Common sense and consulting

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SUMMARY. Three hundred and forty-two general practitioners in Scotland presented their views on content and training in relation to consulting with patients. Differences in responses from trainers, non-trainers, and trainees are examined and possible reasons for the divergences are discussed.

Introduction

THE case for vocational training in general practice is now generally accepted, although there is some disagreement about whether training in the skills of consultation is necessary or even possible. Learning by experience is not to be denied, though the style of consultation may reflect the doctor's personality.

In any training programme numerous aspects of aims and methods must be considered: for example, what material should be presented to the trainee? Which form of presentation is most appropriate? What should be the balance between theoretical and practical forms of teaching? What teaching aids might be used? In which other disciplines might useful materials and methods be found? Who should be responsible for such training?

In addition to such questions, training in communication skills for the consultation raises the issue of when formal training should be given.

Method

People who use such skills in their daily work should have something worthwhile to contribute to thinking and planning for vocational training for general practice. Accordingly a postal survey of the views of general practitioners and trainees was carried out in Scotland in 1976. Details of methods and characteristics of those applying have been published (Bennett *et al.*, 1978). This article analyses the responses about *training* in communication skills in the consultation.

Respondents were classified into three main groups: trainers, non-trainer principals in NHS general practice, and trainees. They answered a series of 'closed' questions and in addition they commented on the topics raised.

The questions

The questions were of the check-list type, respondents being required to select three of about eight items presented. Provision was made for further comments after each question.

1. When training in consultation should take place. Respondents were asked at which stage(s) of a doctor's medical career systematic training in interviewing would be of greatest benefit for intending general practitioners, and what in particular might be done at any or all of the chosen stages

2. Methods of training. Several established methods of training exist in education, some being more relevant than others in training in interviewing. Doctors were asked to indicate the methods they considered might be most effective in helping trainee general practitioners in developing appropriate styles and techniques of consultation.

3. Other relevant disciplines. In addition to family medicine, various professional disciplines may be sources of knowledge relevant to training for interviewing in general practice. A list of such disciplines was presented from which the respondent was required to select those he felt to be the most relevant.

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4. Training materials. Material for training can be presented in several forms—audiovisual, tape recordings, tape-slide packages, written material, and verbal materials such as lectures: the content of this material can be far-ranging. Doctors were requested to indicate which of a list of specific materials, if generally available and given access to the necessary equipment, they would find most useful as a trainer or trainee. We are aware that trainers and non-trainers may have differing degrees of knowledge about these methods and materials, all of which, however, are in common use.

Results

1. When training should take place

Respondents thought systematic training in interviewing would be most beneficial to the intending general practitioner if given during the clinical years of undergraduate education and continued later as vocational training (Figure 1). There is a slight but definite expression in favour of this introduction being in the earlier, rather than the later, clinical years of the undergraduate course.

Respondents felt that formal training in the art of consultation would be of little benefit in the first two years of the undergraduate medical course, which is perhaps understandable because the experience of most, if not all, of the respondents as undergraduates was that students at this stage have very full curricula and patient contact appears rather distant. Although there is some feeling that the clinical facts should be mastered first, individual doctors commented that training of this kind can never be started too early and should continue throughout medical school: "Unless a doctor can interview a patient, he's useless at any stage in his career, therefore the sooner he learns to do this, the better, certainly *long before* he starts the general practitioner component of his *experience (not* training)."

Both trainers and trainees are more agreed about the appropriateness of training at particular stages than are non-trainers, who tend to consider that training at any stage from early clinical onwards would be beneficial (Figure 2).

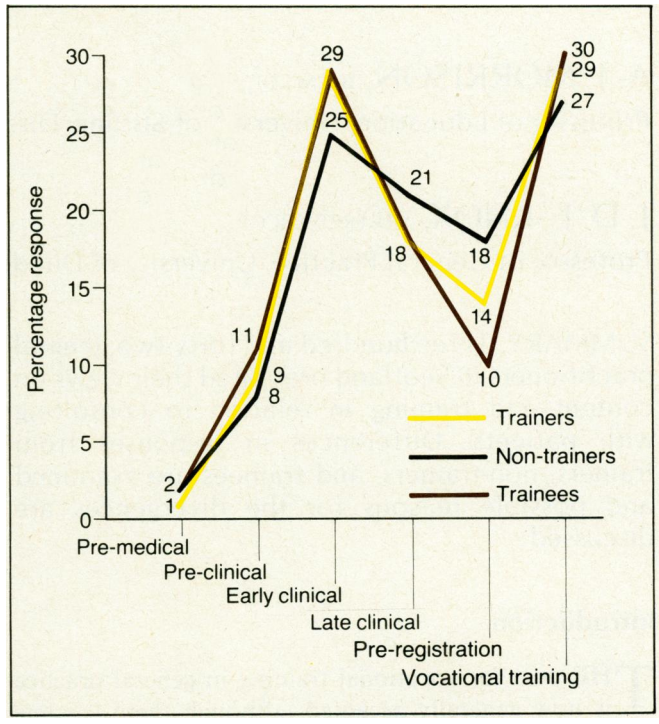
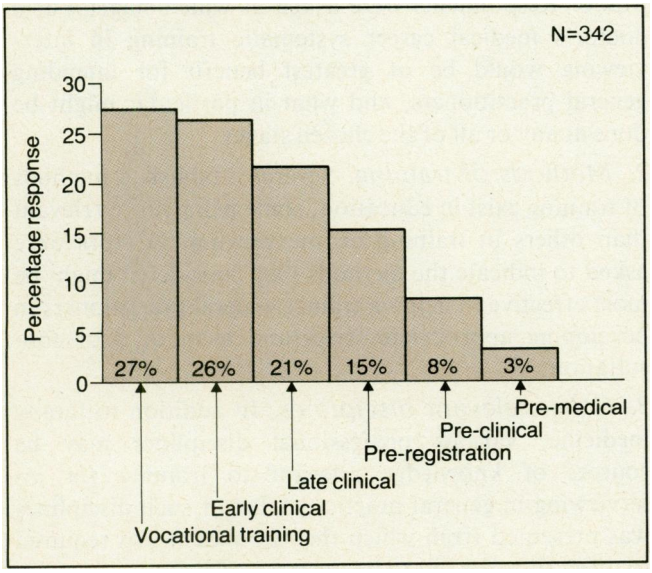


Figure 2. *Percentage response per doctor category to the question on the stage at which interview training should be introduced.*

Figure 1. *Percentage distribution of all responses to the question on the stage at which interview training should be introduced.*



Several respondents indicated that in their view although training might be beneficial at early stages in medical education, it is not feasible because of the way medical education is currently organized. "Medical teaching has, historically, been hospital orientated, dealing with one aspect at a time of a patient's total problems. As long as teaching hospitals exist, training for general practice must then be a mainly postgraduate exercise . . . "; "When I was a student, one learnt the hospital method—where patients were largely 'cases'. This is perhaps the best way to learn the facts of medicine and the art of consultation may best be learnt at postgraduate level when one is more mature and knows the basic facts. As a student, though, a little on the art of interviewing is certainly of great value, so that one remembers that patients are human beings, though most students are naturally fairly conscious of this . . . "

2. Methods of training

There was general agreement among respondents that apprenticeship, by working in a practice, was one of the most effective methods for helping the trainee develop effective styles and techniques for interviewing. This was especially felt to be the case by non-trainers, whereas trainers and trainees tended to mark other methods more highly, probably because of greater familiarity with those techniques. Seven per cent of doctors specifically mentioned that practical experience by apprenticeship was the only type of effective training, though it was stated that this should not take the form of 'cheap labour'.

Apprenticeship was defined by one respondent as "Access to the surgery of an experienced general practitioner, respected by his general practitioner and hospital colleagues, who does not overprescribe or refer to hospital without good reason, who has, over a period of years, managed to maintain his list size and the respect of his patients, and has remained aware of using recent advances in medicine—in short, a saint!"

Apart from merely sitting in on consultations, it was suggested that discussion of the techniques and behaviours used by the doctor would be useful; also the trainer observing the trainee's attempts at interviewing and then discussion. Another suggestion envisaged the trainee conducting the preliminary interview alone with the patient and then observing the experienced doctor with the same patient: they might both examine their approaches afterwards. It was also indicated that it might be beneficial for the trainee to sit in on consultations by the other doctors in the training practice in order to observe psychiatric consultations, hospital outpatient consultations, and consultations with different patients having the same illness. It was felt that feedback from the patients involved might be helpful in order to establish their interpretation of the consultation, and views on how it had been handled by the interviewer.

Written self-analysis and criticism by the trainee after a consultation was suggested as a useful means of understanding consultation behaviour.

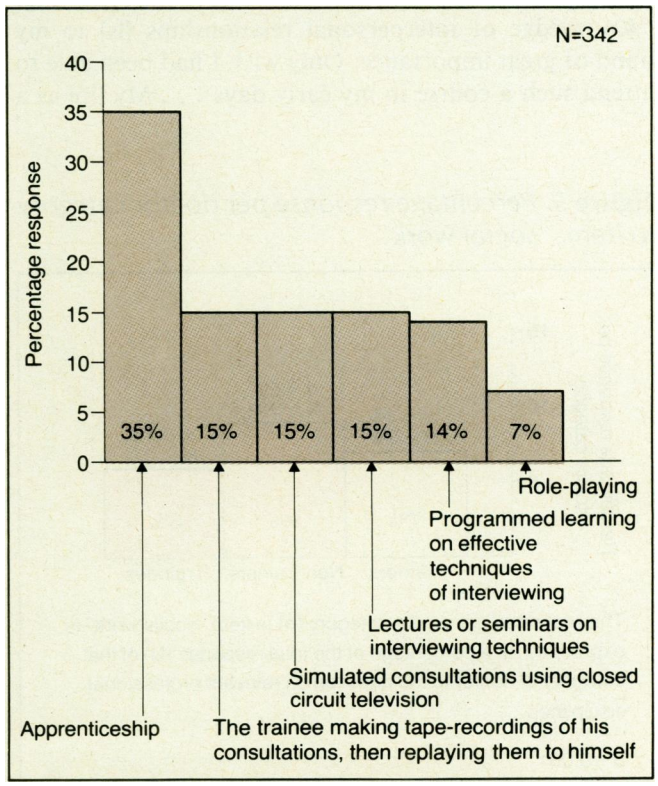
Various discussion topics were suggested: for instance, the comparison of case histories taken by different interviewers, real cases with back-up information from health visitors, social workers, and nurses, and issues such as 'The opening gambit' and 'What's the problem?'

Figure 3 presents the responses of the total sample to the various items contained in this question on training methods. Apart from apprenticeship, programmed learning, tape-recording one's own consultations, simulated consultations using closed circuit television, and lectures or seminars on interviewing techniques were felt to be equally effective as training methods. Role playing received only seven per cent of the total response. One reason for their low scoring may be the lack of first-hand experience of the method by respondents. Another criticism of role playing was illustrated by one doctor: "My outlook on the trainer/trainee relationship is coloured by the fact that I know I would have been dead bored and uninvolved as a trainee. I am a poor looker-on at other people working, and am poor at training 'games' where the outcome doesn't matter. And 'games' using actual patients I find embarrassing (and did even as a student). I only really participated when my actions had relevance to the actual outcome of the care of the patient."

Respondents drew attention to the practical problems to be overcome in the recording of consultations from the technical and ethical points of view. Audiovisual techniques are thought to be too threatening and may distort the behaviour of the participants. "I have a deep-seated feeling of unease when watching simulated situations on video—as I believe the people who do well on it may do so more because of histrionic than communicating ability, and the ones who appear to do badly are probably the good communicators in a private situation but 'seize up' under the spot-light's glare." Despite all such problems there is a demand for the use of recorded consultations, whether real or simulated, for training in interviewing.

The method of training involving the trainee making tape-recordings of his consultations then replaying them to himself was considered to be significantly more effective by the trainees themselves than by trainers and especially non-trainers (Figure 4).

Figure 3. *Percentage distribution of all responses to the question on methods of training.*



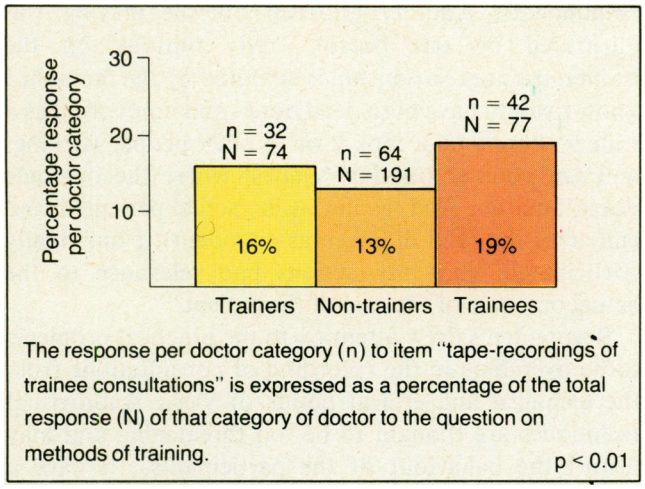


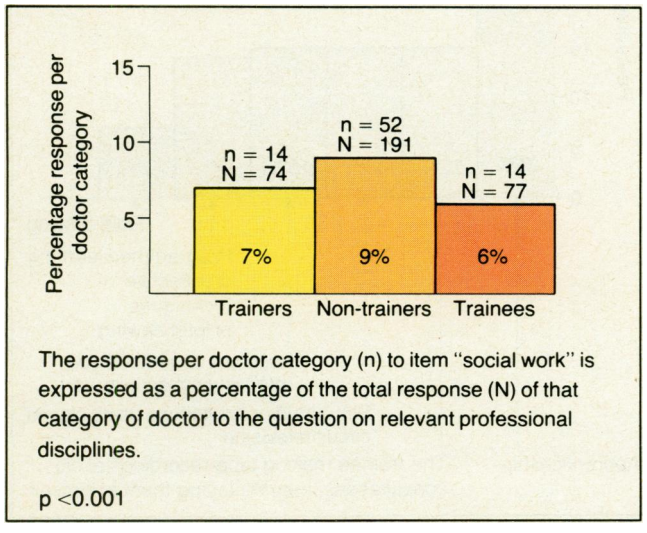
Figure 4. *Percentage response per doctor category to item: "tape-recordings of trainee consultations."*

3. Other relevant disciplines

Marriage guidance (16 per cent of total response to question), social psychology (study of interpersonal relationships: 15 per cent), family planning (14 per cent), and especially psychiatry (21 per cent) were the professional disciplines selected most frequently as being possible sources of knowledge having the most relevance to training for interviewing in general practice. Non-trainers, as opposed to both trainers and trainees, felt strongly that social work and nursing could help in training in the art of consultation (Figures 5 and 6).

Free comments in this section included the following: "Knowledge of interpersonal relationships [is] to my mind of great importance. Only wish I had been able to attend such a course in my early days . . . My life as a

Figure 5. *Percentage response per doctor category to item: "social work".*



References
1. Cimetidine in the treatment of active duodenal and prepyloric ulcers. (1976) Lancet, **ii,** 161.
2. The effect of cimetidine on duodenal ulceration. (1977) Proceedings of the Second International Symposium on Histamine H_2-Receptor Antagonists. Excerpta Medica, p.260.
3. Oral cimetidine in severe duodenal ulceration. (1977) Lancet, **i,** 4.
4. Cimetidine treatment in the management of chronic duodenal ulcer disease. (1978) Topics in Gastroenterology. (In Press).
5. Maintenance treatment of recurrent peptic ulcer by cimetidine. (1978) Lancet, **i,** 403.
6. Prophylactic effect of cimetidine in duodenal ulcer disease. (1978) Brit. med. J., **1,** 1095.

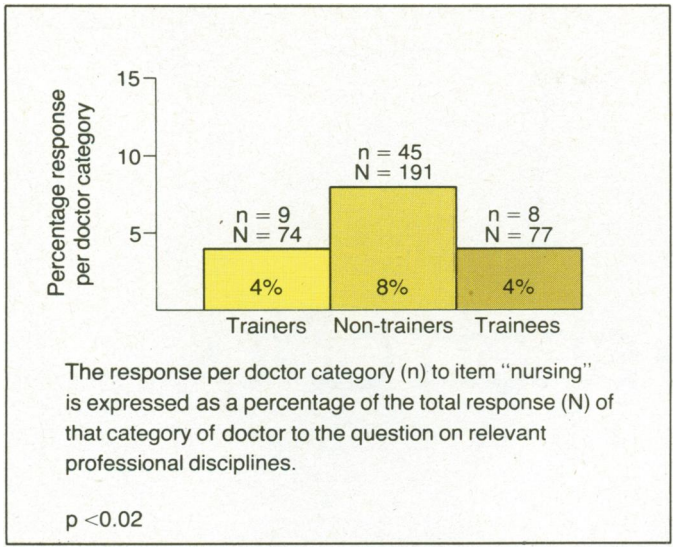
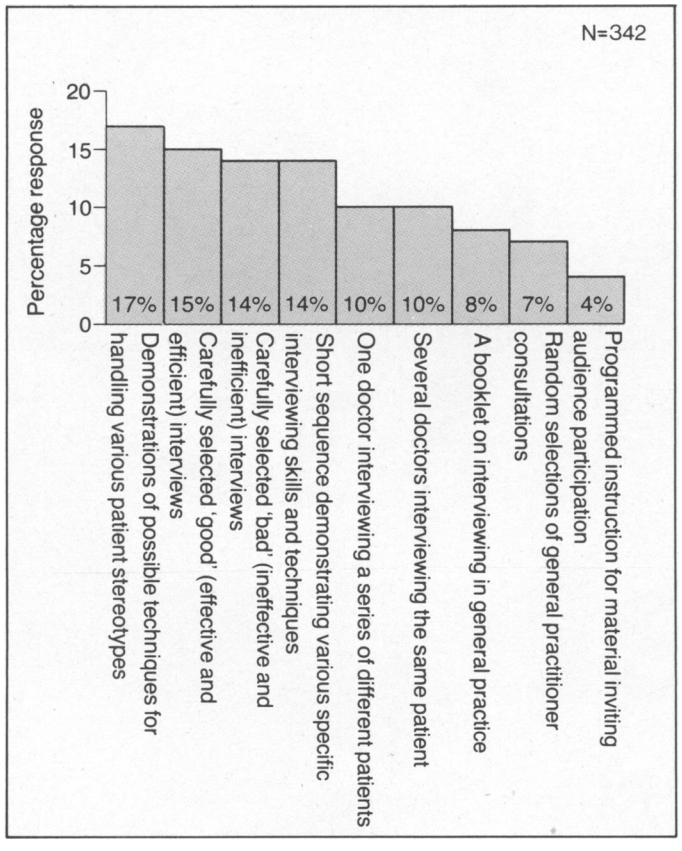


Figure 6. *Percentage response per doctor category to item: "nursing".*

whole and especially my life in general practice related to patients, partners, and staff would have been much easier."

When asked to indicate if there were any other disciplines they considered particularly relevant, doctors responded most frequently in terms of comparative theology, counselling, and interviewing skill from other disciplines such as personnel management and salesmanship.

Figure 7. *Percentage distribution of all responses to the question on useful training materials.*



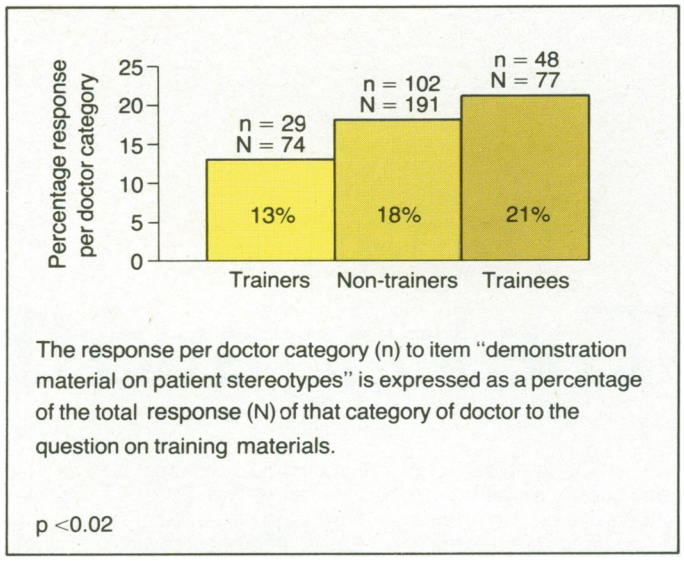


Figure 8. *Percentage response per doctor category to item: "demonstration material on patient stereotypes".*

4. *Training materials*

Responses to the question concerning useful training materials are shown in Figure 7.

It appears that doctors would find material containing demonstrations of possible techniques for handling patient stereotypes (for example, the over-talkative patient, the shy patient, the defensive patient) the most useful out of those presented. Further analysis indicates that trainees are most, and trainers least, frequently in favour of such material (Figure 8).

There is also a general demand for carefully selected 'good' and 'bad' interviews and also short sequences demonstrating various specific interviewing skills and techniques. Non-trainers considered that material concerning one doctor interviewing a series of different patients (varying in age, sex, organic/socio-emotional problems, and so on) would be more useful than did trainers and trainees (Figure 9).

Discussion

The survey is beset with many of the problems of a postal questionnaire—the bias of a relatively low response and possibilities of misunderstandings arising. The subject is personal and there were indications that the idea of exploring this sensitive area was repugnant to some. It was clear from some of the free comments that a small proportion of the respondents (and by implication a larger proportion of doctors who were sent questionnaires but did not respond) questioned the need for any such training; for example: "It is only the odd misfit who needs training. Interviewing is a wealth of common sense, and the medical entrant to university is in the top 10 per cent intelligence group"; and again: " . . . I'm damned if a hairy monster is to practise interviewing me on my death bed as if I were in television.

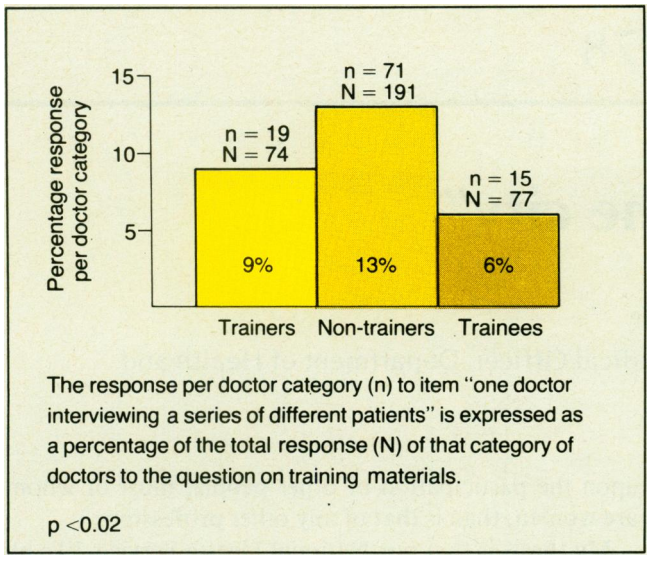


Figure 9. *Percentage response per doctor category to item: "one doctor interviewing a series of different patients".*

If he knows his medical ABC he doesn't need to do a Robin Day." Others read perhaps more into the work than the authors intended, as the following comment indicates: "The above ideas are fine but you produce a cold calculating machine using them. Selection of doctors must be by brain, character, and personality, not just brain, and he should ideally have worked with people before his studies. You can teach a dog to do tricks but Practice equals People of all classes and mentalities . . . " In the absence of any organized data relating to an increasingly important aspect of medicine, the findings likely to interest those directly concerned with training may be summarized as follows:

1. The majority of respondents clearly felt a need for systematized formal training in communication skills. This should follow in a planned sequence based on an introduction early in the undergraduate course, with greater emphasis during vocational training.

2. The *personal* contact (in one-to-one learning and teaching) was clearly expressed as the one most favoured method.

3. Teaching materials were no substitute, but were useful adjuncts in the form of demonstrations, both 'live' and recorded (sound and video) with books and programmed instruction being less favoured. If videotape demonstration material can help trainees to be better communicators, and there is evidence from microteaching to support this (McIntyre *et al.*, 1977), there may be a place for making available on loan to trainers in a region a simple portable videotape play-deck, for use in the practice. In the meantime, greater use might be made of the simple sound tape-recorder, used with due consideration for the ethics of the situation *(Journal of the Royal College of General Practitioners,* 1975).

4. Those disciplines which use counselling skills, such as marriage guidance, were seen as contributing to the knowledge relevant to the trainees' care of patients. Course organizers who incorporate visits to allow trainees to see such services at work might wish to reconsider their educational objectives for such parts of their day release courses.

References

Bennett, A., Knox, J. D. E. & Morrison, A. J. (1978). Difficulties in consultations reported by doctors in general practice. *Journal of the Royal College of General Practitioners,* **28**, 646-651.

Journal of the Royal College of General Practitioners (1975). Tape recording consultations. Editorial, **25**, 705-706.

MacIntyre, D., MacLeod, G. & Griffiths, R. (Eds). (1977). *Investigations of Microteaching.* London: Croom Helm.

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Trial of prostaglandin-synthetase inhibitors in primary dysmenorrhoea

The prostaglandin-synthetase inhibitors, mefenamic acid and flufenamic acid, were compared with the analgesic, dextropropoxyphene-paracetamol, in the treatment of primary dysmenorrhoea in a double-blind crossover trial. Results were assessed in 30 patients who took each drug during menstruation for three consecutive cycles. The patients' assessment of each drug suggests that both mefenamic acid and flufenamic acid are more effective than the other analgesic for general relief of symptoms and for most of nine individual symptoms subjectively assessed by the patients. There was less abstention from work or school during treatment with mefenamic acid and fewer capsules of mefenamic acid were taken compared with the other two drugs. Patients took significantly fewer additional analgesics during mefenamic acid therapy than during treatment with the other two drugs. Five patients had possible side-effects, three of whom were patients on mefenamic acid and two who were taking dextropropoxyphene–paracetamol.

Reference

Anderson, A. B. M., Fraser, I. S., Haynes, P. J. & Turnbull, A. C. (1978). *Lancet,* **1**, 345-350.