MORECAMBE BAY HOSPITALS NHS TRUST

CONSULTATION SKILLS PROJECT

Supported by the North Western Deanery under the Blending Service with Training initiative

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Abstract

This project set out to design and facilitate a programme to improve the consultation skills of hospital based junior doctors. We intended to involve local hospital consultants in as much of the programme as possible (from design to evaluation) in order to encourage transfer of learning back in the workplace. The various elements of the programme were designed on current thinking such as action learning and open learning support materials to complement skills training, video taped role play and feedback. In our search of the literature on consultation skills the Calgary Cambridge Framework as developed by Drs Silverman, Kurtz and Draper emerged as the most up to date and pertinent for our objectives. The report describes the process and outcomes of our experiences in designing and delivering the programme. The outcome of the report concurs with Silverman et al that consultation skills can be explained and taught; the use of videotaped consultation with structured feedback is a powerful learning method and finally that we should explore the potential for using the framework with other health care professionals.

Outline of the project

Aims of the project

- Through a structured development programme, develop the communication & consultation skills of hospital based junior doctors i.e. Senior House Officers
- Incorporate in the development programme, a range of developmental activities and methods such as videotaped consultations both pre and post project, structured feedback on performance, open learning, skills workshops and action learning set meetings
- To strengthen the learning and support infrastructure for junior doctors by developing consultants as facilitators. This would involve including consultants in the design, delivery and evaluation of the project.

This project took 7 Senior House Officers (SHOs) from a range of clinical specialities through a structured development programme, over a period of 4-5 months, to enhance their communication and consultation skills. Based on qualitative observations of the videotaped consultations before and after the project and supported by feedback from the SHOs there is evidence to suggest that the programme has had a definite and positive impact. The confidence of the SHOs to structure and manage a doctor-patient consultation has significantly increased along with their appreciation of the importance and influence of the consultation on the doctor patient relationship. Feedback from the professional actor, who played the patient in the video taped consultation and who is very experienced in this type of work, also indicates an improvement on the skills and ability of the SHOs to conduct meaningful consultations from a patient perspective.

Review of previous work

Much has been written on the structure of the medical interview or consultation. Different models have been developed and promoted in the various medical specialities. Some specialities, general practice and psychiatry being the most notable examples, pay particular attention to the consultation process and regard this aspect of the doctor patient interaction as critical (Pendleton et al 1984, Tate 1994, Gask in Forrest 1998). In many other specialities, emphasis is placed on technical skills, knowledge of anatomy, physiology and related sciences rather than on communication and interpersonal skills.

A brief literature search of this subject reveals an extensive range of text. These texts vary in terms of content and presentation. Many are personal reflections on the authors experience and perception of doctor-patient communication and the importance of the consultation process, others describe theories on what is happening or should be happening in a doctor-patient consultation whilst others suggest models for structuring the consultation. A list of the documents, which were used or considered when developing this project, is included in the references.

In our view, the work which stood out from the rest in terms of being up to date, based on sound and compelling evidence and, although primarily designed for general practitioners, could be applied to doctors working in secondary care settings was that of Silverman, Kurt & Draper (1998a, 1998b). The authors published 2 books, which were used extensively throughout this project:

Teaching and Learning Communication Skills in Medicine

Skills for Communicating with Patients

The unique features of these texts was that they not only suggested a model, the *Calgary-Cambridge Model* (Appendix1), for the doctor-patient consultation, along with evidence to support their approach, they also identified the skills necessary for an effective consultation (Appendix 2). A review of the different teaching and learning methods were also considered and suggestions made for how communication and consultation skills can be taught. In the light of this evidence, we decided to adopt the Calgary-Cambridge Model as the basis for our project.

There is now a growing awareness and realisation that communication skills and in particular the consultation process, is an important, if not critical, part of the doctor-patient relationship. Increasing emphasis is now being placed on this issue in both undergraduate and postgraduate medical education teaching. Consultation skills, which have formed an essential component of the membership examinations for the Royal College of General Practitioners and Royal College of Psychiatrist, are now being considered for other membership examinations such as the Royal College of Physicians.

Precise statement of the scope and the aims of the investigation

As already stated, the consultation process is regarded as a critical component of the doctor-patient relationship in general practice and psychiatry. Less importance is attached to this issue for an SHO pursuing a career in medicine or surgery and who is usually hospital based. As an acute hospital we have identified that a significant proportion of our patient complaints involve issues related to a lack of or poor communication and in which, the doctor is often cited as the primary protagonist. We were interested to learn how we could help develop the communication skills among our medical staff, promote best practice in doctor-patient communication, enhance patient satisfaction and reduce the number of complaints.

If successful, we would then wish to explore ways of including such learning and development opportunities for all junior doctors within the Trust. It was for this reason that we wanted to involve consultants in the design, delivery and evaluation of the project.

It was against this backdrop the aims of the project were developed:

- Through a structured development programme, develop the communication & consultation skills of hospital based junior doctors i.e. Senior House Officers
- To strengthen the learning and support infrastructure for junior doctors by developing consultants as facilitators. This would involve including consultants in the design, delivery and evaluation of the project
- Incorporate in the development programme, a range of developmental activities and methods such as videotaped consultations both pre and post project, structured feedback on performance, open learning, skills workshops and action learning set meetings

Several limitations impacted upon the project, these included:

- Human Resources – The project was developed and managed by the Trust Training Manager. This meant that the demands of the project had to be balanced with the existing and ongoing roles and responsibilities of the Training Manager.
- Expertise – Although there is a wealth of expertise within the local health organisations availablity of expertise to contribute to the design, delivery and evaluation of the project was extremely limited and was compounded by the existing commitments of these people to other areas of work.
- Geography – Morecambe Bay Hospitals NHS Trust is geographically dispersed. It has 3 main hospital in Lancaster, Barrow and Kendal and 2 minor hospitals in Morecambe and Ulverston. A catchment area of 900 square miles means that involving doctors from more has 1 site has significant time and resource implications.
- Timing – The project commenced in June 2000 and concluded in September 2000 in order to meet the deadline for the Deanery. This timing bridged the traditional SHO rotation in August 2000. This created difficulties as we were tied to recruiting doctors to the project who were planning to remain in the Trust for their next job.
- Numbers – This was designed as a pilot project and as such would only involve small numbers of doctors. Only cautious conclusions can be drawn from this small scale project based on such small numbers.

Description of the procedure

A flow chart outlining the sequence of events is attached (Appendix 3) to support the following description of the procedure.

Stage 1 - Project Design Team Meeting

The Project Design Team comprised the following people:
Michele Pomphrey, Training Manager (Project Manager)
Carl Hunter, Training & Development Adviser
Mr Stuart Durham, Clinical Tutor (Lancaster)
Dr Bill Mitchell, Clinical Tutor (Barrow)
Dr Andy Craven, GP, Lancaster
Dr Peter Nightingale, GP, Lancaster
Dr Mike Cook, Associate Dean, St Martins College, Lancaster

The project design team met on 5th May (Dr Bill Mitchell was unable to attend this meeting due to other commitments) to discuss and agree (a) the project design (b) the teaching methods (c) the project timetable (d) the involvement and commitment each member was able to give to the project and (e) how many SHOs could or should be recruited to the project.

Agreement was reached at this meeting for the project design as illustrated in Appendix 3. Mr Stuart Durham informed the group that due to his clinical commitments and his clinical tutor role he would be unable to give very much time to the project. Michele Pomphrey agreed to try and get another consultant from the Lancaster site involved in the project (Dr Paul Gibson, Consultant Paediatrician subsequently agreed to be involved). Dr Andy Craven and Dr Peter Nightingale agreed to contribute to the videotaped consultations both before and after the project and also to the skills workshop and action learning set meetings. Dr Mike Cook agreed to develop, along with his colleagues at St Martins College, an open learning resource pack to support the project. It was also agreed that we should attempt to recruit 8 SHOs on to the project, 4 from Lancaster and 4 from Barrow. The clinical tutors on each site would identify suitable candidates. 8 SHOs were identified however, 1 of the Lancaster SHOs withdrew at the last minute due to other commitments. It was too late to recruit a further SHO from Lancaster so it was decided to continue the project with a total of 7 SHOs.

Stage 2 – Preparatory Meetings

Meetings were organised with the SHOs to explain in more detail the purpose of the project, what they could expect from the project and what was expected of them within the project. This was also an opportunity for the SHOs to raise any concerns or queries regarding the project and fully appreciate that nature of the project they had become involved in.

Stage 3 – Pre-Project Videotaped Consultations

Prior to any teaching or development, each of the SHOs was videotaped conducting a consultation. The consultation involved using a professional actor, used to playing the role of a patient, and was based upon a case scenario developed by Dr Andy Craven (Appendix 4). The 4 SHOs from Barrow were all videotaped on the same day, one after the other. A copy of the programme for the day is attached (Appendix 5). Having been videotaped, the SHOs immediately met with Michele Pomphrey, and Dr Andy Craven. The SHOs were then invited to reflect on their management of the consultation and identify where they had performed well and where they felt they could develop. This was followed by structured feedback from Dr Andy Craven. It was envisaged that Dr Bill Mitchell would facilitate the SHOs reflection and give the structured feedback, supported by Dr Andy Craven. Unfortunately, Dr Mitchell was unable to attend this or any other part of the project. The actor (Mrs Sue Power) was asked to record her thoughts, feelings and observations regarding the SHOs performance from a patient perspective.

This process was repeated for the 3 Lancaster SHOs. However, Dr Paul Gibson was able to attend this session and did facilitate the SHO feedback session, supported by Dr Peter Nightingale and Carl Hunter.

Stage 4 – Open Learning Material

Each SHO was issued with an open learning workbook designed specifically to support this project (Appendix 6) and encouraged to work through this prior to the skills workshop planned for July. This material also encouraged the SHOs to begin documenting their thoughts, feelings and experiences as a component part of their continuing professional development (CPD) portfolio.

Stage 5 – Skills Workshop

This was a 2-day residential workshop, which focused on presenting and explaining the Calgary-Cambridge Model in greater depth and giving the SHOs an opportunity to practice and develops the skills necessary for conducting an effective consultation. All 7 SHOs were brought together for this part of the project. The programme for the 2 days is attached (Appendix 7).

Stage 6 – Action Learning Set Meetings

The sessions were organised in order to give the SHOs an opportunity to consolidate their learning and skills development from the residential workshop. Initially, plans were made for the Lancaster SHOs and the Barrow SHOs to meet on their separate sites for the action learning set meetings. However, the SHOs requested that they these meetings be organised on a joint basis. Due to the summer period it was only possible to organise 2 action learning set meetings. Nevertheless, this did provide the SHOs with an opportunity to share their experiences to date, to discuss their learning and to explore concerns or difficulties in applying the skills covered on the workshop to their everyday practice.

Stage 7 - Post-Project Videotaped Consultations

This was simply a repeat of the process discussed in stage 3 apart from on this day the SHOs also received feedback from the actor. This feedback focused on how, from a patient perspective, the pre and post project consultations differed, which felt the more involving, rewarding and beneficial.

Stage 8 – Summative evaluation Meeting

This meeting was organised a couple of weeks after the videotaped consultation in order to allow the SHOs time to reflect on their experience of the project. We adopted a structured format for this meeting (See Appendix 8). Following a group discussion around these issues we then asked each SHO to complete the evaluation form from a personal perspective.

Statement of results

Due to the very small sample covered by this project and the essentially qualitative nature of the project a high degree of caution needs to be exercised when interpreting the outcome or results of the project.

The results of the project are presented under 2 main headings:

1. *Junior Doctor Perspective*
   This relates to the first aim of the project, i.e. to develop the communication and consultation skills of junior doctors.
2. *Consultant involvement*
   This relates to the third aim of the project, i.e. to involve consultant medical staff in the design, delivery and evaluation of the project. To develop their skills as facilitators and support the teaching of consultation skills as an integral part of everyday clinical practice.

The Junior Doctor Perspective

Videotaped consultation – For many of the SHOs this was the first time they had been videotaped conducting a consultation, albeit a role-play. Being able to watch themselves communicating with a patient, responding or not responding to the patients ideas, concerns or expectations and observing the body language of the patient and themselves proved a very powerful learning experience. Many of the SHOs had not realised how much medical terminology or jargon they used when explaining things to patients. They had not appreciated the impact their own body language might be having on the patient and how the careful use of body language can help a patient open up and explain what they are thinking or feeling. Reflecting on their performance and discussing the feedback they each received immediately after the consultation provided some very powerful insights into their particular skills and developmental needs. These results are illustrated by some quotes from the SHOs:

"The pre & post videos were very helpful, especially the feedback"

"Most valuable for feedback about one's skills"
"Videos were very useful"
"Very useful and informative, it's good to see if any improvements made"

Open Learning – One of the aims of the open learning material was to set the scene and provide some foundation learning ahead of the skills workshop. A number of the SHOs did spend time working through the material whereas others didn't. The amount of time each SHO had to go through the workbook, i.e. 10 days, may also have been a factor. Overall, a more interactive rather than individual learning appeared to be the preference for most of the SHOs. This does not reflect on the quality of the workbook which, when explored and considered as part of a group discussion was felt to be valuable

Skills Workshop – For all the SHOs this experience proved to be the most enjoyable and valuable in terms of learning. Explanation of the Calgary-Cambridge model, exploring how this fits with their own experience/ideas as well as opportunity to practice specific skills in safe and supportive atmosphere was well received. The discussions that took place highlighted the range of different perceptions and understanding different SHOs have about the consultation process. It also challenged people to evaluate their current practice in the light of different viewpoints and with reference to the Calgary-Cambridge model. Listening to Dr Nightingale and Dr Craven relate how they were applying this model in practice was also felt to be extremely valuable. Again, quotes from the SHOs reflect nicely the value of the skills workshop:

"The workshop was excellent"
"Role-play exercises really helped develop my skills"
"Working with each other was intimidating initially but, a valuable learning tool"
"Fantastic support and comments throughout"
"Groupwork and feedback really worked well"
"A good base on which we can develop our skills in specific areas"
"Highlighted the need to improvement in our communication skills"
"Different specialities working together was very useful"
"Very encouraging atmosphere, helped to open up"
"Good mix of theory, discussion, groupwork and role-play on the workshop"
"The workshop was very good, laying the foundations for our continued development"
"I was able to take more information onboard by being away from the work area"
"Well organised and well presented"
"Easy and smooth building up of a totally new concept"

Action Learning Meetings - 2 meetings were organised which, whilst not attended by all the SHOs, were felt to be of benefit. These meetings were designed to be relatively unstructured so that the SHOs could more easily determine the issues to be explored or discussed. They were felt to be very helpful in terms of sharing individual experiences. For example, trying out different ways of managing the consultation process using the techniques introduced on the skills workshop. The meeting also proved useful in clarifying aspects of the Calgary-Cambridge model the SHOs had not fully grasped on the workshop. Interestingly, video equipment had been taken to these meeting just in case individuals wanted to practice particular skills however; none of the SHOs took up this offer. The feedback from the SHOs nevertheless stated quite clearly that more use should have been made of video role-play and feedback on the action learning meetings, i.e. that the facilitators should have "told" the SHOs to do it.

Consultant involvement

The initial aim of the project was to involve at least 2 consultants in this project. The purpose of this was to draw upon the expertise in communication/consultation from each individual consultant and also to develop the facilitation skills of the consultants so that they could begin to incorporate the teaching and development of such skills into their everyday supervision of junior doctors.

Unfortunately, the clinical tutors on the Lancaster and Barrow sites who had initially agreed to contribute to the project subsequently withdrew due to other commitments. Dr Paul Gibson, Consultant Paediatrician agreed to become involved at the Lancaster end of the project. We were unable to secure any further consultant involvement at the Barrow end. Due to Dr Gibsons late involvement in the project, he was only able to attend the pre and post videotaped consultation sessions and was unable to participate in the skills workshop or the action learning meetings.

During the pre and post project videotaped consultations Dr Gibson did take the lead in terms of facilitating the review and feedback session with each SHO, supported where necessary by Dr Nightingale. Although not unfamiliar with giving feedback to SHOs, using a very structured approach and focusing on specific skills that had or had not been demonstrated proved a very rewarding experience. Feedback from Dr Gibson in relation to this process highlighted the importance of good communication and consultation skills to the doctor-patient relationship. Something that is often taken for granted or not carefully considered. Dr Gibson related his own style of consultation, how it had developed over time and how he is continuing to develop it as new or challenging situations arise. Although not based on any published or theoretical model Dr Gibsons own approach did have similarities with the Calgary-Cambridge model. What the model was able to do was to validate for Dr Gibson some of the techniques and skills that he was already using and highlight aspect of his own practice which he could usefully develop. Furthermore, having spent time developing his understanding of this model has provided a clear framework against which to benchmark his own communication skills and those of the people who he works with. Having a clear understanding of this theoretical model also enabled Dr Gibson to begin discussing with his SHOs their particular consultation skills more explicitly.

Analysis and Discussion

The key question here is did we achieve what we set out to achieve? This project set out with 3 main aims:

1. Through a structured development programme, develop the communication & consultation skills of hospital based junior doctors i.e. Senior House Officers
2. Incorporate in the development programme, a range of developmental activities and methods such as videotaped consultations both pre and post project, structured feedback on performance, open learning, skills workshops and action learning set meetings
3. To strengthen the learning and support infrastructure for junior doctors by developing consultants as facilitators. This would involve including consultants in the design, delivery and evaluation of the project

Through a structured development programme, develop the communication & consultation skills of hospital based junior doctor's i.e. Senior House Officers

The results suggest that the project was successful in developing these skills with our 7 SHOs. The feedback from each one of the junior doctors was that their awareness, understanding, confidence and skills in managing the consultation have increased significantly. The professional actor who role-played the patient and gave feedback to each of the SHOs on their performance in the pre confirmed this and post

project videotaped consultation. Furthermore, observation of the SHOs by Drs Craven, Nightingale and Gibson all affirm an increase in skills demonstrated during the post project video as compared to the pre project video. In the evaluation meeting held with the SHOs, everyone of stated that would highly recommend this programme to their colleagues at both HO and SHO level. Many suggested that this type of programme should be available, if not compulsory, for junior doctors in training. Finally, all 7 SHOs expressed an interest in continuing with some further communication/consultation skill development if this was arranged.

Incorporate in the development programme, a range of developmental activities and methods such as videotaped consultations both pre and post project, structured feedback on performance, open learning, skills workshops and action learning meetings

It is clear from this report that the project did incorporate all the proposed methods outlined in our original aims. On reflection, some methods worked better or were better received than others. The most beneficial methods from the SHO viewpoint were the videotaped consultations, structured feedback from a consultant or GP and the skills workshop. Less successful were the open learning materials that many of the SHOs did not utilise fully. However, they may prove valuable at a later date when they begin to reflect on their practice and the testing out of new skills. They will also serve as useful reference material. A greater degree of emphasis on the open learning material and more time in which to work through would be worth testing out in any future project of this nature. Another issue which did emerge throughout the project was that the consultants for whom the SHOs were working sometimes had very limited understanding of this model of application of these skills. This meant that SHOs wishing to try our new skills were not supported to the extent that could be possible. Future projects may wish to consider how supervising consultants can be made aware of the project content and teaching methods and how these can be encouraged and supported on a day to day basis.

To strengthen the learning and support infrastructure for junior doctors by developing consultants as facilitators. This would involve including consultants in the design, delivery and evaluation of the project

This has been the least successful aspect of the project. There was no consultant involvement in the project in Barrow and only partial involvement at Lancaster. Where there was consultant involvement, this enhanced the process and learning for the SHOs. It demonstrated that it is not just GPs who are interested in this aspect of the doctor-patient relationship. Also, the consultant was able to illustrate how the Calgary-Cambridge model could be applied in a hospital setting. The major difficulty of involving consultants in a project of this nature falls in to 2 main areas. Firstly, for a consultant to free up the necessary time from their existing and ever increasing workloads for a project of this nature, is extremely difficult. Therefore, different ways of involving them that are either less time consuming or can be combined with other aspects of clinical work need to be further explored. This raises the second area; some consultants do not appreciate the importance of the consultation in the wider context of providing a health service. Unless consultants can see the value and impact a well managed consultation can make to patient satisfaction and clinical outcomes they are unlikely to create time to become involved. More work needs to be done to make consultants aware of the evidence base on this issue.

The outcomes of this project have already been presented to the Trust Education and Training Committee and the Lancaster & Westmoreland Medical Education Committee. As a result of these presentations the Trust has identified a number of consultants who are interested in developing this project further. This group will be meeting for the first time early in the new year to explore ways in which we can move forward and increase the involvement of consultant medical staff.

Other problems and limitations

Developing new skills can take a long time, especially if these skills involve changing behaviours that have become well established. This project was conducted over 4-5 month period and realistically could only ever hope to achieve limited skills development and modest changes in behaviour. This was further compounded by the fact the project bridged the SHO rotation period, resulting in unavoidable disruption of their working lives and limited the opportunity to practice and develops new skills. Recruiting SHOs onto the project was not easy. Many SHOs we approached were clearly uninterested in this issue for reasons best known to them. Feeling that they already had the necessary skills or that this "touch-feely" aspect of medicine wasn't for them was cited on a number of occasions.

Summary and conclusions

Although this was a very modest project in terms of sample size a number of conclusions can be drawn. These are:

1. Consultation skills are crucial to quality of the doctor-patient relationship and have a significant impact on (a)patient satisfaction and (b) doctor confidence
2. Consultation skills can be explained, described and taught
3. Teaching consultation skills takes time and requires lots of practice
4. The use of videotaped consultations followed by structured feedback is a very powerful learning method
5. The involvement of consultant medical staff in the teaching of consultation skills for hospital doctors is essential if (a) SHOs are to encouraged to practice skills and receive feedback on a day to day basis and (b) this type of teaching and development opportunity is to be made available to all junior doctors
6. Consultation skills need to be underpinned by appropriate education and teaching in pre-registration medical education
7. The Calgary-Cambridge model, although developed in General Practice can be applied in a hospital setting. It also has the potential to be of value to other professional groups/disciplines.

The outcomes of this project have been regularly reported to the Trust Education & Training Committee. We have commenced presentations, describing the project and its outcomes to various medical committees. We are planning to repeat the project, on a multi-disciplinary basis, in March 2001. This project has also prompted us to consider the development of a Trust wide strategy for developing patient centred communication skills and a clinical protocol for patient communication.

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