Assessing your own consultation

A quick guide for GPs wanting to develop their own consultation assessment tools

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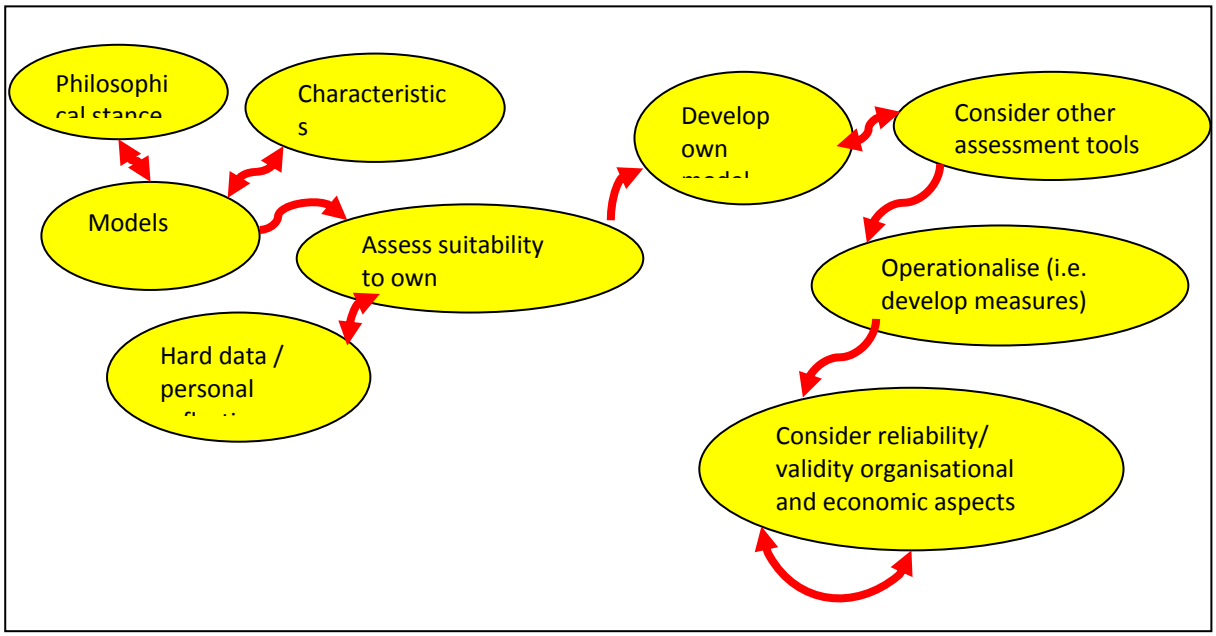
This is part of the course which can be found at:

http://www.robinbt2.plus.com/dprom_2009/index.html

1. Assessing your own consultations

This is a very brief introduction to certain aspects you need to consider when developing your own consultation assessment tool.



1.1 Philosophical stance

You need to think of what particular philosophical stance the person who suggested the model had/has, for example it is clear that Neighbour is very much a humanist and perceives that developing the doctors humanity is possibly more important than her/his diagnostic/analytical skills, in contrast some of the other models stress the importance of diagnostic skills (i.e. the EBM approach etc) and the importance of developing any type of relationship is of minimal significance, they therefore possess a more empirical belief system. Others such as the Cambridge C. Model try to combine these two contrasting/conflicting approaches. Clearly the model(s) you have most affinity with reflect your own philosophical stance.

1.2 Model Characteristics

Many of the consultation models contain similar characteristics such as assessment of patient knowledge or mis-knowledge, Investigating signs and symptons and diagnosis, prescribing, cultural assessment, developing rapport, etc. but use different terms to be able to compare the models you need to be able to link the equivalent concepts even if the authors have given them different names.

1.3 Assessment of suitability of models to own consultations and Pick & mix

Given your own philosophical beliefs, along with the model characteristics you feel are most appropriate given the uniqueness of your situation (Patients, culture, yourself, and your organisation etc) you will hopefully be able to develop something that would form the bases of a model for your own consultations. You might even need to add additional characteristics that are not in any of the models developed so far!

1.4 Consider other consultation assessment tools

There are already several consultation assessment tools around:

The Bryne and Long model is also an assessment instrument – see the course notes.
The Cambridge C. Model also provides a method of assessment – see the course notes.
See the RCGP site http://www.rcgp-curriculum.org.uk/nmrgcp/wpba/consultation_observation_tool.aspx at the bottom of the page there is a downloadable resource "COT - detailed guide to the performance criteria" which should give you some useful information. Aso criteri for video assessment at: http://www.rcgp-curriculum.org.uk/pdf/curr_2_The_GP_Consultation.pdf
The Leicester Assessment Package for video consultation (see the appendix) at http://www.gp-training.net/training/tools/lap.htm has also been developed into a specific nurse consultation model called Caiin. See Redsell, Lennon &Hastings 2004.
Ramesh Mehay runs the Braford vts website for GPS which contains an amazing amount of information including a consultation training toolkit at,
http://www.bradfordvts.co.uk/EDUCATORS/trainers%20toolkit.html

1.5 Operationalise

If you don't understand what this means have a read through
http://www.fhi.rcsed.ac.uk/rbeaumont/virtualclassroom/chap16/s1/sembk2.pdf page 16 to 19.

1.6 Consider Reliability, Validity etc

The diagram below provides a good overview of how to assess any assessment tool you might develop (this actually comes from a book about educational assessment):

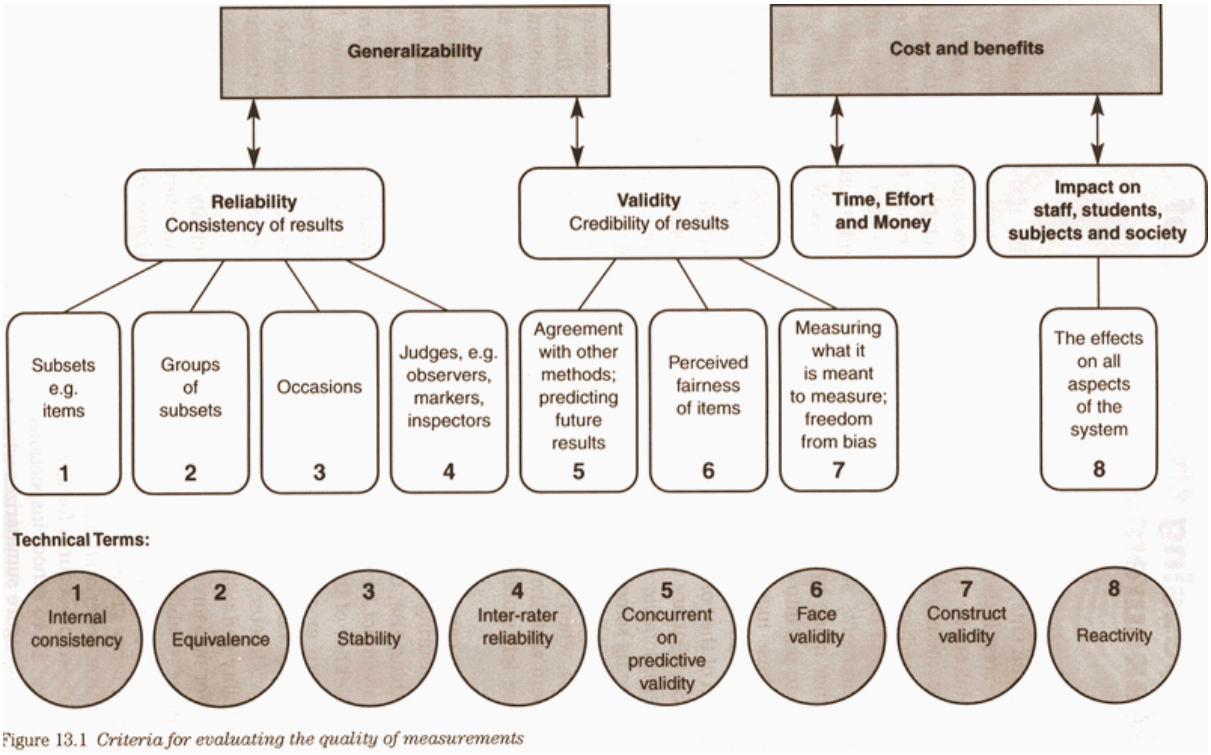


Figure 13.1 *Criteria for evaluating the quality of measurements*

I do not expect you to discuss each of these in detail, unless you want to gain a very high mark. Again for details of what each of these criteria mean see:
http://www.fhi.rcsed.ac.uk/rbeaumont/virtualclassroom/chap16/s1/sembk2.pdf

An excellent book which goes through the process described above in detail is, The Good Consultation Guide for Nurses By Adrian Hastingsand Sarah Redsell 2006 you can see the first three chapters at, take note of the Caiin model:

http://books.google.com/books?id=2JnTHwv4TLAC&lpg=PR6&ots=5wFfH9bHoi&dq=Nottingham%20consultation%20assessment&pg=PR6

2. References

Redsell S A , Lennon M, Hastings A M, Fraser R F 2004 Devising and establishing the face and content validity of explicit criteria of consultation competence for UK secondary care nurse. Nurse Education Today 24, 180–187.

3. The Leicester Assessment Package for video consultations

From: http://www.gp-training.net/training/tools/lap.htm

Name: Date:

Brief clinical details: Consultation duration (mins):

Interviewing/history taking (Relative weighting 20%) *Grade* [ ]

- Introduces self to patients
- Puts patients at ease
- Allows patients to elaborate presenting problem fully
- Listens attentively
- Seeks clarification of words used by patients as appropriate
- Phrases questions simply and clearly
- Uses silence appropriately
- Recognises patients' verbal and non-verbal cues
- Identifies patients reasons for consultation
- Elicits relevant and specific information from patient and/or their records to help distinguish between working diagnoses
- Considers physical, social and psychological factors as appropriate
- Exhibits well organised approach to information-gathering

Physical examination (Relative weighting 10%) *Grade* [ ]

- Performs examination and elicits physical signs correctly and sensitively
- Uses the instruments commonly used in family practice in a selective, competent and sensitive manner

Patient management (Relative weighting 20%) *Grade* [ ]

- Formulates management plans appropriate to findings and circumstances in collaboration with patients
- Makes discriminating use of investigations, referral and drug therapy
- Is prepared to use time appropriately
- Demonstrates understanding of importance of reassurance and explanation and uses clear and understandable language
- Checks patients' level of understanding
- Arranges appropriate follow-up
- Attempts to modify help-seeking behaviour of patients as appropriate

Problem solving (Relative weighting 20%) *Grade* [ ]

Generates appropriate working diagnoses or identifies problem(s) depending on circumstances

Seeks relevant and discriminating physical signs to help confirm or refute working diagnoses

Correctly interprets and applies information obtained from patient records, history, physical examination and investigations

Is capable of applying knowledge of basic, behavioural and clinical sciences to the identification, management and solution of patients' problems

Is capable of recognising the limits of personal competence and acting accordingly

Behaviour/relationship with patients (Relative weighting 10%) *Grade* [ ]

Maintains friendly but professional relationship, with due regard to the ethics of medical practice

Conveys sensitivity to the needs of patients

Demonstrates an awareness that the patient's attitude to the doctor (and vice-versa) affects management and achievement of levels of cooperation and compliance

Anticipatory care (Relative weighting 10%) *Grade* [ ]

Acts on appropriate opportunities for health promotion and disease prevention

Provides sufficient explanation for preventive initiatives taken

Sensitively attempt to enlist patients' cooperation to promote change to healthier lifestyles

Record keeping (Relative weighting 10%) *Grade* [ ]

Makes accurate legible and appropriate record of every doctor-patient contact and referral - minimum information including :

1. date
2. relevant history/examination
3. any measurement (BP, PEFR, weight)
4. the diagnosis/problem
5. outline of management plan
6. investigations and follow-up
7. prescription dose/quantity/special precautions intimated to patient

3.1.1 Overall clinical competence: Grade

Specific strategies for improvement:

3.1.2 Questions to be asked of candidates

At the end of history-taking:

What are your diagnostic hypotheses at this stage?

Why have you erected these hypotheses?

What physical examination do you intend to carry out, and why?

After physical examination:

What did you find on examining the patient?

How have these findings affected your thoughts?

After patient has left:

Why did you choose your management plan?

3.1.3 Criteria for allocation of grades

A: Demonstrates mastery of all (or almost all) components consistently and to the highest standard. The criterion performance.

B: Demonstrates mastery of all (or almost all) components consistently and to a high standard, and some to the highest standard.

C+: Consistently demonstrates capability in all (or almost all) components to a satisfactory standard - some to a high standard. No serious defects.

C: Demonstrates capability in all (or almost all) components to a satisfactory standard but tends to lack discrimination, organisation and good time management.

D: Demonstrates inadequacies in at least one component. Lacks discrimination and/or organisation. Tends to perform inconsistently. Raises doubts concerning capability for independent practice.

E: Demonstrates major omissions and/or serious defects. Grossly unacceptable standard overall. Not safe to practice independently.

3.2 Leicester Assessment Package for video consultation Summary

Name: Date:

Interviewing/history taking (Relative weighting 20%) **Grade (A-E):**

Strengths:

Specific recommendations for improvement:

Physical examination (Relative weighting 10%) **Grade (A-E):**

Strengths:

Specific recommendations for improvement:

Patient management (Relative weighting 20%) **Grade (A-E):**

Strengths:

Specific recommendations for improvement:

Problem solving (Relative weighting 20%) **Grade (A-E):**

Strengths:

Specific recommendations for improvement:

Behaviour/relationship with patients (Rel wt 10%) **Grade (A-E):**

Strengths:

Specific recommendations for improvement:

Anticipatory care (Relative weighting 10%) **Grade (A-E):**

Strengths:

Specific recommendations for improvement:

Record keeping (Relative weighting 10%) **Grade (A-E):**

Strengths:

Specific recommendations for improvement:

Overall clinical competence: **Grade (A-E):**