Bad questions?

Carolyn O'Shea

'There is no such thing as a bad question'. Who knows who first stated this, but we have all probably heard it and quite possibly said it.

Questions – good or bad – are core to the business of a clinical consultation. Too often I start the consult badly by asking the patient – en route to the consulting room – 'how are you?' Each time I say it I cringe. It is a common greeting, one which is often responded to with something like 'good thanks, and how are you?' This is my failing … the patient asks how I am, I reply and add the common response and realise I have done it again. It is a hard habit to break. The patient has come to see a doctor. This raises the prospect that they may not be feeling well, and if this is the case, the corridor to the consulting room is a particularly inappropriate place to start the discussion. The social conditioning of this response is not just mine, not infrequently the patient answers they are well. Then the consultation room door closes and the real answer to my question becomes clear ... why the patient is actually there.

The concept of questions not deserving to be answered was raised by Professor Richard Dawkins.[1] He asserted that there are silly questions, particularly those with no meaning, such as 'What is the colour of jealousy?' and 'Why?', and that these do not deserve to be answered. Take, for example, a young child's constant questioning in the form of 'Why ... but why … but why?' Sometimes there may be meaning, but sometimes it becomes just a game for their own amusement, often at the expense of their parents' patience.

However, he also asserted that there are sensible questions. The features of which we would also recognise as necessary when asking a question to get information in a consultation. There is a purpose, and the question is specific enough to allow both parties to be talking about the same thing.

A single word can make a question. A few years ago, an American study tested the difference one word makes.[2] Patients were asked to list their concerns while in the waiting room. Consultations were then videotaped. After a period of control consults (where the doctor was asked to consult normally), each doctor was then randomly assigned to ask one of two questions to every patient after they had determined the patient's main concern. They asked either 'Is there ANYthing else you want to address in the visit today?' or 'Is there SOMEthing else you want to address in the visit today?' What they found was that asking about something else reduced the number of unmet concerns (based on what was on the previsit survey and not covered in the consult). When asked the 'some' question, about 90% of those with unmet concerns raised a concern, compared to 53% when asked the 'any' question. Asking about anything else was not statistically different in ascertaining unmet needs than the control consults.

General practitioners will have experienced the important unmet concerns – in this study they included potential acute conditions such as chest pain, ongoing conditions such as angina and medication questions. Also, and probably of no surprise, is that having three or four concerns on the waiting room list was also associated with being more likely to have unmet concerns than someone presenting with two concerns. The difference in wording did not affect consultation length or the number of unanticipated concerns raised by the patient that were not on the waiting room list.[2] Much of this will be obvious to GPs, however, asking about 'something' else may be a minor tweak to your consultation question repertoire to try and decrease the number of unmet concerns your patients leave the consultation with.

New situations and experiences can raise many questions. This is especially so for most parents of newborn infants. In this issue of *Australian Family Physician*, Michael Fasher talks about the role of the 6 week check, including the important role of engagement and providing information to parents.[3] Skin problems are there for all to see and the article on birthmarks (by Ryan and Warren[4]) and on common neonatal rashes (by John Su[5]) will help us answer those questions. Feeding is another area where there are often questions from parents, and the article by Allen and Ho[6] looks at reflux and the key diagnostic and management decisions in babies presenting with chronic vomiting.

We hope that this issue of *AFP* will help you to answer some of the questions – good or bad – you get asked in your daily practice.

Author

Carolyn O'Shea MBBS, FRACGP, MMed, is Senior Medical Editor, Australian Family Physician, Senior Medical Educator, Victorian Metropolitan Alliance and a general practitioner, Greensborough, Victoria.

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correspondence **afp@racgp.org.au**