

■ EDUCATION AND TRAINING

Rediscovering the wheel – teaching communication skills using video taped clinical consultations in specialist training

Geraint Fuller and Philip Smith

ABSTRACT – Communication skills are inevitably used during the clinical consultation in medicine. Unlike trainees in general practice, trainees in specialist and general medicine are not formally trained in communications skills. We used methods for training communication skills developed in general practice and videoed consultations with simulated patients, adapted for neurology, and found these to be valued by our trainees.

In specialist medicine we need to begin exploring how to help our trainees learn communication skills; perhaps our colleagues in general practice can show us where to start?

The clinical consultation is the central event around which all medicine revolves. It seems self-evident that developing the skills used during consultation would be an essential part of any training in medicine¹. However, in medical specialties, including neurology, training in consultation skills has been informal or assumed to occur as part of the clinical apprenticeship. This is in striking contrast to the emphasis on the teaching and assessment of consultation skills in general practice in the United Kingdom. Review of videotapes is used regularly throughout training, and as part of both the summative assessment for general practice accreditation and for the examination for membership of the Royal College of General Practitioners².

Consultation skills have four components: knowledge, communication skills, problem solving skills and physical examination skills³. These are interdependent elements, as can be appreciated by the way greater knowledge can improve problem solving. Medical specialist registrars' training emphasises two of these elements: knowledge (increasingly defined by specialist curricula) and problem solving skills. Communication skills are often omitted. In the past there has been the suggestion that these skills are innate and reflect personality, are honed by experience and consequently cannot be taught. However, whilst some people are naturally better communicators than others, there is a substantial body of evidence which suggests that

experience is a poor teacher, and studies involving medical students, specialist trainees and physicians have all shown that such skills can be taught and that the skills are retained (Kurtz *et al*⁴ for review).

Communication skills themselves are in reality a *series* of skills, rather than a homogenous whole. Communication skills can be divided into: content skills, which relate to what is communicated, the substance of questions and responses, for example the questions used to elicit a description of a headache; process skills, including the verbal and non-verbal skills, relating to the way the doctor communicates and the organisation and structure of communication; and perceptual skills, those used in internal decision making, problem solving and awareness of their own reaction to the patient and the illness³. Understandably, specialist trainees and their training schemes focus on knowledge, problem solving and content communication skills since it is these that set the specialist apart from the generalist. Process and perceptual communication skills are rarely taught formally in medical specialties, either during general professional or specialist registrar training.

Some specialists are privately sceptical about the value of a training in generic communication skills. Perhaps this reflects the fact that most communication skills training focuses on process skills, separately from content, giving rise to the misconception that the training results in someone who can communicate very effectively but has nothing to

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Key Points

Effective clinical consultations in specialist medicine depend on good communication skills

Trainees in medical specialties, unlike those in general practice, do not receive formal communication skills training

Trainees in neurology found techniques developed in general practice for communication training, video taped consultations with simulated patients, to be useful

Specialist medical training could be improved by introducing these techniques

say, like a linguist who speaks eight languages but has nothing to say in any of them.

We recently used the methods developed for teaching communication skills to trainees in general practice with a group of specialist registrars in neurology, and took the opportunity to examine their perception of the acceptability and usefulness of this training⁵. The sessions used professional actors as simulated patients. The patient roles included a commonly presenting neurological symptom, an important detail that would only emerge with skilled questioning, and another issue that related to the patient's perspective of their illness. The sessions were run in small groups consisting of three registrars, one consultant neurologist and a facilitator who was a general practitioner. The trainees and the neurologist each saw one simulated patient, in the first part to take the history and in the second stage to discuss the diagnosis and any plans for investigation and treatment. The interviews were videotaped and these were reviewed and discussed by the group with feedback from the trainee, the patient and the group. The neurologist's contribution was to make comments about the content of the consultation (as well as benefiting from the training).

The registrars reported a significant increase in their perception of the usefulness of video teaching after the session using a visual analogue scale (68% rising to 88%) and a greater increase in their valuation of using simulated patients (51% rising to 86%). More telling perhaps were their comments at a debriefing session, which highlighted its relevance and usefulness: 'What we do every day is communication and this is actually far more our bread and butter than learning about...a whole day of Huntington's disease'; 'It wasn't actually as bad as I thought and far more useful'; 'I...thought in the real life situation when I see patients in the clinic and they go away happy I am doing a very good job. But looking at myself, I think there is a lot more scope for improvement'. Whilst the registrars recognised that they were aware of the camera they felt it not too intrusive. Interestingly, when asked about obstacles to this method, there was a resounding agreement with the comment that the most difficult task would be 'persuading our colleagues'.

Our colleagues in general practice would be unsurprised by our experience and may wonder why it is worthy of comment, as for them this is now entrenched in their culture. The debate in general practice has moved on, addressing issues such as the relative merits of using real consultations or surgeries, made up of simulated patients, for assessment⁶. In specialist medicine we need to start exploring how we should be training our registrars in communication and consultation skills. The use of video consultations with simulated or real patients would seem to be an essential part of this. Perhaps at the same time we should consider how to evaluate competence in these areas.

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NEW TITLE

Assessment and Appraisal of doctors in training

Principles and Practice

Edited by George Cowan

All doctors in training after full registration are now required to be *assessed* regularly against criteria devised by their respective specialties and based on the qualities of a doctor as set out by the General Medical Council in *Good Medical Practice*. This assessment is usually conducted by a consultant who is in overall charge of the training of the junior doctor – with external input when necessary. However, fair and open judgements cannot be made without the support of a framework of *appraisal* of doctors in training by their trainers. Both trainees and trainers require to be educated in the correct methods of conducting these processes.

The Royal College of Physicians will shortly publish a new generic Curriculum for Senior House Officers in medical specialties and an Appraisal and Education Record to support it. The curricula for higher specialist training in all medical specialties are also being rewritten within a framework designed to enhance the rigour of the assessment of specialist registrars.

It is therefore timely that this book should appear to support these initiatives. The authors, who are experts in both the theory and practice of assessment and appraisal, give clear insight and concise guidance into the processes involved. This short book provides a valuable resource for consultants in all specialties involved in the training of junior doctors and will be equally helpful for specialist registrars who are preparing for their consultant responsibilities.

Contents – Appraisal and assessment: definitions *by George Cowan* ■ Principles of good practice in appraisal *by Edward Rosen* ■ Educational appraisal: process and practice *by Maurice Greenberg* ■ Appraisal as part of the training experience: perceptions of trainees *by Elizabeth Paice* ■ Principles of assessment of doctors in training *by George Cowan* ■ Record of in-training assessment: review in practice in the medical specialties *by Peter Mills and Isobel Williams* ■ Appendix – Specialist Training Authority requirements for the supervision of trainees



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