Assessing the consultation: methods of observing trainees in general practice

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Abstract

We compared two different methods of observing trainees at work in general practice: the traditional one of a senior or training general practitioner sitting in during selected surgeries and the more modern video recording, with the patients' written consent. Patients who had experienced the presence of a second doctor during the consultation were less likely to show an increase in arousal after their consultations than those who had been recorded on video. Patients who refused consent to be recorded were more highly stressed than those who agreed and showed smaller decreases in stress after consultations. The presence of two doctors generated fewer reductions in stress after the consultation than video recording did, but this was a non-significant trend. The group that was recorded on video did not differ appreciably from a control group in changes in stress or arousal.

Introduction

Video recording is used more and more in general practices to review the progress of trainees. Our study was designed to assess the reaction of the patient to video recording for his willingness to be recorded and the effect of the recording process on his levels of stress and arousal. Since some form of assessment is essential to training this was compared with the effect of having a second doctor present throughout a consultation.

A sensitive stress and arousal scale has been developed and was applied here to try to discriminate between the methods of assessing trainee general practitioners.[1-3] Reducing stress and increasing arousal are the most common and desirable affects of the consultation, with the former helping to increase recall of information given in the consultation[4] and the latter improving efficiency of performance generally.

There were several expected differences that might have affected the results. The permanence of video recording might disturb the patient if he wished to disclose sensitive information to the doctor. The camera may be much more discreetly placed than a doctor sitting in, however, and is less directly intrusive on the privacy of the consultation. It is considered ethical to request permission from the patient, preferably before and after video recording takes place. This may give the patient more chance to decline than in the case of entering the surgery to be confronted by two doctors.

Method

Patients were selected as subjects from morning, afternoon, and evening surgeries over five months. Patients who were seen by each of the four doctors in the practice were included in each of the three experimental groups:

Control group—Patients were selected, approached, and taken to a separate room in which they completed the low vocabulary MACL scale with symmetrical response categories.[5] They were then asked to complete a consent form in which they gave permission for their consultation to be video recorded. They were asked to return after seeing the doctor and were then shown back to the waiting room. This group of patients was not video recorded. On returning, they repeated the MACL scale and re-signed the form confirming that they knew no recording had been made.

Experimental group 1—Selected patients completed the scale and consent form as above. These patients were actually recorded, the doctor informing patients as he switched on the camera. They also returned to repeat the scale and confirm their consent to video recording. It was confirmed that all patients used in subsequent analysis were aware that a recording had actually been made.

Experimental group 2—Patients were selected and completed the scale as above, but were not asked for consent to video recording. They also agreed to return (for a second administration of the scale) after seeing the doctor and returned to the waiting room to await their appointment. The consulting doctor informed these patients that a second doctor would be present throughout the consultation if the patient agreed. They completed the scale again but were not required to sign a consent form.

The vocabulary used by the investigator varied only slightly as necessary to give instructions to patients in different groups, or to explain more clearly as required by some patients. Whole surgeries were preselected and assigned to one of the three experimental conditions. Patients who attended the surgeries were randomly selected and approached in the waiting area.

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Results

Table I gives the number of patients in each experimental group who showed decreased stress and increased arousal after their consultations. Table II gives the mean changes in stress and arousal from before the consultation to after the consultation in the groups. The data on two patients who had been video recorded were omitted from analysis since they seemed certain that they had not been recorded.

Of the 91 patients asked, 10 requested that the video camera not be used. Two acceptances were noted to be hesitant and another two patients sought confirmation that no examination would be recorded. Patients were asked for consent to be recorded after completing the first stress scale, whichever group they belonged to. Those who refused were still asked to return to complete the scale again. No patients in the sample of 34 refused to allow the second doctor to attend their consultations.

TABLE I—*Changes in stress and arousal after consultations*

Group	No of patients who showed less desirable outcome			No of patients who showed desirable outcome	Total No
	Changes in stress				
	Increase	*No change*	*Total*	*Decrease*	
Control	6	3	9	27	36
Video recorded	8	3	11	34	45
Two doctors present	11	2	13	21	34
	Changes in arousal				
	Decrease	*No change*	*Total*	*Increased*	
Control	7	3	10	26	36
Video recorded	7	10	17	28	45
Two doctors present	17	7	22	12	34

Desirable and less desirable outcomes were compared using two by two χ^2 tests
For arousal: controls v two doctors present: $\chi^2 = 8.17$ ($p < 0.01$).
Video recorded v two doctors present: $\chi^2 = 4.59$ ($p < 0.05$).
For all other χ^2 tests $p > 0.05$.

TABLE II—*Mean stress and arousal ratings before and after consultations*

Group	Stress			Arousal		
	Before	After	Difference	Before	After	Difference
Controls	33·8	27·8	−6·0	22·0	23·8	+1·8
Video recorded	32·0	26·0	−6·0	23·7	25·3	+1·6
Two doctors present	35·2	30·0	−5·2	23·2	23·4	+0·2
Video refusals	46·8	45·8	−1·0	15·8	16·8	+1·0

The results for stress and arousal were compared using 2×2 χ^2 tests (different groups × decreased/not decreased stress; different groups × increased/not increased arousal), since decreased stress and increased arousal were taken to be the most desirable outcomes of the consultation). The group with two doctors present was less likely to show increased arousal than both the control group ($p < 0.01$) and the video recorded group ($p < 0.05$). The apparent trend for reduction in stress to subside when two doctors were present was not statistically significant. The changes in stress and arousal of the group of video recorded patients did not differ from those of the control patients.

Discussion

Video recording is becoming widely used in many areas of training. Many teacher training courses now include some "micro teaching," where a short lesson taught to a small class in a small room is recorded and discussed retrospectively with a tutor, who usually has greater experience of this technique. Similarly, a survey in 1981 showed that at least two thirds of university departments of general practice in the United Kingdom could produce their own video tape recordings as a teaching aid.[6] Eleven departments found the tapes more useful than they had expected and the remainder found them as useful. It is reasonable to estimate that now every department of general practice has this facility and that many training practices now borrow or purchase equipment to review the performance of their trainees.

In university undergraduate teaching "actors" are sometimes employed to behave as patients and the student is video recorded on the basis of this.[6] The micro teaching technique is as far from the real teaching situation as the dramatised consultation is from a consultation in general practice. A general practice may, however, record real consultations, so that the review may be much more valuable if tactfully executed. The doctor, however, cannot be expected to forget the presence of recording equipment, and the isolated consultation may represent only a fragment of the doctor's relationship with the patient. Nevertheless, there is great potential for training in having a permanent record of consultations for assessment and review, especially if the behaviour portrayed may be regarded as typical.

The sensitivity of the original MACL stress and arousal scale has been demonstrated in a variety of circumstances. The adapted low vocabulary version may be rendered less sensitive by the use of fewer items, but the scoring method used should increase sensitivity to balance this effect. Nevertheless, it shows clearly that most patients return from a consultation with a medical practitioner feeling less stressed and more highly aroused than they had previously. The video recorder has no appreciable effect on this, but the presence of a second doctor appreciably reduces the effect of increasing arousal, which is normally present in the consultation. Fewer (though not statistically fewer) patients showed decreased stress when two doctors were present during the consultation. This indicates that the consultation is more "normal" when video recording has been used than when two doctors have been present, which has two important implications. Firstly, if the outcome from the patient's point of view is the same as would normally be expected it is likely that the content of the consultation has been satisfactory to the patient. Secondly, if the outcome and content closely resemble those of a typical consultation then the method of assessment of the trainee is more reliable.

The video recorder is becoming recognised as an invaluable help to training in general practice. Our findings confirm that the video recorder is viable for collecting more permanent and typical representations of a trainee's work, which is often less noticeable and inhibiting to the patient. Secure storage of such records is essential and obtaining written permission respects the patient's right to refuse. Patients should be informed of the reasons for making such recordings and assured that tapes will be erased as soon as their usefulness is expended. Where video recording is found to be reasonably unobtrusive to the behaviour of both patient and doctor it may be a useful source of information for research since it may be combined with other variables, being presumed to have little or no effect.[7]

Conclusions

The MACL is a sufficiently sensitive scale to detect changes in patient stress and arousal before and after a consultation. We have shown arousal to be differentially sensitive to different circumstances in consultations. Having two doctors present during a consultation has an adverse affect on patients' levels of arousal, whereas video recording the consultation does not.

We thank the doctors and staff of the Collingham Health Centre for assistance, Dr Mike Sheldon, department of community health, Nottingham University, for advice, and Trent Regional Health Authority for funding this research.

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(*Accepted 28 February 1984*)

Young Practitioner Groups

Finding our way

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I pay the schoolmaster, but 'tis the schoolboys that educate my son. Emerson, 1849.

To many doctors vocational training is a time for reawakening the old aspirations that drove them to seek medicine as a career. Learning to apply their knowledge in real situations is exhilarating. Acquiring new knowledge, skills, and attitudes, and exploring their feelings towards practice brings new purpose. As such the vocational year is filled with vigour.

Once they become principals in general practice, however, they face many problems from which they have been shielded during vocational training. Educational ideals may become less important. The competing claims of practice and young family, a new list, difficult patients (and, worse still, those avaricious partners), the financial burdens of a large mortgage, a sometimes reduced income, the need to revise for that Royal College of General Practitioners' exam (which we all said we were not going to take anyway): all compete for time. It is tempting to slip back into the easy educational option—the drug company lunch (with, of course, the lecture and opportunity for REM sleep that goes with it). Until they become trainers themselves it is often difficult for young practitioners to find a forum to continue the style of education to which they have become accustomed during vocational training and, more importantly, to find a forum that enables them to explore their anxieties and frustrations in their own peer group.

History of the group

In 1979, recognising this need within ourselves, three of us, all members of the Royal College of General Practitioners, decided to set up the Epsom and Ewell Young General Practitioners' Workshop. We contacted other peers in the area until we had 15 interested doctors, which we thought would ensure an average monthly turnout of between six and 10. Membership was open to all, whether members of the college or not.

Our aims were not stated at this stage but were: (*a*) to form a support group for young principals; (*b*) to enable young principals and their spouses to meet one another socially; (*c*) to take part in peer group learning. Our first meeting took place in the consultants' coffee room of the local postgraduate centre. Suitably, for such a venue, it was entitled "Great medical disasters—please bring your own." The subject proved ideal to open debate on many areas of personal and clinical insecurity, and afterwards we planned a further term's work. We would meet monthly on a different night each month and would stop for three months during the summer. We appointed a convener and agreed that we would each take turns to facilitate. The social element of our group was strong and members' homes were chosen (and have remained) as the venue for subsequent meetings, suitable refreshments being provided by the host. Section 63 approval enabled us to claim for our small out of pocket expenses.

It was a reflection of our perceived but unspoken needs that the first term's work was largely on interpersonal skills. We discussed verbal and non-verbal behaviour, analysed tape recordings of our interviews using the Byrne and Long model[1] and six category intervention analysis,[2] and did some role play and Balint style work. The attendance fell and members expressed dissatisfaction.

The second term's work was much more clinical. We presented case histories, discussing optimal and actual management—that is, peer review. Members with special interests ran sessions on their topics. Attendance rose again.

Although we did not realise it at the time, we were going through some pronounced birth pangs, reflected in changes of membership during the second year. The first remains to this day—the question of leadership. We see ourselves as a peer group. We have no leader, simply a facilitator at each session. Nevertheless, without effective leadership the group may easily fail and at times during the first year the competing needs of the "lions" of the group threatened its integrity. Effective leadership was needed to give weaker members the opportunity to contribute. Our various facilitators, although egalitarian, were often unequal to the task. We were, after all, young doctors untrained in leading groups, unschooled in the skills needed to quell the unruly. Herein the Catch 22—without these skills the group may fail. With these skills you may be too experienced to be a member of a young practitioner group.

In the second year our leadership skills were tested further for we invited several hospital specialists to attend our meetings as resource persons. Though their contributions were valuable, these doctors were often unused to small group work and some turned the programme into a lecture. Our young general practitioner facilitators found it difficult to control this and to reintroduce contributions from general practitioner members.

The second birth pang was that of identifying our aims and needs, which were poorly defined when we started. Members had joined with different aspirations: some social, some educational. Without defining these aims we were unable to satisfy some members who subsequently left.

The third pang, related to the last, was that of incentives and motivation. Members had joined because of peer group pressure, because they were flattered to be asked to take part, and because of the possibility that they might be missing something interesting. What we were offering was something needing personal effort and interest, which entailed divulging one's interpersonal and clinical style, which by taking place in the evening intruded more into family life than lunchtime lectures. The strongest motivation in our group is the affiliative drive: the desire to be one of the group and to contribute educationally and socially. Not all doctors, even vocationally trained doctors, respond equally to these incentives and motivations. Some left.

In the summer of the second year we held a barbecue for members and spouses, which provided an opportunity for our spouses to meet, often for the first time, and for them to share common ideas and problems—itself a valuable educational ideal. Such was its popularity that since then we have had two social events a year: a Christmas party and a summer barbecue. These events provide the opportunity to catch up with colleagues' family evanescences and to discuss the problems of doctors' families in a relaxing environment—for instance, being on call with a young family, dealing with other partners' wives or with patients who are also friends, or coping with sick children and the general practitioner. We now see these social evenings as an important part of our curriculum.

During the first two years each term was planned in open meetings by the whole group and the responsibility for providing background material, accommodation, and facilitator allocated. We had some successful and some unsuccessful meetings, covering subjects such as new developments in respiratory medicine, paediatric ear, nose, and throat disorders, geriatric screening, urology, and gastroenterology. We invited the administrator of the local family practitioner committee, a community psychiatric nurse, a local dentist, and a veterinary surgeon. We analysed our prescriptions and discussed an audit of records (but never actually got round to it). Twenty five people (including two observers who wanted to set up a similar group) came to the evening on respiratory medicine. Four came to the evening on paediatric ear, nose, and throat disorders. Six was about average, usually the faithful few. This variability made us feel that the future was uncertain.

And so at the end of the second year we felt that we were at a cross roads and nearly gave up. In fact we elected a new convener, a small committee to arrange the programme, and recruited three or four new principals. The third year has seen attendances in the order of seven to 10 each month. We have continued our previous style of meetings but in addition have used patient management questionnaires and multiple choice questions to trigger our discussions. Now, at the end of the third year, our convener tells us that six or seven more general practitioners have applied to join. "Should we set up a second group?" she suggests. The future looks more secure.

We have arranged an annual general meeting when we will decide our aims for 1984 and set the year's programme. We shall elect a new convener and now find that we have the necessary skills in our ranks to lead group work effectively. The previous three years have given us trust in one another so that we can now evaluate both our work and ourselves more effectively. I have no doubt that our future will include such activities as a clinical audit and discussion (possibly action) on the college's "quality initiative."[3] The need to evaluate what we are doing has also been mooted.

Discussion

It is not surprising that the group should have had initial problems. With the exception of one member none was used to leading groups or was conversant with the problems that might arise. There were, and still are, few referenced descriptions of young practitioner groups, although, had we had insight, we would have recognised that our problems were similar to those experienced in many other types of small group work. Background reading or the advice of others would have made us more aware, for example, of the need for effective leadership and of the importance of determining the members' needs and expectations.[4] Recent authoritative articles on postgraduate education in general practice[5] and on section 63 activities[6] make no reference to young practitioner groups. This, despite the recognition that small group work is probably the most effective learning environment outside the doctor's own practice provided that the group is relatively small, stable, and honest, and is not dominated by the resource person.[7] The relative obscurity in which young practitioner groups work may hinder their development but our membership thinks that their informality and flexibility is their strength. It is encouraging that the Royal College of General Practitioners has taken a lead by organising in January 1984 the first study day for leaders and participants in such groups.

The one good description of a young practitioner group mentions a genesis closely similar to our own: a vacuum after vocational training, frustration with the programme of the existing postgraduate education centre, personal initiative to set up the group, a combination of medical education with a strong social flavour, and a non-hierarchical structure. Interestingly, this group also underwent a crisis at around two years of age . . . and survived.

Pendleton, in his interim college report on continuing education, notes the tendency of young practitioner groups to concentrate on subjects relevant to their needs (principally performance review of everyday work) and their degree of openness to the scrutiny of peers. In his opinion such a structure, by providing feedback on performance, is usually highly motivating and reflects "the coming of age of a discipline which attempts to develop its standards by putting its efforts under scrutiny."[8]

Pickering said: "Much of the continuing learning process is derived from the doctor's own experience of practice. . . . The free exchange of experience and ideas among doctors at formal and informal discussion is a valuable medium for their continuing education."[9] This is especially true for principals in their fist few years of practice, and one can but hope that the knowledge, skills, and attitudes acquired in young practitioner groups will form a sound basis for life long continuing education.

I thank Dr S Carpenter, Dr A Hastie, Dr P Jenkins, Dr J Tidman, and Dr J Webb for helpful comments on this paper.

Doctors who are interested in the Royal College of General Practitioners study days for members of young practitioner groups may write for further information to Mrs E Monk, Courses Secretary, Royal College of General Practitioners, 14 Prince's Gate, London SW7 1PU.

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Br Med J (Clin Res Ed): first published as 10.1136/bmj.288.6431.1661 on 2 June 1984. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.