**It Takes Two to Tango : getting the best out of your Simulated Patient as you prepare for your Clinical Skills Assessment examination.**

**Introduction.**

This article explores ways in which your involvement with simulated patients (SPs) can help with the preparation for the Clinical Skills Assessment (CSA) of the MRCGP exam, especially by sharpening up your communication skills, keeping your patient safe, and learning how to make the most of your 10 minute slot. But for this to work, you need to take the process seriously and to realise and appreciate the care and attention given by SPs to enhance your learning and understanding as you prepare for your exam. The article concludes with some useful hints and tips to enable you to do your best in the CSA.

**The GP Curriculum**

**Doctors must be able to :-**

Knowledge and skills guide

* \* Use the skills typically associated with good doctor–patient communication
* \* Demonstrate a non-judgmental approach, treating your colleagues, patients, carers and others equitably and with respect
* \* Value people’s beliefs and preferences in clinical and everyday working
* \* Respond flexibly to the needs and expectations of different individuals

\*Demonstrate effective and safe telephone, …consultations, applying an awareness of their uses and limitations while mitigating risks

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

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

\*Adapt communication skills to meet the needs of the patient,

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

**Using Simulated Patients to help you prepare for your CSA exam**

**Background.**

The use of Simulated Patients to help doctors prepare for their CSA examination is well established. One of the pioneers for this was Professor Howard Barrows, a neurologist and medical educator, whose innovative work in introducing Problem Based Learning transformed medical education. In an era when the predominance of written examinations characterised the training of doctors, he was also among the first to assess clinical skills using a simulated patient, described as a ‘well person trained to simulate a patient’s illness in a standardised way’. This provided trainee doctors with the opportunity to develop their communication skills with real live patients in a safe learning context. ( Vu & Barrow, 1994; Wallace et al, 2002).

Even at this relatively early stage, some key principles about using SPs had begun to emerge. First, SPs are well in themselves; or at least ( because we are all human) whatever conditions they may be experiencing in their own lives will not affect their ability effectively and clearly to simulate the given illness required of them for their role. It is worth noting at this point that medical education also makes effective use of ‘real’ patients who bring to the medical training sessions their own symptoms and their own experience of a particular illness. This approach is also very informative, but is not dealt with in this article.

Secondly, SPs are trained. It is not a question of them turning up for a teaching session with students and making it up as they go along. The risks of idiosyncratic interpretations or invention of irrelevant symptoms would be counterproductive. Therefore all SPs are carefully trained by whatever organisation employs them to ensure two core outcomes: accurate representation of the illness or condition needed to enhance student learning, and well-structured feedback.

Thirdly, the roles performed by SPs are standardised. Quite often in a university medical school there will be several groups of students being taught or assessed at any one time, supported by a small team of SPs playing the same role. It is essential therefore that all the SPs play the role in the same way and that there is agreement about how to portray symptoms; how to talk about background information; and from the outset what words to use to begin the consultation (an agreed opening statement). Standardisation ensures that all students have an equal opportunity to learn from the portrayal of the role; or to put it another way, no student is disadvantaged by an idiosyncratic “off-message” portrayal by an individual SP.

Implicit in the standardisation process, however, is the expectation that SPs will really simulate the role they have been given. There is no formulaic script to be learned. It is not like an actor in a play, who has everything given to them word for word and their task is to deliver those lines accurately and faultlessly. By contrast SPs bring themselves to the role, and the role comes alive in the active dialogue between them and the trainee, in how they respond to questions; the extent to which the trainee picks up cues and explores them (or not); how they respond to the emotional warmth and empathy (or otherwise) that is shared with them by the trainee. It is this aspect of SP work that makes it an art as well as a skill, and brings the human dimension to the very forefront of the process.

Best practice for SPs therefore is a deeply human activity that can lead to a powerful learning opportunity for trainees. But *it takes two to tango*, and unless you treat the SP with respect and with wholehearted commitment to the process, learning opportunities will be diminished, or even lost. Therefore it is to help you derive the greatest benefit from working with SPs that the rest of this article is devoted.

**Some underlying issues to consider.**

 It would be naïve, dangerous even, to regard SPs (or GPs for that matter) as occupying some neutral territory where issues of race, gender, disability and class somehow do not apply to the consultation. Each of us, whatever role we fulfil, brings to the interaction powerful statements about who we are and how we might be, or are perceived. Female patients from minority ethnic backgrounds, for example, may be extremely reluctant to engage with a white male doctor for a wide variety of reasons. Ideally they might well prefer to talk with a female doctor from their own background with whom they might share a common culture and language and an understanding about how women are perceived within different cultures. A white patient may bring elements of prejudice and mistrust to a doctor from a different cultural background. Young people may suspect that much older doctors simply will not understand a young person’s perspective or experience, and fear that they may be treated in an over-bearing, parental, judgemental manner. To what extent will a person with learning difficulties feel confident that a doctor can understand and be willing to spend time really to communicate with them, rather than talking mainly to their accompanying carer? Someone heavily drug dependent may fear a judgemental response. Abuse may simply not be spotted or even ignored. People from disadvantaged areas of society may feel that they are being treated as second class citizens and undeserving of high quality medical care. The oft-quoted ‘postcode lottery’ raises issues of class, deprivation and disadvantage that may well impact significantly upon the patient/doctor relationship.

This brief snapshot of some societal issues raises issues for the training environment as well as real live practice consultations. Power and control; prejudice and favouritism; sexism, racism, disabilism, homophobia – these major issues, so fundamental to a strong professional value base, do not magically disappear as soon as the consulting room door is opened. We hope that throughout their training, and certainly when they approach their CSA exams, trainee GPs will have developed strong self-awareness to ensure that whatever “baggage” they may carry personally, and that their professionalism will ensure every patient is treated with dignity and respect. But no one is perfect, and work with SPs provides an important two-way process whereby these deeper issues can be addressed and if need be confronted through sensitive feedback.

So you should not be surprised if during feedback in role an SP were to say things like:-

* When you said this, I felt really ‘put down’ as a woman;
* As soon as I entered the room I felt you looked at me with contempt;
* You know I am hard of hearing but you keep mumbling and I can’t hear you
* When you spoke to me I felt you were being hugely judgemental;
* You made me wonder whether a white doctor would ever understand what it is like to be black and living in fear every day;
* I never felt you took my complaint about abuse seriously; you made me feel it was all my fault;
* You look so posh so how can you possibly understand what my life is really like?
* No one really understands what mental illness feels like… not even you as a doctor.

Such comments, or similar, would be offered by an SP seeking to respond *in whatever role they have* *been playing* to how you as a trainee GP made them feel. And how you make them feel is a vital component in the attempt to establish trust and confidence in you as a doctor. That is why doctoring and consulting is as much of an art as it is a skill. So many unspoken messages can be conveyed, often in ways of which we ourselves are unaware, which is why self-awareness with regard to the issues we have been raising is so crucial.

The SP will only be giving feedback in this way to help you improve your skills as a doctor in establishing a trusting, mutually respectful working relationship. This is why we said at the outset that taking the SP seriously is a really important albeit challenging aspect of your professional development.

**Feedback – theory and practice**

We have just mentioned the importance of receiving positive but also challenging feedback as part of your CSA preparation, for which we hope you will value your SP. Having played the role allocated to them, and having responded to you as a trainee GP, the SP then has the opportunity to help you celebrate what went well, and to explore ways in which you might have handled the case differently.

These two aspects of feedback – acknowledging what went well before suggesting what could have done differently – have been called *Pendleton’s rules* (Pendleton *et al*. 1984). This is an approach that all SPs seek to follow(Moss 2017:122). The temptation is often to emphasise the negative aspects of our performances, highlighting ‘what a mess we made of it’. But everyone training to become a GP will have a core set of good skills already in place, and it is good to celebrate these with each training consultation. It is very confirming to have a SP telling you how positive they felt when you said this or tackled that in the way you did.

The second aspect of feedback explores ways in which the trainee might have done things differently. Pendleton recommended avoiding words like ‘negative’ or ‘bad’, preferring to concentrate on alternative strategies to make a consultation more successful and patient-centred. Again the SP has a crucial role to play here, as suggested in the quotations at the end of the previous section. The opportunity for deeper learning and developing more effective consultation skills is focussed on this contribution made by the SP. (See also Bokken *et al*. 2009)

This is not to say that there is no opportunity for mistakes to be corrected. With communication skills, the SP is trained to give effective and supportive feedback, but when it comes to medical knowledge and expertise then it falls to the tutor who, unlike the SP, is medically trained and can ensure that the trainee is delivering accurate, safe and effective medical care.

**Taking your CSA exam : SP perspectives on how to do your best**

This article so far has had a training perspective, focussing specifically upon preparing for your CSA. The emphasis has been on how to develop your consultation and communication skills in such a way as to keep your patient safe. This is important for all consultations, of course, and the CSA is no different in this respect. Excellent consultation skills in everyday practice will best prepare you for the CSA examination.

Nevertheless, there are particular pressures when sitting the CSA exam, and in the discussion that follows there are several hints and tips from a simulated patient’s perspective that are designed to help you to do your best in the exam..

1. **Before the SP enters**…. or before the telephone consultation begins.

An important aspect of the CSA is the preparation you give immediately before you engage with the SP. You will be given some information in advance and the SP knows what this is because it is fundamental to the role they have been asked to play. Read the information carefully, because everything will have been given for a purpose, and has been designed to help you engage with the SP.

Ask yourself therefore why has this scenario been set? Why have certain pieces of information been included? For example, if the patient is described as being a carer, think what data gathering will you need to include to appreciate the significance of this information. If a date or birth or employment status have been included, why might this be important? If you are given an abnormal test or investigation result, might there be an element of breaking bad news in this scenario? If so, how can you ensure that you allow enough time in the consultation for this to be explored?

Your over-riding concern, and what the SP will want to feel confident about, will be the question : how can I keep this patient safe?

1. **Meeting, greeting and introductions.**

The SP will most likely be feeling anxious about meeting you, wondering if you will take them seriously. They may have concerns around some of the issues raised in the ‘underlying issues’ discussed earlier. ( *I’m conscious that it is sometimes difficult for people from different cultures to talk about sensitive issues together? Would you like an interpreter? Or would you prefer to see a female/male doctor instead?)* Pay particular attention therefore to your own body language; how you meet and greet the patient; and how from the outset you try to put them at their ease. Introduce yourself by name, and find out how they would like to be addressed. Try to avoid being too flippant or over-familiar ( *Hi there*!) , but do seek to be warm and welcoming. Do not assume that first names are automatically the best way of addressing the SP, unless of course you are talking with a younger person or child when first names might help put them at their ease more quickly. (*Would you like me to use your first name or would you prefer to be called Mr or Mrs X?).*

While all this is going on you will also be assessing the patient’s body language and how they are dressed. If they are sullen, withdrawn or looking ‘down’ or dishevelled, you might immediately want to address this by responding in a gentle encouraging way ( *I’m glad you have come to see me but you seem rather upset/low/not quite yourself ? Am I right?)*

At the same time, however, the SP will be assessing your body language too. You may or may not feel comfortable about shaking an SP’s hand upon arrival, but if you stand and welcome them and guide them to their seat this gives a warm welcoming signal to them. Where and how you choose to sit in relation to the SP conveys an important message about attentiveness. If you spend more time looking at your notes, your computer or iPad, your watch or clock, this too gives the SP a clear message about how much you are really focussed on what they are saying. Good eye contact, keeping still, smiling with encouragement from time to time all help the SP to feel at ease.

These opening moments will be very important for the SP in setting the tone for the consultation and the extent to which they feel at ease with you.

1. **Getting started – open questions.**

Trainee GPs are often encouraged to think about the ‘golden minute’, referring to the importance of the consultation’s first minute or so. Good open questions at the beginning can encourage the SP to talk about what is troubling them and what issues they are bringing to the consultation in their allocated CSA role. So much verbal and nonverbal information can be gathered in this period, including what perhaps is *not* being said. Good active listening skills can open up a pathway of conversation that will enable an effective consultation to be conducted.

Bear in mind that SPs are given a number of cues to include in their story. Some information will be given freely, and should flow from being asked good open questions. But other perhaps more significant information will only be available to you if you spot the cues that the SP drops into the conversation. For example, if a SP tells you that “things aren’t the same any more”, this is an invitation to you to explore that statement (e.g. *How aren’t they the same?* or *Can you tell me* *how have things changed?* ) By responding to the cue you will gain further information. But if the SP has to drop that cue three times without eliciting a response from you, then they won’t persist any longer, any more than a real patient would. Depending on your active listening skills you can expect most significant cues to be offered to you in the first 3 - 4 minutes, which will give you sufficient time to explore them and include the issues they raise in your management plan.

Non-verbal cues also are important to spot, e.g. what tone of voice the SP uses, or what body language is used including various gestures, sighing or indications of distress. All these are given to you by the SP for a purpose, and if picked up will provide key information for you to use in your diagnosis and management plan.

Candidates often fear that there will be trick questions or hidden agenda in the scenarios given to the SPs to perform. This fear suggests that there is some devious action on the part of the examiners to trip the candidates up. This is definitely not the case. There will be cues for you to spot and explore, but they will not be any more obscure than in real life. The SPs will quickly close you down if you seem to “barking up the wrong tree” (e.g. if the SP says ‘no’ to a certain question that means you don’t need to pursue it any further.) Good doctoring skills are enough; you do not need a mindset that is afraid of deeply hidden topics that you have no chance of unearthing.

1. **Developing your 10 minute awareness**.

The SP will know that the CSA consultation will last exactly 10 minutes, after which it will be terminated and the examiner and SP both leave the room. But the SP has no responsibility to control how those 10 minutes are used. If you run out of time then that is the end of it! So it is important not only to keep a surreptitious eye on the clock; you also need to develop the sense or what a 10 minute consultation feels like, so that you can use the time available to you effectively.

You may receive a variety of advice about how best to do this. Some will argue for a 50/50 approach whereby you spend the first five minutes introducing yourself; gathering data and examining. This then gives you the remaining five minutes for your management plan and safely netting. Others may suggest a 4-2-4 pattern for data gathering; examination and management. But there are no rules – it is up to you to develop your own style, and to find effective ways of covering all aspects of the consultation in the 10 minutes. If you spend eight minutes data gathering, this may feel very detailed and reassuringly comprehensive to the SP, but if you run out of time and don’t cover your diagnosis, management or safety netting, don’t be surprised if your overall mark reflects that poor structure.

For some CSA cases you will have some clear hints about how to structure the consultation before you even begin (see 1 above). If you realise that there is an element of breaking bad news in the scenario, allow time to do this early enough so that the SP can react in the way the scenario has been written (e.g. perhaps becoming upset and distressed and needing time to reflect on the implications of what you have told them). If they have to stop driving as a result of what they tell you, again plan for enough time to break this news to them. If it is a case involving genetics, then you will need to plan your time in such a way that you can give good clear information, in bite-sized chunks where you check from time to time that the SP understands the story so far. There may be an element of breaking bad news in these scenarios also, so give enough time to deal with that, and how the SP might react.

Ironically, one key skill when breaking bad news is the use of silence. Candidates may feel that time is so short they have to pack as much into the time as possible. But a judicious use of silence will be of enormous value and the SP will respond accordingly. If they feel they are being talked at incessantly they will probably (in role) switch off, and all attempts at empathy will be to no avail (see 6 below).

Once again your main priority is keeping the patient safe, so you need to allow time at the end to offer effective safety netting and to check that the patient understands what will happen next. If you do this effectively, not only the SP but also the CSA examiner will be happy!

1. **Some little things.**

SPs are a varied bunch even though they are standardised before the examinations so that they all give the same information and know how they are being expected to react and behave with the candidate. But that doesn’t stop them wondering why so many trainee GPs ask if they can *quickly* examine the SP. (*Why is ‘quickly’ a virtue*?) Some persist in telling the patient that we can talk about this later (*We jolly well hope so doctor! That is why we are here*!.) Some trainees seem to ask the SP time and time again ‘do you mind if I ask you about …’ (*But that’s your job doctor, to ask us questions!).* To ask it once, or before some potentially difficult or embarrassing topic is being raised, is good sensitive practice, but it doesn’t need to be endlessly repeated. Sometimes trainee GPs will suggest that they have ‘a little chat’ about the issues the SP is raising, even if the topic is worrying or serious. The suggestion of having ‘a little chat’, however much it is intended to put the SP at their ease, risks trivialising the whole discussion from the SP’s point of view.

1. **And two final bigger things.**

There is a high expectation that candidates will empathise with the SP so that the patient will feel deeply listened to and taken seriously by the candidate. Empathy is a word easily bandied around, but it is far more difficult to achieve than some would believe. It takes a deep imaginative leap even to begin to understand how another person is feeling, and empathy can only happen when the full range of consulting skills, values and active listening skills comes together. It demands that you take it seriously. (Moss 2017:98-9). Attempt it well and the consultation will flow; ignore it and the consultation becomes mechanistic and clunky. It reflects the epitome of best practice which ultimately is what your CSA exam is all about.

Secondly, you need to be aware that the only part that the SP plays in each station in the CSA is to play the role allocated to them. The SP does not mark the station; they do not discuss your performance with the examiner, nor do they contribute in any way to the feedback. So try to understand things from the SP’s perspective because that’s what you should do with *every* patient, not just because you might get a few extra marks.

 10. **Conclusion**.

SPs are there to help you do your best in what is admittedly a stressful examination setting. If you can relax into your doctoring role, draw on the skills and medical knowledge you have developed in your professional practice, and know how to make the best and most effective use of your 10 minute consultation, then you will be well on the way to success.

 11. **Key points**

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| 1.Simulated patients are trained and want to help you do your best in the CSA2. Simulated patients will react to how you come across to them as a candidate.3. You need to listen out for cues given to you by the simulated patient because these will take you to the heart of the problem.4. It is important to practise active listening skills in your consultation.5. There are no trick questions or hidden agendas in the CSA.6. Always remember to keep the patient safe. |

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