Royal College of General Practitioners

Recorded Consultation Assessment (RCA) guidance on utilisation of feedback statements

Contents

Feedback is generated in an entirely different and separate way from marking cases. The examiner, in giving feedback for that case, will pick the most applicable items from a list of 24 pre-formed feedback statements given below focussing on where they think you might best focus your learning to continue to improve your consulting skills or demonstration of them.

The feedback statements are not performance indicators and play no part in the marking process for the examination. They are not designed to provide a justification of your mark per se and may be offered to passing candidates.

Many of the statements overlap slightly, some may seem at odds with one another. For example, you may find that exploring the patient's concerns takes time, which in turn might lead to your not being able to complete the consultation in the ten minutes. It is important to remember that the RCA is a test of your ability to integrate and apply your clinical skills to the specific consultation that you have chosen so that in order to do well you need to be able to manage the tensions between different aspects of good consulting.

The primary purpose of feedback is to improve future performance and we would encourage you to share this feedback with your supervisor to inform future learning/examination preparation. For each of the statements, there is a corresponding note below, intended to help you assess your learning needs and build on what you can already do. Please remember, when the statement reads, "does not..." this should be taken to mean "does not sufficiently..." or "does not always..."

Where you have had feedback that identifies areas for improvement, read the text below and, where improvement is needed, look closely at the suggestions that are offered.

Global

1. Disorganised and or Unstructured Consultation

Examiners did not feel that the consultation followed a logical structure. For example, your history taking may have appeared disjointed, with your line of questioning erratic and not following a clearly reasoned way of thinking. The consultation may have appeared disorganised, with some elements (for example, health promotion) thrown in apparently at random.

This gives the impression of a doctor whose line of diagnostic thinking and clinical management may miss important clinical issues because he/she is not systematic.

Suggestions:

Practice with one of the published consultation models (such as Neighbour, Pendleton or Cambridge-Calgary) and analyse some of your video consultations. This might help you develop a more fluent approach. Ask a colleague or your supervisor to critique your consulting. When

taking a history, you should initially listen to the patient and ask open questions to explore the presenting features before focussing on the specific detail with closed questions if appropriate. It is sometimes helpful to signal to the patient that you are about to do this by saying something like “I would like to ask you some specific questions now”

Explain to the patient what you are doing and why. This is good for patient care and will also demonstrate to examiners that you have a clear and systematic approach. Explaining to the patient exactly what further tests (e.g. blood tests, if appropriate to the case) are going to be necessary for further patient management, helps the examiners know what you are planning to do and why.

Summarising aspects of the information you have collected also demonstrates to examiners that you are collating and processing the information and is useful in checking with the patient that you have understood him/her.

2. Does not recognise the issues or priorities in the consultation

Examiners felt that you did not demonstrate that you were able to identify the patient’s problem/agenda or the possible challenges in the consultation and appropriate priorities from the doctor’s perspective. There were aspects to the case that needed to be covered, in addition to the superficial clinical presentation. For example, if a patient presents with an infection that could be sexually transmitted, the consultation should include sensitive enquiry about the likelihood of this (addressing the patient’s worries) AND a section on contact tracing, and whether the regular partner needs to know about the STI (addressing the wider ethical dilemma).

Suggestions:

Patients don’t always tell you straight away what is worrying them, and sometimes have to be asked. Sometimes the way they look, or what they say gives you clues to an underlying worry. They may bring a situation that has an ethical dimension to it that the patient may not have considered, but as a professional, you should be aware of this, and should discuss it with the patient (another example is the issue of confidentiality).

Being alert to verbal and non-verbal cues and analysing your consultations either on video or in shared surgeries might help you with this. Look closely at your ability to encourage the patient to share his/her thoughts and expectations. When reviewing video or if in a shared surgery ask an experienced colleague what they thought the issues and priorities in the consultation were and discuss how these compare with your opinion. Think about the implications of the presentations you see in your own solo surgeries, and whether they might demonstrate your capabilities in the RCA.

3. Shows poor Time Management

Examiners felt that you showed poor time management during the cases, perhaps taking too long over certain tasks or failing to cover what was thought to be essential.

Suggestions:

Seeing patients in ten-minute appointments in your own surgeries and trying to ensure that you remain focussed on the problem presented might help. Try to observe doctors who consult effectively and efficiently and learn how to modify your own approach.

A common reason for running out of time in RCA cases is due to candidates taking too long to take a history, and then having to rush the second half of the consultation, clinical management, explaining and follow up arrangements. Pace yourself and work out how long you should be taking for the different parts of the consultation. Remember, you don't have to submit a case if it runs way over 10 minutes and also that only 10 minutes will be marked after consent and ID is obtained.

Gathering information requires you to be appropriately selective in the questions you ask, the tests you request and the examinations you choose to undertake. You may feel that it would be better to be 'on the safe side' by ordering a battery of tests and whilst understandable, this can make you appear indiscriminate. Likewise, history taking and examination is not expected to be all-inclusive and should be tailored to the circumstances and include psychosocial factors where relevant.

This will help you greatly in clinical practice as well as in the assessment.

4. Poor choice of consultation: Does not demonstrate capability in consulting skills sufficient for independent UK General Practice

The examiners felt that the consultation that was chosen to be submitted did not provide sufficient evidence to demonstrate the skills expected of an independent UK General Practitioner. This may have been because the consultation lacked complexity (sometimes called low challenge). This can occur when a straightforward clinical problem has been chosen that requires few clinical skills; or when a consultation is chosen that does not address a new clinical problem e.g. a review consultation.

Suggestions:

Read the "guidance on consultations to submit" where it is suggested that new patient consultations rather than follow up patients are chosen. Consider the types of low challenge consultations seen in practice and why these would not be suitable to demonstrate your clinical skills. Ask yourself if a community pharmacist or practice nurse could have completed the consultation competently? If the answer is yes, it may be that the clinical problem is not sufficiently complex. If you are unsure about the complexity of a case, you should discuss it with your clinical / educational supervisor.

Data Gathering, technical and assessment skills

1. Insufficient evidence of Data Gathering skills to demonstrate capability of safe independent UK General Practice

The examiners felt that the submitted consultation did not provide sufficient evidence to demonstrate the Data Gathering skills expected of a UK General Practitioner. This may have been because the consultation lacked complexity (sometimes called low challenge). This can occur when a straightforward clinical problem has been chosen that requires few clinical skills; or when a consultation is chosen that does not address a new clinical problem e.g. a review consultation where information about the problem has already been identified either by you or by someone else.

Suggestions:

Read the "guidance on consultations to submit" where it is suggested that new patient consultations rather than follow up patients are chosen. Consider the types of low challenge consultations seen in practice and why these would not be suitable to demonstrate your Data Gathering skills. Ask yourself if the consultation could have been completed competently by a community pharmacist or practice nurse? If the answer is yes, it may be that the clinical problem is not sufficiently complex. Has new information been identified as part of the history taking or are you repeating questions asked previously by yourself or by someone else, as might be the case in a review consultation? If you are unsure about the complexity of a case, you should discuss it with your clinical / educational supervisor.

2. Inadequate history taken to enable safe assessment of disease and its severity

Examiners felt that the history taken was insufficient in terms of breadth or depth to enable you to safely assess the disease presentation and its severity.

Suggestions:

Try to show that you are inquisitive and interested in the patient's presentation, gathering as much information as you can to ensure that you can assess the patient's safety by being able to understand how severely the symptoms are affecting them. Does your history taking allow you to distinguish between a simple non-serious diagnosis and something that might cause the patient harm? Have you gathered enough information to be able to make a safe assessment of the patient's condition? Watching other more senior colleagues consult and practising your questioning with your supervisor might help you to hone these skills. Try to have regular debriefing of your video consultations to ensure that you are not repeating errors that can be improved upon.

3. Does not elicit and develop adequate amounts of new information to demonstrate competence

Examiners need to see that the consultation you have submitted demonstrates your capability in terms of gaining new evidence.

Suggestions:

Candidates often submit consultations where all the history taking/data gathering has been undertaken by another member of the primary health care team e.g. another GP, the team pharmacist or a nurse. Simply re-iterating previously gained information from another clinician does not allow you to demonstrate your capability in terms of gaining the information required to make a reasonable diagnostic differential or hypothesis. This situation often happens in cases such as medication reviews or follow-up consultations where the initial meeting was with another clinician in the recent past. If you undertake consultations where these circumstances prevail, try to decide whether it is worth submitting them for assessment as they might not allow you to demonstrate your capabilities.

4. Does not consider and/or test an adequate range of Differential Diagnoses

Examiners felt that you did not consider sufficient common conditions in the differential diagnosis.

Suggestions:

Practise thinking broadly around each situation you face and try to think of all the possible causes of a particular presenting complaint e.g. whilst a burning epigastric pain might lead to a very simple diagnosis in the vast majority of cases, the examiners will wish you to demonstrate that you are able to rule out more serious and rare conditions. Try to demonstrate that you have thought of these other conditions by discussing alternatives with patients and explaining why you are asking certain things. “I was asking you XYZ to rule out…”

5. Does not identify or use appropriate Psychological or Social information to place the problem in context

Examiners felt that you needed to take account of the social or psychological issues pertaining to the patient in order to put the presenting problem into context and to understand all the issues from the patient’s perspective.

Suggestions:

Sometimes patients present with a very simple physical diagnosis but its effect upon them can be complicated by the social situation they find themselves in or by psychological factors adding to the complexity of the situation. For example a diagnosis of “tennis elbow / lateral epicondylitis” might appear on the surface to be relatively straightforward and easy to manage. However, if the patient is self-employed, currently out of work with a family to support and a newly pregnant partner, it can be seen that offering time away from the factors exacerbating the elbow pain might be entirely inappropriate. If you don’t initially ascertain the complicating factors, then it makes it harder later in the consultation to produce a realistically appropriate management plan.

6. Does not offer/undertake appropriate Physical/Mental examination as part of the diagnostic process

Examiners felt that you could improve your physical/mental examination skills.

Suggestions:

You should be able to demonstrate the appropriate and fluent use of instruments, in a way that does not distress patients, with their full understanding of what you are doing and their consent. Practise undertaking examinations with your colleagues and your supervisor so that you develop a routine – this will allow you to hone your techniques so that they become second nature.

For candidates who are working from home or conducting a telephone consultation this might involve a clear explanation of the choice of examination they need and the likely outcome of any findings from it, which in turn will help the patient understand why they need to attend the surgery for an examination, what will happen and how that will affect their diagnosis and subsequent management.

In undertaking a mental state examination, try to tailor you questions to the patient in front of you and make them contextual rather than just using a formulaic checklist and asking questions that might appear inappropriate and out of place.

7. Does not recognise the implications of any abnormal findings or results

Examiners felt that you did not demonstrate an ability to identify or recognise significant findings in the history, examination or data interpretation from results. Sometimes findings have been identified but then not acted upon appropriately, so that examiners conclude the candidate did not recognise their significance. Issues identified may need to be prioritised clearly.

Suggestions:

This is a clinical rather than interpersonal skill and requires you to make sure that you can correctly interpret the significance of test results or the findings of physical and mental state examinations. The abnormal findings will nearly always relate to common or important conditions, and you should bear in mind that common conditions are more likely than uncommon

ones in real life. This should be reflected in the differential diagnosis you make, and how you explain your differential diagnosis to the patient.

When you prepare for the RCA, pay close attention to your ability to assess and manage risk by picking up on abnormal findings and dealing with them safely. Discuss your management with colleagues, asking them to comment particularly on your risk management and safety netting. Also, take an active part in significant event reviews, look back on these, especially if relating to clinical errors and see what you can learn.

Decision Making and Clinical Management

1. Insufficient evidence of Decision Making and Clinical Management skills to demonstrate capability of safe independent UK General Practice

The examiners felt that the submitted consultation did not provide sufficient evidence to demonstrate the Decision Making and Clinical Management skills expected of a UK General Practitioner. This may have been because the consultation lacked complexity (sometimes called low challenge). This can occur when a straightforward clinical problem has been chosen that requires few clinical skills; or when a consultation is chosen that does not address a new clinical problem e.g. a review consultation where the problem may already have been identified and a management plan put in place either by you or by someone else.

Suggestions:

Read the "guidance on consultations to submit" where it is suggested that new patient consultations rather than follow up patients are chosen. Consider the types of low challenge consultations seen in practice and why these would not be suitable to demonstrate your Decision Making and Clinical Management skills. Ask yourself if the consultation could have been completed competently by a community pharmacist or practice nurse? If the answer is yes, it may be that the clinical problem is not sufficiently complex. Has any new decision making taken place and has a significantly new management plan been generated? It may difficult to do this in a review consultation e.g. review of blood pressure control where, even if a decision is made to modify or change medication, this would not be seen as significant new decision or change in management. Compare this to a new diagnosis of essential hypertension and the introduction of new medication. If you are unsure about the complexity of a case, you should discuss it with your clinical / educational supervisor.

2. Does not identify an appropriate range of Differential Diagnoses and/or form a reasoned Working Diagnosis

Examiners felt that you failed to make the appropriate diagnosis. You should consider common conditions in the differential diagnosis.

Suggestions:

This statement is linked with statement (See DG7), where candidates fail to recognise abnormal information, either in the history, the examination, or data provided by them in the case notes.

Making a diagnosis means committing yourself on the basis of the information you have available to you. Make sure that your knowledge base is adequate and think carefully about all the information that is presented to you by the patient. Then ensure that when you have made a diagnosis in the consultation, you state this clearly and explain it to the patient using language that is understandable to them (See IPS 5). If your summary is too vague, the examiner may not be sure that you have made a diagnosis at all. If you have a differential diagnosis list, explain this to the patient too, remembering that common things occur commonly, and are (usually) more likely! It is not always necessary to make a single diagnosis; you can still do well provided you explain what you are thinking and why. To say you're unsure is OK as long as you explain to the patient how you plan to reach a definite diagnosis or to find out the answer to a question they might have asked, and your plan can be understood by the examiner and judged to be safe for independent UK practice.

It can be useful to share your thoughts on negative findings as a way for the patient to be aware what you have excluded; this is often done by experienced doctors whilst performing an examination or explaining your intended examination. For example, I had thought about XXX but as your YYY is clear/not painful this is unlikely…. This technique is also more time efficient.

3. Does not develop a Management Plan (including prescribing and referral) reflecting knowledge of current best practice

Examiners felt that your management plan for the case was inadequate. You may not have developed an obvious management plan at all, or it may not have been complete enough to satisfy the examiner that you were a safe practitioner. You would be expected to show that your clinical management skills are in line with current UK best practice.

Suggestions:

Your management plan and follow up arrangements should reflect the natural history of the condition and be appropriate to the level of risk. They should be coherent and feasible. You should be aware of up to date national guidelines such as those published by NICE (National Institute of Clinical Excellence) and SIGN (Scottish Intercollegiate Guidelines Network) and demonstrate you have an evidence-based approach.

Possible risks and benefits of different approaches including prescribing need to be clearly identified and discussed. Your knowledge base is also important in this area. Use the concept of PUNs (Patients' Unmet Needs) and DENs (Doctors' Educational Needs) to improve this selectively and discussing the management of cases you have seen with an experienced doctor will help you in these areas.

Your understanding of decisions for referral should also mirror current guidelines and UK best practice.

4. The choice of management was unclear due to missing information

Examiners felt that your management plan was inadequate. This might be due to missing or unclear information given to the patient e.g. on dosage or timing of medicines or missing sharing of information to the patient on investigation (past or future) or likely outcomes.

Suggestions:

The examiner can only mark what is seen and does not have access to the patients' clinical record, notes or letters or any prescription that you write. The patient likewise does not have access to the former and is also likely to benefit from explanation of these if they relate to the problem or give context to the planned management.

It is helpful to the patient to have a clear explanation of your plan, which may benefit from repetition to them. This helps them share ownership and is likely to enhance compliance by empowering the patient. Checking with patients in your day-to-day practice if they have understood your plan will help you be clear if you have regularly missed areas that they need you to clarify. Watch your COTs with your supervisor without the patients' notes available to you. Was the plan completely clear and in context from what you both observed. If in doubt, how could it have been improved? This is a good area to practise in your study groups with peers.

5. Does not demonstrate an awareness of management of risk or make the patient aware of relative risks of different options

Examiners did not feel that you managed risk appropriately. This could mean either that you failed to identify the potential risks or that having done so you did not integrate that into the consultation in a useful way. Alternatively, it might mean that you provided safety netting that was disproportionate for the level of risk apparent from the clinical scenario. . Patients should be made aware of risks in a realistic, proportionate manner.

Suggestions:

In order to manage risk appropriately, you should make the patient aware of the relative risks of different approaches. Managing risk and living with uncertainty are key skills in general practice. Your knowledge base is important here, as is your ability to integrate that knowledge with the specific information you have gained about the patient. Listening to how more experienced practitioners explain common risks might be helpful (for example, the risks of taking Hormone Replacement Therapy or undertaking a PSA test) and then practising doing the same in your own words might help to develop this skill. You don't want to be doing this for the first time in the RCA – an unpractised candidate is very obvious to examiners! Role-plays with teachers and colleagues are a good way of improving your performance.

6. Does not show appropriate use of resources, including aspects of budgetary governance

Some cases may include an aspect that requires you to demonstrate your role as a 'gate-keeper' of NHS resources. This includes aspects of requests for 'fit notes', surgical procedures, newly developed medications, use of appropriate referral pathways and referrals for second opinions. All of which are the 'bread and butter' of UK general practice. It might also include appropriate time periods for review which are safe but do not create over-reliance upon the GP or encourage inappropriate use of other services such as 111, ambulance or secondary care Emergency departments.

Suggestions:

Discuss this issue with an experienced general practitioner, such as your supervisor or one of the other GPs in the practice. Think about the different types of NHS resource that GPs are 'gate-keepers' for, and how reference to them could come up in routine consultations. Look through your video consultations to identify times when appropriate use of resources has come up - you will find it comes up in nearly every consultation in one way or another. This does not mean that you refuse access to services, new medications or 'fit notes', but that you show your awareness of the issues and responsible use of resources.

7. Does not make appropriate, adequate and empowering arrangements for follow up and safety netting

Examiners felt that your follow up arrangements were not adequate and that you did not ensure that there was an appropriate and realistic safety net. It may have been missing from the assessment because your consultation lasted longer than twelve minutes and so the examiner did not view this. It might have been extremely over-cautious and therefore inappropriate or extreme for the actual level of risk of the underlying condition.

Suggestions:

It is easy for consultations to be seen as isolated incidents, rather than a continuum in the course of an illness. Making arrangements for follow up demonstrate your commitment to the continuity of care of patients and your concern for their welfare and safety. It shows that you are prepared to take responsibility for managing the on-going presentation of the condition until the problem has been resolved in some way.

Safety-netting is a term that describes the explanations you should be giving to each patient about what to expect, including a time scale if appropriate, and about what to do if symptoms get worse or develop in some way that is unexpected. If there is uncertainty about the diagnosis this should be communicated to the patient so they are empowered to re-consult if necessary. You should include a description of where and how to get help, at any time of day or night BUT only if this seems appropriate for the case being presented, as well as arrangements for follow up. This may not be necessary in all cases and may indeed alarm patients if the safety netting instructions seem at odds with reassurance given.

To make sure that this is included in most consultations you choose to submit ensure that, where possible, most of them are within the ten-minute limit of examiner viewing.

Interpersonal Skills

1. Insufficient evidence of Interpersonal skills to demonstrate capability of safe independent UK General Practice

The examiners felt that the submitted consultation did not provide sufficient evidence to demonstrate the Interpersonal skills expected of a UK General Practitioner. This may have been because the consultation lacked complexity (sometimes called low challenge). This can occur when a straightforward clinical problem has been chosen that requires few clinical skills; or when a consultation is chosen that does not address a new clinical problem e.g. a review consultation where little discussion is required with the patient about either the presenting problem or its management.

Suggestions:

Read the "guidance on consultations to submit" where it is suggested that new patient consultations rather than follow up patients are chosen. Consider the types of low challenge consultations seen in practice and why these would not be suitable to demonstrate your Interpersonal skills. Ask yourself if the consultation could have been completed competently by a community pharmacist or practice nurse? If the answer is yes, it may be that the clinical problem is not sufficiently complex. Has any new information about the presenting problem been identified? Has any new decision making taken place? Has a significantly new management plan been generated? If the answer is "no" to any one of these three questions, it may be difficult to demonstrate Interpersonal skills as there is little reason to discuss issues in any depth with the patient. This may be especially difficult to do in a review consultation. If you are unsure about the complexity of a case, you should discuss it with your clinical / educational supervisor.

2. Does not demonstrate active listening skills, limited exploration and use of cues

Examiners observed verbal or non-verbal cues in the consultation that you did not use to increase your understanding of the patient's situation. They may also have felt your listening skills were poor, for example asking questions but not listening to or acting upon the answers. They may also have felt that the consulting was 'formulaic'.

Suggestions:

Active listening includes asking questions at the appropriate time, in a logical sequence to the patient's last contribution. It is demonstrated by good use of verbal and non-verbal cues (see below). Good active listening includes allowing the patient to say what they want to tell you, and sometimes helping them by clarifying and summarising what they have already said (which shows you were listening and have understood them).

Recognising cues, both verbal and non-verbal is a key component of the patient-centred clinical method. Cues can include gestures, pauses in speech, facial expressions as well as clues in the patient's account that indicate he/she has additional issues to tell you. The information gained from acting on patient cues is likely to increase patient satisfaction.

By 'formulaic' consulting, we mean that the doctor appears to be rigidly applying a set consulting 'model' to the consultation that does not take into account the patient's agenda or response. The doctor may repeat questions (see active listening above), ask questions at inappropriate times in the consultation and use pre-prepared phrases. Some of these phrases seem to come from RCA

courses or RCA guides, as suggestions for how to show empathy or to elicit and manage patients' concerns. For example, we often hear candidates ask the patient: "How does that make you feel?" To the examiner, especially if it is asked repeatedly during the consultation and then little or no notice is taken of the answer, it appears that the question is being asked as part of a 'formula' that candidates have learnt to pass the RCA. In order to get the right meaning across, you need to find your own way of asking about this, in your own words, and to make sure that you ask this at an appropriate time in the consultation and take due notice of the reply.

This is an area that is sometimes difficult to develop without the help of more experienced doctors. Watching yourself on video and asking your supervisor to review videos with you is a useful way of seeing yourself as others might observe you. It might also be helpful to gather information about what your patients feel about this aspect of your work before and after you have tried to improve these skills.

3. Does not develop a shared understanding, demonstrating an ability to work in partnership with the patient

Examiners felt that you did not demonstrate the development of a shared management plan. Listing options without explaining their relative pros and cons or without taking account of the patient's views does not aid the development of shared understanding.

Suggestions:

This may be improved by responding appropriately to the patient's agenda and by attempting to involve patients in making decisions regarding their problem. Clarifying the respective roles may involve reaching agreement with the patient as to what will happen next, who does what and when and the conditions (i.e. the timescale and circumstances) for follow-up. There should be a shared understanding before the patient leaves and this can be confirmed by asking the patient to summarise what they have understood. How you do this is a matter of finding out what works best for you and taking a lead from the patient.

Using standard questions such as "What will you tell your wife when you get home?" rarely works well, as it is not a 'common' way to talk and sounds synthetic (see above). On the other hand, it might be just the right question to ask when you have identified that the patient's wife has a particular concern about their health. Patient-centred doctors are responsive to patient preferences, including when they don't want to share decision-making, and work to develop common ground and a shared understanding. There are many educational resources (books, DVDs of consulting skills etc.) that will help you to achieve this.

4. Does not acknowledge or utilise the patient's contribution to the consultation including consent

Examiners felt that you might not have made full use of the information given by the patient to you during the consultation. This might also include inadequate consent to undertake an appropriate examination or to convey third party information.

Suggestions:

It is important to acknowledge and show that you understand the issues that the patient wishes to convey to you. Unless you do this, you will be unlikely to address their concerns or their expectations as to the outcomes of the consultation. It may be that their concerns are not appropriate, and so you will need to show sensitivity in how you deal with this.
When deciding to examine a patient it is important to explain what you wish to examine and why as this both informs the patient and thus gains explicit consent. Similarly, you might need to demonstrate that consent has been obtained to share any medical information with or about a third party.

5. Does not use language and/or explanations that are relevant and understandable to the patient

Examiners felt that your explanations were not sufficiently relevant or understandable to the patient OR included unnecessary technical language OR were delivered in a way likely to alarm the patient. One indication of this maybe an apparent increase in anxiety or uncertainty in the patient or questioning e.g. of safety netting advice.

Suggestions:

In developing this skill, it is important to avoid the use of jargon, to establish the patient's level of understanding of medical and health matters, and tailor your explanation to these. Whether or not your explanation has been understood can be checked through non-verbal communication but also (and more explicitly) by asking the patient to summarise.

Explanations are often most effective when you affirm a patient's health beliefs e.g. "Like you, I think this pain might be due to a trapped nerve…".

Similarly, using the same language as the patient aids understanding and helps to make the patient aware that you have listened to what they have been saying.

6. Does not treat the patient with appropriate respect and/or sensitivity during the consultation

Examiners felt that you failed to treat the patient with sufficient respect or sensitivity.

Suggestions

Respect for the patient requires attention to the patient's perspective. Initially, this involves introducing yourself and explaining your role. It also involves taking valid consent before commencing physical examination and offering a chaperone if appropriate. You should also respect patient privacy - for example by ensuring that physical examination takes place off camera. For consultations with children or patients with cognitive impairment, respect can be shown by engaging with the patient rather than relying on a third person.

Respect for a patient involves listening to the patient's perspective. Indications that you are *not* listening include repetition of questions, and failure to identify and act on cues, ideas expectations or concerns.

Other forms of insufficient respect include excessive familiarity with the patient, disengaged body language and patronising behaviour.

Being sensitive to the patient involves noticing distress and responding empathically. A sensitive doctor approaches emotionally charged areas carefully and seeks permission before proceeding to explore areas that are difficult or stressful for the patient.

You can check that you are being respectful by sharing your consultations with experienced colleagues in the practice. Ask whether you are being sufficiently respectful/sensitive to the patient?

Breaches in examination regulations

The following four feedback statements are all related to breaches in examination regulations. These cover mandatory case selection criteria, intimate examination and pauses in recording of consultations. Guidance on all these topics is in the RCA Policy Document on the website. Please refer to these if you need to sit the RCA examination again prior to submission on FourteenFish.

Single case – no marks:

One of your cases has not met the mandatory case selection criteria selected by you at the time of your submission. No other consultations submitted were deemed to have met the missing mandatory case selection criteria. Zero marks were therefore awarded for this consultation under the sanctions for breach of the rules on mandatory criteria. In reaching this decision, the consultation was viewed by two examiners and reviewed by a marshal and senior marshal. Their decision is final, and no appeal is permitted under the MRCGP regulations.

Two cases – whole submission rejected:

Two or more of your cases have not met the mandatory case selection criteria selected by you at the time of your submission. No other consultations submitted were deemed to have met the missing mandatory case selection criteria. Your whole submission is therefore declined and re-application for next diet is advised as per the sanctions for breach of the rules on mandatory criteria. In reaching this decision, the consultation was reviewed by a Panel including the RCA Clinical Lead and a Lay Representative, and then discussed in the RCA Examination Board. The RCA Examination Board's decision is final, and no appeal is permitted under MRCGP regulations.

Case involving an 'Intimate Examination' as defined in the RCA policy and Handbook - no marks:

This case has breached the guidance on a Submission that includes an Intimate Examination as defined in the RCA Policy and outlined on the RCGP website. Zero marks were therefore awarded for this consultation under the sanctions for breach of the rules of the RCA. In reaching this decision, the consultation was reviewed by a Panel including the RCA Clinical Lead and a Lay

Representative, and then discussed in the RCA Examination Board. The RCA Examination Board's decision is final, and no appeal is permitted under MRCGP regulations.

Case involving a 'Pause in Recording' as defined in the RCA policy and Handbook - no marks:

This case has breached the guidance on a Submission that includes a Pause in Recording as defined in the RCA Policy and outlined on the RCGP website. Zero marks were therefore awarded for this consultation under the sanctions for breach of the rules of the RCA. In reaching this decision, the consultation was reviewed by a Panel including the RCA Clinical Lead and a Lay Representative, and then discussed in the RCA Examination Board. The RCA Examination Board's decision is final, and no appeal is permitted under MRCGP regulations.