

THE CONSULTATION AS A GP REGISTRAR: A PERSONAL VIEW

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Laden with a set of questions relating to every system in the body it would surely be a smooth transition from hospital SHO to GP registrar. In the first few weeks of the registrar year it became alarmingly obvious that this false sense of security could not be further from the truth. I had a lot of knowledge but did not know how to apply it.

All registrars experience the endless requests at the start of training from their principals to "shut up and listen". One frightening fact became apparent – the art of listening to the patient as a person, not a medical condition, was a skill that I appeared to have overlooked.

At the start of training all registrars are given longer consultations than the other partners in the training practice. The extra minutes are needed, as experience teaches you that a barrage of endless, often closed, questions leaves yourself and the patient confused, tired and no closer to the reason for attendance than at the start of the consultation. I was introduced to the basic tasks that I needed to achieve in the consultation (see figure) – how was I to achieve all this in ten minutes? The main obstacle to overcome initially is the fear of missing a life-threatening diagnosis – fortunately these are in the minority.

- discover the reason(s) your patient has come to see you
- define the clinical problems
- address your patient's problem(s)
- explain the problem(s) to your patient
- make effective use of the consultation including opportunistic health advice

Figure The aim of the consultation – from Peter Tate, "The Doctor's Communication Handbook".

Initial studies as a GP registrar relate to the numerous consulting styles that have been analysed in great depth by the type of GPs that we all aspire to become. The sheer number of consulting styles highlights the very limited techniques that I possessed from leaving the setting of hospital outpatient clinics.

The most frustrating time as a registrar (for myself and my trainer) were the never-ending hours of video-taped consultations that were necessary for me to assess my progression from a doctor-led style towards more patient participation. The frustration simply stemmed from me believing that I had a good rapport with patients in hospital and in the community – the video tapes were evidence that maybe my consultation style was too one-sided and there was a rather large potential for improvement. Self-assessment using video feedback with trainers and peers in the registrar meetings was initially threatening but became a valuable learning tool. The skill of consulting was learnt and certainly did not occur overnight.

In general practice one great luxury that you possess compared to the outpatient setting is time. I do not refer to the actual consultation time, more the opportunities to see the patient on a number of occasions and also in different situations (ie in their homes). This luxury immediately alters the emphasis of the consultation and allows an element of trust and openness to develop. The relationship between the patient and the GP can hopefully flourish as the patient is seen in a wider context than as simply a medical problem.

Seeing a patient, diagnosing the problem and arranging appropriate management were my aims in the outpatient clinics whilst a hospital SHO. Having completed my VTS scheme, my enjoyment in patient contact stems from listening, understanding, discussing and agreeing a shared plan between the important players in this game - myself and the patient.