

# **Managing Uncertainty**

**General Practice is the Art of Managing Uncertainty**

### Aims

Create the new group  
Deepen participants understanding of the consultation  
Feel more confident Managing Uncertainty  
Plan the content of the term

### Objectives

By the end of the residential each participant will  
Have explored the doctor patient relationship  
Used one model of the consultation  
Planned their session for the half day release  
Explored some principles to help in their management of uncertainty

### Day 1

**9.00** Coffee/ tea  
Guess Who I am ?  
**9.30** Introductory Session 1  
Sign Post  
House keeping  
Group Rules  
Sharing of items brought of significance  
**11.00** Coffee/ Tea  
**11.30** Session 2 Alison  
Models of the consultation  
**13.00** Lunch and see Reps  
**14.00** Walk  
**15.30** Tea  
**16.00** Session 3 Managing Uncertainty Fi  
**18.00** End of session  
**19.00** Managing Uncertainty Quiz organised by Ben  
**20.00** Dinner

### Day 2

Sudoku - Alison  
**9.00** Session 1 Ben  
Difficult Consultations and Complaints  
**10.30** Coffee  
**11.00** Balint Groups  
**12.30** Walk  
**13.00** Lunch  
**14.00** Planning the term Alison  
**15.30** Tea  
**15.45** Team Quiz Fi  
**16.45** Evaluation and Close

### **Consultation models exercise.**

- Divide group into four small groups.
- Each group is going to role play the same basic consultation, but using a different consultation model.
- There needs to be a patient, a doctor and a narrator nominated in each group. Other group members will be needed for feedback at the end.
- The doctor and patient will act out the consultation according to their consultation model. The narrator will stop the consultation at appropriate times to point out to the audience the different stages of the consultation model being used.
- At the end of the consultation, the other members of the group will point out the advantages and disadvantages of their particular consultation model in this consultation.

The aim is to highlight the differences between the various consultation models, not to focus on the medical details of the consultation.

**Basic consultation outline.** (other information can be added as necessary by each group as required by their consultation model)

- 30 year old woman
- presents with recurrent headaches
- no red flags or worrying symptoms, nothing to find on examination
- sound like classical tension headaches
- lives with partner and 2 children
- works part-time as a receptionist
- financial worries and debts, partner's job not secure
- smokes 20cpd, drinks alcohol occasionally
- otherwise fit and well, slightly overweight, no regular exercise
- IUD for contraception
- mother has a history of hypertension and father has NIDDM

### **Consultation models to use:**

1. Pendleton
2. Murtagh
3. Helman
4. Stott and Davies

## **Consultation models.**

The traditional medical model is concerned with diseases and diagnoses. This is what we are often trained to follow and feel most comfortable with. With a scientific approach, every illness is caused by a disease with a definable cause. With a holistic approach, problems have a physical, a psychological and a social component which must all be considered. This approach was first described by Hippocrates.

Ivan Illich talked about the 'medicalization of health'. If patients believe an illness is due to a disease with an external cause, then they are not responsible for their own health, the doctor is. However, all problems have psychological and social components which the patient is responsible for.

There are many different consultation models. Their aim is largely to teach and refine consultation skills. Different models will be more appropriate in different situations and individuals will relate better to different models depending on their own personal style of consulting. It is not that there is a 'right and wrong' way to go about a consultation, but sometimes we may slip into a routine and forget certain areas if we do not consciously try to work on them.

Our consulting styles will be different for different individuals and will also evolve over time. We may, at times, use element of different models during a single consultation, or stick to a single model throughout. It is often useful to try out different models to get a feel for them and to ensure you are not consistently missing areas of the consultation.

Here is a brief look at just a few of the consultation models that are out there. We will use four of them in an exercise, but the others are there for reference and trying out. There are plenty more consultation models out there and you may find another one that you prefer to use.

### **1. Stott and Davis model.**

This is a task orientated model. It's advantage is that it includes health promotion and prevention, but the disadvantage is that it has little psychodynamic content. It has four elements, although it has been suggested that a fifth element of administration should be added.

The four components are:

- management of the presenting problem
- modification of help-seeking behaviour
- management of continuing problem
- opportunistic health promotion

### **2. Byrne and Long's model.**

This is a mechanistic model that was derived from the analysis of many consultations. Overall it is quite a limited and basic model.

Phase 1: the doctor establishes a relationship with the patient

Phase 2: the doctor attempts to discover the reason for the consultation

Phase 3: the doctor conducts a verbal and/or physical examination

Phase 4: the doctor, or the doctor and patient, or the patient consider the problem

Phase 5: the doctor, and occasionally the patient, discuss management

Phase 6: the consultation is terminated

### **3. Pendleton *et al*'s model.**

This combines a structural element with a psychodynamic element and forms the basis of many consultation maps.

**-Define reason for attendance:** -nature and history of problems

-their aetiology

-the patient's ideas, concerns and expectations

-the effects of the problem

**-Consider other problems:** -continuing problems

-at-risk factors

**-With the patient,** choose an appropriate action for each problem

-Achieve a shared understanding of the problems **with the patient**

**-Involve** the patient in the management plan and encourage them to accept appropriate responsibility for it

-Use time and resources appropriately in the consultation and in the long term

- Establish/maintain the appropriate relationship with the patient which helps to achieve other tasks

### **4. Helman's model.**

This model is based on the concept of health beliefs. People's interest in their health and the degree to which they are motivated to do change vary enormously. This is known as **health motivation**. People also think very differently about how likely they are to be affected by a specific health problem. This is their **perceived vulnerability**. Patients vary in how dire they believe the consequences of contracting a particular illness would be and what would happen if it were left untreated. This is the **perceived seriousness**. Patients will weigh up the advantages and disadvantages of a course of action i.e. the **perceived costs and benefits**. Patients beliefs are prompted/created by a number of stimuli and triggers e.g. symptoms, other people, the media etc. These are known as **cues to action**.

Social factors are behaviours and beliefs shared by members of a group e.g. doctors and patients. They can be classed as norms and values. **Values** are shared beliefs at an abstract level e.g. truth, honesty. **Norms** are more concrete ways of thinking and behaving. They are often learnt from other group members and are maintained over time. Social factors affect illness and presentation and also the doctor's approach to it.

This is an anthropological model. It is useful for gaining an insight into the patient's agenda. It is a series of questions which a patient may ask themselves and allows the doctor to put themselves 'in the patient's shoes' and look at the consultation from their perspective.

- What has happened?
- Why has it happened? Why me? Why now?
- What would happen if I did nothing about it?
- What can you (the doctor) do about it?
- How can I stop it happening again?

## **5. Heron's six-category intervention analysis.**

This model describes the range of intervention available to the doctor. It can be useful if you are having problems with the management of a 'difficult' patient.

- Prescriptive: advising/telling
- Informative: instructing/interpreting
- Confronting: challenging/feeding back
- Cathartic: releasing emotions
- Catalytic: encouraging exploration
- Supportive: comforting/affirming

## **6. Murtagh's model.**

This is another pragmatic model. It can be useful when there are uncertainties around the diagnosis or when you are anxious you might be missing something.

- What is the probability diagnosis?
- What serious diagnosis should not be missed?
- What conditions are often missed?
- Is this a 'masquerade'?
- Is the patient trying to tell me something I've missed?

## **7. Cambridge-Calgary model.**

This model adopts a more evidence-based approach to consultation skills. It is also quite practical, which makes it popular.

- Initiating the consultation

- Gathering information
- Building the relationship/facilitating the patient's involvement
- Explanation and planning
- Closing the consultation

## **8. Neighbour's model.**

This is a very popular model with five simple key elements.

### **Connect:**

Establish a rapport with the patient, get on the same wavelength

### **Summarise:**

Check you have a clear idea of the patient's real reason for being here by summarising back to them why you think they are there

### **Hand over:**

Involve the patient with the management plan you have come up with. Make sure it is OK with them and that they understand it.

### **Safety net:**

Planning for the unexpected in general practice involves the art of managing uncertainty. Hospital medicine often aims to prevent the unexpected from happening in the first place whereas in general practice we learn to settle for knowing what to do next if it does.

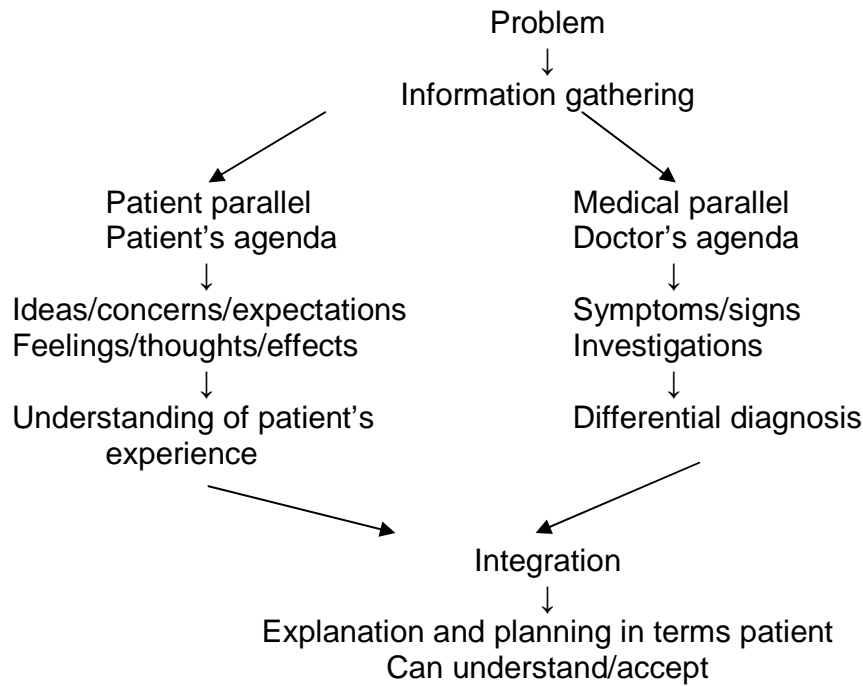
### **Housekeeping:**

Look after yourself. What are your sources of stress at work? What feelings intrude into consultations? How do you recognise them? How do they affect your work performance? How do you deal with them?

## **9. McWhinney's disease-illness model.**

This draws a parallel between the traditional medical model of illness and a patient-centred perspective. McWhinney described a dual concept to help understand why a patient presents at a particular time. Patients reach either their 'limit of symptom tolerance' or their 'limit of anxiety'. If the doctor can understand which trigger is at work the consultation is

more likely to be successful. This model can be useful in helping you to focus on the patient's agenda.



## 10. RCGP model.

Asks the doctor to look beyond the organic and include the psychosocial elements of presentations and ill health. It encourages you to look at the consultation from three dimensions: **physical, psychological and social**. Most of you will be all too familiar with

this model as the basis of the video marking schedule or the 'have I got a tick in that box' model.

- The doctor is seen to encourage the patient's contribution at appropriate points in the consultation
- The doctor is seen to respond to signals (cues) that lead to a deeper understanding of the problem
- The doctor uses appropriate psychological and social information to place the complaint(s) in context
- The doctor explores the patient's health understanding
- The doctor obtains sufficient information to include or exclude likely relevant significant conditions
- The physical/mental examination chosen is likely to confirm or disprove hypotheses that could reasonably have been formed OR is designed to address a patient's concern
- The doctor appears to make a clinically appropriate working diagnosis
- The doctor explains the problem or diagnosis in appropriate language
- The doctor's explanation incorporates some or all of the patient's health beliefs
- The doctor specifically seeks to confirm the patient's understanding of the diagnosis
- The management plan (including any prescription) is appropriate for the working diagnosis, reflecting a good understanding of modern accepted medical practice
- The patient is given the opportunity to be involved in significant management decisions
- In prescribing, the doctor takes steps to enhance concordance, by exploring and responding to the patient's understanding of the treatment
- The doctor specifies the conditions and interval for follow-up or review

# Uncertainty

“The trouble with the world is that the stupid are cocksure and the intelligent are full of doubt” Bertrand Russel

“Doubt is not a pleasant condition but certainty is absurd” Voltaire

“Fame is a vapour; popularity an accident; the only earthly certainty is oblivion”  
Mark Twain

“Inquiry is fatal to certainty”- Will Durant

“Science has proof without certainty. Creationists have certainty without any proof”  
Ashley Montague

“Life is uncertain. Eat Dessert first”

“If a man will begin with certainties, he shall end in doubts; but if he will be content to begin with doubts, he shall end in certainties.” Francis Bacon

“Fear comes from uncertainty. When we are absolutely certain, whether of our worth or worthlessness, we are almost impervious to fear. Thus a feeling of utter worthlessness can be a source of courage” Eric Hoffer

“Science does not give us absolute and final certainty. It only gives us assurance within the limits of our mental abilities and the prevailing state of scientific thought”-  
Ludwig von Mises

# Coping with uncertainty

How good are you?

<p>The doctor, having failed to make a firm diagnosis shows intolerance of uncertainty by a hurried rush to treatment investigation or referral, without thought for the patient's convenience, or proper concern for NHS economy.</p>					<p>The doctor, having excluded immediate risks is prepared to 'use time as a tool' to allow things to become clear, while giving the patient support and gaining his/her trust; when this is not possible he or she uses diagnostic and referral facilities appropriately, economically and with due regard to the patient's feelings.</p>				
1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	5 <input type="radio"/>	6 <input type="radio"/>	7 <input type="radio"/>	8 <input type="radio"/>	9 <input type="radio"/>	10 <input type="radio"/>
Has little understanding of this.		Attempts to do this but is not yet skilful and sometimes runs into difficulty.			Attempts to do this and is usually successful but recognises his/her limitations.			Perfect	

## Subscales

The doctor:

		Rarely	Occasionally	Fairly frequently	Often	Usually
(a)	Once he or she is sure that the patient is not endangered, is prepared to wait and watch.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(b)	If he or she has decided on 'masterly inactivity' sets out to gain the patient's trust for the course of action.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(c)	Where necessary chooses	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

investigations which take into account both the feelings and convenience of the patient and also health service costs.

- (d) Where necessary gets consultant help in the most cost effective and considerate way.\*

### Notes for raters

This area of behaviour is best assessed by case discussion, asking, "Why did you do that?", "Had you thought whether. ..?", "Couldn't it have waited?"

# Uncertainty

Tips for dealing with uncertainty

## ***Tip 1 recognise there are different types of uncertainty***

There are 3 types of uncertainty in medicine

### Type 1

When medical knowledge about a topic is deficient – No doctor on earth knows the answer to this one

### Type 2

When medical knowledge about a topic is sufficient but your own knowledge or recollection is deficient

### Type 3

Am I type 1 or type 2?

## ***Tip 2 distinguish between stake and odds***

What do I or the patient stand to win or lose?

What are the odds? 25:1

What could happen and what are the chances (probability) for each option?

Unlikely clinical outcomes can still be a problem if there is a lot at stake e.g. death. A 1:1000 chance of a skin rash is not the same as a 1:1000 chance of anaphylaxis or agranulocytosis.

## ***Tip 3 Define the risk more precisely.***

Allocate the patient to a more precise prognostic category. Is the patient a typical case of the disease?

Take a better history – this is nearly always the best option

Examine the patient

Do tests (hardly ever as effective as a good history).

## ***Tip 4 Use a safety net.***

Graded response

Things you can say

- “Come back if...”
- “Ring me if...”
- “I’ll ring you ...”
- “If... then ...otherwise...” instructions

Things you can do:

- Diary and Review patients notes after a time

➤ Revisit

### ***Tip 5 Gamble professionally***

Making decisions under conditions of uncertainty is a form of gambling. Like the gambler, the decision maker( whether or not with the help of formal decision analyses, seeks information about possible gains and losses and the weighs the gains with the losses in terms of their probability and value”

Play percentages; accept probability rather than certainty

Not all decisions are either or

Diseases are not uni-causal not all management follows algorithms

Don't go for the big pay out, the long shot that will solve all problems e.g. “amputating your leg will cure all your mental health problems”

Separate the knowns, from the unknowns

Separate out where outcome is down to chance or there is an opportunity that skill may influence the outcome

Realise that we are often drawn to known risks because we feel more comfortable

### ***Tip 6 Deal with Risk***

There are 2 ways of dealing with risk

#### Avoid Risk

Not really recommended but can be used

Refer everyone

Bring every patient back for review

Treat everyone

Escape to another speciality ( Non clinical)

#### Accept Risk

Accept responsibility

### ***General Practice is the art of managing uncertainty***

Accept that you will get it wrong, and it will hurt and that someone will complain.

### ***Tip 7 Beware of Deception***

Perception is the appearance, not reality – beware of this gap

Is the situation all that it seems? How would look to another?

What would it look like to an outsider? Another GPR, my trainer, a lawyer?

#### Anxiety

Anxiety is infectious. Anxious patients can make anxious doctors

Is there a good cause for anxiety or are the patients perceptions out of line with reality?  
Is my or the patients anxiety making the situation look worse than it is?  
Is the diagnosis anxiety?

Check things out  
Do a mental health assessment  
Temporise. Maybe things will look very different next time you see them

***Tip8 Don't deny uncertainty , use a black box***

Whilst not denying uncertainty you can work around it. Separate the unknown and the unfathomable and put it in a black box and work with the known bit that you have control over.

***Tip 9 Separate the Zebras from the Horses***

In the frenzy of a busy clinic it can be difficult to know what to do when a rare disease comes to mind during the consultation Do we investigate to rule out all disease processes ( all zebras) regardless of the cost or do we look only for those disease that are likely ( assuming that all the hoof beats are horses) Neither extreme is optimal

- Common disease occur commonly and rare disease occur rarely
- The mind is an imperfect estimator of risk
- The unusual presentation of a common disease is generally more unlikely than the usual presentation of an uncommon disease
- Not everything we are taught is correct.

**[Green C, Holden J.](#)**

Haydock Medical Centre, St Helens WA11 OJN, UK. caroline.e.green@btinternet.com

General practice encounters often involve vague symptoms, potentially representing illness in its early stage. Managing such undifferentiated symptoms is difficult, but one of the key tasks of the general practitioner is to discover serious disease at an appropriate stage whilst also minimising over-investigation. Although the diagnostic process and methods of coping with uncertainty in general practice have been described, the early course of disease, especially undifferentiated presentations, is poorly understood. PMID: 14611009 [PubMed - indexed for MEDLINE]

# Four Principles for separating Zebras into Horses Worksheet

*Common diseases occur commonly and rare diseases occur rarely*

Over the next **10 minutes** please complete the following worksheet as an individual.

Write down your case and include your differential diagnosis.

Differential diagnosis

## Principle 1

➤ *Common disease occur commonly and rare disease occur rarely*

Look for red flags and distractions i.e. things that may lead you astray.

1. Are there any red flags?
2. Are there any distractions ie things that may lead you astray?
3. How reliable is the feature?
4. How often is it encountered in the rare disease?
5. How often is it encountered in the more common disease?

## Principle 2

➤ *The mind is an imperfect estimator of risk*

1. Is the story “to good to be true” and did I lead the witness?

2. Has recent experience affected my judgement?
3. Is my experience with this condition too limited?

### **Principle 3**

- *The unusual presentation of a common disease is generally more unlikely than the usual presentation of an uncommon disease*

Corollary , screening everyone for a rare disease is not helpful. When faced with an unusual clinical feature, ask first if it can be explained by something other than rare disease

Are there any tests that would be helpful?

### **Principle 4**

- *Not everything we are taught is correct.*

Do not attach too much importance to it e.g. from university Professor, look for support from the literature.

Do I have reliable information?

In pairs discuss you case and take your colleague through the model as applied to your case 10 mins per case(20 mins total)

Join together with another pair and discuss what issues using the model has raised for you? Has it raised any learning needs for you? ( 10 mins)

# ***“Uncertainty looms over all of medicine, and you must be able to cope with the pain and guilt that it brings”***

## **Issues**

- Uncertainty is inevitable in primary care (and medicine in general)
- Need to use relationships skilfully
- Equipose – exploring individual’s risk-benefit equations

## **How we respond to uncertainty (how does uncertainty make us feel?)**

- Our behaviour with the patient
- Our behaviour with others as a result of our uncertainty
- The novelty factor

## **Aggravating factors in uncertainty**

- The doctor
  - The impostor syndrome – the risk of being found out
  - Personality – some personalities will find uncertainty more difficult
  - The black hole – “I don’t know what I don’t know”
  - Low self-esteem in the doctor
  - The doctor’s need to help
  - Doctors beliefs about societal obligations to protect the vulnerable
- The patient
  - A dreaded outcome e.g. death, a complaint
  - Insoluble problems
  - An uncertain degree of risk in the decision-making process
  - Somatisation
  - Natural variations in the disease process
  - Dependency by the patient on the medical model resulting in the patient expecting that the doctor always will know the answer
- The consultation
  - A problem not recognised by pattern recognition
  - Choices in management
  - Doctor-centred consulting resulting in difficulty with sharing uncertainty with the patient and the ability to encourage or even receive feedback from the patient
  - The doctor’s and the patient’s personal boundaries
  - Medical decision making requires combinatorial analysis to comprehend patients’ uniqueness and avoid harmful, unnecessary trial and error
- Society
  - Socially mediated sense of threat eg mass media or lobby groups

## **Developing strategies**

- For the doctor

- Information systems and decision support
- [Emotional intelligence](#)
- Exploring personal resistance to risk-taking
- Reality-checking – “what is really likely?”
- Narrative based medicine
- Developing the doctor’s personal self-awareness
- Building personal resilience – emotional support, healthy living
- Deconstructing the “pain and guilt”
- Sharing uncertainty – patient, colleagues
- Support – mentoring/co-mentoring
- In the consultation
  - The disease-illness model
  - Negotiation in decision-making – risk management
  - Sharing responsibility for decision-making
  - [Ideas, concerns and expectations](#)
  - Patient-centred feelings-based communication

### [7 habits of highly effective people](#)

#### [Emotional intelligence](#)

- "Accept uncertainty as part of life because it is." What are some simple things they can do to accept uncertainty without inviting anxiety?
- How can you accurately assess the risk of physical or emotional danger?
- How can you "re-educate your brain" to stop obsessing about potential dangers?
- How can using affirmations help restore inner peace and what are some examples of them?
- Stress-reduction techniques
- How can you raise your "frustration tolerance" and how does the help you to cope with uncertainty?
- How could forgiveness help them cope with uncertainty and anxiety?
- Connecting with others to create meaning. Why and what are some ways to do this?
- Flexibility in the face of change yields immeasurable opportunities for positive growth and renewal. How so and what do you suggest for becoming more flexible?



Brad Cheek: These two pages are taken from an excellent web site *Well Close Square* <http://www.gp-training.net/>

# Uncertainty

## Types of uncertainty

- Teacher
- Patient
- Doctor/Registrar
- Knowledge
- Diagnosis
- Management
- Treatment
- Agenda (overt/hidden)
- Shared Uncertainty - with patient
- Resources
  - Can we implement plans?
- Business
  - Organisation
  - Finance

## Concept of the 'safety-net' is essential

Uncertainty in the doctor depends on several aspects

- Knowledge
- Support
- Confidence
- How much uncertainty can we tolerate?
- Use of time
- Overkill (too many tests, etc.)

## Dealing with uncertainty

- Treatment & management
  - Increased number of tests
  - Second opinions
  - Use of time
  - Safety netting
- Treatment
  - Second opinions
  - Increased knowledge
  - Keeping up to date
  - Alternative options
- Management
  - Sharing patient's agenda
  - Health beliefs
  - Negotiation
  - Explanation
  - Identifying and dealing with patient's actual problem

- 'Playing God' (prioritising)

### **Managing Complaints**

In this unit we will explore some aspects of managing the uncertainty around complaints. Complaints will form a routine part of your future medical practice, however many doctors find them emotionally draining and professionally difficult.

You will divide into 4 groups to discuss/role play 4 scenarios which are based on real events. Please attempt to navigate through the complaint procedure as far as your group thinks appropriate in each case. Consider the replies you might give in letters. Consider role-playing meetings with complainants if appropriate. We will join at the end for a discussion.

During the discussion we will explore events from the point of view of:

*The Doctor*

*The complainant*

*Attached professionals.*

You might find it easy to approach the discussion having completed SWOT analyses of the complaint with in your 4 small groups.

NB a standard response to complaints would be:

- 1 A letter to complainant.
2. A meeting between complainant and doctor
- 3 Escalation via PCT Health Care Commission GMC lawyers etc

The vast majority stop at 1.

## **Scenario 1.**

### **Players.**

*Dr White --- a partner in Blacks practice*

*Dr Black, Green and Yellow the partners.*

*Mrs Smith The wife of the dead patient.*

*The practice operates a standard complaints procedure organized by Dr Black. Dr Black is aggressive and un helpful.*

Dr White has received the following letter from Mrs Smith.

Dear Dr White I am writing to complain about the horrific and incompetent treatment you offered my husband who has now died of cancer. Despite him seeing you every week for 6 months you failed to diagnose what the hospital called an obvious and advanced disease. I am writing to the GMC the health commission and my Lawyer. I and my daughters await your response.

Dr White looks through the medical records and discovers he/she saw Mr Smith some months ago with back pain. Mr Smith was a 36 year old policeman finding work more and more difficult. Dr White had arranged an orthopaedic opinion and also an endocopy. The second arranged because Dr White felt the back pain might in fact be epigastric.

Dr White saw the patient several more times prescribing simple pain relief. The last appointment was 4/12 ago.

Since then Mr Smith had seen every doctor in the practice at least once. On the last occasion when seen by Dr Yellow he was admitted having lost a great deal of weight. He died in hospital from an adenocarcenoma of unknown origin.

N.B endoscopy NAD, bloods all normal, orthopods –never got to see them.

## Scenario 2

### Players

*Dr Meat – A locum working for an Ooh service*

*Dr Veg—Medical Director of the Ooh service.*

*Mr Pudd--- Son of the dead patient.*

Dr Meat receives the following letter from Dr Veg .

Dear Dr Meat,

Please find enclosed the following letter from the son of a patient whom you saw and then relevant clinical notes. In line with PCT policy I require a response with in 7 working days. Many thanks for your help. Hope this finds you well.

Yours truly,  
Dr Veg.

CLINICAL NOTE.

MR PUDD. 5/5/05 05 AM

93 NORMALLY WELL ALERT RESPONSIVE NOT DEHYDRATED. IN BED FOLLOWING 3/7 DIARRHOEA. TOLERATES FLUID. SAYS MOBILE TO LOO. SIMPLE ADVICE RE FLUID ETC TO CALL BACK IF WORSE OR UNRESOLVING.

LETTER FROM MR PUDD JUNIOR.

Dear Dr Veg,

I wish to complain in the strongest possible terms about one of your doctors who saw my father on the night that he died. I myself was not present but a neighbour of my father relayed the story to me. Your doctor did not examine my father and told him just to take fluid and paracetamol. How can this be the right advice for a man who was so ill when I arrived that the paramedic told me he had never seen any body so dehydrated. The hospital said it was outrageous that such a frail old man living by him self had ever been left alone. If only he had been admitted sooner he might still be alive.

My father fought for this country . To be treated this way at the end of his life is disgusting.

Yours truly,  
Mr Pudd

Dr Meat remembers the patient. When Dr Meat left a neighbour was with him and knew to call if things changed. Mr Pudd had asked not to be admitted to hospital and said he could easily manage what he felt was a simple illness. He wished the doctor had never been called. Dr Meat had left feeling a little uncomfortable, but did not know why.

### Scenario 3

#### Players.

*Dr Tall—A locum who did a morning surgery for Middle Size practice 3/12 ago*

*Dr Short Dr Round and Dr Lovemachine partners in middle Size practice*

*Mrs Giant wife of the dead patient.*

Dr Tall receives the following letter from Dr Lovemachine.

I am forced to write to you following events at our practice. You saw Mr Giant on the morning of 12.12.05. Your clinical note is enclosed. I would be grateful if you could explain your actions so I can pass these on to the widow of Mr Giant.

CLINICAL NOTE.

NORMALY WELL 38 YEAR OLD WITH SYMPTOMS TYPICAL OF VIRAL ILNESS. SIMPLE  
ADVICE

Dr Tall can't remember the patient. Enclosed is a brief hospital letter from the same day :

15.00 Admitted with advanced meningococcal septicaemia. Died 16.50. Not given any meds by own GP.

#### **Scenario 4**

##### **Players**

*Dr 50 cent—a salaried Gp making £40,000 for 9 sessions in a busy practice*

*Dr Snoop Dog Dr Emandem Dr Bonyem partners at same practice all making £130,000 for 8 sessions*

*Mrs Solicitor.—complainant.*

Dr 50 cent receives the following letter from Dr Bonyem the senior partner.

Dr Dr Nifty Ment,

We have received the following complaint and would like your response.

I wish to complain in the strongest terms about the locum Dr I saw in your practice some weeks ago. They were rude and dismissive and did not take my complaint seriously. I attended when I was six weeks pregnant with some bleeding. The doctor did not listen to my concerns and brushed me off with an appointment for an ultrasound at the hospital 4 days later.

The doctor did not examine me and despite my tears ignored my symptoms saying there was very little they could do.

My bleeding got worse and I went to hospital where they said I was having an ectopic pregnancy. If they had seen me earlier I would not have needed an operation. However they did need to operate taking away one of my tubes. I am a 38 year old solicitor and we have been trying for a baby since we got married 6 months ago. I believe your incompetent locum has wrecked my chances of having a family and I wish to pursue this matter as far as possible.

Please let me have any information about this doctor you may have on file regarding other complaints. I have every right to this information.

Hope that makes sense. I have given her all the files she has requested.

Look forward to hearing from you

Yours truly,

Dr Bonyem FRCS MD

##### **CLINICAL NOTE.**

NORMALY WELL 38 YEAR OLD .6/40 MUCH ANXIETY. MINIMAL PV LOSS LESS THEN 1 PAD IN LAST 24 HRS. NO BLEEDING CURRENTLY. NO PAIN.REASURED +++ EPAU BOOKED 3/7 TO CALL SOS IF ANY CHANGE. SMALL CHANCE OF ECTOPIC PREGNANCY DISCUSSED. ANXIETY MAKES PV NEAR IMPOSSIBLE

**SOUTH WORCESTERSHIRE  
PRIMARY CARE TRUST**

**COMPLIMENTS AND COMPLAINTS  
POLICY AND PROCEDURE**

Approved by	: PCT Board
Issue Date	: February 2005
Review Date	: February 2007

## **Aims of the Policy**

The Trust aims to provide a high quality service in partnership with our patients and their carers, and to actively seek patient opinion regarding the quality of care received.

Compliments and complaints are a measure of patient satisfaction and/or dissatisfaction and should be used to improve the quality of the service provided.

To this end the PCT will:

- record compliments and ensure that they are brought to the attention of the staff involved
- resolve any complaint as fully and speedily as possible. The information gained should be used to improve the quality of our service on a continuing basis.

The Trust is also concerned to ensure that complaints are thoroughly investigated and that staff who are the subject of a complaint receive appropriate support.

## **1. COMPLIMENTS**

### **1.1. Definition**

A compliment is any expression of satisfaction by a patient, their representative or any user of the service. It is an expression of gratitude to staff for the quality of service provided.

### **1.2. Procedure**

In order to recognise the degree of appreciation, it is necessary to record and monitor all forms of compliment.

Whilst the difficulty of recording compliments is recognised, staff should report and monitor the following information monthly, using the proforma provided at Appendix 1:

- letters/cards
- gifts
- donations

Directors are responsible for submitting a return to the Chief Executive at the end of each month.

## **2. COMPLAINTS**

### **2.1. Definition**

A complaint is any expression of dissatisfaction from a patient, their representative or any user of the service.

### **2.2. Principles**

The Trust's complaints policy and procedure will:

- be easily accessible and well publicised
- be simple to understand and use
- allow speedy handling within required time limits and, where this is not possible, an explanation will be provided to the complainant or their representative for any delay
- ensure all concerned are informed of progress
- ensure a full and fair investigation
- respect people's desire for confidentiality
- address all points at issue and provide an effective response
- provide information to managers and staff so that services can be improved.

### **2.3. Time Limit on Initiating Complaints**

Complainants should normally make complaints within 6 months of becoming aware of a cause for complaint, or 12 months from the date of the event which is the cause of the complaint.

### **2.4. Procedure**

The Complaints Procedure will consist of two stages:

- Local resolution
- Independent review.

## **3. LOCAL RESOLUTION**

The Trust aims to resolve complaints through Local Resolution, wherever possible, and to be open, fair and flexible.

### **3.1. Minor Criticisms**

Minor criticisms, even those which appear trivial, should be managed sympathetically and it will frequently be possible to provide an explanation and acceptable answer at the time.

Where a person remains dissatisfied, it will be necessary to use the oral or written procedure.

### **3.2. Complaints**

Complaints may be either oral or written.

#### **3.2.1. Oral Complaints**

Oral complaints should be dealt with on the spot by front line staff, including primary care staff, whenever possible. When a member of staff receives an oral complaint from a patient or their representative he will:

- ensure that the patient's immediate healthcare needs are being met
- obtain factual information from the complainant
- confirm that the complaint will be dealt with in the appropriate manner
- advise an appropriate senior member of staff , eg ward sister, head of department, practice manager of the complaint, outline any action already taken or agree action to be taken
- ensure that a factual record of the patient's concerns and action taken is completed and sent to the Complaints Manager (a proforma is attached at Appendix II)
- advise the complainant orally of the outcome of the investigation
- advise the complainant of the action that will be taken where it is not possible immediately to resolve the complainant's concerns.

Oral complaints will be addressed immediately they are received. Where there will be a delay in investigating such complaints, ie greater than two working days after receipt, the complainant must be advised in writing.

Should the complainant remain dissatisfied, they will be provided with a copy of the Trust's "Compliments, Comments and Complaints" leaflet, which gives details of the Independent Complaints Advocacy Service (ICAS) in Worcestershire. The complainant will be advised to put their complaint in writing to the **Chief Executive** and will be given assistance to do so if required.

Oral complaints to the Chief Executive's office will be treated as a formal complaint and the procedure for responding to a written complaint will be followed.

### **3.2.2. Written Complaints**

Letters of complaint will be received by the Chief Executive, Service Directors, Consultants, Directorate Managers, ward or departmental staff and must be dealt with according to the procedures described below.

Designated staff will investigate written complaints on behalf of the Chief Executive. These individuals will also provide advice and support as necessary, for the investigation of oral complaints.

The Trust will, wherever possible, resolve complaints within 20 working days of receipt. Some complaints may take longer and complainants will be kept informed of progress at regular intervals.

### **3.3. Procedure for Investigating Written Complaints**

Formal complaints will be acknowledged in writing within 2 working days of receipt:

- where complaints are received by directorates, they will be acknowledged in writing by the appropriate **Director or Senior Manager**), who will initiate an investigation and provide copies of the written complaint and letter of acknowledgement to the Complaints Manager at Trust HQ. The Complaints Manager will record receipt of the complaint and monitor progress. Where the complaint has been received and acknowledged other than by the relevant Director, the Complaints Manager will send a copy of the complaint to the Director.
- where complaints are received in the Chief Executive's office, the **Complaints Manager**, who has access to the Chief Executive, as required, will send a written acknowledgement to the complainant within two working days of the complaint being received in the Trust. The **Complaints Manager** will provide copies of the complaint and the acknowledgement letter to the appropriate **Service Director**, who will initiate an investigation.

If appropriate, copies will also be sent to the Director of Public Health, Medical Director, Lead Nurse and PEC Clinical Governance Lead, for information.

Where a complaint involves more than one organisation, the **Complaints Manager** will seek the complainant's permission to make the letter available to the appropriate Complaints Manager or equivalent and will liaise with their counterpart as appropriate.

Where a complaint concerns more than one Directorate, the **Chief Executive** will nominate a lead Director who will be responsible for liaising with colleagues in other Directorates and preparing a single response.

The **Director** will be responsible for nominating an appropriate Investigating Officer, who may or may not be the manager of the service that is the subject of the complaint.

#### **4.3.1 The Investigating Officer will:**

If necessary, contact the complainant, by telephone or in person, to discuss their concerns and to outline how these will be investigated. Points of concern will be confirmed in writing to the complainant within 2 working days. If appropriate, this may form part of the letter of acknowledgement. If the complaint is serious, personal contact should be made by the Service Director.

Meet any member(s) of staff who has been identified in the complaint to:

- explain the investigation procedure
- provide a copy of the complaint
- if the Investigating Officer is the line manager of a person (or persons) named in the complaint, offer another manager who will support the named individuals during the investigation. This is in addition to the rights of staff who are the subject of a complaint to seek advice from their professional association or Trade Union
- investigate the complaint, obtaining such written evidence as necessary e.g. statements, clinical records
- provide a detailed written report, and recommendations to prevent a recurrence of the incident, together with supporting documentation, to the Director, within 10 working days.

#### **4.3.2 The Executive Director will:**

Involve the Lead Nurse, Medical Director, or other Director, as appropriate

Review the investigation report and prepare a response, in conjunction with the Investigating Officer, discussing it with any members of staff identified in the complaint and allowing them an opportunity to comment. This letter will contain a full account of the results of the investigation, an apology for any shortcomings and an explanation of any remedial action taken or planned.

Forward the response, together with the Investigating Officer's report, to the Complaints Manager within 5 working days. This should include copies of all supporting

documentation e.g. patient notes, statements, investigation notes, notes of meetings/telephone calls. The **Complaints Manager** will retain the full complaint file.

#### 4.3.3 The **Complaints Manager** will:

Obtain the Chief Executive's approval and signature on the response letter and send it to the complainant within 3 working days of receiving it.

Send a copy of the final reply, marked "Confidential", to the appropriate Executive Director, who provide copies to any person named in the complaint and, with the patient's consent, to any other organisations involved.

If, having made every effort to resolve the complainant's concern, the complainant remains dissatisfied, the Chief Executive will advise the complainant of the independent review process.

#### 4.3.4 **Complaints Hearing**

Complaints which have not been resolved to the complainant's satisfaction following a written reply may require a Complaints Hearing to consider those matters not addressed to the satisfaction of the complainant. Complaints Hearings should:

- be conciliatory
- be conducted in a comfortable environment, with appropriate refreshment
- be recorded in writing
- be led by the appropriate **Executive Director** or **Investigating Officer**, supported by the **Complaints Manager**, if appropriate
- include any supporters nominated by the complainant.

Copies of the notes will be distributed to those present at the meeting. If the complainant remains dissatisfied, they will be informed of their right to request Independent Review and provided with the address of the appropriate Independent Complaints Advocacy Service should they require further assistance or independent advice.

#### 4.4 **Implementation of Recommendations**

The **Complaints Manager** will write to the Service Director six months after the date of the final reply to request a written report on the implementation of any recommendations made by the Investigating Officer.

## 5 **HEALTHCARE COMMISSION'S INDEPENDENT REVIEW**

## 5.1 Complainants' Action

Complainants who are dissatisfied with the Trust's response, as a result of the local resolution procedure, may request an independent review by the Healthcare Commission as an external body to carry out an Independent Review of the case or of the way the complaints process has been managed so far.

## 5.2 The Process

The Healthcare Commission will consider a complaint and write to the complainant explaining what action they will be taking. The following lists the possible options:

- **reject** the case because the NHS has already addressed the complaint through local resolution
- **refer** the complainant back to the Trust because more can still be achieved through local resolution
- **accept** the case for Independent Review
- **refer** the complainant to the Health Service Ombudsman
- **refer** complainant to another body, if the complaint falls outside the Healthcare Commission's area of authority.

If complainants still have specific issues that have not been addressed by the Trust or the Healthcare Commission they may ask the Health Service Ombudsman to take these on.

## 6 POTENTIAL LEGAL ACTION

### 6.1 Possible claims for negligence

If a complainant reveals a prima facie case of negligence, or if it is thought that there is a likelihood of legal action being taken, the person in receipt of the complaint shall inform the appropriate officer as agreed by the Chief Executive, who is responsible for dealing with risk management and claims management.

The investigation of the complaint will not cease unless the complainant explicitly indicates an intention to take legal action in respect of the complaint.

All correspondence from solicitors must immediately be sent to the Chief Executive who will:

- inform the Medical Director
- inform the Consultant or other clinicians concerned

- inform the National Health Service Litigation Authority and solicitors nominated by that body
- process the claim as appropriate.

## **7 COMPLAINTS WHICH MAY INVOLVE CRIMINAL PROCEEDINGS**

If, from any complaint, it appears, or is alleged, that a criminal offence may have been committed, the matter must immediately be reported to the Chief Executive who will ensure that the police are informed.

The **Chief Executive** will determine whether reference should be made to the appropriate professional organisation.

Should the police decide not to institute proceedings, the **Chief Executive** will decide what further investigation and/or action is required.

## **8 MONITORING OF COMPLIMENTS AND COMPLAINTS**

It is a requirement of the NHSE that the Trust Board should regularly monitor compliments and complaints as part of the Trust's quality assurance programme.

Complaints will be monitored by an appropriate committee established by the Trust Board and it is the responsibility of the Chief Executive to ensure the provision of a quarterly report on compliments and complaints to the Trust Board, in order to:

- monitor the effectiveness of the compliments and complaints procedure
- consider trends in complaints and any remedial action taken
- consider any lessons which could be learnt from complaints, particularly for service improvement.

As part of the Trust's annual clinical governance report, the Trust will publish information relating to the Trust's handling of complaints. This must avoid any possible breaches of patient confidentiality.

**SOUTH WORCESTERSHIRE PRIMARY CARE TRUST**

**RECORD OF COMPLIMENTS RECEIVED**

Please provide the details as requested below:

Ward/service.....  
Address/Base.....

Calendar Month (please ring correct month):

January	February	March	April	May	June
July	August	September	October	November	December

No. of complimentary cards/letters received.....

No of gifts received .....

Details of donations made  
.....  
.....  
.....  
.....  
.....  
.....

Name of person completing this form.....Date.....

Please return this form at the end of each calendar month to:

**Complaints Manager**  
**South Worcestershire Primary Care Trust**  
**Isaac Maddox House,**  
**Shrub Hill Road, Worcester WR4 9RW**

By no later than the 10<sup>th</sup> of the following month i.e. for February by 10 March

APPENDIX II

SOUTH WORCESTERSHIRE PRIMARY CARE TRUST

RECORD OF ORAL COMPLAINT

Date complaint received ..... Time .....

Ward/Dept/Service ..... Address/Base .....

Name of person(s) who received complaint .....

Please present a factual statement of concerns expressed, include name of person who made complaint. If the complaint concerns a patient/client and has not been made by the patient/client, please state the name of patient/client concerned and the relationship of the complainant to the patient/client, e.g. relative, friend.

.....  
.....  
.....  
.....  
.....  
.....  
.....

Please state action taken and by whom to address the complaint.

.....  
.....  
.....

Was the complainant satisfied with the outcome of the oral complaint? Yes/No (please delete as appropriate).

If not, what action was taken?

.....  
.....  
.....

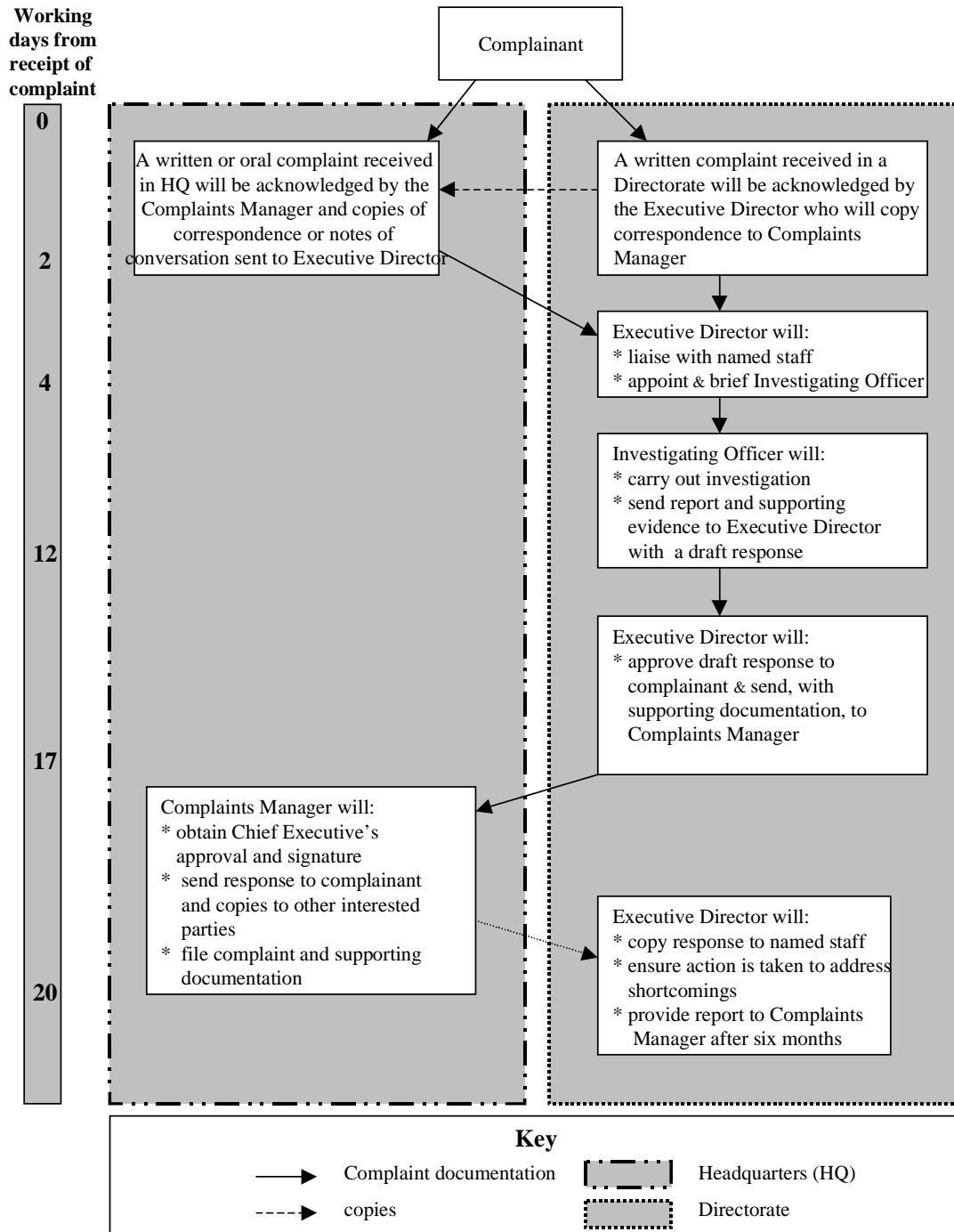
Name of person completing this form..... Date.....

Please send the completed form to  
**Complaints Manager**  
**South Worcestershire Primary Care Trust**  
**Isaac Maddox House,**  
**Shrub Hill Road, Worcester WR4 9RW**

By no later than the 10<sup>th</sup> of the following month i.e. for February by 10 March

APPENDIX III

SOUTH WORCESTERSHIRE PRIMARY CARE TRUST  
 PROCEDURE FOR HANDLING COMPLAINTS - PROVIDER SERVICES



# Worcester VTS Residential

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## In-House Complaints Procedure

The In-house complaints procedure is designed to provide properly authorised complainants with an explanation of the circumstances surrounding an adverse event. It cannot address questions of negligence or compensation. If the partnership considers the complaints procedure is not appropriate in a particular case, the practice manager will advise how the complaint may be pursued through other channels e.g. FHSA or solicitor.

---

**The goals of the in-house procedure** are to provide:

- A clear explanation.
- An apology where appropriate.
- Reassurance that steps will be taken to prevent the same thing happening again.

Care must be taken to ensure patient confidentiality at all times. If you have any complaint or concern about the service that you have received from the doctors or staff working at Well Close Square, please let us know. We operate a practice complaints procedure as part of the NHS complaints system for dealing with complaints. This procedure meets the national criteria.

### How to complain

We hope that most problems can be sorted out easily and quickly, often at the time they arise and with the person concerned. If your problem cannot be sorted out in this way and you wish to make a complaint, we would like you to let us know [*as soon as possible*] - ideally within a matter of days or at most a few weeks - because this will enable us to establish what happened more easily. If it is not possible to do that, please let us have details of your complaint

- Within 6 months of the incident that caused the problem *or*
- Within 6 months of the date of discovering that you have a problem, providing that it is within 12 months of the incident.

### What we will do

We will acknowledge your complaint within two working days and aim to have looked into your complaint within ten working days of the date you raised it with us. We will then be in a position to offer an explanation or a meeting with the people involved. When we look into your complaint, we aim to

- Find out what happened and what went wrong
- Make it possible for you to discuss the problem with those concerned if you would like this
- Make sure you receive an apology where this is appropriate
- Identify what we can do to make sure the problem does not happen again

# Worcester VTS Residential

## Complaining on behalf of someone else

Please note that we keep strictly to the rules of medical confidentiality. If you are complaining on behalf of someone else, we have to know that you have their permission to do so. A note signed by the person concerned will be needed, unless they are incapable (because of illness) of signing this.

## Complaining to the Health Authority

We hope that, if you have a problem, you will use our practice complaints procedure. We believe this will give us the best chance of putting right whatever has gone wrong and an opportunity to improve our practice. However, this does not affect your right to approach the health authority if you feel that you cannot raise your complaint with us [~bold or] you are dissatisfied with the result of our investigation. You should contact the Health Authority complaints manager for further advice. You may also like to contact the Community Health Council (CHC) for help. The CHC is an independent body within the Health Service representing the interests of patients.

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## Balint

Michael Balint was an Hungarian psycho- analyst, who in the mid 50's began running case discussion groups with doctors in Tavistock Square. The aim was to look at the Dr – patient relationship. Doctors were encouraged to analyse what feelings are generated in themselves, as this may represent what the patient feels. The presenter often takes on the role of the presenter and the group that of the Dr. The aim is not to make a diagnosis but to understand the process better.

### Aims of Balint group:

1. Allow us to handle difficult patients more easily
2. Develop a variety of styles with the patient rather than maintaining same style
3. Step back from consultation and analyse meaning behind their requests
4. Critically analyses the process of the consultation with emphasis on the Dr's own response to the patients' behaviour.
5. Exhibit non-judgemental response to the patients behaviour

Helpful questions to ask are: -

What was the patient's **actual** reason for coming that day?

How did you feel when you saw patients name on your list?

What kind of thoughts and feelings did you have during the consultation?

Are there any other patients, who make you feel this way?

Focus on the doctor patient relationship and not the medical management

## Characteristics of effective Balint group leadership

The leaders will:

- Try to keep the discussion centered on the doctor patient relationship
- Discourage too much interrogation of the presenting doctor.
- Encourage people to express their own thoughts and feelings about what they have heard.
- Protect group members from unwelcome intrusions on their privacy or criticism which is hurtful without being helpful.
- Represent the patient if he/she is in danger of being ignored.

## Famous Phrases of Michael Balint

**“The drug ‘doctor’”** (ie the doctor herself/himself is a powerful medication)

**“The collusion of anonymity”** (patients may bounce from one specialist to another with nobody taking responsibility for the patient as a person)

**“The courage of one's stupidity”** (Go on, say it, you may be absolutely right and if you are not, we will probably still talk to you)

**“The mutual investment fund”** (All the shared experience and trust that doctor and patient accumulate over many years in general practice)

**“The doctor's apostolic function”** The doctor's tendency to have unrealistic expectatons of the patient based on the doctor's own values. ('You should give up alcohol. I never touch it')

**“Sometimes your patients have to hit you over the head before you take any notice of them.”**

# Worcester VTS Residential

# Worcester VTS Residential

## The New GP Curriculum – A Learner’s Guide

### **Key messages**

- Important changes in curriculum, assessment and certification are being introduced over the next few years
- *Being a GP* is the most important curriculum statement and you should become very familiar with it
- Even if you are already on a scheme at present, there are important changes to the way you obtain your Certificate of Completion of Training (CCT)
- If you are just starting on a three year scheme for General Practice, the assessment and MRCGP examination at the end will be different from what happens now
- More detail about these changes and the reasons for change can be found in *The New GP Curriculum – an overview* from the West Midlands Deanery web site Downloads section

### **What will the new Curriculum contain?**

The curriculum is stated in terms of what knowledge, skills, attitudes and expertise the learner will achieve. It covers:

#### **Generic professional competencies**

The qualities that are expected from all doctors, such as those that appear in *Good Medical Practice*.

#### **Competencies that are specific to General Practice.**

There are many skills expected of GPs but some can be referred to as **core skills** and are found in the statement *Being a GP*. Examples of core skills are: managing the primary contact with patients, consulting in a patient-centred way, selective history-taking, tolerating uncertainty, managing co-morbidity, fair and efficient use of resources and having a holistic approach to practice.

### **The Curriculum documentation is extensive, what are the priorities?**

The most important curriculum statement is *Being a GP*. Become familiar with this, and the rest will follow easily. To a great extent, the other curriculum statements merely interpret the core skills in a variety of contexts. They will help you prepare for assessments but are not essential reading for the early days.

Two other documents are worth read early in training: firstly *The Enhanced Trainer’s Report* which will orientate you to how you will be assessed in the workplace and what is the standard you have to reach in order to pass your assessments; and also read the curriculum statement *The General Practice Consultation* which outlines the communication skills needed to make good diagnostic and management decisions.

### **What else is in the Curriculum?**

There are statements on the professional and managerial aspects of general practice; a series of statements on the care of special groups (acutely ill, children, elderly, women’s & men’s health, sexual health, cancer & palliative care, learning disabilities) and statements on clinical areas (cardiovascular, neurological, skin, metabolic, respiratory, musculoskeletal, trauma, ENT, eyes, digestive problems, mental health, minor surgery).

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## ***Do I have to meet all the learning outcomes in every curriculum statement?***

We believe that all the learning outcomes listed are achievable within the three years of GP training.

## ***How will teaching and learning change?***

The most obvious change is that more training for general practice will take place in practice rather than hospitals. All three year rotations in this Deanery will contain some general practice in the first year as well as 12 months in a practice at the end. The middle section will be spent in speciality training in shorter (usually 4 month) posts, either in hospitals or in innovative posts. A diversity of programmes may include traditional half-day release programmes, more flexible, self-selected teaching modules or a mixture of both, whatever is appropriate for the individual's learning preferences and final career choices. There will be a one-to-one relationship with a trainer as a mentor throughout the three years.

## ***What form will the new Assessments take?***

Summative assessment and the MRCGP exam are merging into a single assessment called nMRCGP. There are three elements to this new assessment:

1. Workplace-Based Assessment (WBA), which will take place throughout the three years;
2. Applied Knowledge Test (AKT), a machine-marked test
3. Clinical Skills Assessment (CSA), which will probably take place at the start of the third year.

Satisfactory completion of these three components will make candidates eligible for Membership of RCGP

More detail about assessment can be found in the factsheet *The New GP Curriculum – Assessment* available at <http://www.wmdeanery.org/Downloads/downloads.asp>

## ***How will the Certification and Assessment changes take place?***

The transition arrangements are still being decided so much of the detail here is provisional (Make sure you check the facts with the relevant authorities).

The Postgraduate Medical Education and Training Board (PMETB) have taken over responsibility for certification (from the JCPTGP). They have indicated that, until they have approved the new curriculum, the regulatory framework for a Certificate of Completion of Training (CCT) will remain the standard of Summative Assessment.

Details are on the Royal College of General Practitioners (RCGP) website,

The college - through its Certification Unit - will process all applications to practise as a GP in the UK on behalf of the PMETB. Doctors in training should register with the RCGP Certification Unit as soon as possible after starting their programme, a one-off payment of £350 covers all processing of documents, as well as associate membership of the RCGP.

For people on three-year schemes the transition is already fairly clearly laid out. The MRCGP becomes the nMRCGP in August 2008. For any GP registrars doing self-construct schemes, planning a break or working part-time, the transition will be managed to ensure that no GPR is disadvantaged. The old exam will overlap for a short time, but if you register for the old exam (up to Feb 08) there will be a shorter

# Worcester VTS Residential

time available to sit all the modules. The expectation is that most GP registrars will choose to undertake the new assessment because it is more straightforward.

## ***What if some of my training took place outside the UK?***

If some of your training was undertaken abroad, you have had no UK training, or some of your UK posts were not approved for training, but you believe you meet the standards required of a UK GP then, instead of applying for a CCT, you apply to PMETB under article 11. Information on this is found on the PMETB website at: <http://www.pmetb.org.uk/index.aspx?articleid=438#forms>

## ***Further information***

There are further information sheets available from the Deanery downloads section: <http://www.wmdeanery.org/Downloads/downloads.asp#gp>

## The New GP Curriculum - Assessment

### ***Key message***

Summative assessment and the MRCGP will merge and the whole assessment will probably become known as nMRCGP (where n stands for new). The new assessments are not yet finalised but we have some strong indications of what is likely.

### ***What is changing?***

Standards for Assessment are now set by the Postgraduate Medical Education and Training Board (PMETB). The RCGP has been charged with the task of producing a new Curriculum for Training for General Practice which meets the PMETB criteria for training and assessment. The PMETB will be responsible for the approval of Training programmes posts within the programmes and the assessment package. Instead of the exam-based end-point assessment we have now, PMETB are looking for an **assessment system**, parts of which will take place at various times throughout the three years. In talking of an assessment system, PMETB means an integrated set of assessments for the entire postgraduate training programme which supports the curriculum.

### ***What format will the new assessments have?***

Summative assessment will be replaced by three assessment components:

- **Workplace-Based Assessment (WBA)**, which will take place throughout the three years
- a machine-marked **Applied Knowledge Test (AKT)**, which the candidates is expected have more freedom of choice to sit when they feel ready
- a **Clinical Skills Assessment (CSA)** which will probably take place in the third year

The difference between examinations and assessments in the workplace principally relates to the relationship between competence and performance. Competence (what a doctor *can do*) is necessary but not sufficient for performance (what a doctor *does do*), and as experience increases so performance based assessment in the workplace becomes more important.

# Worcester VTS Residential

## ***What will Workplace-Based Assessment consist of?***

The picture is becoming clearer but is not fully resolved. The main part of Workplace-Based Assessment will be an **Enhanced Trainer's Report (ETR)** which will set out more clearly the competencies a Registrar is to acquire. This document will in time be used throughout the three years. The learner will be responsible for completing a number of assessments demonstrating their competence and for assembling documentation to prove it. Many of the different methods of assessment used will be similar to assessments elsewhere, such as in the Foundation programme and in other specialities. For example, it is likely that there will be **case-based discussions**, **observation of consulting skills**, direct **observation of procedures** such as examination skills, resuscitation skills, and **multi-source (360°) feedback**. The trainer will not do all the assessments but will be responsible for the final signing off of the trainer's report.

There may be some external moderation of these workplace-based assessments. Six methods are being piloted: Video, Criterion Audit, Significant Event Analysis, Multi-Source Feedback, Patient Satisfaction questionnaire and Referral Letter review.

## ***What will the Applied Knowledge Test look like?***

The Applied Knowledge Test will be a machine-marked paper very similar to the current MRCGP multiple-choice paper. This is currently moving beyond testing whether you have an adequate knowledge-base to be a GP to seeing whether you can use your knowledge to deal with clinical or practice problems. There are fewer factual questions and this trend will continue.

## ***How will Clinical Skills be assessed?***

The Clinical Skills Assessment is a new examination in OSCE format. It will resemble the current Simulated Surgery in that there will be a number of stations - possibly 14 of 10 minutes each. The candidate will be expected to deal with typical GP problems demonstrating a synthesis of skills (clinical problem solving, communication, dealing with ethical issues, etc.). Simulated patients are likely to be involved in most or all cases.

## ***What about the Transition to the new exam?***

PMETB have said there will be no change in current licensing procedure (Summative Assessment) in the short term. It is envisaged that the nMRCGP will start from August 2007. No applications for current MRCGP will be accepted after 2nd February 2007. Any doctor wishing to sit the current examination for MRCGP from 3rd February 2007 would be required to complete the nMRCGP. Satisfactory completion of the three components of assessment (nMRCGP) will make candidates eligible for Membership of RCGP.

## ***How do I get a Certificate of Completion of Training (CCT)?***

The Royal College of General Practitioners (RCGP) - through its Certification Unit - will process all applications to practise as a GP in the UK on behalf of the Postgraduate Medical Education and Training Board (PMETB).

Doctors in training should register with the RCGP Certification Unit as soon as possible after starting their programme. There is a one-off administration payment of £350 which covers all submissions to the Certification Unit, and also includes associate membership of the RCGP. Once registered, applicants submit all VTR

# Worcester VTS Residential

forms to the RCGP Certification Unit in order to document each training post as it is completed. In the last month of training the final VTR form is submitted. The Certification Unit check the application and then recommend to the PMETB whether the applicant is eligible for a CCT. The PMETB fee is £250.

Doctors who have done some or all of their training abroad will normally apply for a Statement of Eligibility for Registration.

Details can be found in *Fact Sheet number 7: Vocational Training and Certification for General Practice* available at

<http://www.rcgp.org.uk/information/publications/information/PDFFact/7OCT05.pdf>

## ***Will the burden of Assessment be reduced?***

Many trainers have raised concerns about the burden of assessment and its effect on teaching. I was optimistic that, with the merger of Summative Assessment and the MRCGP, the burden would reduce, but the reintroduction of video into external Workplace assessment makes this less likely.

## ***Further information***

There is further information on the curriculum at <http://gpcurriculum.co.uk> and in the GP downloads section of the Deanery web site:

<Http://Www.Wmdeanery.Org/Downloads/Downloads.Asp#Gp>

# Worcester VTS Residential

## VTS Programme Spring Term 2006

Date		Session		Subject
<u>February 2006</u>				
15 + 16		1+2+3+4		<u>Residential at Three Ways Mickleton near Evesham</u>
23	<u>Simulated Surgery</u>	5	<u>All Day</u>	<u>Afternoon normal VTS Examination of Joints – Gordon Smith</u>
<u>March</u>				
2	<u>Practice Visits</u>			
9		6	<u>Ben</u>	<u>Elderly Care and Polypharmacy</u>
16		7	<u>Alison</u>	<u>Minor Ailments</u>
23		8	<u>Alison</u>	<u>Heart Failure</u>
30		9	<u>Ben</u>	<u>Endocrine Disorders</u>
<u>April</u>				
6				<u>Unofficial VTS Subregional study day</u>
13				<u>Mrcgp Writtens</u>
20				<u>Subregional study day Mrcgp ORALS</u>
27		10	<u>Fi</u>	<u>MS</u>
<u>May</u>				
4				<u>Unofficial vts / PMDE educational conference Birmingham</u>
11		11	<u>Fi</u>	<u>Erectile dysfunction and HRT</u>
18		12		<u>Debrief and forward planning</u>
25				<u>Unofficial vts</u>
<u>June</u>				
1	<u>Leadership Module Day 1</u>	13+14		<u>Facilitated by Veronica Wilkie</u>
8	<u>Leadership Module Day 2</u>	15+16		<u>Facilitated by Veronica Wilkie</u>

# Worcester VTS Residential

## Plans for the Term

### **Topic**

### **Aims**

What are the key messages that you want to get across? What are the learners needs around this topic? Do my aims cover this? Remember that last term people wanted to know about red flags and prepare themselves for the exam. Could I find an old exam question around the subject to give as homework the week before?

### **Objectives**

What specifically will the learners learn by the end of this session?

### **Methods**

What would be the most appropriate way to teach about this subject?

### **Resources**

Should we do this in house or invite an outside resource? If so, how much will they cost? Can we afford it? Have I swapped email address with my co organisers so we can email each other to co-ordinate our preparation?



# Worcester VTS Residential

A lot  
10    9    8    7    6    5    4    3    2    A little  
1

8. How far do you think that some members feel out of the group?

A lot  
10    9    8    7    6    5    4    3    2    A little  
1

9. How committed are you to task and purpose?

A lot  
10    9    8    7    6    5    4    3    2    A little  
1

10. How committed do you think the rest of the team are?

A lot  
10    9    8    7    6    5    4    3    2    A little  
1

11. How good are the procedures for getting where you want to be? i.e. activities on VTS for helping you become an excellent GP?

A lot  
10    9    8    7    6    5    4    3    2    A little  
1

12. Do you think the VTS has enough guidance from the facilitators on how to get the most out of the half day release

A lot  
10    9    8    7    6    5    4    3    2    A little  
1

13. Are you generally happy with the way decisions have been made on the VTS and in this residential in particular?

A lot  
10    9    8    7    6    5    4    3    2    A little  
1

14. Is a balance achieved between attaining goals and being supportive?

# Worcester VTS Residential

A lot  
10 9 8 7 6 5 4 3 2 A little  
1

15. How well do you think the team members manage their time on the VTS?

A lot  
10 9 8 7 6 5 4 3 2 A little  
1

16. Is there a sense that every one shares responsibility for what happens on the half day release?

A lot  
10 9 8 7 6 5 4 3 2 A little  
1

17. How much do you think the part you play contributes to the whole team activity?

A lot  
10 9 8 7 6 5 4 3 2 A little  
1

18. How well do you think that the group members participate in the various aspects of the functioning of the group?

A lot  
10 9 8 7 6 5 4 3 2 A little  
1

19. How open honest and friendly is the communication?

A lot  
10 9 8 7 6 5 4 3 2 A little  
1

20. Do you think the group feels safe from an emotional point of view?

A lot A little

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10 9 8 7 6 5 4 3 2 1

21. How do you rate the quality of the relationship between members of your team?

A lot  
10 9 8 7 6 5 4 3 2 A little  
1

22. Is there a willingness to look at how members get on or fail to get on with each other?

A lot  
10 9 8 7 6 5 4 3 2 A little  
1

23. Do members listen to the views of other team members – do they really want to hear what is being said?

A lot  
10 9 8 7 6 5 4 3 2 A little  
1

24. Do members feel free to respond when they have listened to what other members have to say?

A lot  
10 9 8 7 6 5 4 3 2 A little  
1

25. How sensitive do you think team members are to each others feelings and needs?

A lot  
10 9 8 7 6 5 4 3 2 A little  
1

26. How well do you think conflict and confrontation are handled with the team?

A lot  
10 9 8 7 6 5 4 3 2 A little  
1

27. How easy is it to express feelings with in the group especially frustration / anger etc

A lot  
10 9 8 7 6 5 4 3 2 A little  
1



# Worcester VTS Residential

## Debrief Sheet Team Work

Appoint one person to fill in the boxes on the collated Action Sheet

Make sure you decide who what and when for each action

Aims	Action		
	What	Who	When
What needs to be done to make the aims clearer?			
What is most important to your team?			
What needs to be done to help the team share a greater sense of purpose?			
What needs to be done to develop members sense of commitment to the team?			
Is the half day release fit for purpose i.e. does it help you become an excellent GP? In what ways could this be improved?			
In what ways could decision making be improved?			

## Worcester VTS Residential

<p>In what ways could time be better managed?</p>			
<p>Giving and receiving Feed back? Are there any ways that this could be improved?</p>			
<p>How could you improve the way in which you contribute to the effectiveness of the team?</p>			
<p>How could all the team members be helped to feel that their contribution is valued as part of the whole?</p>			
<p>How could you be more creative in your contribution to the team's activities?</p>			
<p>In what ways could communication with each other be improved?</p>			
<p>In what ways could we be more understanding of each other?</p>			

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In what ways do you feel the way the group deals with frustration, stress & emotions could be improved?			
What would the group need to do to make this the best term ever in terms of VTS?			