Some Ideas about Consulting in General Practice

We can use the 'Consulting Cycle' to consider the consultation in the context of the patient's life.
We can use the 'Consultation Navigation Tool' to analyse the structure of how we consult.
Aim to firstly gather all relevant information, then 'cross the bridge' to discuss management.

Gathering Information

When consulting, we should be **flexible** and **respond** to the patient, not simply go through a checklist of standard questions. Note the difference between *looking for the diagnosis* and *understanding the patient's problem*. Think of '**receiving'** the history rather than '**taking'** it.

We need to listen and **show** we are listening. We can do this by giving the patient a 'receipt' for information, eg a mini-summary phrase to show that the doctor has heard and understood.

Active Listening involves paying attention to the **meaning** of what the patient is saying, not just the answers to questions. We actively listen to the way the patient talks, what is said and what is not said, the non-verbal behaviours etc. This is not possible if we are writing notes whilst the patient is talking, as the best we can do in this situation is record basic data. By really listening we can understand the issues, and then write a succinct record afterwards. Overall it is also quicker to write notes afterwards rather than during.

"You see what you expect to see".
The doctor brings her own ideas and priorities to each consultation, and we need to be mindful about how we influence the patient's story-telling, options of diagnosis and problem definition. As we are consulting, we also need to observe ourselves, to reduce our interference.

We can use various consulting **micro-skills** to encourage the patient to tell their story, while we listen to the content and the style, noting the patient's ideas, concerns and expectations.

Some ideas about language
"~~Why~~ …" questions usually lead to a defensive justification. Avoid.
"**What** reasons …" is a curious question, which usually promotes sharing of useful information.

When a sentence contains '**but'**, the listener often does not remember the positive things that were said before the 'but'.

My own blocks to active listening:

My ideas for overcoming these blocks and for developing my active listening:

Crossing the Bridge

When we think we have elicited all relevant information it is useful to **summarise,** to check that we have understood the problem. The patient then has an opportunity to confirm the accuracy of the summary, or amend it.

Ask an internal question of your 'second head', "Have I got all the information I need in order to discuss management?" If yes, 'cross the bridge' and proceed; if no, continue with gathering information.

Discussing Management

Some principles include:

- explain in appropriate way, using **few** words
- involve the patient in decision making
- ask for patient's own ideas before sharing doctor's suggestions
- link options with the ICE already obtained
- ensure patient understands; this is a two-way process

Explaining
If we lay out our reasoning, leading to a conclusion, the patient will listen carefully, and will often anticipate the diagnosis, or add relevant information during the process, before the doctor gets to the diagnosis:

> Summary of evidence → Diagnosis
> Eg *You have some flashing lights and then pains on the left of your head, and my examination does not show any serious signs which might indicate a tumour … so it **seems** that this is a migraine.*

When we state our diagnosis first and then justify the reasons, if the patient does not agree then she will not be listening to our explanation:

> ~~Diagnosis → Justification~~
> ~~Eg *I think you have migraine **because** you have pains only on the left of your head, you have some visual disturbance, my examination is normal …*~~

"~~Should~~" implies wrong, promote defensiveness, dependence, and implies a "right" way. Avoid.
"**Could**" offers opportunities, possibilities, variety of options, choosing individual solutions.

Options and suggestions are best offered using tentative language:

- How about …
- Would you like to …
- Perhaps we could …

Positive language is more effective when offering suggestions, as negative suggestions make it difficult to know what to do. For example, "~~do not eat sugary foods~~" is a negative comment, and the patient still does not know what to do. It is more effective to say, "Eat foods such as fruit …"

The **order** of words or phrases makes a difference. For example, the last thing that is said is often received by the listener as being more important, and given greater weight. Compare:

~~"These tablets should sort it out, but if you do not get better, then come back next week."~~
"Do come back if you do not recover, but I think these tablets should sort the problem."

The second version leads to fewer people returning, because the **last thing** that is said is a **positive** expectation that they will recover.

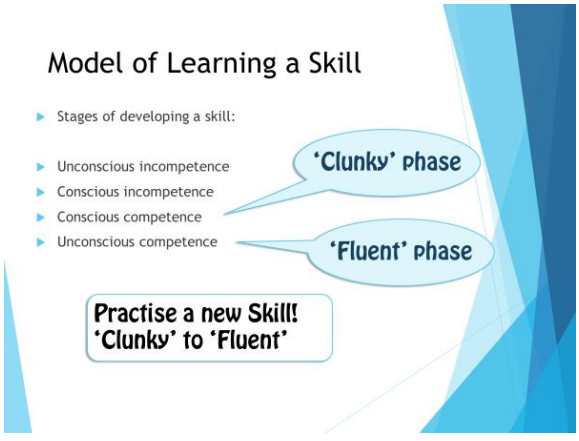
Ideas about Learning Consulting Skills

- personal 'ideal consultation', read before and after consultations, reflect how close the real consultation was to ideal, and practise a specific phrase before next consultation
- 'teddy' technique for brief practising
- practise to move from 'clunky' to 'fluent' for each skill

A Model of Learning

To learn well, a learner needs to …

1. **Want** to learn
2. **Feel** they **can** learn
3. **Know how** to learn
4. **Do** the learning ie **practise**
5. **Use** new learning for real



My reflections

Ideas which I found useful:

How do I plan to develop and practise my consulting skills?