2.01 THE CONTEXTUAL STATEMENT ON

# The GP Consultation in Practice

This statement is part of the curriculum produced by the Royal College of General Practitioners (RCGP) which defines the learning outcomes for the discipline of general practice and describes the skills you require to practise medicine as a general practitioner in the National Health Service (NHS) of the United Kingdom. Although primarily aimed at the start of independent work as a general practitioner, it must also prepare the doctor beyond the training period and provide support for a professional life of development and change.

Royal College of General Practitioners
30 Euston Square, London, NW1 2FB Phone: 020 3188 7400; Fax 020 3188 7401

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# KEY MESSAGES

- As a general practitioner you must have a commitment to patient-centred medicine
- A non-judgemental attitude is necessary to promote equality and value diversity
- Clear, sensitive and effective communication with your patient and their advocates is essential for a successful consultation
- The epidemiology of illness presenting in general practice requires a normality-orientated approach, as opposed to the disease-orientated approach of secondary care
- Negotiating management plans with the patient involves balancing the patient's values and preferences with the best available evidence and relevant ethical and legal principles
- As a general practitioner you must manage complexity, uncertainty and continuity of care within the time-restricted setting of a consultation

# INTRODUCTION

The consultation is at the heart of general practice. It is the central setting through which primary care is delivered and where the curriculum outcomes detailed in the statement *Being a General Practitioner* are demonstrated. As a general practitioner, if you lack a clear understanding of what the consultation is, and how the successful consultation is achieved, you will fail your patients.

Underpinning the learning outcomes in this statement is a commitment to patient-centred medicine.[1,2] This term is often used so loosely that it can sometimes seem to mean little more than 'good' medicine. For the purposes of the curriculum, however, as a patient-centred doctor you should be able to demonstrate an awareness of the following three key areas:

1. Understanding the wider context of the consultation: this means perceiving that your patient is a person; a belief that the sick patient is not a broken machine; and that 'health' and 'illness' comprise more than the presence or absence of signs and symptoms. A constant willingness, therefore, to enter your patient's 'lifeworld'[3] and to see issues of health and illness from a patient's perspective.
2. Recognising that patient-centred medicine depends on an understanding of the structure of the consultation – in particular that good consultations are often associated with particular consultation styles and skills.[4,5,6,7,8] However, the expectations and preferences of your patients will vary, so that as a patient-centred doctor you must be able to select from a range of styles and skills.
3. Being committed to an ethical, reflective attitude that enables you to understand and monitor your practice, and develop it to the benefit of your patients.

Consulting and communication skills are often used interchangeably, but effective communication skills, while essential, are only a subset of the knowledge, skills and attitudes required to consult effectively. Within the consultation your patients rely on your skills as a doctor not only to identify any significant illness, but also more frequently its probable absence. Understanding the epidemiology of illness presenting in general practice requires a normality-orientated approach, as opposed to the disease-orientated approach in secondary care. This approach requires the recognition of 'red flag' elements in the patient narrative which may represent a significant illness in its early and undifferentiated stage, where urgent intervention is needed in order to minimise

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[1] Mead N and Bower P. Patient-centredness: a conceptual framework and review of the empirical literature *Social Science & Medicine* 2000; 51:1087–110

[2] Stewart M, Brown JB, Freeman TR. *Patient-Centered Medicine. Transforming the clinical method (2nd edn)* Oxford: Radcliffe Medical Press, 2003

[3] Mishler EG. *The Discourse of Medicine: dialectics of medical interviews* Norwood, NJ: Ablex, 1984

[4] Stewart M and Roter D (eds). *Communicating with Medical Patients* London: Sage, 1989

[5] Stewart M. *Patient-Centered Medicine: transforming the clinical method* London: Sage, 1995

[6] Silverman J, Kurtz S, Draper J. *Skills for Communicating with Patients (2nd edn)* Oxford: Radcliffe Medical Press, 2004

[7] Kurtz S, Silverman J, Draper J. *Teaching and Learning Communication Skills in Medicine (2nd edn)* Oxford: Radcliffe Medical Press, 2004

[8] Maguire P and Pitceathly C. Key communication skills and how to acquire them *British Medical Journal* 2002; 325: 697–700

risk. Physical examination and investigations should be appropriate, timely and should follow the best available evidence. As a GP, one of the most effective tools at your disposal is the use of time, watching and waiting when it is safe to do so, and also using the continuity of contact with individual patients and their families. The long-term relationship between you and your patient acts as a repository for mutual trust and understanding, which enables high-quality care.

There are ethnic and cultural differences in the way that illness presents. Health beliefs and preferences have a major impact on patient management and on a patient's willingness to engage with health services. You must be able to handle the challenge of consultations with patients who have different languages, cultures, beliefs and expectations, and in localities where the management possibilities are significantly different (many are illustrated in the case below). Management plans should be negotiated taking account of and respecting your patient's values and preferences. As a GP you should understand the make-up of your practice population in order to understand the context of your patients. This includes socio-economic factors, ethnic and religious groupings, housing, and unemployment rates. In the increasingly complex world of modern-day healthcare you may also have to act as an advocate for your patients in helping them make choices concerning their own healthcare.

General practitioners, in common with all health professionals, are expected to act in accordance with the ethical principles set out in professional codes of conduct.[9] These codes set both minimum standards and limits of behaviour beyond which a practitioner must not go. Within this framework health professionals make decisions that require application and interpretation of these codes and guidelines to the circumstances of particular cases or situations. To do this they must be able to identify ethical issues arising in practice, evaluate the moral reasoning for different courses of action, and justify their decisions. As a doctor you must be aware of your own personal attitudes, values, and ethical viewpoints and strive to ensure that these do not have a detrimental impact on your care of a particular patient problem.

Consultations are time-constrained. Longer consultations tend to be associated with better health outcomes, increased patient satisfaction and enablement scores. However, your clinical effectiveness depends on effective consulting skills to ensure that whatever time you have with the patient is used efficiently, rather than consultation length per se. As a doctor you need to navigate the patient through the usual phases of the consultation in the appropriate sequence and at an appropriate pace. For example, if you don't spend sufficient time discovering the reason for the attendance and your patient's expectations of the consultation, then your management plan is less likely to be appropriate, and patient safety and satisfaction may be compromised.

International studies have shown that effective and informed primary care by highly trained family doctors delivers care that is more cost-effective and more clinically effective than systems with a lower emphasis on primary care.[10] General practitioners need to make efficient use of available resources for any user of the healthcare system and therefore need to know how to find and apply best scientific knowledge that is relevant to a patient at the time they present in primary care.

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[9] General Medical Council. *Good Medical Practice* London: GMC, 2013

[10] Starfield B. *Primary Care: balancing health needs, services and technology* Oxford: Oxford University Press, 1998

Many doctors understand and value the consultation, which is often the 'implicit curriculum' that they are able to articulate without ever having read the curriculum statements. Appreciating the relationship between the consultation and the rest of the curriculum may help you to explore, learn, use and value the whole curriculum. The 'areas of competence' used in the consultation are transferable to other areas of the curriculum, where they can be used and developed further. For example:

- Your communication skills and attitudinal approaches with patients are transferable to working with colleagues
- The mindset of the 'holistic approach' is transferable to 'community orientation', where we move beyond considering the impact of problems on the patient/family unit to consider the community/societal impact and our responses to these
- Shared decision-making (to some degree) is transferable to the context of distributed leadership in the primary healthcare team
- 'Specific problem-solving skills' are transferable to a 'comprehensive approach', where they are applied in often more challenging contexts, e.g. dealing with multiple problems simultaneously rather than a single issue

# CASE ILLUSTRATION

Mrs Leela Patel, a 45-year-old Indian lady who has breast cancer, attends your surgery to discuss her treatment following a recent hospital appointment. Her oncologist has informed her that the cancer has not responded to the latest course of chemotherapy and has suggested that she should consider further treatment with a new drug. She informs you that she had a terrible time with the chemotherapy and she does not wish to have any more treatment.

She says that she would like to see an Ayurvedic doctor who specialises in cancer treatment. She says that she does not mind paying for this treatment if you are unable to refer her on the NHS.

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

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| Primary care management | What open-ended and sympathetic questions would I use in order to establish the facts and reasons for my patient seeking a referral to an alternative practitioner? |
| Person-centred care | What are Mrs Patel's health beliefs, cultural norms and concepts regarding health issues?<br>Are there possible language/cultural difficulties and how could these be managed (e.g. using an interpreter)? |
| Specific problem-solving skills | How would I approach the patient's right to choose what treatment she wishes to have and not have (respecting her autonomy) with my doctor's duty to protect my patient from harm?<br>And how would I define the various potential harms that might result from different courses of action? |
| A comprehensive approach | What are the implications of Mrs Patel's request and need for support in terms of service provision and time management? |
| Community orientation | How would I ensure support and reassurance regarding continuity of care, primary care team support and assessing support for the carers? |
| A holistic approach | Am I aware of the issues relating to ethnic populations' perception of the healthcare system and health? |
| Contextual features | What do I know about the regulation of complementary medicine, its availability on the NHS and, if not available, where it could be accessed? |
| Attitudinal features | What are my feelings about the request? For example, do I feel sadness, personal inadequacy about dealing with such issues?<br>Do I have personal views regarding complementary medicine or cultural influences on medicine? |
| Scientific features | What do I know about complementary medicine and the evidence base for it compared to the chemotherapy regime being offered by the oncologist? |

# LEARNING OUTCOMES

This is one of four contextual statements (2.01–2.04) which explore in greater detail particular aspects of your work as a GP. They contain learning outcomes in the 'areas of competence' and 'essential features' relevant to their topic. These learning outcomes or objectives are in addition to those detailed in the core statement, *Being a General Practitioner*. The core statement and this statement should be used in conjunction with the other curriculum statements. In order to demonstrate the core competences in this contextual statement you will require knowledge, skills and attitudes in the following areas:

## The RCGP areas of competence

### 1 Primary care management

This area of competence is about how you manage your contact with patients, dealing competently with any and all problems that are presented to you. (This area of competence is not limited to dealing with the management of the practice.)

This means that as a GP you should:

1.1 Understand the common models of the consultation that have been proposed and how you can use these models to reflect on previous consultations in order to shape your future consulting behaviour

1.2 Use the skills typically associated with good doctor–patient communication

1.3 Adapt communication skills to meet the needs of the patient, including working with interpreters to deal with patients from diverse backgrounds

1.4 Demonstrate focused questioning and examination to obtain sufficient relevant information to diagnose, manage and refer appropriately

1.5 Demonstrate sufficient knowledge of the breadth of scientific evidence in order to provide the best information for patients about their illness

1.6 Effectively use patient records (electronic or paper) during the consultation to facilitate high-quality patient care

1.7 Use time and resources effectively during the consultation

1.8 Demonstrate techniques to limit consultation length when appropriate

1.9 Recognise the roles of health and social care colleagues and draw on this expertise appropriately

1.10 Keep accurate, legible and contemporaneous records

## 2 Person-centred care

This area of competence is about understanding and relating to the context of your patients as individuals, and developing the ability to work in partnership with them.

This means that as a GP you should:

2.1 Recognise that patients are diverse: that their behaviour and attitudes vary as individuals and with age, gender, ethnicity and social background, and that you should not discriminate against people because of those differences

2.2 Be aware of the range of values that may influence your patient's behaviour or decision-making in relation to his or her illness

2.3 Respond flexibly to the needs and expectations of different individuals

2.4 Demonstrate how to use the computer in the consultation while maintaining rapport with your patient

2.5 Share information with patients in an honest and unbiased manner, in order to educate them about their health (doctor as teacher)

2.6 Negotiate a shared understanding of the problem and its management with patients, so that they are empowered to look after their own health

2.7 Achieve meaningful consent to a plan of management by seeing the patient as a unique person in a unique context

2.8 Apply ethical guidance on consent and confidentiality to the particular context of an individual patient

2.9 Apply the law relating to making decisions for people who lack capacity to the particular context of an individual patient

2.10 Understand the importance of continuity of care and long-term relationships with your patient and their family in identifying and understanding the values that influence a patient's approach to healthcare

## 3 Specific problem-solving skills

This area of competence is about the context-specific aspects of general practice, dealing with early and undifferentiated illness and the skills you need to tolerate uncertainty, and marginalise danger, without medicalising normality.

This means that as a GP you should:

3.1 Formulate appropriate diagnoses, rule out serious illness and manage clinical uncertainty

3.2 Base treatment and referral decisions on the best available evidence

3.3 Make timely and appropriate referrals, using relevant information

3.4 Demonstrate the ability to communicate risks and benefits in a way that is meaningful to patients

3.5 Demonstrate the skills to offer patients health choices based on evidence so that an informed discussion can occur, taking into account patients' values and priorities

3.6 Recognise that the efficacy of evidence-based interventions depends on concordance with agreed therapeutic aims

3.7 Recognise the opportunities offered by continuity of care and how a long-term relationship can be used to enhance therapeutic concordance with evidence-based interventions

3.8 Recognise the scarcity of evidence derived from a patient's perspective

3.9 Recognise the range of values that influence decisions by your patients, their families and health professionals, and where these values conflict

3.10 Apply ethical and legal frameworks to analyse issues and resolve conflicts of values

## 4 A comprehensive approach

This area of competence is about how you as a general practitioner must be able to manage co-morbidity, co-ordinating care of acute illness, chronic illness, health promotion and disease prevention in the general practice setting.

This means that as a GP you should:

4.1 Use the consultation to educate patients about self-management of acute and chronic disease

4.2 Demonstrate a commitment to health promotion within the consultation, while recognising the potential tension between this role and a patient's own agenda

4.3 Use the 'best possible evidence' to inform patients of the 'best possible' way to navigate the healthcare system

4.4 Understand that co-morbidity or disease progression may affect a patient's decision-making capacity

4.5 Recognise and respond to a patient entering a terminal stage of illness, and the values that are important in managing this

## 5 Community orientation

This area of competence is about the physical environment of your practice population, and the need to understand the interrelationship between health and social care, and the tensions that may exist between individual wants and needs and the needs of the wider community.

This means that as a GP you should:

5.1 Be aware of the obligation to use available healthcare resources in a prudent manner, balancing individual patient needs with fairness to other patients

5.2 Manage the potential conflicts between personal health needs, evidence-based practice and public health responsibilities

5.3 Recognise that socio-economic deprivation is a major cause of ill health

5.4 Understand how the values and beliefs prevalent in the local culture impact on patient care

5.5 Understand how the demography and ethnic and cultural diversity of your practice population impact on the range and presentation of illness in the individual consultation

5.6 Identify lessons from individual consultations, such as unmet health needs and gaps in service provision, and use these to develop appropriate services for the community as a whole

## 6 A holistic approach

This area of competence is about your ability to understand and respect the values, culture, family structure and beliefs of your patients, and understand the ways in which these will affect the experience and management of illness and health.

This means that as a GP you should:

6.1 Be able to explain the concepts of ethnicity and culture

6.2 Include the cultural values and circumstances of your patient in the consultation

6.3 Understand the process by which patients decide to consult, and how this can affect consulting outcomes

6.4 Understand that consultations have a clinical, a psychological and a social component, with the relevance of each component varying from consultation to consultation (the 'triaxial' model)

6.5 Recognise that episodes of illness usually affect more than merely the patient

6.6 Understand the relationship between the interests of patients and the interests of their carers

6.7 Negotiate whether and how relatives, friends and carers might become involved, while balancing your patient's right to confidentiality

6.8 Understand that your patient's views and perspectives may change during the course of a chronic disease

6.9 Accept that patients may wish to approach health (and illness) in a non-scientific way. The reality for patients is that they make their own choices on the basis of their own values and not necessarily on the basis of clinical efficiency or resource implications

6.10 Accept that patients may prefer to delegate their autonomy to you as their GP, rather than accept this responsibility themselves

# The essential features of you as a doctor

The three essential features (EFs) below are concerned with the features of you as a doctor which may influence your ability to apply the core competences to real life in the work setting.

## EF1 Contextual features

This essential feature is about understanding your own context as a doctor and how it may influence the quality of your care. Important factors are the environment in which you work, including your working conditions, community, culture, financial and regulatory frameworks.

Examples of this are:

- EF1.1 Recognising how consultations conducted via remote media (telephone and email) differ from face-to-face consultations, and demonstrating skills that can compensate for these differences
- EF1.2 Understanding interprofessional boundaries with regard to clinical responsibility and confidentiality
- EF1.3 Understanding local referral pathways and services to ensure appropriate and efficient provision of care
- EF1.4 Understanding how the social context of primary care frames the identification and resolution of ethical issues by general practitioners

## EF2 Attitudinal features

This essential feature is about your professional capabilities, values, feelings and ethics and the impact these may have on your patient care.

Examples of this are:

- EF2.1 Recognising your roles and responsibilities as a GP towards your patients
- EF2.2 Recognising the limits of your own abilities and expertise
- EF2.3 Recognising, monitoring and managing personal emotions arising from the consultation
- EF2.4 Recognising how personal emotions, lifestyle and ill-health can affect your consultation performance and the doctor–patient relationship
- EF2.5 Understanding that your attitudes, feelings and values are important determinants of how you practice
- EF2.6 Demonstrating a non-judgmental approach, treating your colleagues, patients, carers and others equitably and with respect
- EF2.7 Valuing people's beliefs and preferences in clinical and everyday working
- EF2.8 Recognising and taking action to address discrimination and oppression by yourself and others
- EF2.9 Challenging behaviour that infringes the rights of others
- EF2.10 Reflecting on how particular clinical decisions have been informed by ethical concepts and values such as consent, confidentiality, truth telling and justice
- EF2.11 Being able to clarify and justify your personal ethics to patients and to external reviewers

## EF3 Scientific features

This essential feature is about the need to adopt a critical and evidence-based approach to your work, maintaining this through lifelong learning and a commitment to quality improvement.

Examples of this are:

- EF3.1 Understanding the principles of evidence-based practice and how you can apply these principles, given the condition of the patient and the healthcare system

EF3.2 Demonstrating an awareness that a combination of evidence-based treatments is not always evidence-based in itself. Interactions between single interventions may increase or decrease efficacy

EF3.3 Exploring patient values and placing them in context with clinical evidence, so that you can develop an appropriate shared-management plan

EF3.4 Demonstrating an awareness of your own attitudes, values, professional capabilities and ethics so that, through the process of reflective and critical appraisal, you are not overwhelmed by personal issues and gaps in your knowledge

EF3.5 Undertaking self-appraisal through such things as reflective logs and video recordings of consultations, and seeking out opportunities for your educational development based on this

# LEARNING STRATEGIES

## Work-based learning

As a specialty trainee, primary care is the ideal place for you to learn about the GP consultation in practice. There will also be excellent opportunities in secondary care settings. Examples of how to make the most of your clinical experience include:

- Video analysis of consultations. This can be done using the consultation observation tool (COT)
- GP trainers can sit in with specialty trainees to give formative feedback. This can be done using the COT
- Random case analysis of a selection of consultations. This can be done using case-based discussion (CBD)
- Reflection on secondary care consultations using the clinical evaluation exercise (mini-CEX)
- Patients' feedback on consultations using validated satisfaction questionnaires or tools, for example the RCGP patient satisfaction questionnaire (PSQ)
- Sitting in with GPs and other healthcare professionals in practice to observe different consulting styles
- Observation of consulting behaviour during outpatient clinics

As a GP specialty trainee you should have opportunities to discuss ethical and other values-related aspects of your practice with colleagues as these arise in your day-to-day work: in addition to contact with patients, their families and the wider community, relevant contexts include such areas as audit and significant event review meetings, and developing practice policies (e.g. on patient consent or on the appropriate use of health service resources). As a trainee, it is particularly helpful if there is 'protected time' for reflection and shared learning in which training resources (articles, case studies, etc.) are combined with discussion of real issues arising in your own practice. Presenting cases to your peer groups as part of the more formal training programme will promote reflective practice and can be used to illustrate the diversity of values within a specific professional group.

It is also important for specialty trainees to understand that the practice of medicine has its own culture, values, morals and beliefs that may set doctors apart from patients. During your training you should be supported to gain a better understanding of the diverse nature of the society in which you will work. You should also learn to ask questions and look critically at your assumptions and attitudes about people who are different from yourself, as well as to reflect on these issues and, importantly, on your own feelings. The specialty trainee working in a hospital or in primary care should be training in an environment that embraces differences and similarities in culture, backgrounds and experience. This should be an environment free from racism, sexism and bullying where there are positive role models and processes in place that promote equality and value diversity in the workplace.

## Non-work-based learning

Courses or teaching using role-played consultations are tremendously valuable in exploring consultation behaviour in a safe environment, especially those using 'standardised patients'.

Peer-group meetings, such as GP vocational training scheme meetings, are an excellent forum for you to discuss, in confidence, video-taped consultations recorded in your surgery or using commercially available teaching packages. For example, the RCGP's training DVD '*Consulting Communication Skills for GPs in Training*'[11] is an excellent resource for specialty trainees and established GPs who wish to improve their consultation skills.

Competent GPs who wish to develop further expertise in consulting may find the consultation expertise model useful.[12] This model presents a schematic representation of what expert family doctors actually do, which can be used to analyse an individual consultation to produce a 'fingerprint' of the level of expertise demonstrated in that consultation. The consultation expertise model was developed to explain the observed differences in behaviour between specialty trainees and experienced GPs during simulated consultations.

**Balint groups**

The Balint group is a highly developed and tested method of small-group consultation analysis that aims specifically to focus on the emotional content, not just of single consultations but of ongoing doctor–patient relationships. Many doctors who have had the experience of Balint training attest to the lifelong benefits that it can bring in terms of interest in patients' lives, self-knowledge, job satisfaction and prevention of 'burn out'. A growing body of research evidence supports the effectiveness of Balint training in many countries.[13],[14],[15],[16]

The aims of a Balint group, as recognised by the Balint Society (www.balint.co.uk) are:

- To provide a safe environment where group members are able to talk in confidence about the feelings aroused in them by their patients
- To encourage the doctors to see their patients as human beings with a life and relationships outside the surgery, and a history going back to childhood that has helped to determine what they have become
- To help doctors explore in detail the emotional content of their interaction with a particular patient: to understand how their behaviour and reactions have been unconsciously affected by the feelings projected by the patient, and resonating with those of the doctor

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[11] Hull M. *Consulting Communication Skills for GPs in Training* Birmingham: RCGP Midland Faculty, 2005

[12] Worrall P, French A, Ashton L. *Advanced Consulting in Family Medicine: the consultation expertise model.* Oxford: Radcliffe Medical Press, 2009

[13] Matalon A, Rabin S, Maoz B. Communication, relationships and Balint groups. In: *Proceedings of the 14th International Balint Congress* Stockholm: International Balint Federation and the Swedish Association of Medical Psychology, 2005, pp. 25–9

[14] Kjeldmand D. Balint training makes GPs thrive better in their job *Patient Education and Counseling* 2004; 55(2): 230–5

[15] Samuel O, Sackin P, Salinsky J, *et al*. Balint in GP Vocational Training Schemes *Work-Based Learning in Primary Care* 2004; 2: 26–35

[16] Pinder R, McKee A, Sackin P, *et al*. *Talking about My Patient: the Balint approach in GP education* Occasional Paper 87. London: Royal College of General Practitioners, 2006

- To help them learn how to contain a patient's feelings even when these are uncomfortable and to tolerate feelings such as helplessness and anxiety
- To help them understand how a distressed patient may need to be held and supported in an ongoing therapeutic relationship, in a series of consultations with the same doctor over a period of time

If you have concerns about your own clinical performance – for example perhaps you are returning to work after a period of absence, or you have health problems which may be impacting on your performance – you can self-refer to the National Clinical Assessment Service (NCAS) through their telephone advice numbers on their website. They provide expert advice about the steps you can take and where you can go for help. See the NCAS website www.ncas.nhs.uk/.

## Learning with other healthcare professionals

The consultation can be used as a focus for your discussion with other health professionals, either by observing a live consultation, using role-play or by watching video-taped consultations. Consultations are a rich learning resource that can trigger multidisciplinary discussion about consulting skills, patient management, ethics, evidence-based practice, clinical guidelines, etc.

# LEARNING RESOURCES

## Examples of relevant texts and resources


- Adults with incapacity (Scotland) Act, 2000, www.opsi.gov.uk/legislation/scotland/acts2000/asp_20000004_en_1
- Berne E. *Games People Play* London: Penguin, 1964
- BMA Consent Toolkit. BMA 2009, http://bma.org.uk/practical-support-at-work/ethics/consent-tool-kit
- Bowman D, Spicer J. *A Reader in Primary Care Ethics* Oxford: Radcliffe Publishing, 2007
- Byrne P and Long B. *Doctors Talking to Patients* London: HMSO, 1976
- Dowrik C and Frith L (eds). *General Practice and Ethics: uncertainty and responsibility* London: Routledge, 2005
- Fulford KWM, Peile E, Carroll H. *Essential values based practice: clinical stories linking science with people* Cambridge: Cambridge University Press, 2012 ISBN 978-0-521-53025-5
- Gidekel L, Topolevski L, Abecasis G, *et al*. Balint group operation in internal medicine residents of an emergency hospital. In: *Proceedings of the 11th International Balint Congress* Southport: Limited Edition Press, 1998, pp. 134–50
- Goleman D. *Emotional Intelligence* London: Bloomsbury, 1996
- Greenhalgh T. *How to Read a Paper: the basics of evidence-based medicine (4th edn)* London: BMJ Books, 2010
- Hull M. *Consulting Communication Skills for GPs in Training* Birmingham: RCGP Midland Faculty, 2005
- Hope T, Savulescu J, Hendrick J. *Medical Ethics and Law: the core curriculum (2nd edn)* Edinburgh: Churchill Livingstone, 2008
- Kurtz S, Silverman J, Draper J. *Teaching and Learning Communication Skills in Medicine (2nd edn)* Oxford: Radcliffe Medical Press, 2004
- Marinker M. Myth, paradox and the hidden curriculum *Medical Education* 1997; 31: 293–8
- Mental Capacity Act Code of Practice. Provides an explanation of the Act and the obligations of those caring for people who lack capacity, including health professionals, www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf
- Moulton L. *The Naked Consultation* Oxford: Radcliffe Publishing, 2007
- Neighbour R. *The Inner Consultation: How to Develop an Effective and Intuitive Consulting Style (2nd edn)* Oxford: Radcliffe Publishing, 2004
- Pendleton D, Schofield T, Tate P, *et al*. *The Consultation: an approach to learning and teaching* Oxford: Oxford University Press, 1984
- Pendleton D, Schofield T, Tate P, *et al*. *The New Consultation: developing doctor–patient communication* Oxford: Radcliffe Medical Press, 2003
- Salinsky J and Sackin P. *What are You Feeling Doctor? Identifying and avoiding defensive patterns in the consultation* Oxford: Radcliffe Medical Press, 2000
- Sackett DL, Straus SE, Richardson WS, Rosenberg W, Haynes RB. *Evidence-based medicine: how to practise and teach EBM* (*2nd edn)* Edinburgh & New York: Churchill Livingstone, 2000
- Silverman J, Kurtz S, Draper J. *Skills for Communicating with Patients (2nd edn)* Oxford: Radcliffe Medical Press, 2004
- Slowther A, Ford S, Schofield T. Ethics of evidence based medicine in the primary care setting *Journal of Medical Ethics* 2004; 30: 151–5
- Stewart I and Joines V. *TA Today: a new introduction to transactional analysis* Nottingham: Lifespace Publishing, 1987

- Stott NC AND Davis RH. The exceptional potential in each primary care consultation *Journal Royal College of General Practitioners* 1979; 29: 201–5
- Tate P. *The Doctor's Communication Handbook (5th edn)* Oxford: Radcliffe Medical Press, 2007
- Toon P. *What is Good General Practice?* London: Royal College of General Practitioners, 1994
- Working Party of the Royal College of General Practitioners. *The Triaxial Model of the Consultation* London: RCGP, 1972
- Worrall P, French A, Ashton L. *Advanced Consulting in Family Medicine: the consultation expertise model* Oxford: Radcliffe Medical Press, 2009


## Web resources

**The Balint Society**

The aim of the Balint Society is to help GPs towards a better understanding of the emotional content of the doctor–patient relationship. The Balint method consists of regular case discussion in small groups under the guidance of a qualified group leader.

www.balint.co.uk

**BMA ethics section**

Has a range of guidance for doctors on ethical issues in practice including a section on the questions practitioners most commonly ask of the ethics team.

http://bma.org.uk/practical-support-at-work/ethics

**Clinical Ethics**

Aimed at practising clinicians and researchers. This journal has practically focused articles on ethical and legal issues in healthcare.

www.rsmjournals.com

**GMC website**

Contains all recent GMC guidance including guidance on consent and confidentiality. The site also has a series of interactive case studies covering ethical issues faced in day-to-day practice called *GMP in Action* (from *Good Medical Practice*).

www.gmc-uk.org

**Institute of Medical Ethics website**

This site has a range of learning resources for practising clinicians and teachers of medical ethics linked to the IME's core curriculum for medical ethics and law. These include links to relevant guidelines and legislation, video clips and case vignettes as well as an extensive range of further reading. Resources are organised under useful headings such as mental health and care of children.

www.instituteofmedicalethics.org/website

**RCGP website**

The RCGP website contains the key information about workplace-based assessment (WPBA) of communication skills in general practice. Several methods are available to assess competence in the consultation, in both primary and secondary care. These include case-based discussion (CbD), the consultation observation tool (COT) and the patient satisfaction questionnaire (PSQ). It is an essential site for GP specialty trainees.

www.rcgp.org.uk/gp-training-and-exams/mrcgp-workplace-based-assessment-wpba.aspx

**RCGP e-learning resources**

***e*-GP**

For *The GP Consultation in Practice, e*-GP includes courses on The Consultation in Context, Practical Consulting, Clinical Ethics and Values, and Promoting Equality and Valuing Diversity.

www.e-GP.org

**UK Clinical Ethics Network**

This website has a range of information and educational materials for clinicians on ethical issues arising in clinical practice.

http://ukcen.net

# ACKNOWLEDGEMENTS

This curriculum statement is based on and replaces the following statements in the 2007 version of the RCGP Curriculum.

- *2 The General Practice Consultation*
- *3.3 Clinical Ethics and Values-Based Practice*
- *3.4 Promoting Equality and Valuing Diversity*
- *3.5 Evidence-Based Practice*

It has drawn on various national guidelines and policies, current research evidence and the expertise and clinical experience of practising general practitioners.

**The authors and contributors for this statement are:**

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|---|---|
| **Authors:** | Dr Adam Fraser, Professor John Skelton, Dr Anne-Marie Slowther, Dr Has Joshi, Dr Veronica Wilkie |
| **Contributors:** | Members of the RCGP Curriculum Development Group |
| **Editors:** | Dr Frances Peck, Dr Charlotte Tulinius |
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The 2007 version of the statement and subsequent updates can be found on the RCGP website. The Royal College of General Practitioners would like to express its thanks to all the individuals and organisations who have contributed so generously to past and present versions of this statement.