COMMON PROBLEMS IN THE CONSULTATION

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We only have to ask doctors and patients about the problems they experience - if proof is required that we need to learn consultation skills.

Doctors often say they have difficulty in controlling the consultation

If you ask doctors which part of the consultation gives them most problems – they most often complain they are unable to close or resolve complaints. Patients seem to keep bringing up new problems – and worse still…. after ten minutes or so dealing with their arthritis they come out with...

> *"...by the way Dr...I've got a breast lump"*

The evidence is that in fact the problem is at the beginning and the reason is that doctors get off to a bad start and don't find out what's on the patient's agenda first.

One of the main reasons is that doctors tend to interrupt the flow of information very early on in the consultation. It has been shown that on average a doctor interrupts the patient after only twenty-three seconds. Only twenty-three per cent of patients complete their opening statement, which if left alone would mostly last only sixty seconds or so. Once the doctor 'takes the floor' only four per cent of patients are allowed to continue and finish their opening statement.

Even if we do get off to a good start, doctors can be seen to commonly make other serious assumptions early on in the consultation.

Frequently the doctor assumes the first complaint is the most important and only complaint, when in fact the patient wants to discuss between two to four issues. Furthermore there is no relation between order of presentation and order of importance. Therefore the doctor cannot make assumptions and needs to ask.

When doctors are following up patients after recent interval or with a recurring or chronic complaint, they often assume the current consultation will be a continuation of last one. Often the doctor can be seen omitting any of the usual greetings or opening question - and go straight into the last week's problems *"…and how are you getting on with those pills?"*

Later on after spending a lot of time on this – the patient informs them that they had in fact brought another new problem and hadn't intended taking time with the previous consultation's topic.

The solution is to screen for other problems after the patient's opening statement at the beginning of the consultation rather than wait for things to come up later on. Revealing an agenda at the beginning allows the doctor to negotiate what can and can't be addressed and allocate time more efficiently and appropriately.

Large percentages of doctors say consultations are difficult.

Over a third of doctors label a quarter of consultations - and ten per cent of doctors label half or more of consultations difficult to deal with - or dysfunctional.

The single most important cause of dysfunctional consultations is the failure of doctors to discover the reason(s) for why patients see them. Berne & Long.

If you interview doctors and patients after consultations - there are considerable differences in their perceptions over what occurred.

- On average doctors and patients disagreed over half the time as to which of the problems was the main complaint. This was better at six per cent when physical complaints were presented – but a lot worse at seventy-six per cent when psychosocial issues were presented.
- On average only fifty per cent of the total number of problems were discovered by doctors.

It is important to look at the reasons for this.

Once again it is partly due to the doctor interrupting the patient early on in the consultation. Frustratingly for the sake of a few seconds more, they would then hear information that would completely re-direct their clinical reasoning or problem solving processes.

There are perhaps two main reasons why early interruptions occur.

1) Some of it is to do with the constraint of time – and with it the relentless pressure to diagnose, treat and move on.
2) More fundamentally it is probably more to do with the way that doctors make a diagnosis. As doctors become more experienced they use a process often described as a 'stab in the dark' approach. This where doctors start to increasingly rely on a 'pattern of recognition' of what they see to make a diagnosis. As soon as feel they have enough evidence - they interrupt to test out their hunch. The trouble is that they do this too soon and as a result get the diagnosis wrong first time more than they get it right.

This has two important effects on the consultation and patient. It ends up making the consultation less efficient and longer because the doctor is forced to stop and re-start the consultation again. The idea that jumping in early might shorten the consultation is thwarted and in fact reversed.

Secondly, and perhaps more seriously – the patient then becomes passive from that point onwards. They now defer to the doctor even if they sense that the line of questioning is irrelevant often assuming the doctor knows something that they don't. If they do bring up the information they had hoped - they tend to do this at the end when the doctor has had their say.

Another important reason why doctors face dysfunctional consultations is because they automatically use a disease or doctor-centred approach to the consultation. They are trained to selectively explore symptoms of disease.

Yet research shows that in many situations this is not the case. Over fifty per cent of patients with chest pain do not have a clinical diagnosis after six months of investigation and review - (missed diagnoses would have come to light in this time) which is similar for many other presentations that include abdominal pain, headache and tiredness.

Doctors are trained to either 'rule-in disease - or rule-out' disease. Making a diagnosis traditionally rests on using a string of closed questions that interrogate the patient's presenting symptoms or organ systems - otherwise known as the functional enquiry. All of us have been trained to use Macleod's system of assessing a pain for instance. When presented with a pain we instinctively feel forced to enquire along disease orientated lines with "…is it sharp or is it dull, does it hurt on breathing or walking etc, etc …"

In short we impulsively use closed questioning techniques at the expense of open type of questions to pursue objective facts. However open questions are a much more efficient and effective way to gain information. You wouldn't ask a person who has just been on holiday to answer a long list of pursuits they might possibly have done. Instead you ask them to tell you in their own words what they did - and in a few minutes you have a clear and accurate picture of their experience.

Relying on closed questions automatically puts doctors in control - but puts patients in a position to which they are only able to passively answer back.

The question of poor compliance

All of us are aware that compliance is poor after patients are given advice. On average fifty per cent of patients do not take medicine properly – with as much as much as £700 million lost to NHS each year. Research shows that only twenty to thirty per cent follow advice with medication that is given for acute illness; thirty to forty per cent for medication for prevention (think of cost from waste when prescribing Statins!); and fifty per cent with medication that is given for chronic conditions. The best is seventy-two per cent for diet.

When compliance is looked at in more detail there is in fact a much bigger variation (between ten and ninety per cent) between doctors. Compliance appears to depend on the consulting style and techniques used by the doctor. Doctors that use certain communication skills have much higher compliance rates.

First, they can be seen to be giving more information in a more ordered and clearer form. They use simple communication giving techniques – that reinforce information and improve recall by the patient.

Perhaps the one important factor is clarity - giving information in a clear and unambiguous way – allowing the patient to understand what's said. They either omit or explain medical terms or jargon.

They can be seen to summarise and repeat important information. Simply asking a patient to restate what they have understood in their own words increases recall by up to thirty per cent.

Chunking & checking is a powerful technique for delivering information. The aim is to give information in repeated small chunks with intervening periods of silence. This allows the patient to absorb information at their pace as well as acknowledge through their no-verbals they understand and agree with it. The problem is the doctor is often on the fourth sentence – whilst patient is still trying to make sense of the first!

Another problem is that most of us have been taught that there is little point in giving patients much information because they can't remember it.

> *"Pts don't remember much of what is said..." .....furthermore*
>
> *"The more you tell them the less they remember"*

More recent research suggests that patient do in fact recall much more of what is said than we first thought. Patients probably forget less than ten per cent of information.

Understanding low compliance rates is more to do with understanding the difference between recall, understanding and interpretation. Recall and compliance are not the same thing.

It's one thing to remember and even understand what's said but another if they don't agree with it - they tend not to carry out your advice.

It is therefore vital to explore the patient's own viewpoint – or explanatory framework - first and then try to reach mutually understood ground through negotiation.

This is known as reaching a **Shared understanding.**

Research shows that the patients who automatically comply with doctor's advice - tend to have similar ideas and expectations as the doctor before seeing them. They therefore hear the information or advice they wanted and expected.

Consultations go wrong where there is a prior difference between doctors and patient's explanatory frameworks or their explanation, understanding and expectations about a problem. The trouble is that doctors rarely explore the patient's views beforehand – which is despite patients giving them the chance to do so.

Over eight five per cent of patients try to become actively involved in the consultation. However this is often done in covert or indirect ways. Often this leaks out by patients seeking

clarification, expressing doubts or rationale for doctor's opinions or through their non-verbal behaviour.

Sadly of those that do attempt involvement – only seven per cent of doctors take up their concerns and become actively engaged in conversation, thirteen per cent of doctors listen passively with no comment or exchange of views and the majority - eighty per cent - make no effort to listen or even deliberately interrupt the patient to stop them.

Patients often say they are unhappy with the way doctors communicate with them.

Traditionally the main aim of doctors is to interpret and classify the patient's symptoms in terms of disease and pathology, whereas the patient is hoping their symptoms will be seen as part of their life-world - along with the way this personally affects them.

All surveys show that patients prefer a patient-centred approach. The more patient-centred the consultation – the more they are satisfied. However, doctors persist in pursuing a doctor-centred approach partly through a fear of loosing control and possibly encouraging patients to make even more demands.

However, research consistently shows that patient satisfaction is linked directly to major positive outcomes within the consultation that include compliance, disclosure and even reduced litigation.

At the same time the same research shows that patients do not in fact need to get what they wanted to remain satisfied. They simply need to feel have their ideas, concerns and expectations explored and their opinions considered – and therefore the doctor doesn't have to give in to their demands to keep them happy and satisfied.

Patients complain that they don't receive enough or the right type of information

Doctors are criticised in no less than 4 areas: -

1) The amount of information
2) The type of information
3) The timing and appropriateness
4) The use of medical terms or Jargon

The amount

Doctors often underestimate the amount of time they spend giving information by a large factor. Most doctors only devote ten percent of consultation time to giving information when they personally believe they use fifty percent or more of total time.

Whilst most patients want more information and time devoted to it - twenty percent don't and do less well if overloaded. It is therefore important to pitch information at the right level for each individual. The problem is that it is difficult to know beforehand which patients want more information and which don't. They need to be asked for their own each individual starting point.

The type

Again there is a difference in perception between doctors and patients as to what type of information is most useful. Doctors tend to feel that treatment and management issues are paramount. Patients – on the other hand – are equally if not more interested in causes of symptoms, their seriousness, the immediate and long-term effects on them and their prognosis. Yet these are the areas that are often left out by doctor even when seeing patients over a period of time.

Patients have been shown to ask a stereotyped list of questions each time they try to make sense of what is happening to them when changes in health occur.

What has happened?

Why now?

Why me?

What ... if I don something about it?

What... if I do something about it?

Doctors also make assumptions based on prejudices and perceptions about the detail and type of information needed by individuals.

At first sight, explaining the diagnosis of diabetes to a university lecturer and a manual labourer would be approached in a different way according to intellect.

However the lecturer may know very little about practical things – whilst understanding some of the metabolic effects excess sugar has. The labourer, on the other hand, may have practical experience because his father had diabetes and ultimately an amputation, and his sister has recently gone blind with it.

Good communicators pitch information at the right level finding the individual's starting point. This means asking them - not only how much they want to know - but what they know and want to know. It also helps doctors to use the limited time they have available by allowing them to concentrate on filling in the gaps.

Even when patients don't possess factual knowledge or practical experience - it is useful to know and 'iron out' any misunderstandings or distortions about illnesses early on.

Timing

Doctors tend to give premature information and reassurance. Sometimes when faced with the scenario of being asked *"Do you think little Jenny needs antibiotics for her cough…doctor?"* most of us will immediately react to decline - especially when Jenny appears to look reasonably well. However shortly afterwards - when we find a temperature and associated localised chest signs – we are forced into an embarrassing and humiliating retreat.

We are also often found 'guilty' of giving reassurance too soon about diagnoses and outcomes especially when dealing with serious or terminal illnesses - leading to us eventually being found out and loosing the patient's trust and respect.

Jargon

Doctors use medical terms or jargon in half of consultations. This tends to confuse and frustrate patients - leading to reduced understanding and compliance. Amazingly they appear to tolerate it - possibly for fear of looking stupid or ungrateful. Yet their understanding of medical terms can sometimes lead to disastrous results. In one study fifty two per cent of patients thought medication for oedema caused water retention and stopped them.

Sadly, using jargon is often used as a device by doctors to control information and end consultations.

Doctors are facing increasing levels of Medico-legal problems

The medical defence unions cite two main causes for litigation - poor communication skills and clinical errors.

Contrary to what might be expected the majority of these – forty five per cent - are due to problem with communication whist only twenty per cent of litigation involves purely clinical errors. More than eighty per cent of cases involve difficulties with communication in some form or another.

In the USA there is now a seven per cent reduction in defence fees for those who attend a consultation course. Perhaps the same will happen in Britain!