TEACHING CONSULTATION SKILLS IN GENERAL PRACTICE: HOW TO AVOID THE 'PYGMALION EFFECT'

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INTRODUCTION

There are two main aims of GP training:

1 To produce doctors who will analyse their work critically and continue to update their practice to meet standards based on the best available evidence.

2 To equip doctors with the skills and attitudes required to consult with patients in a way that maximises the chance of the patient benefiting from the doctor's medical expertise.

In this article I shall concentrate on the second aim and explain why there is such a great emphasis on teaching the art of consultation in GP training. The subject is very topical. The BMJ on 18th September 1999 had a theme issue exploring the ways doctors may consult with patients, in which most of the authors are committed to the idea of doctors working 'in partnership' with patients to address their health needs. This very much supports the approach used in modern GP training.

WHAT DO WE KNOW ABOUT DOCTOR-PATIENT COMMUNICATION?

For more than 3000 years the basic style of doctoring has been described as 'beneficent paternalism'[1]. This approach is very appropriate and effective in certain situations, such as a medical emergency. There are, however, problems with this style if used for every patient encounter. What works for a passive patient lying in a hospital bed is very different to what is effective in an outpatient clinic and certainly becomes unacceptable to most patients in modern general practice. For example, when patients present to doctors for help, 54% of patient complaints and 45% of patient concerns have been shown not to have been elicited by physicians. Most complaints by the public about physicians deal not with clinical competency problems but with communication problems[2].

The way the clinician and the patient relate to one another is a major determinant of the outcomes of the consultation.

Expectations seem to be changing[3]. Patients are increasingly critical of professional paternalism and are more likely to expect active participation in decisions about their care. They also, however, may like to leave decision-making to the doctor, especially when facing serious illness or if they are elderly. It requires considerable skill on the part of doctors to establish which approach a patient wants. Doctors need to elicit and understand the patient's treatment preferences and to be flexible enough to respond appropriately. Patients greatly value the fact that their doctor is listening to them but are often reluctant to express their true concerns and expectations unless skilfully encouraged to do so. Doctors can be helped to refine and to have insight into their way of communicating with patients so that their verbal and non-verbal messages can be adapted to the type of person they are dealing with.

The patient who reads the *Guardian* or *Telegraph* health page (internal controller) usually needs a different response from the fatalist (external controller) whose grandmother lived to 95 years, smoked 30 cigarettes a day, never took any exercise and drank gin every day.

Traditionally doctors have not been good at tailoring their communication style to the individual but it is a skill that can be learned[4].

HOW ARE CONSULTATION SKILLS TAUGHT?

The most commonly used technique for teaching consultation skills in modern GP training is video consultation analysis. For most trainers this has surpassed audio recording although there still may be a place for this. Role play or simulated consultations with actors are used occasionally and for some people these are powerful tools to encourage reflection on how communication skills could be refined. It is known that communication skills do not reliably improve from mere experience. In some cases traditional medical education can be so stressful for medical students and junior doctors that it has induced a cynicism and callousness that can be barriers to the use of the effective communication abilities the students once had[5].

It has been shown that new entrants to general practice often find it difficult to share decision-making with patients and little negotiation of management options occurs[6]. If this were identified as a weakness through either complaints or problems with patient compliance, then the trainer would devise a strategy to look at this area. This would probably involve using videos and critically analysing how management options were arrived at and how they could have been different. Theories on negotiation skills and the use of logic, emotion or threat/coercion to generate movement in a person's position may be introduced. Role play may possibly be used then as a safe way of practising new skills. The registrar may then deliberately introduce the demonstration of negotiating skills into a videotaped surgery and then evaluate the outcome.

With a skill as personal as consulting, *how* the subject is

taught is for some just as critical as *what* is taught. Consulting is, in effect, a structured conversation and we have all had a lifetime's experience of these.

It is essential for a new entrant to general practice to have the self-belief and self-awareness to deal effectively with uncertainty and the communication challenges he or she will face throughout a career. The hypothetico-deductive problem-solving model[7] taught in general practice requires confidence to tolerate levels of diagnostic doubt rarely experienced in hospital training. For many patients, no new identifiable organic pathology will be apparent; their problems will be psychological, social or even soteriological ('pertaining to salvation')[8]. The 'gatekeeper' role of the doctor in British primary medical care depends for success on a high degree of clinical confidence and competence.

Unfortunately (and, hopefully, in the past) some consultants and trainers have unintentionally treated their trainees in a way that undermined their efforts and failed to develop their potential as doctors. There is a growing body of evidence that demonstrates the power of positive expectation – the so-called Pygmalion effect[9].

'I shall always be a flower girl to Professor Higgins because he always treats me as a flower girl . . . But I know I can be a lady to you because you always treat me as a lady, and always will . . .'.

For many of us, having our consultations video-recorded and analysed is immensely threatening. Trainee surgeons making their first attempts at procedures and being analysed by their peers may well feel likewise. A technique for structuring feedback was developed in the early 1980s to deal with this problem. This method has proved to be invaluable for any feedback discussion, formal or informal, both in hospital and general practice. The structure would work as well for teaching a surgical skill as for consultation skills.

1 The registrar GP starts by identifying his or her strengths

2 The trainer or group reinforce these and add further strengths

3 The registrar GP is asked to identify areas for improvement

4 The trainer or group reinforce these, adding further areas if necessary.

This technique effectively and powerfully satisfies the need most of us have for knowing how well we are doing. Positive reinforcement of good skills and behaviour increases the chance of that behaviour being repeated. If, as has happened, only the poor aspects are identified, then this may indeed have the effect of reducing repetition of this behaviour, but it also increases anxiety. This could induce a loss of confidence and fear of exposure to any learning situation where more humiliating negative feedback may be given.

WHAT STANDARDS ARE WE TRYING TO ACHIEVE?

The summative assessment at the completion of the training programme for general practice has given clear basic standards of competence for the consultation skills required for general practice (Table 1).

DISCOVER THE REASONS FOR A PATIENT'S ATTENDANCE
elicit the patient's account of the symptoms
encourage the patient's contribution
observe and use cues
obtain relevant items of social and occupational circumstances
explore the patient's health understanding
DEFINE THE CLINICAL PROBLEMS
EXPLAIN THE PROBLEMS TO THE PATIENT
explain the diagnosis management and effects of treatment
use appropriate language
use the patient's health understanding
check understanding
MANAGE THE PATIENT'S PROBLEM
make sure the plan is appropriate for the working diagnosis
share the management options
EFFECTIVENESS
use time appropriately
prescribe appropriately
develop and use your relationship
opportunistic health advice

Table 1 A consultation critique sheet.
Based on Tate: The doctor's communication handbook[1]

The MRCGP exam has a different emphasis and is looking for more sophistication in the way certain patients' problems are dealt with. Credit is given for taking into account a patient's health beliefs and understanding. For example, eliciting that the patient is a faith healer who first tried a psychic surgeon to solve their problems may have an important effect on any proposed treatments used (Table 2).

ARE BASIC SKILLS UNIVERSALLY APPLICABLE?

Many of the basic principles of dealing with patients in a setting where they can choose whether or not to follow a doctor's advice are readily applicable to hospital practice as well as to care in the community.

Accepting that most patients have a preferred expected outcome from a consultation, it is important to understand what the expectation is, as a basis for a satisfactory encounter. Good letters of referral from primary care may speed this process but it need not take a long time[10]. One study showed it took a maximum of 2½ minutes to listen effectively to a patient's concerns. Even this amount of time, however, would obviously have resource implications.

Having achieved that baseline knowledge, the doctor can then negotiate an acceptable management plan. This usually means a compromise between what a patient wants and what the doctor thinks is either possible (within NHS or professional constraints) or would be in their best interests. Patients involved with decision-making are more likely to comply with agreed management plans and this approach may empower an individual to take more responsibility for his/her own health if appropriate.

DISCOVER THE REASONS FOR A PATIENT'S ATTENDANCE

a) elicit the patient's account of the symptom(s) which made him/her turn to the doctor

PC the doctor encourages the patient's contribution at appropriate points in the consulltation

PC the doctor responds to cues

b) obtain relevant items of social and occupational circumstances

PC the doctor elicits appropriate details to place the complaint(s) in a social and psychological context

c) explore the patient's health understanding

(M) PC the doctor takes the patient's health understanding into account

DEFINE THE CLINICAL PROBLEM(S)

a) obtain additional information about symptoms and details of medical history

PC the doctor obtains sufficient information for no serious condition to be missed

b) assess the condition of the patient by appropriate physical or mental inspection

PC the doctor chooses an examination which is likely to confirm or disprove hypotheses which could reasonably have been formed OR to address a patient's concern

c) make a working diagnosis

PC the doctor appears to make a clinically appropriate working diagnosis

EXPLAIN THE PROBLEM(S) TO THE PATIENT

a) share the findings with the patient

PC the doctor explains the diagnosis, management and effects of treatment

b) tailor the explanation to the patient

PC the doctor explains in language appropriate to the patient

(M) PC the doctor's explanation takes account of some or all of the patient's elicited beliefs

c) ensure that the explanation is understood and accepted by the patient

(M) PC the doctor seeks to confirm the patient's understanding

ADDRESS THE PATIENT'S PROBLEM(S)

b) choose an appropriate form of management

PC the doctor's management plan is appropriate for the working diagnosis, reflecting a good understanding of modern accepted medical practice

c) involve the patient in the management plan to the appropriate extent

PC the doctor shares management options with the patient

MAKE EFFECTIVE USE OF THE CONSULTATION

a) make efficient use of resources

PC the doctor's prescribing behaviour is appropriate

b) establish a relationship with the patient

PC the doctor and patient appear to have established a rapport

Table 2 Based on RCGP examination guidelines
PC = performance criteria M = merit if well done

Taking a moment to summarise what has happened in the consultation and to check the patient's understanding may also help to avoid the common problem of misunderstandings arising after doctor–patient contacts.

CONCLUSION

It seems clear from the evidence that patients' expectations of doctors and of the healthcare system are changing. This poses a great challenge to those responsible for dealing with these expectations. The essence of consultation in medicine seems to be to elicit a patient's ideas, concerns and expectations regarding a problem. We then have the challenge of working out what options are available to solve the problem, and then, in partnership with the patient, choosing the best.

In primary care, increased teamwork should help by sharing the burden of responsibility. For many, the development and extension of the core primary care team of doctors and nurses working collaboratively offers the best way for the future[11].

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