

# Attitudes and perceptions of rheumatologists regarding consultation skills training for specialist trainees: a qualitative study

Ravinder S Sandhu, Bie Nio Ong, Vincent Cooper and Andrew B Hassell

**ABSTRACT** – Within rheumatology specialty training, direct observation and formal assessment of consultation skills rarely occur. This study explored the attitudes and perceptions of rheumatology specialist registrars (SpRs) and consultants regarding consultation skills training and potential barriers to its successful implementation in the context of specialist training. Semi-structured interviews with rheumatology consultants and focus groups with rheumatology SpRs were conducted in four UK deanery regions. All participants value consultation skills training and believe it requires observation of trainees consulting. The skills of consultant trainers in providing feedback on consulting skills are sometimes sub-optimal. Direct, real time observation of trainees is difficult and happens infrequently. Recording consultations is a potentially attractive alternative. Important issues regarding the successful implementation of videotaped consultations include time constraints, consistency in the assessment of consultation skills, and expertise in providing constructive feedback that is individualised and tailored to the trainee’s learning needs.

**KEY WORDS:** assessment, communication, consultation, education, videotape

## Introduction

Highly developed consultation skills are essential for rheumatologists. Competence in consultation incorporates the complex interaction of specific skills including not only communication skills, but also knowledge, problem solving and physical examination skills.<sup>1</sup> Communication and consultation skills are now taught widely in UK medical schools and are core abilities required by the General Medical Council.<sup>2</sup>

There are strong arguments for continuing consultation skills training and assessment at a postgraduate level in rheumatology

and in other specialties. Effective consultations within rheumatology depend upon the integration of skills and knowledge developed during postgraduate training. The consultation is the bedrock of practice in medicine. Yet often the development of consultation skills in higher medical training is taken for granted rather than consciously fostered. Moreover, studies have demonstrated that communication skills acquired by undergraduates decline soon after training.<sup>3</sup> Clinical experience alone has been shown not to correlate with communication skills proficiency.<sup>4</sup>

Historically, as with other medical subspecialties, there has been no culture of direct observation of consultation skills within rheumatology. The mini-Clinical Evaluation Exercise (mini-CEX) is one step towards direct observation of practice.<sup>5,6</sup> However, direct observation involves both the consultant and the trainee doctor seeing one patient at the same time, which can slow the running of often oversubscribed clinics. This can have a negative impact on service delivery and on the timeliness of feedback.

The use of videotaped consultations is an integral part of both training and assessment of general practice (GP) trainees in the UK.<sup>7</sup> There is evidence that assessment of videotaped consultation skills is reliable and valid.<sup>8</sup> However, little is known about the acceptability or feasibility of such assessments in hospital specialist training.

Given the relative paucity of consultation skills training in rheumatology, the objective of this study was to explore the attitudes to consultation skills training of rheumatology trainees and their consultant trainers in four different UK deaneries. At the same time, participants’ views on the potential for videotaped consultations in this context were explored.

## Methods

### Research method

Focus groups were held with rheumatology SpRs in four UK regions: the West Midlands, North West, Yorkshire and Northern.<sup>9</sup> Consultants participated in individual semi-structured interviews. Focus groups were not considered feasible because of logistical considerations.

### Recruitment

An invitation letter and an information sheet were emailed to all rheumatology SpRs in a region via a local collaborating rheumatologist. A reminder email was sent out two weeks after the original email. Focus groups took place on SpR regional training in order to maximise recruitment.

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Ravinder S Sandhu,<sup>1,4</sup> consultant rheumatologist and educational research fellow; Bie Nio Ong,<sup>1</sup> professor of health services research; Vincent Cooper,<sup>1</sup> general practitioner and senior lecturer; Andrew B Hassell,<sup>2,3</sup> consultant rheumatologist and director of undergraduate studies

<sup>1</sup>Arthritis Research Campaign National Primary Care Centre, Primary Care Sciences, Keele University, Staffordshire; <sup>2</sup>Staffordshire Rheumatology Centre, Haywood Hospital, Stoke-on-Trent, Staffordshire; <sup>3</sup>School of Medicine, Keele University, Staffordshire; <sup>4</sup>Dudley Group of Hospitals NHS Foundation Trust, Dudley, West Midlands

**Table 1. Participant demographic data for specialist registrar (SpR) focus groups.**

	Number of SpRs	Male:Female	Undergraduate medical training outside the UK	English as first spoken language	Seniority range (years)
West Midlands	5	3:2	2	3	1–3
North West	6	1:5	1	5	3–5
Northern	7	5:2	1	5	1–5
Yorkshire	6	2:4	0	6	1–5
Total	24	11:13	4	19	1–5

Consultant participants were invited to participate by email. A purposive sample of one senior (>10 years' experience) and one junior (<5 years' experience) consultant was selected for interview in each region. Selection was after discussion with the local collaborating physician. Multi-centre Research Ethics Committee (MREC) approval was given for the study.

### Data collection

One focus group and two consultant interviews were conducted in each of the four regions. All focus groups and individual interviews were semi-structured, facilitated by one investigator (RSS), audio-taped and transcribed verbatim. Participants were asked to describe their experiences in consultation skills training and assessment throughout their career, beginning from medical school. Consultants were also asked about their experience in teaching and assessing the consultation skills of their trainees. All participants were asked about the need for consultation skills training in the context of specialist training. The acceptability of videotaping consultations in rheumatology outpatient clinics was also explored.

### Data analysis

Audiotapes were listened to following the interviews (both focus groups and individual interviews) and prior to further interviews. In subsequent interviews, the researcher was therefore able to explore any new themes that had arisen and thus provide richer interpretive data. The verbatim transcripts served as the raw data to be analysed and thematic analysis was used.<sup>10</sup> Coding was carried out with the aid of N-vivo (version 2) data management software.<sup>11</sup> The analysis and corresponding raw data were then presented to the co-authors of this study who gave their input into the interpretation of themes. This provided further development of the analysis and conceptual arguments. An independent, experienced qualitative researcher unconnected with the study coded one of the focus group transcripts. This exercise revealed a close agreement between coders.

## Results

### Participants

Participant data for the SpR focus groups and consultant interviews are illustrated in Tables 1 and 2 respectively. Participants

are referred to using the coding scheme: 'Con' consultant, 'SpR' specialist registrar, followed by an assigned identity number.

### Participants' experience of consultation skills training

Three of the 24 SpRs and two senior consultants did not recall any consultation skills training at medical school. Both consultants qualified in the 1970s. Two of the three SpRs had trained in India. The remaining SpR was in the final year of training. For those who received it, general practice training had provided the only systematic communication skills teaching. None of the consultants recalled having any postgraduate training or assessment in communication or consultation skills. Consultants recalled emphasis on other aspects of medical training:

*I don't think there was much emphasis on communication. I think the emphasis was more on your knowledge, attaining knowledge and applying your knowledge and learning to be a doctor, a good doctor, so by knowing your stuff, you were a good doctor. (Con 3)*

In the postgraduate setting, both rheumatology consultants and SpRs felt that they had developed their consultation skills by observation of colleagues and modelling aspects of their behaviour. All participants agreed that formal consultation skills training is not currently taking place.

All participants discussed the introduction of the mini-CEX as a method of observation and assessment of SpRs in the consultation. Consultants on the whole viewed it as useful but had concerns about it being resource intensive and difficult to manage

**Table 2. Participant data for consultant interviews.**

	Consultant	Gender	Seniority (years)
West Midlands	1	F	4
	2	M	26
North West	3	F	2
	4	M	10
Northern	5	F	5
	6	M	19
Yorkshire	7	M	3
	8	M	10

within a busy clinical service. They also had concerns about how accurately they were assessing the true performance of their SpRs:

*You know, you've got to try and concentrate. They (the SpR) are trying to be on their best behaviour and slightly intimidated by your presence. The patient, especially if it was your patient, you wouldn't know, they might be turning to you and all these sort of things that you might influence. (Con 6)*

For their part, SpRs felt that consultants had little time to provide constructive feedback during the mini-CEX as it often took place in the middle of a busy clinic. SpRs perceived variation in the quality of the feedback from different consultants.

### **The perceived need for consultation skills training in the context of higher medical training**

All consultants reported that SpRs were rarely observed in consultation and a more objective assessment of their consultation skills was required. Three of the eight consultants (two junior and one senior) debated the need for further consultation skills training at SpR level, because they perceived the majority of SpRs to be consulting to an acceptable standard:

*I'm not sure (about need for training). You would hope that they would have had the training earlier on in the career. You'd hope that by the time they got to SpR level, that their consultation skills are good, or honed. So, I seem to be making quite a lot of assumptions there really...I suppose we should really assess what consultation skills are like in our SpRs and if they are not good, then there is a need for training. (Con 1)*

Five of the eight consultants did feel the need for structured training specifically at SpR level. Reasons given included shorter training periods for SpRs and a reduction in working hours both of which, it was felt, jeopardised consultation skills development in an apprenticeship model of learning.

All SpRs considered that there is a need for more structured training in consultation skills within higher medical training. They reported the desire to develop both communication and other (eg problem solving and time management) consultation skills. They felt that they are rarely observed in consultation and expressed some doubts about self-assessment of their performance:

*If you go through the entire lot of your training thinking that you're doing a job well and in actual fact you're doing it abysmally and there's no-one around to point it out because no-one's ever watched you. (SpR 1a)*

Observation and feedback on consultation skills were considered important. SpRs reported that they had poor access to consultants in the outpatient clinics because of the demands placed on them by medical students and more junior colleagues.

### **Priorities in implementing consultation skills training within higher medical training**

Protected time was considered an essential element to the successful implementation of training. This issue was raised in all

focus groups and interviews. Time would be required in order to observe SpRs in consultation and provide good quality feedback. SpRs felt that consultation skills training should be individualised in order to address their learning needs. In this context, they believed that it was important to have a rheumatologist experienced in giving feedback.

All consultants felt confident in their ability to provide feedback in a formative setting. This was despite having little formal consultation skills training themselves. Some of the consultants felt that they were better suited to provide feedback than other communication/consultation skills teachers who were 'non-rheumatologists':

*Yeah, I wouldn't trust an educationalist... You know, there would be some dogma that went with it, that just wouldn't function and, you know, they [SpRs] need to be assessed by people who know what the consultation is about because I think I now understand pretty well what I'm doing in clinic. (Con 6)*

SpRs perceived a lack of consensus on what constitutes a 'good consultation'. Consultants' feedback emphasised aspects of the consultation that differed from the SpRs' expectations. This impacted on the acceptability of the feedback provided:

*But then it was ironic...I was explaining this to the patient and I was asking her 'what do you think is wrong and what's your opinion of the disease', and doing all these nice things and I got heavily criticised for resorting to generic communication things and not being more medical and rheumatological about it. (SpR 2a)*

In addition to the content of the feedback, the process by which it is delivered was also considered important. It was evident from the SpR comments that a hierarchical relationship exists between themselves and their consultant colleagues. SpRs therefore felt that the feedback they received was not always a two-way process:

*But then I know better to disagree with [the consultant] who is assessing you, do you know what I mean? So I felt that [the feedback] was interesting but I would like to have taken that further. But I didn't really get the chance. It's like, 'Here's your bit of paper, I'm going now'. (SpR 3d)*

Both consultants and SpRs believed it was important to give balanced and constructive feedback.

### **Attitudes to videotaped consultations in the workplace**

When questioned about the use of videotaped consultations with real patients in the workplace, SpRs perceived this method of training to have potential although they were apprehensive about personal involvement and felt it should be confined to formative assessment. Practical challenges were identified, including the availability of recording equipment, clear guidance on obtaining patient consent and storage of videotapes.

Seven of the eight consultants favoured videotaping consultations, believing it to be more practical and effective than direct observation:

*I think that a great motivator for change is to see yourself do it. Mini-CEX doesn't allow you to do that, you just hear what somebody thinks and to be honest, I don't think that's as persuasive as you seeing yourself.* (Con 4)

Most of the consultants felt videotaping consultations enabled more efficient use of time by avoiding the need for them to sit on their trainee's consultations. Both consultants and SpRs believed that acceptability of videotape would be enhanced by provision of objective evidence of its efficacy in comparison with other methods of learning consultation skills. Both groups also perceived a changing attitude to postgraduate training and assessment in that structured training and objective assessment have become the requisite.

## Discussion

This study identifies an evolving culture among rheumatology trainers and trainees regarding consultation skills training and assessment. There is a growing perception of a need to observe trainee rheumatologists consulting in order to provide constructive, robust feedback. Videotaped consultations are felt to offer potential in this context although a number of challenges to their successful implementation in rheumatology training were identified.

The study highlights the variable experience of trainee doctors in consultation skills training, also noted in other studies.<sup>12</sup> Most SpRs who had not received structured training as undergraduates, trained abroad. It cannot be assumed that all trainees have had training in consultation skills before entering specialist training.<sup>13</sup>

There is considerable evidence that consultation skills training is effective at modifying doctors' behaviour and that postgraduate doctors retain these skills post-training and develop them further with time.<sup>14,15</sup> Despite this, in contrast with general practice, there is little consultation skills training in rheumatology specialist training or, indeed, in the other medical specialties.<sup>16</sup> A review of the literature shows that, in the secondary care setting, consultation skills training has been embraced by oncology but by few other specialties.<sup>17</sup> It could be argued that there is little evidence to suggest poor performance in consultation skills of physicians and SpRs. However, consultations are rarely observed. Studies suggest that many patient complaints are a result of poor communication.<sup>18</sup> Moreover, evidence indicates that most clinicians can benefit from consultation skills development.<sup>14</sup>

Both consultants and SpRs expressed concerns regarding the effectiveness of the mini-CEX, in which assessors make global judgements in a number of areas that define clinical competence. A major shortcoming identified by all is that it is often not given the time required because of pressures of service delivery. Additionally, the scoring of a mini-CEX is against broad areas, which can pose difficulties in providing feedback in an area in which the consultants may have had little formal training themselves.<sup>19</sup>

Our results show that SpRs and consultants frequently had different ideas about the important aspects of the consultation, as

reported by Buyck and Lang.<sup>20</sup> Poorly standardised and unreliable feedback can have a negative impact on learning and influence trainees' attitudes to the usefulness of such training and assessment. It is interesting that, whereas consultant participants felt confident in their ability to provide feedback on consultations, trainees perceived this to be a specific skill not possessed by all rheumatologists. Howells, Davis and Silverman outline the fundamental principles of feedback, including clarity of purpose, allowing self-assessment of the consultation by the learner first, being behaviour specific rather than judgemental, being concise and balancing reinforcing statements with corrective ones.<sup>21</sup>

In conclusion, consultation skills training is deemed important by rheumatology SpRs and consultants. It is felt to be most effective when it involves direct observation of practice, and this is supported by the literature. Currently, such training happens infrequently. The use of videotape is viewed as having potential as a pragmatic way to observe and provide feedback upon consultations in the context of a busy clinical environment. Areas of future research include the characterisation of those consultation skills which are key in the context of rheumatology specialist training and the development of simple tools for facilitating effective provision of feedback on consultation skills.

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**Address for correspondence: Dr RS Sandhu,  
Dudley Group of Hospitals NHS Foundation Trust,  
Russell's Hall Hospital, Dudley, West Midlands DY1 2HQ.  
Email: [rav@doctors.org.uk](mailto:rav@doctors.org.uk)**