

Application of Workshop-based Teaching Model Combined with the Leicester Assessment Package in Outpatient Consultation Training for Undergraduate Interns in General Practice

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Abstract: Objective: To investigate the effect of a workshop-based teaching model combined with the Leicester Assessment Package (LAP) on the basic outpatient consultation skills of undergraduate interns in general practice. Methods: A total of 84 undergraduate interns in general practice were randomly divided into an intervention group (workshop teaching, n=42) and a control group (traditional teaching, n=42). The intervention group received a three-stage workshop teaching model consisting of pre-consultation activation, intra-consultation role rotation, and post-consultation integration, with LAP embedded in the observation and feedback phases during consultations. Consultation abilities were assessed using four LAP dimensions: history taking, physical examination, doctor–patient relationship, and medical record keeping. Results: After training, the intervention group had significantly higher total LAP scores and scores in all four dimensions than the control group (all $P<0.05$). The improvements were particularly notable in history taking (14.3 ± 1.4 vs. 12.6 ± 1.5 , Cohen's $d=1.17$) and medical record keeping (6.8 ± 1.2 vs. 5.6 ± 1.2 , $d=1.00$). Physical examination and doctor–patient relationship also improved significantly ($P<0.05$). The intervention group showed significant increases in exploratory dimensions (problem solving, patient management, and preventive care) after training ($P<0.001$), whereas the control group showed no changes. In the intervention group, 83.3% of the interns were very satisfied with the improvement in their self-learning ability. Conclusion: The workshop-based teaching model combined with LAP can effectively enhance key outpatient consultation skills among general practice undergraduate interns, especially in history taking and standardized medical record writing, providing a feasible approach to homogenizing general practice internship training.

Keywords: Workshop-based Teaching Model; Leicester Assessment Package; Outpatient Consultation Ability; General Practice Education; Undergraduate Interns.

1. Introduction

Outpatient consultation in general practice is the core process through which general practice students translate theoretical knowledge into clinical practice, and its quality directly affects the post competency of primary healthcare professionals. Against the backdrop of the continuous expansion of medical education, the limitations of the traditional apprenticeship model have become increasingly apparent: the teaching structure is loose, feedback is delayed, and objectives are vague, making it difficult to achieve the goal of homogeneous training. Exploring more systematic and standardized outpatient teaching models has therefore become an urgent need for general practice clinical teaching reform [1].

The workshop-based teaching model is a student-centered form of medical education that emphasizes practical interaction and problem orientation, and has attracted considerable attention in the field of medical education in recent years [2,3]. Our research group previously applied it to the retraining of general practitioners and achieved good results [4]. However, most existing workshop studies take students' self-rated satisfaction or self-perceived ability as the primary outcome indicators, lacking a standardized external assessment system, which compromises the objectivity and comparability of their teaching effects [5]. The Leicester

Assessment Package (LAP) systematically assesses general practice consultation ability across seven aspects—history taking, physical examination, problem solving, patient management, doctor–patient relationship, preventive care, and medical record keeping—and is recognized as a consultation assessment tool with good reliability and validity. Studies in China have preliminarily applied LAP to the assessment of primary care physicians' competence [6,7], but mostly at the level of summative assessment, without embedding it into the teaching process to serve the function of formative feedback.

Based on the above, this study attempts to integrate the workshop-based teaching model with the LAP framework: the intra-consultation role rotation and peer feedback of the workshop create learning opportunities, while the dimensional framework of LAP serves as the basis for structured observation and feedback, transforming the assessment tool from a single outcome measure into formative assessment support throughout the entire teaching process. This study embeds the four main LAP dimensions into the workshop's intra-consultation observation and post-consultation feedback, establishing a general practice outpatient teaching model with a teaching framework, evidence-based feedback, and standardized assessment, and examines its effects on undergraduate interns.

2. Subjects and Methods

2.1. Study Subjects

Eighty-four undergraduate general practice interns who completed their clerkship in the Department of General Practice, First Affiliated Hospital of Bengbu Medical University, between March 2024 and February 2025 were enrolled as the study subjects. The inclusion criteria were: full-time general practice undergraduate students who had completed the clinical theoretical curriculum, participated voluntarily, and signed informed consent. The exclusion criteria were: taking leave for more than 3 working days during the clerkship (intervention exposure less than 80% of the total duration) or simultaneously participating in other teaching studies. The participants were divided into an observation group (workshop teaching, $n=42$) and a control group (traditional teaching, $n=42$) using the random number table method. Due to the nature of the teaching intervention, the supervising teachers and students could not be blinded, but the assessors were unaware of the group allocation. All participants joined voluntarily after fully understanding the purpose, methods, and risks of the study, and signed written informed consent. Students had the right to withdraw at any stage without affecting their clerkship grades.

2.2. Teaching Methods

2.2.1. Teaching Arrangement and Faculty

The teaching venue was a dedicated outpatient teaching clinic in the Department of General Practice of our hospital, equipped with two-way observation glass, a real-time audio-video recording system, and a teaching display screen. The outpatient teaching area was managed separately from the general outpatient area to ensure that teaching activities were not disturbed by routine outpatient work. Each group of students was provided with an independent consultation workstation and a medical record writing terminal. The teaching content of both groups followed the requirements of general practice undergraduate clinical practice teaching, focusing on the diagnosis and treatment processes of common and frequently occurring diseases in the general practice outpatient setting; the content mainly consisted of standardized, structured consultation process training. The supervising teachers were eight attending physicians or above from our hospital, all of whom had received provincial-level or above general practice teacher training and obtained qualification certificates. To prevent crossover contamination between teaching methods, the two groups were taught in separate time slots and separate clinics. To control for the effect of teaching duration, the total teaching period was identical for both groups: twice per week for 4 consecutive weeks (8 sessions in total). The control group received an additional 30-minute structured case discussion after each outpatient session (centralized explanation and question-and-answer session on the cases seen that day), while the post-consultation integration session of the observation group workshop lasted approximately 30 minutes, ensuring that the total weekly teaching time was basically the same in the two groups.

2.2.2. Training Method of the Control Group

The control group received the traditional apprenticeship teaching model. The detailed process was as follows: the student consulted independently in the clinic (history taking, physical examination, and preliminary management) and then reported the consultation and preliminary diagnosis to the

supervising teacher, who supplemented the history taking and physical examination and gave structured verbal comments on the spot. The comments uniformly covered four aspects—history taking, physical examination, doctor–patient relationship, and medical record keeping: the teacher first affirmed 1–2 strengths, then identified 1–2 main deficiencies with detailed improvement suggestions, and each comment was limited to 5–8 minutes. The student recorded the key points of the comments and reflected independently after class.

2.2.3. Training Method of the Observation Group

The observation group received the workshop-based teaching model. In this study, the workshop refers to a short, intensive teaching model that is student-centered, driven by small-group tasks, and emphasizes practical output and peer collaboration. The teaching process was divided into three stages:

(1) Stage 1: Pre-consultation activation workshop. Before each outpatient session, using the day's clinical theme (e.g., the diagnostic approach to chronic cough, the differential diagnosis of chest pain) as the background, the students were divided into small groups (3–4 students per group) and, based on case summaries, jointly completed the following tasks: summarizing the key points of history taking and the reasoning of differential diagnosis, listing the aspects that required special attention during the consultation, and selecting one representative from each group to give a 2-minute “consultation strategy report”. The supervising teacher circulated among the groups and provided targeted guidance.

(2) Stage 2: Intra-consultation role rotation. The students took turns serving as the consulting physician in a real outpatient environment; every student had the opportunity to act as the consulting physician, while the remaining students served as structured observers, recording the consultation performance in real time according to the LAP framework. The supervising teacher acted as facilitator and safety supervisor. After each consultation, one peer first identified a specific strength, and then another peer offered a constructive improvement suggestion; the supervising teacher then asked heuristic questions or gave a brief demonstration. Through role rotation, each student not only led the consultation to gain direct practical experience, but also learned from peers' strengths in the role of observer and practiced assessment skills.

(3) Stage 3: Post-consultation integration workshop. A group debriefing was conducted immediately after the outpatient session. Each group selected one real case from the day, summarized the highlights of the consultation and the key areas for improvement, and distilled one transferable clinical rule. Inter-group exchange and feedback then followed, with each group presenting its analysis and listening to the suggestions of the other groups. The supervising teacher finally summarized the common patterns and frequent pitfalls, enabling the students to integrate their scattered experiences and engage in clinical reflection.

2.3. Assessment of Teaching Effects

The Leicester Assessment Package was used for assessment. Since the teaching objectives at the undergraduate clerkship stage are mainly to consolidate clinical fundamentals—standardized history taking, physical examination, doctor–patient communication, and medical record writing—while independently solving clinical

problems and managing patients are not the primary requirements at the undergraduate stage, this study designated the four LAP dimensions of history taking, physical examination, doctor–patient relationship, and medical record keeping as the primary outcome indicators; the three dimensions of problem solving, patient management, and preventive care were set as exploratory analysis indicators.

Two senior general practitioners performed blinded scoring before and after training. The pre-test was conducted within one week before the start of training, and the immediate post-test was conducted within one week after all teaching ended. Assessor reliability: before the formal scoring, the two assessors received unified training and independently scored five simulated consultation videos; the inter-rater reliability was calculated, and the intraclass correlation coefficient (ICC) was 0.87 (95% CI: 0.81–0.92), indicating good agreement. For the formal scoring, the two assessors scored separately, and the mean was taken as the final score.

2.4. Survey on Satisfaction with Teaching Effects

A self-designed questionnaire was used to survey the observation group students' acceptance of the workshop teaching model. The questionnaire was completed anonymously and was collected and entered independently by

non-teaching staff. The questionnaire contained three items: improvement in self-learning ability, acceptance of the interactive teaching method, and the fit between the cases and the LAP dimensions, rated on a 5-point Likert scale (very satisfied, satisfied, neutral, dissatisfied, very dissatisfied), and the very-satisfied rate was reported.

2.5. Statistical Methods

SPSS 22.0 software was used. Measurement data are expressed as $\bar{x} \pm s$; paired t-tests were used for within-group comparisons and independent-samples t-tests for between-group comparisons; count data were analyzed by chi-square tests. For the between-group comparisons of the primary outcome indicators, the effect size Cohen's d was also calculated to assess the practical magnitude of the differences. $P < 0.05$ was considered statistically significant.

3. Results

3.1. General Information

There were no statistically significant differences between the two groups in sex, age, or pre-training LAP total score ($P > 0.05$), indicating comparability. No participants were lost during the study; all 84 students completed the entire teaching and assessment procedures (Table 1).

Table 1. Baseline characteristics of the two groups of study subjects

	Observation group (n=42)	Control group (n=42)	Statistic	P
Sex (male, %)	22 (52.4)	24 (57.1)	0.192	0.661
Age	22.7±0.64	22.5±0.64	1.375	0.173
Pre-training LAP score	47.7±7.47	47.6±6.94	0.106	0.916

3.2. Comparison of LAP Scores Before and After Training Between the Two Groups

After training, the LAP total scores of both groups were significantly higher than before training ($P < 0.001$). In the observation group, the LAP total score increased from 52.2±5.7 to 69.5±4.8, and in the control group from 51.9±5.7 to 57.2±5.1; the magnitude of improvement in the observation group was significantly greater than that in the control group ($P < 0.001$) (Table 2).

For the primary outcome indicators, the post-training scores of the observation group in the four dimensions of history taking, physical examination, doctor–patient relationship, and medical record keeping were all

significantly higher than those of the control group ($P < 0.05$). The between-group difference was largest for the history-taking dimension (observation group 14.3±1.4 vs. control group 12.6±1.5, difference 1.7 points, 95% CI: 1.1–2.3, Cohen's $d=1.17$), followed by medical record keeping (difference 1.2 points, 95% CI: 0.7–1.7, $d=1.00$); doctor–patient relationship (difference 0.6 points, 95% CI: 0.1–1.1, $d=0.54$) and physical examination (difference 0.8 points, 95% CI: 0.3–1.3, $d=0.72$) also improved significantly. For the exploratory indicators (problem solving, patient management, and preventive care), the observation group improved significantly before versus after training ($P < 0.001$), whereas the control group showed no statistically significant changes ($P > 0.05$) (Table 2).

Table 2. Comparison of overall LAP scores before and after training between the observation group and the control group (points)

	Observation group			Control group			
	Pre-training	Post-training	P_a	Pre-training	Post-training	P_b	P_c
History taking	10.8±1.3	14.3±1.4	<0.001	10.4±1.4	12.6±1.5	<0.001	<0.001
Physical examination	6.0±1.3	7.5±1.0	<0.001	5.9±1.5	6.7±1.2	<0.001	0.024
Problem solving	9.2±1.4	13.0±1.5	<0.001	9.1±1.7	9.4±1.6	0.311	–
Patient management	9.6±3.1	13.2±2.0	<0.001	9.7±3.0	10.1±2.7	0.074	–
Doctor–patient relationship	6.0±1.2	7.6±1.2	<0.001	6.0±1.1	7.0±1.0	<0.001	0.004
Preventive care	5.7±1.2	7.2±1.0	<0.001	5.7±1.2	5.8±1.1	0.255	–
Medical record keeping	5.7±1.2	6.8±1.2	<0.001	5.1±1.2	5.6±1.2	0.001	<0.001
Total LAP score	52.2±5.7	69.5±4.8	<0.001	51.9±5.7	57.2±5.1	<0.001	<0.001

Note: P_a : comparison before and after training within the observation group (paired t-test); P_b : comparison before and after training within the control group (paired t-test); P_c : independent-samples t-test of the pre–post differences between the control group and the observation group

3.3. Results of the Satisfaction Survey on Teaching Effects

The results of the satisfaction survey of the observation group students regarding the workshop teaching model are shown in Table 3. 83.3% of the students were very satisfied with the “improvement in self-learning ability”, 76.2% with

the “acceptance of the interactive teaching method”, and 50.0% with the “fit between the cases and the LAP dimensions”. The complete distribution of ratings for each item is shown in Table 3, indicating that the students had a high overall acceptance of the course, while the match between the cases and the LAP dimensions still needs to be improved.

Table 3. Distribution of satisfaction of the observation group students with the workshop teaching model

Item	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied
Improvement in self-learning ability	35 (83.3)	5 (11.9)	2 (4.8)	0	0
Acceptance of the interactive teaching method	32 (76.2)	7 (16.7)	2 (4.8)	1 (2.4)	0
Fit between the cases and the LAP dimensions	21 (50.0)	13 (31.0)	6 (14.3)	2 (4.8)	0

4. Discussion

This study shows that the combined use of the workshop-based teaching model and LAP can significantly improve the key outpatient consultation skills of general practice undergraduate interns, particularly in history taking and medical record writing. The results demonstrate that an integrated teaching–assessment design is feasible and effective in undergraduate clinical teaching.

The three-stage workshop forms a closed-loop learning mechanism, which is the structural guarantee of the improvement. In the pre-consultation activation stage, case summaries and small-group cooperation prompt the students to actively mobilize their relevant knowledge reserves and clarify the consultation goals before entering the clinic, solving the passive learning problem of “only starting to think after entering the consultation room” in the traditional model; task-driven group discussion replaces pre-class independent reading, and cognitive schemas are activated through knowledge complementarity among peers. The intra-consultation role rotation stage is the core of the model: each student is not only the leader of the consultation but also a structured observer, participating in the assessment and feedback of peers’ performance. This dual-role design transforms students from passive recipients of skills into active observers and evaluators, promoting the metacognitive development of clinical thinking [8]. At this stage, the LAP framework provides the observers with a structured recording reference, turning peer feedback from a vague “not bad” into specific and actionable improvement directions, such as “no further inquiry about the precipitating factors when taking the present illness history (history-taking dimension)”, thereby overcoming the delayed and vague feedback of the traditional model. In the post-consultation integration stage, group debriefing and inter-group exchange help students organize scattered experiences, summarize transferable clinical rules, and form a spiral process of “action–reflection–re-action” [9].

The dimension-specific results also reveal the differential mechanism of the model. The improvement in the history-taking dimension was the most pronounced, because the task of integrating the key points of history taking and the logic of differential diagnosis in the pre-consultation workshop enabled the students to form a structured interviewing framework in advance, while the peers’ real-time recording and feedback on the history-taking dimension according to the LAP framework during the consultation further strengthened the students’ self-monitoring of specific

behaviors such as the seven elements of the present illness history and the probing of accompanying symptoms; the dual mechanisms produced a marked combined effect. The significant improvement in the medical record keeping dimension is related to the task design of the post-consultation debriefing, in which the students continuously compared their own records with those of their peers during the group discussion and gradually internalized the standardized writing criteria as the supervising teacher summarized and concluded. Although the physical examination dimension improved statistically, the post-training mean of the observation group had already reached 7.5 points (out of 8), indicating a clear ceiling effect; undergraduate physical examination teaching focuses on procedural skills such as standardized technique, reasonable sequence, and recognition of positive signs. After 8 outpatient sessions of repeated practice over 4 weeks, most students had already become quite proficient, leaving limited room for further improvement.

The exploratory dimension results offer important methodological implications. The limited progress of the observation group in comprehensive abilities such as patient management and problem solving reflects the limitations of the traditional model, which emphasizes skill imitation and one-way transmission of experience, consistent with previous findings [10,11]. The primary task of the undergraduate clerkship stage is to “lay the foundation”—standardized history taking, physical examination, doctor–patient communication, and medical record writing—whereas independently analyzing clinical problems, formulating management plans, and delivering preventive care are higher-level post competencies that are usually trained systematically during residency [12]. This result, in turn, validates the design decision of this study to designate the four main LAP dimensions as the primary outcome indicators, because only by selecting assessment tools matched to the teaching objectives can the validity bias of “assessing what is not taught” be avoided. It also suggests that future researchers should carefully select the applicable LAP dimensions for undergraduate teaching, or develop a simplified assessment system suitable for the undergraduate stage [13].

The satisfaction feedback points to specific directions for improving the model. The very-satisfied rates for “improvement in self-learning ability” and “acceptance of the interactive teaching method” reached 83.3% and 76.2% respectively, consistent with the workshop’s design features of active participation, immediate feedback, and peer collaboration. However, the very-satisfied rate for “the fit

between the cases and the LAP dimensions” was only 50.0%, with 2.4%–4.8% of the students expressing dissatisfaction, indicating deficiencies in the current case library design. The reason is that the case summaries used in the pre-consultation workshop were compiled by the supervising teachers based on the diseases likely to appear in the day’s clinic; some cases had complex clinical manifestations beyond the coverage of the four LAP focus dimensions for undergraduate interns (for example, cases involving polypharmacy management focus more on the “patient management” dimension), causing a mismatch when the students used the LAP framework for structured preparation. Future research should establish a standardized case library to ensure that the key teaching points of the selected cases closely align with the four LAP focus dimensions, pay attention to the matching of students’ personalities when grouping (to reduce the social pressure induced by peer observation), or provide alternative forms combining written and verbal feedback, thereby enhancing the inclusiveness of the model.

The key innovation of this study lies in integrating the workshop with LAP rather than simply superimposing them. The two complement each other: the role rotation and peer feedback of the workshop provide numerous learning opportunities, but without a structured observation framework, the quality of feedback depends heavily on the observer’s personal experience; LAP provides a mature dimensional framework and scoring criteria, but it functions only in end-of-term summative assessment and cannot deliver the formative feedback value of teaching. This study embedded LAP into the workshop’s intra-consultation observation and post-consultation debriefing, transforming the assessment criteria from a checklist “taken out only during evaluation” into a teaching tool “used in every session”, achieving the integration of assessment and teaching. The deeper mechanism of this transformation is that the LAP framework serves as a “cognitive scaffold”, enabling students to self-calibrate against explicit behavioral standards during every consultation and observation. Compared with the traditional teaching state in which the assessment criteria remain implicit in the supervising teacher’s mind, the explicit and structured assessment framework effectively reduces the students’ cognitive ambiguity about “what constitutes a good consultation”, thereby accelerating the process of skill internalization. From the perspective of teaching management, this model does not require substantial additional teaching time or space resources and is highly scalable.

This study has several limitations. First, the sample came from a single center with only 84 students, and the generalizability of the findings requires further verification. Second, only an immediate post-test was used, without long-term follow-up data (e.g., consultation skill retention at three or six months), so the sustained effect of the model cannot be determined. Third, the additional 30-minute case discussion for the control group would reduce the effect size of the between-group difference, making this study’s estimate of the workshop effect more conservative; nevertheless, significant differences were still observed, which conversely supports the advantage of the workshop model. Fourth, the workshop model places high demands on the facilitation skills of the supervising teachers, and individual teachers differ in facilitation style and depth of feedback, which is difficult to eliminate completely.

5. Conclusion

In conclusion, the workshop-based teaching model combined with LAP can significantly improve the basic outpatient consultation skills of general practice undergraduate interns, with notable effects on key competencies such as history taking, doctor–patient communication, and medical record writing. The model is student-centered, problem-oriented, and structure-supported, transforming assessment criteria from a “final examination” into a “daily tool”, which meets the requirements of general practice undergraduate practical teaching and provides a feasible path toward the homogenization of general practice clerkship teaching. In the future, multicenter, large-sample randomized controlled trials could be used to test its external validity, and long-term follow-up could be used to assess the durability and transferability of the teaching effects. In addition, establishing a standardized case library highly matched to the LAP focus dimensions and developing training courses for supervising teachers based on the LAP framework will be important steps for the wider implementation of the LAP model.

Author Biography

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