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Starting off in general practice – consultation skill tips for new GP registrars

Background

For many new registrars, starting general practice is highly challenging. The general practice environment is characterised by unfamiliar presentations, relative independence of decision-making, greater time pressures and clinical uncertainty. As a regional training provider, we deliver a 'consultation survival' session as part of an introductory workshop for registrars at the commencement of the first general practice training term. This focuses on key general practice consultation skills.

Objectives

In this paper, we highlight a number of practical and evidence-based tips to help new registrars navigate the general practice consultation effectively.

Discussion

We discuss practical consultation tips including adequate preparation and 'housekeeping', use of silence, appropriate use of expressive touch, strategic use of the computer, appropriate examination, strategies to manage uncertainty, adequate explanation of the problem, shared decision-making, comprehensive follow-up and safety netting, time management, and asking about ideas, concerns and expectations.

Keywords

consultation; doctor–patient relations; vocational education/graduate education; education; medical; patient-centred care

The transition from hospital work to consulting patients in the general practice setting is highly challenging. For the new registrar, the general practice environment is characterised by a wide breadth of clinical problems, chronic disease management, relative independence of decision-making, time pressures, clinical uncertainty, unfamiliar practice systems, and financial and billing issues.[1,2]

Internationally, clinical and consultation skill deficits have been identified in senior medical students,[3] doctors in training[4] and early-term general practitioner (GP) trainees.[5] These skills include identification of the reasons for encounter; generation of a working diagnosis; consideration of social and psychological factors; dealing with emotions; time management; and arrangement of follow-up. An older study of the consulting skills of Australian registrars identified several areas of concern, including recognition of patient cues and involvement of patients in decision-making.[6]

Our training provider delivers an introductory workshop for registrars at the commencement of the first general practice training term, covering a range of 'survival' clinical and organisational topics. More recently, we have introduced a 'consultation survival' session into this orientation workshop, focusing on key general practice consultation skills. This was in response to a number of skill deficits consistently observed through external clinical teaching visits and in recognition of trainers' difficulties with teaching consultation skills in the practice setting.[7]

Several formal models of the general practice consultation have been described,[8–14] but we do not adhere to any particular framework in the teaching session. We believe that they all have merit, and we make reference to specific practical elements as appropriate. Nor do we exhaustively discuss core communication skills, which we assume have been taught previously. Rather, we highlight a number of practical tips to help navigate the general practice consultation effectively and, where able, support their use with evidence.

This paper describes the content of our consultation survival session (summarised in *Table 1*). We believe this paper will be a valuable resource for new GP registrars, junior doctors working in general practice, medical students and their supervisors to help navigate the first weeks of general practice.

Purpose of the general practice consultation

We frame the session by asking registrars to reflect on the objectives of the consultation. Murtagh[15] describes these objectives as:

- to determine the exact reason for the presentation
- to achieve a good therapeutic outcome
- develop a strong doctor-patient relationship.

Preparing for the consultation

Adequate preparation for the consultation is an important but commonly overlooked element of registrar clinical practice. Good practice includes routinely reviewing the medical record, in particular the last consultation and recent investigations or correspondence, before calling the patient into the room. We also emphasise the importance of Neighbour's 'housekeeping',[11] especially not transferring emotions from the past encounter to the current one. We suggest taking a physical break (eg making a cup of tea) after a difficult consultation.

Table 1. Practical tips for surviving the general practice consultation

Preparing for the consultation
• Check whether you have seen the patient before (or as a parent of a child) • Review the last visit and recent investigations/correspondence • Take a break after a difficult or emotional consultation
Connecting with the patient
• Let the patient talk uninterrupted for the first minute • Use appropriate expressive touch • Avoid being distracted by the computer – take 'time out' to look up results, read letters and write notes
Identifying the patient's agenda
• Ask about the patient's ideas, concerns and expectations (ICE) • Ask the patient 'Is there something else you want to address in the visit today?'
Examining the patient
• Examine the patient routinely • Expose the patient adequately
Managing uncertainty
• Seek information routinely • Ask your supervisor • Use Murtagh's (restricted rule-out) framework • Use a diagnostic pause • Use watchful waiting • Order tests judiciously • Listen to your gut feelings – if you feel a 'sense of alarm', seek help • Safety net
Explaining the problem
• Discuss probable diagnosis and clinical reasoning before management • Address the patient's agenda
Forming a partnership in management
• Involve the patient in decision-making • Use 'we' when discussing management plans
Following up and safety netting
• Have a low threshold for getting patients back for review • Telephone patients if concerned • Safety net patients of concern
Manage time
• Identify the 'list' of problems early in the visit • Prioritise which is the most important issue for both the patient and the doctor • Ask patients to return for another visit

Connecting with the patient

Our observation of registrar consultations is consistent with previous well-quoted studies showing that doctors frequently interrupt their patients after only a short period of time.[16,17] We highlight the power of silence, in particular the importance of allowing the patient to talk uninterrupted at the start of the consultation.[18]

Expressive touch has been found to improve interactions between GPs and patients.[19] Patients have described touch as appropriate on the hand, forearm and shoulder. Registrars can be reassured that touch is generally welcomed by patients and is a useful tool to improve doctor–patient communication and rapport.

The computer has been described as 'a third party in the consultation'.[20] Previous studies have shown that computers can negatively impact on the consultation,[21] including reducing rapport[22] and patient-centredness,[23] and lead to missed patient cues.[24] We orientate registrars to the potentially distracting influence of the computer on the consultation. One useful approach is to take 'time out' to use the computer to enter notes or seek information, by saying to the patient something like '*Just excuse me while I take some notes*'.

Identifying the patient's agenda

In the patient-centred clinical method, the doctor's aim is to ascertain the patient's agenda and to reconcile this with his or her own.[25] Patient-centred communication is positively associated with patient satisfaction, adherence and better health outcomes.[26]

Pendleton introduced the notion of identifying the ideas, concerns and expectations of the patient as a key element of understanding the patient's reasons for presentation.[10] This can

be remembered by the acronym 'ICE' for ideas, concerns and expectations. Using this framework, useful questions to help identify the patient's agenda include '*What do you think is going on?*' (ideas), '*What are you particularly worried about?*' (concerns) and '*What were you hoping to get out of the visit today?*' (expectations).

Hidden patient agendas are very common in the general practice setting[27] and often emerge late in the consultation.[28] One recent study has shown that patients' unmet concerns can be substantially reduced by asking '*Is there something else you want to address in the visit today?*', rather than '*Is there anything else you want to address in the visit today?*', without significantly increasing visit length.[29] Another approach is to ask the patient, '*You have come today with concerns and expectations from the visit. Do you feel that these have been addressed?*'. We advise registrars to be particularly aware of hidden agendas in teenagers, middle-aged men and the elderly.

Examining the patient

The ability to perform a physical examination and correctly elicit physical signs is a core clinical skill. However, over recent years a decline in the physical examination skills of doctors has been described.[30] Registrars should consider a focused examination a fundamental element of the consultation unless there is justification to omit it. In addition, our anecdotal experience is that patients are frequently not adequately exposed (eg for respiratory and joint examinations). Registrars are also reminded about appropriate use of chaperones.[31]

Managing uncertainty

Establishing the correct diagnosis is fundamental to effective patient care. However, undifferentiated presentations are very common in general practice.[32] In many patients, establishing a pathological diagnosis is not a realistic goal. As a result, management of uncertainty is an essential skill for general practitioners.

A number of practical strategies have been described to assist the diagnostic process and help manage uncertainty.[33,34] Clinical information in the form of evidence summaries and guidelines should be sought during the consultation. Junior doctors overestimate the negative effect on patient confidence of information seeking – there is evidence that looking up appropriate sources of information in front of the patient is not only acceptable, but positively regarded in some cases.[35] Registrars can always access help through their supervisor or specialist colleagues.

The 'restricted rule-out', or Murtagh's process, is a diagnostic strategy based on the most common cause of the presenting problem and a list of serious diagnoses that must be ruled out.[36] The 'diagnostic pause' or 'time out', has been described as a useful tool to minimise diagnostic error.[37] This involves literally taking 'time out', for example when washing hands, to reflect on the current working diagnosis.

Ordering investigations is an important element of the diagnostic process. However, tests can also be unhelpful and at times harmful to the patient.[38] Registrars should be discerning about the tests they order and avoid a 'scattergun' approach in the context of the undifferentiated presentation. Time has been described as the best investigation in general practice, and registrars can institute watchful waiting in many cases.

Responding to gut feelings (a sense of reassurance or a sense of alarm) has been described as having a role in managing uncertainty.[39] If the registrar feels a sense of unease or alarm, even in the setting of an unremarkable clinical presentation, they should act on this by seeking appropriate advice. Another core strategy to help manage uncertainty is appropriate safety netting (discussed below).

Explaining the problem

Murtagh lists as the first point in patient management 'Tell the patient the diagnosis'.[15] However, our observation is that this step is frequently overlooked in registrar consultations. It is critical to formulate and deliver a simple and clear explanation, including the provisional and differential diagnosis and the evidence supporting this (clinical reasoning). This explanation should specifically refer back to the patient's ideas, concerns and expectations.[40] A suggested form of words for this is '*After taking your history and examining you, I think the most likely diagnosis is…*'. Even if uncertain, it is important to describe what can reasonably be excluded and the range of diagnoses being considered.

Forming a partnership in management

Shared decision-making is an approach where patients are genuinely involved in decisions around their care.[41] We encourage registrars to explicitly involve patients in discussion of management options. One practical tip to reinforce the partnership approach in management is to use plural pronouns such as 'we' and 'our'; for example, '*Where do you think we should go from here?*'.

Following up and safety netting

Arranging appropriate follow-up for patients is an essential element of the consultation but one often unfamiliar to new registrars. Not infrequently, registrars are not explicit about follow-up plans – we encourage having a low threshold for asking patients to return for review. We also highlight the benefits of telephoning patients when particularly concerned.

The term 'safety netting' was introduced by Neighbour as a key strategy in managing uncertainty.[11] Comprehensive safety netting includes communication of uncertainty; what to look out for (including red flags); how to seek further help; and what to expect about the time course.[42] Safety-netting is particularly important in the context of undifferentiated presentations with the potential for serious illness (eg febrile child), diagnoses with a known risk of serious complications (eg bronchiolitis) and patients with an increased risk of complications (eg age, comorbidities).

Time management

Time management is a core consulting skill but one that can take some time to develop. As a survival tip, we discuss the value of identifying and prioritising a 'list' of problems early in the consultation. In particular, we emphasise that the two most important problems on any list of complaints are 1) the top priority for the patient and 2) the top priority for the doctor. We also discuss the general acceptability of asking patients to return for another visit.

Conclusion

We believe use of the practical tips described in this paper will help registrars and other learners

new to general practice navigate the consultation effectively and support effective, patient-centred care.

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