

The exceptional potential of the consultation revisited

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SUMMARY. A new framework is proposed for analysing the consultation in primary care, and for integrating other models relevant to the consultation. Use of communication skills helps to reconcile the respective agendas of doctor and patient into a negotiated plan, which includes both management of problems and health promotion. Achieving the potential of consultations depends on cooperation between patient and doctor, and on sufficient time for appointments.

Introduction

THE consultation is the crucial core of medicine. All else in medicine flows from this interaction between the patient and the doctor. Understanding the nature of consultations is vital to the development of the discipline of general practice. The problems which patients bring to general practitioners are undifferentiated and our job is to make sense of them. The increasing importance ascribed to the ethical and social value of autonomy leads to the view that more weight needs to be given in analysis of consultations to the concepts, perceptions, views and rights of patients. Thus in making sense of undifferentiated consultations the patient's understanding of the problem is at least as important as that of the doctor.

Since Byrne and Long's classic study of the consultation¹ a proliferation of models for analysing consultations have been suggested. Pendleton and colleagues² have provided a comprehensive rating system which is ideal for studying video-recordings, but it is too complex to be useful to the doctor during the consultation. The need for a succinct framework able to be used 'live' has been addressed by Stott and Davis³. This paper attempts to update their framework by explicitly including the contribution of the patient and will relate the new framework to the other available models of the consultation.

The new proposed framework is shown in Figure 1. One important difference is that awareness of problems must precede their management. Successful consultations respect the agendas of both patient and doctor, 'agenda' being used here in the sense of a list of items brought to a meeting. These agendas are not always explicit⁴ and may overlap or be in conflict. It follows that negotiation is necessary to produce a plan which satisfies both parties. 'Negotiated plan' incorporates the management both of presenting and of continuing problems from Stott and Davis' model. Health promotion, which comes primarily from the doctor's agenda, is part of the negotiated plan.

Skills occupy the central part of the new framework since they are a resource to be used when the consultation goes badly at whatever stage and a way of integrating other models which are of relevance to the consultation.

Patient's agenda

'Patient's agenda' corresponds roughly with Stott and Davis' 'Management of presenting problems'. However, presented pro-

blems and the underlying agenda of the patient may not be the same. Difficulties in communication on the part of the patient and a failure in perception and sensitivity on the part of the doctor may prevent full exploration of the patient's agenda. Establishing the reason for the patient's attendance is an integral part of both the Byrne and Long and the Pendleton models.

What is presented in the consultation may be the tip of an iceberg.⁵ The presenting problem may be that which is easiest or least threatening to express, perhaps even a ticket of admission. What develops from this will depend largely on the response of the doctor. Asking specifically if there is anything else may often avoid the frustration of the 'by the way' syndrome.

Doctors need to be aware of the chain of antecedents leading to the consultation and to be sensitive to patients' ideas about their symptoms, especially the cultural factors and health beliefs which underlie these ideas.⁶⁻¹¹ Failure to be aware of these important elements is often to miss the point of the consultation, and may not help the patient to feel understood.¹² If the doctor asks himself: Have I discovered the patient's agenda?, there is unlikely to be a difficulty.

Doctor's agenda

Unless faced with a completely new patient with no previous records, the doctor brings to every consultation a background of knowledge about the patient's previous and continuing problems and known risk factors. While this is important for a full understanding of the patient's problem and for prevention, it may mean that the doctor will have his or her own preconceived ideas about the presenting problem.

Continuing problems which are known to the doctor need to be considered in the consultation as they may not be raised by the patient. Chronic diseases such as diabetes mellitus fall into

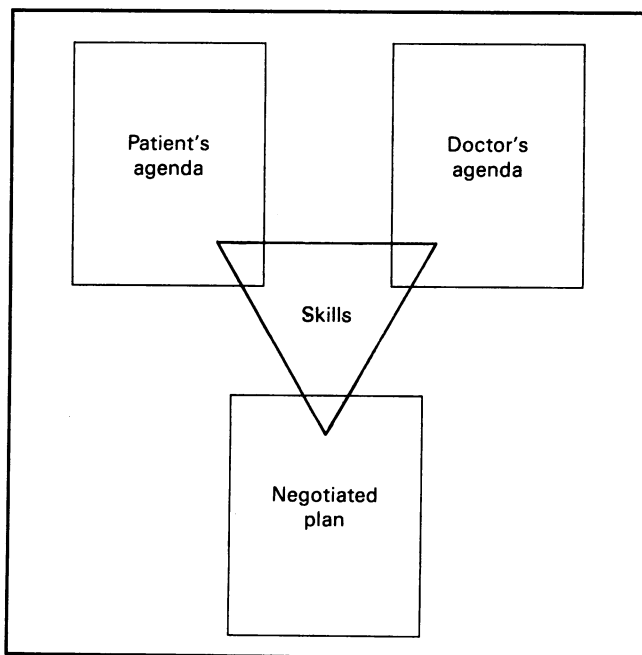


Figure 1. A new framework for the primary care consultation.

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this category,¹³ but so also do sociopsychological stresses such as an unhappy marriage. If the doctor ignores or conveniently forgets this area he may risk colluding with the patient in avoiding difficult and possible intractable problems. These continuing problems may have an important bearing on what is being presented.

Enquiring about and recording risk factors is an important part of the doctor's agenda. These include smoking, obesity, hypertension, alcohol consumption, familial diseases (for example hyperlipidaemia), immune status (for example rubella) and screening deficiencies (for example needing a cervical smear). The absence of such information in the notes may trigger enquiries to fill the gaps and so create a data base for the prevention of disease.¹⁴

Another part of the doctors' agenda is to check on his or her own approach to the consultation. Doctors' feelings in consultations can be classified according to how far they are directly connected with the patient, indirectly connected with the patient, or purely connected with the doctor.¹⁵ It has been suggested that doctors have a negative stereotype of patients as a whole and consider patients to have only limited ability to participate in decisions about their illnesses.¹⁶ Whatever the truth of that suggestion, certain patients create feelings of 'heartsink' in their doctors¹⁷ and doctors need to know how to cope with these strong feelings. Neighbour's concept of 'housekeeping', or checking that one is in a fit state both physically and mentally to be able to give the next patient a reasonable hearing, is a good ideal to aim for.¹⁸

The agendas of the patient and doctor often overlap; for example the patient may independently mention continuing problems or bring up the subject of risk factors.

Negotiated plan

Having elicited the agendas of patient and doctor respectively, the next task is to reconcile them. It is important to recognize the real possibility of a conflict of agendas. For example, the doctor may be so concerned with doing a good job in managing continuing problems and identifying risk factors that he may not be sensitive to what the patient wants out of the consultation. However, while it is legitimate in general practice to postpone some problems for consideration at another occasion it is necessary to have an explicit and negotiated agreement with the patient about which problems are to be tackled at the first consultation.

Management of problems

Management of problems involves choosing and implementing an appropriate course of action for each problem by negotiation between doctor and patient. In many cases the traditional medical model will be used. This consists of: (1) verbal and/or physical examination; (2) investigations; (3) diagnosis; (4) treatment, explanation and reassurance. In the last category, treatment should be taken to include many different ways of acting on the problem, and not just drug therapy. It is often incorrect to assume that patients expect prescriptions.¹⁹ Many cases are best managed in some other way, for example by counselling or behaviour modification,^{20,21} and the primary care physician may need considerable skill to choose the appropriate approach.

In discussion about treatment options, explanations should be 'reactive' to the patient's perception of his or her problems, as Tuckett has suggested.¹⁶ It is desirable for the patient to have an overall idea of the likely outcome of treatment and to have explicit instructions for follow up. This aspect of the consultation corresponds with the 'handing over' phase of Neighbour's model.¹⁸

Aims for the future can include tactful advice on how to use

the services of the practice. Appropriate use could be gently reinforced, and constructive suggestions might be employed where the services had been used inappropriately. This is similar to Stott and Davis' 'modification of help-seeking behaviour'.³

Health promotion

Lifestyle is a matter of personal choice and any discussion on the health implications of particular lifestyles has to be patient centred.

Doctors can fulfil the role of a resource person for patients because of their expert knowledge of the medical consequences of different lifestyles. With a completed data base of risk factors about a patient, it is feasible to offer advice which is specifically tailored to the individual and therefore more likely to be effective.

This raises two questions: first whether the doctor has this expertise; and secondly whether a completed data base of risk factors is available. Clearly doctors need to acquire detailed knowledge in this sphere. Opinions about lifestyle need to be backed up by reasoned arguments, and doctors should be prepared to justify what they say by reference to the appropriate literature if necessary. Since the data base of individual risk factors is known to be generally inadequate, putting this right becomes an urgent task for which computerization may be the only effective way.

There are five main issues in health promotion at the personal level: not smoking, healthy eating, reducing alcohol intake, exercise and relaxation.²³⁻²⁸

Skills

When a consultation is going well a whole range of skills connected with eliciting information, negotiating, explaining and persuading are taken for granted. When things are going badly, it may help the doctor to (metaphorically) step outside the action for a short while and ask what skills he or she needs at that point.

Following the model in Figure 1 the questions to ask are: Have I sufficiently considered the patient's agenda as well as my own? Is the plan of management appropriate to the problem and does the patient agree? To manage each of these phases successfully requires highly developed communication skills.

John Heron's six intervention categories²⁹ are particularly suitable for use in the consultation, if only because they are easy to remember: prescriptive, informative, confronting, cathartic, catalytic and supportive. The transactional analysis model of parent-adult-child provides another approach which is easy to apply on the spot.³⁰ Asking the question: What are my feelings, where do they originate, and are they relevant to the proceedings?, may transform the situation even to the extent of experiencing a 'flash' in the Balint tradition.³¹

Being prepared to say: Things are going wrong — can we start again?, might salvage the situation. Willingness to keep asking the patient: Is this reasonable? might save getting into the position in the first place.

In the short time available for the consultation it is relatively easy to be aware of skills and strategies that we need at the 'macro' level. The fine tuning or 'micro' level of skills, however, is best approached by retrospective analysis of audio or video-recordings of consultations.

According to the social skills model, human behaviour can be compared with a complex motor task such as driving a motor car.³² Learning the skill requires feedback about performance, and repeated practice. Pendleton's rating scale for consultations is based on the social skills model.²

Microteaching is a technique related to the social skills model

in which small areas of behaviour are practised repeatedly, with immediate feedback, until the desired result is obtained.³³ This technique has now been applied to the teaching of single skills in general practice consultations.³⁴

Discovering why the patient has come, or eliciting his agenda, is a fruitful area for this kind of analysis. It is an area where communication often fails because it requires a complex line of questioning. Tuckett has provided detailed guidelines about the kinds of question required and how to ask them, including the metaperspectives of the participants,¹⁶ that is, the opinions of the participants in an interaction about the thoughts of the other person. Incorrect assumptions can lead to what Laing calls 'knots' of misunderstanding.³⁵ For example, the doctor asks 'What can I do for you?' — the patient's metaperspective is: 'He thinks I want tablets'; the doctor's meta-metaperspective is: 'He thinks that I don't want to give him any tablets'. It is interesting to note that the skills of eliciting, clarifying and summarizing (which are very similar to Tuckett's approach), have long been central to the simple counselling model.³⁶ Here is certainly an argument for general practitioners to learn basic counselling skills, and the microteaching technique could be useful, in combination with role play.

Whereas the social skills model can be seen as looking at both verbal and non-verbal communication from an outside perspective, an inside perspective gives equally valuable insights. This is achieved by becoming sensitive to the thoughts and feelings taking place within oneself and extrapolating from these to conjecture on the inner thoughts and feelings of others. Using feedback about our own behaviour from the other person helps us to build up a mirror-image of ourselves (the 'looking-glass self')³⁷ as well as to make sense of the other.

The dramaturgic model views the participants in a consultation (or any social interaction) as actors playing roles, the crucial skill involved being taking the role of the other.^{38,39} Swapping the roles in role play or developing and expanding roles in psycho-drama⁴⁰ are useful ways to develop this skill. Being able to take the role of the other is the essential prerequisite for achieving accurate empathy, which along with warmth, genuineness and non-possessive caring, make up the ambience of the ideal therapist.⁴¹

Learning about the self in order to use oneself better in the consultation is central to Balint training. The fantasies which take place in a Balint group about what happens in consultations and the underlying meaning often give the participants more insight into themselves than into the case being presented.

Conclusion: time and cooperation

More cooperation in the consultation is needed. The essential motivation for rational cooperation is mutual regard⁴² and since patients are being seen increasingly as experts in how their own problems affect them their underlying ideas and reasoning must be valued. Of course doctors need good communication skills, but initiatives like Tuckett's guide to asking questions of the doctor are equally welcome.¹⁶

Already there is evidence that health promotion does not feature significantly in consultations lasting less than 10 minutes,⁴³ or that it may be squeezed out by preventive screening.⁴⁴ There is also likely to be more time needed for the complex tasks of properly eliciting the patients' agenda and negotiating meaningfully what is reasonable at each stage.⁴⁵ How much time is needed remains to be discovered by more research. In this new spirit of cooperation there is much to be said for letting patients decide the length of their appointment. There is some evidence that their decisions are realistic.⁴⁶ Furthermore, there is evidence which suggests that the time con-

straints present in primary care, undoubtedly related to the open-ended commitment, often lead to the doctor closing down the consultation to a strictly biomedical mode (Middleton JF, Johnson DJ, unpublished), which certainly excludes the patient as a partner in care and, as Stanley has pointed out, better communication may in many cases actually be the cure.⁴⁷

It is time to clarify our ideas about communication in the consultation. This framework is a simple aide memoire to enable doctors to stop and check at each stage of the consultation whether the tasks have been completed.

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