CONSULT MENTOR

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Educators Learning Progress Report - VTS Module

A structured discussion guide for the educational supervisor and trainee: highlight recurrent challenges, review quoted evidence, and agree focused next steps.

Stable

Based on 5 consultations

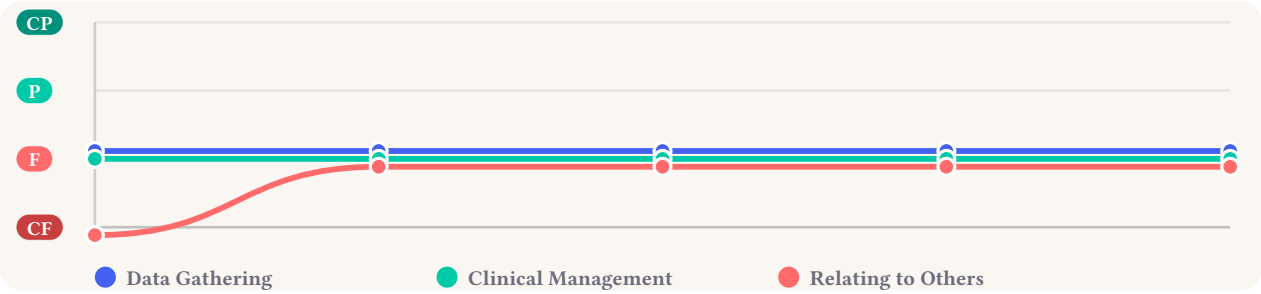
Progress summary
Performance is consistently at a Clear Fail level across all five cases, with no observable improvement.

Performance consistency
Consistent and significant deficits are replicated across all consultations, indicating a pattern rather than isolated errors.

Key Insights

- A critical and recurring failure is the lack of proactive exploration of the patient's Ideas, Concerns, and Expectations (ICE). This results in consultations being doctor-led and missing the patient's core emotional driver.
- Safety-netting is consistently absent or unsafe (e.g., 'It won't. Just try the medication.'). This represents a significant patient safety concern and a critical failure in Clinical Management.
- Communication frequently involves invalidating or dismissing the patient's stated concerns (e.g., 'That's different. This is tension.'). This undermines rapport and shared decision-making.
- The history-taking, while asking some focused questions, is not systematic for a common presentation like headache, missing a comprehensive red-flag screen which is essential for safe practice.

Grade Trajectory



Grade progression across completed cases

Domain Analysis

Data Gathering & Diagnosis

Stable

Average grade: F

Fail

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Calgary-Cambridge integration
Fails in the 'Gathering Information' and 'Providing Structure' stages. The consultation lacks a clear, patient-centred structure initiated by understanding the patient's perspective.

Competency indicators
- Asks some focused questions related to duration and associated symptoms.
- Fails to systematically explore the full picture, including patient context, ideas, and concerns.
- Omits a complete red-flag screen for a high-risk presentation (headache).

Strengths
- Initiated a basic history including duration, location, and asked about nausea and visual disturbances, which are relevant symptoms.

Areas for development
- History-taking is not systematic or comprehensive for the presenting complaint.
- Does not proactively explore the patient's ICE, leading to a mismatch between clinical focus and patient needs.
- Fails to gather sufficient information to confidently rule out significant pathology (e.g., no questions about thunderclap onset, fever, neck stiffness, focal neurological signs).

Recommendations
- Practise using a structured headache history tool (e.g., SNOOP criteria) to ensure a thorough red-flag screen every time.
- Agree a plan to always ask open questions about ICE within the first 2-3 minutes of any consultation (e.g., 'What were you most worried this might be?').
- Review cases focusing on common presentations to build a systematic data-gathering approach.

Clinical Management & Medical Complexity

Stable

Average grade: F

Fail

Safety awareness
Significant concerns. The consistent provision of unsafe safety-netting represents a critical lapse in patient safety and is the primary reason for the Clear Fail in this domain.

Competency indicators
- Provides a basic, directive management plan.
- Safety-netting is vague, unsafe, or absent.
- Does not engage in shared decision-making or explain the rationale for management.

Strengths
- Proposed a specific pharmacological intervention (paracetamol) and a follow-up timeframe, showing basic management structure.

Areas for development
- Management plans are simplistic, not evidence-based (e.g., recommending frequent regular paracetamol without discussing duration or alternatives), and imposed without patient collaboration.
- Critical safety-netting is repeatedly missing or dangerously dismissive (e.g., 'It won't. Just try the medication.' when asked about deterioration).
- Does not verbalise clinical reasoning or discuss differentials, making management appear arbitrary.

Recommendations
- Study NICE guidelines for common conditions (e.g., headache CG150) to understand evidence-based, first-line management.
- Practise formulating and verbalising a management plan that includes: 1) rationale, 2) options for shared decision, 3) specific safety-netting.
- Role-play providing safety-netting for high-risk presentations, using phrases like: 'While it's unlikely, if you experience [red flag symptom], you must...'

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Relating to Others

Stable

Average grade: F

Clear Fail

Competency indicators
- Communication is predominantly transactional, not relational.
- Patient concerns are acknowledged minimally or dismissed.
- Lacks empathetic responses to patient cues about anxiety or fear.

Strengths
- Uses basic acknowledgements (e.g., 'Right.' when told about nausea), which is a minimal starting point.

Areas for development
- Repeated invalidation of patient concerns using dismissive language ('That's different. This is tension.'; 'It won't.'), which destroys rapport.
- Fails to elicit or engage with the patient's emotional context and hidden agenda, such as anxiety about serious illness.
- Adopts a paternalistic, directive style that overrides patient preferences and does not facilitate shared decision-making.

Cross-Case Patterns

Consistent strengths
- Asks some relevant, focused questions during the history-taking phase (e.g., about visual disturbances).
- Proposes a basic management plan and follow-up interval, demonstrating awareness of consultation structure.

Recurring issues
- Systematic failure to explore Ideas, Concerns, and Expectations (ICE) early.
- Provision of unsafe or absent safety-netting for high-risk symptoms.
- Use of invalidating and dismissive language when responding to patient concerns or emotional cues.
- Superficial history-taking that does not complete a necessary red-flag screen for the presenting complaint.

Case-type insights
- The pattern is consistent across all simulated cases, regardless of the specific patient scenario (e.g., tiredness, antibiotic pressure), indicating a core skill deficit rather than a condition-specific knowledge gap.

Consultation phases
- The consultation often stalls in the 'Information Gathering' phase due to lack of patient-centred questioning.
- The 'Management' phase is not collaborative and lacks essential safety components.

Quoted evidence examples

Turn numbers are retained only as source markers from the case feedback; each item includes the quoted words needed for discussion.

- vts-demanding-imaging — Explore the patient's ideas, concerns, and expectations early.: #11: 'Is that all? I was hoping for something stronger maybe.'
- vts-demanding-imaging — Validate the patient's concerns to build rapport.: #18: 'That's different. This is tension.'
- vts-tiredness-hidden-agenda — Safety-netting was absent or unsafe, with the patient being told their headache wouldn't worsen.: #21: Patient asks 'What if it gets worse before then?' #22: 'It won't. Just try the medication.'
- vts-tiredness-hidden-agenda — The patient's concern about a family history of brain tumour was dismissed, missing a chance to explore anxiety and provide reassurance.: #17: 'My mum had a brain tumour so I am quite anxious about headaches.' #18: 'That's different. This is tension.'

Communication Patterns

Medical jargon usage

No significant issues noted with jargon usage.

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Patient centredness
Low. Consultations are doctor-led and directive, with minimal attempt to understand or incorporate the patient's perspective.

Explanation skills
Poor. Diagnoses and management plans are stated without explanation, rationale, or linking to the patient's understanding.

Professional boundaries
Not tested in these scenarios. The primary deficit is in collaborative and empathetic communication within the professional role.

Educational Supervision

Discussion priorities

- The critical need to explore the patient's Ideas, Concerns, and Expectations (ICE) early in every consultation. We will look at how questions like 'What were you most worried this might be?' change the consultation dynamic.
- The serious patient safety issue of unsafe safety-netting. We will discuss specific phrases and scenarios for providing clear advice on red-flag symptoms.
- The impact of using dismissive language ('That's different. It won't.') on rapport and patient engagement. We will explore alternative, validating responses.
- Building a systematic approach to history-taking for common complaints to ensure no critical red flags are missed.

Evidence to discuss

Use these prompts to guide reflective discussion and agree next steps.

- Discuss the quote from Case vts-demanding-imaging: #11 'Is that all? I was hoping for something stronger maybe.' to explore how not exploring expectations early leads to dissatisfaction.
- Ask the trainee to reflect on the impact of their response in Case vts-demanding-imaging: #18 'That's different. This is tension.' when the patient expressed anxiety about a family history of brain tumour.
- Review the unsafe safety-netting provided in Case vts-tiredness-hidden-agenda: #22 'It won't. Just try the medication.' and agree on a safer, specific alternative script.
- Look for evidence in future practice of asking at least two open-ended questions about the patient's perspective (ICE) in the first few minutes.

Support interventions

- Schedule a focused session on consultation structure using the Calgary-Cambridge model, emphasising the 'Initial Interview' and 'Gathering Information' phases.
- Provide written examples of safe and effective safety-netting phrases for common high-risk conditions.
- Arrange supervised practice with a focus on consultations involving anxious patients, with post-consultation review of ICE exploration.
- Provide access to a recorded exemplar consultation demonstrating strong rapport-building and ICE exploration.

Celebration points

- Acknowledges that the trainee is asking some relevant clinical questions and has a basic framework for consultations.
- Recognises the trainee is attempting to screen for at least one red flag (visual disturbances) in headache cases, which is a starting point.

Statistical Summary

Total cases analysed: 5
Valid cases: 5
Performance distribution: All 5 cases received an overall grade of Clear Fail (CF).
Improvement rate: 0%. Performance is stable at a Clear Fail level with no upward trajectory.
Consistency score: High consistency in performance deficits across all cases and domains.
Competency trajectory: stable
Data Gathering & Diagnosis: average grade F; average score 2; 5 attempts; trend stable
Clinical Management & Medical Complexity: average grade F; average score 2; 5 attempts; trend stable
Relating to Others: average grade F; average score 1.8; 5 attempts; trend improving

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References

Assessment framework

Assessment commentary is aligned to the RCGP WPBA Consultation Observation Tool (COT) detailed guide to performance criteria PC1-PC13: https://www.rcgp.org.uk/mrcgp-exams/wpba/COT

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