Difficulties in consultations reported by doctors in general practice

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SUMMARY. General-practitioner trainers in Scotland responded to a questionnaire on difficulties in consultation significantly more readily than did non-trainers. Their answers to some questions were significantly different.

Trainer and trainee views of difficulties in communication with different types of patients and situations are broadly similar. Because of this similarity of views, the experienced doctor can plan an approach to training which is valid for the inexperienced trainee. He may, however, modify his estimate of the degree of difficulty for the trainee of consultation by involving some categories, for example, adolescents (easier for the trainee), dying patients (more difficult), patients of socioeconomic status which is different to that of the doctor (more difficult).

Some aspects of the consultation merit special attention: techniques such as those appropriate to ending the interview and discovering the patient's reasons for seeking medical help.

While trainees' problems associated with lack of familiarity with patients and their circumstances are likely to decrease with time spent in the teaching practice, adequate records can help to diminish the trainees' insecurity.

This survey confirms the need to continue to focus attention on patient management as a component of training as relevant as the detailed diagnosis and treatment of disease.

Introduction

THE consultation between patients and doctors is of paramount importance both in establishing the nature of problems presented by patients and in managing situations and people. Evidence is accumulating that medical students and doctors trained by traditional methods often fail to elicit key problems (Korsch *et al.*, 1968; Maguire and Rutter, 1976; Byrne and Long, 1976).

Achieving proficiency in consulting skills is an important part of vocational training (Royal College of General Practitioners, 1972); hence trainees need a firm base for their teaching, and methods need to be developed to ensure that trainees have acquired the basic skills by the time they leave their teaching practices. Much work remains to be done before appropriate methods are devised and the content of the teaching has been defined (Tanner, 1976). Even when this has been achieved, teaching material must be related to the needs of everyday general practice and must be presented in a form which is seen to be relevant to the care of patients and not simply as "frills and luxuries" (Roberts, 1977).

Aim

The purpose of the survey was to obtain the views of general practitioners in Scotland on the skills needed in consultations in general practice. Many doctors expressed their views on problems in communicating with different patients, forms of training which general practitioners feel would be helpful in improving communications, and the suitability of various types of training materials for use by trainers and trainees.

Method

This survey was carried out in Scotland by postal questionnaire during the autumn of 1976. A pilot study, which had a low response rate of ten per cent, confirmed many of the known difficulties inherent in this method and highlighted the need for special efforts if the co-operation of participants was to be enlisted. The questionnaire was simplified, and help was obtained from the Scottish Council of the Royal College of General Practitioners and Scottish General Medical Services Committee. The support from these bodies, acknowledged in a covering letter sent with the questionnaire, was an important factor in boosting the response rate in the main survey.

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Table 1. Composition of sample and return.

Sample type	Number of question-naires sent out	Number of replies	Percentage return
Trainers	114	74	*65*
Trainees	156	77	*49*
Non-trainers	477	191	*40*
Total	747	342	*46*

The questionnaire

A check-list of items was presented for selective endorsement and opportunities were given for comment. Three parts of the enquiry related to:

1. Problems of communication.
2. Methods of training.
3. Details about the respondents and their practices.

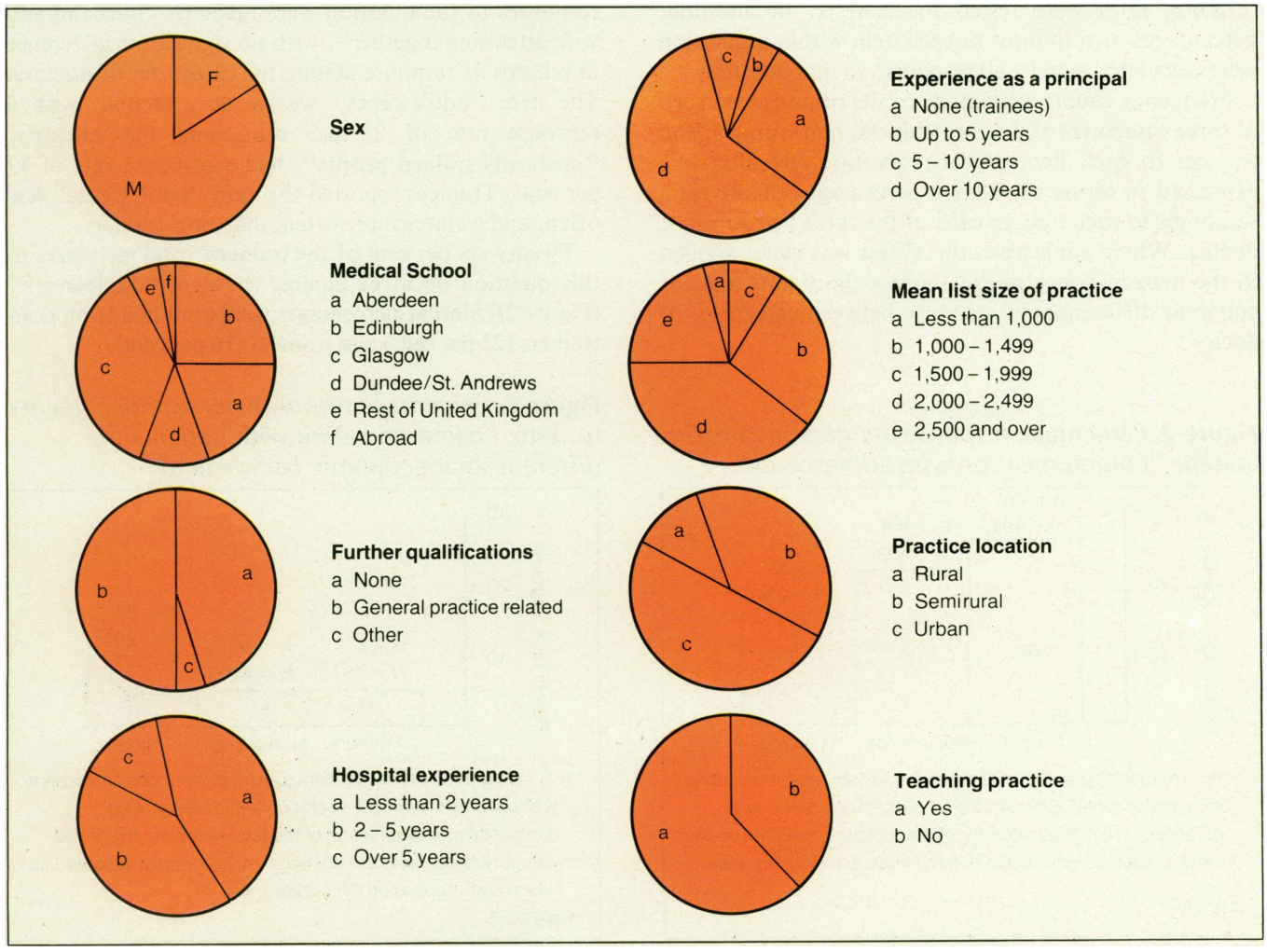
A further series of open-ended questions sought information on the respondent's view on his own style of communication, on the influence of experience on consulting, and on important techniques in managing patients and their problems.

The sample of doctors

We tried to obtain a representation of the professional views from trainers, non-trainers, and trainees. To avoid overloading the sample with the numerically much larger group of non-trainers, names were selected from the list of NHS principals in general practice in Scotland of every second registered trainer and every fifth non-trainer. In addition, the questionnaire was sent to all trainees currently in post in Scotland. These proportions were selected to produce a sample of manageable size.

Because it had been agreed to maintain anonymity, there was no opportunity to supplement replies by a second approach. Nevertheless, 65 per cent of trainers responded to the postal questionnaire while there was a lower response rate from trainees (49 per cent) and non-trainers (40 per cent). Response rates of between 40 and 60 per cent are typical of those who have no special interest in the subject (Oppenheim, 1968), while even in

Figure 1. *Proportional breakdown of personal demographic characteristics of the respondents.*



studies of interested groups the response very seldom exceeds 80 per cent. The responses to this survey accord with such expectations. Evidence from late respondents, who are known to give similar answers to non-respondents (Oppenheim, 1968), suggests that the views of non-respondents in this survey are similar to the respondents.

This report is based on replies obtained from 342 general practitioners from among approximately 3,000 general practitioners in Scotland (including trainees). The composition of the sample is shown in Table 1.

Some personal and demographic characteristics of doctors responding are illustrated in Figure 1. In interpreting results, bias introduced by factors such as the different proportions of trainers, non-trainers, and trainees must be remembered; for example, the sample contains a much higher proportion of teaching practices than is the norm for Scotland. Nevertheless, most of the characteristics are representative of general practice in Scotland.

Analysis

Responses to predetermined check-list items were coded on mark-sense cards, and analysed by computer. Overall frequency counts were made first, and the number of responses to the check-list items within each question were totalled. Differences between item response rates were tested by x^2 tests. In addition, percentages of responses to each item within a question were calculated against all responses to that question.

Frequency counts were made of the responses of each of three categories of doctor, trainers, non-trainers, and trainees to each item of each question. Results were expressed in terms of relative percentages of the total responses to each item in each of the three categories of doctor. Where applicable, the x^2 test was again applied to the item response rates to assess the significance of apparent differences in response between categories of doctor.

It was possible to categorize the open-ended questions under general headings, examples of which included the following:

Responses	*Category*
"Difficulty in communicating with a patient wanting an abortion"	Interpersonal
"Difficulty in communicating with professionals"	Occupational
"Difficulty in refraining from over-running the consultation time"	Time

This information was used to amplify and interpret the results obtained from the check-list questions.

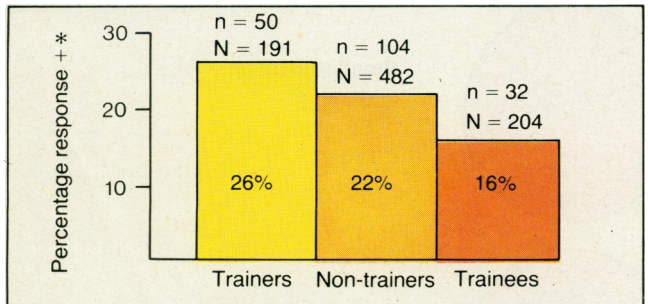
Results

Patients with whom doctors find difficulties in communication

From a list of seven broad categories of patient, respondents were requested to mark the three which they considered were in general more difficult to communicate with than others. Analysis of the responses indicated that three categories of patient were seen as posing the most problems, namely; husband and wife attending together, adolescents, and medically trained patients. Twenty-four per cent of the total responses to the question were made to "husband and wife attending together", with no significant difference in pattern of response among the categories of doctors. The item "adolescents" was a close second, with a response rate of 22 per cent, and the category, "medically trained people", had a response rate of 19 per cent. Trainees reported the item "adolescents" less often, and trainers more often, than non-trainers.

Twenty-six per cent of the trainers' total responses to this question occurred against the item "adolescents" (Figure 2). Similar percentages were obtained from non-trainers (22 per cent) and trainees (16 per cent).

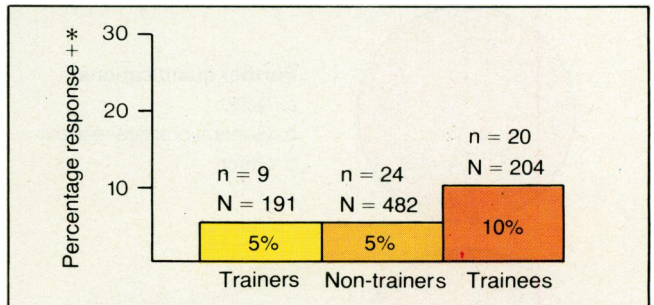
Figure 2. *Percentage response per doctor category to item: "communication with adolescents".*



*% = response per doctor category (n) to item "communicating with adolescents" expressed as a percentage of the total responses (N) of that category of doctor to the question on the kinds of patients with which communication difficulties arise

+p<0.01

Figure 3. *Percentage response per doctor category to item: "communicating with patients of different socioeconomic background".*



*% = response per doctor category (n) to item "communicating with patients of different socioeconomic background" expressed as a percentage of the total response (N) of that category of doctor to the question on the kinds of patients with which communication difficulties arise

+p<0.05

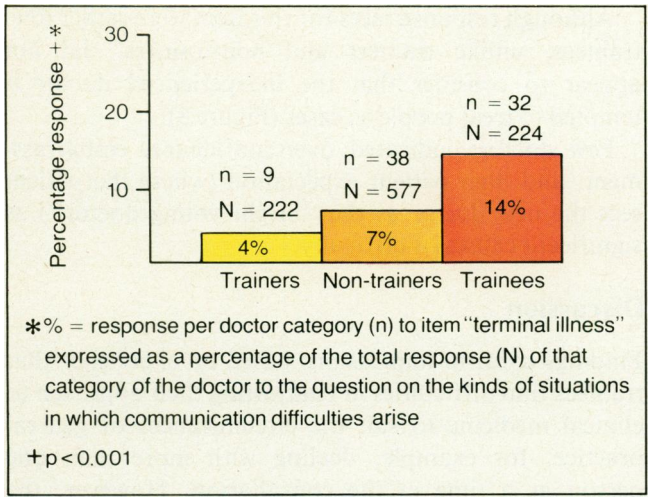


Figure 4. *Percentage response per doctor category to item: "terminal illness".*

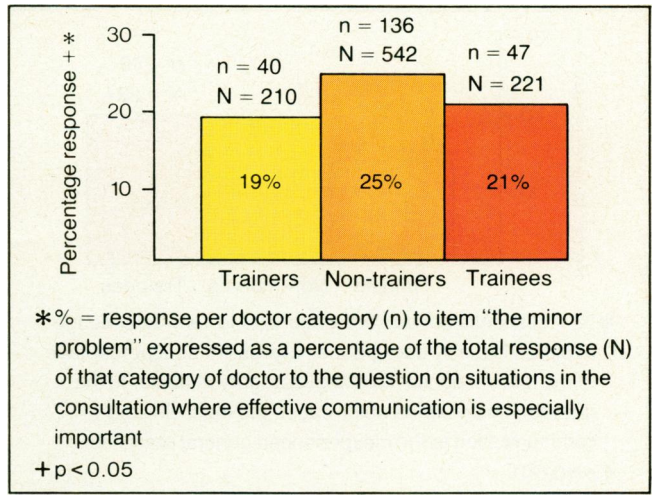


Figure 5. *Percentage response per doctor category to item: "the minor problem".*

Although the item "patients of different socio-economic background to yourself" was not ranked high, trainees marked this item significantly more often than did either of the other categories of doctor (Figure 3).

By far the most common type of free-answer responses concerned "interpersonal" and "disability" categories. Immigrants and foreigners, deaf patients, and those with a low IQ were often mentioned. The list included school teachers, ministers of religion, and policemen more often than others, and disabilities prominently represented included alcoholism and various psychiatric disorders.

Situations in which doctors find communication difficult

The most common were situations involving drug dependencies (21 per cent), exploring the possibility of child abuse (20 per cent), and refusing requests for certificate or prescription (18 per cent). In each item there was little significant difference among the three categories of doctor.

Trainees reported difficulty with terminal illness significantly more often than did trainers and non-trainers (Figure 4).

"Marital problems" (eight per cent), "psychosocial problems" (six per cent), "requests for a second opinion" (five per cent), and "when the patient weeps" (one per cent), though given relatively low ratings in this question, were alluded to in other questions, especially by trainees.

Of the few free-answer responses, two thirds were classified as "interpersonal".

Particular problems in communication

Among the items most often indicated were communication problems inherent in conveying to patients the triviality of a minor problem (22 per cent) and the seriousness of a potentially fatal disease (15 per cent). The non-trainers indicated the first of these items significantly more often than trainers and trainees (Figure 5).

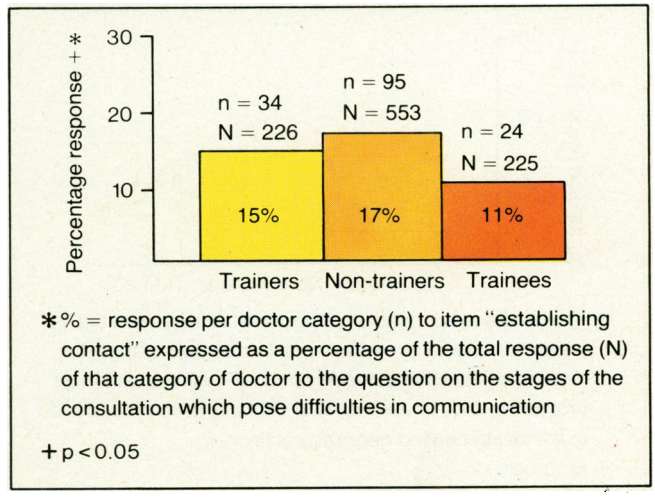
Items such as dosage of drugs and general child care were indicated less often (nine per cent and seven per cent respectively) with no significant differences among the doctors.

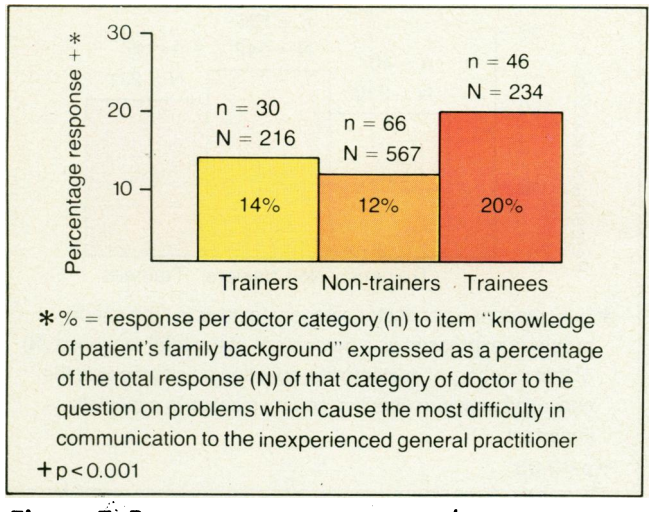
Half of the free-answer comments were categorized as "management", including potential problem areas like dieting and patients not wanting to accept the doctors' advice.

Stages of the communication

Respondents were asked to indicate which stages of the consultation in their experience posed the greatest difficulties in communicating for the new entrant to general practice. The items most often indicated were discovering the reasons for the attendance (24 per cent), ending the consultation (20 per cent), and establishing contact with the patient (16 per cent). This last item was

Figure 6. *Percentage response per doctor category to item: "establishing contact".*





*% = response per doctor category (n) to item "knowledge of patient's family background" expressed as a percentage of the total response (N) of that category of doctor to the question on problems which cause the most difficulty in communication to the inexperienced general practitioner
+p<0.001

Figure 7. *Percentage response per doctor category to item: "knowledge of patient's family background".*

considered to pose problems more often by trainers and non-trainers than by the trainees themselves (Figure 6).

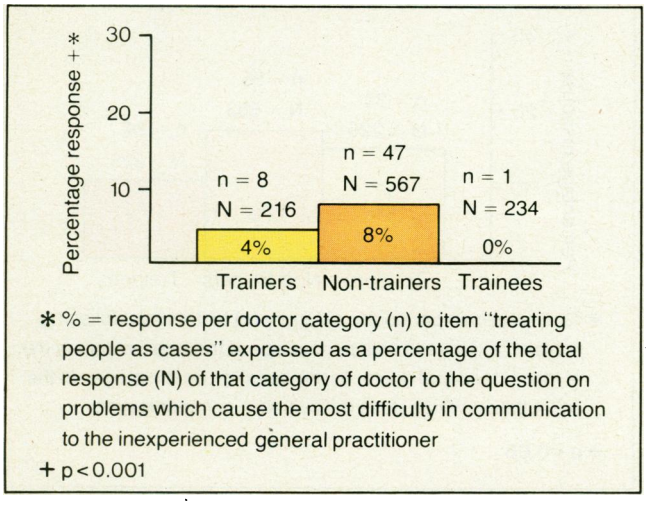
Difficulties in ending the consultation were often referred to by doctors in other parts of the questionnaire and the subject appears to merit attention during training.

The stages of the consultation involving technical skills—examining the patient, detailing treatment, and detailing further investigation—rated two per cent each.

Problems of the inexperienced general practitioner

Of the many factors which might hinder effective communication, the following were mentioned most often: unfamiliarity with the patient's background (psychological, social, and physical; 21 per cent), working against the clock (18 per cent), and lack of information about the patient's family (14 per cent). Trainees themselves feel this lack of sufficient information most often (Figure 7).

Figure 8. *Percentage response per doctor category to item: "treating people as cases".*



*% = response per doctor category (n) to item "treating people as cases" expressed as a percentage of the total response (N) of that category of doctor to the question on problems which cause the most difficulty in communication to the inexperienced general practitioner
+p<0.001

Although response rates for this item were rather low, trainees, unlike trainers and non-trainers, did not appear to consider that the inexperienced doctor is tempted to treat people as cases (Figure 8)!

Few doctors indicated over-confidence, embarrassment, and high patient expectation (where the patient sees the new doctor as the "bright young doctor") as significant causes of difficulty.

Discussion

Findings confirm impressions based on experience that trainees find difficulties in readjusting their approach to clinical medicine to suit the circumstances of general practice; for example, dealing with more than one person at a time in the consultation. However, the trainer's own experience is not necessarily always in accord with that of the trainee. For example, experienced doctors (both trainers and non-trainers) indicated communication difficulties with adolescents more often than did trainees: it is probable that this is an expression of differences in age between doctors and patients. Terminal illness emerged as a problem where trainees appear to encounter difficulties more often than trainers: deficiencies in undergraduate education and differences in age between doctor and patient are among factors likely to contribute to this.

Management of patients and situations were seen to pose problems more often than treatment of disease. This, coupled with low response rates to questions relating to stages of the consultation involving technical skills, possibly reflects the emphasis of present day undergraduate medical education on physical aspects of disease.

Other difficulties facing new entrants to general practice include the lack of background information about patients and their families. Although this may be one expression of a more general inability to tolerate uncertainty, this finding may be related to inadequacies of records and record systems in general practice.

The significance of this survey lies as much in the attempt to provide as precisely as possible information on which to plan as in the confirmation (or otherwise) of existing impressions of those involved in vocational training. The apparent failure of those concerned with training to make suitable efforts in the past has been sharply criticized by Cargill (1977).

Such information can be used to create awareness among trainees of the issues they need to concentrate upon and some of the skills they need to develop. It can also assist trainers and trainees to select training techniques suited to their needs. These issues will be developed and discussed more fully in a further paper.

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Acknowledgements

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Sulphinpyrazone in the prevention of cardiac death after myocardial infarction

The 'Anturan' Reinfarction Trial is a randomized, double-blind multicentre, clinical trial comparing sulphinpyrazone (200 mg four times a day) and placebo in the prevention of cardiac mortality among patients with a recent documented myocardial infarction. Results represent data accumulated on 1,475 eligible patients entered 25 to 35 days after myocardial infarction and followed for an average of 8·4 months. The data reflect excellent randomization, compliance with therapy, and tolerance of the drug.

All 69 deaths were of a cardiovascular nature (68 cardiac and one cerebrovascular). For cardiac deaths, the annual death rate was 9·5 per cent in the placebo group and 4·9 per cent in the sulphinpyrazone group, representing an observed reduction of 48·5 per cent ($p = 0·018$). The annual sudden-cardiac-death rate was 6·3 per cent for the placebo and 2·7 per cent for the sulphinpyrazone group, representing a 57·2 per cent reduction in sudden-cardiac-death rate ($p = 0·015$). Sulphinpyrazone appears to be effective in reducing cardiac deaths during the first year after myocardial infarction.

Reference

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