

Teaching about learning in a consultation

I. MARSH, MRNZCGP, DRCOG

General Practitioner, Auckland, New Zealand

SUMMARY. The concept that a diagnostic interview is an education of the doctor by the patient is advanced. The application of educational theory to the interview is examined and inferences about training are drawn.

Introduction

TO diagnose: to identify by careful observation (*Shorter OED*). Thus, to diagnose means to acquire a new piece or pieces of information, in other words, to have been educated. In so far as a consultation is concerned with diagnosis, and surely diagnosis is a primary objective, then it becomes an educational experience in which a lesson is given by the patient to the doctor: the patient teaches the doctor about himself, his illness or problem(s). If the consultation is seen in this light, educational concepts can be applied to it.

Exposition

In normal educational practice the teacher decides what it is he wants his pupil to do (writes behavioural objectives), and then devises methods to enable the pupil to achieve those objectives, having assessed what his pupil already knows (diagnostic assessment). Except in sophisticated educational programmes the pupil's role in making these decisions is small. It is often, and probably correctly, said that one cannot teach, but only facilitate learning. The doctor therefore has a peculiarly difficult task. Although he is a pupil, it is he who has to arrange the whole environment (physical, social, and emotional). His teacher-patient can then formulate his objectives and needs, and present them as best he may using such methods as he has available, even though these may be inappropriate, oblique, or indirect. The pupil-doctor must be especially motivated to learn, because he may otherwise mistake what his patient is trying to teach him.

When the doctor has been able to allow his teacher to achieve his task and teach about the real problem(s),

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patient and doctor will come to agree on a complete diagnosis and share a common goal; the process of the consultation will be smooth, even though it may be impossible to arrive at a correspondingly successful treatment. When a common goal is not shared the process will go wrong, and then usually both patient and doctor are dissatisfied. This common goal may not, of course, be achieved in a single consultation or even in a short series of consultations, but it must be the overall aim of the doctor. As soon as the patient has completed his task of educating the doctor, the roles of pupil and teacher must be reversed, in order that the doctor can help his patient to learn new things about himself, his illness, or his problem and how to manage them.

Educational objectives

Objectives which describe behaviours have been classified by Bloom (1965) and others into different levels (hierarchical taxonomies), in which the higher order behaviours are possible only when lower order ones are mastered. Bloom describes three taxonomies, or classes of behaviour: cognitive, of learned knowledge; affective, of relationships, emotions, and attitudes; and psychomotor, of physical skills. The last is obviously relevant to medicine but not to consultations and I will not consider it further.

Cognitive behaviours: knowledge

The cognitive taxonomy (Figure 1) is immediately applicable to what I have been discussing. During a consultation the doctor has to recall certain facts about health and disease, to comprehend their meaning, and to apply them to the particular case. He will then analyse these facts and synthesize new propositions, both about the patient in front of him and about medicine in general. Finally he will evaluate these new propositions and also his part in solving the patient's problems. Analysing and synthesizing are at the top of the hierarchy of behaviours in the cognitive domain; they are the desirable culmination of teaching in this field, but they are achieved all too infrequently. Methods of continuing education which encourage doctors to work in these two behaviours are much needed. Since they demand application and creative ability they are hard work.

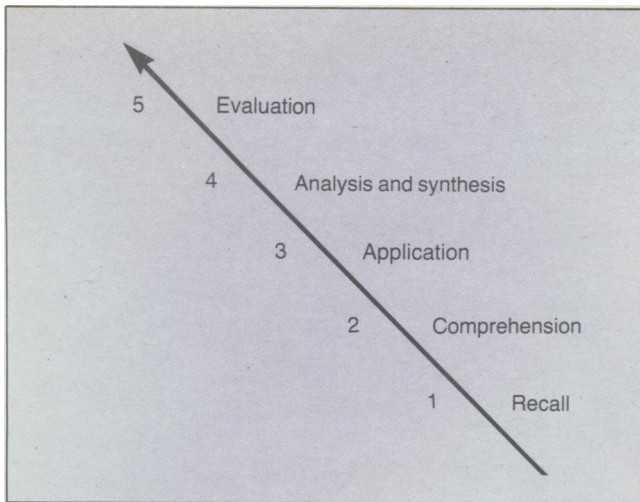


Figure 1. Taxonomy of cognitive behaviours (knowledge).

Affective behaviours: attitudes

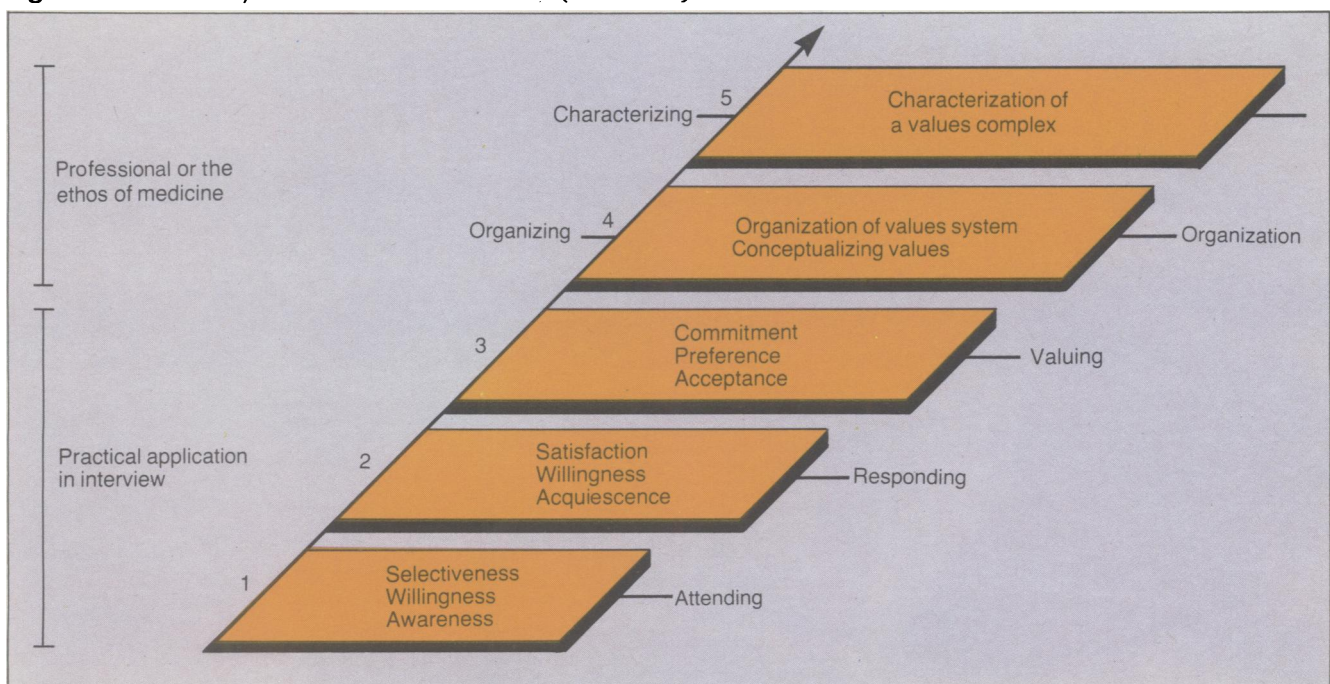
Educational theory is at first sight less applicable to the affective domain (Figure 2). I must stress that in this context I mean a hierarchy of behaviours learned and later exhibited by doctors—the doctor’s affect, attitudes, and set of values—I am not describing a classification of psychoneurotic illness. In Figure 2 some divisions of the main classification have been included to make the taxonomy immediately relevant. The lowest order objective shows that the doctor must first learn to attend to his patients. Audio tape recordings of actual consultations (Byrne and Long, 1976) have shown how frequently a doctor is doing other things—writing notes about other patients, signing prescriptions, briefing his

nurse, talking on the telephone, or answering an internal call system. All these things occur during consultations, so that at times the doctor barely shows awareness of his patient. He needs to be aware willingly and later selectively of what the patient says and does. This awareness is a learned skill. The next order of objectives shows that he must then respond to what his attention has detected. Audio recordings have again demonstrated a frequent discontinuity between a patient’s statements and the doctor’s response, so much so that Byrne and Long (1976), in their research on the interview, regard the patient’s component as no more than a random event in determining the doctor’s response. What the doctor must learn is first to acquiesce in responding to the patient’s input and not to his own (medical) need, then to respond willingly, and last of all to achieve personal satisfaction from finding that responses of this kind promote useful consultations.

It is the manner of the doctor’s response which is of overriding importance. Even if he chooses to limit himself to symptoms of organic disease or to symptoms of one particular organ system, he must respond in such a way that he enables the patient to do the wide range of teaching described above. He himself will have to learn to tolerate the stress and distress which these methods produce in patients, and at times even to create stress in order to stimulate the release of information instead of damping it down by ‘reassurance’. When the doctor has had sufficient experience of these responses to see how effective they are, and when he comes to value them and be committed to them so that he now works in this way, he has reached, so far as the consultation is concerned, the highest behaviours of the affective domain.

The uppermost behaviours shown in Figure 2 are

Figure 2. Taxonomy of affective behaviours (attitudes).



concerned more with the ethos of medicine. These behaviours constitute what is probably the most important learning doctors ever do, but they are seldom the subject of any formally written objectives or teaching. Because they do not concern the mechanics or process of the consultation they will not be pursued here, but it is worth pointing out that they are learned in the same way as all the other affective behaviours, from personal experience of the emotional content of medical interviews. This learning is most easily arranged in small groups.

Cognitive and affective behaviours combined

The whole group of affective behaviours—attending, responding, and valuing—may be said to determine the process of the interview. This process in its turn, by allowing of a wide compass, will influence the content. The content itself will demand that the doctor uses special verbal skills, which are behaviours of the cognitive domain. Figures 1 and 2 show cognitive and affective behaviours arranged in levels or hierarchies; if a doctor is working at a given level, it follows that he is using behaviours at or below that level, but none above it.

In Figure 3 I have tried to show graphically a model of the consultation in which the behaviours in the cognitive and affective domains are combined to form a triangle representing the amount of work done. Figure 3a represents a consultation at the level of recall (cognitive domain level 1) and awareness (affective domain level 1), whereas 3d is at the much higher levels of evaluation and commitment to a value. Figure 3b represents a consultation typically seen in hospital practice, where the doctor works at a high level of cognition

but a much lower level of affect, and 3c—rather a rare type of consultation—is one seen in doctors who suddenly become aware of the emotional content of medicine. The amount of work done can be seen to be much reduced in both b and c when compared with d.

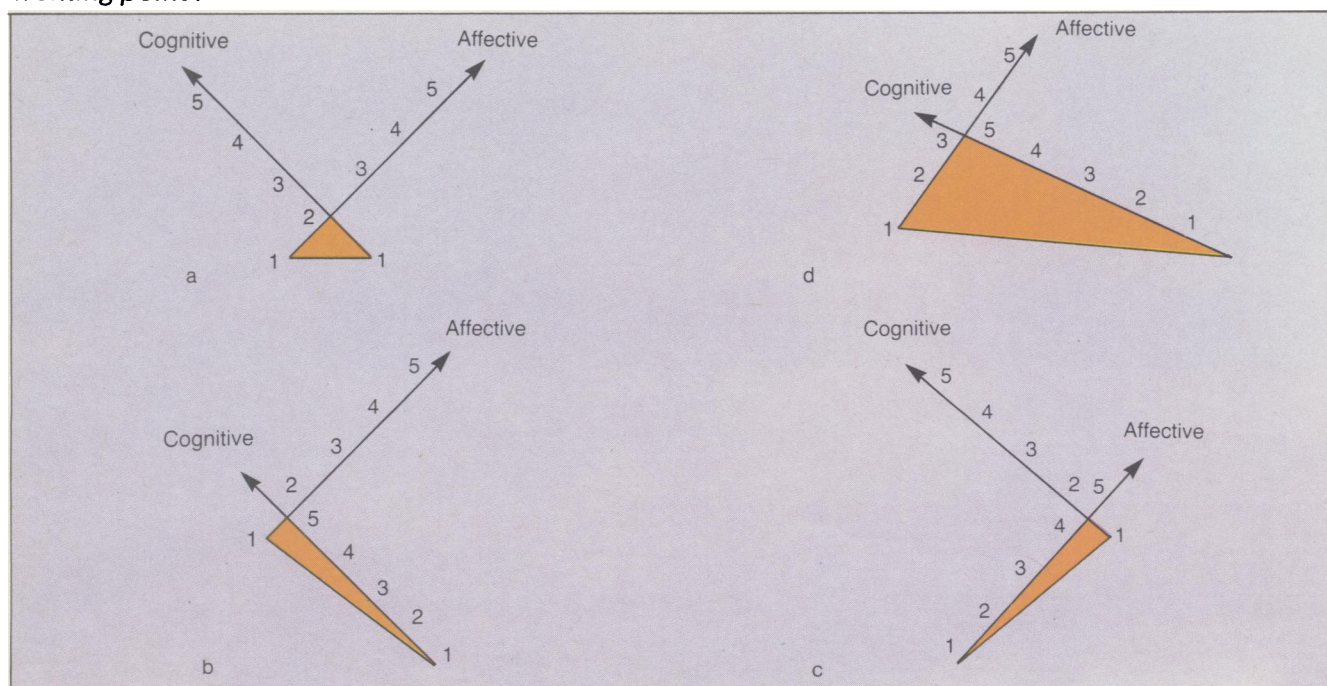
Learning the art of consultation

In *The Future General Practitioner* (RCGP, 1972) it is suggested that educational objectives can be classified under five headings:

1. Recall of factual knowledge
2. Performance of manual skills
3. Employment of knowledge and skills
4. Demonstration of interpersonal skills
5. Demonstration of self-understanding.

Later workers subdivided 4 into social skills and interpersonal skills. It is an oversimplification to assume that knowledge and the use of knowledge and skills correlate with behaviours in the cognitive domain, and that demonstrations of interpersonal and social skills and self-understanding correlate with behaviours in the affective domain. Observation of doctors in training suggests that they often fail to respond to their patients because they lack the necessary interpersonal skills to do so. These skills are matters of cognitive learning: it is the knowledge of how to use the appropriate verbal and non-verbal skills which these doctors must acquire. A scheme for doing this has been devised by Byrne and Long (1976). It may be said that the willingness to allow patients to explore all their needs is part of the doctor's affective training, the wherewithal to do it of his cognitive training. Without knowledge the affect is

Figure 3. Models of consultations showing the affective and cognitive elements crossed at the doctor's 'working point'.



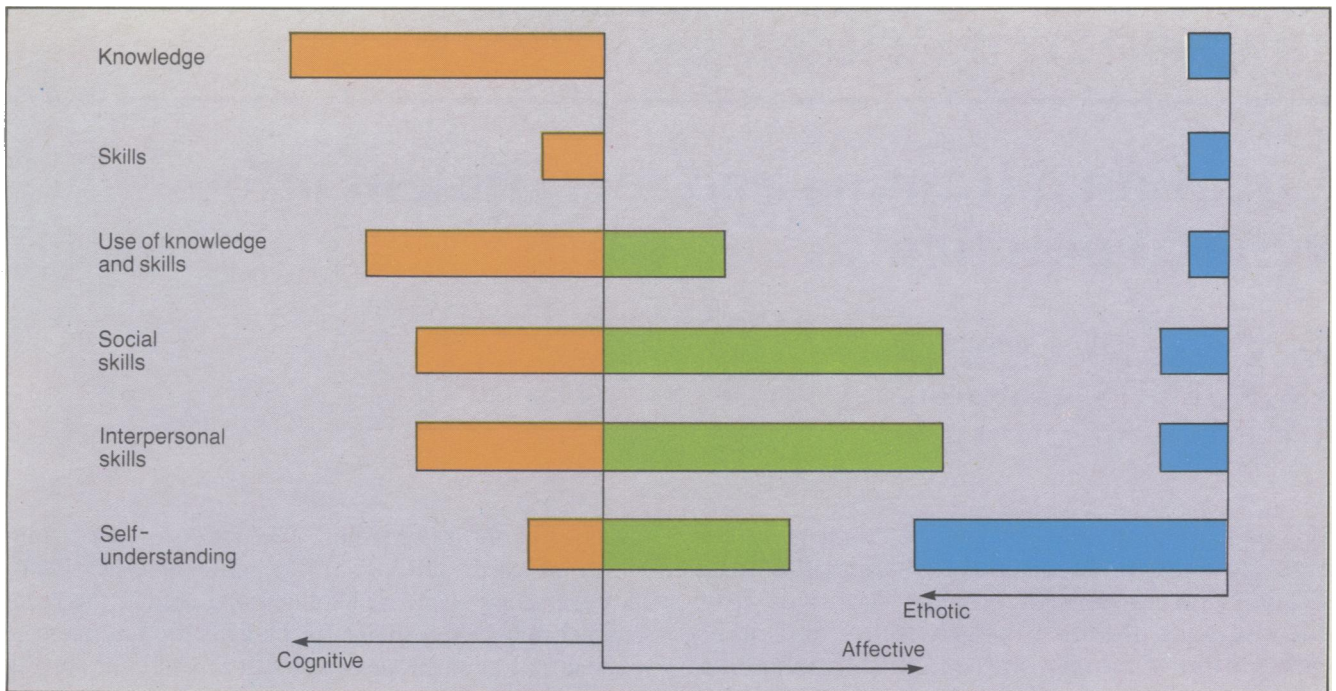


Figure 4. The contributions of narrow objectives from the cognitive and affective domains to the broader aims of training.

powerless, without affect knowledge is useless. The intertwining of the two is the art of the consultation.

Figure 4 is an attempt to show the relative sizes of the contributions which narrow or circumscribed objectives from the cognitive and affective domains make to the broader aims of training. The affective domain has been split as previously described. Figure 4 is based on my subjective assessment of apparently successful consultations and must reflect my personal bias. It is in a sense a statement of ideals against which other consultations may be measured. It will refer more to the balance within a number of consultations than to a single one. Perhaps every doctor who has a teaching commitment needs to make such a construction for himself. Its importance lies in the justification it gives to allocate resources—particularly time—to affective as well as cognitive learning.

The importance of the ethos of medicine as a separate

area of affective learning also becomes obvious. Learning about a values system that will continue with the doctor all his working life comes to be seen as a part of training, for herein lies the difference between the good and the merely clever doctor.

References

- Bloom, B. S. (Ed.) (1965). *Taxonomy of Educational Objectives. Handbooks 1 and 2.* London: Longman.
- Byrne, P. S. & Long, B. E. L. (1976). *Doctors Talking to Patients.* London: HMSO.
- Royal College of General Practitioners (1972). *The Future General Practitioner—Learning and Teaching.* London: *British Medical Journal.*

Acknowledgement

My thanks are due to Mrs L. Whiston, who carefully typed the manuscript.

Work of the practice nurse

During a four-year study period 43,985 patients were seen in the treatment room and 61,806 coded procedures carried out. Thirty per cent of these procedures were not part of usual nursing curricula and required initial supervision and assessment or training (or both). Nearly 15 per cent of the patients seen were making a first visit and did not require referral to a doctor. A further 17 per cent were also making a first visit but were referred to a doctor.

The treatment room made an important contribution

to the work of the practice, but this would not have been possible if the staff concerned had been attached nurses requiring area health authority authorization for procedures carried out, as opposed to practice nurses for whom procedures were authorized on a personal basis.

Reference

- Waters, W. H. R., Sandeman, J. M. & Lunn, J. E. (1980). A four-year prospective study of the work of the practice nurse in the treatment room of a South Yorkshire practice. *British Medical Journal*, 280, 87-89.