4 Within the consultation

INTRODUCTION

In the preceding chapters we have described the events surrounding the consultation. When we started to look into the consultation itself and began to teach about it, our emphasis was on the various skills that the doctor needed. It was not long, however, before it became very apparent that this was not a suitable starting point, since it begged the essential question: what should the doctor use his skills to achieve?

We have therefore started again by defining an effective consultation as one which brings about desired outcomes, including the successful operation of the cycle of care. In this chapter we shall describe seven tasks which, taken together, form comprehensive and coherent aims for any consultation.

THE NEED TO DEFINE TASKS

Unless we have a clear idea of the purpose of any consultation it is impossible to know which behaviours or approaches are more or less helpful. If the purpose is only to get the patient out of the surgery in the shortest possible time, writing a prescription for an antibiotic before even looking at a painful ear is effective behaviour. If the purpose is to make an accurate diagnosis, examination is essential, and if the purpose is also to educate the patient on future management, explanation would also be required.

The tasks we are about to describe can be achieved using many different approaches and skills. We are not prescribing consulting methods – we do not want all doctors to consult like automata. This is not a recipe for a restriction of individual flair. We want doctors to define what they wish to achieve in their consultations and to be able to bring this about in their own way.

THE DERIVATION OF TASKS

In the previous chapter the consultation was placed in its chronological context, with inputs from both the patient and the doctor, and outcomes for the patient which may be seen as more or less desirable by the doctor.

The case was made that the patient comes to the consultation not only with a problem that may have physical, psychological, and social dimensions, but also with his own ideas and concerns about the problem and expectations about the medical care that he is about to receive. It was also argued in the previous chapter that the doctor comes to the consultation with an idea of his own role,

which not only includes defining problems, managing and caring for patients, but also his responsibility for prevention and patient education.

We have also considered the desirable outcomes of any consultation. These may be immediate, such as the patient's clear understanding and recall of the information given, a definite committment to the planned management, and, where possible, a reduction of concern. After these immediate effects the consultation may lead to the patient adhering to the planned management, and in the long-term to improvements in the patient's health, and to a development of the patient's own health understanding.

We have placed considerable emphasis on exploring the patient's own ideas, achieving a shared understanding of the nature of the patient's problem, and an agreement on shared management, principally because of the evidence reviewed earlier that this is more effective at achieving desired outcomes.

We are not suggesting that a doctor should complete all seven tasks in every consultation, and the use of the word 'appropriate' is intended to balance ideas with reality. We will, however, argue that continued omission of one or more of the suggested tasks would adversely affect the outcome of that doctor's consultations.

The first five tasks are separate statements of what the doctor needs to achieve, while the final two tasks deal with the use of time and resources, and the creation of an effective doctor–patient relationship. These tasks therefore affect all the previous five. The tasks are set out in a logical sequence, but this is not necessarily the order in which they will be tackled in each consultation.

THE FIRST TASK

To define the reason for the patient's attendance, including:

1. **The nature and history of the problems.**
2. **Their aetiology.**
3. **The patient's ideas, concerns, and expectations.**
4. **The effects of the problems.**

It would seem self-evident that the first task in any consultation is to define the reason for the patient being there. Byrne and Long (1976) found in their study of consultations that the most frequent reason for a consultation becoming 'disfunctional' was that the doctor had not discovered why the patient was there.

In Chapter 1, pp. 3–5 we discussed the nature of 'diagnosis', in the setting of general practice, and concluded that this comprised:

> a statement of the nature and cause of the patient's problem sufficient to make an accurate prognosis and plan rational treatment.

We also discussed the need for this statement to include physical, psychological, and social dimensions. This holistic approach operates at a number of levels

which can be defined logically, but are often more difficult to separate in practice.

The first is **the nature and history of the problem(s)** themselves. For example, a patient with the illness that we label 'depression' may be experiencing physical symptoms, disturbed thought patterns, and altered social relationships, each of which may contribute to our 'diagnosis'.

The second level at which a combination of physical, psychological and social factors interact is the **aetiology** of the problem. The evidence that the majority of episodes of depression could be accounted for by social factors was discussed in Chapter 1. Another example is ischaemic heart disease, which we now believe to be due to interaction between physical factors such as blood pressure and serum lipids, social factors such as lifestyle, and individual personality.

It was argued that, without knowledge of the aetiology or cause of the patient's problem, management can often not be rational. Defining the aetiology of the patient's problem is thus an essential part of defining the reason for the patient's attendance. This is particularly important if we are seeking to help the patient to prevent the development of the same problem in the future.

The argument so far would probably be accepted by most general practitioners. The crucial part of the argument, however, is that if we wish to establish the reason for the patient's attendance it is not only necessary to determine the nature of the problem and its cause, but also to explore what the patient thinks about his problem and about what caused it.

As we discussed in the previous chapter, a patient comes to a consultation not just with a disease or a problem, but with his own **ideas** about the nature of the problem, its causes, its importance and its possible outcomes. Patients also have more general beliefs about the importance of their health and varying degrees of motivation to look after it themselves. In Chapter 1, we reviewed the evidence that these health beliefs are a major determinant in the decision by the patient to consult the doctor in the first place, and of his likelihood to adhere to any management afterwards. Determining the patient's ideas about the problem will therefore enable the doctor to plan appropriate management with the patient, give appropriate information and explanation, and develop the patient's health understanding. The crucial role of health understanding in the cycle of care was described in the previous chapter.

Another dimension of the patient's understanding is his **concerns** about his problems. For example, with a newly diagnosed diabetic the doctor may take great care in exploring and explaining ideas about the disease and how it should be managed, but the patient's principal concern may be how it will affect his driving licence and his job. The doctor may see no problem in a maturity onset diabetic controlled by diet alone continuing to drive, but it is only if the doctor establishes that this is his patient's concern that he is likely to explain this. If the doctor regards reducing patient's concern and giving care and reassurance to his patients as important then he must make this appropriate by first establishing what his patient's concerns really are.

The third element in the patient's health understanding that is included in the reason for the patient's attendance is his **expectations** about the consultation and the help that can be offered. These expectations will come from a variety of sources, particularly the patient's previous experience of medical care, and, like the patient's ideas and concerns, may frequently be the same as the doctor's, and are therefore met without exploration and discussion. On the other hand, there are occasions when the patient expects something which is not done (for example, having his blood pressure taken or being referred to a specialist), and it is only by establishing this expectation that it can either be met or its inappropriateness explained. There are also occasions when the doctor over-estimates the expectations; Cartwright and Anderson (1981) found that only 41 per cent of patients expected a prescription before their consultation, but 65 per cent actually received one. Doctors, on the other hand, will frequently say that they prescribe because the patient expects it, and this again highlights the importance of determining what each patient actually expects from each consultation.

Finally, the patient may have attended not because of the problem itself or his ideas about it, but because of the **effects** that the problem has had – for example, on his work, his leisure, or his relationships with other people. In Chapters 1 and 3 we reviewed the evidence that a large proportion of the symptoms that patients experience are not brought to the doctor, and Tuckett's conclusion (1976) that their motives for consulting the doctor often have more to do with some change in their social circumstances than with any change in their symptoms. If these social effects are the most important reason for patients attending it may also be that they are the most important aspect of the problem that the patient would like to change. Without determining what these are, a definition of why the patient has come, and hence the management plans, may be incomplete.

Dividing the reason for the patient's attendance in this way may at first sight seem unnecessary, complex or artificial, but one example may help to reinforce our argument that each subheading is discreet and important. A 50-year-old woman presents with backache and tiredness. Further exploration of the **nature and history** of her problem reveals that she is also experiencing early waking, loss of confidence and concentration, irritability, and tearfulness.

She also tells the doctor that she has recently moved from London to a rural area; her teenage children have decided to stay in London; she has been unable to find herself another job, and she feels very isolated. These may all be part of the **aetiology** of the problem.

Her husband is a sales manager, and the **effect** of the problem is that she is finding it increasingly difficult to take part in social functions associated with her husband's work. The reason that she has come today is that her husband is becoming increasingly concerned, and she has just said that she was unable to go with him on a promotional weekend to the Channel Islands.

Her **ideas** are that her symptoms are an inevitable consequence of the change of life, and out of her control. She says that her mother was never the same again after her change. While the doctor might expect her concern to be the

effect her depression is having on her relationship with her husband, she tells him that her principal **concern** is that she might need a hysterectomy, and that she would not be able to look after her elderly mother when she comes to stay as on previous occasions she has had no help.

Her **expectation** of the consultation beforehand was that it would be very short and would involve the doctor examining her internally and prescribing pain-killers.

Different doctors might choose to explore some of these avenues more fully, and to set about helping this patient, probably over a number of consultations, in a variety of ways. It is clear, however, that it is only when all these reasons for the patient's attendance have been established that the doctor can proceed to achieve fully the other tasks for the consultation.

THE SECOND TASK

To consider other problems:
(i) continuing problems;
(ii) at-risk factors.

The second task is to consider those problems that are present but not presented by the patient. Continuity of care in general practice gives the doctor the opportunity to build up information about his patients and families that can be used to help him understand the problems that have presented in subsequent consultations. In addition, however, there are many problems which may continue to present in patients which may not be directly related to the problem at that time. He then needs to consider whether to raise the continued problem in that consultation. For example, a young woman whose previous consultations have been concerned with difficulties with contraception may present with an ingrowing toenail. As well as dealing with the toenail, the doctor must consider whether or not to raise the previous problems, and this decision will be affected by many factors, including the previous consultations, the behaviour of the patient, and the time available. It is not necessary for the doctor to explore every problem in depth every time he and the patient meet, but he should at least consider other problems and make a conscious decision as to whether or not to explore them further at that time.

We have previously argued that one of the doctor's roles in the consultation is prevention, and Stott and Davies (1979) included opportunistic health promotion as part of the exceptional potential in each consultation. Doctors have the opportunity to perform simple screening measures, such as taking blood pressures and cervical smears and checking on immunizations, for example, for rubella and tetanus. Doctors can also help patients with continued health problems such as smoking, and can take the opportunity of offering anticipatory guidance, for example, before retirement. Again, these need not all be done at one consultation, but these factors should be considered, recorded and acted

upon as seems appropriate within the framework of the extended consultation that general practice affords.

THE THIRD TASK

With the patient to choose an appropriate action for each problem.

Once the doctor has elicited the reasons for the patient's attendance and considered any continuing problems, he must make a choice of how to respond to each problem that has been identified. These choices could include doing nothing at that time, using the consultation itself to explore the patient's ideas and develop their understanding, and a wide range of therapeutic procedures from prescribing to referral. The essential points are, however, that the actions chosen should be appropriate for both the problem and the patient, and that the patient himself should be involved in making the choice. At first sight this may be seen as abdicating some of the doctor's responsibility. Many doctors have traditionally taken the responsibility for illness away from the patient, and accepted that it was their job to cure the patient. Many patients acquiesce with this view, as it is cosy and reassuring to have someone who looks after ones health. In the short term, sharing information and sharing the decision may make the doctor feel less powerful and the patient less satisfied, but ultimately better educated patients will be more able to look after their own health and be more likely to seek medical help when appropriate. A final reason for involving patients in a decision about their own management is the evidence that patients are much more likely to adhere to plans that they have been involved in choosing for themselves (Fink 1976).

THE FOURTH TASK

To achieve a shared understanding of the problems with the patient.

Earlier in Chapter 3 we described the central importance in the cycle of care of the patient's health understanding. Health understanding was defined as the patient's attitudes to and beliefs about health, illness, and medical treatment, and it was argued that this understanding could be changed, both by the consultation itself, and by the patient's interpretation of its consequences. The consultation can be used as an opportunity for the doctor to give information to the patient, and Tuckett (1982) divided the possible content of the information that can be given into:

(i) the nature and significance of the problem;

(ii) the appropriate course of action or pattern of behaviour best suited to tackle the present episode of the problem;

(iii) the appropriate course of action or pattern of behaviour suited to prevent future episodes of the problem;

(iv) possible adjustments the patient may have to make in the light of the problem or the way it is understood.

The patient may also develop a wider understanding about other health problems and the use of health services, either because more general information was shared or, more commonly, by generalizing his particular experience in one consultation.

Giving information to patients, however, is not the same as sharing understanding. Tuckett went on to explore what he meant by shared understanding, which included not only whether patients remembered what the doctor had said on a particular occasion, but also whether they understood what the decision meant, whether they understood the relevant details, why and how the doctor had reached the decision, and lastly how the information related to the patient's own pre-existing theories and ideas about the problem.

This difference is important, since it involves:

(i) eliciting the patient's own theory and ideas;

(ii) offering explanations that fit in with this framework of ideas;

(iii) establishing that the patient has understood and accepted these explanations.

Byrne and Long (1976) found that giving explanations to patients was the phase that was most frequently absent from the consultations which they recorded, and Tuckett (1982) was able to identify explanations given in response to the patient's ideas in only 1 per cent of the consultations he studied. Cartwright and Anderson (1981) reported that patients' most frequent criticism of doctors' consultations was the lack of time and information given to the patient.

This task, however, need not be extremely time-consuming, since, if the doctor tailors his explanation to his patient's own ideas and theories, time is not wasted giving information that the patient already has, or dealing with concerns that the patient does not possess.

THE FIFTH TASK

To involve the patient in the management and encourage him to accept appropriate responsibility.

At first sight this task is fairly similar to choosing an appropriate action for each problem with the patient, but this task takes this process one stage further. Not only is the patient involved in choosing the plan, he is also involved in implementing it. Naturally, the degree of involvement that is appropriate will vary; while in some instances (for example, acute appendicitis) it is appropriate for the doctor to assume full responsibility for the patient's care, in many of the problems that are faced every day in general practice – for example, upper respiratory tract infections, obese arthritics, or even patients with chronic anxiety – the value of what the patients can do for themselves far outweighs anything the doctor can do for them. This may be uncomfortable for both patient and doctor, but Illich (1977) not only argued his belief that the process

of medicalization was inappropriate, he also produced the evidence to show that it was ineffective.

Encouraging patients to see themselves as responsible for their own health may, on the other hand, be more reassuring if it avoids creating a feeling of helplessness in the face of events outside their control. In Chapter 1 the evidence was cited (Wallston and Wallston 1978) that patients who regard themselves as in control of their own health are more likely to ask the doctor for information, take their medication appropriately and adopt a healthy lifestyle.

The final two tasks are quite different to the other five, inasmuch as they relate to the consultation as a whole, rather than to any specific part of it, and the touchstone of these final two tasks is in fact the achievement of the other five.

THE SIXTH TASK

To use time and resources appropriately:
(i) in the consultation;
(ii) in the long term.

General practitioners in the United Kingdom almost universally report that shortness of time is one of the major constraints on their work. It is therefore essential to consider the appropriate use of time in each consultation and the appropriate allocation of time between consultations in the surgery and other activities.

If we accept that the argument for each of the five tasks that have been described is valid, and if it is appropriate to attempt to achieve each task in a particular consultation, then spending the time that is required to achieve the tasks must also be appropriate.

In Chapter 3 it was argued that each consultation should be seen as part of a cycle of care, and if this cycle is to operate to greatest effect, then the way that time is used in one consultation may have a number of important effects on the use of time in subsequent consultations. If enough time is taken in one consultation to define, manage, and explain the patient's problems fully, the patient may not need to return a second time. On the other hand, very lengthy consultations may be disruptive to appointment systems, and it may be better to use time between consultations to allow the problem to evolve and perhaps to resolve itself. Between consultations both doctor and patient may also organize their thoughts, the effects of therapy may be seen, and investigations may provide additional information.

Adopting these tasks in the consultation may also change patients' expectations about the appropriate use of time in subsequent consultations. On the one hand, the doctor who is receptive to patients' ideas may help patients to express their true reasons for attending, rather than feeling that they must wrap them up in a way they think the doctor will find acceptable. In this way the

whole unwrapping process can be shortened. On the other hand, patients may come to expect that more time will be available to them in each consultation. If we aim to increase patients' understanding about the nature and appropriate management of their own problems there may be less need for them to seek medical care, but if patients are more satisfied by this type of consultation then it may be that they will see greater value in consulting with other problems in the future.

Another dimension of the appropriate use of time is the relationship between the time general practitioners spend on consulting and the time spent on other activities. If consultations become more effective at achieving the tasks that are recognized as important, and if it is found that this requires longer consultations without a corresponding drop in the frequency with which each patient consults, then the way consulting time is organized may have to be re-examined.

Resources

Time is one resource available to general practitioners; others include diagnostic facilities both in the surgery and in the laboratory and X-ray departments. The skills and time of other members of the health-care team, self-help groups and other agencies are also available, and referral to hospital consultants and other colleagues are further possibilities. Again, the appropriate use of these resources can be defined in terms of what is necessary to achieve the other tasks, and again, patients have expectations about the appropriate use of these resources – for example, whether they need an X-ray, a prescription, or whether they will be referred to hospital. These expectations are in part created by their experience of previous consultations, and while it may often be inappropriate to comply with the expectation, each consultation can be an opportunity to develop the patient's understanding about the appropriate use of resources.

THE SEVENTH TASK

To establish or maintain a relationship with the patient which helps to achieve the other tasks.

The essential point of this task is that it defines a desirable doctor–patient relationship in terms of its effectiveness, rather than any preconceived idea of good, bad, or less appropriate behaviour. While earlier tasks are fairly prescriptive about what should be considered and achieved in each consultation, this task deliberately avoids making any statement about how it should be done. The same approach is adopted in the next chapter, when we consider the range of strategies and skills that the doctor may choose to employ in his consultation.

This neither diminishes the essential importance of the doctor–patient relationship, nor does it mean that all behaviours will be equally effective in achieving the tasks. The tasks require that the doctor must not only be able to

take a clear 'history' from the patient, but also encourage him to communicate his ideas and fears. The relationship must also encourage the sharing of decisions, of information and of management, and must be resilient enough to allow appropriate responsibility to be given to the patient.

SUMMARY

Seven tasks to be achieved in the consultation can be derived from the previous approaches to the consultation and the place of the consultation in the cycle of care. These tasks are:

1. To define the reasons for the patient's attendance, including:
(i) the nature and history of the problems;
(ii) their aetiology;
(iii) the patient's ideas, concerns, and expectations;
(iv) the effects of the problems.
2. To consider other problems:
(i) continuing problems;
(ii) at risk factors.
3. To choose with the patient an appropriate action for each problem.
4. To achive a shared understanding of the problems with the patient.
5. To involve the patient in the management and encourage him to accept appropriate responsibility.
6. To use time and resources appropriately.
7. To establish or maintain a relationship with the patient which helps to achieve the other tasks.