letters to the editor

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Consultation skills training for specialist trainees (1)

Editor – I was pleased to see a further contribution to research into attitudes about workplace-based assessment. Sandhu *et al* (*Clin Med* February 2010 pp 8–12) obtained the views of consultant and trainee rheumatologists concerning the mini-Clinical Evaluation Exercise (mini-CEX) and some related issues. Their results echo those of previous studies, indicating that trainees value the assessment for its formative potential (but do not always feel that the feedback process is optimal) and that time factors are perceived by all parties as a major barrier.[1–4]

Sandhu *et al* also consider video recording. Interestingly, in my own study, only two out of 138 respondents suggested videotaping consultations or surgical procedures.[4] Though this issue was not the primary focus, this suggests that the idea does not carry overwhelming enthusiasm among dermatology trainees. Sandhu *et al* conclude that the method has potential but that it carries certain challenges. The obvious benefit is that trainers can review the recording when not time pressured. The trainee would no longer have to coordinate a time for the consultation with their consultant (but they would still have to meet for feedback). Reliability of the assessment can be improved by having more than one assessor, rarely an option in mini-CEX. However, disadvantages may go deeper than the logistical problems of acquiring, setting up and using the recording and playback equipment. As with direct observation, validity might still be reduced by the 'audience effect': both trainees and patients could be influenced by an awareness of being recorded.[5] Patient preferences are likely to restrict the selection of consultations available to be recorded.[6] For example, patients who are embarrassed by their medical problem seem more likely to refuse to be recorded, though this type of potentially difficult consultation may be of most use in assessing the trainee. The loss of such cases may impact on the validity of the assessment. Patients who, despite misgivings, agree to be recorded may avoid full discussion of their problems, leading to a detrimental impact on their quality of care.[6] Sandhu *et al* mention the issue of consenting patients for recording, which leads to a further drain on time.

It seems likely that workplace-based assessment by direct observation is here to stay. It is incumbent on both trainers and trainees to make the process as smooth and constructive as possible. Trainers must become adequately skilled in giving feedback.

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Consultation skills training for specialist trainees (2)

Editor – The study on attitudes and perceptions of rheumatologists regarding consultation skills raised important points (*Clin Med* February 2010 pp 8–12). Standardised approaches to assessment would help maintain both trainee and trainer acceptability and reliability. However, this must require training from both sides. Thus, it would be interesting to note if a larger survey would still show all consultants feeling confident to provide feedback irrespective of levels of formal training in consultation skills.

Videotaped consultations can sometimes be just as intimidating as directly observed consultations.[1] They do, however, provide opportunities for self-observation and re-evaluation in cases of controversial feedback. Using several consultations for assessments and opportunities to view simulated consultations for training purposes can help increase trainee confidence and reduce apprehension.[2] I agree, however, that there is still a need for directly observed training as consultation skills are developed in various settings including ward areas where videotaping may be more difficult.

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