Consultation Domain and competency	Strategy for improvement

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Opening

OP1: Introduces self

1. If you are unknown to anyone in the consultation, introduce yourself professionally using your name and role.
2. Even if the patient launches in as soon as they are through the door it is worth saying who you are.

OP2: Establishes identities of patient and third parties and preferred forms of address

1. Check the identity of the patient against the name of the person you expect to see.
2. Ask accompanying people their names and relationship with the patient.
3. Ask those attending 'What would you like me to call you?'
4. Introduce any other people (health staff, students) in the room and check that it is acceptable for the patient for them to be there.
5. Check the pronunciation of unfamiliar names with the patient.
6. Use your judgement to decide what is appropriate. The default strategy is to start formal with an older person (than yourself) and to consider what will feel appropriate for a younger person.

OP3: Establishes agendas

1. Identify the patient's agenda. Develop a range of opening questions for different situations with which you are comfortable
2. Check that your understanding of the patient's agenda is complete: 'Is there anything else you would like me to do today'
3. Clarify your agenda for the patient: 'I understand that you have come because/for XX'
4. Consider all presenting complaints and then quickly prioritise them and pay attention to what is necessary. Involve the patient in prioritising 'What is the most important thing to deal with today?'
5. Explain your agenda if you are a learner, and seek consent for this 'I am learning how to consult with patients. Could I interview you before you see Dr X and I will then report to her and we will complete the consultation together?'
6. Although confidentiality may be assumed in a healthcare consultation, consider whether it would help to make it explicit in this consultation
7. Recognise that it may not be possible to sort out all the problems presented on that day

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History Process

H1: Enable the patient to fully elaborate presenting problem

1. Resist the temptation to interrupt at the start of the consultation, although this may be necessary later if the patient becomes repetitive.
2. Use open questions to begin with e.g. 'How did it start?'; 'What happened next?'
3. Use prompts as appropriate e.g. 'I see'; 'Tell me more about that'.
4. If the patient makes a significant statement and then stops, encourage the patient to continue, for example by repeating the last statement or word
5. List the symptoms so far and check in different ways, for example "was there anything else you noticed?", "were there any other symptoms?"

H2: Listens attentively

1. Demonstrate to the patient that you are listening by using appropriate body language and maintaining eye contact.
2. In a patient-centred consultation you will receive information out of sequence. Remember key points. For example: 'You said earlier you are a smoker, how much do you smoke?' is preferable to asking the same patient 'Do you smoke'.
3. If you need to write information down, or record data on the computer, do so in a way that does not interfere with your communication with the patient.
4. Don't stop listening to the patient whilst you think about the next question to ask. Use other strategies if you need time to think eg mini summary
5. If you need time to think, tell the patient that you are gathering your thoughts. Make some brief notes if necessary.

H3: Skilled use of questioning including open and closed questions

1 Move from open to closed questions e.g. 'Why have you come today?' 'Can you tell me more about that?', 'Is it getting worse?'

3 Encourage the patient to tell their story by using expressions like 'And then….?' or 'What happened next?'

4 Avoid using 'leading' questions, i.e. those that imply a particular answer e.g. 'Your baby doesn't have diarrhoea does he?'

5 Don't use 'double' or 'nested' questions e.g. 'What is your pain like and how long have you had it?' 'Is your appetite normal and have you lost weight?'

6 Tailor the questions you ask to the level of the patient's ability to understand. Don't patronise or talk down to the patient.

7 Don't use technical jargon.

8 It may be that you have to ask the same question again or in a different way if the patient has misunderstood or evaded answering. Don't be afraid to do that or you will be left feeling unclear

H4: Clarifies words used and/or symptoms presented by patient as appropriate

1. If you don't understand what the patient means, ask them to explain.
2. If the patient uses a medical or technical term (e.g. constipation) make sure you understand exactly what they mean by it.

H5: Recognises and responds appropriately to verbal and non-verbal cues

1. Listen carefully for and follow up all cues that the patient gives you e.g. 'My husband's at home all day now'
2. Notice unusual words and/or surprising omissions and follow up on these.
3. If a symptom is shown during the consultation, consider acknowledging it and ask whether it is typical (eg if patient coughs or has a tremor).
4. Acknowledge patients' expressed feelings to give them a chance to explain them or feel that they have been shared. e.g. 'I can see that this is difficult for you to talk about . . .'
5. If the patient is having difficulty telling the story or is distressed, allow time for the patient to regain composure.

6 Try to tolerate the discomfort of appropriate silences. Resist the temptation to talk when the patient is thinking about their response.
7 If the patient seems particulary uncomfortable, pause to assure the patient of the confidentiality of the interview and check whether the patient is happy to continue with the topic
8 Be sensitive to behaviour that is incongruous e.g. the patient who laughs when stating something serious.

H6: History Content - Sequence of events

1 Ask the patient to describe and clarify when and in which order each event occurred
2 If a patient appears to have skipped a period of time and you are aiming to determine a chronology, ask what happened in the relevant period
3 If a patient gives a jumbled sequence of events, repeat the sequence in the order you understand for confirmation
4 Always check when they were last well or when their new symptom(s) FIRST started
5 If the patient has had symptoms for some time, find out why the patient has presented now?
6 If the patient has difficulty ask 'Can you tell me about it from the beginning?' and follow up with 'What happened next?' until the story is complete

H7: History content - Details of symptoms

1 Allow the patient to finish their opening statement and clarify their presenting complaint(s) before you seek relevant associated symptoms
2 Use a mental checklist such as SOCRATES (which is useful for many symptoms) to clarify the presenting complaint(s)
3 Ensure you have checked whether or not the patient is experiencing the 'cardinal' symptoms for relevant system(s)
4 Note taking can help you to keep track of disordered information.

H8: History content - Effect on the patient's life

1 Ask the patient how his/her ability to sleep, toilet, wash, dress, cook, eat, work, relax or socialise (as appropriate) have been affected.
2 In consultations with a third party, ask about effects on the patient's behaviour if appropriate
3 Ask the patient 'how is this affecting you? How is it affecting others?'
4 Ask the patient "what does it stop you doing?"

H9: History content - Patient's ideas, concerns and expectations

1 In every consultation you must be satisfied that you know: What does the patient believe is wrong? What are they concerned about? What do they hope can be done? Sometimes this may require gentle but persistent questioning.
2 If the patient has indicated their ideas, concerns or expectations avoid direct questions. It is better to reflect back a remark they have made. E.g. 'You said your mother had headaches like these, what was the cause of her headaches?'

H10: History content - Background information including: Past Medical, Family and Social History; Systems review; Factors influencing health

1 Remember that a problem will often have physical, psychological and social components ('Triple Diagnosis').
2 Patients with psychological illness may have unrecognised physical disease, and vice versa, so ensure you have thought about this possibility.
3 When satisfied that physical disease is present always consider its impact on the social and psychological well-being of the patient.
4 Consider the impact on the patient of other social and psychological factors in their life such as their work, housing, family and other relationships, personality, sexuality, cultural background, spiritual beliefs and practices.

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Examination

E1: Examination - Obtains maintains consent

1. Ask the patient’s permission to carry out the examination, especially 'intimate' examinations
2. Check whether the patient has understood and has any questions before you proceed
3. If the patient is unable to give consent (lacks competency eg. a young child or confused adult) you must act in their best interests. At all times try to achieve their cooperation, with the help of a familiar person if appropriate.
4. If the examination is uncomfortable at any point, apologise and ask for permission to continue

E2: Displays competent practice of infection prevention

1. You must always cleanse your hands before (for the patient) and after (for yourself)
2. You should wear non-sterile gloves in examinations which might involve contact with body fluids. You should wear sterile gloves where the patient could be at risk of transmitted infection from your skin.
3. Dispose appropriately of gloves, apron, tissues etc. according to your workplace policy

E3: Displays sensitivity to patient’s needs and dignity; offers chaperone if appropriate

1. Ensure a chaperone is available for intimate examinations and explain the need for this to the patient
2. When a chaperone is required either by the patient or by yourself, the chaperone should be acceptable to the patient
3. Give the patient privacy to undress and dress where possible
4. If the patient has difficulty in positioning or undressing themselves, ask whether you or the chaperone can help
5. Expose the part(s) to be examined with due sensitivity to the patient’s dignity and cover them as soon as possible

E4: Gives clear instructions and explanations of process

1. Explain clearly to the patient what you want them to do. Demonstrate the required action if appropriate.
2. Give an explanation of what you are doing to the patient, particularly if this might involve discomfort.
3. Explain in terms the patient can understand
4. Explain to the patient that you will wait until they are dressed, settled, and ready to discuss your findings

E5: Performs examination competently

1. Review the examination in the textbook and/or watch a competent practitioner perform the examination
2. Be familiar with the instruments you use, first practising under supervision
3. Set the situation up to maximise your chances of success e.g. light from the side (JVP), low light levels (fundoscopy), correct side for your examination (apex beat).
4. Ensure the comfort of the patient before proceeding with an examination.
5. Ask the patient to point to the pain (if they have any).
6. Aim to do the examination once, correctly, and as fluently as possible
7. Watch the patient for signs of discomfort and respond accordingly
8. Find a competent colleague who is willing to observe you performing the examination and to give you feedback

E6: Elicits normal and abnormal findings

1. Obtain repetitive practice with feedback from a competent colleague who can tell you what signs they are finding
2. Never be afraid to ask a colleague for their opinion about a sign of which you are uncertain
3. Keep practising examination skills so that the sequence is second nature, as this will free up your mind to assess the significance of findings

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Management

M1: Relates explanations to patient's perspective

1. Check what the patient already knows before beginning your explanation.
2. If appropriate, determine what they want to know and whether they want anyone else to be present
3. Establish what you can about the patient's lifestyle, beliefs, cultural background and abilities and take these into consideration.
4. Whenever possible, link back in your explanation to the patient's initial ideas, concerns and expectations
5. Explain what you are thinking and seek their views
6. Mentally rehearse good questions about dilemmas in patient management for example "People who are nearing the end of life sometimes like to state a preference about where they should die. Do you have any views on that?"

M2: Gives clear information in small chunks

1. Use clear language, avoiding technical jargon
2. Provide information in 'small packages' particularly if it is distressing or complex.
3. Use the patient's response as a guide to how to proceed
4. Give information in ways which promote recall and understanding (eg using diagrams)
5. If appropriate use leaflets and good quality internet information to reinforce your explanation and advice.

M3: Negotiates a mutually acceptable plan with patient and/or third parties

1. Think about how the patient can actively participate in decisions about their care and encourage them to do so
2. Determine whether they want to be involved in planning and whether they have any preferences
3. Offer suggestions and choices rather than instructions
4. Discuss with the patient the management options and your recommendations and ensure they have sufficient knowledge to make informed decisions.
5. When planning, focus on the patient's goals rather than the patient's problems, for example the elderly patient with heart failure who doesn't want to risk incontinence by taking their diuretics
6. Check whether they agree to your suggested plan

M4:Reassures appropriately

1. Where appropriate, aim to reassure and offer hope.
2. Get the full picture before offering reassurance

M5: Checks understanding

1. Ask the patient whether they have understood what you have said and give them sufficient opportunity to question you.
2. Explore the patient's reactions (beliefs and feelings) about the information you have given them and address them where necessary
3. Sometimes it may be appropriate to ask the patient to repeat back their understanding of the management plan and what they are to do.
4. Enquire of the patient 'Is there anything else you would like to ask about what we have said?' before ending the consultation.

M6: Gives key evidence-based information

1. Guidelines for management are often published with the strength of supporting evidence. Choose management strategies in line with current best evidence

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2. Identify and use routinely a trustworthy clinical evidence website such as http://clinicalevidence.bmj.com or www.evidence.nhs.uk to evaluate the treatments you propose.
3. Identify the patient's needs and adapt the information you give accordingly

M7: Explores available options, risks and benefits

1. Start exploring options by acknowledging the patient's expectations eg. "I realise you were hoping for antibiotics but…"
2. Explain the likely impact of each management option
3. Explain risk and benefit in terms the patient is likely to understand
4. Make sure options are realistic and relevant

M8: Investigates appropriately

1. Remember to consider the need for investigation and consciously be aware of the reasons for and against any potential investigation.
2. Remember that any investigation should only be performed if the result will change management
3. Discuss the value of the investigation with the patient
4. Make sure the patient knows when and how they will hear about the investigation and its results.

M9: Prescribes rationally

1. Think about the reasons for and against prescribing a particular drug.
2. Always consider the major side effects and interactions.
3. If in doubt don't guess – consult the British National Formulary. Don't be afraid to do this infront of the patient
4. Ensure the patient understands how prescribed items should be taken, the expected impact and the principal side effects to be expected.

M10: Refers appropriately

1. Remember to consider the need for referral and consciously be aware of the reasons for and against any potential referral.
2. Become familiar with the potential options including interprofessional referrals
3. In some cases self-referral for example to support groups, a religious advisor or complementary therapist may be appropriate.

M11: Makes appropriate use of opportunities for health promotion

1. Remember to provide preventive advice relating to the presenting problem. For example the need to give up smoking for the patient with angina.
2. Consider whether to address any of the opportunities for promoting good health which are not directly related to the presenting problem eg smoking cessation.
3. Check the patient's readiness and motivation to change before giving advice.
4. Emphasise the positive benefits for making the change, as well as the harmful consequences of continuing.
5. Focus on areas of the patient's responsibility and what they can and should do
6. Where appropriate, ask the patient to commit to the behaviour change they are going to make.

M12: Agrees appropriate follow-up

1. Remember to always "Safety-Net". Explain to the patient what the expected course is and what to do if it differs.
2. Make clear if and when the patient should return.
3. Consider who is the most appropriate health-care professional to follow up your patient

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Clinical Reasoning

CR1: Seeks relevant and specific information from patient's record or third parties

1. Prior to consultation review patient's record to elicit key information such as age, significant past medical history, current medication, and reason for recent consultation(s).
2. Consider whether 3rd parties could contribute information useful to the patient's assessment or management and, if so, approach them with the necessary consent
3. During the consultation re-examine the record where this is likely to contain information you require, particularly if the patient is unsure of factual details. Signpost that you are doing this.

CR2: Generates appropriate working diagnoses or problem list

1. Where possible try to construct specific pathological, physiological and/or psychosocial diagnoses. If this is not possible, try to identify specific problems.
2. Consider your pre-diagnostic interpretation when generating appropriate hypotheses.
3. Consider using pathological sieves to help you to generate appropriate hypotheses.
4. Appreciate the importance of the background factors influencing the health of your patient
5. Consider your diagnostic hypotheses in the light of your pre-diagnostic interpretation and challenge any inconsistencies.
6. In generating any single hypothesis deliberately test it with information for and against, and then try to identify and fill any gaps.
7. When considering your diagnosis, think about what is MOST likely, what is LESS likely and what needs to be EXCLUDED
8. Be prepared to reject diagnoses for which there is little or no support.

CR3: Seeks relevant and discriminating information from history, examination and investigations to help confirm or refute working diagnoses

1. Consciously identify the key clinical features of each of your working diagnoses.
2. Use focused questions to fill gaps in the information you are attempting to gather.
3. Always assess whether the patient looks well or ill, particularly children, and consider how this might influence your working diagnoses.
4. Actively seek clinical signs that are appropriate to your differential diagnosis and its severity
5. Consider whether specific tests/investigation are needed to confirm/exclude important diagnoses

CR4: Correctly interprets information obtained

1. Take sufficient time to consider what the information you have gathered means and how to apply it
2. To help your thinking summarise and reflect back to the patient what they told you. This will confirm to the patient you have understood the problem, and will clarify your thoughts.
3. If you recognise a pattern of symptoms and signs that nearly fits a diagnosis, consider carefully any feature that does not fit, and think again.
4. If there appears to be an obvious diagnosis, consider alternatives
5. If in doubt, consult reference ranges for limits of normal values – you are not expected to memorise all of these.
6. All tests are subject to error, and false positive and false negative results are common so consider this in interpreting results.
7. Make sure you consider all the information you have gathered before making your final diagnosis
8. Each history/examination does not necessarily yield a clear diagnosis, and patients may have more than one condition. Be careful not to dismiss symptoms or signs that could be significant, particularly if felt to be so by the patient

CR5: Applies basic, behavioural and clinical sciences to solution of patient's problem

1. If in doubt about the nature of the problem think how your knowledge of anatomy or physiology can help you reconsider it from a different angle.

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2. Improve your awareness of the key features of particular diagnoses.
3. Be prepared to check with books, 'on-line' sources; colleagues, etc., particularly for single items of information.
4. Focus your learning on the discriminating features of diagnoses.
5. Practise translating findings into abstractions (semantic qualifiers). E.g. 'last night' becomes 'acute', food getting stuck becomes 'dysphagia'.

CR6: Recognises limits of competence and acts accordingly

1. Do not be afraid to tell the patient you do not know something. They will usually appreciate your honesty.
2. When you have reached the limits of your competence, do not guess – seek appropriate help by asking a colleague, or consulting information sources.

Building and Maintaining the Relationship

R1: Develops and maintains a professional relationship with patient

1. Adopt professional courteous behaviour relevant to the circumstances
2. If you have met the patient before, remind them who you are, check what has already happened, and ask what has happened since last meeting
3. When presenting a patient to a colleague, remember that you are talking about a person who is in the room with you. Think how you would want your story told. For example, use the patient's name: 'This is Mr John Smith…' in preference to the term 'This patient has…'

R2: Respects the patient's ideas, beliefs and autonomy

1. Acknowledge the patient's coping efforts and appropriate self-care
2. Respect the patient's right to decline investigation/treatment, explain the impact of their decision and make it clear that that you will continue to care for them

R3: Responds empathically

1. Try to consider what it would be like to be in the patient's shoes and respond appropriately within professional boundaries. Appropriate responses can include verbal (e.g. 'I can see you are angry'; 'I can understand that', 'I can see why you are distressed about it') and non-verbal acknowledgement of the patient's state.
2. Do not make assumptions about how a situation may affect a patient
3. Beware using your personal experience to align with a patient
4. When examining a child consider it from the childs perspective
5. Be aware of your reaction when the patient says something which shocks or surprises you

R4: Fosters collaboration

1. Be prepared to explain your thinking to help the patient to understand their condition and to engage them in its management
2. Acknowledge the patient's views about the problem and its management when you are sharing decision-making.
3. If the patient does not want to collaborate with your management plan, explore why and consider alternatives
4. Specifically consider what information (good or bad) you can share and consider who this is shared with (relatives etc).
5. Using the patient's own words will sometimes help collaboration
6. Allow the patient the opportunity to ask questions

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Organisation

O1: Considers and optimises the setting

1. Organise your consulting space (e.g. chairs, screens etc) and minimise potential distractions (e.g. bleeps, telephone calls) for the benefit of the patient and the consultation.
2. If a consultation is still on your mind take a moment to compose your thoughts before seeing the next patient
3. When you have done what you can to optimize the setting and it is still not ideal, acknowledge this and apologise if appropriate

O2: Uses third parties appropriately

1. Ensure you identify and acknowledge any third parties within the consultation.
2. Where appropriate, obtain patient's consent for disclosure of information to third parties.
3. Be aware of the effect a third party may have on the information you can obtain and give. You may need to ask the patient whether they would like the third party to stay; you may need to ask the third party to let you talk to the patient alone first.
4. Make good use of the contribution that third parties can make to the different areas of the consultation such as the history, examination or patient management.
5. Consider the ideas, concerns, expectations and other agendas of third parties in your thinking, and explore those in more detail where it may be relevant to the consultation.
6. Keep the focus on the patient. Always make sure you address the patient first even if they cannot respond

O3: Exhibit a well-organised approach to gathering and giving of information

1. Be systematic in gathering information , for example - finish one area before moving on
2. Before you examine the patient, consider whether you have gathered sufficient information from the history.
3. When managing the patient, first reach a shared understanding of the problem and then move on to give advice or explain the treatment you are recommending.

O4: Makes organisation of consultation overt to patient

1. If appropriate, clarify the time both you and the patient have available for the consultation
2. Indicate to the patient what is going to happen next (Signposting).
3. At appropriate stages, summarise back to the patient the key elements of the consultation (for example the history) to demonstrate that you have understood each other
4. If you need time to think, tell the patient that you are gathering your thoughts. Make some brief notes if necessary.

O5: Prioritises agendas appropriately

1. Be sure you understand the patient's agenda by allowing them to complete what they wish to say, checking whether there is anything else.
2. Where there is more than one agenda (including your own), agree to deal first with the most urgent (medical priority) unless the patient cannot focus on that one before another is discussed (patient's priority).
3. Take note of the other agendas to be addressed later and indicate/negotiate how they are to be covered.

O6: Summarises appropriately

1. Summarise to enhance the consultation (e.g. to clarify, before signposting or to emphasise important points)
2. At appropriate stages, summarise back to the patient the key elements of the consultation (for example the history) to demonstrate that you have understood each other.

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O7: Uses time appropriately

1. Be aware of the time. It may be helpful to keep a clock in view.
2. Having identified your priorities, allocate time appropriately to the tasks of the consultation.
3. Be efficient (have your tools to hand; good pace; concise choice of words and examination)
4. Aim to be successful with your examination at your first attempt so that you avoid repetition

O8: Closes consultation appropriately

1. Indicate that you are about to close and ask whether there is anything else the patient would like to say or ask
2. Summarise the consultation briefly and clarify the plan
3. Remember safety netting - tell the patient what you expect to happen, things to be concerned about and what to do if it doesn't happen as predicted
4. Medical students should thank the patient for what they have gained from the consultation. This may sometimes be appropriate for doctors too

Record Keeping

RK1: Makes concise and accurate notes without interfering with dialogue or rapport

1. Do not write during the patient’s opening statement, as you will miss important information and may appear not to be listening
2. Your notes during a consultation should be minimal – train yourself to remember, and write only what you will forget
3. Particularly important to jot down are: people present; key words in information gathered from and given to the patient; examinations and procedures carried out
4. If you are taking notes, explain why and gain the patient's consent

RK2: Record - Diagnoses/ problems

1. After every consultation record the problems or diagnoses in specific terms

RK3: Record - Relevant history and examination

1. As a minimum, record the features of history and examination which support or refute possible diagnoses
2. (For computerised records) If there is a read code the general rule is use it rather than writing free text.
3. Record assessment of capacity to consent if this might be in question
4. Record your impression at that time (diagnosis and differential)

RK4: Record - Outline of management plan; therapy, investigations, referral and follow up

1. Document what tests will be done and, if appropriate, how these might affect management choices.
2. Record in the notes to whom a referral has been made, and how (by telephone, fax, Choose and Book, Post etc) Indicate whether the referral was routine or urgent.
3. Keep a copy of the referral in the patient records.
4. Document plan for unexpected deterioration for example who should be contacted and how
5. Record management options discussed with the patient and the patient's choices.
6. Ensure referring professional and others involved in patient's care are copied into correspondence, as appropriate.

RK5: Record - Information, instructions and special precautions given to the patient

1. This information should appear on the prescription and also in the patient’s records.

RK6: Record - Identification of the author and date of record

1. When recording in the patient's record ensure that you document clearly: Date, time, your name and role (and when available GMC number)
2. Sign all entries you make in the notes

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Case Presentation

CP1: Engages and orientates colleague

1. State purpose of communication if not implicit in situation e.g.: 'I would like to practice case presentation'
2. Orientate listener with basic patient details and key background information. E.g. 'This 24 year old man with diabetes has been admitted with a vomiting and since admission he has become drowsy'
3. Consider what the function of your presentation is and frame your presentation in this light for example a teaching presentation will be long, requests for emergency assistance will be very brief

CP2: Delivers relevant detail with clarity and logical order

1. Paragraph grouped data appropriately with headings and their relevant content
2. Invite the listeners to ask questions at appropriate points in your presentation
3. Signpost the hypotheses you are considering or have considered.
4. Present relevant data. This will depend on the context e.g.social factors may be less important on acute admission than when planning the patient's subsequent discharge
5. Identify and present data that allow determination of the patho-physiology, the aetiology and the functional effect of the health problem.
6. Use SBAR (Situation, Background, Assessment, Recommendation) to organise your presention.
7. Allow, promote and manage dialogue during the presentation to ensure that all important aspects are adequately explored. This may require that you point out that there is more data which you consider relevant e.g. 'There are social factors which I feel need to be considered'

CP3: Communicates Interpretation of data transparently

1. With your interpretation offer the evidence on which it is based. E.g. 'This patient has rapidly progressive dysphagia. He has gone from difficulty swallowing meat to only swallowing water in 4 weeks.' 'I have a patient who is in shock with a BP of 90/50 and pulse of 120. '
2. Distinguishes clearly between historical report, examination findings and interpretation / opinion.
3. Be open about omissions in your assessment, for example 'I forgot to percuss the chest'

CP4: Draws purposeful conclusion

1. Consider the triple diagnosis (at the level of physical, psychological and social patho-physiology) and present what is relevant
2. Summarise succinctly with backing evidence. Be honest about uncertainty.
3. Invite comment on specific request, suggested management plan or need for clarification in a way that relates to the purpose for the communication declared previously.