"We may praise communication, but in the human species non-communication might seem to be the more striking feature of our way."

Robert Ardley (1970)

We know this to be true politically, in unhappy marriages and in many other spheres of life. However there is evidence that this is just as true in the medical setting as it is in ordinary life. The area of medicine where we communicate or try and communicate with our patients is the consultation.

Spence in 1960 wrote "The essential unit of medical practice is the occasion when in the intimacy of the consulting room or sick room a person who is ill or believes himself to be ill seeks the advice of a doctor whom he trusts. This is the consultation and all else in the practice of medicine derives from it."

So if the consultation lies right at the heart of all that we are trying to do as doctors it is right that we look at it, analyse it, study where we fail in it and try and do it better.

There are several ways in which we can look at the consultation — several models which we can use to analyse it. First of all there is the medical model.

MEDICAL MODEL

In this model we see a patient bringing in

1. **A complaint**
   This complaint is then considered to elucidate it.
2. **An investigation takes place.**
   Following the investigation and due consideration
3. **A diagnosis is made** — we have decided what is going on
   Having decided what the diagnosis is —
4. **A prognosis is made** — we decide what the outcome is likely to be for this problem. Finally, having decided what the problem and the likely outcome are —
5. **An intervention is planned** either to remove the cause of the problem or at least to minimise the effects of the problem.

Now I doubt if anybody will challenge the fact that this pattern has some validity or that it describes what goes on in many consultations. However this description of the consultation is really of little practical use because although it describes what is going on it does not give any indication of how it happens. It is rather like talking about making a cake and saying that one buys the ingredients, mixes them up, bakes the cake and puts it in a tin — all true but one is none the wiser about how to make a cake.

PROBLEM-SOLVING MODEL

In this model of the consultation:

- A **problem** is presented.
- The patient, or whoever is presenting the problem makes a **statement** about what is troubling them.
- The doctor then **clarifies** what is going on and makes sure that all the information is fully understood.
- The problem is then **defined** and agreed between the patient and the doctor. Having defined the problem, **solutions** are then considered. Usually a range of solutions are **generated** i.e. for a tennis elbow: you could just wait for it to get better; you could rest the arm; or you could have an injection of methylprednisolone and lignocaine into the extensor tendon insertion. Having generated the possible solutions, the doctor and patient need to **clarify** what is involved in each and finally a **selection** is made of which solution will be tried.

This model is a little bit more than the previous one because at least it does define some of the tasks to be carried out to complete the stages of the consultation which we described in the first model. However even this model is very mechanistic and does not say anything about the interaction between two people, the doctor and the patient, both of whom are individuals with their own personalities and life experiences. Thus the consultation is a social as well as a medical encounter.

SOCIAL MODEL

Now there are certain rules of social encounters whether they take place in the setting of ordinary life, or in the setting of a medical consultation.

In any **encounter** there is an **ostensible reason** for the contact between two people.

The ostensible reason provides an **acceptable context** which allows a **social transaction** to take place. The acceptable content provides most of the **overt content** of the meeting. There is also a **covert content** which stems from the **expectations** of the two people concerned and reflects their **role perception** and their personalities and attitudes.

Now all of that may sound like doubledutch and may seem totally unrelated to the medical consultation. However I would like to put that concept first of all into

the context of the traditional Hollywood setting of boy meets girl at a dance, then into the setting of a medical practice.

First of all then, the dance.

A boy and a girl separately go to a dance. The boy likes the look of the girl, so goes up to her and says "Is the seat beside you free?" — he can already see it is free, but he is establishing an **encounter.** The **ostensible reason** for the encounter is that the boy wants to sit down. The **acceptable or overt content** of the encounter may then continue by the boy talking to the girl about how good or bad the band is. All the time there is **covert content to** the encounter involving thoughts such as "Does she like me?" "Will she dance with me?": this covert content stems from the **expectations** of the boy and the girl, for instance, they may be confident that at such encounters they usually can make girls (or boys) like them. Who eventually asks whom to dance depends on the **role perceptions** of the boy and the girl. In America it might well be the girl, in Italy it would rarely be so.

In the Medical Setting

When a patient goes to see a doctor, he or she establishes an **encounter** with an **acceptable content** for instance: "I have a sore throat". However the patient may have a **covert content** to his consultation. This may vary from "I want antibiotics for this complaint whatever the doctor believes about the treatment of sore throats" to " I am sad and lonely and I want this powerful figure, the doctor, to respect me and give me lots of sympathy". Whether this covert or hidden part of the consultation comes into the open or not depends partly on the **expectations** of the two parties of the consultation and partly on the **role perceptions** of the two people.

It is these last two factors, expectations and role perceptions, within the consultation that I would like to consider now. To the extent that we are familiar with a role, we each have expectations of the person who fills that role. So as the patient gets to know a doctor he or she likes to know what role that doctor likes to play. If the doctor likes to play the role of the dominating professional, the patient will have few expectations that he will be able to discuss with the doctor why he should do what the doctor suggests. Much of the underlying worries of that patient will never surface and his covert concerns and problems will not be brought to the doctor's notice. Instead they will probably frequently be presented as physical ailments. However if the doctor takes a more flexible role the patient may be able to discuss the covert as well as the overt reason for his encounter with the doctor and develop enough confidence to manage his own minor illnesses and anxieties.

Relationship Model

So the social factors which we have discussed vary the way that the doctor and the patient interact. These differences in relationships affect the progress of the consultation.

Szaz and Hollender 1956 recognised three sorts of relationships between patients and doctors:

1. Active/Passive or Authoritarian

In this case, the doctor obtains information from a largely passive patient. He then makes a decision about what should be done — the doctor generates the solutions and the patient is expected to carry them out. This may be a relevant model for certain life-threatening conditions but with other conditions, the solutions are doctor-generated and the patient may well not feel committed to them. There is no real reason why the patient should carry them out. Doctors who practice in this way often complain about ignorant and rude patients without realising that the reason why patients don;'t carry out their instructions is that they have not been themselves involved in working out the solutions to their own problems.

2. Guidance/Cooperation

This second style of consultation is where the doctor acts as guide to the patient. The doctor is still in the dominant role, but rather than acting as a dictator he collects information, makes a decision then persuades the patient about his view of the problem and about his view of a solution. Rather than demanding obedience from the patient, the doctor tries to persuade the patient to accept the doctor's view of the situation.

3. Counselling

In this third style of consulting, the doctor tries to get the patient to define the nature of their own problem using the doctor only as an information resource. The patient is then encouraged to define the options for resolving the problem, again using the doctor as an information resource. Once having decided what they are going to do in this sort of consultation, on the whole patients feel that the solution reached is theirs and they are committed to it and compliance with treatment is usually very good. However this sort of consultation is much more difficult for the doctor to carry out. It is much easier for us to define a way out of a problem as we see it and then impose this on the patient than it is for us to help the patients find their own way out of their problems, simply giving them the information with which to make their decisions. Many doctors reject this way by saying that patients are too stupid, ignorant or dependent to make up their own minds when really these doctors mean that they, the doctors, are too rigid to learn this style of consulting.

Mediums of Communication

So far we have looked at patterns of communication in the consultation. We have not looked at the actual mediums of communication within the consultation.

1 Verbal communication

The easiest form of communication is verbal communication. Words convey meaning. However even with verbal communication there are ways of transmitting messages other than by words, for instance:

a) Tone of voice can indicate depression, elation, shyness, aggression etc. and many other things.
b) The language used i.e. formal language or slang can indicate what role the patient perceives the doctor to be taking.
c) The cadence of the speech i.e. the stumbling speech of the shy person with a poor self image or the slurred speech of the drunk or the person with CVA can tell a lot about what is going on in a particular patient.

2 Non-verbal communication

This is possibly the most powerful form of communication. There are people who say that 60% of all communication is non verbal. Quite apart from the obvious forms of non verbal communication such as the patient who breaks down in tears, or who thumps the desk, the slumped immobility of the severe depressive, the stiff posture of the person with the bad back and the restlessness of the patient who has not yet plucked up the courage to tell you what they have really come to see you about tells you more than many words.

So far we have considered various models of the consultation and the mediums of communication within the consultation. I would now like to consider what the pattern of the consultation should be and what tasks have to be carried out in a consultation.

Pattern of a Consultation

What then should be the pattern of a consultation? What is the broad spectrum of what should go on in each consultation? Stott and Davis have claimed that four main tasks should be carried out in each consultation. These tasks are as follows:

1 The presenting problem should be addressed with the patient and dealt with.
2 Every meeting with the patient is an opportunity to continue the management of what patient's long term problems. For instance if a patient comes in with an itchy scalp and you know that they are an asthmatic it is important that you also enquire about the patient's symptoms of asthma, check their inhaler techniques and do a peak flow estimation as well as dealing with the itchy scalp.
3 Every consultation with a patient for whatever reason is an opportunity to practice opportunistic health promotion. A patient comes in with tinea pedis. As well as dealing with their presenting problem one should ask form other things. Are they a smoker, are they overweight, what is their alcohol intake? If one doesn't know it is important to enquire and to give any necessary advice and help.
4 Finally when a patient consults it is important to consider whether they are using the health service intelligently. Do they think that we can cure colds and flu? Do they need some help with managing their own minor illness by themselves without using us? Some gentle advice and education may give them the confidence to take responsibility for their own health and change their help seeking behaviour.

We have seen then that the consultation is not a simple procedure but a very complicated process right at the heart of our professional life. So what tasks do we have to carry out within the consultation?

Consultation tasks

1 Create the right atmosphere to establish rapport
2 Encourage the patient to volunteer information and feel involved in his own care
3 Tolerate emotionally disturbing things which this patient may say
4 Interview the patient logically and systematically
5 Use a style which is appropriate to each patient at each stage of the interview
6 Recognise when a consultation is going wrong and make appropriate adjustments
7 Avoid medical jargon and explain the meaning of medical terms
8 Understand and use non-verbal communication
9 Right at the heart of the consultation come to a joint decision about diagnosis and solutions with the patient.

To carry out these tasks we need to be able to do several things-

1 Ask open ended questions
2 At times ask focussed questions
3 Clarify inconsistencies in what patients say
4 Define the meaning of what a patient is saying- this may involve bringing out covert or hidden meanings.
5 Summarise what patients have said
6 Notice non verbal clues that patients give us
7 We need to be able to listen to what the patient is saying, not what we want them to say
8 Remember what has been said and heard

9 When a patient is rambling we need to be able to interrupt them and bring them back on course.

10 We need to enable patients to say things they are shy or scared of saying

11 We finally need to challenge patients when they are practising denial. i.e. the wife who will not face to the fact that her husband is dying.

In Conclusion

It would seem that we need to be supermen and women to be skilful at consultation. This of course is nonsense. Many of the skills we use in consultation we also use in our ordinary social lives. However where we are using these professionally we have to identify them, develop them and learn any that we are not good at. Skill in consultation is the first hurdle in a medical man or women's life. If we have not jumped this hurdle really we have not started to practice high quality medicine however long we have been qualified. I have not considered the continuing nature of family medicine consultations. I have not considered the outcomes of consultations, nor have I considered 101 other aspects of consultations. However you have given me one of the largest subjects in medicine to speak on and I hope you will excuse me in being selective. ◆