The Review

The consulting room fog

A DREAM OF GOOD PRACTICE

I have a dream, that one day all my diagnoses will be accurate, my prescribing decisions coherent, and my coding fully accurate. I dream that I will appreciate the bigger picture and the wider context, and put everything together into that useful synthesis that we call a diagnosis.

And I dream that all my colleagues are wanting to achieve exactly the same: that logical sequence of history, examination, diagnosis, investigations, and treatment done repeatedly, accurately, and reliably that marks out careful, considered, and coherent medicine.

And I dream we will do all this with great style, compassion, and care for our patients, who will understand what is happening to them, and knowledge of who can do what about it.

WAKING UP IN THE SWAMP

And then I wake up and in comes the Information Management and Technology Directed Enhanced Service and its searches. The part I am sorting out is the respiratory section, but similar findings have been made in other areas of activity, and my colleagues are checking them. It shows that my colleagues and I are not fully coherent and lucid in our treatment of patients. The computer searches point at us Paxman-like and ask:

'Look you used an asthma treatment here. Surely that means you were thinking about asthma? Why haven't you coded it as such? This must be a case of asthma mustn't it?'

And in the background I can hear researchers chiding us for poor case definition, inaccurate diagnosis, and under-ascertainment of cases. Also some criticism for misdirected, sometimes expensive and possibly inappropriate prescribing. And the *Daily Mail* lapping up such findings for yet another assault on GPs' competence.

And when I look at some of the cases the computer search prompts me to look at, I despair. Some of them are obvious asthma: there's the family history, the previous eczema, the numerous presentations with coughing and wheezing over time. Surely it should have been obvious to me or my colleagues that there was enough evidence here to say with great confidence, 'This is a case of asthma'? And yet just as clearly, for

whatever reasons, my colleagues and I have not managed to put the picture together and make the diagnosis.

(Equally obviously on some occasions the computer search was over sensitive and the salbutamol had been given for symptomatic relief of wheeze and there was no diagnosis of asthma needed).

WHAT IS GOING ON HERE?

I think that there are two positions from which we can view medical practice. One is the disassociated, detached observation of researchers and audit, and the computerised criterion. This is what Donald Schon¹ describes as 'the view from the sunlit uplands'. When you look at the cases I was reviewing the diagnosis of asthma in many of them was patently obvious and to be honest it probably could and should have been made.

And yet equally obviously my colleagues and I had failed to make the diagnosis at the time of the consultation. The other half of Schon's great metaphor is 'the swamp'. The swamp is where professionals practice, and try to navigate their way through their work. The Kings Fund² want GPs to become more like navigators for patients. Actually I suspect we need some help with navigation ourselves. The swamp is wet, mucky, not entirely clear, with odd bits of solid ground in it. It may be shrouded in mist. The clarity of vision that exists from the sunlit uplands is largely lost when you are in the swamp. It seems as if a fog rolls into our consulting rooms and stops us seeing what there is to be seen. To a large extent our doing the job may actually be hindering us from seeing and doing the job that needs doing.

WHAT IS CAUSING THE FOG TO DESCEND?

What I think happens in clinical practice in the consulting room is that time pressure, distractions, and inattention lead us astray. We tend to label symptoms. We may

sometimes be reduced to drowning men and women clutching at diagnoses, even if it just adding '-itis' to the end of something. We may prescribe largely for symptoms, without either having, or not taking the chance, to put the current symptoms together with past episodes and personal background. Perversely, the way we work as doctors in short time-pressured consultations may actually be blinding us to what is going on, and may be preventing a proper considered assessment of symptoms and their context. The temptation to focus on the here and now, on the present consultation only, leads us to miss the larger picture and context. So we treat repeated episodes of cough and miss the underlying asthma. We forget that in general practice the patterns of attendance and non-attendance are a physical sign in their own right, and just as important as any wheeze or heart murmur.

What we are seeing here I wish to describe as 'the consulting room fog'. The consulting room fog is like a mist that descends over our clinical senses and sensitivity. We become unable to see the diagnosis among the symptoms. We become unable to take things apart and analyse them clearly. We get caught up in the mess of the consultation, and fail to sort it into a problem. Basically we get as lost as our patients sometimes do.

There is something about doing the consultation that is categorically different from reviewing the consultation and its outcomes. I could review your consultations from an external disassociated viewpoint and go, 'Surely it's obvious that ...' I am equally sure that you could return the favour to me.

But to be able to put everything together in a consultation is hard and difficult work,³ and a process that easily goes astray.

SO WHAT ARE THE COMPONENTS OF THE 'CONSULTING ROOM FOG'?

What I am describing here is a version of

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"The amazing thing is how often the consultation goes right despite the systematic disadvantages we have to work against."

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mental block, and I suspect its causes can be described as external and internal to the consultation.

External to the consultation

The obvious external feature that contributes to the consulting room fog is time pressure. British general practice has always run under very tight time constraints, and this practice has gone unchallenged for many years. The rush to finish is stronger than our rush to think. Indeed thinking and consideration are processes that take time, and in the consultation that is something we are not allowed. In the consultation we are too involved and too reactive, and the effort to step back and think is often a step too far for us.

There are other factors such as what is going on for the doctor in terms of their own life, and their relationships within the practice. If these are difficult then the doctor is distracted from the start.

Factors within the consultation

It is not just time, and I have previously described the consultation as 'beleaguered'⁴ and as 'crowded'.⁵ The consultation is a contested space and there are many other agendas in play in and around the consultation. The person who reviewed my beleaguered consultation article⁴ said I was being too pessimistic. I now agree, and accept that the consultation is resilient despite its problems. I think the amazing thing is how often it goes right despite the systematic disadvantages against which we as GPs have to work. I am not sure how far this will continue into the future as the tolerance of the British patient may wear thinner.

The consultation is the key unit of general practice delivery. It goes partially right and partially wrong. Mostly it seems to go right, and most people seem satisfied with it. Yet it has significant risks (medical errors) and there is sustained evidence of unrecognised and unmet need.² The consultation is far from a perfect mechanism for detecting all the problems that could usefully be identified and treated.

The consultation can go astray in many ways from both doctor and patient

perspectives. I think the concept of the consulting room fog descending helps capture this, and it probably applies to patients, 'I never got around to mentioning that ...' as much as to doctors, 'I wonder why I didn't get on to ...'.

SOME EDUCATIONAL REVIEWING?

Perhaps we need to be reviewing our consultations, and looking for the moments when the fog rolls in? In our training years we set great store by random case analysis, problem cases analysis, and review of videotaped consultations. Should we continue such activities after completing our training? Why do we expect not to return to this educational review in later life? Is this something the appraisal system should facilitate?

CONCLUSION

Somewhere in our practice and in our researching we need to balance doing the work with reviewing the work. What can we do with our consulting that would allow us to actually see the larger picture rather than just the current symptom? And so get our accuracy rate up from the start?

Or maybe we need to consciously own and run parallel processes of acute reactive medicine and proactive reviewing and value them equally. We can accept that in our foggy consultations, some things will go undone. All consultations have an aching sense of incompleteness to them, and would still have this even if we had longer for them. And yet we also have to get through our day. Perhaps all we can do is say that the consultation is the start, but we also review and integrate that information with other sources. How many of us as GPs are still seeing the many consultations and surgeries we do as the 'real work' and not really building the review and reflection into our work? Or we find the reviewing part of the work an added intrusion rather than value added to our work. Was Sir Ian Kennedy fair or unfair when he described general practice as often being unreflective?²

I hope that in this essay I have shown that 'the consulting room fog' is worth recognising as a phenomenon. Whatever

can help to shine a way through the fog is likely to be worth investigating further.

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Provenance

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