GPSA
GENERAL PRACTICE SUPERVISION AUSTRALIA

FAQ

FREQUENTLY ASKED QUESTIONS

WEBINAR

Teaching your registrar how to conduct a consultation

Is there a preferred consultation model or should I encourage my registrar to adapt their style to suit either their personality or the patient's needs?

The successful completion of your registrar's training in general practice largely depends on their ability to conduct a well-structured consultation. As their supervisor, what you need to teach to this end is a matter of process rather than content.

Having landed in General Practice following their stint in the hospital setting, your registrar is likely to focus on diagnosis and treatment rather than on how they manage patient expectations.

Accordingly, your registrar needs your guidance to understand the importance of the consultation to not only the patient's health outcomes but also to their own reputation and to that of the clinic as a business. In other words, while they need to get the consultation right for the sake of passing their exam, they also need each consultation they conduct to reflect on them as being:

- effective;
- efficient;
- likeable and trustworthy; and
- unlikely to be sued.

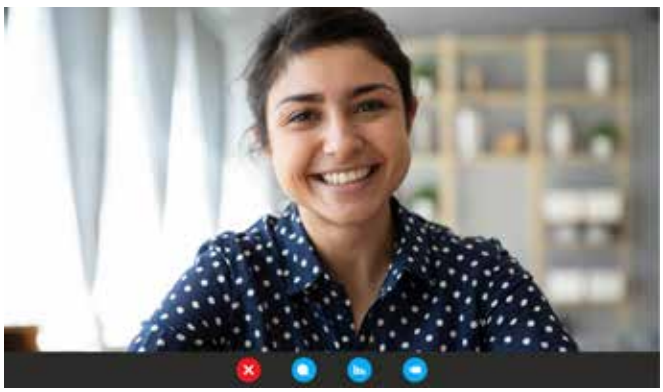
A structured model helps to achieve this, providing labels for the important elements of the consultation process. Registrars need to learn from observation, practice and role playing, and ultimately develop their own style.

You've got to be you: take on board all the strategies, handy phrases and suggestions your supervisor offers… then rework these through practical application and role play until you've created your own style.

The below consultation model can be adapted to suit your registrar's personality and needs as much as those of the patient.

Here is the summary:

1. Prepared
2. Icebreaker
3. Rehearsed Opener
4. Any other issues?
5. Two agendas
6. Reflection
7. Gathering facts
8. Examination
9. The Wrap
10. Acceptance Set
11. Safety Net



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Consultation Model in detail

- **PREPARE BEFORE CONSULTATION**: read up on patient history, confer with supervisor if necessary.
- **ICEBREAKER:** use banter at start of consultation to establish likeability, trustworthiness, tone of consult, leading into…

  How may I help you today?

  What have you got for me today?

  NOT *"How are you today?"*
- **REHEARSED OPENER:** the patient has come in to communicate one or more concerns, and after you deliver your rehearsed opener you need to help them get to what they may have rehearsed to tell you.
- Listen actively, engage with and look at your patient while they answer your opening question. Use encouragers – body language, silent prompts - to assist them through the important points.
- Don't underestimate the power of silence, especially when dealing with sullen teens. Your silence communicates contemplation and focus on what the patient is saying. And always address the patient specifically. Where they are accompanied by a parent/ carer/ translator, make sure your attention is given to the patient first and foremost, then allow others to fill in the gaps. Remember to communicate this as your intention from the outset.
- **ANY OTHER ISSUES?** Ask. It's better to know up front than down the track! If the response to this question is too much to address during the assigned session, suggest another appointment and lock in a time to get through what they need to cover with you.

  Is there something else?
- **TWO AGENDAS:** remember your patient comes in with their own set agenda; while you may have one or more agendas of your own through the consultation, whether relating to prevention or observed issues, the patient's agenda must be addressed as a prime concern.
- **REFLECTION:** reinforce what you have heard from the patient, tidy up your understanding of what's been communicated, then turn to the computer to enter in your notes at this stage

  I hear your concerns. This is what I have taken from what you've said: ... Does that sound about right?
- **GATHERING FACTS:** ask all relevant questions – finish off history taking.
- **EXAMINATION:** this is essential because it's diagnostic and therapeutic: don't assume - even when you have reliable information from the patient history, it's never a good idea to reach a conclusion without carrying out an examination. The examination also serves to reassure your patient that you've taken them seriously and reaffirms their faith in what you tell them in 'the Wrap'.
- **THINKING TIME:** take a figurative and even literal step back to collect your thoughts - wash your hands or enter extra information into the patient notes.
- **THE WRAP:** tell your patient what you think is going on, how you arrived at this conclusion, how to proceed, making sure you refer back to the patient's agenda noted at the start of the consultation. If your conclusion is in itself inconclusive, explain your plan eg running tests, talking to colleagues, then having a follow-up appointment with them in x days' time.
- **ACCEPTANCE SET:** the goal is to have your patient say yes and mean it. They need to believe you/trust you and commit to what you tell them... Are you convinced they're convinced?
- **SAFETY NET:** the disclaimer in case Plan A isn't effective. This is where you outline possible risks, what Plan B entails if the anticipated scenario doesn't unfold - leading to…
- **NATURAL CONCLUSION** to consultation.

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What are the best teaching tools for developing a good consultation style?

- **OBSERVATION:** encourage your registrar to sit in on your own and your willing colleagues' consultations so they can glean the different ways the model plays out to suit both the doctor and the patient.
- **VIDEO RECORDING:** with the patient's consent, the benefits of making video recordings of consultations for the registrar to review (both alone and in educational sessions with the supervisor) are many and varied. The issues involved with storing recorded videos on the patient file need to be weighed against the value these videos have in terms of being able to identify where communication falls down, unconscious behaviours and missed cues, etc.
- **ROLE PLAYING:** while role playing through the entire consultation process is valuable, the trickiest part of the consult tends to be 'the wrap'. Focus role playing on this aspect specifically, provide your registrar with the patient history and situation and invite them to skip straight to 'the wrap'.

Why does my registrar always seem to finish history taking too early when I'm observing their consultations?

Anxiety often makes us rush through processes that we otherwise take longer to perform. This is especially the case when we are being openly observed and assessed. Consider the speed of your registrar's history taking in this light, and maybe observe a recorded consultation to see if they show less haste without you in the room with them.

How do I tailor this teaching to registrars of different levels?

Even the most experienced practitioners can benefit from the reminder the structured consultation model provides. Discuss it and reward good listening and 'wrapping'.

Does this resource need to be updated? Contact GPSA: P: 03 9607 8590, E: admin@gpsa.org.au, W: gpsa.org.au
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