TALC for educators and clinical supervisors

The TALC resources can be used independently by anyone who wants to learn, refine or improve their consultation skills. Educators can also use these resources to help others to develop their skills.

The two introductory chapters (THANK YOU FOR LISTENING – WHY ARE CONSULTATION SKILLS SO IMPORTANT? and WHAT DOES EVERYONE NEED TO KNOW ABOUT IMPROVING CONSULTATION SKILLS?) introduce the background to the TALC resources. Consultation skills increase medical accuracy, make for better patient and clinician satisfaction and create safer and more compassionate care.

The TALC resources are divided into modules that cover different aspects of the consultation, mapped to the Calgary Cambridge Framework:

> **Module 9** focuses on effective methods for teaching consultation skills

> **Modules 1 to 7** cover the CORE SKILLS needed for effective consultations

> **Module 8** provides INSPIRATIONS (learning nuggets for when you only have 5 minutes)

> **Modules 10 to 14** cover more ADVANCED SKILLS

Within each module there are a series of linked chapters which all include:

1. **A general introduction to the skill**, where it fits into the consultation as a whole and why it is important. This will be especially useful for any clinicians in training programmes. Notes are given about applying the skill when consulting remotely.
2. **Reliable methods for teaching skills**, in one to one situations for example a tutorial or supervision session with a learner, or in groups, for example, a study release course. There are comments about using remote teaching methods.
3. **Comments on how to engage, motivate and energise participants**, structuring training, and suggestions for evaluating understanding and use of the skills.
4. **Resources** including references for background reading, 'skills checklists' for observers/educators to ensure that feedback is SMART, possible scenarios for skills practice.

How can educators teach consultation skills effectively?

There are three aspects to an educator's role, often expressed as the 'Educational Triangle', which links the CURRICULUM (what are we aiming to teach?), ASSESSMENT (how much is known already by our participants?) with EDUCATIONAL METHODS (how are we going to help people learn?). Educator training often quite rightly concentrates on how to assess levels of achievement accurately, and on how to give effective feedback.

However, if we want people to develop their skills, effective teaching methods play a big part. Educators can help participants learn by developing skills in a variety of educational methods. This subject is covered in detail in Reference 14 – *ENGAGE ENERGISE ENRICH EVALUATE*. The TALC resources focus on reliable educational methods to teach effective consultation skills. In other words, this resource is about what happens after assessment and feedback have been completed and the educator needs to teach something.

There is often an assumption that 'insight will lead to improvement'. For example, an educator may believe that if a learner realises that they are asking too many closed question, or that they cannot remember what patients say, then better consulting strategies will naturally follow. All too often this is not the case. In many masterclasses, educators assess consultations carefully and give appropriate feedback about what needs to be improved. Yet those same educators struggle to find a good method to teach the skills needed.

However, if effective teaching methods are used after assessment and feedback, learners will quickly identify, understand, value, learn and perfect new skills. Where carried out in groups, these methods assume a degree of facilitation skill in the educator, and a familiarity with basic group educational methods (see Reference 14).

The approach outlined in the TALC modules offers subtle attitudinal messages. Firstly, that educators can help learners 'buy in' to the idea that improving consultations is possible, via practice and feedback. Secondly, that this means working on individual skills that build together into effective communication. Thirdly, that the skills that need to be learned can be chosen by the clinician, and can be honed and improved with practice. Finally, that the consultation is an important area of academic scrutiny and learning. It may take some learners quite a while to realise this and educators can help them develop their thinking.

Helping clinicians to develop their consultation skills

Many clinicians learning to consult have unhelpful study habits. They may think it can all be learned online, though most of the academic material is only available in book form. Many of the online video material is positively unhelpful or demonstrates inadequate levels of skill. Some learners are resistant to using the most effective learning methods such as skills rehearsals and many are unsystematic, relying on 'tips' rather than exploring in depth.

Tried and tested teaching methods can help to overcome many obstacles to learning and show that consultations can move from the level of competence, to excellence and in a post CCT situation, to a place of true 'expertise'. When the skills of the consultation are fully developed, the consultation moves from being a transaction towards being a healing relationship. When the clinician forms an effective relationship, whether as part of a single consultation or part of a series of consultations over time, the interaction moves from being a two dimensional one like a snapshot, to being a three dimensional one, like a novel or a film. This enriches both parties for sure, and is also more medically effective. This is because more information is brought to bear on the clinical assessment, so that explanations, planning and negotiating care are done more skilfully. Trust is developed so that effective follow up and adherence occur.

Improving consultations skills can be difficult for educators and clinicians alike

Although most of the ideas outlined above will be familiar to many educators, teaching and learning to improve consultation skills can still be difficult. Realistically, learning new skills is always challenging. When clinicians begin to work seriously on improving their skills, consultations may be a bit longer and some skills more 'clunky'. However, when clinicians improve their skills so that they really pay attention and listen properly to the patient, less time is wasted in consultations in the end.

Clinicians may also struggle with the attitudinal shift required to move from clinician centred to patient centred behaviours. New skills may fail to become routine as clinician, default to less effective consultations when under stress, when the situation is complex or when they feel they are no longer being observed. Why is it so hard to learn and embed new skills? The answer may partly lie in understanding the process of learning a new skill, and the approach that learners take to this.

14 ***ENGAGE ENERGISE ENRICH EVALUATE – A practical guide to medical education*** – Avril Danczak. This book is available for the cost of postage from Health Education England North West. For more information, contact gptraining.nw@hee.nhs.uk, or send an A4 self-addressed envelope along with £5.50 in stamps to: NW GP Team, Health Education England NW, 3rd Floor, 3 Piccadilly Place, Manchester M1 3BN. Also available electronically at https://www.gmthub.co.uk/effective-teaching-methods-for-primary-care-education.

Learning a new skill is really part of a cycle. Understanding this cycle as a necessary part of learning can help to speed up the acquisition of new skills and make it feel easier. The cycle is summarised in the diagram below.

Unconscious incompetence is where learning begins. Initially, a clinician may not be aware that a skill even exists or is necessary. For example, a clinician may not be aware that there is a skill that really helps in getting consultations off to a good start, a skill called agenda setting (see TALC SKILLS FOR BEGINNING CONSULTATIONS EFFECTIVELY – HOW IS A CONSULTATION LIKE A BUSINESS MEETING?)

Conscious incompetence is the next stage in the cycle, when the clinician does realise that there is a new skill to learned, and also recognises that they do not yet have this skill. This realisation may come from feedback from someone else, or as a result of reading and becoming aware of new skills.

Conscious competence happens as the clinician starts to learn and practice new skills. The skill is there, but needs to be consciously thought about and is not yet routine, intuitive or natural.

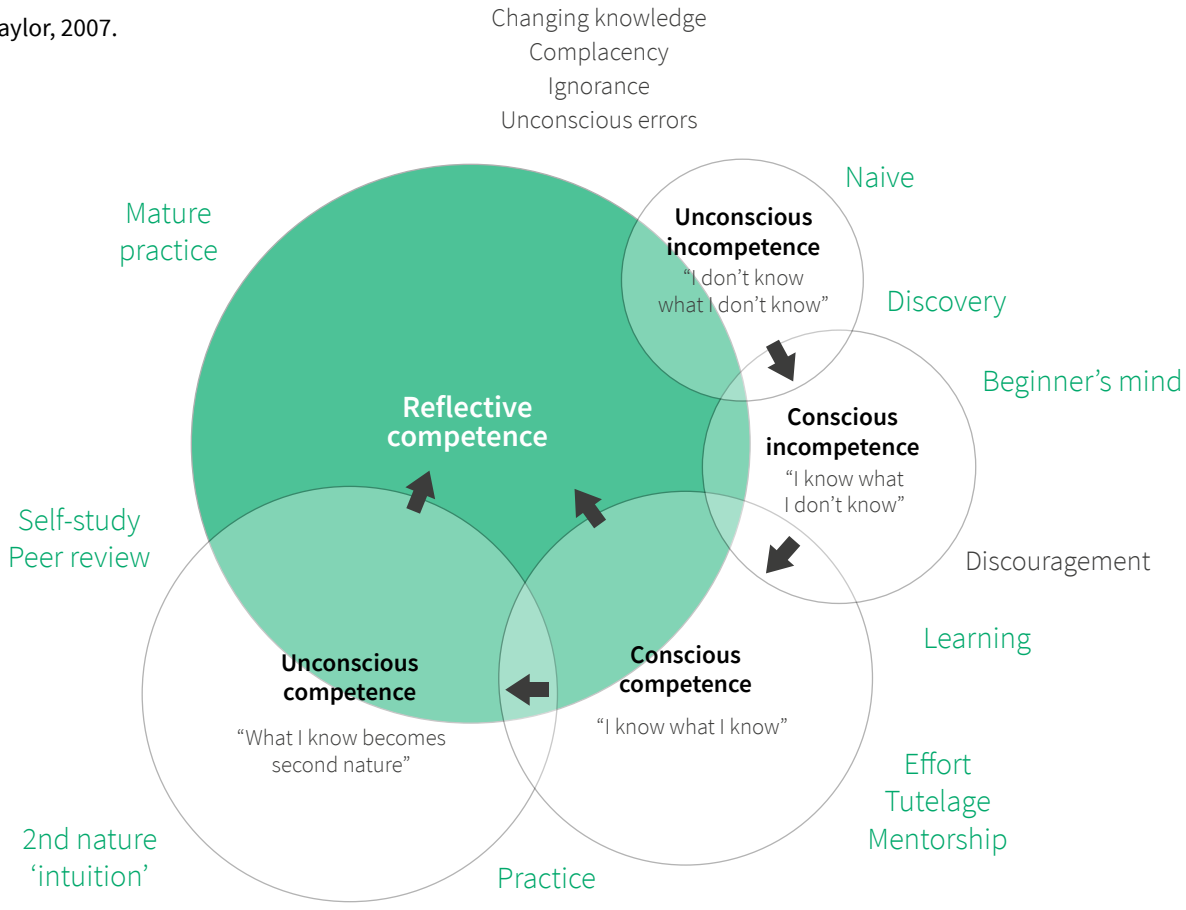
Think about learning to change gear when learning to drive. At first, even when a learner driver can change gear, it may feel awkward and clunky.

Unconscious competence happens when the new skill is embedded fully, it becomes so easy and intuitive that the skill is hardly noticed and seems effortless to an observer. Thinking about driving again, experienced drivers hardly notice when they change gear, it has become an unconsciously competent thing to do whenever needed.

With continuous development of skills, we gradually move towards expertise and mastery beckons. However, continuing to develop, means going back to the stage of conscious incompetence again, as new possibilities and new skills come into awareness. Some clinicians find this stage uncomfortable, so they avoid finding out about the new skills they still need to develop. However, the effective and self-aware clinician will always be keen to seek out new skills, and will return to the stage of conscious incompetence repeatedly. This is called REFLECTIVE COMPETENCE. See Reference 3 for more information about this cycle of learning.

Reflective competence model

William Taylor, 2007.



3 https://www.businessballs.com/self-awareness/conscious-competence-learning-model
There is a lot of interesting detail here for anyone wanting to understand more about how we learn new things.

Why is it important to talk about failure?

The concept of **FAIL** = **FIRST ACHEIVEMENTS IN LEARNING** or **FIRST ATTEMPTS IN LEARNING** (educators can choose!) is helpful here. No learning will occur without a first attempt and an early first achievement. These early achievements are likely to be first steps rather than perfect outcomes.

Most clinicians, especially doctors, are used to succeeding in their training endeavours. They pass examinations, the get promoted, they like to feel on top of their work. Learning any new skill requires experiences which can be aversive to successful clinicians. First of all a state of unconscious incompetence must be replaced by the painful realisation of conscious incompetence. While many educators relish this as a trigger to curiosity and new learning, most people find the state of conscious incompetence unpleasant and best avoided. The stage of conscious competence, while an improvement, still feels clunky, requires a lot of mental effort and is therefore tiring. Inexperienced clinicians often find their work more exhausting than their older counterparts for this very reason.

Finally, when a skill is embedded into routine work, the resulting state of unconscious competence, can only really be a temporary state. To achieve true excellence and expertise means we have to re-enter the cycle and identify areas in which we can again become consciously incompetent. Many clinicians have learned to consult well during their early clinical experience, via trial and error and painful reflection after the event (*"that did not go well"*). However, some clinicians do not go on to continuously develop their skills. Rather than benefiting from their years of experience, it feels as if they have the same year of experience many times over, and get better and better at making the same mistakes in their consultation skills, but making those mistakes with increasing confidence.

Clinicians with perfectionist traits, have often been used to getting high marks, or even 100%, finding that effort is repaid with good outcomes. The pathway to effective consulting can often be rockier than this. The result is that perfectionist clinicians tend to have quite binary thinking. Either, on the one hand, they are doing well, doing everything properly and getting 100%. On the other hand if things are not perfect they are see themselves as frustrated failures. This is not helpful for the long-term development of skills. Relationships with colleagues and patients are for the long haul, being good enough along the way is better than being perfect at times and burned out the rest of the time. Incremental improvement is acceptable and necessary.

All clinicians can learn to tolerate a state of partial skill, of incomplete mastery. Scrutiny, feedback and reflection on consultations inevitably create a sense of vulnerability and a sense that the clinician may not 'measure up'. Care must be paid to acknowledge these difficult feelings and also to create robust teaching environments in which vulnerability and failure are accepted and supported. Firm boundaries (feedback about behaviour not criticism of the person), objectively assessed skills (the use of checklists can help here), and sufficient time spent identifying the presence of skills as well as their absence, can all help to encourage a good learning climate.

In Quality Improvement activities in Japan, a phrase often used is ***"every defect is a treasure"***. This captures the idea that finding an area of incompetence is equivalent to finding treasure; recognising the issue offers the promise of learning a new and helpful skill, which will make consultations easier and more effective.

Talking though these issues can be a very important part of learning to consult better, and of enabling clinicians to make the fullest use of the training opportunities available to them. Some clinicians have been trained in educational systems where it is not acceptable to ask questions, to identify weaknesses or areas for improvement, or where it is important to maintain an air of 'knowing what to do', especially in the presence of seniors. Some professional groups, for example nursing and social workers, may have the belief that they do not need to learn consultation skills because they are already 'empathic, caring and skilled'. Exploring these underlying attitudes and values and proposing different approaches to learning, can be an essential pre cursor of effective learning and teaching in this important area of work.