

COT: Detailed Guide to the Performance Criteria

PC1: The doctor is seen to encourage the patient's contribution at appropriate points in the consultation.

This PC is particularly looking for evidence of a doctor's active listening skills, the ability to use open questions, to avoid unnecessary interruptions, and the use of non-verbal skills, in exploring and clarifying the patient's symptoms.

Remember to think of the competences as active ones. In many consultations there is little need to encourage; the patient comes in and states what is the matter, and the doctor may not necessarily be given credit for that. You should seek for evidence that the doctor can encourage a contribution from a patient when encouragement is needed.

PC2: The doctor is seen to respond to signals (cues) that lead to a deeper understanding of the problem

The competence is to respond appropriately to important, significant (in terms of what emerges afterwards) cues.

Take account of non-verbal cues, if these are evident. However, the doctor's response to a non-verbal cue may either be verbal (commenting that a patient seems upset, worried etc), non-verbal (use of silence) or active (a change in body posture, a touch to the patient, offering the patient a tissue). It is important that you are alert for these responses.

This PC certainly incorporates "showing empathy", and if you notice an empathic response, consider whether it represents a response to a cue (i.e. the "cue" may be explicit, but the emotional significance that is being responded to may be quite subtle).

PC3: The doctor uses appropriate psychological and social information to place the complaint(s) in context.

*We expect candidates to consider relevant psychological, social including occupational aspects of the problem: these may be known beforehand, or offered spontaneously by the patient, or elicited. The competence is to **use** the information in exploring the problem e.g. "how does your backache affect your life as a builder".*

PC4: The doctor explores the patient's health understanding.

This PC incorporates exploring the patients "ideas, concerns and expectations", in the context of the Unit - "Discover the reasons for the patient's attendance". The competence is the curiosity to find out what the patient really thinks - a cursory "what do you think?" without any response to the answer will not do. But questions like "what did you think was going on.....what would be your worst fear with these symptoms.....were you concerned this was serious.....what were you hoping I would do for this condition are much more likely to get a valuable response.

PC5: The doctor obtains sufficient information to include or exclude likely relevant significant conditions.

Registrars demonstrate this competence by asking questions around relevant hypotheses. It is important to remember the context of general practice, and especially that registrars are not (usually) specialist-generalists in any field.

This is the medical safety PC, which addresses the focused enquiry that commonly occurs during the consultation, not necessarily at a particular stage: it may happen during an examination, or later, during the explanation, or even as an afterthought.

This is an occasion when closed questions may be the most efficient method of obtaining the information, for example to determine whether or not a patient with headaches might have a serious illness such as raised intracranial pressure. It does not mean that the doctor has to go into every conceivable detail or chase rare diagnoses. Remember that it is part of the element **obtain sufficient information about symptoms and details of medical history** which in turn is part of **defining the clinical problem(s)**. It is about taking a history in the degree of detail which is compatible with safety but which takes account of the epidemiological realities of general practice.

PC6: The physical/mental examination chosen is likely to confirm or disprove hypotheses that could reasonably have been formed, OR is designed to address a patient's concern.

The competence will usually be the choice of examination, not the way it is done (because the video may not be the best place for that to be assessed- however it may generate discussion in this area). A mental state examination would be appropriate in a number of cases. Intimate examination should not be recorded!

PC7: The doctor appears to make a clinically appropriate working diagnosis

Whilst this is included in the consultation summary form there should be evidence on the video of a clinically appropriate diagnosis or hypothesis having been made.

PC8: The doctor explains the problem or diagnosis in appropriate language.

*There must be evidence of an **explanation** of the patient's problem. The element states that the findings should be shared with the patient. As educational supervisors we need to judge the quality of the explanation. A short explanation may be enough but it must be relevant, understandable and appropriate. It is essential for an adequate explanation.*

Excellent registrars will incorporate some or all of the patients' health beliefs - in other words, one that responds to the health beliefs considered in PC4. It is unlikely that this PC could be demonstrated in the absence of PC4. However, on occasion, the patient will volunteer their health belief without prompting.

Essentially it requires a reference back to patient-held ideas during the explanation of the problem/diagnosis.

PC9: The doctor specifically seeks to confirm the patient's understanding of the diagnosis

This competence implies a quite discrete process: a digression after the explanation, to check how well it has been understood. A cursory "Is that OK?" or the patient simply nodding is not enough. It must be an active seeking out of the patient's understanding. Questions such as "Tell me what you understand by that" or "What does the term angina mean to you?" and a dialogue between patient and doctor ensuring that the explanation is understood and accepted, are essential.

PC10: The management plan (including any prescription) is appropriate for the working diagnosis, reflecting a good understanding of modern accepted medical practice.

*It is important that the management plan relates directly to the working diagnosis and **must** represent good current medical practice. Please remember, however, that in the UK there are large differences, due to local guidelines or resources, in the availability of investigations in primary care, such as PSA tests, access to ultrasound and echocardiography. Management must be a safe plan even though it may not be what you would do. Investigations and referral should be reasonable. The prescribed medication (if any) should be safe and reasonable, even if not your preferred choice!*

PC11: The patient is given the opportunity to be involved in significant management decisions.

*This was formerly "sharing management options" - the new version seeks to reward the underlying competence of doctor and patient engaging in **shared decision making**. Included in this competence is establishing the conditions for shared decision-making, such as the patient's willingness to be involved (at least a third are unwilling), their ability to take decisions (some are not able), and the evidence-base on which any decisions are being made.*

The registrar should be rewarded for addressing any of these aspects of the competence: they do not need to take the patient right through to a decision.

PC12: Makes effective use of resources

This criterion relates to the doctor using resources effectively (e.g. effective use of time).

PC13: The doctor specifies the conditions and interval for follow-up or review.

*This criterion within the unit Make effective use of the consultation **should be straightforward. It should be interpreted broadly**, so that any reference to returning ("next week", "when the tablets run out", "if not better in a few days", "see the nurse for a BP check in 1 month", etc.) may be rewarded.*