The beleaguered consultation

The consultation is the central event in medicine at which the hopes fears and expectations of the patient meet the knowledge, skills and attitudes of the physician. From this event emerge the prescriptions, and treatment plans that healthcare systems struggle to afford. Performed well the collaboration in the consultation is one of the purest examples of the second commandment in action, to love our neighbour as we love ourselves. Performed badly the consultation can be a venue for rejection, misery and complaint.

The central importance of the consultation was well described in *The Future General Practitioner*.[1] This book has set the frame for general practice learning and teaching for the past 33 years. Its recommendations have directly led to modern medical standards such as summative assessment and 'Good Medical Practice'.[2–4]

The positive side of the consultation has been celebrated by many authors.[5–8] The celebration is of the combination of professional skill with compassion unfolding into a long-term continuing relationship between doctor and patient.[9–11] The achievement of this relationship is seen as the embodiment of the aspiration of the college motto, *Cum scientia caritas* (knowledge with compassion).

In this essay I want to acknowledge this work and its achievements. I want to thank my trainers for making me think about my consultation style and therefore helping me improve it. I would love to spend the rest of my career enacting the skills I have acquired.

However, although I recognise this I need to say that I find the conditions in which I practise do not allow me to fully deploy my abilities. I have a grief that there are forces arising that threaten to damage the practice of medicine. If unchecked they will nullify the great professional drive to practise good medicine. This will harm both the givers and recipients of medical care. These forces are massed around each and every consultation. If we fail to deal with these forces then we as a profession and I as an individual, face professional failure.

In this essay I want to name these inimical forces so that we can all see them for what they are. In doing this I am following the example of Admiral Stockdale, the American admiral, captured and tortured by the North Vietnamese in the Hanoi Hilton between 1965 and 1973.[12] He states, from his experience, that,

> *'This is a very important lesson. You must never confuse faith that you will prevail in the end — which you can never afford to lose — with the discipline to confront the most brutal facts of your current reality, whatever they might be.'*

As a profession we need now to confront the brutal facts of our current reality.

TIME SCARCITY

Sir Clifford Allbutt notoriously described general practice as, 'perfunctory medicine performed by perfunctory men.' Like all gross caricatures it has an element of truth in it. One example will suffice. A patient wants to move on to her fourth item. She has already had 12 minutes of a 10 minute slot. I point this out to her. She is offended and says, 'The last doctor always had time.' 'Yes,' I reply, 'and he also always finished an hour late.'

This example embodies the tension between meeting every need of the patient and balancing her needs against those of the next patient and those of the doctor to get to end of his daily work. If I was a business man charging by the item, or by the minute not meeting this lady's needs would be lost business opportunity. In a time and resource limited service this is the kind of sharp time constraint necessary to get through the day.

To this patient I may well have seemed a perfunctory clock-watcher.

We need to realise that the general practice consultation is a time poor environment. We need to be clear to our patients and paymasters that consultations are short, and that patients who present focused problems are likely to get better results. We can say all we like about the exceptional potential of every consultation but without time this will not be fulfilled.[13,14]

RESOURCE SCARCITY

Medicine is an expensive activity and money has to be found for it. The British NHS[15] was, and is, rare in attempting to provide free access to all care.

The fiasco over the introduction of Viagra® is just one example of how resource scarcity prevents doctors from rising to the challenge of unmet need.[16] As a doctor I would sooner get on with treating the patient, rather than explaining why I am acting as an agent of irrational rationing.

The advent of practice based commissioning threatens to make this conflict between meeting the needs of the individual in front of me against the overall health budget of an area even sharper.[17,18] There is an irreconcilable role confusion between the role of GPs as the gatekeeper to NHS resources and their role as advocates for their patients.

INADEQUACY

Fear of inadequacy is huge in medicine.[19] For GPs it is a huge fear and regularly some specialist comes out with a report that says, 'GPs do not diagnose or treat this particular disease as well as specialists.'

To give recent examples GPs have recently been criticised for under diagnosing and under treating heart failure, eating disorders, and cancer. These are all major areas of medical activity. If our practice is as bad as these experts imply should we really be allowed to continue working at such a low standard? Are we really perfunctory men and women carrying out perfunctory medicine?

To some extent of course as GPs we are. What we offer is a quick, mostly accurate assessment of the patient and then call in specialised help that may not be immediately available. Of course GPs could always do better, but so could everyone. There is always a knowing/doing gap[20,21] and we will all let someone down at some stage.

What is really galling here is not the expert saying he or she knows more about their area of expertise than non-specialists. What is galling is the misguided attempt to superimpose the narrow focus of the specialist over the broad and balanced vision of general practice. Philosophically this is known as the error of mistaking a part of something for the whole of something.

LOSS OF TOLERANCE AND TRUST

Engineers have 'tolerances.' Physicists describe their 'approximations.' GPs are more like physicists than engineers. We work to a close approximation which will rarely have the specificity of a diagnosis from a radiologist or histopathologist. It requires a different mindset to work with approximations as opposed to exact entities.

As GPs we are what Haslam[22] describes as the 'risk sink' for the NHS. We absorb much of the uncertainty inherent in medicine and life and so reduce the demand on expensive secondary care facilities. We do so reasonably accurately, but we will never be totally accurate in doing this. We try to sort out the more serious from less serious cases and refer appropriately. However we know that at some stage we will make a mistake and that then there will be major personal consequences for us as well the patient. This is the burden carried by GPs.

If the NHS as a system, the GMC as regulator, and our patients as consumers will no longer accept our approximations as being sufficient, then general practice and our 'management of uncertainty' will fail.

MISUSE OF MEDICINE TO ILLEGITIMATE ENDS

The aims of medicine are noble, including the description and treatment of sickness and suffering in most of its forms. However many patients find that they get other gains from the sick role. So rather than observing the terms of the sick role some patients use the fact of their disease as a means to other benefits for them.[23–26]

For people with severe disease this is a fair process. For those who try to use gastroenteritis or dysmenorrhoea as a reason to miss work or to excuse attendance at court when they really had just not turned up is a misuse of medicine. The phenomenon of welfare claimants being told to 'get a note from your doctor' is a sad reflection of how low trust in society has become.[27]

As doctors we need to reinforce the boundary between illegitimate and legitimate claims on medical time and resource. And it would help if the politicians would back us as we do this. Not all patients are innocent victims of disease wanting to get better and we need to face this fact. The political drive to cover the unemployment figures by reclassifying people as incapacitated has been a major social, rather than medical, phenomenon of the last 20 years.[28]

INDECISIVE MANAGEMENT

Almost everyone agrees that the NHS is a good thing. Nigel Lawson said that the NHS is 'the closest thing the English have to a religion.' Rabbi Julia Neuberger described the NHS as being like a theological institution.[29] Although many people believe the NHS is a good thing the question begged is good for what purpose?

At present we do not know what the NHS is meant to achieve.[30] As a consequence of this managers are confused and so can end up 'managing not to manage.'[31,32] The result of this comes up in the conflicting imperatives known as double binds. So for example we experience,

> *'You must diagnose depression and affective disorders more frequently … but … (3 years later) … you are prescribing too many antidepressants.'*

The number of people who profess to offer advice to GPs is huge, but the number who will come and see patients with us is actually very small indeed. The managers who cannot understand that waits for appointments will go up if we go to too many meetings are just one example of managing not to manage. No doubt they will call another meeting to discuss the problem.

As doctors we get caught in the eddies of indecision.

PASSIVE AND ACTIVE AGGRESSION

This is experienced by most who work in the health service at some stage of their careers.[33–37] The active version is direct physical violence usually by patients on staff.

The more subtle version is passive aggression in its classic forms, 'You wouldn't want to rock the apple cart would you?' The correct response is, 'the apples are rotten already.'

The presence of direct and indirect threats to the personal safety of practitioners is not conducive to free and open communication between doctors and patients.

EXCESS OF EXPECTATIONS

In business the rule is to under promise and over deliver. The customers are then delighted to get better than expected results. In the NHS we do the opposite, we over promise and under deliver. This guarantees disappointment all round and makes it difficult to tell patients that everything sensible has been done for them. McEwen[38] describes exactly why

such a strategy is a recipe for disaster. A cash limited, time limited service can never provide everything everyone wants, and the country needs to be able to live with this.

COMPLAINTS

The NHS cannot provide everything everyone wants from it. And when people fail to get their expectations met they tend to complain. Furthermore mistakes are inevitable both by patients and doctors as no-one is perfect. In a sensible system such imperfections would be allowed for and accommodated. However for all the fine words about 'blame free investigations' and 'an organisation with a memory' the reality for most doctors exposed to complaints processes is that they are very much about name, shame and blame.[39,40]

The fact that a patient can use the threat of a complaint as a means towards getting a doctor to comply with his or her demands tips the balance of power away from the doctor in the consultation. The aim of the consultation is not for one side to overpower the other but for mutual understanding to emerge. The threat of complaints hinders achieving this aim.

Avoiding complaints by defensive medicine is a creeping, often un-acknowledged practice. It can always be hidden as 'taking extra caution.' However it is driving extra referrals and investigations. It is hindering good medicine and pushing up health care costs. No one is really benefiting from this culture.[41–46]

LITIGATION

'Courts, damages, newspapers, and all that sort of thing.' Sir Lancelot Spratt's summary beautifully catches what most doctors think about going to court for any reason. Lord Denning put it thus, 'an action for negligence against a doctor is for him unto a dagger. His professional reputation is as dear to him as his body, perhaps more so, and an action for negligence can wound his reputation as severely as a dagger can his body'.

You can see from this why doctors fear litigation against themselves. The rise in negligence actions against doctors may be justified in terms of damaged patients deserving compensation. However at a higher level the whole process is damaging to the process of consultation which cannot necessarily withstand minute scrutiny especially when past events are viewed from the frame of a known outcome. We live life forwards, and as a Sheriff's officer put it, 'courts have all the wisdom of hindsight and regret.'

LOSS OF CONTINUITY

One of the defining characteristics of general practice used to be its pattern of ongoing relationships with patients.[9,10] This is now changing rapidly,[47] and this process will change the nature of doctor–patient consultations. Taken with the increasing sub-specialisation in hospitals it leaves a risk that patients end up having medical care in a series of disjointed episodes rather than as a continuous whole. This may be a good pattern for acute problems but it leaves the old, the mentally ill and those with multiple morbidities at risk of ill planned purely reactive care.

The great strength of general practice is with those who have ongoing and multiple problems and if we lose this strength many of the weaker, and less vocal, in our community will suffer.[48] Also the costs of caring for them will increase.

Peters[49] points out that in blue collar jobs machines have reduced the need for labour by 98.5% over the last 100 years. He predicts that professional jobs could be broken down into parts and become 'blue collarised' in the future. There is a risk in this that what can be counted will be what is measured, and that that which is difficult to count will be deleted from the record. Consultation skills are difficult to count and so may not appear on the official record.

LOSS OF CONFIDENTIALITY

Confidentiality is considered crucial to allowing doctor and patient to trust each other so that full details of the context of a patient's symptoms can be appreciated. However in medicine confidentiality is being reduced as the need to share information around the NHS is beginning to take precedence over the patient's rights to secrecy of the information.

Medical information is now being used for many purposes, many far removed from the original purposes for which the data was gathered. The whole industry of sickness benefits, compensation for mistakes and injuries depends on release of apparently (and originally) confidential medical information to outside parties. Maintaining confidentiality is impossible in these circumstances.[50–53] To pretend that we are confidential is currently misleading.

MEDIA MISREPRESENTATION

Korzybski said, 'The map is not the territory, it is a representation of the territory, and its use depends on its accuracy to the territory.'

The media give the public, which includes doctors, a map of reality but it is rarely entirely accurate. Doctors are portrayed either as 'top experts' or 'dangerous and deadly.' Most of us are somewhere between Roger Neighbour and Harold Shipman as GPs and most of us are trying to provide a reasonable service, to the best of our ability under time and resource limited circumstances.

'Who sets the frame will set the game' and with the media it is the editor who has the great power to set the frames of debate. Piers Morgan describes well exactly how and why this done.[54] We could learn much from him about how better to represent ourselves.

CONCLUSION

In this essay I have started from the premise that the aim of general practice is the building of useful and therapeutic relationships with patients. I see this as being good for both patients and doctors. I have listed the ways in which the doctor–patient relationship is currently coming under threat.

I have described the view from the general practice consulting room. Most of what I have said here would apply to hospital doctor–patient interactions.

If a professional life based on relationships and service ethos is to survive and even flourish then we need to deal firmly with the threats to good consultation that are currently massing around the doctor-patient relationship. We need to make this relationship central to the practice of medicine.

'You have a very difficult job to do doctor, and my job is to make it easier for you'.

So said an old fashioned administrator many years ago and it is doubtful that he would even get a job now thinking like that. The supporting structure of the NHS must exist to support in turn the doctor–patient interaction and at present it seems to hinder it.

Until we deal with the threats to the consultation, the central event in medicine is beleaguered and the effectiveness of medical care reduced. This is bad both for patients and doctors. The great era of general practice development that followed from the thinking represented in *The Future General Practitioner* is coming to an end, and my generation of GPs is going to have to take the courage to renegotiate and rewrite its understanding and contract with both itself, and the public it serves.

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