

## Discussion paper

# A unifying theory of clinical practice: Relationship, Diagnostics, Management and professionalism (RDM-p)

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### ABSTRACT

This discussion paper puts forward a unifying theory of clinical practice using three core performance areas of relationship, diagnostics and management, underpinned by professionalism. The model is described, explained and applied to current frameworks for selection, curriculum and assessment. The model is currently being used as a diagnostic tool for defining, exploring and explaining clinically related behaviour in general practice and across a range of hospital specialties, in particular with

doctors whose performance has been a cause for concern. There is potential to further apply, develop and research the model in other clinical areas, in non-clinical groups working in health care or other client-based environments.

**Keywords:** clinical competence, communication, continuing medical education, educational models, professional ethics

### How this fits in with quality in primary care

#### What do we know?

Previous models of competence in clinical practice have focused on the consultation, for which there are a variety of models and frameworks, and less often on issues outside this including professional aspects or managing the work of practice.

#### What does this paper add?

The Relationships, Diagnostics, Management and professionalism (RDM-p) model proposes a unifying theory of the work of clinical practice, relevant to practitioners, educators and assessors. It is not only a metasynthesis of previous models, but extends them in particular to highlight the key areas beyond relationship (specifically diagnostics, management and professionalism) which have not been as fully developed in previous frameworks.

## Background

Few professions can match medicine for the lack of internal agreement on what being ‘a good doctor’ involves. At the broadest level, the battle has been between the ‘art and science of medicine’: between those who speak of indefinable qualities such as intuition,<sup>1</sup> and those

who argue that positive outcomes should be achieved through the application of specific skills and processes.<sup>2</sup> More recently, the international focus on professional regulation has centred on how best to define the particular attributes required of ‘a good doctor’.<sup>3,4</sup>

The simplest way to illustrate these internal struggles is to consider developments in a single medical specialty, perhaps the most familiar being general practice. The medical consultation lies at the heart of what defines a good general practitioner (GP), but even a cursory study of the literature demonstrates the range of theories and models available to understand good consulting. The many widely used task-orientated consultation models,<sup>5–11</sup> and behavioural models<sup>12–14</sup> each has its own particular language and structure. Ask a cross-section of GPs which model they use and you will hear two or three spoken of more often than the others, but each model has its own disciples. Others have developed their own language of consulting, an eclectic blend of theories and styles.<sup>15,16</sup> Many of these complex models can also be summarised in simpler models involving information gathering and shared decision making.<sup>17</sup>

Each consultation model invites a more or less subtle variation in emphasis, in priorities and therefore skills. This is immediately evident with the consultation tasks described in three commonly used models (see Box 1). For example, establishing the explanation of the problem and the consequent action plan is described in different ways in each of the models, suggesting slight differences in the roles played by doctor and patient in that process. Thus the Cambridge–Calgary model talks of the doctor ‘explaining the problem to the patient by providing appropriate information’ en route to shared decision making;<sup>11</sup> Neighbour speaks of regular checkpoint summaries to ensure negotiation of both explanation and planning,<sup>10</sup> and Pendleton similarly emphasises the need to establish shared understanding of the problem but then suggests more patient-led decision making by enabling the patient ‘to choose an appropriate action for each problem.’<sup>8,18</sup> On the other hand, housekeeping is unique to and suggests a particular emphasis on the doctor taking care of their own well-being in one model.<sup>10</sup>

Not surprisingly, many doctors in training are bemused as they try to make sense of such a smorgasbord of definitions and descriptions. And of course this is only the consultation. GPs also have wider responsibilities within a practice, centred on building relationships within the team and handling a number of processes and professional duties (e.g. paperwork, home visits).

The past decade has seen a dramatic increase in attention to defining the work of a GP based on the now familiar language of a competency-based approach. Yet again, there is a surprising degree of variation in the different models and definitions that have emerged for specialty training in general practice: four core models, a combined total of 36 domains, and not one of the domains in any of the models directly replicated in any of the others. A potentially confusing situation has thus developed.

### Box 1 Three familiar GP consultation models

#### Pendleton<sup>8</sup>

- Understand the reasons for the patient’s attendance
- Take into account the patient’s perspective, to achieve a shared understanding
- Enable the patient to choose an appropriate action for each problem
- Enable the patient to manage the problem
- Consider other problems
- Use time appropriately
- Establish or maintain a relationship with the patient that helps to achieve the other tasks

#### Neighbour<sup>10</sup>

- Connect (with the patient)
- Summarise (your regular ongoing assessment of the presenting complaint communicated to the patient)
- Hand over (appropriate responsibility to the patient through negotiation of the management plan)
- Safety net (the plan, by informing about other possible outcomes and making appropriate ‘back-up’ arrangements)
- Housekeep (by acknowledging and addressing your own thoughts, feelings and needs at the end of the consultation)

#### Calgary–Cambridge<sup>11</sup>

- Initiate the session (by establishing initial rapport)
- Gather information (by exploring the problem, understanding the patient’s perspective, and providing structure)
- Build the relationship (by developing rapport and involving the patient)
- Explain and plan (by providing appropriate information, aiding accurate understanding, achieving a shared understanding and sharing decision making)
- Close the session

We first have a selection model for entry to general practice training (with 12 domains),<sup>19</sup> then a curriculum for the training programme itself (with 9 domains),<sup>20</sup> and two assessment models: one for ‘workplace-based assessment’ (with 12 domains),<sup>21</sup> and one for ‘clinical skills assessment’ (with 3 domains).<sup>22</sup> Anyone wishing to see where general practice sits within the wider profession will find seven more domains in the generic language of *Good Medical Practice* for all doctors (recently updated to four areas for appraisal and revalidation purposes).<sup>23</sup>

The simple question is this: does there really need to be such a complexity of models and checklists? How is the trainee or qualified GP to establish a consistent understanding of the skills and attributes underpinning competence as an independent practitioner, if each model or checklist has its own language and emphasis? Surely this is both unhelpful and unnecessary. An overarching model, one which would embrace other models of the work of a GP, must therefore be sought.

There have been important attempts to create generic medical models. *Good Medical Practice*,<sup>23</sup> reinforced by *Good Medical Practice for General Practitioners*,<sup>24</sup> is the benchmark for GPs in the United Kingdom, but its domains are not sufficiently discrete. For example, ‘good clinical care’ is so comprehensive in range that it carries elements of most other domains, and many domains refer to the role of ‘respect’ alongside relevant knowledge and skills, rather than as a separate attribute within the overall model. In truth, the creators of *Good Medical Practice* did not appear to set out with the purpose of creating a comprehensive model of the job itself, but rather a summary of how doctors should approach their various roles.

Another generic model often referred to is the Canadian Model of Seven CanMEDS roles.<sup>25</sup> This goes some way to clustering the core responsibilities (medical expert, communicator, collaborator, manager, health advocate, scholar and professional), but separating a job into roles rather than competency areas again leads to unhelpful overlaps in definition. Thus ‘collaborator’ may be more appropriately seen as a subcategory of ‘communicator’, and ‘health advocate’ – as defined – is largely a subcategory of ‘medical expert’ (e.g. *identifying* key determinants of health affecting patients, and *recognising* issues where advocacy is appropriate). The latter are arguably functions of expert judgement rather than measures of a commitment to the role of advocate.

As often happens, the CanMEDS roles confuse communication with the cognition that underpins it. Thus a competency of the ‘communicator’ is described as ‘obtaining and synthesising relevant history ...’, which clearly blurs the function of expert clinical judgement (in this instance determining and prioritising ‘relevance’) with the dialogue that accompanies it.

Those who speak for the ‘art’ of medicine might suggest that the lack of a unifying model is precisely because the core activity of medical practice – consulting – is too complex to be described or measured by a reductionist or two-dimensional formula (as they might also describe competency-based approaches). The way doctors make sense of complexity, it is argued, is largely by intuitive recognition of patterns or scripts in the patient or the presentation. Equally, establishing rapport with the patient is somehow

beyond rules or techniques. So the fundamental activities are indefinable, mysterious even.

By contrast, those arguing for the accuracy and efficiency of a competency-based approach suggest that there is a finite and discrete number of skills and attributes that inform good practice. In essence, this approach argues that effective performance in each job role demands competence in particular combinations of knowledge, skills, attitudes and personal qualities.<sup>26</sup> That was the basic initial premise behind the research that generated the now national competency model for selection to GP training, and the same premise has allowed the creation of new performance models in a number of hospital specialties.

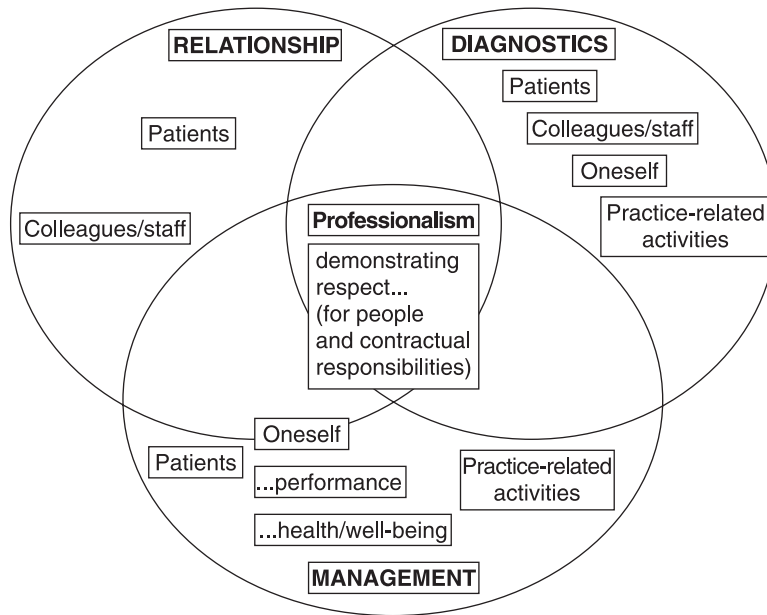
It is logical therefore that any unifying model of medical practice and training should synthesise existing research-based competency models. And given that general practice has done the groundwork for this, with its current four related models (as outlined above), one of the authors (TN) studied these models in search of common ground. This served as a validation study, in effect, for ideas emerging from his eight years of close observation and engagement with GPs and trainee GPs, involving numerous detailed discussions and analyses of factors affecting performance at selection, in training, and finally in practice.

The outcome of this combination of research, discussion and close observation is the model outlined in this paper: Relationship, Diagnostics, Management and professionalism (RDM-p, Figure 1). Using this model, it becomes clear that all domains within the four core GP models (as outlined above), as well as *Good Medical Practice*, can not only be clustered into meaningful performance areas but also compared and cross-referenced in a way that has been, until now, impossible, due to the disparity in their structures and terminology. In addition, using the RDM-p model one can also see how each of the ways that general practice is framed (selection, curriculum or assessment models), emphasises or defines the basic elements of the job slightly differently. The potential ambiguity here, the mixed messages, cannot be ideal for those involved in the training or appraisal of GPs – whether they seek to guide or be guided.

What also becomes evident from application of the model is that what started out as a journey to define general practice ended up producing a model that is capable in principle of defining any area of medicine.

## RDM-p: overview of the competent GP

In essence, general practice involves a subtle interaction between three core activities: relationship, diagnostics



**Figure 1** Relationship, Diagnostics, Management and professionalism (RDM-p)

and management. They could perhaps be visualised as the three interlocking ‘cogs in the wheel’, for which professionalism then provides the essential oil. Within the dynamic interaction between these three areas lies every component of the job, though most attention centres on relationship and diagnostics.

## Relationship and diagnostics

‘Relationship’ here involves engagement with patients, colleagues and other members of the practice team, and is primarily about the way we communicate with each other – our verbal and non-verbal behaviour. Functional working relationships, based on understanding and trust, allow effective collaborative care of patients. ‘Diagnostics’ involves every aspect of our thought processes while we assess what is going on in front of us (whether with patient or colleague) – including both the choice of information to seek, and the analysis and interpretation of that information up to and including the point where a decision is made about its full meaning and significance (and the appropriate actions that might follow).

One of these activities is clearly internal (diagnostics), and the other is external (relationship); together they determine the quality of much of our interaction with others at any given moment. For example, dealing effectively with a seemingly anxious or frustrated practice partner requires the same analytical skills, and similar communication skills, to dealing with a seemingly anxious or frustrated patient. We may have very different roles in the two conversations, which may demand adjustments in style and emphasis, but the basic skills are the same.

## Management

What turns these momentary skills into fluent, sustained effectiveness over a period of time (whether during the length of a consultation, a working week or a career) is the way a GP *manages* his or her various relationships and responsibilities. ‘Management’, in this sense, describes an ongoing process, for example providing clear structure within a consultation, pacing a surgery, organising one’s time to balance visits alongside surgery and paperwork, monitoring one’s own performance levels and health and so on.

The use of the term ‘management’ in this way to suggest an ongoing responsibility for applying diagnostic and relationship skills (as also implied by the term ‘manager’), can be and is widely understood and applied. Indeed medicine echoes this when speaking of ‘management plans’ for patients, which refers to treatments or actions designed to apply across specified periods of time.

It is a source of confusion, however, that the medical literature has widened the application of the term management, often including decision making within ‘clinical management’. Surely each judgement, each single decision to include or exclude pieces of information or options – right up to the point of the final choice or decision – is a cognitive, *diagnostic* act? By contrast, the management here is the *ongoing process* across all stages of the consultation, where the doctor aims to structure or organise events so that a patient, however complex the presentation, can be dealt with efficiently and effectively within a given timeframe. The same would apply to managing one’s thinking and decision making through the course of a practice

meeting, or managing one's workload on a specific day – thus, many individual *diagnostic* assessments being made at various points, and the process needing to be *managed* through efficient planning, organisation, structure and pace.

## Professionalism

So in this model, three broad activities define the work of a GP (relationship, diagnostics and management). As we shall see, each of these demands particular knowledge and a corresponding skill set. What then determines much of the quality of the *application* of these skills is the 'professionalism' that underpins them – defined here, in line with the profession's own typical emphasis, as commitment to (and respect for) best practice. The terminology varies, but the broad theme recurs.

Medical professionalism has, for example, been described as 'embracing a doctor's personal responsibility for their competence and conduct',<sup>27</sup> and similarly, as 'a personal and professional obligation to strive for excellence, humanism, accountability and altruism'. *Good Medical Practice* is itself an attempt to capture 'the principles and values on which good practice is founded, [which] together describe medical professionalism in action', and speaks of probity ('being honest, trustworthy and acting with integrity') as lying at its very heart.<sup>28</sup> The parallel 'physician charters' in Europe<sup>29</sup> and the United States<sup>30</sup> describe medical professionalism as a set of responsibilities, talking specifically of *commitments* to competence, honesty, fair distribution of resources, maintaining trust by managing responsibilities, improving access to care etc.

What complicates the definition of professionalism is any blurring of the boundary between skills and attitudes, which can allow the assumption that a failure to demonstrate a particular behaviour must necessarily imply a lack of commitment. Suppose, for example, 'the presence of empathic comments' was considered to be a measure of professionalism.<sup>31</sup> Dealing with a patient with an acute presentation might offer little opportunity for empathic engagement, but does this then by definition imply a lack of professionalism? Of course not. The professionalism is not defined by the behaviour, but the effort or commitment made in search of best practice in each given situation or context.

We are speaking therefore of professionalism as a purposeful attitude, a positive and deliberate way of viewing or approaching one's work that will maximise the possibility of performing competently or better, whether in relationship with others or when working alone. Based essentially on this notion of respect for

best practice, the quality of an individual GP's professionalism therefore depends on the *value* they attach to the various aspects of their job. Clearly, anyone who does not view as fundamental to modern NHS medicine the importance of seeking to understand the patient perspective, would rightly have their professionalism immediately questioned. But the same expectation applies to any aspect of the job that has been formally agreed to be important – whether by the profession itself (e.g. developing and maintaining fluent working relationships with colleagues (and staff) or maintaining accurate records), or by the practice (e.g. the promotion of book prescriptions for depressive patients).

Put simply, if the professional value attached to any individual activity is insufficient, then the energy levels and attention to detail required to ensure that activity can be performed effectively will also be weakened, and the quality of performance will very often suffer. Thus a GP may well struggle to develop good relationships with colleagues (and staff) if they view this aspect of their work as peripheral rather than essential. Such individuals often speak passionately of patients being their 'absolute priority', as if everything (and everyone) else is somehow secondary to the pursuit of that goal.

## Summary

The four components of RDM-p together map the essence of any service profession: *relate* to someone, *diagnose* their needs, *manage* the process and at all times ensure you act *professionally*. The difference between general practice and many other services is that to be a 'competent' GP, all four elements need *consistently* to be demonstrated at high levels. The model constituting these elements is now described in more detail.

## RDM-p: the model

### Relationship

This involves all aspects of how we relate with others in a professional context (whether patients or colleagues/staff) and includes:

- *empathy* – the desire and ability to take in someone else's perspective, and use that understanding to facilitate discussion
- *communication skills* – adapting language and style to suit the circumstance, whether with individuals or groups. For example, being able to use appropriate eliciting techniques, or positively reframe information/suggestions to encourage patients (and others) into constructive action (verbal and non-verbal when

in dialogue; verbal and numerical when writing letters/reports)

- *negotiating skills* – drawing patients (or others) into an open, honest and equal exchange in search of agreement about any issue relevant to both the individual and other(s); reconciling potentially opposing views, while acknowledging the needs of both (closely linked to concordance)
- *leadership skills* – being able to encourage or persuade patients (and others) to respond willingly/positively to one's decisions or suggestions, especially when related to changes in policy or behaviour (e.g. health promotion)
- *advocacy skills* – combining the skills of negotiation and leadership to support patients (and others) in search of a positive outcome to issues.

## Diagnosics

This involves all aspects of gathering and interpreting information in search of optimal decision making (whether with patients, colleagues/staff or oneself). A combination of knowledge and expertise, this will include:

- *information-gathering skills* – the ability to judge (a) the appropriate range of questions or examinations required to elicit (b) enough potentially relevant information from others to allow for (c) viable/meaningful analysis of the information (also requires an adequate range and depth of appropriate knowledge to help inform and validate the process)
- *analytical skills* – the ability (a) to prioritise elicited information in terms of relevance and significance, (b) to identify viable explanations or suggestions, and (c) to prioritise alternative explanations or suggestions (also requires an adequate range and depth of appropriate knowledge to help inform and validate the process)
- *decision-making skills* – the ability to draw together prioritised information and options in such a way that a clear, rational and defensible decision can be reached (with regard both to the diagnosis and management options relevant to a particular patient's problem – e.g. whether to treat, to refer, to wait and see etc)
- *examination and technical skills* – the ability to conduct physical examinations and use instruments and procedures appropriately and effectively.

## Management

This involves skills related to the wider handling of one's professional responsibilities (to patients and

colleagues). The challenge is to keep track of relevant issues over varied lengths of time, and will include:

- managing *particular events* – e.g. pacing/structuring a consultation, surgery, visit or meeting; writing a batch of referral letters
- managing *comprehensive/ongoing events* – e.g. handling one's full practice timetable over a period of months or years, maintaining adequate records, fulfilling one's ongoing role(s) within a team, meeting wider responsibilities to community health and resources
- managing *relationships* – providing continuity of care for patients (e.g. using existing knowledge of patient's personality/preferences, history and current circumstances to help build trust/understanding and fluency of dialogue), monitoring the quality of one's interaction with colleagues (especially if in a leadership role), and, where necessary, taking steps to improve specific relationships
- managing *oneself* – monitoring (a) one's performance/learning/development in all relevant areas, and (b) one's mental and physical health/well-being (and thus capacity to operate at a sufficiently effective/safe level).

## Professionalism

The simplest way to picture professionalism is in terms of commitment or respect: to others (relationship), to due process in gathering and analysing information (diagnosics), and to ongoing responsibilities (management). Inherent here is a fundamental respect for the importance of behaving with integrity and probity, a commitment that will determine where each individual 'draws the line' on the appropriateness of their own choices when relating, diagnosing and managing.

More specifically, medical professionalism therefore includes:

- *respect for others* (patients, colleagues, staff etc) – a non-judgemental approach that treats others, and their contribution, with equal attention and positive intent; commitment to assist others equally, irrespective of differences, in whatever way appropriate
- *respect for position* – acting in full awareness of one's professional roles and boundaries, potential influence over the behaviour/actions of others, and personal limitations, thus acting to *maximise* professional possibilities (e.g. backing one's own judgement when appropriate, or taking potentially significant initiatives) and to *minimise* risk (e.g. taking steps to deal with circumstances where one's own performance or health, or that of others, might compromise effectiveness or safety)

- *respect for protocol* – acting in accordance with published or formally agreed guidelines (in relation to professional codes of practice, local practice policies/initiatives, educational responsibilities etc).

## Applying the RDM-p model

To be effective, any diagnostic model must clearly be directly applicable to the specific environments it targets. Perhaps the simplest and most powerful way to demonstrate this here is to consider the RDM-p model in relation to the 12 performance domains listed for the workplace-based assessment (WbA) of trainee GPs.

Laid out as 12 separate domains, a closer look at the WbA indicates that these domains offer a more detailed breakdown of the expectations of a GP in the areas of relationship, diagnostics, management and professionalism (see Figure 2). For example, a dominant theme running through the behavioural indicators of three of the domains is the need to establish and maintain appropriate relationship with others (communication and consultation skills, practising holistically and working with colleagues and in teams). Similarly, four other domains capture the functional process and demands of the wider ‘diagnostic’ journey (domains 3, 4, 5 and 6).

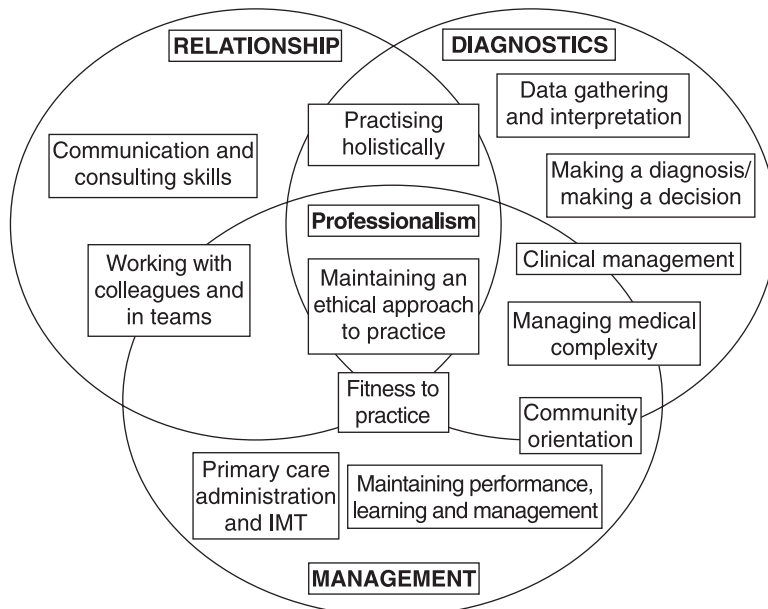
This is not to suggest, of course, that performance areas can be seen as discrete in any absolute sense. As the use of the Venn diagram implies, there are natural overlaps between all performance areas. For example, individual diagnostic judgements within a consultation are made within the ‘management’ of that

consultation over say 10 minutes; thus the domain ‘clinical management’ is defined in WbA as ‘... about the recognition and management of common medical conditions ...’. The ‘recognition’ is clearly a diagnostic skill rather than a management skill, hence the positioning of ‘clinical management’ (within the RDM-p framework) as lying across both Diagnostics and Management.

The model helps highlight some interesting emphases within individual domains. For example, *practising holistically*, from an intuitive clinical perspective is primarily about relationship. However, studying the descriptors for this domain within the WbA competence framework, the emphasis is clearly diagnostic, e.g. ‘demonstrates understanding of...’, recognises the impact of ...’, rather than relationship. Hence the position within Figure 2 spans both Relationship and Diagnostics.

Taken to a more micro level, even an individual indicator within the one domain can itself describe the interaction between different RDM-p areas. For example, within ‘Maintaining performance, learning and teaching’, a measure of competence is described as ‘shows a commitment to continuous professional development (CPD) through reflection on performance and the identification of and attention to learning needs’. The ‘commitment’ is evidence of professionalism (i.e. respecting the need for CPD); the ‘identification’ is a diagnostic skill; and the ‘attention to learning needs’ is part of the management of one’s responsibilities.

Separate skills and attributes are thus embedded here within the one statement – and, importantly, each needs to be recognised and tracked as such when measuring and developing performance. More typically,



**Figure 2** RDM-p and GP workplace-based assessment (WbA) domains. IMT: information management and technology

the tendency is to view such an indicator in a more generalised way, thus losing the fine accuracy of what exactly is required to be able to demonstrate competence in this aspect of the job. This principle, applied more widely, has obvious implications for the training (or retraining) of individuals in particular performance areas.

The same principle and process described in relation to WbA could be applied to all current models used within general practice – thus *Good Medical Practice*, the postgraduate curriculum, selection to

postgraduate training, and clinical skills assessment (CSA). Each model can be framed within RDM-p, thereby not only generating meaningful and distinct performance areas but, importantly, allowing continuity across the profession (see Figures 3–6). In particular, the fundamental targets for the assessment and development of competence (whether as a trainee or practising GP) would become seamlessly recognisable across each stage and level.

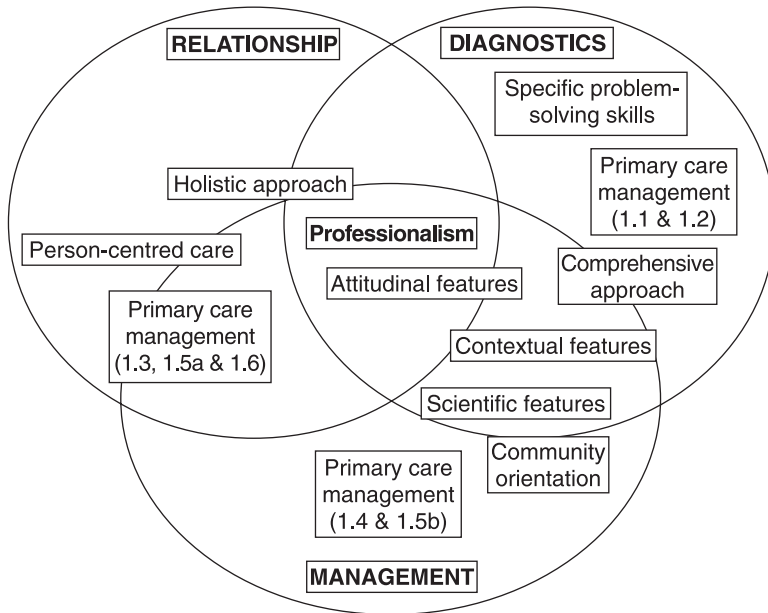


Figure 3 RDM-p and GP curriculum domains

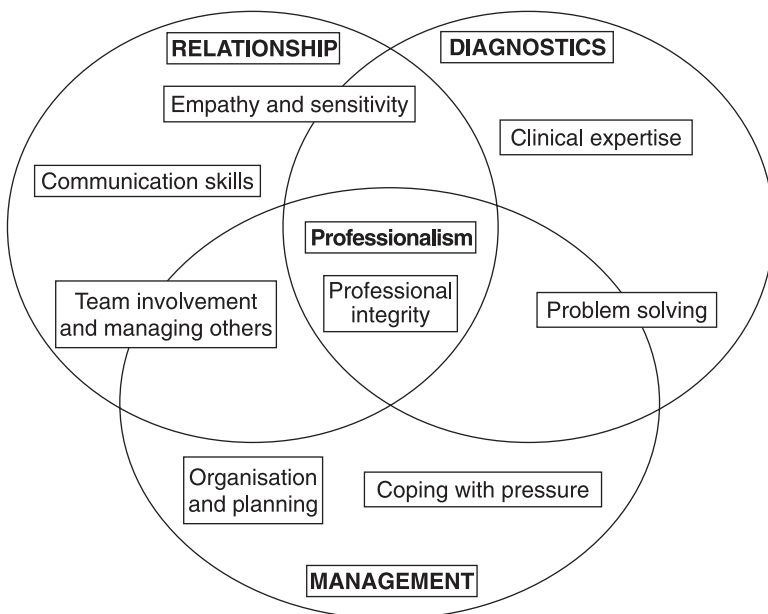
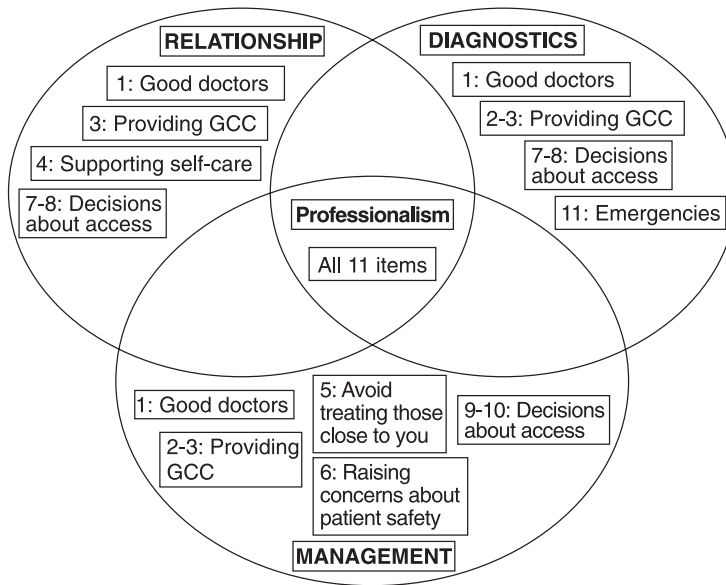
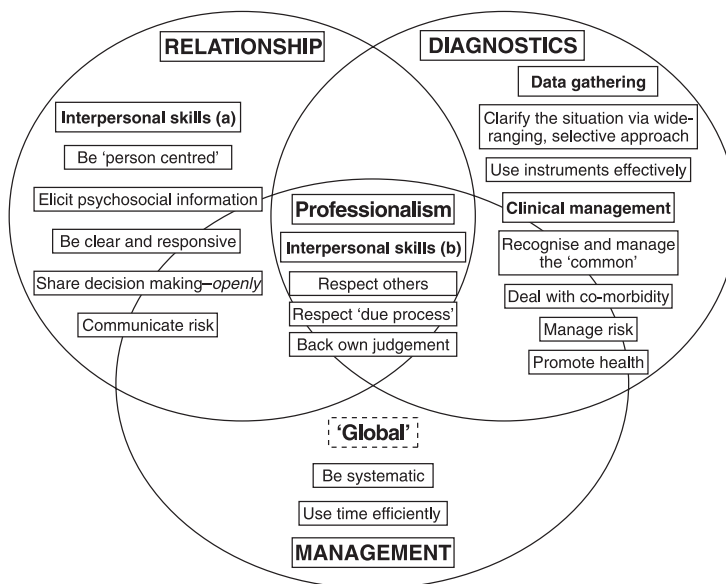


Figure 4 RDM-p and GP selection competencies





**Figure 5** RDM-p and Good Medical Practice (Domain 1: Good Clinical Care – GCC). NB Because all items within GCC describe more than one performance area, and some involve all four domains in the RDM-p model, the only way to capture such a degree of overlap here is to repeat the items within each relevant domain (e.g. ‘Item 1: Good doctors’ describes attributes within all four areas, so is listed here in all four domains)



**Figure 6** RDM-p and clinical skills assessment (CSA)

## Wider implications

The RDM-p model offers a unifying theory of the work of clinical practice, and would be relevant to practitioners, educators and assessors. It is not only a metasynthesis of previous models, but extends them in particular to highlight the key areas beyond relationship (specifically diagnostics, management and professionalism), which have not been as fully developed in previous frameworks.

The strength of any theoretical model will ultimately be judged by its usefulness and practical application – in this case for clinical learning, teaching and assessment. The model is currently being used as a diagnostic map for defining, exploring and explaining GP-related behaviour, in particular with doctors whose performance has been a cause for concern. Its more generic potential as a model of medical performance has also allowed it to be used to map performance in a range of hospital specialties (only specific clinical and technical aspects of diagnostics vary significantly from the detail of the general practice model).

The feedback from individuals involved to date with RDM-p as a diagnostic tool – both those whose performance has been in the spotlight and those responsible for managing doctors in difficulty – has been encouraging. Responses suggest that the model brings a unifying clarity and common sense meaning to what have previously been seen as rather disparate lists of competencies or definitions. In particular, significant insights have been reached by a number of individuals who have explored their own performance through the model. Many trainers introduced to the model have also felt that it has given them an accessible language and structure for helping guide and support their trainees.

Although the model has been developed in general practice, and is currently being used widely in this setting, there are clear opportunities to further apply, develop and research the model in other clinical areas, including nursing and allied health professions. Its generic nature suggests that it may have even wider application to non-clinical groups working in health-care or other client-based environments.

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## PEER REVIEW

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CONFLICTS OF INTEREST

None.

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