C) Introduction for Clinical Skills Assessment candidates and other GP registrars

I'm going to take you through the 6 reasons that you will pass the Clinical Skills Assessment after using this course. The 6 reasons are:

1. Shared surgeries
2. Flexible structure
3. Doing 10 minute consultations
4. Getting used to others watching your consultations
5. An arsenal of common and important presentations
6. Effective shared decision-making

I'm not sure how many of you are Monty Python fans, but here goes anyway…..
Our *three* main weapons are: shared surgeries; a flexible structure; doing consultations in 10 minutes; and getting used to others watching your consultations. Or was that *four* main weapons….?
And then of course we have an arsenal of common and important presentations.
Not to mention effective shared decision making.
As I said before: we have 6 weapons to get you through your Clinical Skills Exam.

Our publication uses all of the above weapons to promote an effective consultation style, a style that communicates effectively with patients, and will get you through the Clinical Skills Assessment.

First weapon: Shared surgeries
When I do a shared surgery, I start by doing the first consultation. My registrar observes me and records the consultation on the computer. For the next consultation we swap places. I only intervene if I feel I have something important to add to the consultation. The surgeries are booked at 10 minute intervals and we usually have 2 catch up slots per hour.
Shared surgeries allow you to listen to, and watch, your trainer, and to acquire her or his consultation skills and knowledge. You then, immediately, apply some of those new skills, when you see the next patient, under your trainer's supervision.
This publication also gives you real audio consultations to listen to. This is the other half of what you do in a shared surgery. The cases are similar to those that you might encounter in the Clinical Skills Assessment.

Second weapon: A flexible structure
The audio consultations demonstrate how experienced GPs go with the flow, yet ensure that they stick to the structure. Osmotic learning moves you towards more effective use of the flexible structure, that facilitates good communication and allows exam success. Print out the scripts in our CSA scenarios and colour in the areas between the [brackets] to demonstrate how flexible you might be in covering all of the areas in the map of the consultation headings. Soon it will become second nature that you can include each key area in your consultations without appearing overly formulaic.

Third weapon: Doing 10 minute consultations
Many of my consultations are longer than 10 minutes and many are shorter than 10 minutes. Don't worry too much if you can't always finish a consultation in the exam within 10 minutes. However, it *is* important for you to demonstrate good communication skills and use of structure. Your examiners want to be satisfied that they could trust you to work in their practice, independently. Part of that means that your consultations are not over-long, and demonstrate good communication skills and evidence based practice. Taking part in role-

play Clinical Skills Assessment groups teaches you how to work towards having an effective tempo and style.
This helps you to consult more effectively. Listening to an experienced GP consulting, up-tempo, can help you to improve your skills. Agenda setting is a crucial part of your time management within the consultation. Your surgeries should be set with a 10 minute booking interval, as early as possible in your training. This allows you to get used to working towards this goal. Of course: catch up slots will be vital, and can be numerous, at least in the first instance.

Fourth weapon: Getting used to others watching your consultations
It's an alien feeling for many: being observed in the CSA exam. The presence of an examiner can be quite unsettling. Unfamiliarity can lead to anxiety and this can make the CSA exam more stressful. It's a good idea to get used to the feeling of having somebody watching you as you consult. The best way to do this is to have shared surgeries with your trainer. But also recording your consultations with a video recorder, or even an audio recorder, with the potential for later playback with your trainer, will make you used to the feeling of being watched. This can be a helpful advantage.
Our role play scenarios, acted out in you own Clinical Skills Assessment groups, offer you the opportunity to be watched consulting by your peers (and potential also by your trainer). After role-playing the scenarios, you can listen to an effective version of the real consultation. Your study group, with or without a trainer's support, can provide you with constructive feedback to allow you to rehearse new techniques and to add knowledge.

Fifth weapon: An arsenal of common and important presentations
Learning the art of general practice benefits from the apprenticeship approach. Not just that, we need to learn from the outset; how to divine for our patients' ideas concerns and expectations, skillfully. We need to be able to structure our consultations to make them safe and to make the communication effective. We also need to be up-to-date.

Like any skill, general practice is best learnt under expert supervision. The sort of patients that we see in our consulting rooms every day are ideal for you to learn your art on. The more that you can learn from other peoples' consultations, the better. This course gives you a collection of some of the common and important presentations typically encountered in general practice. These real consultations show you how consultations can be done. I'm very grateful to all of the patients who have allowed me to share these consultations with you so that the skills of future and current GPs can be improved. I have attempted to preserve their anonymity to a degree but have their consent in sharing this information with you.

I recommend that GP registrars seek out experienced GP colleagues and trainers to share surgeries with them. Experienced GPs also benefit enormously from these shared surgeries, because new blood brings in enthusiasm, knowledge and skills that will teach them plenty too.

Sixth weapon: Effective shared decision-making
Much of effective shared decision making occurs as a result of really listening to what your patients say when you explore their ideas, concerns and expectations. I would thoroughly recommend that you explore the shared decision-making tools available on patient.info (patient.info/doctor/decision-aids).
Truly involving patients in making decisions for themselves, involves providing them with enough information regarding the viable options, and guiding them, skilfully, through making an informed decision. For simple decisions you will often be expected to make a pragmatic compromise. You should share with them information about the options that they are likely to prefer, and those that may be most effective for them. Our audio recordings seek to give you practical insight into how this shared management is conducted. Your trainer's supervision in this is likely to be invaluable. Follow the swings and roundabouts icon link:

to listen to some of the more complex decisions faced by our patients. I suggest that you signpost patients to relevant audio decision aids prior to reviewing them to further support them in making an informed decision that suits them.

The audio component of this publication is particularly accessible to busy GPs. We all struggle to prioritise and negotiate what is reasonable to fit into a 10-minute appointment. The audios will help you, as a busy GP, to absorb new skills and knowledge by osmosis. You will, in effect, be joining me, in my consulting room, perhaps on your way to work.

When you see your first patient; you will be able to negotiate a realistic agenda and *achieve a satisfactory consultation within 10 minutes.* With the Calgary Cambridge consulting skills that you have assimilated, each patient will be an exciting challenge, rather than a random mass of confusing symptoms and social problems. You will skillfully touch on what the patient knows, what the patient is worried about and what the patient wants. You will rule out the nasties with a quick-fire series of red flag questions that link to the possible pathologies. You will even touch on the important aspects of your patient's lifestyle that are affected by, or might link to, the illness.

You will be able to empathise with your second patient's difficulties. There is often a morass of social and emotional issues that could easily overwhelm a busy GP. ***Touch*** on what is important, and how they might go about getting support, and ***go*** on with the rest of the consultation. The rest of the consultation being: the things that you as a GP are best trained to deal with. GPs don't need to be overly burdened with complex social and emotional problems. Understanding that they are there is often sufficient. Don't expect to solve these problems in this 10 minute slot. Consider signposting your patient to help from others.

When you see your third patient - on time - you, and your patient, will be more positive. You will focus on asking questions that are relevant and examining aspects that will help you to make an effective working diagnosis. The problem becomes clear to you and to your patient. And you check that you and your patient understand each other. Your suggestions of management options, and your explanations, will be better targeted towards what your patient knows and wants. And you can either allay their fears or at least address them. Your patient will even be able to choose from personalised, evidence based, management options.

When your final patient leaves your consulting room: they will be aware of what comes next: when and how to see, or talk to you, again. And what to look out for if things get worse or haven't got better within a specified time.

I would encourage you to include shared surgeries in your Personal Development Plan. Shared surgeries with colleagues who are members of the RCGP (passed since 1995, when consulting skills were first prioritised) or with colleagues who have attended a Calgary Cambridge training course.
Another recommendation is to attend a GP update or Hot topics course annually. Of course, it's even better to read the course manual. Making notes that are accessible to you, in your consulting room, would be the icing on the cake.

Malcolm Thomas has been kind enough to speak to us about consulting skills that work. Skills that help us to keep to time. Skills that allow us to satisfy our patients and to permit us, as GPs, to feel less stressed and more confident that we have dealt, more effectively, with our patient's problems. His Calgary Cambridge micro skills explanations give you realistic

tools that you can either add to your repertoire or refine to fit with your own consulting room style.

Chris Marr can be thought of as our headmaster. Chris was an RCGP examiner and a Clinical Skills Assessment skills trainer. He wants us to stay organised. His map of the consultation will make sure that you don't lose your way or miss vital clues in your 10-minute maze. We have adapted his map and I recommend the Lands End to John O'Groats, or LEJOG, map of the consultation to you. The LEJOG map will keep you organised but allow you to be flexible and natural.
Malcolm Thomas helps us to make using the LEJOG map second nature. The map will help you to make order out of each patient's chaotic tale. Our interactive, colour-in, scripts of the CSA scenario consultations allow you to test yourself and to ensure that you understand how busy GPs structure their consultations. That structure is so important to ensure that communication is effective, in our time limited surgeries. Soon you will be able to throw away your printed map and rely on your own integrated Sat Nav system.

Dave Tomson gives us some tips on sharing decisions with patients. Our patients need guidance from us to support them to choose options that work for them. We can't help them without understanding what our patients know, fear and want. But the options aren't all as accessible as each other. It's not like choosing from a shop window. We can guide them to rational choices and tell them when the evidence is poor, for their original preference. The age of doctor centered decision making may be over.