Consultation Analysis

Understanding the consultation

Historically, undergraduate medical education focused on the diagnostic process. After qualifying, doctors were expected to refine these skills but also to develop knowledge and skills with a greater emphasis on the management of patients and their ailments. This took place largely in a hospital setting and most often on hospital wards. Doctors were ill-prepared for general practice consultations even though such consultations were commonplace in medical practice. There was a need to define and improve skills more appropriate for general practice. Such skills were neither taught nor learned in medical schools or teaching hospitals. The development of general practice as a discipline witnessed analysis of the consultation and the development of a better understanding of the consultation. This in turn helped improve the teaching of the skills required for better consultations and better care of patients. Such skills are now taught to undergraduates and it is widely accepted that improving these skills is of benefit to doctors and the patients who consult and communicate with them. Advice from doctors to new medical students by Richard Smith perhaps also reflects changing attitudes amongst doctors and an appreciation of the kind of approach needed to maintain a good doctor-patient relationship.

What is the consultation?

The consultation is described by Pendleton as 'the central act of medicine' which 'deserves to be understood'. It is clearly central to the transaction between doctors and patients and central to the relationship between doctors and patients.

The consultation is the basic tool of general practice and, like general practice, it has changed and evolved over the years. Many factors have contributed to changes in consultation styles, content and length. In the 1950s patients did not usually have booked appointment times and queued to see the doctor. Appointments were of necessity very short. The brief clinical notes on consultations still evident in Lloyd George records often reflect a more succinct consultation.

The 1960s and 1970s saw the advent of allocated appointment times, with each patient allocated 5 minutes. Today the Quality and Outcomes Framework demands consultations at 10-minute intervals. Short consultations can still successfully achieve important objectives.

In one study in the UK, average consultation lengths were 8 minutes. Patients with psychosocial problems were given 1 minute longer on average and this was sufficient to improve quality of care. Patients continue to express dissatisfaction with the time spent with their GP. Although this can be improved by increasing the length of consultations, it may be more realistic to improve the way time is spent within the consultation.

Why is consultation analysis important?

Medical students are taught to diagnose disease with the basic template of history, examination and investigation, but analysis of the consultation takes a much more profound view of why the patient came and what has been achieved within the consultation. Consultation analysis by a number of notable pioneers has helped doctors to recognise and improve consultation skills. The application more widely of these methods through teaching (undergraduate and postgraduate) and professional development have disseminated wider knowledge, understanding and application of consultation skills.

There is increasing pressure of time within the consultation to complete a growing list of ever more complex objectives which stretch beyond those driven by doctors’ objectives and patients’ expectations. Targets set by the NHS and politicians hoping to achieve and demonstrate efficiency and efficacy can impinge on the consultation as well.

A good consultation should achieve a number of objectives, including perhaps an enhanced doctor-patient relationship. The skills to improve consultation outcomes can be learned and developed through consultation analysis. Such improvements can simultaneously recognise and improve the important relationship between doctors and patients.

However, excessive external influences (for example, from target setting and the need to demonstrate efficiencies for political and financial reasons) can pose an extra challenge to the consultation and an agenda extra to that of the doctor and patient. Such influences may obfuscate the benefits to doctor and patient of developing and improving consultation skills.

How can consultations be analysed?

Consultation analysis is most often undertaken as part of teaching, learning or research. In general practice it has become a routine part of teaching and learning consultation skills. Consultations can be real or simulated. They can be observed or recorded in a number of ways.

- An observer ‘sits in’ on real consultations.
- An observer or observers may watch through one-way glass so that they are not physically present in the consultation.
- Consultations can be recorded using appropriate rules and guidelines (see below) for subsequent discussion and analysis.
- Consultations can be described and discussed after the consultation by doctors, doctor and patient or more widely with others.
Mock consultations can be undertaken with participants playing the role of doctor or patient. Actors can be used to play the role of patient.

More obtrusive observation of the consultation is more likely to affect what goes on within the consultation.

Discussion and analysis usually take place with reference to the various consultation models described (see below).

Consultation models

Consultations have been studied by a variety of people over the years. Although these demonstrate some similar conclusions, they also reflect great variety, as one might expect, from often subjective and qualitative descriptions. These studies used different techniques to analyse the consultation, starting with the retrospective group discussion of Michael Balint. Despite their differences, these studies all demonstrate that benefit is most likely to accrue from participation in a process of study and evaluation rather than independent, abstract, academic or theoretical analysis alone.

Much of this work is very much 'of its time' and it is clear that analysis of the consultation has evolved and will continue to evolve.

Notable contributions to the literature on understanding and analysing the consultation include:

- **1957: Michael Balint's book 'The doctor, the patient and his illness'**. Michael Balint and his wife Enid were psychoanalysts, originally from Hungary, who worked with GPs in London in the 1950s and 1960s:
  - The results of a research project by fourteen GPs and a psychiatrist at the Tavistock Clinic in London.
  - Groups of GPs met and were encouraged to explore psychological aspects of their consultations.
  - In a very personal account, Balint described the most frequently used drug in general practice as the doctor himself ("the drug doctor").
  - This led to setting up of Balint Groups for similar discussion of cases and consultations.
  - The work described and recognised emotional aspects of the relationship between clinician and patient.
  - It described how attentive listening helped make patients feel better. Balint described listening as a skill and held that 'asking questions only gets you answers'.

- **1972: 'The Future General Practitioner'** marked the start of work by many within the Royal College of General Practitioners (RCGP) which helped define general practice and included consideration of the physical, psychological and social condition of the patient.

- **1976: 'Doctors talking to Patients' by Byrne and Long**. They analysed over 2,500 tape-recorded consultations from over 100 doctors in the UK and New Zealand.
  - They described six stages to the consultation. They also made interesting observations. They recognised that doctors tended to use a narrow repertoire of consultation skills and that doctors who asked more open questions tended to see their patients less frequently. The six stages to the consultation are:
    - The doctor establishes a relationship with the patient.
    - The doctor attempts to discover the reason why the patient attended. This might not be as transparent as first it seems. What is the patient's agenda? What are their fears and concerns?
    - History and possibly examination occurs.
    - The doctor, in consultation with the patient, considers the condition.
    - Treatment or further investigations are discussed.
    - The doctor brings the consultation to a close.

- **1979: 'The Exceptional Potential in each Primary Care Consultation' by Stott and Davies**. This paper described four areas to be systematically explored each time a patient consults:
  - Modification of help-seeking behaviours.
  - Management of continuing problems.
  - Opportunistic health promotion.

- **1984: David Pendleton**, who wrote his PhD thesis on analysis of the consultation, has had a great influence on subsequent work and thinking:
  - He was not a GP but a social psychologist and worked in association with a number of GPs in the Oxford region.
  - He pioneered use of the newly available medium of video recording for analysis of consultations.
  - He developed safeguards for use of video recording, which form the basis of current recommendations.
  - Video recording of consultations for analysis by one's peers is now a standard part of the training of registrars and a requirement for the MRCPG examination and the FRCGP assessment.

- **1987: 'The Inner Consultation' by Roger Neighbour** describes an intuitive five-stage model:
  - Connecting with the patient and developing rapport and empathy.
  - ‘Summarising’ with the patient their reasons for attending; their feelings, concerns and expectations.
  - ‘Handing over’ or sharing with the patient an agreed management plan which hands back control to the patient.
  - ‘Safety-netting’ or making contingency plans in case the clinician is wrong or something unexpected happens.
  - ‘Housekeeping’ or taking measures to ensure the clinician stays in good shape for the next patient.
1994: ‘The Doctor’s Communication Handbook’ by Peter Tate developed some of the themes from work with David Pendleton. Peter Tate is a recently retired GP and former Convenor of MRCGP examinations, who worked with David Pendleton:

- He was responsible for the introduction of a video module to MRCGP examinations in 1996.
- This book emphasises the importance of the patient's agenda, particularly their ideas, concerns and expectations (ICE).
- He outlines useful strategies and skills as well as succinctly reviewing how consultations have changed with the advent of the internet and availability of information.

1997: Stewart and Roter from the Department of Health Policy and Management, the Johns Hopkins University School of Hygiene and Public Health analysed consultations between over 100 doctors and 500 patients, using audiotape. They outlined a gathering of information about the patient's problem along two parallel pathways, one following the illness framework (patient's agenda) and one following a disease framework (the doctor's agenda):

- Patient's agenda, exploring ideas, concerns, expectations, feelings, thoughts and effects, culminating in an understanding of the patient's unique experience of the illness.
- Doctor's agenda, exploring symptoms, signs, investigations and consideration of the underlying pathology and a differential diagnosis.

The two frameworks are then brought together to give a shared understanding. This then allows for explanations, planning and decision-making.

2000: The Calgary Cambridge method of analysing consultations is now used by a large number of medical schools in the UK. This method derives from Pendleton's approach and is an evidence-based approach to integration of the 'tasks' of the consultation and improving skills for effective communication. The consultation is divided into:

- Initiating the session (rapport, reasons for consulting, establishing shared agenda).
- Gathering information (patient's story, open and closed questions, identifying verbal and non-verbal cues).
- Building the relationship (developing rapport, recording notes, accepting the patient's views/feelings and demonstrating empathy and support).
- Explanation and planning (giving digestible information and explanations).
- Closing the session (summarising and clarifying the agreed plan).

2002: John Launer, a London GP, describes the use of a 'narrative-based' model of the consultation. He described techniques to help understand the patient's story:

- Circular questioning or picking up patients' words to form open questions and help patients to focus on meaning.
- A focus on listening (for example, avoiding note-making during the consultation).
- Exploring the context of the problem (may lie outside medical presentation in family, work or community).
- Developing a joint story with the patient (emphasises equality of relationship with the patient).
- Shifting the balance of power to the patient.
- Using genograms and constructing a family tree to help understand the context of a patient's problems.

2002: Lewis Walker, a GP in Buckie, Scotland, published 'Consulting with NLP'. Neuro-linguistic programming techniques are described which can be used to improve communication with patients.

Transactional analysis has offered techniques for use in the consultation and uses Eric Berne's model of the human psyche (three 'ego states' of Parent, Adult and Child). This can introduce flexibility to the doctor's repertoire, allowing consultations to break out of repetitious cycles of behaviour (or 'games').

**Video recording of consultations**

Rules have been set for video recording of consultations because the medium is so revealing and intrudes into the privacy of the doctor-patient relationship. These should be applied and are detailed in the separate article on Videoing Consultations. Subsequent viewing and analysis of the recording should accord with the Pendleton rules.

**Pendleton rules**

These have been varied slightly over the years but basically they state the following:

- The first person to comment on the performance is the subject of the recording and they start by stating what they think they did well, before moving on to aspects that might have been done better.
- Then it is the turn of others but they too are compelled to start by itemising the good aspects before being allowed to become critical.
- Areas for personal development may be identified.
- This technique is important to prevent hurt or a feeling of humiliation in the person who reveals his video.

Now also being used is the 'Set-Go' method of descriptive feedback.

**Aims of the consultation**

These are variously defined according to which model or models of the consultation are used. The basic aims of the consultation as outlined by David Pendleton et al remain intact, although they have been developed over the years by Roger Neighbour and Robin Fraser to name just a few. David Pendleton, Theo Schofield, Peter Tate and Peter Havelock developed seven basic tasks:
• **Define the reason for attendance.** Include the history, the patient’s ideas, concerns and expectations, and the effects of the problem. Why did the patient really come? Is there a false or unrealistic expectation? Are there fears that need to be allayed or other issues that need to be addressed? Is there a hidden agenda? Sometimes patients present with something grossly trivial and then proceed with ‘By the way doctor, while I’m here ...’ and proceed with the reason why they really came.

• **Consider other problems.** Include continuing problems and risk factors. This might include health promotion and addressing risks like smoking or obesity. It could include problems like social conditions.

• **Choose an appropriate action.** This includes clinical management. It may be prescription, reassurance or referral. It may involve follow-up. Analysis of the consultation is not simply about the psychosocial aspects but it also checks that good clinical practice is being observed. Appropriate action may also include a relevant and competently conducted physical examination.

• **Achieve a shared understanding.** It is important that the patient understand the disease, its aetiology and its treatment, as this may improve compliance, although the word compliance is regarded by some as derogatory and implying passive acquiescence and paternalism. The patient may need to know why it is important that certain lifestyles and habits be changed and the need to follow specific regimes of treatment. This puts a degree of responsibility on the patient.

• **Involve the patient in management.** This may also be part of getting the patient to take responsibility or it may be a valid discussion about alternative approaches.

• **Use time and resources appropriately.** This applies both during the consultation and long-term.

• **Establish or maintain a relationship.** The doctor-patient relationship remains crucial for successful medical practice. Always appear interested in the patient.

### Consultation skills

There are many and varied skills that can be learned by adopting an open and self-critical approach to consultation analysis. Examples of some of the basic skills are listed below:

- **Welcoming.** Does the doctor encourage comfort and trust from the outset? Is the patient at ease and ready to bare their soul? Do not be finishing off the notes for the last patient when the next arrives. Check the records before the patient enters so as to be able to offer full and undivided attention. It may be mundane to you but to the patient this might be the most important thing to have happened all week.

- **Questions.** Questions should be open, giving the patient the opportunity to expand - not closed and limited or leading. In reality we sometimes have to break this rule to get a meaningful answer from certain people. Try not to interrupt unless for clarification, although some people do need reining in. Listen and maintain a flow. Sometimes patients say something that needs further investigation but it is inappropriate to break the current chain of thought and focus. They should be returned to later in the consultation but it is very easy to forget until after the patient has left the room. A useful tip is to write a note to remind oneself before the patient leaves.

- **Listening.** Appear attentive and maintain eye contact as much as possible. It may or may not be appropriate to make notes as the patient speaks. In the early days of computers patients used to complain, ‘He was more interested in that screen than in me’. Listening includes looking and noting non-verbal cues and body language.

- **Response.** This involves clarifying points, summarising, reflecting statements and feelings, ascertaining understanding and possibly defusing anger. Empathy forms an important response and, for some patients, may be all that is required, thus forming a therapy as well.\[15\]

- **Explanation.** Use language that the patient will understand. Give important information first. Possibly repeat important points and ascertain that the patient understands. Written information or visual aids may help too.

- **Closure.** The closing act of an consultation used to be the issuing of a prescription and no consultation was complete without one. Some form of closure is required with clarification of what is expected of the patient or the next step. Make correct, adequate and contemporaneous notes.

- **Safety-netting.** Doctors are encouraged to consider;\[9\]
  - What do I expect to happen if I am right?
  - How will I know if I am wrong?
  - What would I do then?

Asking these questions leads the doctor to advise patients what to do to cover or take account of the answers to these questions and record these clearly in the notes.

### Summary

- There is far more to general practice than simply diagnosis and treatment. The good doctor is a clinician with knowledge of diagnosis and management, but he should also understand the complexity of interaction between doctor and patient and embodied in a good understanding of the consultation.

- Developing consultation skills through consultation analysis takes time and practice. It involves self-criticism and self-awareness.

- Video recording of consultations allows close analysis of consultations and is a very potent observational tool. At first the doctor and, as a result the patient, feels conscious about the presence of the camera but before long they relax and behave normally. Doctors who record regularly relax more rapidly. Even when the surgery is not being recorded it is worth pretending that it is and ascertaining that one acts at all times as if the surgery were for review by one’s peers. This is like the Hawthorne effect, that just observing people makes them change their behaviour.

- Consultation skills can be developed and practised throughout a doctor’s career. This applies to all doctors - not just those in primary care.

### Further reading & references

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