

Using the clinical consultation as a learning opportunity

Authors:

Dr Frances Carter

BSc MBBS MRCP MRCOG ILTM
General Practitioner and Honorary Senior Lecturer,
Faculty of Medicine, Imperial College London

Dr Anita Berlin

MBBS MRCP MA (Institute of Education)
Senior Lecturer, Department of Primary Care and Population Sciences
Royal Free & University College Medical School

This paper was first written in 2003 as part of a project led by the London Deanery to provide a web-based learning resource to support the educational development for clinical teachers. It was revised by Judy McKimm in 2007 with the introduction of the Deanery's new web-based learning package for clinical teachers. Each of the papers provides a summary and background reading on a core topic in clinical education.

Aim

The aim of this paper is to introduce you, as a clinical teacher, to the breadth of learning opportunities available in the clinical consultation. It describes a range of practical techniques suitable for teaching *about* the consultation as well as *during* the consultation and locates these within different models of consultation analysis.

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Introduction

This paper is designed for all clinicians. It is relevant to patient encounters in outpatient clinics, community clinics, general practice, A&E, at the bedside on the ward and in patients' homes. In this paper we look at teaching **about** the consultation as well as teaching **during** the consultation.

In order to illustrate the learning potential of the clinical consultation we will

- show you how to look at the consultation in ways that help you plan teaching and learning
- give practical examples and teaching tips for using the consultation as a learning opportunity
 - provide a menu of "quick tips" for special consultations.

In common with the other papers in this series, we introduce some 'thinking points' throughout the paper. These culminate in a suggested final activity that might be of use for your personal portfolio of teaching and learning.

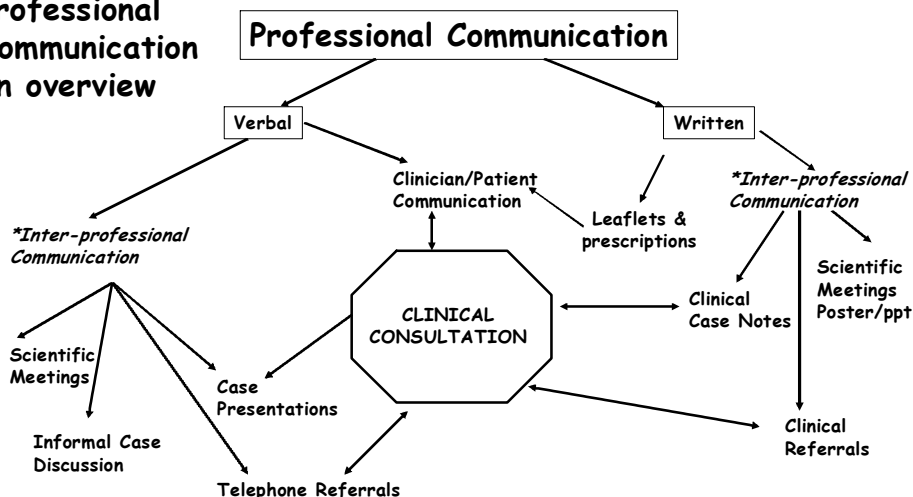
Definition of the Clinical Consultation

"The essential unit of medical practice is the occasion when, in the intimacy of the consulting room, a person who is ill or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is the consultation and all else in the practice of medicine derives from it."

James Spence (Professor of Paediatrics, Newcastle), 1960

This definition relates to consultation in medical practice but of course consultations take place in all healthcare professions. The consultation lies at the heart of professional communication. Figure 1 **Professional communication an overview** outlines some of the different types of professional communication.

**Figure 1 -
Professional
Communication
an overview**



Note: *Inter-professional communication (whether written or verbal) tends to conform to a "ritualised" structure (and language). Attempting to impose this structure on the dialogue between patient and doctor in the clinical consultation is often neither efficient nor clinically effective. Alerting novices to the need to be systematic in terms of **what** information they gather and give (not rigid in the **way** they do this) is helpful. It is important that as teachers we try to model a flexible approach which attends to the patient's narrative, expectations and choices and recognise that novice-students tend to be over-controlling because they feel insecure and cling to the "ritualised" structure.

Each element of the diagram can be analysed and described in much more detail and should be so dissected before attempting to teach your learners. For this paper we are concentrating only on direct patient/professional communication.

There are many different ways of studying what happens during the consultation. Our diagram shows doctor/patient communication as part of verbal communication and clinical case notes as written communication during the consultation. This is a good starting point when teaching learners or trainees but it is necessarily a simplification of the highly complex interactions between clinicians and patients that occur during each clinical encounter.

Thinking point

Consider your clinical practice. Think of a recent typical consultation with a patient/client.

Can you list the verbal and written communication that occurred during the consultation?

This list can be used when asking a learner to observe a consultation.

Models of the consultation

Since the beginning of the 20th century and the work of Freud a number of authors from a variety of disciplines have proposed models for analysing the doctor-patient relationship. The authors constructed their models of the consultation from different disciplinary perspectives particularly psychology, sociology and anthropology. Medical authors have included general physicians, psychiatrists and general practitioners. They employed different strategies to analyse the consultation, for example – use of time, essential tasks that occur during the consultation and roles of the protagonists.

Much of the work in developing consultation models was done in general practice, which reflects both the sheer volume of primary care consultations and the relative importance of the clinical and personal history in patient management in the community. Key models have evolved over decades.

The authors' ideas, are, in part a product of ideology current at the time and so the models start by incorporating ideas from psychoanalysis and move through behavioural approaches, humanistic response to patient-centred approach and finally to a synthesis of all previous perspectives. Some of these models are listed (in chronological order) below. More recent authors tend to refer more explicitly to the evidence base underpinning their proposals. Many will of course be familiar to GP registrars because the study of consultation models is part of basic vocational training.

Models of the Consultation

The Doctor as Treatment – Balint

Balint, a psychoanalyst, worked in discussion groups highlighting the therapeutic role of the relationship in the doctor/patient encounter.

Balint. M The doctor, the patient and his illness. London Tavistock 1958

Transactional Analysis – Berne

Berne used concepts from psychoanalysis to describe the roles that people adopt in relationships and encounters. The matching of such states leads to more successful communication. These “ego states” are those of child, adult and parent.

Berne E. Transactional Analysis -Games People Play .Penguin London 1970

Patient Centred approach - Byrne & Long

This GP and psychologist team audio-taped 2000 general practice consultations. They concluded that most consultations proceed through a sequence of 6 stages

- (1) relating to the patient
- (2) discovering reason for attendance
- (3) conducting verbal and physical exam
- (4) considering patient's problems
- (5) detailing treatment or further investigation
- (6) terminating the consultation

Importantly they observed that doctors' styles varied across a spectrum with a “patient centred” approach and “doctor-centred” approach at the two extremes

Byrne PS, Long BEL Doctors talking to patients DHSS 1976

Four Task Approach - Stott & Davies

Stott and Davis in their classic paper “The exceptional potential of each primary care consultation” describe a four-point framework aimed at helping general practitioners to achieve greater breadth in each consultation. The four essential elements are

- Management of presenting problem
- Modification of help seeking behaviour
- Management of continuing problems
- Opportunistic health promotion

Stott CP, Davis RH. The exceptional potential in each primary care consultation. J.RCGP 1979

Biopsychosocial Interpretation – Engel

The work of Engel was instrumental in orientating our view of medicine. He advocated that as well as focussing on the body and its organs we should consider the person in their whole psychosocial context. Not only scientific but sociological and psychological factors affect every patient so should be considered in every consultation patient encounter.

Engel G The clinical application of the biopsychosocial model. Am.J Psychiatry 1980

Anthropological/Folk model - Helman

Helman, a GP anthropologist, defined a set of questions that all people who feel unwell will ask themselves. Consultations where these questions are addressed likely to be more holistic and therefore more satisfactory for both clinician and patient

- What has happened?
- Why has it happened?
- Why me?
- Why now?
- What would happen if nothing was done?
- What should I do about it?
- Who should I consult for further help?

Helman C G Disease versus Illness in General practice. J RCGP vol 31 pp 548-62 1981

Consultation Maps - Pendleton et al

Pendleton and colleagues described a method of analysing and learning from the consultation based on a set of seven key tasks – an expansion of Byrne and Long and Stott and Davis They proposed a system of mapping these tasks chronologically. Furthermore in this book they propose a set of (now eponymous) rules for giving learning feedback (see *Assessment* paper in this series)

Pendleton D. et al The Consultation – an approach to teaching and learning Oxford 1984

The inner consultation – Neighbour

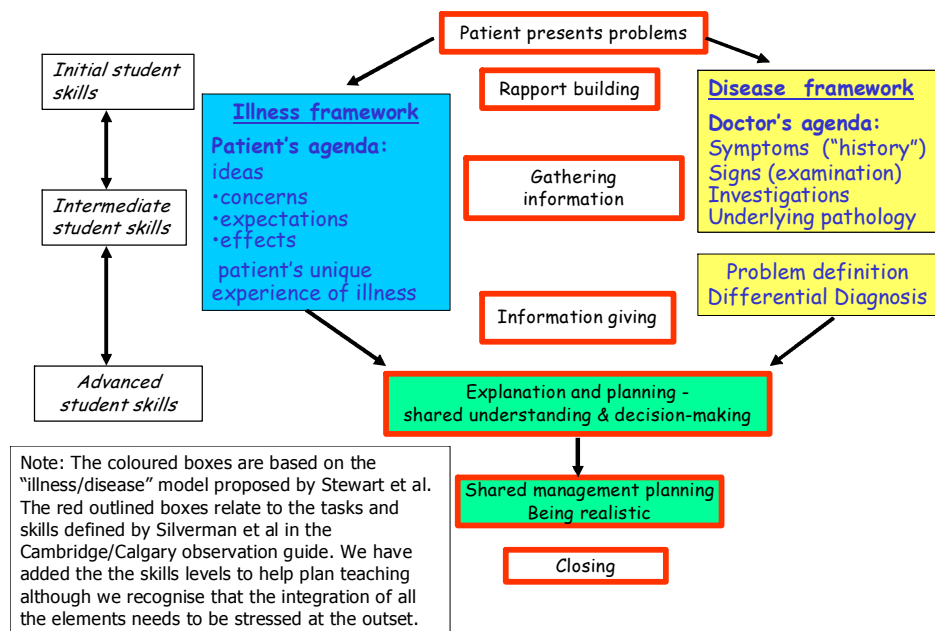
Neighbour developed the concept of the “inner consultation”. He suggested that while doctors perform the tasks described by other authors, they should also reflect on their activity and progress. They should pay attention to handing over back to the patients, safety netting and to their own needs (he called this activity “housekeeping”).]

Neighbour R. The inner Consultation Petroc Press 1987

Disease-illness model (Integrated patient centred clinical method) - Stewart & Roter

These authors further developed the work of others, esp Balint, Byrne & Long and Engel, by devising an approach to the clinical method which places the disease approach (doctors agenda) in parallel with the illness approach (patient agenda). These two processes are brought together as the doctor incorporates both agendas in his/her explanations. In this way a shared understanding of problems can be achieved before proceeding to negotiate management.

Figure 2 - Patient Centred Consultation



They identify six interlinked and interwoven components:

1. Exploring the disease and illness experience
2. Understand the whole person
3. Finding common ground
4. Enhancing the patient-doctor relationship
5. Incorporating disease prevention & health promotion
6. Being realistic (re time, resources, expectations and personal limitations)

Stewart MA, Roter D (eds) *Communicating with medical patients* Sage publications, Newbury Park, Ca, 1989

Stewart M et al *Patient-centred medicine – transforming the clinical method* Sage, Thousand Oaks, Ca 1985

Communication Tasks, Cambridge - Calgary model -Silverman Kurtz and Draper

These authors based their ideas on years of experience in undergraduate and postgraduate education. They build on the task-based approach, refining tasks and the individual skills needed to be accomplished for effective communication in the light of research based evidence for each element. The tasks are

- Initiating the session
- Rapport building
- Information gathering
- Information giving & planning
- Closing the session

The authors explicitly examine settings other than primary care in well written and useful books

Skills for Communicating with Patients

Silverman J, Kurtz S, Draper J Radcliffe Medical Press 1997

Teaching and Learning Communication Skills in Medicine

Kurtz S, Silverman J Draper J Radcliffe Medical Press 1998

Applying consultation models

Each model of the consultation contributes to the considerable body of understanding of the medical consultation and the existence of such a wide variety of models indicates the complexity of the consultation. The models are useful for describing what is happening. Beyond description they provide a basis for identifying and remedying problems in order to improve patient satisfaction and clinical outcome.

Most clinicians would adopt a “pick’n’mix” approach – applying which model seems appropriate to their own situation. Teacher-clinicians will find it useful to reflect on their own patient encounters with reference to these models when planning teaching sessions.

Thinking point

Look at the list of consultation models above.

Choose one model, perhaps one that seems most natural to your style of consultation. Think about a recent patient encounter and how the model might apply to the consultation.

How could you explain this model to a learner?

Amongst the wide array of models we find that the patient-centred clinical method - combining the disease/illness model (Roter and Stewart) and Cambridge/Calgary tasks (Silverman et al), see Figure 2 above, offer the most useful approach in our every day teaching practice – especially for undergraduate teaching. There is also a growing body of evidence supporting the strategies advocated by these approaches.

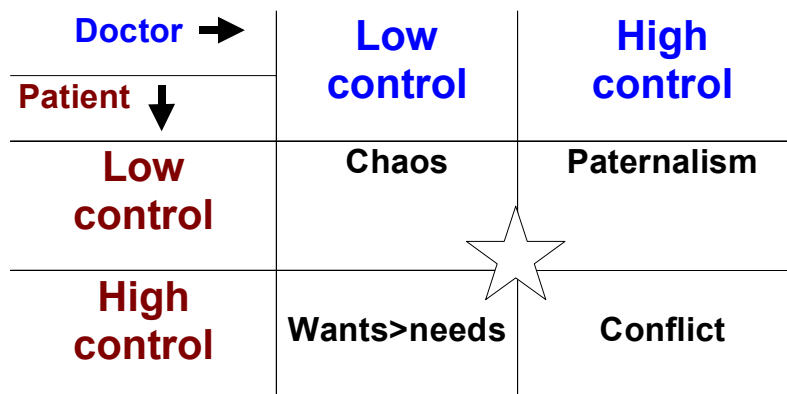
A Consultation Curriculum – what to teach when

“Patient-Centred Consultation”

This term refers to creating a balance between the doctor’s agenda (the “disease” framework) and the patient’s agenda (the illness framework) – seeing the consultation as two parallel processes.

This contrasts with the dominant model driven largely by the clinician’s disease-centred frame of reference. In order to achieve this, six basic elements have been defined by Roter and Stewart (1995). Key is the notion that the clinician should take the patient’s ideas, concerns, expectations and unvoiced agendas into account when he/she is conducting the consultation as well as his/her own clinical agenda. It does NOT mean that the patient is in control of the consultation but implies there is greater partnership between doctor and patient

Figure 3. Balancing control in the consultation
 Note: There are no set rules regarding who should be in control during the consultation. The ideal probably varies within and between consultations. At the extremes communication may become dysfunctional. Some degree of partnership will allow the patient to tell their story and to exert some choice while the doctor carries out clinical tasks and manages time to the best of his/her ability.



They stress the intricate relationship between the different dimensions of the consultation – and the interwoven nature of clinical content with communication process. Early research shows that when the patient’s agenda is addressed, then the encounter is much more satisfactory for both parties and leads to greater concordance with management decisions and ultimately health improvement. There are parallels with learner-centred education, which, if constructed to take into account learners needs and wishes, (within strict boundaries) leads to better learning.

The Patient centred clinical method (Fig 2 above) adapted from Roter and Stewarts’ patient centred consultation model, shows differing agendas that doctor and patient bring to a clinical encounter. Learners at all stages should be aware of what is happening during a consultation but they will not be able to carry out these tasks without a sound basis of clinical knowledge, an understanding of communication skills and the experience of using both together. To the side of the diagram we suggest what is appropriate for novice, intermediate and advanced learners.

Thinking point

Consider the same consultation as you did above.
What clinical (doctor-centred) tasks did you undertake?
Did you use any problem solving or clinical reasoning skills? How did this affect the doctor-patient communication and the focus of the physical examination? How did you integrate these activities with the patient's agenda?
Jot down how you could help a learner understand these "perceptual" skills while observing a consultation.

For further learning on this and related topics, have a look at the paper in this series:
Teaching and learning through active observation.

Taking a history - Moving from Novice to Expert

Both experienced clinicians and novice learners make a diagnostic hypothesis within a very short time of beginning the consultation, often under a minute. However the rest of the interview can differ dramatically.

Figure 3 - History Taking -from Novice to Expert

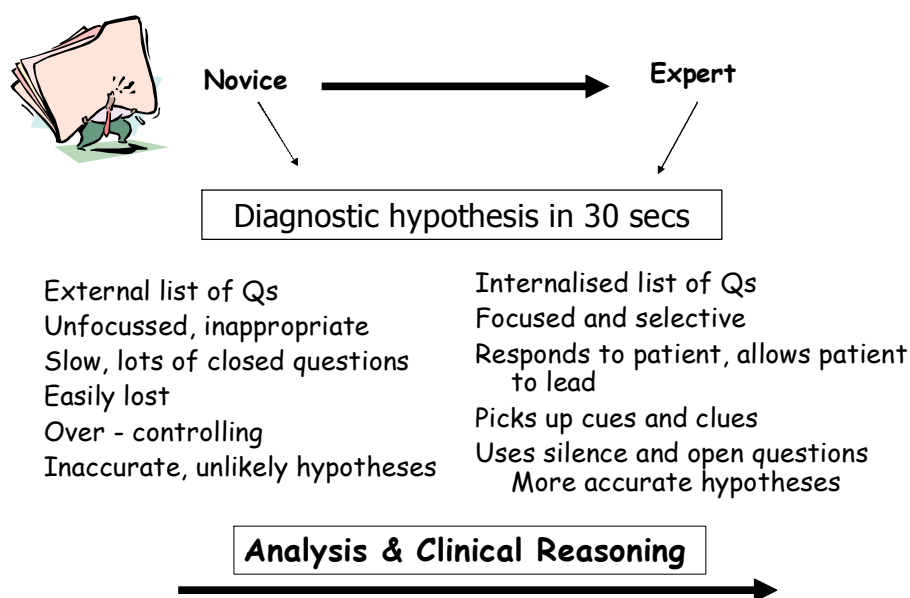


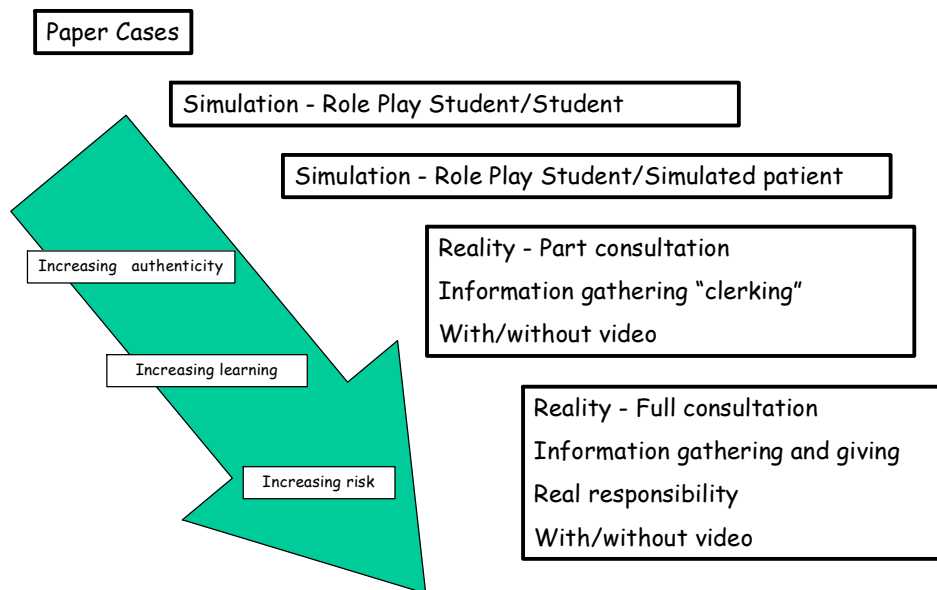
Figure 3 shows some of the differences between novice and expert consultations. You may wish to explore these differences with your learners, reminding them that they should aim for small steps at a time and that there is no substitute for repeated practice.

Practical tips for devising a consultation curriculum

Discuss differing models of the consultation, see above.

- Revise basic communication skills see Annex 1, *Summary of core communication skills*
- You should aim to make learners aware of the components of patient-centred consultation paper (see Figure 2)
- Remember learners bring their own natural style and experience to consultations - use their experiences as examples and in explanation
- Look at the move from novice to expert in history taking shown in Figure 3 and show it to your learners
- Consider the learners' stage of the curriculum and plan teaching methods that reflect this. Figure 4 suggests a series of exercises that move along the spectrum from simulation to reality.

Figure 4: Teaching methods from simulation to reality



Choosing learning outcomes

Learning outcomes arise out of your aims for a session, which in turn are related to the learners' stage of development, learning needs, aptitudes and wishes. Your session must also fit into the overall curriculum aims. Practical aspects such as time, number of learners and size of the consulting room will also influence your aims for a session. Remember that learning outcomes should be realistic, achievable and ideally capable of measurement. Consider how to judge whether your aims and outcomes have been achieved. Matching your intended aims with the actual achievements of your learners is good teaching practice.

Such "reality checks" encourage self-reflection and self-assessment of your clinical teaching. The 'Assessment' section in this paper provides some practical examples.

Thinking point

Think about your last teaching session in or about the consultation.
Did you have an aim for the session?
If so, which factors led you to choose these aims?

Some of the key factors relevant to choosing learning outcomes *during* the consultation or when teaching *about* the consultation include:

- Curriculum aims
- Learner stage
- Time
- Learning needs
- Learner wishes
- Individual learner's learning needs
- Service requirements
- Learner Numbers
- Size of room
- Patient factors

Each factor will influence your choice of learning outcomes. Consider these factors when you choose learning outcomes for planned sessions. Opportunistic or unplanned teaching should still be directed towards learning outcomes. If you are asked at the last minute to take a group of learners, for example in outpatients, the experience will be more satisfactory for all concerned if you spend a few minutes at the beginning planning, either on your own or with the learners/trainees. Even one clear learning outcome can add direction to a session and provide a yardstick to judge the success of your teaching.

Look at the paper in this series, *Curriculum design and development* for more information about learning outcomes.

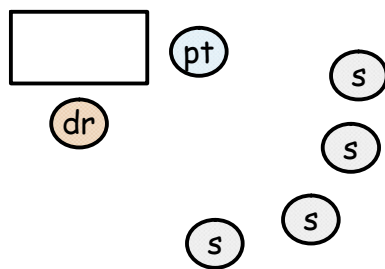
Teaching methods

Preparation for teaching

As with all teaching your preparation should include

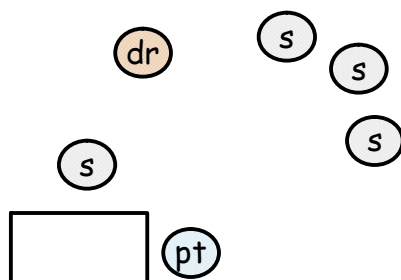
- Clear aims and learning outcomes (objectives for each session as well as each series of sessions or course)
- Preparation of the teaching space ie physical considerations such as the arrangement the room, number of chairs, minimising interruptions etc. Figures 5a, 5b and 5c provide some ideas about room layout

Figure 5a: Room layout for teaching four students in a clinic



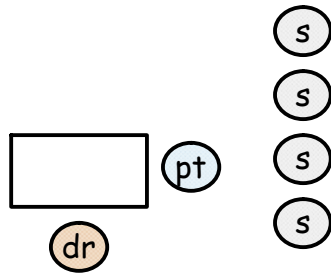
This layout shows clinician and patient in a consultation with students observing. The primary connection is between clinician and patient so each can give full attention to the other. The curved arrangement of the students allows the clinician teacher to include or exclude the students as appropriate. The teacher has full eye contact with all the students so he/she can monitor the progress of their learning.

Figure 5b: Room layout for teaching four students in a clinic



Here the student is taking a history from the patient. The clinician sits behind and to the student's left ready to intervene with questions or support if necessary. He/she can question the other students while the history taking is in progress to maintain their interest. He/she can maintain eye contact with all the other students and with the patient.

Figure 5c - Room layout for teaching four students in a clinic



Thus sort of layout is probably the most usual. Compare it with the other two layouts illustrated. A good point is that the clinician teacher can maintain eye contact with the patient and all the students. But the formality of the straight line and the setting of the students behind him/her could make the patient feel uncomfortable. Those students furthest away from the teacher might feel excluded as it is tempting to question only those nearest to the teacher.

- Preparation of staff - warn them to expect learners and explain how teaching will affect your clinical practice for that day
- Preparation of teaching aids including books, models, charts and patients
- Psychological preparation of the learners, for example warning them of the topic of the session in advance

The papers *teaching and learning in the clinical context* and *Using learning resources to enhance teaching and learning* provide more information about teaching techniques and learning resources in general.

Techniques for teaching *about* the consultation

Teaching methods can vary from simulation to reality – a suggested hierarchy of such methods is shown in Figure 4 (above). Adult learners prefer teaching that is as close to reality as possible but plunging a learner straight into a real consultation can be difficult for teacher, learner and patient alike. If possible allow your learners to practise some of their skills in safe situations using paper cases or role-play before letting them consult with real patients. They then have a chance to make mistakes and correct them in (hopefully) a supportive environment.

Simulation and role-play

Role-play and simulation are useful and potentially powerful tools for teaching about communication and human relationships. However their use often meets with resistance from both undergraduate and postgraduate learners. Frequent learner concerns should be considered and addressed in advance, see Annex 2, *Frequent learner concerns about simulated consultations* for a summary of these issues. It is worthwhile planning carefully and clarifying the purposes of the different strategies which are summarised below:

1. Learner plays role of patient

Purposes: Reinforce patient perspective (early/undergraduate)
Contextualise learning of sociology, psychology and ethics
Review a real patient encounter where learner assumes role of their own patient (later/postgraduate)

2. Learner plays role of doctor

Purposes: Rehearsing early skills before meeting real patients
Practising advanced skills in difficult areas (e.g breaking bad news, dealing with addiction, dealing with patient aggression)
Practising advanced skills, in morally/emotionally complex areas (e.g. TOP counselling, HIV or genetic testing, end-of-life decisions)

Simulated patients and patient-teachers.

Most medical schools now employ actors who are skilled at undertaking a scripted role for the purposes of teaching. It is useful to provide a basic amount of relevant information for actors with teaching points relevant for the level of the learners. Through experience and collaboration with simulated patients (SPs) we have developed a standard structure for simulated patient scripts, see Annex 3, *Example of simulated patient script*. SPs can contribute greatly to learning about the consultation by giving feedback using the patient's voice. Clinical teachers are often asked to facilitate such role play and should spend a little time with the SP before and after the session clarifying any clinical points and agreeing "rules of engagement".

There are also an increasing number of projects aimed at recruiting and training real patients (for example with back pain or visual impairment) to teach learners about clinical method – both communication skills and, in some cases, examination skills. Such patient-teachers have much to offer with proper support and preparation.

Feedback, debriefing, and critical reflection

In order to maximise learning from the experience provided by simulated consultations we have found it helpful to ensure that all participants are encouraged to reflect critically on what has happened in writing during or immediately after the role-play. This includes the interviewing learner, the observing learners and teacher and the SP. Critical reflection using a semi-structured format appears to aid recall and ensures that specific skills and verbatim quotes are noted and commented on rather than unhelpful generalisation. To this end we have designed some prototype observation checklists for evaluation by peers, self and SPs, see Annex 4 *Examples of consultation observation checklists*. These can be copied and the exact format can easily be adapted to your needs. The principle of everyone involved spending a few moments reflecting on what has gone on before launching into feedback has proved valuable and acceptable.

Using the video camera in teaching

The use of the video camera has revolutionised teaching about the consultation. It provides an opportunity to analyse what happened during a real or simulated consultation without interrupting the progress of the consultation as it occurs. Often the doctor or learner is not aware of all aspects of the patient/professional interactions and may be surprised at reviewing the video. Videos can provide a record of achievement over time and are used this way in both undergraduate and postgraduate medical education. Remember that reviewing a video in a group or even individually with a clinician can be a very threatening situation for learners. Establish ground rules for the group that include constructive peer feedback if you are using peer feedback, and follow the rules yourself, a summary of which is at Annex 5, *Feedback Guidelines*. In addition remember that feedback should be timely ie immediate, to be beneficial.

As well as the established rules for feedback that should be used in all teaching there is the added element of patients' presence during real or videoed consultations. It is your responsibility to obtain written permission for videoing and for reminding learners of the need for confidentiality. You may wish to extend confidentiality to learner contributions in a session in order to encourage learners to relax and feel freer to discuss their "mistakes" in front of their peer group.

Some practical suggestions for teaching about the consultation

- Video a learner consulting, then together analyse the video using a standard proforma that you have constructed yourself from the different models of the consultation. Your local medical school communication skills teachers or postgraduate course organiser may be able to provide examples of suitable forms.
- Video yourself consulting. Ask learners to analyse the video using a standard proforma
- Show a video of a consultation to the learners. Ask each of them to look for different aspects of the consultation.
- Prepare handouts on the different consultation models. Distribute them to different learners and get them to compare notes.
- Get learners to role play consultations while observed by their peers and/or videoed and lead a group discussion on their performance

Many more aspects of teaching about the consultation and communication skills are discussed in two useful books by Silverman and Kutrz, see Further Reading section.

Techniques for teaching during the consultation

The rules of feedback and confidentiality discussed in the section on teaching about the consultation of course apply equally to teaching during the consultation. While preparing your session you will need also to consider how to brief patients, learners and staff before the consultation, debriefing if necessary after the consultation, how teaching fits in with service requirements as well as the usual preparation for teaching of writing a lesson plan that incorporates realistic aims and learning outcomes. The layout of the room in which the consultation takes place is an important factor for successful teaching. Figure 5 shows some ways of arranging chairs for doctor (or other health professional), patient and four learners. It is important that you can see the faces of all the learners as well as the patient so you can monitor the patients' well being and the understanding and involvement of the learners as the session progresses. The arrangement of the chairs can demonstrate support for a junior learner (see Figure 5b) and be inclusive or exclusive of learners or patients.

The long established practice of "sitting in with Nellie" when a learner passively watches you work does not encourage interesting and productive learning for learners. Make sure that learners are actively learning. There is always tension between fulfilling service needs and teaching the learners but planning how to make the most of teaching during service delivery makes the experience much less stressful.

Some practical suggestions for teaching during service consultations

- Choose very clear aims and outcomes for the session. If you are busy confine yourself to one or two only that are readily achievable. Examples could be that at the end of the diabetic eye clinic each learner should have seen the full range of diabetic retinopathy or at the end of neurology outpatients learners should know the sinister causes of headache and when to arrange further investigations. Share your aims with the learners so they are aware of your plan and all will feel a sense of achievement if the aims are fulfilled (if they are not you can suggest how to do so!)
- Give learners the BNF, MIMS and textbooks to use during the consultation if they are not familiar with a drug or topic. If they look it up themselves they are more likely to retain knowledge and it will be more interesting and relevant to do so while the patient is in the room. It saves you time as well.
- Set tasks, that need not be the same for each learner, to do during the whole clinic or one consultation. Examples could be to learn the side effects of all the drugs prescribed for renal transplant patients or to observe the doctor or other health professionals non verbal communication skills or to guess at the doctor's and patients' "hidden agendas". You need not check their learning in great detail at the end of the clinic just enough to confirm they have been actively listening during the consultations
- Prepare check lists for learners to use when observing you consult

PACS 2 Observation as an active learning approach has more practical suggestions on how to avoid passivity and engage the learners in active learning.

Practical Exercise 5

Think about your last clinic and choose two tasks that you could have asked a group of learners to do while sitting in with you.
Keep your notes.

Some practical suggestions for teaching during specially arranged consultations

You will have more time for planning, questioning and giving feedback than teaching during service consultations.

Before the patient comes in

- Discuss theory and practise examination before patient comes in
- Arrange role play on the consultation topic
- Ask learners to look through the patient's notes and to prepare questions or guess what the patient will say
- Brief the patient on exactly what will happen including the possibility of sensitive topics being raised, how much they will be expected to undress etc.

With the patient in the room

- Ask one learner to take a history while others observe. You intervene to support, clarify or confirm the learner's thought processes. This is very beneficial for learners as they are so rarely observed taking histories but has to be handled in a way that does not disrupt the participating learners fluency in history taking. Involve the watching learners by asking them for example to guess a diagnosis after the first minute or two. (You will need to encourage them to guess freely by reassuring them that they will not be ridiculed for wild guesses)
- Get a learner to examine a patient while talking though what he/she is doing
- Ask one learner to examine patients while you question others on related topics
- Ask a confident learner to teach a less confident learner – this is a very good way of checking whether the learner really does know the examination technique or topic
- Ask learners to look up topics during the session
- Ask the patient to give feedback on the performance of the learners, revealing his feeling during history taking or comparing your examination with a learner or different learners with each other. The patient will need to be briefed beforehand on the rules of feedback. Refresh your memory on these by reading *Feedback Guidelines* (Annex 5).

After the patient has left the room

- We usually ask what the patient thinks of the learners in private, conveying an edited version to the learners
- Clarify factual information, discuss sensitive information and any upsetting topics with the learners

Role Modelling

Teaching during a consultation provides both an implicit and explicit opportunity to demonstrate your attitudes as a clinician to the learners. If learners are interviewing or examining patients in your presence you can also see at first hand how they react to the patient and how they are developing as future professionals. Learners are subjected to a variety of different clinical role models throughout their undergraduate years and will follow the example of high status and admired clinicians as well as behave according to individual personality. You should be aware at all times that the learners will note the way you talk to patients and staff, how you handle difficult situations and react to the normal stress of clinical interaction. There is some evidence that later medical specialty choice is influenced by individual undergraduate experience so your role modelling during consultations could have very far-reaching consequences and implications for your specialty. If you have time you may wish to discuss some of these topics with the learners.

Common problems with teaching about or during the consultation: More practical teaching tips

With the best will in the world sometimes teaching goes badly. Often external factors such as the size of the room, the levels of heating or noise or inevitable interruptions contribute to the failure of a session. But there are other things that can affect consultation teaching. Look at the lists and make yourself aware of some reasons for unsatisfactory teaching. The first step is to be aware of problems, the next is to be proactive in addressing them and we offer some suggestions below.

Tips for teaching about and during the consultation

Teacher problems

Insufficient preparation	
Comment	This is the commonest reason for unsatisfactory teaching. Unfortunately knowing your subject inside out is not enough. We need to plan how to run teaching sessions paying attention to teaching methods as well as content.
Suggestion	Revise your knowledge and understanding of teaching and learning methods, lesson planning and look at some of the practical tips in this module

Dealing with patient consent for participation in teaching	
Comment	Written consent is mandatory if using a video camera and ideal for all consultations. However in practice verbal consent is often used. Occasional refusals by patients to participate demonstrate that phrasing your requests in an appropriate "patient-centred" fashion.
Suggestion	Make sure that your patients are thoroughly prepared for teaching. Put notices in the waiting room and prepare written consent forms and handouts. When you ask a patient to participate in a teaching consultation be very explicit about their expected role. Tell them how they should behave (naturally), if to be examined exactly what to expect and how much they will be need to undress. Reassure patients that that refusal to participate in teaching will not affect their clinical treatment. We always thank the patients in writing afterwards.

Interruptions during a session	
Comment	Telephone calls, mobile phones and beeps interrupt the flow of teaching and cause resentment from the students who will feel rightly that they do not have your full attention
Suggestion	Warn your staff that you are teaching and make sure they understand the importance of this activity. Ask students to turn off their mobile phones

Unexpected high level of emotion (in patient or students)	
Comment	Sometimes students unwittingly upset patients by being clumsy in their questioning or being so probing that they uncover sensitive topics. The latter may in fact be the mark of a good student. Patients may become embarrassed tearful or angry.
Suggestion	Keep eye contact with patient and students and constantly monitor the emotional temperature of the interaction. Intervene if you feel that either are struggling and don't hesitate to end the consultation if you feel that the patient should return by him/herself on another occasion. After the consultation use the incident to replay what happened and discuss alternative strategies with students. If appropriate ask the patient how the student made him/her feel. If you are using a simulated patient they are trained to give feedback in such delicate situations.

“Balance” in teaching	
Comment	There are many aspects to any consultation and it is difficult to bear them all in mind when teaching.
Suggestion	Be very clear about the synthesis of different elements of the consultation and decide which are most important for each teaching session. With early students who lack factual knowledge you concentrate more on the communication skills aspects but with more advanced students clinical content will be just as important. Look again at Figure3 to contrast the novice and expert approach to a consultation.

“Acting as an Expert” during the consultation	
Comment	As experienced clinicians we usually conduct consultations without being aware of what we are doing. Yet in order to teach we must deconstruct and reflect on our performance. Students will observe you but unless they understand what and why you are acting they will be cannot maximise their learning.
Suggestion	Be explicit about your clinical reasoning during consultation - “subtitle” thought processes as you teach. Constantly analyse your own consulting using models and other ways of looking at the consultation mentioned in this PACS

Student problems

Students believe that consultation and communication skills are all “natural” and do not need to be taught	
Comment	This is quite a common belief but communication skills like other skills (including teaching) can be learned as a craft.
Suggestion	Discuss this with your students. If necessary use concrete examples from your observation of their performance to make your point!

Underestimating the importance of the history in clinical decision making	
Comment	It is said that 80% of diagnosis can be made on history alone and that we set up a diagnostic hypothesis within 30 seconds of the start of the clinical encounter.
Suggestion	If one student is taking a history we sometimes ask his/her peers to guess at the diagnosis after a minute or so then later in the interview. We ask them to justify their guesses. Of course this should be in a safe educational environment where students are encouraged to explore hypotheses with you and their peers without fear of ridicule.

Students get on badly with the patient	
Comment	Students may lose their natural ability to be active listeners unless specifically encouraged. They often don't understand that information gathering is not the only function of the consultation and may neglect to set up rapport with the patient. Or they may ask the right questions (for example about the patient's comfort) yet not listen to the answers. They may not respond to cues and clues from the patient.
Suggestion	Remind them about their natural ability by asking them to pretend that they are talking to a friend or relative. Point out that the clinician/patient relationship is a fragile entity and that students have a collective responsibility to maintain patients' trust in your profession. You could say that they will obtain more information from the patient if a good rapport is first established.

Students may be overwhelmed by a long external list of questions (systems review)	
Comment	Early in their career students find it difficult translating the systems review into reality before they have learned their own “illness scripts” and schema. They can become so anxious about completing their list of questions that they use a series of closed questions to interrogate patients, forgetting about other aspects of the consultation and usually making patients feel uncomfortable.
Suggestion	Suggest that students limit their questions to one topic or system and rehearse these questions before the patient comes in. Use patients with classical symptoms only for early students. Discourage the rote asking of questions by getting the students to justify and think about what they are asking patients. If one student is taking a history you could ask the purpose of each question. Share with them the information in Figure 5

Assessment

Formative assessment

Formative assessment is given during the course or session. Feedback based on this assessment encourages learners to improve their performance. Traditionally learning about clinician/patient communication has been through observation of others or unobserved practice. Recently medical educationalists are moving towards providing feedback on the basis of direct observation i.e. teachers are observing learners for the way they perform as well as *what* they are performing. There are many ways of structuring such observation to maximise the quality (reliability and validity) of assessment. See *Assessment* paper in this series for more about general principles of assessment.

Annex 4 offers some examples of consultation observation checklists, remember to use the Feedback Guidelines (Annex 5) when using these checklists for formative assessment.

Practical tips for using checklists

- Use checklists as a basis for discussion before the consultations
- Distribute checklists to learners for them to assess their peers
- Ask each learner to mark a different section of the checklist so they can concentrate on a smaller number of items

Summative assessment

Summative assessment often takes place at the end of teaching before the learner moves on to the next stage in their curriculum.

It is difficult to assess communication and consultation skills yet the General Medical Council (www.gmc-uk.org) emphasises the necessity of assessing values and attitudes that medical learners and trainees bring to patient encounters. Click on the Educating Tomorrow's Doctors link to look at the new *Tomorrow's Doctors* (refers to undergraduate education) and *The New Doctor* (PRHO training). Follow the Medical

Education links to look at *The Doctor as Teacher*, which sets out what the GMC regard as essential attributes and skills which medical teachers should possess.

Checklists and Objective Structured Clinical Examination (OSCE)s provide a directly observed opportunity to assess learners' strengths and weaknesses but both have their limitations.

Look at the *Assessment* paper in this series for more information on OSCEs and other clinical skills assessments.

Assessment tends to undervalue some of the key dimensions in consultation and if not carefully planned will stress information gathering at the expense of other elements. Assessment often doesn't reward learners who conduct patient-centred consultation. Using simulated patients provides some standardisation of the consultation experience but may not mirror what the learner will do with real patients in a real consultation. There is currently interest in using real life situations to make judgements about medical learners' values and attitudes but this is only at the research stage.

Tips for special consultations

This box below suggests advice you can offer learners and some teaching tips for some special consultations. The suggestions are not comprehensive but offered as a guide for new clinical teachers for different client groups on conducting the consultation and teaching tips.

Tips for special consultations

Deaf/hearing impaired patients

Advice on conducting the consultation

- Sit so your face is in the light
- Face the patient at all times
- Don't gesticulate, as it is distracting
- Don't obscure your face or talk with your back to the patient
- Repeat if not understood
- If you have a telephone call the patient may not hear it
- Have pen and paper handy
- Articulate clearly
- Be patient
- Be prepared to write things down

Teaching Tip

Role play a deaf patient before the real patient comes in so the learner has already thought about the techniques to be used in the consultation

Children

Advice on conducting the consultation

- speak to the child directly
- remember that the mother or other adult may be the real patient
- acknowledge mother's anxieties

Teaching Tips

Before the consultation

- Discuss the law on confidentiality and the Children Act

After the consultation

- Discuss any hidden agenda of adult
- Discuss the model of consultation used

Depressed patients

Use the fact that depressed patients may make you feel sad in diagnosis

Teaching tips

- Discuss the diagnosis of depression before the consultation
- Discuss how you may approach the topic of suicide with the patient
- Warn learners that the patient may be tearful and have tissues available
- Discuss how to deal with tearful, anxious patients etc
- Think about communication skills that enable the patient to express his/her feelings
- Prepare handouts of a depression rating scale
- Show learners patient leaflets on depression

Complex medical/social problems

- ask patient to prioritise their concerns
- deal with one problem at a time
- find out what is most important to the patient - do not assume you know!
- make another appointment or a longer appointment to complete the consultation

Teaching tips

- before consultation look at clinical case notes
- ask each learner to look at one illness or aspect of the patients problems
- discuss how to follow both doctor and learners agenda - the doctor will have time constraints and the patient will have some issues that are more important than others.

Final thinking point and suggested activity

Here we encourage you to pull together some of the learning from this paper and use it to plan a teaching session about or during a clinical consultation.

Gather any notes you have made in relation to the 'thinking points' above.

These might include:

- A list of the verbal and written communication that occurred during a consultation and how you might use this when asking a learner to observe future consultation
- A consultation model chosen to reflect your current clinical practice and a plan of how you would explain this model to a learner.
- Notes on your aims for a recent teaching session and the factors which led you to choose these aims?
- Two tasks that you could have asked a group of learners to do while sitting in with you during your last clinic.

Using these notes and information from this paper

- Write a lesson plan for your next teaching session either about or during a clinical consultation. Remember to include learning objectives
- After the session compare your plan with your actual teaching session and make notes of the differences, if any
- Adjust your lesson plan for the next session
- Keep the plan and notes as a record for your teaching portfolio

Further reading

Silverman J, Kurtz S, Draper J (1997) *Skills for Communicating with Patients* Radcliffe Medical Press

Kurtz S, Silverman J, Draper J (1998) *Teaching and Learning Communication Skills in Medicine*, Radcliffe Medical Press

Edwards A, Elwyn G (2001) *Evidence Based Patient Choice* Oxford University Press

Annex 1 - Summary of core communication skills

Establish and maintain rapport

- Throughout the encounter:
- Non verbal communication – especially eye contact and posture
- Use written notes appropriately
- Show empathy and sensitivity

Structuring

- Use clear sign-posting to indicate move from one topic to next
- Summarise at the end of each section and at the end of the consultation

Gather relevant information

- Discover the reason for the patient's attendance:
- Active listening: Allow the patient to talk at the beginning: a few minutes uninterrupted narrative can often save time and allow you to discover what the patient is actually concerned about (the patients' agenda). It also gives a picture of that person and his or her life
- Use open questions followed by closed questions "open to closed cones" start broad, then focus down.
- Use "set pieces" in order not to miss key aspects of certain presentations
- Respond to clues and cues: visual (physical ie. limp, tremor) or verbal (psychological – "thought I was dying", or social eg. "I didn't want to come, my husband made me")
- Use clarification, silence, repetition and paraphrasing to help the patient
- Obtain relevant social and occupational information
- Explore effect of the illness on work and/or home
- Explore the patient's health beliefs and understanding of causes of problem
- Ascertain their ideas, concerns and expectations
- Enquire about other problems
- Make a working diagnosis if possible or clearly define the problem(s)
- Examine the patient – think about the timing and focus according to the history
- Share findings even if normal, with patient

Prioritisation

- If there are several unrelated items ask the patient what is the most important, urgent matter she/he wishes to discuss, you may feel that other problems are more important – negotiate!
- Define the clinical problems –share this with the patient

Clinical reasoning & judgement

- Assess the severity of the presenting problem(s) while gathering information
- Is this something which can "be sat on" and reviewed, or is urgent referral/action required?
- Is the nature of the problem clear to you, are more information, investigations, test treatments or simply time needed
- Remember that you have the opportunity to review the patient

Information giving

- Aim for a shared understanding of the problem
- Explain the problem(s) to the patient - tailor and relate to patient's expressed ideas, concerns and expectations
- Break information into chunks
- Avoid jargon
- Ensure that the explanations are understood and accepted

Involve the patient in the management plan

- Share the options with the patient, but be sensitive to how much he/she wishes to be involved.
- Be honest about your understanding of the risks/benefits of the options
- Avoid coercion, blackmail or collusion to enhance compliance.
- Offer appropriate management plan – mindful of patients social circumstances
- Explore ways of enhancing patients' responsibility for their own health.
- Key "take home messages" can be reinforced by asking the patient to summarise the agreed plan or giving written instructions, notes or diagrams
- Prescribe, refer and follow up appropriately.

Make effective use of the consultation

- Time management -not everything can be achieved in one consultation.
- Resource management - Patients can come back and other individuals can provide advice, support and treatment eg. health visitor, the specialist nurse, etc.
- Be sensitive to the patient - do not delegate automatically

Annex 2 Frequent learner concerns about simulated consultations

Notes for learners

Artificiality

Many learners are concerned about the artificiality of role-play. Remember that artificiality is often the whole point – the simulation is an opportunity to practise new or complex skills WITHOUT putting real patients at risk or making a fool of yourself. Some learners feel they will not be able to "suspend their disbelief" and be themselves. In practice, this is rarely a problem. Most learners lose their self-consciousness during the first role-play consultation and are able to focus directly on the patients' problems rather their own performance.

Real and Ideal Consultations

Not all consultations you see in real clinical practice are perfect, it is sometimes difficult to be entirely patient-centred and doctors are not always clinically expert in all areas. This may be due lack of time but there are many other reasons – in particular conflicts with the doctors' own feelings and ethical values. Usually these consultations are "good enough" but sometimes they lead to problems. Most doctors aspire to do their best and patients have the right to expect this. You are expected to do your very best in the role play – developing good skills now will stand you and your patients in good stead for the future, even if you can't be perfect all the time.

“I know how to communicate”

There are few absolutes in consultation methods, although some behaviours are likely to be less successful than others. You will note that your fellow learners have different approaches and styles but may be just as successful in gaining information and promoting patient satisfaction. Learning to integrate and apply an ever-growing body of clinical knowledge is a demanding process. We have observed a common tendency to abandon good basic communication in an attempt to be clinically comprehensive. Accomplishing the medical tasks of the consultation are entirely compatible with a patient-centred approach but requires thought and practice.

‘Hidden Agendas’:

Patients very rarely have a simple straightforward organic problem - usually there is a complex interplay of clinical, psychological and social factors. The patient who presents with organic somatic symptoms may have psychological dimensions to their problems as well; the converse is also true. Patients may not even be aware that psychological distress is playing a part in the presentation. Nonetheless it is a basic tenet of good consulting that you should always seek to explore the patient’s ideas, concerns and expectations. This is not the same as wasting time trying to find an elusive hidden agenda - there might not be one!

Feelings:

Some simulated consultations may unexpectedly trigger powerful emotions in you. If you genuinely feel unable to carry on – feel free to halt the role-play. If you do experience strong feelings you might find it helpful to share these with the tutor and the group, and reflect how these may be coming from the patient; or sometimes they may be linked to your own personal experiences. It is important that we are aware of our own emotional responses to our patients as they may adversely affect the quality of the care we provide. But the converse may also be true: this awareness may provide a rich insight into the patient’s experience, and/or the nature of your relationship with the patient. You will have to find effective strategies for self-care in the longer term so that you do not become overwhelmed by patients’ problems, or unable to cope with them (“burn out”).

Ethical Issues:

Many consultations will raise ethical and moral issues. Communication and ethics are closely inter-related. Moral dilemmas may be obvious but they can also be experienced as a strong emotional response to a patient or their problems. Not knowing how to deal with moral issues in the consultation can have serious consequences. Tutors need to facilitate group discussions on these issues if they are of interest and relevant to the learners’ understanding of the consultation.

Annex 3 Example of simulated patient script

Role A (Aged 36, Single)
(learner level: 4th year undergraduate)

Background

Living with boyfriend of five years. Works as secretary. Due to get married next year (finally). Desperately wants children. Previously good health. Had termination aged 18. No family history.

Presenting problems

Noticed lump in breast last week. Not painful. Periods normal. Not on pill. Using diaphragm.

Behaviour in interview

"Must I have an operation? !" "I can't tell my fiancée" (afraid wedding will be called off).

Examination slip

If learners wishes to examine you hand them this slip

Firm hard lump in upper quadrant (Rt) breast. No glands.

Information for learners Most breast lumps, particularly in this age group, are benign. However there is a small possibility with a firm hard lump of malignancy.

Now decide how this should be investigated and what the patient might need/want to know

CLINICAL ASPECTS (info for SP)

Current guidelines would recommend referral to a breast clinic. The patient should not wait more than two weeks to be seen. At this age an ultrasound rather than a mammogram may well be preferred. She would also probably have a biopsy. Normally the result would be given that same day. The benefit of breast self-examination is controversial. It is more likely to be accurate if taught.

TEACHING POINTS:

Dealing with uncertainty
Giving appropriate versus inappropriate reassurance
Dealing with overwhelming anxiety
Importance of psychosocial history
Not "jumping the gun"
Strategic planning for follow-up
The role of the doctor in providing support

ETHICS

Consent
Confidentiality
Honesty vs false reassurance
Patient's history of TOP & how that influences the doctor

CLINICAL INFORMATION FOR LEARNERS - BREAST LUMPS

The likelihood of cancer in a woman below 40 is low (2-4%). Benign causes include fibroadenomas, macrocysts, sclerosing lesions, as well as lipomas, sebaceous cysts. New guidelines include new discrete lumps should be referred to a specialist centre. Suspicion of malignancy should result in an appointment within two weeks of referral. Many units have a fax referral system, and will see urgent cases within a week. The evidence for the benefit of self-examination is low and most lumps are discovered "by chance". A woman under forty would normally have an ultrasound in preference to a mammogram. She might also have a needle biopsy, and should receive the results of the test on the same day.

Annex 4 Examples of consultation observation checklists

1 Consultation Checklist Feedback Pro-forma for SPs/actors

Evaluation of Learner Interviewer (by actor/SP in role) Date: _____

Name of Learner _____

Name of Actor _____

Name of Simulated Patient _____

Please complete this proforma immediately after the consultation

Please Circle appropriate number	Agree Strongly 0	Agree 1	Unsure 2	Disagree 3	Disagree Strongly 4
1. I felt comfortable talking to the student	0	1	2	3	4
2. The student allowed me to tell my story without unnecessary interruptions	0	1	2	3	4
3. The student helped me to explore my main problem(s)	0	1	2	3	4
4. The student didn't seem to sit in judgement of me	0	1	2	3	4
5. The student appreciated the importance to me of my problem(s)	0	1	2	3	4
6. The student always used terms or phrases that I could understand	0	1	2	3	4
7. I was happy with the student's overall assessment of my problem	0	1	2	3	4
8. The student cared about me as a person	0	1	2	3	4
9. I was clear about what was going to happen next	0	1	2	3	4
10. I would come back to see the doctor (student)	0	1	2	3	4

2 Peer Observation Sheet – to be used by peers and tutor.

DATE:

NAME OF SIMULATED PATIENT:

NAME OF LEARNER:

- Write short notes DURING the consultation - use verbatim quotes where possible

- What facilitated the consultation? Give specific examples if possible.

- Is there anything that might have been done differently? Give specific examples if possible.

- Comment on the clinical aspects of the case:

- What were the ethical issues?

Annex 5 Feedback Guidelines

Setting The Scene

- Create an appropriate environment
- Clarify your ground rules with the learners – what part of the history or examination the learner is to concentrate upon, when you will interrupt, what other learners are to do, how the learner can seek help during the consultation etc.
- Agree a teaching focus with the learner
- Gain the patient's consent and co-operation
- Make notes of specific points

Giving Feedback – DOS

- Establish the learner's agenda
- Get the learner to start with what went well – the positive
- Teach starts positive– however difficult it may seem
- Comment on specific aspects of the consultation – i.e. in history taking
- Active listening (eye contact, stance etc.)
- Use of silence
- Clarifying
- Responding to cues (verbal, non-verbal, psychosocial)
- Summarising
- Empathising etc.
- Move to areas “to be improved” (avoid the term “negative”!) – follow the learner's agenda first
- Ask other learners to comment – but remind them “No criticism without recommendation”
- Teacher offers own observations & constructive criticisms
- Be specific
- Always offer alternatives
- Begin with “.....I wonder if you had tried”
- “....perhaps you could have.....”
- “...sometimes I find.....helpful....”
- Distinguish between the intention and the effect of a comment or behaviour
- Distinguish between the person and the performance (“what you said sounded judgmental” – rather than “You are judgmental”)
- Do discuss clinical decision making
- Do be prepared to discuss ethical and attitudinal issues if they arise

Giving Feedback – DON'TS

- Don't forget the learner's emotional response
- Don't criticise without recommending
- Don't comment on personal attributes (that can't be changed)
- Don't generalise
- Don't be dishonestly kind – if there was room for improvement be specific and explore alternative approaches
- Don't forget that your feedback says as much about YOU as about the person it is directed to!

Receiving feedback

- Listen to it (rather than prepare your response/defence)
- Ask for it to be repeated if you didn't hear it clearly
- Assume it is constructive until proven otherwise; then consider and use those elements that are constructive
- Pause and think before responding
- Ask for clarification and examples if statements are unclear or unsupported
- Accept it positively (for consideration) rather than dismissively (for self-protection)
- Ask for suggestions of ways you might modify or change your behaviour – opportunity to rehearse
- Respect and thank the person giving feedback