

# The Review

## The crowded consultation

Have you ever asked yourself just how many people are actually present in your consulting room? You should, as it is an interesting reflection. Let me show you why. For example you may think you are just dealing with a quiet afternoon appointment between you and Mrs Ackroyd, who is a 65-year-old lady who you know well and like. But actually, who else is also in the consulting room, either by invitation, or has muscled their way in by force, or inveigled their way in by implication? Let us have a look at this question.

### THE PATIENT'S SIDE

We will look at Mrs Ackroyd's side of the consultation first. Why has she come today? Who or what has prompted her to come? Now this is a fairly standard MRCGP-type question and it can be answered with reference to her lay medical network and her health beliefs around her symptoms and their perceived level of severity and seriousness.

Briefly in this case we know that she has significant relationships to her family; her husband who is at home digging the garden, her daughter who is a nurse, her neighbours, her friends and acquaintances, and that she is an avid reader of the newspaper medical column. She has had various past experiences of health and illness, and usually has had a good experience of the surgery, the doctor, and the staff. She is basically stoical, and can usually handle external information sensibly without either diminishing or exaggerating its accuracy and relevance to her own case.

She may have either an obvious intrusive symptom such as pain, or an embarrassing problem that she has not mentioned for years and finally it has got bad enough for her to come and seek medical advice. At the start of the consultation she may still not be sure whether she dare mention it or not.

She may well have chosen you as you are the doctor in the surgery who is known for listening well and who she thinks she can present her problem to. Or it may be a duty doctor surgery and she just wants some quick treatment for her chest.

However, and for whatever reasons, Mrs Ackroyd has arrived in your surgery, it is clear that there are far more people and events involved in her arrival at the

consulting room than just Mrs Ackroyd. It's not just about Mrs Ackroyd.<sup>1</sup>

Good GP consulters know this and as part of the consultation they often tease out who these significant others are and what role they have played. Part of the treatment plan is often to work out what messages to send back to them.

### THE DOCTOR'S SIDE

What about the doctor's side in all of this? Who is whispering in our ears, and trying to influence how we handle what we do with Mrs Ackroyd?

#### Our prior experience

There is our prior experience with her. We know what sort of a person the patient is, and what sort of consultation she is likely to want and need. We are ready to adapt our style accordingly. I sometimes wonder if GPs should be described as 'generally pleomorphic'. It is one of our great strengths as GPs that we can usually adapt our style to treat almost everyone from the local landowner to a skid row alcoholic.

#### Our basic medical knowledge

Then there is our basic medical knowledge of symptoms and their significance. Hopefully our basic medical training and our continuous professional updating has equipped us well for this. But this basic information is not neutral and unbiased, either in its presentation, its compilation, or our interpretation of it (Moran *et al*, unpublished data, 2012). Also, our cognitive biases lead us to have weak spots in some areas, and also to have some misperceptions and misvaluations of the evidence that we have considered.<sup>2</sup> We all have a view of medicine, which has some similarities between ourselves and many idiosyncrasies and differences. We are not a completely consistent tribe of professionals, and intra- and inter-

practitioner variation is the norm, not the exception. Why do we get so surprised and worried by this?

#### Consultation ability

Then there is our ability to consult well with the patient, what history we can collect from them, and how we can formulate and discuss the problem with the patient. The discipline of repeatedly taking a good history in every consultation is a tough one, and we probably each do it too many times a day. The fact that some doctors get less assiduous at the task over time is probably in part a function of this attrition.

#### Shared understandings?

From this hopefully shared formulation the doctor can then come to know which are the relevant bits of our medical knowledge to bring forward to help Mrs Ackroyd, and equally important, which bits of our medical knowledge are useful background for us but not relevant to Mrs Ackroyd this afternoon.

#### Interventions and their suitability

Then there is our ability to investigate and refer further if necessary. As the surgeons put it, 'A good surgeon knows how to operate, a great one knows when to operate'. Hopefully we get this balance right in practice, but it is a fine line. We go back to Hippocrates and, '*Ars longa, vita brevis*'. As doctors we rarely know our personal specificity and sensitivity as decision makers.<sup>3</sup> Furthermore, the medical evidence is rarely accurately enough known to determine what set points of sensitivity and specificity we should operate at for any particular symptom or collection of symptoms. The work of William Hamilton<sup>4</sup> and Roger Jones,<sup>5</sup> among others, on the significance and predictive values of common symptoms in primary care over many years helps us here, but they would be the first to admit how much more needs doing to refine

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*"Hidden agendas in the consultation? Yes, there are rather a lot of them about, aren't there?"*

#### ADDRESS FOR CORRESPONDENCE

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our basic accuracy of symptom analysis in consultations. This leads us to struggle to define the utility of the individual decisions we do make. We also fail to account for the utility of other decisions we could have made. We struggle to know whether we have made the best choice of action in any given scenario. We struggle even to define the terms in the question, and whose viewpoint we are answering it from.<sup>6</sup> It's not easy, and as Hippocrates summarises:

*'Ars longa, vita brevis, occasio praeceps, experimentum periculosum, iudicium difficile.'* (Life is short, the art long, opportunity fleeting, experiment treacherous, judgment difficult).

This lack in the medical evidence applies to both the level of an individual doctor attempting to apply it with an individual patient, and at the wider system level when you review how the doctors in an area handle a particular problem.

#### The problem with our advisors

Behind all this is an army of 'advisors' who all want to help doctors make better decisions. These may be the local commissioning group trying to advise on which investigations are helpful in certain scenarios. They may want you to follow a particular local care pathway. It may be the guideline setters at the National Institute for Health and Clinical Excellence or Scottish Intercollegiate Guidelines Network, or similar organisations, who want to tell you how to treat a particular condition because they have read the evidence, and interpreted it correctly, and they know what should be done. The guidelines are conspicuous by being a bit Delphic — they give a less clear basis for action the closer you get to any one particular patient. All of these most worthy advisors have their own biases that they do not acknowledge, and their own blind spots either because the relevant knowledge does not exist yet, or because they are ignorant of it, or have chosen to ignore it (Moran *et al*, unpublished data, 2012).

Is your consulting room starting to feel crowded yet? Are there more people involved than just you and Mrs Ackroyd?<sup>1</sup>

#### Significant others

*Local colleagues.* Your senior partner thinks you are too soft and kind to Mrs Ackroyd. He is worried that you are encouraging doctor dependence.<sup>7</sup> He wants you to speed up your consultations. You had a conversation with him about such issues last week.

And then the receptionists want to get away early tonight as it is the Christmas party and they want to get ready for that.

*The computer.* We have the computer and its alerts that function as demands for additional information. Its message seems to be, 'I know you care doctor, but you must fill out the following while you're at it ...' Behind that you can hear the QOF inspectors adding, '... to show that you care properly, doctor'.

*The next patient waiting.* You have your appointment system. You want to answer Mrs Ackroyd's questions as fully and accurately as you can but you can see the clock moving on, and the computer says there are other patients arriving in the waiting room. How will you solve the problem of the one versus the many?

*Your own ideals.* Do you have your internal map of what a good and complete consultation would look like? Have you touched all of Stott and Davis's four quadrants?<sup>8</sup> Have you gone on a 'Neighbourly' journey?<sup>9</sup> You have your internal conscience, and your endless sense of incompleteness — that sense of rush throughout the day, and of what many over time have described as, 'So much done, so much undone'. At the back of the mind lurks, 'What am I missing today?'<sup>10</sup>

*The external ideals.* You have your clinical governance structures, and some fear of complaints. Will all this look OK if it ever gets reviewed? Are the notes written well enough?<sup>10</sup>

#### SO MANY PEOPLE

From the above you can see just how many people with different hopes, ideas, and concerns are all trying to claim a bit of attention in any consultation. So many people, so much activity, so many

demands, most of them at least partially legitimate. As the sociologists may put it, your conversation with Mrs Ackroyd is taking place within a 'contested space'.

Hidden agendas in the consultation? Yes, there are rather a lot of them about, aren't there?

How could we simplify all this?

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#### Provenance

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