Audio-COT: Detailed Guide to the Performance Criteria (PC)

Consultation introduction

Introduces self and establishes identity of caller(s), ensuring confidentiality and consent

The doctor is heard clearly to state their name, professional role and where they are calling from (GP surgery/out of hours (OOH) setting). The doctor is also heard to establish the identity of the caller, and if not the patient, obtains full relationship and name of caller. The PC encourages the doctor to make every effort to speak directly to the patient, using a high level of tact and negotiation skills. When clinically appropriate, the doctor should consider speaking briefly to a child or a patient with communication difficulties.

The doctor overtly obtains consent to the telephone call being listened to by a Supervisor. If the doctor has initiated the call, s/he should check with the caller that it is convenient to speak.

Establishes rapport

Rapport-building is an integral part of the communication process. The doctor creates a comfortable 'state' where both parties converse freely and comfortably. An 'introductory verbal handshake' is offered. The doctor is observed listening well, recognising non-verbal cues, responding with soft 'ums', 'ahs' as they speak, using words the caller uses. The doctor is 'approachable' and makes the caller feel supported, safe, and provides a reassuring approach, which gives the caller confidence in the care being delivered. Displaying confidence in the clinical ability can be harder over the phone. This PC encourages the doctor to develop good rapport with patient to facilitate effective communication.

Information gathering

Identifies reason(s) for telephone call and excludes need for emergency response in a timely manner (when appropriate), demonstrating safe and effective prioritisation skills

The doctor is able succinctly to ascertain at the start of the consultation the reason for the call, allowing a timely and appropriate history to be taken. The doctor is able quickly to recognise and exclude/confirm the manifestations of serious disease, demonstrating an appropriate knowledge of acute life-threatening conditions, e.g. chest pain, bleeding, altered consciousness.

This PC expects the doctor to respond appropriately and demonstrate an awareness of the need for an emergency response, by requesting in a focused and systematic way any relevant information to exclude medical, surgical and psychiatric emergencies. The PC incorporates the doctor showing s/he is able to act on information in an appropriate and timely manner, which includes indications that an emergency response may be required.

The doctor demonstrates a high level of prioritisation skills ensuring patient safety whilst maintaining efficiency. The doctor is able to prioritise the order of a telephone call, if appropriate, and the order in which problems are discussed on the telephone.

Encourages the patient's contribution using appropriate use of open and closed questions, demonstrating active listening and responds to auditory cues

The doctor uses an appropriate amount of open questions and implies ‘active listening’ by using reflection and facilitation. The doctor rarely interrupts the patient/caller and, if doing so, demonstrates clear advantages to their approach. The doctor effectively switches to closed questions during the telephone consultation if this is 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. The doctor does not pursue minor details or inappropriately explore rare diagnoses.

The doctor must choose the appropriate questioning technique to obtain sufficient information about symptoms and details of medical history, which in turn is part of defining the clinical problem(s). Appropriate questioning technique will allow a history in the degree of detail which is compatible with safety, but which takes account of the epidemiological realities of general practice.

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.

The doctor is seen to respond to signals (cues) that lead to a deeper understanding of the problem. This competence is to respond appropriately to important, significant (in terms of what emerges afterwards) cues. The use of the telephone loses the doctors ability to detect visual cues, therefore attention to auditory/non-verbal cues is imperative.

This PC incorporates ‘showing empathy’; if an empathetic response is observed, consideration should be given to 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).

The doctor quickly accesses Language Line or an alternative local translation service for non-English speakers. If appropriate, s/he may consider the use of a relative/friend to interpret for non-English speakers.

Places complaint in appropriate psycho-social contexts

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

This PC expects doctors to consider relevant psychological, social (including occupational) aspects of the problem. These may be known beforehand, offered spontaneously by the patient, or elicited. The competence requires the use of the information in exploring the problem, e.g. “How does your backache affect your life as a builder?”

The doctor must utilise the psychosocial information gathered to help inform decisions and actions made throughout the telephone consultation. The doctor recognises the effect this may have on whether s/he decides to convert the telephone consultation to a home visit, bring the patient up to the surgery at an appropriate time interval, or manage purely on the telephone.

Explores the patient's health understanding/beliefs including identifying and addressing patients ideas, concerns and expectations

The doctor demonstrates an effective exploration of the patient’s health understanding in the context of the problem discussed on the telephone.

This PC incorporates exploring the patient’s ideas, concerns and expectations, in the context of the patient’s current illness or problem e.g. callers concern regarding an elderly parent not coping.

This PC expects doctors to demonstrate 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. This may include reflecting on PC5, such as ”You said earlier xxx, what did you mean by that?” which may enable the patient to talk more easily about their concerns.

Defines the clinical problem

Takes an appropriately thorough and focused history to allow a safe assessment (includes/excludes likely relevant significant condition)

The doctor obtains sufficient information to include or exclude likely relevant significant conditions and understand the problem.

This PC expects doctors to ask questions around relevant hypotheses. It is important to remember the context of general practice, and especially that trainees are not (usually) specialist-generalists in any field.

The doctor makes use of the pre-existing medical notes on the system (if applicable) and takes enough history of presenting symptoms to be able to make a safe and accurate assessment of the patient, to enable a safe management decision. In the way the information is gathered, the doctor demonstrates an awareness of all the more serious causes of the presenting symptom(s).

In the OOH setting or with a temporary patient registered at the surgery, the doctor compensates for the lack of pre-existing notes available where information about the patient on the computer system may be sparse. The doctor takes enough history of presenting symptoms (and current medications, allergies and any relevant social history or circumstances, etc.) to be able to make a safe and accurate assessment of the patient’s problem to enable a safe management decision. The doctor appropriately manages the request of the patient/caller, e.g. prescribing appropriate amounts of medication, for example tramadol, on the telephone.

The doctor uses a robust and effective structure to demonstrate well-developed triage skills for assessing clinical presentations from the information given to him/her. S/he demonstrates when to ask for more information if not enough is provided, or as a result of the response to a cue, some additional information is elicited leading to a deeper understanding of the problem.

The doctor must assess whether it is appropriate to undertake a physical or mental examination on the telephone. Although the doctor is unable to see the patient on the telephone, at times it can be helpful to ask the patient to perform examinations - e.g. “Does a rash go white when pressed?”, “Is the patient able to complete a full sentence in a breath/count to 10 in one breath?” An appropriate mental examination may be checking if a patient is suicidal – is the tone of voice, flow of conversation congruent to the history provided? An examination performed over the telephone could confirm or disprove hypotheses that could reasonably have been formed, OR is designed to address a patient’s concern.

This PC covers medical safety; it addresses the focused enquiry that commonly occurs during the telephone consultation, not necessarily at a particular stage even during the explanation, or even as an afterthought.

Makes an appropriate working diagnosis

There should be evidence observed that the doctor makes and records a clinically appropriate diagnosis or hypothesis.

Management plan construction

Creates an appropriate, effective and mutually acceptable treatment (including medication guidance) and management outcome

The doctor must give the patient the opportunity to be involved in significant management decisions. The PC recognises the doctor's ability to establish 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 doctor does not necessarily need to take the patient right through to a decision. The PC incorporates the assessment of the doctor's ability to negotiate, if appropriate, with the patient/caller, if they have initially been opposed to the management decisions but then agree with the outcome. The doctor should ensure the patient is fully consulted and understands the management decision, and as a result a mutually acceptable management plan is agreed.

There must be evidence of an adequate explanation of the patient's problem, appropriate to the clinical context/caller. A short explanation may be enough but it must be relevant, understandable and appropriate. The PC encourages the doctor to incorporate some or all of the patient's health beliefs, i.e. referring back to patient-held ideas during the explanation of the problem/diagnosis. Techniques such as summarising to clarify the problems will be used by the doctor to ensure understanding.

This PC includes an expectation that the management plan (including any medication guidance) relates directly, and is appropriate to, the working diagnosis and must represent good current medical practice.

The management offered or agreed must be a safe plan even though it may not be what the doctor would do as first line. Investigations and referral should be reasonable. The prescribed medication (if any) should be safe and reasonable, even if not the doctor's preferred choice.

Closure of consultation

Seeks to confirm patient's understanding

The doctor specifically seeks to confirm the patient's understanding of the diagnosis. S/he uses appropriate language to explain the problem or a diagnosis and seeks to confirm that the patient understands the diagnosis, e.g. "Does that make sense, is there anything you want to ask me?" or "so what are you going to do? /look out for?" etc.

This competence implies quite a discrete process: a digression after the explanation, to check how well it has been understood. A cursory, "Is that OK?", 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. This PC is more important in a telephone consultation than in a face-to-face consultation as visual cues of agreement are not available.

Provides appropriate safety-netting and follow-up instructions

The doctor provides clear and precise safety-netting and follow-up instructions appropriate to the outcome of the telephone consultation. S/he provides clear instruction on contacting the surgery/OOH service again or other organisations if symptoms worsen, if the condition changes or the patient requires further information. The doctor also communicates clear time frames for the level of care agreed.

The safety-net instructions given should include a full description of relevant symptoms which indicate a significant worsening of the patient's condition that may require earlier intervention, tailored to the needs of the patient/caller and safety/risk of the consultation (e.g. 'If your headache is not better in 2 hours, ring back and we will re-assess the situation or sooner if you develop xxxx symptoms').

The doctor checks that the patient/caller is happy with the outcome and able to comply with any advice given.

Effective use of the consultation

PC12: Manages and communicates risk and uncertainty appropriately

The doctor is able to tolerate uncertainty, including that experienced by the caller, where this is unavoidable. The doctor anticipates and uses strategies for managing uncertainty.

The doctor is able to communicate risk effectively to the caller and involves them in its management to an appropriate degree. The doctor uses strategies such as monitoring, outcomes assessment and feedback to minimise the adverse effects of risk.

PC13: Appropriate consultation time to clinical context (effective use of time taking into account the needs of other patients), with effective use of available resources

The doctor demonstrates an awareness of time-management by taking control of the call when appropriate and focusing the questions and responses accordingly, to ensure the outcome was reached in a timely and safe manner. This is particularly important in the OOH setting.

The PC encourages the doctor to use appropriate communication skills and awareness of time-management:- for example, by taking control of the call and focusing the patient at all times when inclined to 'ramble', or by allowing the patient time to respond when appearing reluctant to discuss sensitive issues or demonstrating mental health issues e.g. suicidal ideation.

This PC also relates to the doctor using resources effectively. The doctor demonstrates an awareness of other resources to which it may be appropriate to refer, thus utilising the time more effectively. The doctor may signpost the patient/caller to a wide range of resources, e.g. patient information leaflets online, a minor injuries unit, district nurse referral, routine GP review at a timely interval or voluntary care sector resources, e.g. the Samaritans.

N.B. in the UK there are large differences, due to local guidelines or resources, in the resources available and the availability of investigations in primary care, e.g. access to d-dimer blood test and ultrasound scans.

PC14: Accurate, relevant and concise record keeping to ensure safe continuing care of patient

The doctor provides a clear, concise, accurate and relevant contemporaneous record of the patient encounter that includes all salient points relating to the diagnosis and management of the situation. S/he allows others involved in the care of the patient to be fully informed of the encounter and avoids the use of repetition, unusual or unacceptable abbreviations or subjective language.

All relevant medical information is recorded including a working diagnosis and also relevant social information, information regarding the patient's specific ideas and concerns and any advice about follow-up arrangements.