WATCHING CONSULTATION VIDEOS

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The objectives of this chapter

- Learning a list of skills and relating them within a structure is not enough
- The suggested guidelines or set of 'rules' when watching videos with your trainer
- The different ways videos can be used to increase learning
- How to analyse problems on your videos
- Common problems that crop up in the consultation

Learning skills using experiential methods

It is not enough to simply learn skills and place them within a structure or model to help you remember them. To transfer skills and make them an enduring part of your future consulting behaviour requires a further additional step that involves the method you use whilst learning them.

New knowledge and skills become incorporated into behaviour only when you use experiential learning methods.[1] This comes from an understanding of Adult Learning theory which emphasises the need for you to try out the things you learn. This is different to previous learning methods you probably experienced during most of your school and medical student years. In short, as mature students, you respond and retain much more when presented with opportunities to get your hands 'dirty'!

The three essential ingredients are

1) The learner needs to be seen consulting (usually on videotape)
2) The learner needs to receive constructive and where necessary corrective feedback from their trainer acting as 'coach'
3) The learner needs to get opportunities to try out alternative skills and solutions, ideally in safety using role-play first and trying them out 'live' and seeing them succeed in future consultations.

Similarly, educational research confirms that new consulting skills and behaviour will only be learnt and retained if you get into regular habits of looking at video consultations and getting constructive feedback.[2]

It is important for you and your trainer to be aware that there are some possible difficulties and dangers whenever this type of experiential learning is used.

Problems watching videos

Because personal communication is closely related to your own individual concept of clinical competence as well as identity and personality, it is all too easy for you to become threatened and defensive when your communication skills come under scrutiny.

Not only are you supposed to have done this right for several years of your professional life, the longer you have been a doctor the further you 'feel you have to fall'.

Most of us have experienced the negative and often unsupportive observations that characterised hospital ward rounds, which leaves you with both unpleasant memories and a natural reluctance to expose yourself once more.

Because of these experiences and perceptions – it is important to watch consultations using a strict set of guidelines that incorporates a code of behaviour between anyone who shows a video and those that watch them. The aim is to prevent awkwardness and defensiveness that gets in the way of learning and change.

The basic guidelines suggested for watching videos with your trainer

This is a suggested method for looking at video consultations on a one-to-one basis.

Agree first whether you are going to look at the whole consultation, a specific part, or use a stop-start approach that are linked to specific aims. (see below)

Before starting the video allow your trainer watching the consultation to 'sink' themselves into your shoes by briefly outlining any important matters of fact. Any relevant information and circumstances should be divulged. This might include previously known information or contact with the patient or factors that might influence how the consultation might be affected (such as surgery being 45 minutes overdue you appearing unsettled because you had only just returned from an emergency visit etc.)

Whilst watching the video it is helpful to write down your observations using a consultation guide that helps to prompt you to consider the objectives and outcomes you are trying to achieve as you go along (a copy is included the end of this manual).

After watching the video - you should start by identifying any difficulties or problems (or successes!) you had noticed in the consultation and try and make an assessment of these. A list can be made at the top of the Consultation Analysis Log including any suggestions added by the trainer. (Again a copy is included at the end of this manual)

Break down each problem into a logical sequence to assess it objectively

Identifying where you were in the consultation when difficulties started to arise on the tape. Rewind and review this part on of the tape if necessary.

Discussing what happened descriptively in the form of a commentary WITHOUT making any judgements or evaluations about how effective it was. (see SET-GO below)

Attempt to identify what you were trying to achieve at this point and compare these with the objectives suggested in the relevant section of the consultation model.

Making suggestions as to how the problem might be approached differently along with which skills might be used to try and achieve this.

Try them out in role-play and focus particularly on the new skills used. Your trainer can offer his own observations and feedback including alternative suggestions for you to try.

Reflect on why the difficulties or problems occurred. Use the Consultation Analysis Log to record where the problem possibly originated in terms of the three broad types of

communication skills – Knowledge, Skills or Attitudes (see below - Content, Process or Perceptual difficulties)

Write down which areas need addressing and identify which skills might work better in similar situations in the future.

What other issues are important when looking at videos?

It is important to develop a trusting and supportive relationship between yourself and your trainer from the beginning. The table below outlines areas of behaviour and feedback that should to be considered.

Supportive climate	Defensive Climate
• Descriptive	• Evaluative
• Direct Observations	• Passing Judgement
• Non-judgemental assessment	• Evaluating as Good or Bad
• Reflecting opinions	• Questioning motives & standards
• Collaborative	• Control
• Mutually defining & solving problems	• Telling them what to do
• Spontaneity	• Strategy
• Straightforwardness	• Control and rigidity
• Flexible response to situations	• Manipulation through tricks or hidden plans
• Empathetic	• Neutrality
• Respect & Understanding	• Indifference
• Accepting	• Detachment
• Becoming involved with learner	• Viewing the learner as an object of study
• Equality	• Superiority
• Recognising worth & contribution of others	• Arousing feelings of inadequacy
• Work mutually together	• Communicating that one is better than the other
• Provisionalism	• Certainty
• Tentativeness	• Dogmatism
• Open-mindedness	• Resists alternatives
• Willingness to explore alternatives	• Proving a point rather than solving a problem

The importance of describing what happens descriptively

The way in which a problem is described is important. Problems need to be described objectively, specifically and accurately rather than reflecting a gut reaction or subjective feeling.

The 'SET-GO' method is a useful and descriptive way of analysing the consultation, which helps prevent unnecessary defensiveness and evaluative responses.

(After Silvermann, Kurtz & Draper)

- What did you **S**ee?
- What **E**lse did you see? (What happened next?)
- What do you **T**hink?
- What **G**oal(s) were you trying to achieve at that point in the consultation?
- Any **O**ffers how where and how to go next?

Different ways of looking at videos

There are three different ways of looking at video consultations depending on the stage and context of the training - or the objectives of the session.

1 Watching complete consultations

Sometimes it is useful to look at the whole of a video consultation – from beginning to end to get a complete feel for how things have gone. This is particularly useful when you are beginning to watch videos at the start of your GP Registrar year.

Strengths: It allows problems to be seen most easily and fully in the context of the whole consultation. Sometimes the source or origin of the problem may not be seen easily by restricting observation only to the part where the difficulties arose. (e.g. difficulty ending a consultation may at first not be seen as being due to a bad start). It is also more likely that you will become aware of additional areas in the consultation that went well to balance up areas that caused difficulties. It is especially important at the beginning of the GP Registrar year, when confidence is only just developing, for your trainer to give balanced feedback about what went well - as well as what didn't.

Weaknesses. Watching videos all the way through takes time with the result that fewer examples of consultation skills will be seen. It is also difficult to remember an accurate description of what was said or what actually occurred within a long consultation. Unless written down verbatim we rely on memory and subjective impressions that risk an evaluative rather than an objective assessment.

2 Looking at specific parts of the consultation

This is a powerful way of focussing attention on the objectives and skills of a particular part of the consultation.

Strengths: Many consultations can be seen relatively quickly and it allows you to focus on the specific aims and skills of each section. It is easier to observe descriptively what happens and to assess difficulties objectively. Role-play is less threatening and more fun since rapid short sections can be looked at and several alternative skills and micro-skills can be tried out quickly as alternatives.

Weaknesses. Focusing on a selected area of the consultation can provoke defensiveness in some of us. If the same difficulties occur repeatedly in many videos there is a danger of the deficiencies becoming 'rubbed in'. It is important to balance problems equally with success within each section if possible. Alternatively the use of 'prepared' tapes that highlight specific problems or using your trainer's own consultations as good or bad examples can help lessen the effect of continually focusing on the weaknesses of the GP Registrar.

Finally, sometimes the source or origin of the problem may not be easily seen without seeing the whole consultation. (See watching complete consultations above).

3 Stop - Start methods of looking at the consultation

This is a good way of looking at the whole or perhaps large parts of the consultation without some of its weaknesses. Either an agreement is made to stop the tape after two or three minutes – irrespective of where it has got to – or you can hold and control the pause button and stop it where you see something interesting and worth looking at.

Strengths: The whole consultation can be seen if needed. Breaking it up into time intervals is a good way of looking at problems that may arise. Again it allows you to focus on the specific skills of each section whilst observing them descriptively and objectively. Again, role-play is less threatening and fun since rapid short sections can be looked at and several alternative skills and their associated micro-skills can be tried out quickly as alternatives.

Weaknesses. Watching the whole video like this can take a very long time. It can also provoke defensiveness if only problems and difficulties are focussed on. This is partly prevented if you have overall control over the stop-start sequence.

Analysing your video using the three types of communication skills

There are three broad types of communication skills, which run in parallel during the consultation. The success of the consultation depends on all three being addressed adequately.[3]

Content Skills

This is the clinical knowledge learnt and used by doctors. It is the information they gather when taking a history and the knowledge they give during treatment and giving explanations to patients.

Process Skills

This is how knowledge is communicated with patients as well as how doctors go about discovering information from the patient. It involves both the verbal and non-verbal skills they use to do this including rapport-building skills to develop relationships with patients. It is also how well doctors organise and structure communication. Traditionally, process skills are thought of as 'communication skills' proper - which is the main focus for a course such as this.

Perceptual Skills

This constitutes what doctors think and the emotions felt by them during the process of problem solving and clinical reasoning. Perceptual skills are influenced by feelings and thoughts about the patient and about how doctors view the illnesses they see. It also involves issues about doctors' own self-confidence, biases, and attitudes - and their day-to-day stresses and personal distractions. Perceptual skills therefore are often referred to as being 'Attitudinal'.

How they relate to each other

Consultations will go wrong when there are one or more weaknesses within each of these three broad types of communication. They are interrelated and reliant on each other.

There is little point you having first class knowledge (content skills) if you can't find out why patients come to see you. Equally, if you can't communicate a plan of action that can be clearly understood by the patient (communication or process skills) then all your hard work and knowledge will be wasted.
Irritation with a patient's personality (attitudinal or perceptual skills) will make you blind as a doctor to important non-verbal cues (communication or process skills) just as physical attraction to a patient (attitudinal or perceptual skills) might prevent you from asking sensitive questions about sexual matters (knowledge or content skills) that are vital in making a diagnosis.
It is therefore useful when looking at videos to try and categorise whether a problem is related to one or more areas of clinical knowledge, communication skills or attitudinal origins.

Common consultation Problems

It is useful at this stage to mention a number of common recurring problems that appear repeatedly in consultations.

Content

1) The doctor does not take an accurate clinical history
2) The doctor does no elicit the patient's illness framework and takes a doctor-centred approach throughout the consultation

Process

1) The doctor doesn't listen and interrupts with early closed questions
2) The doctor doesn't discover why the patient has come or feels he hasn't understood his agenda
3) Problems of structuring information and controlling the consultation; the patient talks all the time; the doctor has difficulty bringing the consultation to an end
4) The consultation appears aimless, long-winded and the doctor appears to get lost

Perceptual

1) The doctor does not like the patient
2) The doctor shows little empathetic skills or rapport building skills
3) The doctor makes erroneous assumptions about or during the consultation
4) There is conflict (usually about management) during the interview
5) You and your trainer may find this list useful to refer to when problems arise without clear explanations. Hopefully they may direct you to cause(s) and skills that resolve them.

[1] Knowles MS: (1984) The Adult Learner – a neglected species. Gulf, Houston, Texas.
[2] Maguire et al (1978) The value of feedback in teaching interviewing skills to medical students. Psychological med. (8) 695-704.
[3] Kurtz, Silvermann & Draper (1988) Teaching & learning communication skills in medicine (1) 18-19