

CONSULTATION SKILLS:

Inadequate Active Listening

Active listening involves listening to both the content and the feeling behind what a patient says. It should involve not only use of open questions (which allow the patient to explain what is wrong in their own words, rather than answering 'yes' or 'no') but verbal and non-verbal communication that encourages the patient's contribution. This may include reflecting key phrases back at the patient, use of silence, nods, attentive eye contact and verbal encouragements e.g. 'humm....', 'go on...'.

Those weak in listening often showed a mechanical approach to exploring ideas, concerns and expectations of the patient (ICE) which was not contextual or natural, and as the consultation continued many candidates demonstrated that they had not actually heard the patient's view point though the patient had shared it.

Rather than asking 3 questions in quick succession directly relating to ideas, concerns and expectations, a high performing candidate listens carefully and responds to patients' cues (e.g. 'this chest pain is really worrying me doctor...') to explore the patient's perspective in a way that integrates with the flow of the consultation (e.g. 'you say it's really worrying you; what in particular concerns you?')

Inadequate Probing

Building on careful, active listening to the patient, patient-centred consulting involves fully exploring the patient's agenda. This includes both a clear understanding of the nature of their symptoms, but also involves appreciating how the problem is affecting them day-to-day, and what their reason is for coming to you (e.g. they have a worry or concern they are looking for answers to or reassurance, or they want to know what can be done to help them). The skills listed below all contribute to the process of probing and understanding the patient's perspective:

- using open questions
- reflecting back key points to the patient
- summarising
- interpretation (suggesting a meaning to what the patient has said)
- responding to cues
- seeking agreement
- using silence
- effectively closing the consultation

Ideas, Concerns & Expectations not adequately Explored

These need to be explored during the flow of consultation, not as separate entity. Many atimes patients give cues or express their concern, ideas or expectation in the consultation without being asked. These should be picked up, and further explored. Most candidates ask these through separate questions without building these into the consultation, at times repeating the questions showing inadequate listening and demonstrate following a checklist in their mind.

Used Medical Jargon

Take care to ensure that the language you use with patients is relevant to their understanding of medical matters. Generally this means avoiding medical terms in your questions and explanations and instead finding ways to explain things in common English.

Judgemental

Directly criticising the patient's behaviour is rarely what is required to address their medical problem or help them to change harmful behaviours or habits. Whilst you may hold moral objections to something the patient reveals to you, try not to demonstrate a judgemental attitude towards the patient or their actions, and ensure that to the best of your ability the treatment you provide is not detrimentally affected by your beliefs.

Unethical Approach

Unethical behaviour may include actively withholding truth or information from patient who is requesting it, agreeing to mislead or lie to a third party on the patient's behalf, divulging confidential information when there is no issue of public/third party interest to justify doing so or offering a treatment approach that is known to have no clinical value or benefit to the patient. As you consult consider the 4 ethical principles of beneficence (seek to do good), non-maleficence (do no harm), autonomy (the patient's right to make his own choices) and justice (to understand these further do read <http://www.bmj.com/content/309/6948/184.full>)

DATA GATHERING:

Poorly Focused History

Skilful general practice does not involve asking the same standard set of questions to every patient, in the way in which we learn to take a thorough history as medical students. This is not an undergraduate level exam and high marks are not obtained by asking an all-encompassing history – rather by gathering information relevant to the presenting complaint and that helps rule in or rule out important differential diagnoses. A focused, relevant history can be obtained by using **a series of open questions**, followed by **relevant** background information.

E.g. 'Tell me more about the loose motions... what changes to the motions have you seen?... what other problems have you experienced with the motions?... how has this been affecting you?...' which gradually become more specific and closed, e.g. 'can I clarify, have you seen any blood?... any mucus?... had any fever?... or stomach pains?... and have you had problems like this before?..'

Red flags not excluded

Many presenting symptoms can be associated with serious underlying causes, which can be screened for by checking for the presence of red flag features, e.g. is a headache associated with motor weakness or sensory disturbance, or worst in the morning associated with vomiting; is new onset epigastric pain associated with age >55, wt loss or melaena. With the use of such lines of questioning during data gathering serious possible causes can be ruled in or out.

Inadequately Explored Psychosocial Impact

Assessment of Psychological and social effect of any illness on one's health is very important in General practice as many patients present to physician for counselling and empathy besides the presenting complaint. Many candidates forget to explore these in the consultation. These may be assessed by asking for example, how does the (symptom e.g.) headache affects your office work?, how are you managing household work with this problem?

Poor Rapport Building

It was all too apparent that many candidates had been on preparation courses which simply “prepared” them to ask set questions in a set order, regardless of the patient or his/her history. Such candidates failed to adopt any sort of patient centred approach which developed a rapport through active listening to their expressed concerns and responded to verbal or non-verbal cues from the patient. Such skills can and should be practised in your normal daily interactions with patients.

COUNSELLING SKILLS:

Advice not based on best evidence

It is important to ensure that your knowledge is up to date, as this is essential to patient management. Candidates should be familiar with international guidelines for common conditions and the indications and important contra-indications of common medications.

False reassurance

False reassurance may take the form of empty platitudes, used in an effort to try and relax the patient, e.g. ‘don’t worry, I am here to help you’, ‘no, no, everything will be fine’, or may involve giving a patient an unrealistically positive impression of the problem to avoid upsetting them. This is not patient-centred consulting, and rarely works in the best interests of the patient. Instead, aim to provide counselling that **focuses in on the concerns of the patient** as explored earlier in the consultation, or address previously elicited health beliefs. In this way accurate information and reassurance can be provided on the issues that matter to the patient.

Non contextual options

Consider whether you can offer the patient the choice of 2 or more management options, with some guidance on your part of the pros and cons associated. E.g. a lady with first episode UTI with mild symptoms for 1-2 days could be offered the choice of urine alkalisating treatment and increased oral fluids, with the understanding she start antibiotics in 48hours if symptoms are not resolving, or could start a 3 day course of antibiotics today, depending on her preference. Generic advice should also be tailored to the patient’s situation as much as possible – e.g. explore the patient’s current diet to understand key areas for change before discussing how to alter diet to low cholesterol/BP etc.

EXAMINATION SKILLS:

Not focused on pertinent examination

‘Focused’ examination does not mean ‘superficial’ examination, but that which focuses on eliciting findings that will help confirm or refute a possible diagnosis. This usually includes relevant elements of general examination and some system-specific examination tailored to the nature of the complaint (e.g. assessing bowel sounds or shifting dullness is not going to be essential in a case focused on recent onset epigastric pain).

Incomplete Examination

Examination involves both the general physical examination as well as the focussed relevant examination related to the differential diagnosis. For example, while examining looking for causes of breathlessness, candidate should look for pedal oedema in addition to auscultation of lungs and heart. Similarly, for any thyroid condition, one needs to check reflexes in addition to examination of thyroid.

Ineffective exam technique

Some examples of poor technique or superficial approach seen include:

- placing stethoscope on different, symmetrical sites on the chest to auscultate for breath sounds, but consistently not leaving the stethoscope in one place long enough to hear inspiration or expiration
- palpating over the abdomen in random fashion, or performing deep palpation out of habit despite having elicited tenderness to superficial palpation
- testing for reflexes at sites or with technique which will not elicit a reflex response

You are encouraged to consult standard textbooks on examination (e.g. McCloud's Clinical Examination) to refine your technique and may find video resources such as can be found on websites such as Utube helpful for demonstration purposes. However, please remember that a relevant focused examination is required in general practice and therefore in the MRCGP(int) exam, and that good technique needs to be practised and applied in a relevant, focused manner in your daily practice such that it comes naturally to you.

Overlooking patient comfort

Ensure that during any examination you stay watchful of any signs of pain from the patient, e.g. facial expressions/grimaces, and if it is unavoidable to cause some discomfort it can be helpful to explain why this is necessary to the patient. Expose the patient only as much as is required for relevant examination and ensure they know when they are able to dress again, allowing privacy for this wherever possible.

MANAGEMENT SKILLS & INVESTIGATIONS:

Poor or No Explanation of Likely Diagnosis

Once history taking and examination is done, generally candidates give the name of the diagnosis without explaining the condition in simple terms, assuming as if the patient is familiar with this term.

Inappropriate investigations

Some candidates over-investigated, rather than perform those investigations that would help confirm or exclude a diagnosis. As in normal practice, the diagnosis is clear on first encounter in some cases, and not in others. Some cases require candidates to develop a differential diagnosis, and through investigation or treatment rule in or out the leading diagnostic possibilities.

Patient insufficiently involved in management / decisions

Wherever desired by the patient management decisions should be made by the doctor and patient together, the doctor negotiating with them over options available and discussing implications of various approaches. In patient-centred consulting, the doctor is patient's informed and experienced guide by their side rather than an authority always choosing the way.

Patients concerns poorly addressed

Whilst many candidates are asking questions related to the patient's ideas, concerns and expectations, a far smaller proportion are actually addressing these intentionally as they counsel and manage patients. Appreciating the patient's prior knowledge about the condition, and focusing on the aspects of concern to the patient demonstrates good patient-centred practice and helps avoid the problems of a monologue from the doctor or overloading the patient with too much information to take in.

E.g. 'You told me earlier you were worried by this cholesterol result as your father in law had the same level and he recently had a heart attack. I can understand you want to avoid having a heart attack also...*(acknowledges and empathises with patient's concern)*

The good news is that as a younger man who does not smoke your risk of heart attack is much lower than your father-in-law's, and so I don't need to recommend tablet treatment for your cholesterol *(addresses concern of heart attack and expectation of medication)*.

Inadequate explanations

Poor time management meant a number of candidates had inadequate time to cover the explanation of the condition, investigations or treatment. Others overlooked the need to explain matters to the patient, be that the working diagnosis, possible investigations or treatment options. You are encouraged to try and structure the information you share with patients, using sub-headings to 'chunk' the information into manageable pieces, or to offer to write down key points. Patient-centred management ensures that the aspects most important to the patient are covered in explanations, so cues from the patient regarding this should be watched for carefully and explored sensitively.

Poor problem identification

A number of candidates lacked knowledge to interpret given test results or of appropriate management options, and so could not demonstrate the required skill of agreeing a suitable management plan with the patient. The candidate is not expected in every case to make a clear diagnosis in one 10 minute encounter, for this is not possible in every consultation in general practice. However, candidates should be trying to develop differential diagnoses or a working hypothesis through the process of data gathering and examination, which can then be tested or confirmed through further investigation or a therapeutic trial of treatment.

Unsatisfactory pharmacological management

A number of candidates lacked knowledge to interpret given test results or of appropriate management options, and so could not demonstrate the required skill of agreeing a suitable management plan with the patient.

It is important to ensure that your knowledge is up to date, as this is essential for patient management. Candidates should be familiar with international guidelines for common conditions and the indications and important contra-indications of common medications. Candidates should be able to prescribe appropriate medication for commonly encountered conditions in primary care and explain to the patient about the drugs.

Unsatisfactory non pharmacological management

For majority of conditions seen in primary care, non-pharmacological management is as important as pharmacological management. Candidates should be able to advice on appropriate non-pharmacological aspects. These should be practical and socio-culturally acceptable.

Poor safety-netting

Safe practice can be demonstrated through both excluding or confirming relevant red flag symptoms and safety netting as part of your forward planning with the patient. In your regular practice try and ensure you make it clear to patients under what circumstances they should seek further help from yourself or secondary care, whether that relates to evolving symptoms, side effects of treatment or failure of the problem to resolve. This is the process of safety netting.