Consult eff

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INTRODUCTION
Consultation in outpatients is the core of neurological practice. Excuse the hyperbole, but the outpatient clinic is our operating theatre, the place where those finely honed diagnostic and therapeutic skills are demonstrated. And while neurological training has for many years concentrated on the hallowed ‘where is the lesion, what is the lesion’ approach to diagnosis, and – in the UK at least – the ‘here is a pile of follow ups for you to wade through’ approach to therapeutics and continuing care, there has been little recognition of the importance of communication skills and consultation techniques. However, things are changing rapidly. Consultation techniques are now taught and examined in medical schools and it seems inevitable that observed consultation will become part of assessment in UK neurology training, and perhaps in appraisal and revalidation for consultants as well.

Good communication in consultation is not just a matter of being nice to people, but leads to more accurate diagnosis (Silvermann et al. 1998), better compliance with treatment plans (Eisenthal et al. 1990; Benson & Britten 2002) and better symptom resolution (The Headache Study Group of the University of Western Ontario 1986). Moreover, improving communication skills may decrease investigation, referral and prescribing (Goldberg et al. 1983). There is also evidence that learning consultation skills decreases physician frustration, as well as complaints and litigation (Levinson et al. 1997). Acknowledging the importance of communication in consultation adds another dimension to outpatient work.

But how do we know if we are consulting effectively, and is there a painless way to identify where improvements can be made? Communication skills teaching at medical school and in general practice has produced methods of analysis that can be applied in other settings. Through such methods we can develop a deeper understanding of the skills that we use in neurological consultation. By discussion of our consultation techniques with colleagues we can learn new skills and borrow unique phrases and approaches from each other. Such discussion is not a new phenomenon in neurology. Matthews (1963), for example, gently advised on how to ask questions throughout his classic text Practical Neurology. When discussing headache for example, he noted that the question ‘why do you think you have it?’ can produce an account of gross psychological stress that the question ‘have you any worries?’ fails to elicit. In this journal David Thrush (Thrush 2002) has explained his personal approach to history taking, a distillation of many years experience, for the benefit of both junior and senior colleagues.

It is perhaps self-evident that once we are capable of examining our own skills, we might begin to be able to teach and assess the skills of others.

The aims of this article are to dissect the process of consultation in neurology, and explain how we can study our own and others’ consultation style and practice. We hope to help you to practice fulfilling and effective medicine in clinics that run to time, and to keep the letters of complaint and unnecessary referrals to other colleagues to a minimum.

WHAT IS THE POINT OF A NEUROLOGICAL CONSULTATION?
There may still be neurologists who believe that ‘where and what is the lesion’ is their raison d’être,
and that everything beyond diagnosis can be left to others. This seems a little unhelpful for the new patient presenting with neurological symptoms with or without a neurological ‘disease’, and for the patient with chronic neurological disease and the usual complex mix of physical, social and psychological problems. We should be able to provide more, for the patient and for the referring doctor. One-third of new referrals to general neurology clinics have symptoms that are poorly explained by identifiable organic disease, and almost one half meet DSM IV criteria for anxiety or depression (Carson et al. 2000a; Carson et al. 2000b). Again we could offer more to this group than telling them they don’t have a neurological disease and sending them away.

The patient-led disease societies are keen that patients with chronic neurological disease are followed up by experts in the condition. What would be the point if that expert only offered a confirmation of the diagnosis, and its continuing effect? In Parkinson’s disease, consultants are reported to see the priority as the diagnostic and medical treatment needs of the patient (Lloyd 1999) yet other factors, for example depression and loss of independence, have greater influence on quality of life (Morrish 2000). This is not only our opinion (and prejudice). David Thrush gave his view that neurologists are there ‘to help and care for that unique patient with his or her neurological problem’. Matthews writes on ‘the incurable patient’ that ‘the first essential is that the doctor should be interested, and should be seen to be interested, in the patient and his symptoms’ (the order seems important).

An eminent predecessor of ours kept this quotation by Aristotle on his office wall:

‘It is a mark of the educated man and a proof of his culture that in every subject he looks for only so much precision as its nature permits and its solution requires.’

‘Where and what is the lesion’ may be the way to make a neurological diagnosis, but when it comes to the busy general neurology outpatient clinic, we need to think further.

THE PROCESS OF CONSULTATION

The consultation is a meeting between the differing agendas of patient and doctor (Stewart & Roter 1989). And in the neurology clinic there are often other agendas to consider as well, for example those of the referring doctor and carer. The key to an effective consultation and a successful outcome is to identify, declare and attempt to meet all the agendas.

The patient agenda

The patient agenda is a complex product of that individual’s symptoms and his or her physical, social and psychological background. Some examples might be:

• ‘I have these symptoms and I want to know why.’
• ‘I’ve come for the head scan (and I’m not going to be happy unless I get one).’

The agenda may be less obvious, and perhaps hidden from the referring doctor, for example:

• ‘My mother has multiple sclerosis, have I got it too?’
• ‘My doctor says I’ve had a fit and can’t drive but you may let me drive again (if I tell you the right story).’
THE BEGINNING, MIDDLE AND END OF THE CONSULTATION

Beginning the consultation - the introduction and history

Such things as finishing the last task, ensuring we have the right notes and introducing ourselves are the start of good communication and an effective consultation. We might choose to read the referral letter and notes before opening the door, and then call the patient from the waiting room (sometimes making a diagnosis at the same time). It is helpful to ensure the patient is comfortable and we may choose to shake hands.

How to start consulting? We need initially to gather some background information (for example about job and family) that is important, and helps establish rapport. A good start is to put aside the referral letter and ask ‘Tell me about it from the beginning’ (this risks the retort ‘hasn’t my doctor written to you?’). An alternative might be ‘I’ve read your doctor’s referral letter, but I’d like to hear the story from you.’ Goldberg et al. (Goldberg et al. 1983) emphasized the importance of starting with open questions and keeping them open until all the problems are disclosed, and then asking clarifying questions. Starting with specifics such as, ‘tell me about your fits’ may lead to a narrow history and an inaccurate diagnosis, as may asking questions to clarify whilst the patient is still telling their story. In one study (in outpatients in the USA), physicians interrupted the patient after an average of 18 s and, astonishingly, only 23% of patients reached the end of their opening statement (Levinson et al. 1997). After 90% of the interruptions the doctor gained the floor and the patients never finished their story. It can be instructive to try that level of interruption with friends at a dinner party and watch the effect. When allowed to talk and finish, patients averaged 1 min and the longest was just over 2 min, a small dent in the overall time given to the new patient, and time well spent. Try setting your watch and observe how difficult it is to avoid interrupting in that first few minutes. Loss of eye contact, and note writing, are other interruptions to be avoided in this early part of the consultation.

Aside from gaining a good history, there is another reason for allowing patients to talk. In his book ‘Stories of Sickness’ (Brady 1988), Howard Brady explored the therapeutic value of telling our story, an idea that has been taken further.
by Greenhalgh and Hurwitz (Greenhalgh & Hurwitz 1998).

The middle - information gathering and clarifying, and the examination
When you have heard the patient's story, clarify what you have heard. We were taught, in a traditional history, to ask questions that encourage a narrow response. The argument is that 'we don't have time, so it's quicker to ask what we need to know', but to take a detailed history by direct questioning invariably takes more time than listening and will not be as helpful in management. Resolution of headache at 1 year was found to be three times more closely related to whether the patient's story had been heard than whether they had CT scanning, medication or referral (The Headache Study Group of the University of Western Ontario 1986).

Listening is not passive. We need to show the patient that we have heard and understood. So-called 'reflective' listening involves paraphrasing and summarising to check our understanding and to allow the patient to come back if we have misunderstood. If we reflect the feelings that the patient has communicated, this empathy will build the relationship and help unlock the true patient agenda. This process also allows us to keep control of the consultation, particularly with the vague or garrulous patient. Having summarised what we have heard, we can clarify and ask the direct questions needed to complete the history.

This is not the place to discuss the finer points of examination technique but it seems reasonable to point out that the tone, style and rigour of the examination all contribute to the patient's experience. The comment that 'I've never been examined as fully as that before' is helpful in confirming that you are as conscientious as you like to be, and that the patient is, perhaps, telling you that they trust you.

The ending - summing up, explaining and planning, and closure
After the examination, a summary should bring together the reason for the referral, the patient's story, and the neurologist's interpretation. The explanation should be tuned to the patient and carer. This will involve discovering what the patient and carer already know and would like to know, allowing one to avoid repetition and being patronising. Attunement implies that the level of explanation and language (without jargon) are appropriate to the individual patient. Discovering and incorporating the patient's health beliefs improves adherence to treatment.

Specific techniques of explanation improve recall. Providing an overview, followed by more detailed explanation, and a summary of the key points is useful. Repetition, writing down instructions, and drawings help too. Leaflets are useful if they reinforce what has been said. Giving patients a chance to ask questions is important. Patients may not ask, they may be embarrassed at appearing ignorant, they may feel that doctors are too busy or they may already have lost the thread of the conversation.

Closure (getting the patient out of the door and the door closed) is important in keeping to time. In a successful consultation, the patient will agree when it is appropriate to end. Once the decision to end is made, it is better to stick with it unless you feel you have missed something. White and colleagues (White et al. 1994) found that three behaviours at the end of the consultation were associated with longer endings:

- the physician asking open questions;
- the physician showing emotion, concern or responsiveness;
- patients being friendly, dominant, responsive or in distress.

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It is useful to develop strategies to deal with each of these. An awareness that the end of the consultation is not the time for any of the above is helpful, just as it is helpful to remind oneself that there is a duty (to yourself and to other patients) to keep to time.

In General Practice the `anything else you want to discuss?’ question as the patient leaves may be useful. In neurological practice we may not want or need to hear this out, although on occasion the last words exchanged can betelling (`you’ll be hearing from my lawyer!’).

**H ow to Look at your own and others consultation**

You can learn about your communication skills by complaints, litigation and a declining private practice, or more positively by the glowing letters of praise to the Chief Executive of your hospital. There is an easier way. Video and audio recordings of the neurological consultation can be done sensitively, and can be enjoyable. They can also bethreatening and distressing. Here are some ground rules for working on consultation observation that can take some of the threat away:

- don’t forget consent (on all sides);
- don’t let anybody (however, senior) look at your video if they won’t let you look at theirs;
- look at your own video in private and decide for yourself what, if anything, you would like to show and discuss;
- only work with facilitators experienced in consultation assessment.

Our experience is that small groups of 4–8, with a mix of specialties and seniority, work best. Alternatives to videos include working with audio recordings (which may well be less threatening but still give plenty of information for discussion) and attending communication skill courses (e.g. MITA - Medical Interview Teachers Association; for information on courses run by this group go to www.mita.soton.ac.uk). Many courses use actors to allow participants to arrange and then to learn how to handle scenarios such as breaking bad news or dealing with the aggressive patient. For those who might want to read more before dipping their toe in the water we recommend `Skills for Communicating with Patients’ (Silvermann et al. 1998).

**The prize**

Communication skills improve accuracy of diagnosis, adherence to treatment, outcomes, symptom resolution, and patient and doctor satisfaction. Dare we suggest you give them a try?

**References**


