GUIDE TO CONDUCTING

CLINICAL TEACHING VISITS

Remote Vocational Training Scheme Ltd.

PO Box 37 Albury NSW 2640

Phone: 02 6057 3400

www.rvts.org.au

Contents

Introduction 1
Why do Clinical Teaching Visits? 1
CT Visits – 'hot learning' 1
Supportive critique 1
Aboriginal Community Controlled Health Services 1
Skills needed 1
Formative MiniCEX forms and training 2
ACRRM formative MiniCEX requirements 2
The Clinical Teaching Visit 2
Clinical Advice and Medical Indemnity 2
Workers Compensation Insurance 2
Selection of Visitors and Conflict of Interest 2
The CTV process: The CTV Coordinator 3
The day before the visit 3
The Visit 3
Further CTV Tips 4
Shortage of patients to see in remote communities 5
Suggestions for activities if there are insufficient patients 5
The Write Up 6
Minimum requirements for a CTV report 6
Recommended Further Reading 7
APPENDICES: 8
Appendix 1: Sample email to practice 8
Appendix 2: Sample Patient Consent and Declaration 9
Appendix 3: Sample Completed Report 11
Appendix 4: Guidelines on giving constructive feedback, PEARLS and Pendleton 20
Appendix 5: Recognising Consultation Styles 21
Document control: 21

Introduction

Thank you for agreeing to do a clinical teaching visit for a Remote Vocational Training Scheme (RVTS) registrar. We hope that you enjoy the experience.

Why do Clinical Teaching Visits?

Clinical teaching (CT) visits are an essential part of the Remote Vocational Training Scheme program and provide an opportunity to observe registrars working in their practices and seeing first-hand the relationships between the registrar, staff, patients, other health professionals and the community in general. While aspects of clinical practice can be assessed at a distance using video, audio and file review, the CT visit gives the visitor the chance to directly observe the registrar within the context of their practice, including the opportunity to assess physical examination skills.

Clinical teaching visits are particularly important for RVTS registrars who work in solo or isolated practices and cannot get direct feedback from practice colleagues.

CT Visits – 'hot learning'

Clinical practice is varied and unpredictable – that's what makes it so interesting, but it also creates a risky learning environment. Clinical practice is described as a place of 'hot' learning: you cannot predict the workload or its urgency so a flexible approach to what to discuss is needed.

Supportive critique

A CT Visitor needs to set a positive tone for the visit and strike a balance of supportive critique. It's important to encourage the Registrar actively and specifically in what is being done well. We all thrive on positive feedback and it's particularly important for solo practitioners. To learn and develop as clinicians, Registrars also need learner centred, specific, clear feedback on what could be done differently. The CT Visitor can also be a sounding board for the Registrar or a 'mirror' reflecting back observations to the Registrar and leaving them to decide on whether change is needed.

Aboriginal Community Controlled Health Services

Since 2014 RVTS has been providing GP Vocational Training to doctors practising in Aboriginal Community Controlled Health Services (ACCHS) across the country. In addition to offering GP services, many ACCHSs offer a wide variety of support services to local Aboriginal and Torres Strait Islander communities. In some cases, the local Aboriginal Health Workers may also be present during consultations. It would be useful to make yourself aware of some of the history and traditions of the community prior to your arrival.

Skills needed

A CT Visitor needs to:

- Observe accurately
- Be curious not judgemental
- Negotiate with the Registrar and agree on priorities for teaching
- Resist the temptation to interfere in consultations unless asked
- Encourage self-reflection of the Registrar
- Distinguish between differences in style and substance – base comments on patient outcome not 'fashion'
- Give clear, specific, feedback – (see appendix 4 for information regarding PEARLS, Pendleton's rules, and Calgary– Cambridge guide)
- Encourage Registrars to experiment with different consultation skills and not get defensive

Formative MiniCEX forms and training

The mini Clinical Evaluation Exercise (MiniCEX) is an excellent form of assessment of the components of the Registrar's consultation skills. RVTS uses this assessment technique for all its Registrars.

A minimum of **three** MiniCEX's per visit **must** be completed. Use the current year's supplied form and a different MiniCEX form for each consultation. Use the MiniCEX forms for consultations requiring a physical examination, where possible.

It is the Registrar's responsibility to have copies of the Formative MiniCEX Scoring Form (including notes on the reverse side) printed out and available for the CT Visitor to complete on the day of the visit. After feedback and advice for improvement has been added, a copy should be made for the Registrar and the CT Visitor should take the originals with them. The CT Visitor is then responsible for returning the completed forms to RVTS along with their completed CTV report.

ACRRM formative MiniCEX requirements

As from 2017, summative MiniCEX was no longer offered to registrars. All registrars are required to undertake summative Case Based Discussion (CBD) and meet the revised formative MiniCEX requirements.

Formative MiniCEX remains an important component of the assessment program and will continue as a formative assessment conducted by supervisors and medical educators throughout training. Registrars are required to have a formative MiniCEX conducted on a minimum of nine patient consultations during their training.

The Clinical Teaching Visit

Clinical Advice and Medical Indemnity

RVTS, as an organisation, does not have medical indemnity insurance. It is therefore extremely important that the CT Visitor has their own medical indemnity cover. Any direct patient contact by the CT Visitor is not encouraged and is done on a personal basis rather than on behalf of RVTS, and therefore such advice must be covered by the CT Visitor's own medical insurance.

All CT Visitors must provide RVTS with evidence of current medical indemnity cover. This can be emailed to rvts@rvts.org.au. RVTS staff will remind each CT Visitor when a copy of their new medical indemnity cover is required.

Workers Compensation Insurance

Visitors who undertake a clinical teaching visit and invoice RVTS as a Company or Partnership must have Workers Compensation Insurance via their Company or Partnership. Doctors who undertake the visit as a sole trader are covered for workers compensation by RVTS.

Selection of Visitors and Conflict of Interest

Visitors are usually only asked to undertake visits within their local area, therefore the number of visits any individual visitor may be asked to undertake will depend on where our registrars are located in any given year and what stage they are at in the training program.

It is noted that at times there may be situations that could cause a conflict of interest and it may not be possible for a visitor to do visits in their immediate area. It is important that visitors declare any conflict of interest and decline requests for visits with registrars, particularly where they are the registrar's line manager or employer; a work colleague; a relative of the registrar; are currently in or have previously had a personal relationship with the registrar; or are the registrar's GP.

The CTV process: The CTV Coordinator

- Sends the CT Visitor an Agreement to be completed and returned with a copy of their current medical indemnity.
- Co-ordinates the CT visit dates and duration of visit (generally half day).
- Arranges travel, accommodation and hire car (if applicable).
- Provides the registrar's practice phone number, and practice address to the CT Visitor.
- Sends a confirmation letter/email to the practice outlining the patient requirements, timing and a patient consent form with a copy to the CT Visitor and registrar (see appendices 1 and 2). Blank MiniCEX forms are also attached so that they can be printed out by the registrar prior to the arrival of the CT Visitor.
- Emails a reminder to the practice before the visit and cc's the registrar and the CT Visitor.

The day before the visit

- We suggest that you phone the registrar/practice manager and confirm your time of arrival and departure.
- Photocopy and pack:
    - CTV Report Template
    - travel arrangements (if applicable)
    - RVTS office phone number (02) 6057 3400

RVTS prefers to arrange a hire car for land travel where available. If a hire car is not available or a visitor chooses to drive their own car, an amount equivalent to the cost of a hire car for the journey may be claimed by prior agreement with the CTV Coordinator. Please note that RVTS cannot be held responsible for any damage that may occur to your own vehicle.

The Visit

On arrival / before commencing

- Introduce yourself to the practice manager and other staff.
- Ideally, spend 15 minutes talking to the registrar about
    - their medical background
    - how long they have been at the practice
    - how things are going
    - which assessment they plan to undertake (RACGP or ACRRM) and when they intend to sit exams
    - whether they would like you to focus on anything in particular e.g. management phase of the consultation, body language etc
    - be clear with the registrar that you will not talk during the consultation unless they ask for your opinion
    - advise the registrar to obtain patient consent before the patient enters the room. Occasionally patients will say no.
    - discuss with the registrar how you would like to be introduced, (as a visitor can be taken as indicating that the doctor is being checked for poor performance), for example:

- "This is doctor x from y who is sitting in to observe me today because I'm studying for a higher degree in general practice"

- advise the registrar that if they conduct sensitive physical examinations e.g. PR or vaginal examination/Pap smear, to draw the curtain around the patient as you will not be observing the examination. Registrars need to advise patients about this.
- discuss a strategy at the beginning of a CTV, for instances that may require you to intervene in some form for the benefit of patient welfare. Once you have alerted the registrar, options include:
    - Can I offer you something from my experience?
    - Tell registrar 'This is the way I like to do this' (i.e. correct positioning of an instrument).
    - (Rarely) Ask the registrar to come out of the consultation room with you to discuss issues regarding the patient (e.g. where the patient or the registrar may be embarrassed by the discussion or where a serious error of judgement is concerned).
- The registrar should feel free to ask questions if they or the CT Visitor thinks they are out of their depth.
- Ask the registrar to brief you on the patient. This encourages the registrar to read the notes and summarise before the patient comes in.
- Suggest to the registrar that you go through their notes and their list of patients from yesterday together and discuss how accurately the notes reflect what was going on.
- Looking at referral letters is a good way to see how the registrar has relayed the information to the person that's receiving the referral letter.
- **Advise the registrar that you will be filling out three MiniCEX forms during your visit**. The MiniCEX should be completed for patients requiring a physical examination. Before departing, ensure that a copy is made for the Registrar, and then take the originals with you to return to RVTS with your full report after the visit has concluded.

Further CTV Tips

Observing rather than talking may feel alien at first and takes considerable discipline. Tell the registrar to ask you to leave the consultation if your presence is stopping the patient saying something crucial to the doctor or might prevent culturally appropriate health care. The latter is more common if the CT Visitor and registrar are of different genders.

Find a place to sit in the consultation room where you can see the registrar and the patient but be unobtrusive, ideally out of the line of sight of the patient. In small rooms this can be a challenge.

Make electronic or paper notes during the consultation on what you observe. Some people keep chronological notes, others divide a page into aspects of the consultation that were effective and points for discussion. Make detailed notes during a CTV so you can quote the registrar during feedback sessions if appropriate.

After each consultation ask the registrar to reflect on the consultation. For registrars early in training, making use of Pendleton's rules is recommended, but advanced registrars may learn more by a more focussed approach discussing elements of the consultation that they recognise they want feedback on (see appendix 4). Information about recognising different patterns of problems in the consultation is available in appendix 5.

At the end of the visit thank the registrar for the privilege of sitting in and the clinic for their hospitality.

Strategies to use if the cases are too simple:

- After the patient has gone, think of how to make the case more complex.
- Ask the registrar what they would have done in that situation.
- Role play the scenario (if appropriate, with the registrar as the doctor).

Ask the registrar what they would have done differently if they had been in an exam. Then ask them to reflect on why they didn't do it differently in real life.

If you have serious concerns about a registrar's progress, safety, or welfare, and feel they may be at risk from a professional or personal point of view, please contact the RVTS CTV Medical Educator or the registrar's Registrar Training Coordinator (RTC) as soon as possible after the visit. If you do not know who the RTC is, please contact the CTV Coordinator at RVTS and they will provide you with the RTCs contact details.

Giving feedback to a registrar who lacks insight into their performance can be very challenging. The following questions may be helpful.

'How do you think the patient felt?'

'Do you think the patient would come back to you if they had a choice?'

If a registrar is an International Medical Graduate (IMG) and English is not their first language, encourage them to check their patient's understanding by asking the patient to repeat what they have been told.

Shortage of patients to see in remote communities

This may be an issue in some remote and Aboriginal and Torres Strait Islander communities where the non-attendance rate is generally high, and/or due to sorry business. This possibility can be planned for in advance by discussing contingencies with the registrar prior to the visit, e.g. ask if they would like a particular skill or topic(s) taught if things are quiet. Only agree to teach something if you feel comfortable doing so.

Suggestions for activities if there are insufficient patients

- Role play cases from your own practice and give the registrar feedback
- Discuss exam(s) and give tips if you are familiar with the process
- Do a chart audit - discuss patient management and/or look at the quality of the record keeping
- Discuss practice management topics e.g. IT, billing Medicare, recall and reminder systems, dealing with conflict, human resource management
- Discuss current patients that they are concerned about and management strategies
- Provide the opportunity to debrief on past concerns
- Visit the local shop if in a remote community and discuss relevant public health issues with the registrar, including the cost of food, its quality and placement
- Discuss possible ways of improving the public health of the community. Encourage the registrar to consider community relevant activities that could be initiated
- Discuss the registrar's career aspirations and their feeling about working in a remote community, if applicable
- Discuss online resources and systems in clinics

The Write Up

Minimum requirements for a CTV report

Reports must be typed, not handwritten, using the MS Word template provided and returned to RVTS within one week of the visit in MS Word format. Please contact the CTV Coordinator if you do not have access to MS Word so alternate electronic arrangements can be made.

The report should be **written in the first person** as if the registrar is the reader, e.g. "You established rapport with all of your patients" rather than "John established rapport with all his patients".

The report is individual patient based (refer sample at appendix 3) whilst the Clinical Consultation Assessment Tool should be based on an overall review of all patients.

For each patient seen:

1. Summarise the case, (except for MiniCEX see below) e.g. **patient's age and gender**, their problem/diagnosis and management. **Please do not use the patient's name or initials in the report.**
2. Write a specific example(s) of what was done well (if applicable).
3. Write a specific example(s) of what could be done better, concentrating on areas for improvement in clinical knowledge and in communication skills in each case observed.
4. Conclude the report by listing or writing about what the registrar does well overall (e.g. good rapport with patients, relaxed manner) and some general issues that need improving (e.g. don't interrupt, avoid asking several questions one after the other without getting an answer).
5. If appropriate, suggest the registrar discuss a scenario and/or role play it with their supervisor.
6. End the report with something positive e.g. wishing them all the best for the future.
7. There is no need to duplicate information about the MiniCEX patients in your written report. Just write e.g. Patient 4 - see MiniCEX report.

Email (to the CTV Coordinator) the completed CTV report (in MS Word format), MiniCEX forms and tax invoice **within one week of visit.** Keep copies of tax invoices (e.g. petrol for hire car) so that they can be claimed and submitted with the tax invoice.

Notify CTV Coordinator at RVTS if you have any concerns about the visit e.g. registrar over/under-booked or if you have concerns about the registrar's performance. This can be discussed confidentially with an RVTS Medical Educator.

NB. RVTS will provide feedback on report writing if something needs to be done differently by the visitor for future visits.

Recommended Further Reading

Hays RB, Content validity of a rating scale for General Practice Consultations, Medical Education 1990; 2:100-116 as quoted in The Royal Australian College of General Practitioners, RACGP training program curriculum companion 1999, South Melbourne, Vic

Hays R, *Sitting in* Chapter 5 in Practice based teaching A Guide for General Practitioners (2006), Eruditions Publishing, Melbourne

John Spencer *ABC of learning and teaching in medicine* Learning and teaching in the clinical environment *BMJ* 2003; 326: 591-594

Jill Gordon *ABC of learning and teaching in medicine* One to one teaching and feedback BMJ 2003; 326: 543-545

Fiona R Lake and Gerard Ryan *Teaching on the run* Teaching on the run tips 3: planning a teaching episode MJA 2004; 180 (12): 643-644
http://www.mja.com.au/public/issues/180_12_210604/lak10260_fm.html

John Fraser Registrar clinical teaching visits, Evaluation of an assessment tool Australian Family Physician Vol. 36, No. 12, December 2007 pp 1070-1072
http://www.racgp.org.au/afpbackissues/2007/200712/200712fraser.pdf

The **Skills Cascade website** is a collection of resources set up by East Anglia Communications skills cascade facilitators to promote and support the teaching of communication skills in health care. The website has handouts and presentations on aspects of teaching communication skills such as teaching time management and dealing with the angry patient.
http://www.skillscascade.com/index.html

APPENDICES:

Appendix 1: Sample email to practice

Email sent by RVTS staff to Registrar's practice about clinical teaching visit plans.

Dear Practice Manager

This email is to confirm the arrangements for Dr [Registrar's name] Clinical Teaching Visit (CTV).

TIME/DATE: **xxPM/AM Day Month**
LOCATION: **Practice name**
Practice Address
CT VISITOR: **Dr [CT Visitor's name]**

CTV schedule
CTVs are to take at least three hours (up to a maximum of four hours). Please arrange the patient load to ensure:

- 15 minutes without patients at the beginning of the CTV to allow for introductions between the Visitor and the Registrar
- No more than three patients are seen per hour

It is understood that urgent cases will be managed as needed.

Example of CTV Schedule

15 mins	*Brief meeting with CT Visitor (introductions; purpose of visit; anything that the Registrar would like the Visitor to focus on; how critical incidents will be managed, should they arise).*
30 mins x 6	*Consultation with patient and feedback*

Total = 3.25 hours

Patient consent
It is important that patients are advised of the visiting doctor's presence when booking their appointment and when they arrive. They should also be offered the opportunity to see their doctor without the visitor if they prefer.
Each patient will need to sign a consent form for the practice to keep. The practice manager (or delegate) then signs the Practice Declaration confirming that patient consent forms were received by the practice. The Practice Declaration is then emailed to RVTS.

On the day of the visit:

- **Patient Consent forms (attached)** - Provide a printed copy to each patient to sign before their consultation.
- **Practice Declaration (attached)** - Practice Manager to complete after the visit and return via email to rvts@rvts.org.au. Copies of the Patient Consent forms are not required by RVTS.
- **Formative MiniCEX forms (attached):**
    - Printed copies to be provided to the CT Visitor prior to the first consultation (or enable access to electronically complete the interactive pdf)
    - CT Visitor needs to complete 3 MiniCEX forms during the visit
    - Practice to make copies for the Visitor and the Registrar
    - CT Visitor to email copies to RVTS after the visit along with full report. A copy should also be retained by the Registrar.

Thank you for your assistance with the arrangements for this visit.

Please do not hesitate to contact me if you have any queries.

Regards
[CTV Coordinator]

Appendix 2: Sample Patient Consent and Declaration

RVTS
Remote Vocational Training Scheme Ltd

PATIENT CONSENT FORM

Dear Patient

Direct observation of consultations by a Clinical Teaching Visitor

Today Dr. _____ has a Clinical Teaching Visitor,

Dr. _____ In the room with them.

The Clinical Teaching Visitor is present to observe and discuss aspects of General Practice as part of ongoing professional development.

The Clinical Teaching Visitor will not participate directly in the consultation. The content of the consultation will remain confidential.

If you would prefer not to have another doctor present for all or any part of the consultation, please let the receptionist or your doctor know.

Please tick:

I consent to having Clinical Teaching Visitor present during my consultation ☐ YES ☐ NO

Full Name _____

Signature _____ Date _____

An Australian Government Initiative
ACN 122 891 838
PO Box 37 Albury NSW 2640 Tel: **02 6057 3400** Email: **info@rvts.org.au** Web: **www.rvts.org.au**

PRACTICE DECLARATION

(to be completed by Practice Manager or delegate after visit)

I, ... (*insert name*) as Practice Manager/Delegate

at .....(*insert Practice name*),

confirm that this Practice has sought patient consent for those patients seen by

Dr ..... (*insert Registrar's name*)

during the Clinical Teaching Visit conducted on ..... (*insert date*)

Signed ..... Date: / /

Please return completed declaration to RVTS via email: xweber@rvts.org.au.

An Australian Government Initiative
ACN 122 891 838
PO Box 37 Albury NSW 2640 Tel: **02 6057 3400** Email: **info@rvts.org.au** Web: **www.rvts.org.au**

Appendix 3: Sample Completed CTV Report

(including Clinical Consultation Assessment Tool and MiniCEX Scoring Form)

Registrar Name	*Please type full name of Registrar here*	**Cohort**	
Visitor Name		**Date of Visit**	
Start time		**Finish time**	

Section 1: Patient Summaries

Patient 1	Gender:	MALE	Age:	83
***Details*:**				
Requesting cryotherapy for skin damage. He actually wanted you to check a lesion on his lip. Hypertension review.				
Observations:				
The patient came in for a lesion on his lip, but you went to examine his BP before you looked at the lip. The lesion you rightly considered possibly an SCC, but not till after the patient had left! You were going to follow this man up on the next visit in 1-2 weeks and biopsy the lesion. You used simple English words rather than medical jargon. Well done! Your follow-up instructions were not clear. Be specific about how soon you want the patient to return e.g. "Come and see me in one week" rather than "come back and see me".				
Knowledge and/or Skills Learning Point/s:				
• Check whether the lesion is at the same or a different site to the biopsy undertaken by your colleague some time ago. • When you do a BP reading on your machine to see how it compares with the patient's home readings, explain why you are doing this. Otherwise it looks like you don't trust the patient's readings. It is a good idea to have the patient bring in their machine to you once or twice a year so you can check the readings against your own at the same time.				
Communication Learning Point/s:				
• Attend to the patient's presenting complaint first before doing anything else you think is necessary. • Give your patient time to fully explain their reason for seeing you [lesion on the lip] before you start doing what you would like to do [checking the BP].				
Clinical Reasoning Skills (if applicable):				
• How did you decide this lesion was an SCC? How did it differ from a BCC? What other differentials can you name for this lesion? How does this lesion differ from your differentials?				

Patient 2	Gender:	MALE	Age:	51
***Details*:**				
Hand dermatitis				
Observations:				
You had not seen this condition before.				
Knowledge and/or Skills Learning Point/s:				
• Don't be afraid to ask for advice. • Consider taking a photo and sending it to Telederm with a history. You will have an answer and helpful advice very quickly! The patient always sees this as you are being interested in them, not as a deficit in your skills.				

- There is a new Eczema/Dermatitis module on RRMEO that would help you a lot in this area of general practice.
- We discussed emollients, different strengths of topical steroid and the different role of creams [for moist areas] and ointments [for dry areas] and salicylic acid to dissolve thickened skin to allow the steroids to get to the skin.
- We also discussed the use of glad wrap plastic occlusion for up to 30 minutes to assist steroid penetration into the skin when strong treatments are needed. Review in 1-2 weeks is useful.

Communication Learning Point/s:

- Listen to the patient's story and make sure you understand what he/she thinks caused the problem [in this case sheep and handling oil] neither of which were the cause here.
- You must explain the disease in such a way that the wrong ideas are corrected, and correct ones are learned [e.g. prevention strategies etc.].

Clinical Reasoning Skills (if applicable):

- What differential diagnosis can you name for this problem. How did you rule the others out?

Patient 3	Gender:	FEMALE	Age:	26

***Details*:**

Refer MiniCEX

Patient 4	Gender:	MALE	Age:	53

***Details*:**

Pt presented for follow up for gangrenous left 5th toe likely caused by malnutrition, poor self-care, and episode of cellulitis. He lived in a remote poorly serviced community 80 km away with no services.

Observations:

You clearly knew the history, had treated him in hospital with referrals and had previously examined him thoroughly. You performed a systematic and thorough examination of the foot and leg to mid-calf as well as vitals including pulse and temperature. You had previously assessed his (good) peripheral pulses. You explained what you were doing and reports you were waiting on, and what further tests need to be done. You discussed your management plan with the patient. There was a lot of information given that I am not sure the patient could take in. You asked if the pt had any questions and offered to communicate with and/or be available to a GP if he visited family in Victoria, including phone and fax contact for practice.

Knowledge and/or Skills Learning Point/s:

- You might consider examination of proximal nodes, although infection seemed settled.

Communication Learning Point/s:

- You could consider writing down complex or multiple directions for the patient.
- You might speak more slowly to assist communication.

Clinical Reasoning Skills (if applicable):

- You showed excellent CR here.

Patient 5	Gender:	MALE	Age:	45

***Details*:**

Video consultation review: patient recovering from a serious leg injury.

Observations:

You interrupted the patient's story with questions. This resulted in him repeating himself a few times.

Knowledge and/or Skills Learning Point/s:
• Nil
Communication Learning Point/s:
• When the patient has finished their story, summarise it and ask them if you have the details correct. • Acknowledge how they must have felt suffering such a serious injury. • Try not to interrupt the story until the patient has clearly finished all they want to tell you. • Then ask, "Can you tell me more?" Many a tricky problem has been solved by careful listening!
Clinical Reasoning Skills (if applicable):
• What factors might be delaying this patient's recovery?

Patient 6	Gender:	MALE	Age:	60
***Details*:**				
Refer MiniCEX				

Patient 7	Gender:	FEMALE	Age:	55
***Details*:**				
BP script renewal. Patient doing home readings. Borderline low thyroid, [asymptomatic]. Bone density [back pain but playing golf and tennis]. Checking level of Alcohol intake.				
Observations:				
Communication Skills. You showed excellent consultation skills here. You gave reassurance where appropriate, negotiated achievable change in healthy activities, and rightly discussed lowering the level of antihypertensive medication, telling the patient "you might be able to do without it".				
Knowledge and/or Skills Learning Point/s:				
• Try to increase your local knowledge of crops, harvests, rainfall, the seasons etc. as this will give you invaluable insight into how your patients are faring and will help you detect those who are suffering more than average and at risk of depression, anxiety or suicide.				
Communication Learning Point/s:				
• Nil				
Clinical Reasoning Skills (if applicable):				
• NA				

Patient 8	Gender:	FEMALE	Age:	80
***Details*:**				
Review of BCC excision. Interpreting results and communicating this to the patient. Cramps at night.				
Observations:				
Cramps at night: Ask the patient "Tell me more?" rather than "What time ". We discussed that "What time" is your usual question when you don't know what history to ask or what the correct English words are. The patient's daughter gave you some cues about what was in fact good treatment, but you did not acknowledge her, partly because you were looking at the computer while she and her mother [the patient] were talking and partly because you were trying to look up the problem on a website[?]. Sometimes the patient already has the therapeutic answer and all you need to do is check that is OK and say "Yes, it is a good idea to try that".				

Knowledge and/or Skills Learning Point/s:
• Your explanation to the patient of the Marginal excision was clear. However, your explanation of conservative management was confusing. You might benefit from having a set saying such as "It is close to the edge, but not serious, so we can just watch it and see if it re-appears". • When you do this, give a definite time in which this might happen e.g. 2-3 months or "up to 6 months" and how often the patient should check e.g. once a month or every two months, based on how quickly the lesion appeared. • You need to have a clear history of how long it took to grow.
Communication Learning Point/s:
• Develop a bank of questions to improve your history taking for the times when you don't know what the patient has wrong with them, or you don't know what they are trying to say.
Clinical Reasoning Skills (if applicable):
• How will you recognise an early BCC on this patient?

Patient 9	Gender:	MALE	Age:	46
***Details*:**				
Refer MiniCEX				

Section 2: Clinical Consultation Assessment Tool

To be completed as an overall review of visit (not individual consultations).

Guide to rating scale *(please type x in the relevant column for each statement)*	Not applicable	Never	Sometimes	Mostly	Always
Building Rapport					
The introduction to the patient was appropriate					
The patient was placed at ease					
The patient was given time to explain why they had attended					
History-taking phase: Attending Listening and Responding					
The patient was listened to attentively					
The doctor responded to patient questions					
Non-verbal cues were appropriately followed up					
Verbal cues were appropriately followed up					
The doctor used open questions where possible					
The questioning was organised/logical					
The questions were in context					
The doctor asked if the patient had any further questions					
Other problems were acknowledged					
Appropriate eye contact was made					
Managing Doctor /Patient Talk					
The doctor used simple words for medical terms [i.e. avoided jargon]					
The patient's words were understood					
The doctor affirmed appropriately e.g. nodding, saying yes etc.					
The doctor faced the patient or relative whenever they were speaking					
Empathy					
The doctor showed empathy towards the patient's situation					
Language skills					
The doctor was easily heard					
The doctor's accent was no hindrance to understanding					
The doctor spoke at a rate suitable for the patient					
Examination phase					
Permission was obtained for the examination					
The examination was appropriate to the history					
The patient's presenting problem was examined first					

Clinical Consultation Assessment Tool **Guide to rating scale** *(please type x in the relevant column for each statement)*	**Not applicable**	**Never**	**Sometimes**	**Mostly**	**Always**
Diagnostic phase					
Appropriate hypotheses were formed, and problems defined					
Reasons for coming to the clinic were adequately defined					
Other relevant problems were defined					
Management phase					
Appropriate action for each defined problem was taken					
Correct use of time and resources was made					
Explanation to the patient was adequate					
The patient was appropriately involved in decision-making					
The patient was given appropriate written information					
Closing phase					
The timing of closure was appropriate					
Clear follow-up arrangements were made					

Overall Performance (click on relevant box)		
☐ **Significant improvement required**	☐ **Improvement required**	☐ **At expected standard**

Clinical Notes (click on relevant box)		
Registrar notes consulted prior to patient coming in:	☒ **YES**	☐ **NO**
Standard of notes:	☐ **Not yet satisfactory**	☒ **Satisfactory**
Areas for improvement:		
Please add any comments you feel are relevant or would assist the Registrar		

Section 3: CT Visitor Comments

Registrar strengths:
You showed a keen interest and enjoyment in knowing your patients and managing their health problems. You are enjoying the challenge of continuing care compared to the "One off" care of the Emergency department. The Practice and the patients enjoy your gentle and humorous approach to things so much so that you have been invited to stay on in the practice. Well done! You are keen to learn and have been making regular videos of consultations for discussion with your supervisor. You always read the patient's notes before they come into the room. This is excellent practice!
Scope for Registrar improvement (include details of additional resources if applicable):
A few things are listed above. A few other details are: Check your pronunciation of some common words e.g. xxxxxxx. Continue working on slowing down your words so others can understand what you are saying. If you are confused by a patient's story, try to summarise then ask them to fill in the details rather than restart the history by asking lots of questions which usually makes it even more confusing. Then if you have no luck, ask for help.
Comment on overall clinical reasoning skills (if applicable):
Any other comments/additional information relevant to the Registrar's circumstances or future plans:
Please add any comments you feel are relevant or would assist the Registrar's Supervisor, ME and/or RTC.

Report Components	**Completed**
Section 1: Patient Summaries	☐
Section 2: Clinical Consultation Assessment Tool	☐
Section 3: CT Visitor Comments	☐
Attachments: At least 3 MiniCEX Forms (must be completed during the CTV for all Registrars; regardless of College pathway)	☐

Return report in Word document format to xxxx@rvts.org.au

OFFICE USE ONLY - CTV Report read by RVTS Medical Educator and approved for release.

Signed: Date:

Formative MiniCEX Scoring Form

Date of assessment:

Registrar Name:

Assessor Name:

Assessor Position: ☐ FACRRM ☐ Medical Educator ☐ Accredited ACRRM Supervisor

Name and address of assessment location:

Curriculum Requirement:

☐ Primary Curriculum ☐ Emergency AST ☐ Mental Health AST ☐ ATSIH AST
☐ AIM AST ☐ Paediatrics AST ☐ Remote Medicine AST ☐ Surgery AST

Patient gender: ☐ Female ☐ Male **Patient age:** **New patient:** ☐ Yes ☐ No

Reason for consult:

Body system:

☐ Cardiovascular ☐ Respiratory ☐ Endocrine
☐ Abdominal ☐ Neurological ☐ Musculoskeletal region
☐ Mini-mental state assessment ☐ Neonatal/Paediatric ☐ Antenatal (first visit)

Case complexity: ☐ Low ☐ Medium ☐ High

Strengths:	**Suggestions for development:** *If a candidate receives a rating which is borderline or unsatisfactory, the assessor must complete this section*
BOTH of these boxes are to be completed - please ensure handwriting is easy to read	

Please rate the candidate against what you would expect of a candidate in that stage of training:

	Unsatisfactory	Borderline	Satisfactory	Excellent
Overall clinical competence	☐ 1	☐ 2	☐ 3	☐ 4
Clinical management	☐ 1	☐ 2	☐ 3	☐ 4
History taking	☐ 1	☐ 2	☐ 3	☐ 4
Communication skills	☐ 1	☐ 2	☐ 3	☐ 4

Physical Examination: Please rate the candidate against what you would expect of a candidate in that stage of training:

Tick if no physical examination ☐ **N/A**

	Unsatisfactory	Borderline	Satisfactory	Excellent
Overall competence in physical examination	☐ 1	☐ 2	☐ 3	☐ 4
Appropriateness of physical examination in the context of the consultation	☐ 1	☐ 2	☐ 3	☐ 4
Appropriate examination technique	☐ 1	☐ 2	☐ 3	☐ 4
Correct interpretation of findings	☐ 1	☐ 2	☐ 3	☐ 4
Professional approach to patient and family	☐ 1	☐ 2	☐ 3	☐ 4
Accurate recording of physical examination findings	☐ 1	☐ 2	☐ 3	☐ 4

A Physical Exam Reference document is available on the assessment webpage.

Assessor Signature: Date:

Registrar Signature: Date:

Time taken for observation: **minutes** **Time taken for feedback:** **minutes**

Guidelines for completing the MiniCEX form are provided - see next page for details

Mandatory physical examination categories Five different systematic physical examinations conducted within the context of a consultation are required, each from a different system across the nine cases • Cardiovascular • Respiratory • Abdominal • Neurological • Endocrine • Musculoskeletal • Mini-mental state examination • Neonatal/paediatric • Antenatal (first visit)	**Patient consent forms** Please ensure patient consent forms are collected and stored as per the protocol of the venue where the miniCEX is being conducted.
How to rate a candidate **Unsatisfactory:** The candidate has not managed this case presentation appropriately at the level of a safe practitioner. **Borderline:** The candidate is not performing at a level expected at this stage of training. **Satisfactory:** the candidate is performing at a level expected at this stage of training. **Excellent:** The candidate is performing at a level above expected at this stage of training.	**Definitions of case complexity** **Low:** this may include presentations where there is a single problem, requiring limited history, physical examination and straight forward management. **Medium:** this may include presentations where there are one or more problems, requiring a detailed history and examination of multiple systems, the diagnosis is not straight forward and patient review following a period of management will be required. **High:** This may include difficult problems where the diagnosis is unclear and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order of which they should be performed.

Definition of Terms: Specific Areas of Assessment

Overall clinical competence Characteristics of a 'satisfactory' candidate in this area may include: overall the candidate demonstrates a systematic approach; is consistently competent across the marking categories; and has made clear efforts to ensure patient comfort and safety and to reduce risk where appropriate in the clinical situation.	**History taking** Characteristics of a 'satisfactory' candidate in this area may include: the candidate effectively uses appropriate questions to obtain an accurate, adequate history with necessary information, and response appropriately to verbal and non verbal cues.
Clinical management Characteristics of a 'satisfactory' candidate in this area may include: the candidate makes an appropriate diagnosis; formulates a suitable management plan; selectively orders or performs appropriate diagnostic studies; and considers the risks and benefits to the patient. The candidate has a clear and demonstrated understanding of the patients community needs, the socioeconomic context and the particular mortality and morbidity patterns of that community; and provides high quality care to the patient, family and broader community that is delivered locally (as far as possible).	**Communication skills** Characteristics of a 'satisfactory' candidate in this area may include: the candidate explores the patient's problem using plain English; is open; honest and empathetic; negotiates a suitable management plan/therapy with the patient; shoes respect; compassion and empathy establishes trust; attends to the patients needs of comfort; shows awareness of relevant legal frameworks; and is aware of own limitations. Where relevant, the candidate demonstrates an understanding of the differing cultural beliefs, values, and priorities of Aboriginal and Torres Strait Islander people, as well as other cultural groupings regarding their health and health care provision, and the candidate communicates effectively respecting these cultural differences.

Revised June 2018

Appendix 4: Guidelines on giving constructive feedback, PEARLS and Pendleton

The ability to give constructive feedback is critical in medical education. It is the one teaching skill for which there is overwhelming evidence of its effectiveness. This guide is designed to help you give constructive feedback.

As teachers or mentors, we are giving feedback all the time whether we are aware of it or not. RVTS registrars are competent and experienced doctors but feedback from peers or colleagues is rare. Seeming uninterested or an over concerned look from a clinical teaching visitor could have unintended ramifications for reducing registrar confidence. To avoid this, mistake the opposite can occur of the clinical teaching visitor being overly positive and avoiding addressing important clinical issues. Finding the balance is important.

PEARLS (1) is a useful acronym for setting the tone for feedback.

Partnership – joint problem solving
Empathic understanding
Acknowledge unavoidable barriers to the learner's success – this is particularly relevant with the demands of solo or remote practice
Respect for the registrar
Legitimise the registrar's feeling and intentions
Support for efforts at correction

With the relationship and basis for feedback set, listen carefully to the first few words that the registrar says after the consultation finishes. Give them space to breathe and reflect – you need to hear their emotional reaction to the consult and often they will come up with plenty of ideas on what they could do differently. These few seconds of self-reflection are vital for showing how much insight the registrar has into their consulting and its effectiveness. You can then pitch your teaching appropriately. Often your role is merely to agree with their self-diagnosis and help them work out how things can improve in the future.

But it does help to have a framework for what you are going to say.

Pendleton's rules can feel odd to use at first but have the great advantage that they force the doctor to verbalise what they have done well.

Pendleton's Rules

- Briefly clarify matters of fact
- The doctor first says what was done well, and how
- The observer says what was done well, and how
- The doctor then says what could be done differently, and how
- The observer says what could be done differently, and how

Once you have done a few consultations using Pendleton's rules it begins to feel rather cumbersome and the registrar begins to want more focussed feedback. You can then switch to using the Calgary-Cambridge SET-GO method.

SET-GO

Facilitator: What I **S**aw – descriptive, specific, non-judgemental

Registrar: What **E**lse did you see?

Facilitator: What do you **T**hink? Registrar given opportunity to acknowledge and problem solve

Facilitator: What **G**oal does registrar want to achieve?

Facilitator: **O**ffer suggestions, alternatives to be rehearsed

Further details about the Calgary-Cambridge method of giving feedback are available on the skills cascade website www.skillscascade.com

To avoid defensiveness by the registrar it's recommended that your comments are: non-judgemental, specific, directed towards behaviour rather than personality, based on patient outcomes, addressed to the registrar's self-identified learning needs, and aimed at problem-solving by suggestions rather than prescriptive comments.

References:

Milan FB, Parish SJ, Reichgott MJ. A model for educational feedback based on clinical communication skills strategies: beyond the "feedback sandwich". Teaching and Learning in Medicine. 2006; 18(1):42-7.

Pendleton D, Schofield T, Tate P, Havelock P. The Consultation: An Approach to Learning and Teaching. Oxford: Oxford University Press; 1984 Kurtz SM, Silverman JD, Draper J (1998) Teaching and Learning Communication Skills in Medicine. Radcliffe Medical Press (Oxford)

Appendix 5: Recognising Consultation Styles

A useful set of questions to ask yourself as you are watching any consultation are:

- can you recognise any patterns here?
- have you seen this problem before?
- how might the registrar who performed the consultation be feeling?
- how might the "patient" be feeling?
- what does the registrar already know?
- how could you "generalise away"? i.e. from the specific problem demonstrate a broader principle of medical practice
- when would the best time be to do it? i.e. during or after the session
- what area or what research and theory would be relevant to teach on?

Some of the common problem patterns which occur in consultations are as follows:

- the registrar does not discover all the issues or problems the patient wishes to discuss
- the registrar does not listen, often not asking open ended questions initially or interrupting with closed questions
- the registrar does not elicit the patient's ideas, concerns, expectations, and feelings; or establish a collaborative relationship, and instead takes a doctor-centred position throughout the interview
- the registrar develops little rapport or is not responsive to the patient
- the registrar misses important cues from the patient
- the registrar obtains an inaccurate or incomplete clinical history because of failure to get the balance right between open and closed questions, summarising, checking, or sharing his/her thinking process
- the registrar forgets to find out what the patient already knows before giving an explanation
- the registrar gives too much information at once and uses jargon
- the registrar does not negotiate with the patient and check that the patient is agreeable to the plan
- the registrar makes inadequate follow up arrangements or none at all

Adapted from http://www.skillscascade.com/handouts/pattern_recognition.htm

The SkillsCascade website is a collection of resources setup by East Anglia, UK Communications skills cascade facilitators to promote and support the teaching of communication skills in health care.