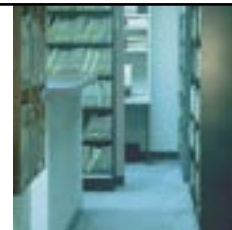


The skill of the consultation

Some observations on how not to do it



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I have recently been an 'expert witness' in the district court, an examiner for the RACGP, and an observer of medical practice in San Francisco. In the first situation I was being grilled; in the second I was doing the grilling. The last situation is more gentle than the first, but both are artificial situations with potential for error.

Litigation

The court case was about a misdiagnosis of a very rare subcutaneous sarcoma. One of the plaintiff's reasons for suing was his wife's anger at having her concerns about her husband's lump 'dismissed'. She was a nurse, and said she told one of the doctors involved that she thought the lump on her husband's leg should be removed or biopsied. The doctor had no memory – nor any written records – of this event. The judge believed the plaintiff's wife.

A cardinal rule of empathetic and safe medical practice is to listen carefully to the concerns and opinions of the patient, their partner, their parent and any involved health professional.

RACGP Examination

My case in the RACGP examination required the examiner to simulate severe abdominal pain. That is a difficult role to keep up for 12 rounds of 19 minutes – and at least a part of the distress became real. Despite repeated briefings to treat each examination station as if it were a real consultation, some 40% of candidates were so intent on

taking an exhaustive history that they failed to focus on the patient's urgent reason for 'consulting' them.

Doctors' vs. patients' agendas

In medical school, we teach students to take a formal history. Presenting complaint, past history, social history, family history and systems review. The completion of this task can become so obsessive that the medical student and intern fail to focus on the presenting complaint and miss some of the most obvious clues to the patient's diagnosis. I once videotaped a fifth year medical student conducting a consultation with an obviously myxoedematous new patient who complained that her typing had become so slow that she was in danger of losing her job as a legal secretary. The student set about what the Foundation Dean of Newcastle University Medical School, Professor David Maddison, has called 'avulsing the history'.¹ Fifty minutes later he parroted a long list of negatives, eg. no chest pain, no dyspnoea, no guilty thoughts, no repetitive washing of hands. When he was directed to listen to the patient for 5 minutes without interrupting she told him that her hair was falling out, her finger nails broke off and wouldn't grow, her voice had become hoarse and she was cold all the time. He then made the diagnosis, of course, and learned how to 'invest in the beginning' of a medical consultation.

FRACGP candidates have been in general practice for several years and have, through

the necessity for time management, learned to focus on those bodily systems most pertinent to the presenting complaint. But their preventive medicine teaching – and examination coaching – has also left them with a need to demonstrate their 'holistic approach' to patient care. While the simulated patient/examiner retches and clutches his stomach, they plough on about family history, occupation, stress, depression, anxiety, memory, drugs, sex and the intake of 'complementary' medicines.

Now I am one who publishes occasional articles on the tasks of general practice, so I should hardly complain about FRACGP candidates trying to follow the same roadmap.² But the examination station is about the diagnosis and management – in 19 minutes – of a patient with an acute abdomen. One criterion for being awarded an FRACGP is to be able to tell the immediately important from what could and should be put off for another day.

General practice has been a formal part of Australian medical education for over 30 years. We have broadened the teaching of formal history taking to include the broader qualities of consultation skills. We have tried to help students to understand patients' feelings and concerns and what it is like to be ill. But, I sometimes have doubts about our success. One such occasion was at the conclusion of a lecture when the first year class representative rose to thank me for 'organising the brilliant course' on 'the patient, the family and the doctor'. She said:

'When we are real doctors we will not have time for that stuff any more'. She became an endoscopist.

18 seconds for the patient

In 1984, the average time an American doctor gave a patient before interrupting was 18 seconds.³ My recent observations in California were congruent with this finding. The only patient who managed to get permission to speak did so by reverting to his school days and putting up his hand! Furthermore, no consultation reached the 5 minute mark without the ordering of a battery of tests. These MDs were no longer doctors, they were technicians.

There are two ways of not listening to patients. One is to focus on the technical aspects of their symptoms. The other is to lose their main concerns in a fog of politically correct 'holistic medicine'.

However, all this has been said – much better – 50 years ago, by the English paediatrician Sir Robert Hutchison: 'From inability to let well alone, from too much zeal for what is new and contempt for what is old; from putting knowledge before wisdom, science before art, and cleverness before common sense, from treating patients as cases, and from making the cure of the disease more grievous than the endurance of the same. Good Lord! Deliver us!'⁴

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