revise the strategies following the student validation exercise.

All “Rejected” strategies were discarded unless the round table felt they could improve the wording and all “Not validated” strategies were returned to a final student group whether or not they could be improved. All “Validated” strategies about which students made comments about improvement were also reconsidered by the round table of the authors and returned to the final student group if potential improvements were made.

All strategies reconsidered by the final student group were validated if they achieved more than a 70% “Useful” vote and rejected if not. Nevertheless, the “round table” (including AT) retained the final editorial control to ensure that there was choice of strategies available for each GeCoS competence.

Results

Figure 3 is a flow chart of the results which may help understanding of the process.

In 984 educational prescriptions for 128 students from May 2010 to June 2011, GP tutors had used 200 of the 205 strategies but also had offered alternative wordings and new strategies. These were reviewed by one author (JL) and from these, 24 amendments of existing strategies and 16 new strategies were identified for this study.

In the tutor Delphi study 35 hospital tutors (22 male/13 female; 21 consultants/14 juniors all with some experience of teaching covering surgical, emergency and general medicine, paediatrics, psychiatry anaesthetics and radiology) and 21 experienced GP tutors (10 male/11 female) generated 250 comments containing 84 potential amendments and 68 potential additions to the original strategies.

These were all considered at three round table meetings attended by between five and eight members of the research team. This resulted in a new list of 268 strategies.

Seven student groups of between five and eight participants voted on and then discussed each strategy. A total of 41 students were involved at this stage; 16 male and 25 female; 33 from year 5 and 8 from year 4 with five students attending two groups. Although 190 of 265 strategies were validated on their first consideration by these groups, the student discussion suggested that 35 of the validated strategies could be further improved. 33 strategies were rejected (received <30% approval) and 42 were not validated (received 30-70% approval). 3 were inadvertently omitted at this stage and were therefore included in the second stage nominal group instead.

A further five round table meetings of the researchers including AT reviewed the outcome of the student groups. The round table omitted 11 of the rejected strategies together with 8 strategies which had not been validated and 1 validated strategy which was considered to be a duplicate. The remaining 22 strategies which had been rejected by the students plus the remaining 34 non-validated strategies and the validated strategies for which improvements had been suggested were revised by the round table of researchers being guided by the students’ comments. Three strategies were added at this stage by suggested splitting of strategies. A total of 97 strategies (including the three missed from the first nominal group stage) were prepared for the final student group.

Ten Year 5 students attended the final group, five male and five female, of whom five had attended a previous group, bringing the total number of students involved to 46. 77 strategies were validated by this final group. 14 strategies were not validated by that group, and the researchers therefore had to determine what was to be done with them. Seven of these had been validated but refined by the previous group. For six the previously validated version was included. One amended version was included as it was preferred by the students. Five were included even though not validated by either group, but were further amended guided by student comment. Two strategies were

considered not worth including or amending and were dropped. One strategy was rejected by the final student group but they suggested improvements. On discussion, the researchers determined to revise this according to student comment and included it in the final set of strategies. Five other revised strategies which had slipped the attention of the final student group were also considered worth including by the round table. Four of these had been previously validated.

The final 249 strategies modified and face-validated by the two-stage student group process can be seen in Appendix 2.

An example of the changes made to one strategy by this process is shown in Fig 4.

Discussion

Two major challenges in providing useful feedback to trainee clinicians have been lack of specificity in the information and advice given and lack of time in which to give it. A step towards making workplace-based assessment and feedback more effective could be the provision of support materials for those giving feedback. To address the specificity gap and the time challenge, such materials would contain accepted suggestions for improving skills and should save time taken in constructing the advice given.

In this study, we have developed a valid and comprehensive set of strategies to inform the content of formative feedback on consultation skills and the strategies are considered useful by the medical student recipients of such feedback. We are only aware of one similar set of strategies for enhancement of generic consultation skills (which informed the development of our original strategies)[16] and one for the enhancement of clinical procedural skills[10] and neither has gone through a process of formal validation by tutors and students nor a review of 'usefulness' by students. Thus we believe that this is a unique resource for students and teachers which was developed using a novel combination of methods and participants.

The major strength of this study is that a total of 110 stakeholders with experience of workplace-based assessment contributed: 46 students who had had a minimum of six workplace-based assessments each, 56 experienced clinical teachers all of whom had conducted workplace-based assessments and the 8 strong research team, representing the major stakeholders in workplace-based assessment and formative feedback (students, clinical teachers and the core school staff). In order to enhance its utility for workplace-based assessment in both hospital and general practice and enhance its accessibility to students for self-assessment and feedback, it was desirable that clinical tutors from both hospital and general practice were involved in its development, that medical students should validate those strategies which were useful to them and that they should also suggest improvements. In addition, the methodologies were carefully chosen. The modified Delphi tutor study enabled a broad consensus to be achieved across the hospital and GP tutor base with important refinements on advice to give to medical students who need to improve specific consultation skills. The modified nominal group student study involving the final consumers, medical students, enabled both validation of the strategies as 'fit for purpose' and, by capturing the discussion, the final refinement of the strategies incorporating the student perspective. Furthermore, even if students had validated a strategy but had suggested ways in which it could be improved the 'round table' then attempted to do so. We consider that our refinement of the nominal group by anonymising voting through use of 'audience response' electronic key pads, so that students voted 'blind' to each other's opinions, was a particular strength.

A clear limitation is that this was a study conducted in a single school and with a particular consultation skill curriculum and assessment framework albeit that GeCoS has been validated in a multi-speciality, multi-school study. Furthermore the consensus on individual strategies was derived from small groups and a different student group might have reached a different consensus. Nevertheless few items were rejected as a result of a single student group without being reconsidered by the researchers and by the final group and we consider our methodology to have been a pragmatic solution to the problems this project presented.

This set of strategies for improving each skill required by tomorrow's doctor can be considered a 'primer' for consultation skills. We are using them throughout our curriculum from the skills lab in year 1 to final year workplace-based assessment and in all clinical settings from hospital to general practice in which our students learn. Our tutors now conduct approximately 1,400 formal workplace based assessments incorporating these strategies on our students each year with very positive

student evaluations. Having developed the tutor support materials, we will next improve and evaluate the electronic feedback interface to make them easier and quicker to use in any clinical setting. Studies of the effect of such feedback on student learning will be the final test of the utility of this teaching resource. One such study is planned in which the use made by students of the various sections of their web-based feedback portal will be evaluated. A study of sequential assessments and the feedback given would be another way of assessing the impact of this feedback although, because this is a complex system, this would be insufficient to attribute change exclusively to use of the strategies. .
The wider application of this study is that any medical school with consultation skills curricula based on the Calgary-Cambridge framework for effective consultations can immediately take any or all of these strategies and map them to their own consultation skills assessments to inform the content of either verbal or written feedback. We offer them as a resource to others interested in supporting their tutors to improve the quality of the feedback they give their students.

Ethics: The study protocol was approved by the Keele University School of Medicine Research Ethics Committee.

Appendices:
Appendix 1: GeCoS (Generic Consultation Skills) framework and competencies
Appendix 2: Final list of strategies for improvement of consultation skills

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Fig 1:

An example of one GeCoS competency and its corresponding strategies for improvement (validated in this study)

Competency (from the History Process and Content domain of consultation skills)

Enable the patient to fully elaborate presenting problem

Strategies for improvement of this competency (one or more selected depending on what the student had done)

- Resist the temptation to interrupt at the start of the consultation, although this may be necessary later if the patient becomes repetitive.
- Use open questions to begin with e.g. 'How did it start?'; 'What happened next?'
- Use prompts as appropriate e.g. 'I see'; 'Tell me more about that'
- If the patient makes a significant statement and then stops, encourage the patient to continue, for example by repeating the last statement or word.
- List the symptoms so far and check in different ways, for example, 'Was there anything else you noticed?', 'Were there any other symptoms?'

Fig 2:

Instructions for respondents to Tutor Delphi study

What we want is your opinion on:

1. How useful would each strategy be for your students?
    a. If you wish to suggest a rewording of any of the strategies to improve them, please use the text box.
    b. If you have additional strategies to suggest for students to improve any of the competencies in this domain, please use the text box. Put several items in one box if you wish.

Fig 3:

Flowchart of the study process

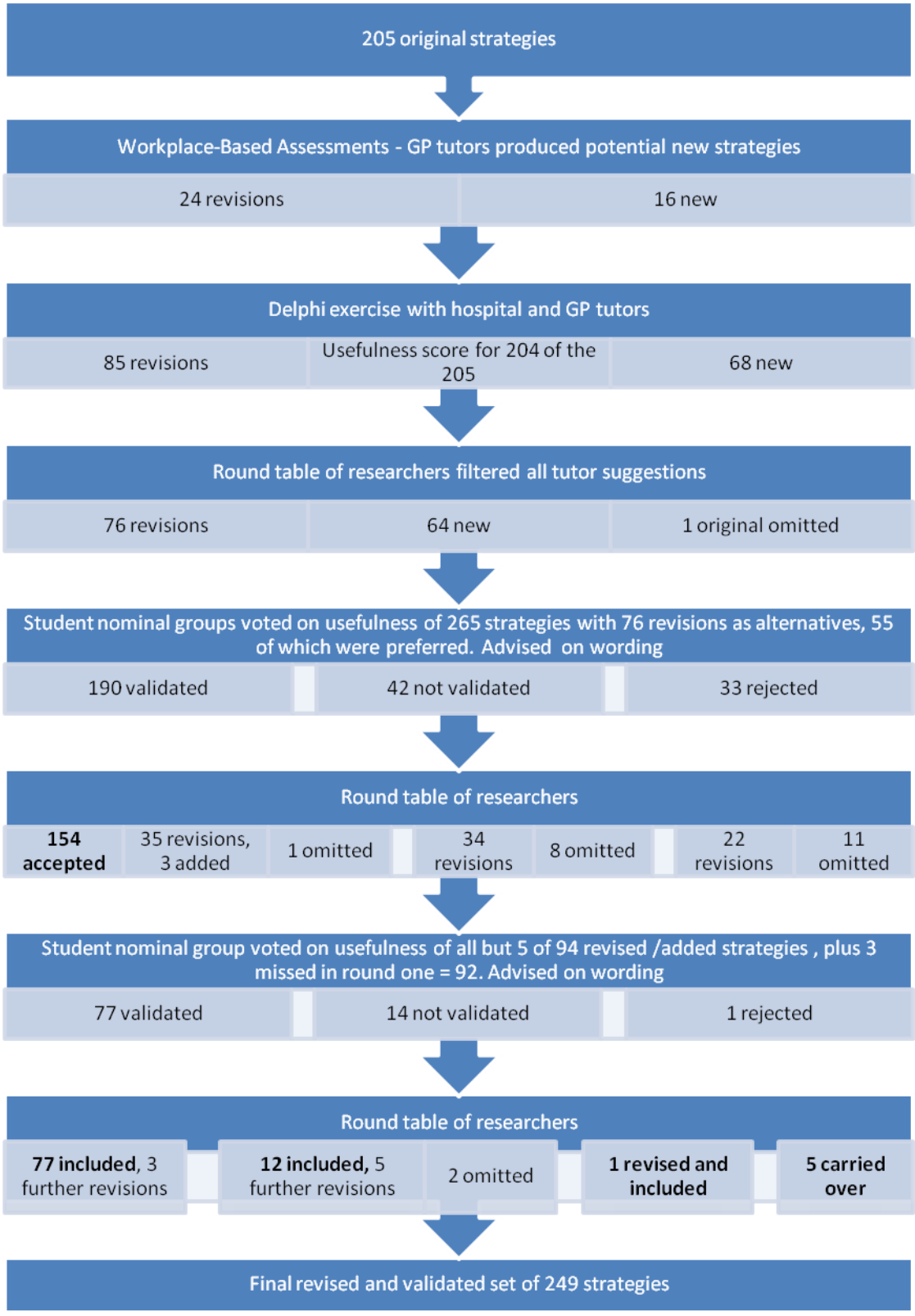


Fig 4:

Examples of the journeys of two strategies through this process

Example 1: To improve on the clinical reasoning competency: ***Correctly interprets information obtained***

One original strategy: ***Avoid over-reliance on features that may support a conclusion you reached prematurely***

Scored 1.67 on the usefulness scale in the tutor study (1 = useful; 4 = not useful) but was revised according to tutor suggestions to:

If there appears to be an obvious diagnosis, consider alternatives

Which was voted useful by 100% of the student group and preferred by 83%

Example 2: To improve on the history taking competency: ***Skilled use of questioning including use of open and closed questions***

One original strategy: ***Use facilitation to encourage the patient to tell their story***

Scored 2.0 on the usefulness scale in the tutor study (1 = useful; 4 = not useful)
Was rejected by the student group (0% useful) and revised according to student comment to:

Encourage the patient to tell their story by using expressions like "And then….?" Or "What happened next?"

Which was voted useful by 78% of the final group

Table 1:

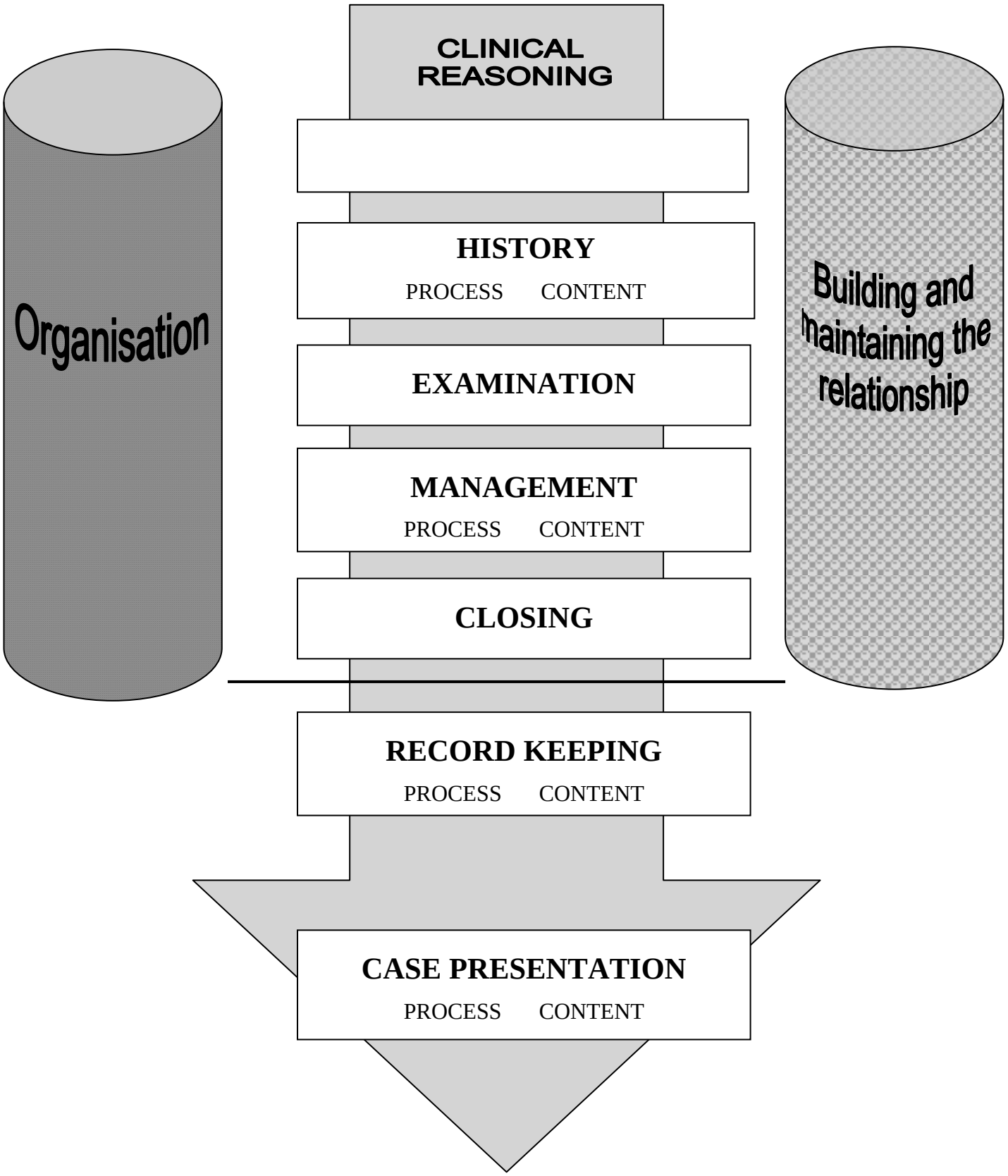
The original strategies for improving competencies in GeCoS mapped to the nine domains of the consultation (categories of skills)

Category of consultation skills	**No. of competencies**	**No. of strategies for improvement**
Opening	3	12
History process + content	10	35
Examination	6	23
Management	12	47
Clinical reasoning	6	29
Building and maintaining the relationship	4	10
Organisation	8	22
Record keeping	6	13
Case presentation	4	14
Total	**59**	**205**

APPENDIX 1

A FRAMEWORK FOR THE CONSULTATION INCORPORATING CONTENT AND PROCESS SKILLS

Adapted from: the Calgary Cambridge Framework for the Medical Interview with the kind permission of Dr Jonathan Silverman, University of Cambridge; Fraser RC. *Clinical Method: a general practice approach. Third ed. Oxford Butterworth-Heinmann, 1999* and material provided by AM Hastings, Department of Medical and Social Care Education, University of Leicester.



Generic Consultation Skills (GeCoS) - overview of skills to be assessed
Keele University School of Medicine

OPENING

- Introduces self
- Establishes identities of patient and third parties and preferred forms of address
- Establishes agendas

HISTORY

PROCESS

- Enables patient to fully elaborate presenting problem(s)
- Listens attentively
- Skilled use of questioning including open and closed questions
- Clarifies words used and/or symptoms presented by patient as appropriate
- Recognises and responds appropriately to verbal and non-verbal cues

CONTENT- obtains the following:

- Sequence of events
- Details of symptoms
- Effect on the patient's life
- Patient's ideas, concerns and expectations
- Relevant background information including: Past Medical, Drug, Family and Social History; Systems review; Factors influencing health

EXAMINATION

- Obtains and maintains consent
- Displays competent practice of infection control
- Displays sensitivity to patient's needs and dignity; offers chaperone if appropriate
- Gives clear instructions and explanations of process
- Performs examination competently
- Elicits normal and abnormal findings

MANAGEMENT

PROCESS

- Relates explanations to patient's perspective
- Gives clear information in small chunks
- Negotiates a mutually acceptable plan with patient and/or third parties
- Reassures appropriately
- Checks understanding

CONTENT

- Gives key evidence-based information
- Explores available options, risks and benefits
- Investigates appropriately
- Prescribes rationally and accurately
- Refers appropriately
- Makes appropriate use of opportunities for health promotion
- Agrees appropriate follow-up

CLINICAL REASONING

- Seeks relevant and specific information from patient's record or third parties
- Generates appropriate working diagnoses or problem list
- Seeks discriminating information from history, examination and investigations to help confirm or refute working diagnoses
- Correctly interprets information obtained
- Applies basic, behavioural and clinical sciences to solution of patient's problem
- Recognises limits of competence and acts accordingly

BUILDING AND MAINTAINING THE RELATIONSHIP

- Develops and maintains a professional relationship with patient
- Respects the patient's ideas, beliefs and autonomy
- Responds empathically
- Fosters collaboration

ORGANISATION

- Considers and optimises the setting
- Involves third parties appropriately
- Exhibits a well-organised approach to gathering and sharing of information
- Makes organisation of consultation overt to patient
- Prioritises agendas appropriately
- Summarises appropriately
- Uses time appropriately
- Closes consultation appropriately

RECORD KEEPING

PROCESS

- Makes concise and accurate notes without interfering with dialogue or rapport

MINIMUM CONTENT includes:

- Diagnoses/problems
- Relevant history and examination
- Outline of management plan; therapy, investigations, referral and follow up
- Information, instructions and special precautions given to the patient
- Identification of the author and date of record

CASE PRESENTATION

- Engages and orientates colleague
- Delivers clear and relevant detail in a logical order
- Communicates interpretation of data transparently
- Draws purposeful conclusion

APPENDIX 2

Category and competency	Strategy
Opening	

OP1: Introduces self

1 If you are unknown to anyone in the consultation, introduce yourself professionally using your name and role.
2 Even if the patient launches in as soon as they are through the door it is worth saying who you are.

OP2: Establishes identities of patient and third parties and preferred forms of address

1 Check the identity of the patient against the name of the person you expect to see.
2 Ask accompanying people their names and relationship with the patient.
3 Ask those attending 'What would you like me to call you?'
4 Introduce any other people (health staff, students) in the room and check that it is acceptable for the patient for them to be there.
5 Check the pronunciation of unfamiliar names with the patient.
6 Use your judgement to decide what is appropriate. The default strategy is to start formal with an older person (than yourself) and to consider what will feel appropriate for a younger person.

OP3: Establishes agendas

1 Identify the patient's agenda. Develop a range of opening questions for different situations with which you are comfortable
2 Check that your understanding of the patient's agenda is complete: 'Is there anything else you would like me to do today'
3 Clarify your agenda for the patient: 'I understand that you have come because/for XX'
4 Consider all presenting complaints and then quickly prioritise them and pay attention to what is necessary. Involve the patient in prioritising 'What is the most important thing to deal with today?'
5 Explain your agenda if you are a learner, and seek consent for this 'I am learning how to consult with patients. Could I interview you before you see Dr X and I will then report to her and we will complete the consultation together?'
6 Although confidentiality may be assumed in a healthcare consultation, consider whether it would help to make it explicit in this consultation
7 Recognise that it may not be possible to sort out all the problems presented on that day

History Process

H1: Enable the patient to fully elaborate presenting problem

1 Resist the temptation to interrupt at the start of the consultation, although this may be necessary later if the patient becomes repetitive.
2 Use open questions to begin with e.g. 'How did it start?'; 'What happened next?'
3 Use prompts as appropriate e.g. 'I see'; 'Tell me more about that'.
4 If the patient makes a significant statement and then stops, encourage the patient to continue, for example by repeating the last statement or word
5 List the symptoms so far and check in different ways, for example "was there anything else you noticed?", "were there any other symptoms?"

H2: Listens attentively

1. Demonstrate to the patient that you are listening by using appropriate body language and maintaining eye contact.
2. In a patient-centred consultation you will receive information out of sequence. Remember key points. For example: 'You said earlier you are a smoker, how much do you smoke?' is preferable to asking the same patient 'Do you smoke'.
3. If you need to write information down, or record data on the computer, do so in a way that does not interfere with your communication with the patient.
4. Don't stop listening to the patient whilst you think about the next question to ask. Use other strategies if you need time to think eg mini summary
5. If you need time to think, tell the patient that you are gathering your thoughts. Make some brief notes if necessary.

H3: Skilled use of questioning including open and closed questions

1. Move from open to closed questions e.g. 'Why have you come today?' 'Can you tell me more about that?', 'Is it getting worse?'
3. Encourage the patient to tell their story by using expressions like 'And then….?' or 'What happened next?'
4. Avoid using 'leading' questions, i.e. those that imply a particular answer e.g. 'Your baby doesn't have diarrhoea does he?'
5. Don't use 'double' or 'nested' questions e.g. 'What is your pain like and how long have you had it?' 'Is your appetite normal and have you lost weight?'
6. Tailor the questions you ask to the level of the patient's ability to understand. Don't patronise or talk down to the patient.
7. Don't use technical jargon.
8. It may be that you have to ask the same question again or in a different way if the patient has misunderstood or evaded answering. Don't be afraid to do that or you will be left feeling unclear

H4: Clarifies words used and/or symptoms presented by patient as appropriate

1. If you don't understand what the patient means, ask them to explain.
2. If the patient uses a medical or technical term (e.g. constipation) make sure you understand exactly what they mean by it.

H5: Recognises and responds appropriately to verbal and non-verbal cues

1. Listen carefully for and follow up all cues that the patient gives you e.g. 'My husband's at home all day now'
2. Notice unusual words and/or surprising omissions and follow up on these.
3. If a symptom is shown during the consultation, consider acknowledging it and ask whether it is typical (eg if patient coughs or has a tremor).
4. Acknowledge patients' expressed feelings to give them a chance to explain them or feel that they have been shared. e.g. 'I can see that this is difficult for you to talk about . . .'
5. If the patient is having difficulty telling the story or is distressed, allow time for the patient to regain composure.
6. Try to tolerate the discomfort of appropriate silences. Resist the temptation to talk when the patient is thinking about their response.
7. If the patient seems particulary uncomfortable, pause to assure the patient of the confidentiality of the interview and check whether the patient is happy to continue with the topic
8. Be sensitive to behaviour that is incongruous e.g. the patient who laughs when stating something serious.

H6: History Content - Sequence of events

1. Ask the patient to describe and clarify when and in which order each event occurred
2. If a patient appears to have skipped a period of time and you are aiming to determine a chronology, ask what happened in the relevant period

3 If a patient gives a jumbled sequence of events, repeat the sequence in the order you understand for confirmation
4 Always check when they were last well or when their new symptom(s) FIRST started
5 If the patient has had symptoms for some time, find out why the patient has presented now?
6 If the patient has difficulty ask 'Can you tell me about it from the beginning?' and follow up with 'What happened next?' until the story is complete

H7: History content - Details of symptoms

1 Allow the patient to finish their opening statement and clarify their presenting complaint(s) before you seek relevant associated symptoms
2 Use a mental checklist such as SOCRATES (which is useful for many symptoms) to clarify the presenting complaint(s)
3 Ensure you have checked whether or not the patient is experiencing the 'cardinal' symptoms for relevant system(s)
4 Note taking can help you to keep track of disordered information.

H8: History content - Effect on the patient's life

1 Ask the patient how his/her ability to sleep, toilet, wash, dress, cook, eat, work, relax or socialise (as appropriate) have been affected.
2 In consultations with a third party, ask about effects on the patient's behaviour if appropriate
3 Ask the patient 'how is this affecting you? How is it affecting others?'
4 Ask the patient "what does it stop you doing?"

H9: History content - Patient's ideas, concerns and expectations

1 In every consultation you must be satisfied that you know: What does the patient believe is wrong? What are they concerned about? What do they hope can be done? Sometimes this may require gentle but persistent questioning.
2 If the patient has indicated their ideas, concerns or expectations avoid direct questions. It is better to reflect back a remark they have made. E.g. 'You said your mother had headaches like these, what was the cause of her headaches?'

H10: History content - Background information including: Past Medical, Family and Social History; Systems review; Factors influencing health

1 Remember that a problem will often have physical, psychological and social components ('Triple Diagnosis').
2 Patients with psychological illness may have unrecognised physical disease, and vice versa, so ensure you have thought about this possibility.
3 When satisfied that physical disease is present always consider its impact on the social and psychological well-being of the patient.
4 Consider the impact on the patient of other social and psychological factors in their life such as their work, housing, family and other relationships, personality, sexuality, cultural background, spiritual beliefs and practices.

Examination

E1: Examination - Obtains maintains consent

1 Ask the patient's permission to carry out the examination, especially 'intimate' examinations
2 Check whether the patient has understood and has any questions before you proceed
3 If the patient is unable to give consent (lacks competency eg. a young child or confused adult) you must act in their best interests. At all times try to achieve their cooperation, with the help of a familiar person if appropriate.

4 If the examination is uncomfortable at any point, apologise and ask for permission to continue

E2: Displays competent practice of infection prevention

1 You must always cleanse your hands before (for the patient) and after (for yourself)
2 You should wear non-sterile gloves in examinations which might involve contact with body fluids. You should wear sterile gloves where the patient could be at risk of transmitted infection from your skin.
3 Dispose appropriately of gloves, apron, tissues etc. according to your workplace policy

E3: Displays sensitivity to patient's needs and dignity; offers chaperone if appropriate

1 Ensure a chaperone is available for intimate examinations and explain the need for this to the patient
2 When a chaperone is required either by the patient or by yourself, the chaperone should be acceptable to the patient
3 Give the patient privacy to undress and dress where possible
4 If the patient has difficulty in positioning or undressing themselves, ask whether you or the chaperone can help
5 Expose the part(s) to be examined with due sensitivity to the patient's dignity and cover them as soon as possible

E4: Gives clear instructions and explanations of process

1 Explain clearly to the patient what you want them to do. Demonstrate the required action if appropriate.
2 Give an explanation of what you are doing to the patient, particularly if this might involve discomfort.
3 Explain in terms the patient can understand
4 Explain to the patient that you will wait until they are dressed, settled, and ready to discuss your findings

E5: Performs examination competently

1 Review the examination in the textbook and/or watch a competent practitioner perform the examination
2 Be familiar with the instruments you use, first practising under supervision
3 Set the situation up to maximise your chances of success e.g. light from the side (JVP), low light levels (fundoscopy), correct side for your examination (apex beat).
4 Ensure the comfort of the patient before proceeding with an examination.
5 Ask the patient to point to the pain (if they have any).
6 Aim to do the examination once, correctly, and as fluently as possible
7 Watch the patient for signs of discomfort and respond accordingly
8 Find a competent colleague who is willing to observe you performing the examination and to give you feedback

E6: Elicits normal and abnormal findings

1 Obtain repetitive practice with feedback from a competent colleague who can tell you what signs they are finding
2 Never be afraid to ask a colleague for their opinion about a sign of which you are uncertain
3 Keep practising examination skills so that the sequence is second nature, as this will free up your mind to assess the significance of findings

Management

M1: Relates explanations to patient's perspective

1. Check what the patient already knows before beginning your explanation.
2. If appropriate, determine what they want to know and whether they want anyone else to be present
3. Establish what you can about the patient's lifestyle, beliefs, cultural background and abilities and take these into consideration.
4. Whenever possible, link back in your explanation to the patient's initial ideas, concerns and expectations
5. Explain what you are thinking and seek their views
6. Mentally rehearse good questions about dilemmas in patient management for example "People who are nearing the end of life sometimes like to state a preference about where they should die. Do you have any views on that?"

M2: Gives clear information in small chunks

1. Use clear language, avoiding technical jargon
2. Provide information in 'small packages' particularly if it is distressing or complex.
3. Use the patient's response as a guide to how to proceed
4. Give information in ways which promote recall and understanding (eg using diagrams)
5. If appropriate use leaflets and good quality internet information to reinforce your explanation and advice.

M3: Negotiates a mutually acceptable plan with patient and/or third parties

1. Think about how the patient can actively participate in decisions about their care and encourage them to do so
2. Determine whether they want to be involved in planning and whether they have any preferences
3. Offer suggestions and choices rather than instructions
4. Discuss with the patient the management options and your recommendations and ensure they have sufficient knowledge to make informed decisions.
5. When planning, focus on the patient's goals rather than the patient's problems, for example the elderly patient with heart failure who doesn't want to risk incontinence by taking their diuretics
6. Check whether they agree to your suggested plan

M4:Reassures appropriately

1. Where appropriate, aim to reassure and offer hope.
2. Get the full picture before offering reassurance

M5: Checks understanding

1. Ask the patient whether they have understood what you have said and give them sufficient opportunity to question you.
2. Explore the patient's reactions (beliefs and feelings) about the information you have given them and address them where necessary
3. Sometimes it may be appropriate to ask the patient to repeat back their understanding of the management plan and what they are to do.
4. Enquire of the patient 'Is there anything else you would like to ask about what we have said?' before ending the consultation.

M6: Gives key evidence-based information

1. Guidelines for management are often published with the strength of supporting evidence. Choose management strategies in line with current best evidence

2. Identify and use routinely a trustworthy clinical evidence website such as http://clinicalevidence.bmj.com or www.evidence.nhs.uk to evaluate the treatments you propose.
3. Identify the patient's needs and adapt the information you give accordingly

M7: Explores available options, risks and benefits

1. Start exploring options by acknowledging the patient's expectations eg. "I realise you were hoping for antibiotics but…"
2. Explain the likely impact of each management option
3. Explain risk and benefit in terms the patient is likely to understand
4. Make sure options are realistic and relevant

M8: Investigates appropriately

1. Remember to consider the need for investigation and consciously be aware of the reasons for and against any potential investigation.
2. Remember that any investigation should only be performed if the result will change management
3. Discuss the value of the investigation with the patient
4. Make sure the patient knows when and how they will hear about the investigation and its results.

M9: Prescribes rationally

1. Think about the reasons for and against prescribing a particular drug.
2. Always consider the major side effects and interactions.
3. If in doubt don't guess – consult the British National Formulary. Don't be afraid to do this infront of the patient
4. Ensure the patient understands how prescribed items should be taken, the expected impact and the principal side effects to be expected.

M10: Refers appropriately

1. Remember to consider the need for referral and consciously be aware of the reasons for and against any potential referral.
2. Become familiar with the potential options including interprofessional referrals
3. In some cases self-referral for example to support groups, a religious advisor or complementary therapist may be appropriate.

M11: Makes appropriate use of opportunities for health promotion

1. Remember to provide preventive advice relating to the presenting problem. For example the need to give up smoking for the patient with angina.
2. Consider whether to address any of the opportunities for promoting good health which are not directly related to the presenting problem eg smoking cessation.
3. Check the patient's readiness and motivation to change before giving advice.
4. Emphasise the positive benefits for making the change, as well as the harmful consequences of continuing.
5. Focus on areas of the patient's responsibility and what they can and should do
6. Where appropriate, ask the patient to commit to the behaviour change they are going to make.

M12: Agrees appropriate follow-up

1. Remember to always "Safety-Net". Explain to the patient what the expected course is and what to do if it differs.

2 Make clear if and when the patient should return.
3 Consider who is the most appropriate health-care professional to follow up your patient

Clinical Reasoning

CR1: Seeks relevant and specific information from patient's record or third parties

1 Prior to consultation review patient's record to elicit key information such as age, significant past medical history, current medication, and reason for recent consultation(s).
2 Consider whether 3rd parties could contribute information useful to the patient's assessment or management and, if so, approach them with the necessary consent
3 During the consultation re-examine the record where this is likely to contain information you require, particularly if the patient is unsure of factual details. Signpost that you are doing this.

CR2: Generates appropriate working diagnoses or problem list

1 Where possible try to construct specific pathological, physiological and/or psychosocial diagnoses. If this is not possible, try to identify specific problems.
2 Consider your pre-diagnostic interpretation when generating appropriate hypotheses.
3 Consider using pathological sieves to help you to generate appropriate hypotheses.
4 Appreciate the importance of the background factors influencing the health of your patient
5 Consider your diagnostic hypotheses in the light of your pre-diagnostic interpretation and challenge any inconsistencies.
6 In generating any single hypothesis deliberately test it with information for and against, and then try to identify and fill any gaps.
7 When considering your diagnosis, think about what is MOST likely, what is LESS likely and what needs to be EXCLUDED
8 Be prepared to reject diagnoses for which there is little or no support.

CR3: Seeks relevant and discriminating information from history, examination and investigations to help confirm or refute working diagnoses

1 Consciously identify the key clinical features of each of your working diagnoses.
2 Use focused questions to fill gaps in the information you are attempting to gather.
3 Always assess whether the patient looks well or ill, particularly children, and consider how this might influence your working diagnoses.
4 Actively seek clinical signs that are appropriate to your differential diagnosis and its severity
5 Consider whether specific tests/investigation are needed to confirm/exclude important diagnoses

CR4: Correctly interprets information obtained

1 Take sufficient time to consider what the information you have gathered means and how to apply it
2 To help your thinking summarise and reflect back to the patient what they told you. This will confirm to the patient you have understood the problem, and will clarify your thoughts.
3 If you recognise a pattern of symptoms and signs that nearly fits a diagnosis, consider carefully any feature that does not fit, and think again.
4 If there appears to be an obvious diagnosis, consider alternatives
5 If in doubt, consult reference ranges for limits of normal values – you are not expected to memorise all of these.

6 All tests are subject to error, and false positive and false negative results are common so consider this in interpreting results.
7 Make sure you consider all the information you have gathered before making your final diagnosis
8 Each history/examination does not necessarily yield a clear diagnosis, and patients may have more than one condition. Be careful not to dismiss symptoms or signs that could be significant, particularly if felt to be so by the patient

CR5: Applies basic, behavioural and clinical sciences to solution of patient's problem

1 If in doubt about the nature of the problem think how your knowledge of anatomy or physiology can help you reconsider it from a different angle.
2 Improve your awareness of the key features of particular diagnoses.
3 Be prepared to check with books, 'on-line' sources; colleagues, etc., particularly for single items of information.
4 Focus your learning on the discriminating features of diagnoses.
5 Practise translating findings into abstractions (semantic qualifiers). E.g. 'last night' becomes 'acute', food getting stuck becomes 'dysphagia'.

CR6: Recognises limits of competence and acts accordingly

1 Do not be afraid to tell the patient you do not know something. They will usually appreciate your honesty.
2 When you have reached the limits of your competence, do not guess – seek appropriate help by asking a colleague, or consulting information sources.

Building and Maintaining the Relationship

R1: Develops and maintains a professional relationship with patient

1 Adopt professional courteous behaviour relevant to the circumstances
2 If you have met the patient before, remind them who you are, check what has already happened, and ask what has happened since last meeting
3 When presenting a patient to a colleague, remember that you are talking about a person who is in the room with you. Think how you would want your story told. For example, use the patient's name: 'This is Mr John Smith…' in preference to the term 'This patient has…'

R2: Respects the patient's ideas, beliefs and autonomy

1 Acknowledge the patient's coping efforts and appropriate self-care
2 Respect the patient's right to decline investigation/treatment, explain the impact of their decision and make it clear that that you will continue to care for them

R3: Responds empathically

1 Try to consider what it would be like to be in the patient's shoes and respond appropriately within professional boundaries. Appropriate responses can include verbal (e.g. 'I can see you are angry'; 'I can understand that', 'I can see why you are distressed about it') and non-verbal acknowledgement of the patient's state.
2 Do not make assumptions about how a situation may affect a patient
3 Beware using your personal experience to align with a patient
4 When examining a child consider it from the childs perspective
5 Be aware of your reaction when the patient says something which shocks or surprises you

R4: Fosters collaboration

1. Be prepared to explain your thinking to help the patient to understand their condition and to engage them in its management
2. Acknowledge the patient's views about the problem and its management when you are sharing decision-making.
3. If the patient does not want to collaborate with your management plan, explore why and consider alternatives
4. Specifically consider what information (good or bad) you can share and consider who this is shared with (relatives etc).
5. Using the patient's own words will sometimes help collaboration
6. Allow the patient the opportunity to ask questions

Organisation

O1: Considers and optimises the setting

1. Organise your consulting space (e.g. chairs, screens etc) and minimise potential distractions (e.g. bleeps, telephone calls) for the benefit of the patient and the consultation.
2. If a consultation is still on your mind take a moment to compose your thoughts before seeing the next patient
3. When you have done what you can to optimize the setting and it is still not ideal, acknowledge this and apologise if appropriate

O2: Uses third parties appropriately

1. Ensure you identify and acknowledge any third parties within the consultation.
2. Where appropriate, obtain patient's consent for disclosure of information to third parties.
3. Be aware of the effect a third party may have on the information you can obtain and give. You may need to ask the patient whether they would like the third party to stay; you may need to ask the third party to let you talk to the patient alone first.
4. Make good use of the contribution that third parties can make to the different areas of the consultation such as the history, examination or patient management.
5. Consider the ideas, concerns, expectations and other agendas of third parties in your thinking, and explore those in more detail where it may be relevant to the consultation.
6. Keep the focus on the patient. Always make sure you address the patient first even if they cannot respond

O3: Exhibit a well-organised approach to gathering and giving of information

1. Be systematic in gathering information , for example - finish one area before moving on
2. Before you examine the patient, consider whether you have gathered sufficient information from the history.
3. When managing the patient, first reach a shared understanding of the problem and then move on to give advice or explain the treatment you are recommending.

O4: Makes organisation of consultation overt to patient

1. If appropriate, clarify the time both you and the patient have available for the consultation
2. Indicate to the patient what is going to happen next (Signposting).
3. At appropriate stages, summarise back to the patient the key elements of the consultation (for example the history) to demonstrate that you have understood each other
4. If you need time to think, tell the patient that you are gathering your thoughts. Make some brief notes if necessary.

O5: Prioritises agendas appropriately

1. Be sure you understand the patient's agenda by allowing them to complete what they wish to say, checking whether there is anything else.
2. Where there is more than one agenda (including your own), agree to deal first with the most urgent (medical priority) unless the patient cannot focus on that one before another is discussed (patient's priority).
3. Take note of the other agendas to be addressed later and indicate/negotiate how they are to be covered.

O6: Summarises appropriately

1. Summarise to enhance the consultation (e.g. to clarify, before signposting or to emphasise important points)
2. At appropriate stages, summarise back to the patient the key elements of the consultation (for example the history) to demonstrate that you have understood each other.

O7: Uses time appropriately

1. Be aware of the time. It may be helpful to keep a clock in view.
2. Having identified your priorities, allocate time appropriately to the tasks of the consultation.
3. Be efficient (have your tools to hand; good pace; concise choice of words and examination)
4. Aim to be successful with your examination at your first attempt so that you avoid repetition

O8: Closes consultation appropriately

1. Indicate that you are about to close and ask whether there is anything else the patient would like to say or ask
2. Summarise the consultation briefly and clarify the plan
3. Remember safety netting - tell the patient what you expect to happen, things to be concerned about and what to do if it doesn't happen as predicted
4. Medical students should thank the patient for what they have gained from the consultation. This may sometimes be appropriate for doctors too

Record Keeping

RK1: Makes concise and accurate notes without interfering with dialogue or rapport

1. Do not write during the patient's opening statement, as you will miss important information and may appear not to be listening
2. Your notes during a consultation should be minimal – train yourself to remember, and write only what you will forget
3. Particularly important to jot down are: people present; key words in information gathered from and given to the patient; examinations and procedures carried out
4. If you are taking notes, explain why and gain the patient's consent

RK2: Record - Diagnoses/ problems

1. After every consultation record the problems or diagnoses in specific terms

RK3: Record - Relevant history and examination

1. As a minimum, record the features of history and examination which support or refute possible diagnoses
2. (For computerised records) If there is a read code the general rule is use it rather than writing free text.
3. Record assessment of capacity to consent if this might be in question

4 Record your impression at that time (diagnosis and differential)

RK4: Record - Outline of management plan; therapy, investigations, referral and follow up

1 Document what tests will be done and, if appropriate, how these might affect management choices.
2 Record in the notes to whom a referral has been made, and how (by telephone, fax, Choose and Book, Post etc) Indicate whether the referral was routine or urgent.
3 Keep a copy of the referral in the patient records.
4 Document plan for unexpected deterioration for example who should be contacted and how
5 Record management options discussed with the patient and the patient's choices.
6 Ensure referring professional and others involved in patient's care are copied into correspondence, as appropriate.

RK5: Record - Information, instructions and special precautions given to the patient

1 This information should appear on the prescription and also in the patient's records.

RK6: Record - Identification of the author and date of record

1 When recording in the patient's record ensure that you document clearly: Date, time, your name and role (and when available GMC number)
2 Sign all entries you make in the notes

Case Presentation

CP1: Engages and orientates colleague

1 State purpose of communication if not implicit in situation e.g.: 'I would like to practice case presentation'
2 Orientate listener with basic patient details and key background information. E.g. 'This 24 year old man with diabetes has been admitted with a vomiting and since admission he has become drowsy'
3 Consider what the function of your presentation is and frame your presentation in this light for example a teaching presentation will be long, requests for emergency assistance will be very brief

CP2: Delivers relevant detail with clarity and logical order

1 Paragraph grouped data appropriately with headings and their relevant content
2 Invite the listeners to ask questions at appropriate points in your presentation
3 Signpost the hypotheses you are considering or have considered.
4 Present relevant data. This will depend on the context e.g.social factors may be less important on acute admission than when planning the patient's subsequent discharge
5 Identify and present data that allow determination of the patho-physiology, the aetiology and the functional effect of the health problem.
6 Use SBAR (Situation, Background, Assessment, Recommendation) to organise your presention.
7 Allow, promote and manage dialogue during the presentation to ensure that all important aspects are adequately explored. This may require that you point out that there is more data which you consider relevant e.g. 'There are social factors which I feel need to be considered'

CP3: Communicates Interpretation of data transparently

1 With your interpretation offer the evidence on which it is based. E.g. 'This patient has rapidly progressive dysphagia. He has gone from difficulty swallowing meat to only swallowing water in 4 weeks.' 'I have a patient who is in shock with a BP of 90/50 and

pulse of 120. '

2 Distinguishes clearly between historical report, examination findings and interpretation / opinion.
3 Be open about omissions in your assessment, for example 'I forgot to percuss the chest'

CP4: Draws purposeful conclusion

1 Consider the triple diagnosis (at the level of physical, psychological and social patho-physiology) and present what is relevant
2 Summarise succinctly with backing evidence. Be honest about uncertainty.
3 Invite comment on specific request, suggested management plan or need for clarification in a way that relates to the purpose for the communication declared previously.