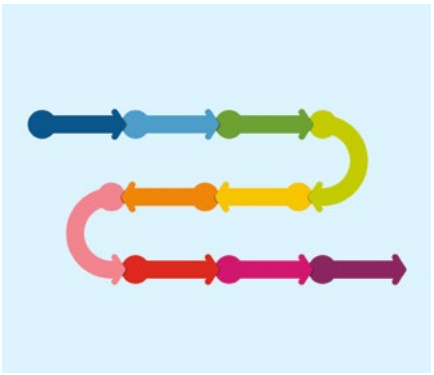
A new framework for teaching the art of general practice consultation to registrars and supervised doctors



CPD

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Background
Medicine is a science; conducting a consultation is an art form. Honing this art enhances patients' satisfaction and good medical outcomes and can also improve general practitioners' satisfaction in their role. A good consultation needs to be effective and efficient. Effectiveness occurs when the patient is heard, understood and acknowledged, and when the doctor is empathic, credible and delivers information and recommendations easily understood by the patient. Efficiency occurs when the consultation is time efficient and flows smoothly.

Objective
The aim of this article is to propose an adaptable, patient-centred consultation framework that is well suited to the modern context and practical for teaching to registrars and supervised doctors.

Discussion
The model for consultation presented articulates a structure of 10 components. The model can be the basis for teaching registrars and supervised doctors how to better structure their consultations. Later, it can be the basis for analysis and critique of reviewed consultations. While the model was developed for the face-to-face context, this article also includes recommendations for how the framework may be adopted for telehealth consultations.

MEDICINE IS A SCIENCE; conducting a consultation is an art form. Registrars enter their general practice training with developed scientific knowledge and enthusiasm. Mastering of the art of consultation is considered to be at the heart of general practice training and is vital in doctor–patient relationships.[1] While registrars commence with significant clinical independence,[2] learning how to run an effective and efficient consultation is an art to be learnt during the journey of their apprenticeship training.[3] They need to be guided in learning ways to turn 'know that' into 'know how'.[4] General practice supervisors teach consulting skills through tutorials and mentoring.

Teaching and learning this art can be both daunting and challenging. Add in the overlay of COVID-19, telehealth and remote supervision,[5] and teaching and learning how to conduct a consultation is as challenging and important as it has ever been. Medical knowledge contextually and appropriately applied, and information conveyed in an understandable and credible manner to patients, enhances patient satisfaction and good medical outcomes. Effectiveness occurs when the patient is heard, understood and acknowledged. Equally, effectiveness occurs when the doctor is empathic, credible and delivers medical information and recommendations in a way that is understood by the patient. Efficiency occurs when the consultation is time efficient and flows smoothly.

Teaching the art of consultation framework

Consultation models provide a structure to the consultation in order to facilitate intercommunications between the general practitioner (GP) and patient, for physical or psychological information gathering, and to ensure patient safety. This consultation structure may also help GPs to communicate more effectively with their patients, which in turn can improve patient outcomes, patient satisfaction and GP job satisfaction.[6]

In teaching the art of consultation to registrars, supervisors and medical educators have a range of consultation models available to them. Each model has its own benefits, and some might be more pertinent to certain situations. Consultation models include task- or process-oriented models such as Neighbour,[7] the Calgary–Cambridge model[8] and Murtagh's consultation structure.[9] Other proposals for constructing consultations come from a less task-focused perspective, such as Helmen's folk model.[10] Still others focus on good interpersonal communication skills, and one particular resource was an early influence in the development

of the framework for consultation being presented in this article.[11] These models can help GPs to understand where their consultations are going awry and may help them find ways to correct problems.[6]

It has been argued that traditional paradigms on which some previous consultation models were founded are losing currency. Hence, the value of the models is diminished by not adapting to significant societal changes including the changing doctor–patient dynamic, increasing complexities of consultations, cultural overlays, GP stress, calls for consultation efficiency, and the rise of remote consultation and supervision as amplified during the global pandemic.[12] Arguably, general practice 'requires new models to supplement previous consultation models, so that GPs can cope optimally in today's pressured primary care landscape'.[12]

An alternative consultation model is presented here. It has been taught in the Australian context for a number of years, having evolved and developed over the lead author's 30-year career in training registrars in general practice. During these years, most consultations had the doctor and patient together in one room. The framework has applicability for the modern primary care landscape. It has been devised to enhance the effectiveness for both the patient and the registrar or supervised doctor and to increase the efficiency of the process. The model can be the basis for teaching registrars and supervised doctors a method of structuring consultations. Later, it can be the basis for analysis and critique of reviewed consultations. Consideration has also been given to how the model can be adapted for telehealth consultations.

The framework has 10 steps in the process (Box 1). Each will be further explored in non-academic language to reflect the language in which these steps might be taught and used.

1. Be prepared

The first step is to prepare by catching up on everything you will want to know, and everything the patient expects you will know, from the previous encounters. Read the notes before the patient enters the room. Undistracted, this can be quickly accomplished. More importantly, when the consultation does start, your gaze and concentration will be on the patient and not averted to the computer screen. This review of the notes will remind you of details of the past presentations, recent results and correspondence. The review may be a reminder of important non-clinical patient details, such as the marriage of a child or passing of a loved pet.

2. Ice breaker

Having read through the notes, it is time to call the patient in. In so doing, read their demeanour. Almost always, before the patient settles into the chair and addresses the issues that brought them to the consultation that day, there is some spontaneous banter. The intent is usually to establish a convivial tone. Weather and football are common topics for this. Sometimes patient dissatisfaction or unhappiness is evident at this stage, such as having waited too long to get an appointment, or the impacts of an argument with their partner. It may be wise to adjust your cheeriness accordingly.

With the patient settled in the chair, you now want to know why they are here. Asking the patient, 'How may I help you today?' or, 'What have you got for me today?' are good options. The question 'How are you?' may take the conversation in a different direction to the primary purpose of consultation at that time.

The patient may be accompanied by someone else, such as a parent, guardian, partner, carer or translator. While courteous acknowledgement of these people is recommended, it is important to primarily address and converse with the patient. As much as possible, collect history from the patient initially before inviting additional input from those accompanying. If a translator is present, try to ensure that they simply translate and do not edit or censor what the patient or you are communicating.

3. Rehearsed opener

In advance of any planned important meeting, most people rehearse what they are going to say and how they are going to say it. They hope to have maximal impact and to convey concisely what is important to them. Patients do this, often subconsciously, before their appointment. Listen to the rehearsed opener very carefully. Most of what they want you to know, and the questions they want answered, is in those opening rehearsed lines.

Giving the rehearsed opener your full attention without interruption ensures you understand the patient's agenda and affirms that the patient's agenda is important to you. Your full attention, without looking at the computer, also gives you important body language cues.

There are very few patients whose rehearsed opener is longer than 45 seconds. Indeed, the use of 'minimal encouragers', such as a moment of silence, may be necessary to encourage additional, relevant information.

In the case of a child, the parent or guardian will have a rehearsed opener. Converse with the child first as the patient, and collect whatever history and/or questions they can offer. Acknowledge the support person, advising, 'Don't worry; I am going to let you fill in all the gaps'.

4. Any other issues?

The patient comes to the consultation with an agenda. Now is the time to find out if the patient has other issues that need addressing. It is perfectly reasonable to ask the patient: 'Is there anything else you wanted us to be dealing with today?' It is important to avoid, 12 minutes into the consultation, the patient providing some

Box 1. Teaching the art of general practice consultation framework

1. Be prepared
2. Ice breaker
3. Rehearsed opener
4. Any other issues?
5. Reflection
6. Gathering facts
7. Examination
8. The wrap
9. Acceptance set
10. Safety net

critical information: 'I also wanted to mention I have been getting palpitations'.

It is very appropriate for the doctor to have an agenda too. For example, the doctor may be noticing clubbed fingers or anxiety. The doctor's agenda may be related to preventive opportunities. The patient and/or doctor may have more than one agenda.

5. Reflection

Patients need to know you have heard and understood their concerns. Therefore, you need to provide them with this feedback by summarising and 'reflecting' back to them. Some patients will tell you the same things over and over if they feel they have not been heard. If they are certain that you have understood their concerns, they will not repeat themselves.

At the start of the consultation, with the rehearsed opener, you have been careful to give the patient your attention without being distracted by the computer; however, you do need to take notes. It is inefficient to leave note writing until after the consultation, and you may have forgotten details by then. This is an ideal time to start writing notes by reflecting and writing at the same time. In effect, you are telling the patient, 'This is important, and I want to write it all in my notes'. This can also be an opportunity to clarify details.

6. Gathering facts

You now have the information the patient believes you need. You have reflected so that the patient knows you have heard them and to ensure you have the details correct. But there will be other information that you know is relevant to the case, but that the patient likely does not. The last step of history-taking is gathering that extra information – important facts that can help you put your jigsaw together. You will ask questions such as, 'Have you coughed blood at any stage?' or, 'Do you have a family history of any bowel conditions?'

7. Examination

Examination can be important for two reasons – it can be diagnostic, and it can be reassuring. Certainly, examination can aid in diagnosis and provide more information for your jigsaw. Oftentimes in general practice you know what you are likely to find, and oftentimes that will not be much at all. However, this is not a reason to bypass examination, because surprises can occur. For example, what you expect will be an osteoarthritic knee may turn out to be a septic knee.

Patients rightfully expect an examination to complete their assessment. They might become anxious that something has been missed if examination is omitted or is cursory. When a patient presents with retrosternal chest pain, it would be unusual for examination to yield information to further the diagnosis, but very few patients would believe their heart has been evaluated if a stethoscope does not touch the chest.

8. The wrap

Until this point, you have listened intently to your patient and you now hope that your patient will listen intently to you. Taking all the information gathered, drawing on your medical knowledge and experience (and nous), you formulate a diagnosis and plan. The presentation of your diagnosis and plan is critical to the success and effectiveness of the consultation. This presentation, or 'wrap', is a skill that can be nurtured and refined. How it is delivered will have an impact on whether that patient understands the information and advice, whether they believe the information and advice, and whether they will follow through with recommendations. The skill of the wrap is formulating and delivering information. Registrars and supervised doctors need to hone this skill. This is best done with example and with practice. Trainees should have plenty of opportunity to observe their supervisors consulting and 'wrapping'. Practising, with many different scenarios, will be very helpful and can also be achieved through role-plays.

The information needs to be presented in a way the patient understands and conveyed in a way that is succinct and not overwhelming. Particularly important is addressing the agenda items and questions that the patient made you aware of during their rehearsed opener. For example, the patient may be cancerophobic although clearly none of the symptoms and signs are at all suggestive of cancer. Unless you have expressly said to the patient in the wrap that you do not believe they have cancer, you will not have met the patient's need on that day. The doctor also needs to address their own agenda items, such as preventive strategies for better long-term health outcomes.

Oftentimes in a consultation you do not reach a certain diagnosis, but rather a differential diagnosis and a plan for how you will progress. For example, you may discuss with the patient what tests might be helpful and in what way. In general practice, a definite diagnosis is not always required. If you are satisfied that no serious condition is evident, you can wait and watch. You can review. You can tell your patient, 'I am not able to tell you the exact diagnosis here, but I am confident that you do not have a serious problem, so if you agree, I am happy for us to both watch and see what happens'.

This is general practice. Not everything needs to be resolved in the one encounter. It is imperative to deal with the primary matters presented by the patient in the rehearsed opener. Other matters may be flagged for follow-up at a later opportunity, as long as the follow-up eventuates. Make notes and definite arrangements, for example, 'I'll organise an appointment now for a full skin examination'.

9. Acceptance set

At this point, you have delivered your formulation and plan. Has your patient understood you? Do they believe you have this right? Are they going to follow your advice? Most patients will be polite. Patients may say yes without meaning yes. This is similar to the situation in a restaurant. If you have had a meal slightly below your expectation, when the waiter asks if you enjoyed the meal, you might say yes without meaning yes.

An 'acceptance set' is a yes that you can see to mean yes. It is a combination of intonation of voice, body language and enthusiasm that tells you the yes means yes. If you do not get an acceptance set, then you need to revisit the wrap; more discussion is required. You need to find out what makes the patient dubious. You

might say, 'I'm not convinced that you're convinced', and see where that takes you.

10. Safety net

The most recognisable aspect of safety netting encompasses managing uncertainty.[13] Not everything goes to plan, so you need to be prepared for unexpected eventualities. This includes discussing with the patient what may happen and what to do in the various circumstances that may arise. For example, 'If the abdominal pain increases or a fever develops in the next 24 hours, I want you contact me'. At this point in the consultation process, everything should be covered; therefore, from the safety net, the consultation should easily draw to a natural conclusion.

Implement the framework

The authors of this article recognise that the literature that has gone before has shaped their thinking and some overlap of ideas has occurred. Doctors in training would do well to draw on a variety of consultation models and theories, and the framework presented here can be a valuable additional tool for honing the consultation art. It is not expected that any trainee will slavishly adhere to this or other models, but it is hoped that this 10-step model will focus the trainee on the importance of structure and will present a framework that can be adapted to the individual doctor's style, preferences and circumstances. Supervisors may also find the model useful for self-reflection on their own consultation practice.

In using this framework for teaching the art of consultation, there are a number of ways in which it can be adopted. It can be used as a basis of a registrar's or supervised doctor's teaching session early in their in-practice training. Having the 10 steps on a document or PowerPoint presentation may be a useful format for that session. For registrars, the teaching session will be pertinent in any training term (for example, general practice term [GPT] 1, GPT2, GPT3 and GPT4). Exploring the 10-step process can assist open discussions with the trainee about developing skills in running consultations that are both effective and efficient. As the term progresses, particularly when the supervisor is observing the registrar's consultations, the framework provides the concepts and labels to facilitate discussion about the aspects of effectiveness and efficiency. The focus of this framework is very much on consultation structure. Other aspects of communications skills – for example, such concepts as clinical reasoning and shared decision making – are discussed in other literature and are important considerations.

An alternative is to show the registrar a video of the teaching resource of the framework – such as the one available online at the GP Supervisors website (https://youtu.be/eAvw-dRoIp4) – and

Table 1. The limitations of telehealth when compared with face-to-face consulting

	Telehealth mode	
Framework step	Video	Telephone
1. Be prepared	No anticipated difference when compared with face-to-face consultations	No anticipated difference when compared with face-to-face consultations
2. Ice breaker	Minimal compromise, but transfers and walking are not observed	Compromised by not seeing visual pointers to demeanour
3. Rehearsed opener	No anticipated difference when compared with face-to-face consultations	Compromised by not seeing body language and visual cues, and by the patient not seeing the doctor's engagement
4. Any other issues?	No anticipated difference when compared with face-to-face consultations	No anticipated difference when compared with face-to-face consultations
5. Reflection	No anticipated difference when compared with face-to-face consultations	No anticipated difference when compared with face-to-face consultations
6. Gathering facts	No anticipated difference when compared with face-to-face consultations	No anticipated difference when compared with face-to-face consultations
7. Examination	Significantly compromised. Examination is possible by visual inspection.	Substantially compromised; the patient can report self-examination findings
8. The wrap	No anticipated difference when compared with face-to-face consultations	Mildly compromised by patient and doctor not seeing the facial expression of the other
9. Acceptance set	No anticipated difference when compared with face-to-face consultations	Substantially compromised by not seeing facial expression and body language
10. Safety net	No anticipated difference when compared with face-to-face consultations	No anticipated difference when compared with face-to-face consultations

guide the registrar though the various steps. Registered training organisations such as Eastern Victoria GP Training have created similar video resources; they also run regular live professional development sessions for supervisors to introduce this framework for their teaching regimen. Supervisor session evaluation consistently rates this training highly.

Challenges of distance consulting and learning

The COVID-19 pandemic has altered the way in which GP consultations have been conducted. The decrease in opportunities for face-to-face consultations has necessitated an increase in the use of consultations through telemedicine as a substitute to protect both patients and frontline healthcare providers.[14,15]

While the 10-step framework emerged from experience with face-to-face consultations, it can potentially be adapted for remote consultations. To be noted, there are important aspects inherent to the in-person consultation that can be compromised with remote consulting, particularly with telephone consultations. Most importantly, immediacy and engagement may be reduced, such as the missing of visual body language cues. In face-to-face consultations, the patient's understanding and reassurance will come partly from the look on the doctor's face, and the doctor's evaluation of the acceptance set will come partly from the look on the patient's face. It is important to be mindful of such shortcomings in telehealth and be looking for an evolution of the consultation model to be better suited to the new circumstances of remote consulting general practice.

With the frequent use of video and telephone consultations during the COVID-19 pandemic, consideration has been given to the transferability of the 10-step model to video and telephone consulting (Table 1).

Conclusion

Teaching a registrar or supervised doctor the art of a good consultation can be difficult; indeed, it is something not generally taught to supervisors themselves. This article presents a new framework for general practice consulting that is suitable for contemporary patient and doctor expectations and accommodates the central values of patient-centred care.[16] This 10-step process can assist open discussions with trainees about the importance of consultation structure, with adaptations for their own style, preference and circumstances. As the term progresses, particularly when the supervisor is observing the registrar's consultations, the framework provides the concepts and labels to facilitate discussion about the aspects of effectiveness and efficiency. Similarly, supervisors may use the model to reflect on their own consulting.

A global pandemic and the rise of telehealth[17] have presented the challenge of how to teach the art of consultation beyond the physical learning space of the consultation room. While the 10-step framework presented in this article emerged from experience with face-to-face consultations and has been taught for a number of years in the Australian context, it can be adapted for virtual consultations via video or telephone consultations. The authors expect that with more experience with telehealth, the emerging generation of GPs will devise steps to optimise effectiveness and efficiency of telehealth consulting.

This model is still relatively new. Wider implementation in multiple contexts is now invited, with evaluation and feedback needing to follow.

Key points

- GPs strive for effectiveness and efficiency in consultations.
- Effective consultations are associated with high patient satisfaction and will positively affect patients' health outcomes.
- A new framework is proposed here to teach the art of effective and efficient consultation skills to registrars and supervised doctors.
- Traditionally, general practice consultations have been face-to-face. The advent of telehealth consultations provides challenges to attain similar patient satisfaction and positive health outcomes.

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References

1. Trumble SC. The evolution of general practice training in Australia. Med J Aust 2011;194(11):S59–62. doi: 10.5694/j.1326-5377.2011.tb03129.x.
2. Wearne SM, Magin PJ, Spike NA. Preparation for general practice vocational training: Time for a rethink. Med J Aust 2018;209(2):52–54. doi: 10.5694/mja17.00379.
3. Wearne SM, Butler L, Jones JA. Educating registrars in your practice. Aust Fam Physician 2016;45(5):274–77.
4. Wearne S, Dornan T, Teunissen PW, Skinner T. General practitioners as supervisors in postgraduate clinical education: An integrative review. Med Educ 2012;46(12):1161–73. doi: 10.1111/j.1365-2923.2012.04348.x.
5. The Royal Australian College of General Practitioners. Telehealth and supervision: A guide for GPs in training and their supervisors. East Melbourne, Vic: RACGP, 2020.
6. Denness C. What are consultation models for? InnovAiT 2013;6(9):592–99. doi: 10.1177/1755738013475436.
7. Neighbour R. The inner consultation. Oxford, UK: Radcliffe Medical Press, 1987.
8. Silverman J, Kurtz S, Draper J. Skills for communicating with patients. Oxford, UK: Radcliffe Medical Press, 2008.
9. Murtagh J. Consulting skills. In: John Murtagh's general practice. 6th edn. Sydney, NSW: McGraw-Hill Australia, 2015; p. 14–19.
10. Moulton L. The naked consultation – A practical guide to primary care consultation skills. Oxford, UK: Radcliffe Medical Press, 2007.
11. Buckley J, Francis W, Greco M. Good interpersonal skills in 15 minutes: An educational module for improving interpersonal skills in the medical consultation. East Melbourne, Vic: RACGP, 1998.
12. Mirza D. The need for new GP consultation models. InnovAiT 2019;12(1):33–37. doi: 10.1177/1755738018806931

13. Jones D, Dunn L, Watt I, Macleod U. Safety netting for primary care: Evidence from a literature review. Br J Gen Pract 2019;69(678):e70–79. doi: 10.3399/bjgp18X700193.
14. Dedeilia A, Sotiropoulos MG, Hanrahan JG, Janga D, Dedeilias P, Sideris M. Medical and surgical education challenges and innovations in the COVID-19 era: A systematic review. In Vivo 2020;34(3 Suppl):1603–11. doi: 10.21873/invivo.11950.
15. Gray DP, Freeman G, Johns C, Roland M. Covid 19: A fork in the road for general practice. BMJ 2020;370:m3709. doi: 10.1136/bmj.m3709.
16. Rathert C, Wyrwich MD, Boren SA. Patient-centered care and outcomes: A systematic review of the literature. Med Care Res Rev 2013;70(4):351–79. doi: 10.1177/1077558712465774.
17. Monaghesh E, Hajizadeh A. The role of telehealth during COVID-19 outbreak: A systematic review based on current evidence. BMC Public Health 2020;20(1):1193. doi: 10.1186/s12889-020-09301-4.

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