



The General Practice Consultation

One in a series of curriculum statements produced by the Royal College of General Practitioners:

- 1 Being a General Practitioner**
- 2 The General Practice Consultation**
- 3 Personal and Professional Responsibilities**
 - 3.1 Clinical Governance
 - 3.2 Patient Safety
 - 3.3 Clinical Ethics and Values-Based Practice
 - 3.4 Promoting Equality and Valuing Diversity
 - 3.5 Evidence-Based Practice
 - 3.6 Research and Academic Activity
 - 3.7 Teaching, Mentoring and Clinical Supervision
- 4 Management**
 - 4.1 Management in Primary Care
 - 4.2 Information Management and Technology
- 5 Healthy People: promoting health and preventing disease**
- 6 Genetics in Primary Care**
- 7 Care of Acutely Ill People**
- 8 Care of Children and Young People**
- 9 Care of Older Adults**
- 10 Gender-Specific Health Issues**
 - 10.1 Women's Health
 - 10.2 Men's Health
- 11 Sexual Health**
- 12 Care of People with Cancer & Palliative Care**
- 13 Care of People with Mental Health Problems**
- 14 Care of People with Learning Disabilities**
- 15 Clinical Management**
 - 15.1 Cardiovascular Problems
 - 15.2 Digestive Problems
 - 15.3 Drug and Alcohol Problems
 - 15.4 ENT and Facial Problems
 - 15.5 Eye Problems
 - 15.6 Metabolic Problems
 - 15.7 Neurological Problems
 - 15.8 Respiratory Problems
 - 15.9 Rheumatology and Conditions of the Musculoskeletal System (including Trauma)
 - 15.10 Skin Problems

Contents

Acknowledgements 5

Key messages 5

Introduction 6

Rationale for this curriculum statement 6

UK health priorities 7

Learning Outcomes 8

Further Reading 11

Examples of relevant texts and resources 11

Web resources 11

Promoting Learning about the GP Consultation 13

Work-based learning – in primary care 13

Work-based learning – in secondary care 13

Non-work-based learning 13

Learning with other healthcare professionals 14

Appendix: COT Performance Criteria 15

References 17

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Key messages

- The general practitioner should be able to communicate clearly, sensitively and effectively with patients and their relatives, and colleagues from a variety of health and social care professions.
- The general practitioner must have a commitment to patient-centred medicine.
- The general practitioner who lacks a clear understanding of what the consultation is, and how the successful consultation is achieved, will fail his or her patients.

Introduction

Rationale for this curriculum statement

The consultation is at the heart of general practice. It is the central setting through which primary care is delivered, and where the curriculum outcomes detailed throughout these documents are demonstrated. The general practitioner (GP) who lacks a clear understanding of what the consultation is, and how the successful consultation is achieved, will fail his or her patients.

Underpinning the outcomes below is a commitment to patient-centred medicine.^{1,2} This term is often used so loosely that it can sometimes seem to mean little more than ‘good’ medicine. For the purposes of the curriculum, however, the patient-centred doctor should be able to demonstrate an awareness of three key areas:

Understanding of the wider context of the consultation: this means perceiving that the patient is a person; a belief that the sick patient is not a broken machine; and that ‘health’ and ‘illness’ comprise more than the presence or absence of signs and symptoms. A constant willingness, therefore, to enter the patient’s ‘lifeworld’,³ and to see issues of health and illness from a patient’s perspective

A recognition that patient-centred medicine depends on an understanding of the structure of the consultation – in particular that good consultations are often associated with particular consultation styles and skills.^{4,5,6,7,8} However, the expectations and preferences of patients vary, so that the patient-centred doctor must be able to select from a range of styles and skills

A commitment to an ethical, reflective attitude that enables the doctor to understand and monitor his/her practice, and develop it to the benefit of patients.

UK health priorities

There is a clear understanding that clinical expertise is necessary for good medical practice, but not its most important facet. There are attributes that go beyond these: the Kennedy report into the tragedy at the Bristol Royal Infirmary speaks, for instance, of ‘broadening the notion of clinical competence’.⁹ The report goes on to argue that:

- Greater priority than at present should be given to non-clinical aspects of care in six key areas in the education, training and continuing professional development of healthcare professionals:
 - ♦ skills in communicating with patients and with colleagues
 - ♦ education about the principles and organisation of the NHS, and about how care is managed, and the skills required for management
 - ♦ the development of teamwork
 - ♦ shared learning across professional boundaries
 - ♦ clinical audit and reflective practice
 - ♦ leadership.

The *general* understanding that clinical competence must be understood in this broader sense is at the heart of

what follows: the *specific* area of most immediate relevance for the consultation is that of communication skills and by extension the consultation structure across which communication takes place.

Communication itself is recognised to be at the heart of good medicine. The Toronto consensus statement,¹⁰ which is still perhaps the most widely known document in the area, begins ‘Effective communication between doctor and patient is a central clinical function that cannot be delegated.’ This view has been reflected, and extended beyond the doctor–patient relationship, in a number of key statements. The General Medical Council’s document, *Tomorrow’s Doctors*,¹¹ states that the graduating medical student should be able to communicate clearly, sensitively and effectively with patients and their relatives, and colleagues from a variety of health and social care professions. That goes for GPs too!

Similarly, for qualified doctors, the BMA argues that: ‘communicative and interpersonal skills are technical skills which can be learned and the doctor who lacks them can be said to be lacking in technique, in the same way as the doctor who lacks clinical knowledge’.¹²

Statements about the importance of communication are best understood as ways of enabling and encouraging doctor–patient partnership, and promoting the openness and trust that is the lifeblood of partnership, and that enables the information sharing on which mutual decision-making depends. This shared decision-making is an essential part of modern general practice.^{13,14}

Effective partnerships between patients and healthcare professionals are the way forward. The exchange and provision of information is at the core of an open and honest relationship between healthcare professionals and patients.

Learning Outcomes

The following learning objectives relate specifically to the general practice consultation. In order to demonstrate the core competencies required for effective consultations, the GP will require the ability to conduct patient-centred consultations.

The GP must, therefore:

1 Demonstrate understanding of the context in which the consultation happens.

With *patients* this means:

- Recognising that patients are diverse: that their behaviour and attitudes vary, for example, by age, gender, ethnicity, social background and as individuals
- Responding flexibly to the needs and expectations of different individuals
- Understanding the process by which patients decide to consult, and how this can affect consulting outcomes
- Recognising the GP's roles and responsibilities towards the patient
- Negotiating a shared understanding of the problem and its management with the patient, so that he or she is empowered to look after his or her own health
- Demonstrating commitment to health promotion, while recognising the potential tension between this role and the patient's own agenda
- Managing the potential conflicts between personal health needs, evidence-based practice and public health responsibilities.

With the *patient's relatives, friends and supporters* this means:

- Recognising that episodes of illness may affect more than merely the patient
- Understanding the patient's right to confidentiality
- Negotiating whether and how relatives and others might be involved.

With other *professional colleagues* this means:

- Working successfully as a member of the primary care team
- Working successfully with colleagues in secondary care and elsewhere
- Working successfully with a range of other professionals such as Social Services
- In all cases, recognising that 'working successfully' involves:
 - ◆ understanding the role of professional colleagues, and where their expertise lies
 - ◆ drawing on this expertise as appropriate
 - ◆ treating colleagues with consideration and respect
 - ◆ understanding interprofessional boundaries with regard to clinical responsibility and confidentiality.

2 Demonstrate understanding of the structure of the consultation.

Demonstrating familiarity with the common models of the consultation that have been proposed and how these models can be used to reflect on previous consultations in order to shape future consulting behaviour.

- Demonstrating in the consultation:
 - ◆ an awareness that consultations have a clinical, a psychological and a social component, with the relevance of each component varying from consultation to consultation (this is the ‘triaxial’ model of the consultation proposed by the RCGP)
 - ◆ an ability to deploy successfully the characteristics represented by the MRCGP assessment criteria
 - ◆ an ability to use techniques to limit consultation length when appropriate.
- Recognising that achieving a successful overall structure involves appropriate use of communication skills, and therefore:
 - ◆ demonstrate in the consultation an appropriate use of the skills typically associated with good doctor–patient communication (see for example Silverman *et al.*⁶ and Maguire and Pitceathly⁸)
 - ◆ demonstrate in the consultation an ability to adapt communication skills to meet patient needs.
- Demonstrating the ability to formulate appropriate diagnoses, rule out serious illness and manage clinical uncertainty.
- Demonstrating effective use of patient records (electronic or paper) during the consultation to facilitate high-quality patient care.
- Demonstrating effective use of time and resources during the consultation.
- Recognising how consultations conducted via remote media (telephone and email) differ from face-to-face consultations, and demonstrating skills that can compensate for these differences.

3 Demonstrate awareness that good consultation requires good professional attitudes.

- Demonstrating familiarity with basic concepts in medical ethics such as confidentiality, consent, resource allocation and truth telling, by:
 - ◆ demonstrating an ability to reflect on how particular clinical decisions have been informed by these concepts
 - ◆ understanding the need to share information with patients in an honest and unbiased manner, in order to educate patients about their health (doctor as teacher)
 - ◆ demonstrating ethically sound practice in consultation performance.
- Demonstrating an understanding of the importance of good professional behaviour, and how it is manifest in successful consultations, for instance by:
 - ◆ demonstrating respect for patients, colleagues and others
 - ◆ demonstrating good team working skills – encouraging and assisting colleagues
 - ◆ keeping accurate, legible and contemporaneous records
 - ◆ making timely and appropriate referrals, using relevant information
 - ◆ good time-keeping.
- Demonstrating an understanding of the importance of reflective practice for good consultation technique by:
 - ◆ recognising the limits of one’s own abilities and expertise
 - ◆ undertaking self-appraisal through such things as reflective logs and video recordings of consultations, and seeking out opportunities for educational development based on this
 - ◆ recognising, monitoring and managing personal emotions arising from the consultation

- ♦ recognising how personal emotions, lifestyle and ill-health can affect consultation performance and the doctor–patient relationship (this is important not just to achieve good single consultations but to achieve good continuity of psychological care).

Further Reading

Examples of relevant texts and resources

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Web resources

The Balint Society

The Balint Society was founded in 1969 to continue the work begun by Michael and Enid Balint in the 1950s. The aim of the Society is to help GPs towards a better understanding of the emotional content of the doctor–patient relationship. The Balint method consists of regular case discussion in small groups under the guidance of a qualified group leader. The work of the group involves both training and research.

Membership of the Society is open to all GPs who have completed one year in a Balint group. Associate membership is available to all those involved in healthcare work including doctors, nurses, psychotherapists and counsellors. Students are especially welcome.

The Society holds a series of lectures and discussions each year at the Royal College of General Practitioners

in London. There are also annual residential weekends in Oxford and Chester, and a study day in London for practice nurses.

The Society is always ready to help with the formation of new Balint groups. The Group Leaders' Workshop provides a forum for all Balint group leaders including GP Course Organisers to discuss their work. The Society is affiliated to the International Balint Federation, which coordinates Balint activities in many countries and organises an International Balint Congress every two to three years. The *Journal of the Balint Society* appears annually and is circulated to all members.

www.balint.co.uk

RCGP curriculum and assessment website:

The RCGP curriculum website contains the key information about Workplace-Based Assessment of communication skills in general practice. Several methods are available to assess competence in the consultation both in primary and secondary care. These include case-based discussion (CBD), the consultation observation tool (COT) (see appendix for criteria), and the patient satisfaction questionnaire (PSQ). It is an essential site for specialty registrars (GP).

www.rcgp-curriculum.org.uk/nmrcgp/wpba.aspx

Promoting Learning about the GP Consultation

Work-based learning – in primary care

- Video analysis of consultations. This can be done using the COT (see appendix).
- Random case analysis of a selection of consultations. This can be done using CBD.
- Sitting in with GPs and other healthcare professionals in practice to observe different consulting styles.
- GP trainer to sit in with specialty registrar to give formative feedback. This can be done using the COT (see appendix).
- Patients' feedback on consultations using satisfaction questionnaires or tools, for example the PSQ.

Work-based learning – in secondary care

- Observation of consulting behaviour during outpatient clinics.
- Reflection on a selection of consultations in different specialties. This can be done using the clinical evaluation exercise (mini-CEX).

Non-work-based learning

Courses or teaching using role-played consultations sometimes using 'standardised patients' are integral parts of GP training programmes across the UK. Peer-group discussions often involve discussing, in confidence, video-taped consultations recorded in the specialty registrars' surgery or using commercially available teaching packages.

The Midland Faculty of the Royal College of General Practitioners has produced a training DVD, available from the RCGP, called *Consulting: communication skills for general practitioners*.¹⁵ It is an excellent resource for specialty registrars and established GPs who wish to improve their consultation skills. It can be used for personal study but is a valuable resource for tutorial or small-group work.

Balint groups

The Balint group is a highly developed and tested method of small-group consultation analysis that aims specifically to focus on the emotional content, not just of single consultations but of ongoing doctor–patient relationships.

Many doctors who have had the experience of Balint training attest to the lifelong benefits that it can bring in terms of interest in patients' lives, self-knowledge, job satisfaction and prevention of 'burn out'. A growing body of research evidence supports the effectiveness of Balint training in many countries.^{16,17,18,19}

The aims of a Balint group (as recognised by the Society) are:

- To provide a safe environment where group members are able to talk in confidence about the feelings aroused in them by their patients
- To encourage the doctors to see their patients as human beings with a life and relationships outside the sur-

gery and a history going back to childhood that has helped to determine what they have become

- To help the doctors to explore in detail the emotional content of their interaction with a particular patient: to understand how their behaviour and reactions have been unconsciously affected by the feelings projected by the patient and resonating with those of the doctor
- To help them to learn how to contain a patient's feelings even when these are uncomfortable and to tolerate feelings such as helplessness and anxiety
- To help them to understand how a distressed patient may need to be held and supported in an ongoing therapeutic relationship in a series of consultations with the same doctor over a period of time.

Michael Balint was a psychoanalyst; the first Balint groups were led by psychoanalysts or psychotherapists, but, although their insights can be invaluable, the Balint Society no longer requires group leaders to have had psychotherapy training. Groups are organised and regulated by the Balint Society whose founder members were GPs trained by Michael and Enid Balint. They also contributed to the ranks of the first generation of GP course organisers and helped to establish the tradition of small-group work in Vocational Training Schemes.

Balint Society leaders are trained to respect the emotional safety and integrity of all group members. They do not go in for psychological intrusiveness and they protect the group from any activities of this sort from group members. They establish a culture of confidentiality, safety and respect. The focus is always on the doctor–patient relationship and not on the doctor's personal lives. Everyone is free to use their imagination to explore the meaning of the clinical material presented. Interpretations based on a particular theory are rarely heard. Jargon is discouraged. Everything is very down to earth. For details on how to contact the Balint Society, see the web resources section (above).

Learning with other healthcare professionals

While the GP consultation is essentially an interaction between a GP and a patient there are often other people present, e.g. a carer or relative of the patient, or medical students, specialty registrars and nursing students. The consultation itself is an ideal learning opportunity but it can also be used as a focus for discussion with other health professionals, either by observing a real consultation or using role-play or video-taped consultations (e.g. the teaching video *Sex-Lives and Videotape* by Matthews *et al.* 1999). Using the consultation as a learning resource can trigger discussion on communication or consulting skills but also as a focus for discussion about patient management issues, prescribing, clinical guidelines, etc.

Appendix: COT Performance Criteria

- PC1: The doctor is seen to encourage the patient's contribution at appropriate points in the consultation.
- PC2: The doctor is seen to respond to signals (cues) that lead to a deeper understanding of the problem.
- PC3: The doctor uses appropriate psychological and social information to place the complaint(s) in context.
- PC4: The doctor explores the patient's health understanding.
- PC5: The doctor obtains sufficient information to include or exclude likely relevant significant conditions.
- PC6: The physical/mental examination chosen is likely to confirm or disprove hypotheses that could reasonably have been formed, OR is designed to address a patient's concern.
- PC7: The doctor appears to make a clinically appropriate working diagnosis.
- PC8: The doctor explains the problem or diagnosis in appropriate language.
- PC9: The doctor specifically seeks to confirm the patient's understanding of the diagnosis.
- PC10: The management plan (including any prescription) is appropriate for the working diagnosis, reflecting a good understanding of modern accepted medical practice.
- PC11: The patient is given the opportunity to be involved in significant management decisions.
- PC12: Makes effective use of resources.
- PC13: The doctor specifies the conditions and interval for follow-up or review.

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