CONSULTATION SKILLS

AN INTRODUCTION
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SUMMARY

1) Consultation skills can be learned and can always be improved, extended and refined whatever stage you are at in your professional career.

2) Learning consultation skills is best achieved in small group work with peer support.

3) Effective learning depends on three factors:
   a) A safe group where you feel able to discuss a consultation which is not your best.
   b) Feedback on your performance through watching yourself and hearing the comments and recommendations of others.
   c) The opportunity to try out changes e.g. through using recommendations in role-play. We learn best through "doing".

4) To make the best use of video analysis, it is important that:
   a) you video yourself consulting,
   b) technical problems, especially with sound, have been overcome. e.g. desktop microphone,
   c) you have had a chance to look at the video and score the consultations for level of challenge.

5) There are many models of the consultation which can help by highlighting particular processes of communication. These range from psychodynamic interpretations to analysis of eye movements. A few of the most useful ones are summarised in this document.

6) In this introductory document, the aim is to focus on the skills involved in patient-centred questioning. Although not appropriate for every consultation, these skills will help in most situations and have been shown to improve patient satisfaction. They include the ability to find out:
   a) The patient's ideas about the cause of symptoms
   b) The patient's concerns about what might happen
   c) The patient's expectations about what the GP might do
   d) The effects of the problem on the patient and their psychosocial environment
**INTRODUCTION**

The aim of this booklet is to summarise a few of the ideas about the consultation which others have found useful. The aim of reviewing consultations with peers is to share experiences of consulting and learn from each other.

1) **There is no one right way of consulting**

The idea is **not** to produce clones who all consult in the same way and have lost their individuality. Balint promoted the idea that “the doctor is the drug” and the doctor's personality is certainly a powerful factor within the consultation. **But there are useful skills which can be learned and adapted by individuals.** These skills cannot be learned by going to a lecture; they are best learned by small group work looking at what happens in real and simulated consultations.

2) **Consultation skills can easily be learned**

That consultation skills can be learned has been shown in many different situations. One study from Manchester gave a group of established GPs a one-day workshop looking at the skills involved in diagnosing and managing depression. At the end of the day, video analysis showed big and positive improvements in counselling skills. A year later further videos of the same GPs were analysed. Not only had the improvements been maintained but many of the GPs had clearly developed the skills far beyond what had been taught on the course. In this way, individuals adapt skills to their own personal style of consulting and choose to use the skills they feel appropriate in any particular consultation.

(Reference: "Improving the skills of established general practitioners: the long-term benefits of group teaching." Bowman F, Goldberg D, Millar T, Medical Education 1992; 26(1): 63-68 )

3) **A range of skills can be used in different situations**

The ability to explore a patient's ideas, concerns and expectations is very valuable but there are situations where it may be appropriate to be doctor-centred and autocratic: leading a cardiac arrest procedure is the obvious example where it does not help to ask a patient about their feelings! But if s/he does not have the skills of becoming patient-centred, the doctor who has led an unsuccessful cardiac arrest may not be able to offer such good care to the bereaved spouse of the patient, let alone support the other members of the crash team who have been upset by what has happened. You need a range of consultation skills in order to make an informed choice about which you will use in any situation.

**A non-medical analogy**

The top ten world tennis players all have their own styles but they are all able to serve, volley and lob.
HOW TO MAKE A VIDEO OF CONSULTATIONS

It is a good idea to have several practice attempts before you attempt to make your video for the course so that you can:

- sort out hitches with obtaining informed consent,
- iron out the inevitable technical problems with lighting, position and especially with sound and
- accustom yourself to the presence of a camera.

It is very important to obtain the patient's informed consent for recording and that the camera does not record intimate examinations. An example of a consent form is included; you may photocopy this if you wish.

Cameras should ideally be sited close to eye level on a tripod or, even better, a wall bracket. The lighting should be bright and curtains must be closed if the camera is directed at a window. You may have to use a wide-angle lens or a mirror if you are filming in a small consulting room.

"PZM" MICROPHONE

Problems most frequently occur with sound. The microphones attached to cameras are usually inadequate for recording of consultations - the volume is usually too low and the clarity is poor. Extension microphones can be attached to most cameras and the flat desktop version available from "Tandy" stores is popular. The Pressure Zone Microphone made by Realistic is a “boundary microphone” and works well for recording consultations (Catalogue number 33-1090B). You may also need to buy a mono adapter for 1/4" to 1/8" jack plug. It has a number of advantages over most desk-mounted microphones:

- it does not look like a microphone, being a flat black metal plate
- it comes with a long lead, so no extension leads are needed
- correct impedance for most video cameras
- omni-directional in a hemisphere, picking up doctor and patient
- "Avoids the threatening phallic contours of conventional microphones"
PENDLETON'S RULES

Pendleton et al wrote "The consultation: an approach to learning and teaching", which is short and easy to read. Although every individual has a unique style of consulting, there are important skills which are common to those who communicate well whatever their particular style. These skills can be learned and improved on throughout a doctor's professional life. One of the best-remembered parts of Pendleton's book is his explicit statement of rules to ensure that analysis of consultations is both an enjoyable and educational process. In the context of showing a video to a group, there are seven points:

1) The person showing the video (the learner) may make a brief factual statement about the recording (e.g. "This was the last consultation at the end of a busy Friday afternoon").

2) After the video has been seen, the person showing the video speaks first and concentrates on the strengths of the consultation. This can be hard because most of us are painfully aware of what we perceive as our own failings rather than what we have done well. If there is a facilitator, it is their job to ensure that the positive features are described first.

3) Other members of the group then add comments about the strengths.

4) The person showing the video then comments on what could be improved.

5) The group comments further on what could be improved. It is important to make "recommendations not criticisms" so that helpful alternative strategies might be suggested rather than simply destructive criticism.

6) "The learner is left with a clear summary of her/his strengths and of those specific changes which might lead to improvement".

7) There should be the opportunity to role-play part of the consultation using the recommendations. This is the crucial part of the process as this is when real improvements occur: we learn through doing. Unfortunately it is very often missed out. Without this "follow-up", consultation analysis can easily become navel-gazing. Be adventurous, try the role-play!

Using this set of rules usually makes a new group of doctors seem "safe" fairly rapidly. Safe in this context means that individuals are aiming to help each other rather than to score points in a destructive or competitive way. This is one reason why it is essential that each person brings a video of himself or herself: trust is much easier to establish when everyone is in it together.
Goodbye Pendleton, Hello ASDA

A Ask the group for help

Pendleton’s rules emphasise ever-present danger in their insistence on rigid ordering of feedback and prevent the doctor from saying what her/his learning needs are. Here safety is ensured by the facilitator making sure that an explicit “ask the group for help” statement is made once the video has been seen. This is crucial in the making the group safe because few people are destructive when their help is solicited.

S Specify the desired outcome

Under Pendleton, comments are made which are often judgmental: “that was a good consultation”, or “first talk about the good things”. Here, the emphasis is on what the doctor is hoping to achieve and making this aim explicit. The interventions are only more or less successful in terms of the desired outcome. This is another way of making the whole process less judgmental and therefore less threatening. It is for the learner to make any judgements- not the group.

D Describe accurately what occurs and the consequences

Once the tape has been seen and the doctor has identified the problem area, part of the tape may be reviewed so that everyone can note accurately what happened. Interpretation from the group should be minimal but the consequences of interventions can be reflected to the learner for his comments.

A Act out alternative suggestions

The doctor should then be encouraged to develop suggestions for alternative approaches and these should be rehearsed, using role-play. Adults learn through ‘doing’ and role-play here is not an ‘added extra’ or ‘optional extra’ as is sometimes seemed in Pendleton, but the goal towards which the group is moving.
CONSULTATION LOG

It helps greatly if you look through your tape before coming and try to score the consultations in terms of the level of "challenge" presented by each. This is a useful task for two reasons. Firstly, and obviously, it can help identify consultations which you have found challenging. Secondly, it can help you choose which consultations to share with a group. If a group does become "safe", those participating often feel able to show consultations where things have not gone as well as they would have liked. The safer the group, the easier it is to reveal those consultations you do not feel proud of and the more you can learn from each other. If the group is safe, you may feel adventurous and try out consultation techniques that are new to you. Some may work, some may not: but if you don't take the risk, you will never know.

Below is an example of the type of table which might be used for logging a videotape of consultations. Use the number 1 to indicate a low level of challenge and 3 to mean a very demanding consultation. If you wish you may use the number 4 to mean "I'd rather destroy it now and forget it forever" but only once per videocassette!

<table>
<thead>
<tr>
<th>Consult'n no:</th>
<th>Video ref counter</th>
<th>Name or initials of patient</th>
<th>Age</th>
<th>Duration of consult'n in mins</th>
<th>Main subject of consultation</th>
<th>Level of challenge</th>
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WORKING IN GROUPS

Much of the work on the consultation course will be done in small groups. Small group learning has been found a very effective tool for the acquisition of new skills and for the exploration of values and beliefs.

In order for groups to function well and, thus, for maximum learning to occur they have to be "safe spaces" for their participants. Experience has shown us that a safe space can be created if all members of the group follow a few simple rules. We suggest the following, though your group may wish to amend the list of rules or add to or subtract from it. Rules can look rather daunting. Above all we hope you will find your group educational and lots of fun!

**RULE 1: the group starts and finishes on time**

Punctuality is a vital part of the functioning of any group. It can be immensely frustrating for the group to wait for one or two late members. Some see lateness as an expression of anger or resentment. Groups should also finish on time, unless all their members agree that they wish to continue in order to finish their work.

**RULE 2: Participation is voluntary**

No member of a group should feel coerced into participating in any of the group's activities and all group members should respect the freedom of each member to opt out of anything he or she feels uncomfortable with. In practice the activities on the consultation course are such that we can recall few if any occasions when this rule needed to be applied.

**RULE 3: The group is responsible for itself**

The success of a group depends on the active participation of all its members.

**RULE 4: Proceedings of the group are confidential**

Members of a group should feel free to talk about sensitive issues concerning, say, patients or their peers or seniors. Unless permission to the contrary is given, it is to be assumed that matters discussed within the group should not be broadcast outside it. The only exception to this is that the group leaders normally discuss with each other how things have gone in each group at the end of the day.

**RULE 5: Group members should speak in the first person**

The group will work better and faster if participants "own" their feelings by saying "I " rather than "one" or "we" or making vague generalisations. The leader might ask, for example, for a member to rephrase the statement, "Doctors find it easier to deal with articulate, middle-class patients." An “I statement” would be “I find it difficult to deal with…”
ESSENTIAL SKILLS AND MODELS

LISTENING SKILLS

Listening is a remarkably complex process. On the course we will do some simple exercises which include some of the skills outlined below.

One of the most obvious skills is the use of open ended rather than closed questions, so that the patient says more than "yes" and "no" and the information generated is more reliable than if it had been framed by the doctor's assumptions in asking a closed question. For example you might ask, "How are things at home?" rather than "Have you stopped beating your wife?"

Of course, if you really suspected domestic violence you might have to ask directive questions such as "How much conflict is there between you? What happens when conflict occurs?" Note that although these are directive ("not beating about the bush"), they are still open questions (not expecting the answer yes or no).

Probably the most powerful and yet the hardest skill is the skill of silence. When a doctor shows s/he is listening and caring and yet is able to keep quiet, the space is often filled by what the patient wishes to say. Non-verbal cues are important here: sitting back receptively, perhaps nodding or grunting to show you have heard etc. Another useful skill is the skill of "reflecting back" in which the patient's last sentence or phrase is repeated by the doctor followed by a pause. The patient usually fills the pause with a clarification or extension of what s/he was saying. The American therapist, Carl Rogers, used this technique extensively in non-directive counselling in which the therapist consciously makes no suggestion about what the client should do but simply asks questions reflecting back the client's comments with the aim of enabling the client to reach her or his own conclusions.

Asking questions to clarify what has been said shows that you have been listening and want to know what the patient means. Making a summary of what you have heard and repeating it to the patient is another way of checking you are on the right wavelength.

Often a summary may be followed by an empathic comment. For example: "I've heard that life has been difficult since... That sounds terribly sad."

Some of these skills may be summarised by the mnemonic "S C O R E S":

S  SILENCE
C  CLARIFYING
O  OPEN ENDED QUESTIONS
R  REFLECTING BACK
E  EMPATHIC COMMENTS
S  SUMMARISING
MODELS OF THE CONSULTATION

Models of the consultation are not cast in stone. Just as there is no one right way of consulting, there is no one right model. Different models choose to emphasize different aspects. One model may emphasise health promotion and another may suggest a completely new way of looking at doctors and patients in terms of adult-child and adult-adult relationships. Which model will be useful will depend very much on the consultation being considered. A brief summary of some of the models follows.

A) SIX PHASES OF THE CONSULTATION

Byrne and Long *Doctors talking to patients*, 1976

1) The doctor establishes a relationship with the patient.
2) The doctor either attempts to discover or actually discovers the reason for the patient's attendance.
3) The doctor conducts a verbal or physical examination or both.
4) The doctor, or the doctor and the patient, or the patient (in that order of probability) considers the condition.
5) The doctor, and occasionally the patient, detail further treatment or investigation.
6) The consultation is terminated, usually by the doctor.

Byrne and Long did pioneering work on consultation analysis. Before videos were in widespread use, they recorded and analysed 2000 consultations using audiotapes and found that:

- most doctors did not vary their consulting style very much,
- doctors could be placed on a spectrum from patient centred to doctor centred,
- one in ten consultations were dysfunctional in that doctor and patient appeared to be on different planets (our term, not theirs),
- the main cause of dysfunction was that doctors had not discovered the patient's reason for coming.

BYRNE AND LONG  
Abbreviated version:

1) Establish relationship  Hello
2) Discover reason for attendance  What's the problem?
3) Conduct examination  Let's have a look
4) Consider condition with patient  Discussion
5) Detail treatment or investigation  Take this...
6) Terminate consultation  Goodbye

At first sight this may seem a rather mechanistic model, concentrating as it does on the temporal sequence of "phases". What is more interesting is their detailed analysis of what can go wrong in a consultation. There are two common patterns of dysfunctional consultations: Inadequacy of phase 2
If real reason for attendance is not discovered, patient may try "While I'm here, doctor.." when the GP feels the consultation should be ending. This creates a phase 5 - phase 2 cycle with several loops, depending on the length of the patient's list of worries. If the patient's full agenda can be discovered early on, the doctor may be better able to help and will probably end up less frustrated.

**Problems in phase 4**

In discussion, try to discover patient's ideas, concerns and expectations about their condition and treatment options. If you are patient centred, the patient is more likely to feel understood. Skilful negotiation may be needed with respect for the patient's autonomy in contributing to the management plan.

**B) SEVEN TASKS OF THE CONSULTATION**

Pendleton, Schofield, Tate and Havelock *The consultation: an approach to teaching and learning*, 1984

1) To define the reason for the patient's attendance, including:
   (i) the nature and history of the problems
   (ii) their aetiology
   (iii) the patient's ideas, concerns and expectations
   (iv) the effects of the problem.

2) To consider other problems:
   (i) continuing problems
   (ii) at-risk factors.

3) With the patient to choose an appropriate action for each problem.

4) To achieve a shared understanding of the problems with the patient.

5) To involve the patient in the management and encourage him to accept appropriate responsibility.

6) To use time and resources appropriately:
   (i) in the consultation
   (ii) in the long term.

7) To establish or maintain a relationship with the patient which helps to achieve the other tasks.

Although this is rather a long and cumbersome list, the crucial points which Pendleton et al emphasised followed in the tradition of Byrne and Long in that they were about being patient-centred. The bold print in the first task is ours and highlights the main aspects of the patient's
agenda which may helpfully be explored:

1) The patient's ideas about what is causing the problem
2) The patient's concerns about what might happen
3) The patient's expectations about the likely outcome of the illness and the likely outcome of the consultation
4) The effects which the problem is already having on the patient in the context of her/his psychosocial environment.

C) HELMAN'S "FOLK MODEL"

Helman Disease versus illness in general practice, JRCGP 1981;31:548-552

Helman developed a simple model to emphasise the patient's perspective even further. The ordinary questions which a non-medical person would want to know include:

1) What has happened?
2) Why has it happened?
3) Why to me?
4) Why now?
5) What would happen if nothing were done about it?
6) What should I do about it or whom should I consult for further help?

D) SIX CATEGORY INTERVENTION ANALYSIS ("Six cats")

Three Authoritative Interventions

1) PRESCRIPTIVE  Giving advice or instructions, being critical or directive
2) INFORMATIVE  Imparting knowledge, instructing or informing
3) CONFRONTING  Challenge a limiting attitude/behaviour
                   Giving direct feedback in a caring context
                   "Telling the truth lovingly"

Practitioners are often comfortable with being authoritative. However, confronting is perceived as more difficult. Confrontation here does not mean aggression and anger, rather it means giving constructive feedback in the context of a therapeutic relationship. There is a short section on confrontation later in this document.
Three Facilitative Interventions

1) CATHARTIC  
   Enabling release of emotion; grief, fear, anger

2) CATALYTIC  
   Promote self-discovery, encouraging the patient to explore and express their own feelings, often inducing a new understanding

3) SUPPORTIVE  
   Offering comfort and approval
   Affirming patient's worth

The skills of confronting and facilitating catharsis are some of the advanced skills of counselling. These skills must be handled with particular care and used only where appropriate. For example, you may take pride in having developed the skills to facilitate the release of sadness by being able to encourage someone to break down in tears. But you need to be sure that you are using catharsis for the patient's benefit rather than for your own. You need to be able to offer the time, skills and commitment to help once the tears have finished.

E) THE INNER CONSULTATION

Roger Neighbour describes a handful of key processes within a consultation. These are called the "five checkpoints" of the consultation:

1) Connecting: getting on the same wavelength as the patient.

2) Summarising: a counselling skill which shows you have listened and clarified what the patient has said and have understood the reason for consulting you.

3) Handing over: giving the patient responsibility in the management plan and making sure s/he is happy with the outcome of the consultation.

4) Safety netting: planning for the unexpected; helps to deal with uncertainty.

5) Housekeeping: being aware of your own emotions, how they have influenced this consultation and how they may influence subsequent ones. A consultation is not really complete until a doctor has at least started this self-check process.

Neighbour's model is unique in three important respects. Firstly, he recognises that GP's have a complex task in dealing with limited information in short spaces of time and that "both you and the patient will feel better if you acknowledge that general practice is the art of managing uncertainty". After making a management plan it may be helpful to make a "safety net" by asking:

1) If I'm right, what do I expect to happen?
2) How will I know if I'm wrong?
3) What would I do then?
The second and most important concept is that of **housekeeping**. This process is one of the skills which can prevent professional "burnout". The thumb of his **hand model** is "housekeeping". Apart from keeping yourself healthy, housekeeping can give very valuable insights into the feelings generated by a patient in other people and this may prove useful in understanding the problems presented and in helping the patient to deal with them. In emphasising the doctor's feelings, Neighbour follows in a strong tradition of British general practice which was started by the work of Balint.

The third important area is the idea of **minimal cues** and is **not** one of the 5 "checkpoints" of the hand model. These are the verbal and non-verbal "physical signs" to the patient's inner world of thoughts and feeling. A brief summary is included later in this booklet.

**F) STOTT AND DAVIS**

Stott & Davis *The Exceptional Potential in Each Primary Care Consultation*, JRCGP;29:201-5

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<td>Management of presenting problems</td>
<td>Modification of help seeking behaviours</td>
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<tr>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>Management of continuing problems</td>
<td>Opportunistic health promotion</td>
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This model highlights the obvious tasks of dealing with continuing as well as presenting problems and also includes the role of the GP in providing opportunistic health promotion.

The most challenging and interesting component is B: modification of help-seeking behaviour. This is a task which requires assertiveness with advice about appropriate use of health services, but in a way which does not damage the doctor patient relationship. See sections on assertiveness and the DESC model for examples.
HOUSEKEEPING

The concept of housekeeping
The concept of housekeeping is central to Roger Neighbour's model of the consultation. This "checkpoint" in the consultation is important because as doctors we have a responsibility both to ourselves and to our patients to remain healthy; recognising and dealing with our own emotions should be an integral part of our work. His book "The Inner Consultation" provides valuable insights into the processes which occur as the doctor "oscillates": "sometimes his attention is directed outwards, and he concentrates wholly on the patient. At other times, he is more aware of his own thoughts and sensations; his attention is directed inwards". The chapter on Housekeeping is essential reading. This short summary introduces some of the main concepts and is intended to stimulate you to read (or re-read) the original.

Frustration of the doctor's unconscious needs
Neighbour sees the origin of job stress as being caused by the frustration of the doctor's own unconscious needs. He points out that "it is largely because of the richness of opportunities for feeling loved, needed or admired that people are drawn to enter the helping professions in the first place… But inevitably clashes of interest arise when the doctor has to suppress or postpone his own needs in favour of the patient's".

The spurious intimacy of the doctor patient relationship
There are some features of the doctor patient relationship which contribute to such stress: "The nature of the job throws doctor and patient together in situations where the exchange of confidences, physical contact, liking and being liked, create an ambience akin to intimacy. But it is an uneven and spurious intimacy: uneven because the patient offers more self-disclosure than the doctor; and spurious because legal, ethical and emotional sanctions set limits to it... Some people think doctors are ambivalent about their own needs for intimacy; they simultaneously crave it and fear it. The professional setting of caring and involvement affords an ideal compromise. We use our professional role both as a passport into the lives of other people and as a defence against our own boundaries being encroached."

Denial of emotional reactions
The problem is that we "don't mind patients and psychoanalysts having unconscious needs, but not us, thank you very much". Many doctors deny their feelings or the relevance of those feelings and are certainly very reluctant to discuss them with others. Neighbour sees the unconscious psychological needs of the doctor arising from what he calls the "red light quarter" of the brain, probably part of the right hemisphere but functionally separate from intuition and perceptiveness. Stress is seen as arising when some "pressing personal agenda" becomes active in the red light quarter and competes for your attention.

Developing self-awareness
The solution is that "the doctor who is aware of all these needs and forces at work in him finds that knowledge of his own human frailty brings with it a deepening humility and compassion. He begins to feel safe without barriers...By knowing what passions govern him, yet remaining unafraid of them, they are subdued".
Developing such self-awareness is likened to housekeeping: minute-to-minute tidying is needed as well as regular spring-cleaning. In other words one needs to be aware of one's feelings at moments within and between consultations as well as making longer term plans for things like regular holidays, rejuvenating hobbies, physical fitness and participating in professional support groups such as young practitioner groups or Balint seminars.

Ways to unwind between patients
- Diversionary rituals: make a cup of coffee, read a book, make a phone call
- Talk to someone: colleagues or staff
- Introduce variety: break up day into periods of contrasting activity
- Icons: have a personal object on your desk which has associations of peace and well-being. Neighbour describes techniques for increasing the personal power and effectiveness of icons.

During the consultation
The first task is to recognise in yourself the early signs of stress. What you do about it partly depends on the cause: "Extraneous stresses" such as interruptions, running late or feeling unwell: many patients are understanding if you explain how you feel and attend to the problem of highest priority. "Intrinsic stresses" are those which "arise as a result of your reactions, often irrational, to the particular patient who has inadvertently rubbed you up the wrong way." Telling the patient how you are feeling is not recommended unless you have had training and supervision in psychotherapy techniques and are planning to use the revelation of your feelings as a prelude to a therapeutic discussion. But there are other options:

1) Spot the projection
Sometimes patients remind us by chance of someone we dislike and we project our negative feelings onto the "innocent" patient in a form of mistaken identity. The way to deal with it is to firstly to recognise that it has happened and then to try to note a few specific features of the person in front of you which are dissimilar to the memory which has been evoked.

2) Spot the stereotype
Stereotypes reflect prejudices about certain categories or groups and can turn one's attention away from the specific qualities of an individual. Again, the first stage is to recognise that it is happening and the next stage is to look for some feature which does not fit in with the stereotype.

3) "Here and now awareness"
Techniques such as focusing your attention on your breathing can be helpful in crowding out unpleasant thoughts and associations. "If you plant your feet on the ground, your head comes out of the clouds". "Do not try to alter your natural breathing or turn it into what you imagine relaxed breathing to be. Just notice the way it is."

4) Adjust your muscle tone
The basis of many relaxation techniques is to monitor and alter muscle tension e.g. in jaw, neck shoulders and fists. "Tense and then let go" techniques can be very effective.
FURTHER SKILLS AND MODELS

MINIMAL CUES

In "The Inner Consultation", Roger Neighbour is particularly concerned with patient-centredness and he argues convincingly that non-judgemental awareness of the "physical signs of the patient's inner thoughts and feelings" both helps to build rapport and helps in choosing the way in which the doctor can most effectively communicate with a particular individual.

In order to understand the patient's internal world, verbal and non-verbal cues are important. These are referred to by Neighbour as the "minimal cues" which are the patient's language of self expression and are described clearly in several very useful sections of "The Inner Consultation". A few of the main ideas are summarised below with extensive quotation from and paraphrasing of that book.

Crucial information is often available early in the consultation. Two things may happen at the start, when their significance may not be immediately obvious, but they deserve special attention: "curtain raisers" and "opening gambits".

Curtain-raiser
This is "an unrehearsed and unscripted remark" which may betray a lot about a patient's state of mind or the way s/he perceives you. It may be generated spontaneously in response to the way the doctor looks.

   e.g. "You're very busy this morning..."
        "I'm sorry to be a nuisance..."
        "I don't think we've met- I usually see the other doctor..."
        "It's the bad penny again..."

Sometimes the curtain-raiser may simply be a bit of social ritual e.g. a comment about the weather and not loaded with particularly useful information. Doctors who say "Hello, come in..." (with a pause) will have the benefit of more curtain-raisers than those who say "Hello, what can I do for you?" which moves the patient straight to the opening gambit. In other words, a doctor's opening ritual may easily suppress curtain-raisers.

Opening gambit
This is the rehearsed "opening move" (chess analogy) and is the only part of the consultation over which a patient has much direct control. While waiting to see the doctor, a lot of thinking and planning takes place about the way in which symptoms are going to be expressed and what is going to be said first. The form of words chosen may be very significant and so it is best to listen and to avoid interrupting with questions.

Gift wrapping
This refers to the ability of a doctor to tailor an explanation or instruction to the patient's own concepts and modes of expression. This requires some "matching" by the doctor of the patient's minimal cues. If this is done, the patient is more likely to feel understood and this
will help build rapport as well as aid compliance.

**Speech censoring**
Take note of the images and metaphors used and also notice if something is not said. What is said is subject to internal censoring: "the spoken part of a communication is a compromise between truth and safety, between the need to reveal and the instinct to defend the self-image". Neighbour adds: "By being frank, you (as a patient) might talk your way into some unpleasant treatment, or finding yourself getting upset, or having to worry about a possible serious diagnosis, or revealing something you feel ashamed of."
There are certain physical signs of speech censoring which represent a "cluster" of cues, verbal and non-verbal:

<table>
<thead>
<tr>
<th>Non-verbal</th>
<th>Verbal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of eye contact</td>
<td>Hesitations</td>
</tr>
<tr>
<td>Change in voice quality</td>
<td>Omissions</td>
</tr>
<tr>
<td>Restless shift in position</td>
<td>Vagueness</td>
</tr>
<tr>
<td></td>
<td>Non-sequiturs</td>
</tr>
</tbody>
</table>

It is important to notice censoring because the information being suppressed may be clinically important and because you may be able to help the patient to find ways of expressing safely what is of most concern.

**Internal search**
This refers to the serious thinking, often in response to a question, where attention is directed inwards and we are "racking our brains" and deciding what to say and what not to say. It is important not to interrupt as you may destroy a line of thought which is particularly productive. Again there are useful signs:

<table>
<thead>
<tr>
<th>Non-verbal</th>
<th>Verbal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immobility: freezing</td>
<td>Quiet: lengthy pause</td>
</tr>
<tr>
<td>Eyes look up (remembering visual memories)</td>
<td></td>
</tr>
<tr>
<td>Eyes go still and unfocused</td>
<td></td>
</tr>
<tr>
<td>Eyes look down and to left (planning what to say)</td>
<td></td>
</tr>
<tr>
<td>Eyes refocus and body shifts at end of search</td>
<td></td>
</tr>
</tbody>
</table>

**Acceptance set**
Speech is subject to considerable censoring but non-verbal cues are less censored. One particular set of cues is the way in which an individual signifies his agreement. Acceptance cues are much more variable than the two clusters already described (speech censoring and internal search). The variation occurs both between individuals and for a single individual at different times. The important thing is to notice how someone shows their acceptance and this may be done by making one or two statements with which they are likely to agree, in order to "calibrate" their individual responses (Neighbour's term). For example, you might say: "It's cold today isn't it?" If the patient nods, looks steadily at you, says "mmm" and then echoes "yes its cold", you may deduce that nodding, steady gaze, "mmm" and echoing indicate acceptance if they occur later in the consultation.
CONFRONTATION

Of the "six category interventions", the one which most doctors find hardest is confrontation. Heron described the interventions in terms of client and therapist rather than doctor and patient and this summary uses the same terminology.

THE CLIENT MAY BE UNAWARE
Some attitudes, beliefs and actions may be perceived by the therapist as being rigid or maladaptive and contributing to a client's problems. One of the features of a therapeutic relationship is the power given to the therapist to raise a client's awareness of these problems, even though this "warrant" is often unstated. Most of us find confrontation hard because we are anxious about the client's reaction to unsolicited feedback about a distorted behaviour pattern.

PSYCHOANALYTIC EXPLANATIONS
Psychoanalytic models presume that a client has an investment in not recognising her/his own contribution to a problem. Such behaviours are often seen as arising from the unfinished emotional business from the past. Exploring such issues may generate a lot of strong feelings within the client and the therapist may feel "Who am I to judge this person?" or "Can I cope with saying this?". Psychoanalytic models attempt to explain such anxiety in the practitioner as arising from that person's own archaic fear and anger due to unresolved conflicts in childhood.

CONFRONTATION IS SUPPORTIVE
Confrontation involves a direct challenge to the client, but is not aggressive or combative. It should be supportive, deeply affirming the worth of the client, but at the same time using an uncompromising spotlight on negative attitudes and behaviour.

THREE DANGERS

1) Aggression - "The Sledgehammer"
   Anxiety in the practitioner is expressed as a hurried, bungled or hurtful statement which leaves the client wounded or unnecessarily defensive. Such interventions are seen as arising from "An archaic legacy of anger".

2) Avoidance -"pussy footing"
   Anxiety about the consequences of the confrontation for the client leads the therapist to collusion, dodging the issue. This fear of hurting someone may also relate to the previous experiences of the therapist.

3) Swinging from aggression to avoidance
   This occurs when a therapist makes an attempt at confrontation and the patient rapidly becomes defensive. This makes the therapist feel guilty and the therapist tries to "make it better" by saying something like "I didn't mean it" or "It doesn't really matter". Once this has happened, it becomes increasingly difficult to raise the avoided issue again.
SUCCESSFUL CONFRONTATION

There are several important factors which contribute to success.

1. The manner of the therapist
   This means what Heron calls "telling the truth lovingly" poised between the pussy foot and the sledgehammer, the therapist keeps to the "razors edge of truth" and at the same time affirms the client's worth.

2. On target and right depth
   It is essential that the therapist is confident that s/he has "got it right" before attempting confrontation and it is important to judge the right depth so that the client is not wounded by the experience.

3. Timing is crucial
   The client must have some willingness to hear what the therapist has to say and this will depend partly on the negative consequences of her/his situation.

4. Opportunities for change
   There is no point in making a confrontation unless there are possibilities for change within the client's psychosocial environment.

DIFFERENT SITUATIONS

Confrontational interventions may be necessary in many different situations. In some ways breaking bad news about a terminal illness or talking to a relative about sudden bereavement of their spouse involves a degree of confrontation in that there is a difficult balance between wishing to soften the blow and telling the truth.

Confrontation is more clearly involved in inter-personal problems such as marital problems or helping clients with alcoholism or drug dependency. Other clients may have problems at work or in larger groups and confrontation has an important part to play in such contexts too.

(Reference - Heron J., Helping the Client - Sage Publications, 1990)
THE ‘DESC’ MODEL

Bower & Bower popularised a model for giving constructive feedback which provides a very practical approach to some types of confrontation. The model is called DESC:

D  describe
E  explain
S  specify
C  consequences

Describe
The first task is to describe the behaviour of concern in the most specific and objective terms possible. For example: "When you decide to stop taking your tablets without consulting me..."

Express or explain
Next, you express your feelings about this behaviour or explain the difficulties it causes for you. Do this calmly and positively without blaming or judging the patient. For example: "Stopping your tablets makes me very concerned because I know that you may suffer in the future and annoys me because I spent a lot of time and trouble trying to get the best combination of tablets to suit your condition."

Specify
Then specify the exact change in behaviour you want from the patient. Only suggest one change and make sure the change is well within the patient's capability. e.g. "So in future, please will you consult me before making such decisions".

Consequences
The likely consequences of the change in behaviour are stated with the benefits both for you and for the patient, along with any concessions you are prepared to make. "If you let me know when you want to stop a tablet, I can at least monitor your condition with extra care and help you to judge whether you have made the right decision."

A further example: this model might be used in "modifying help seeking behaviour":

Describe: "When you ask for an emergency appointment for your elbow which has been sore for six months, you are misusing the appointment system."

Explain: "This irritates me because you have misled both the receptionists and me. In addition I know that I only have a short 5 minute emergency appointment time to try to assess something which has clearly become a chronic problem for you."

Specify: "In future if you have a problem which is not really urgent, please ask for a routine appointment"

Consequences: "If you do, I will be able to provide better medical care to you and to others. For example, I would have time to discuss in detail the pros and cons of physiotherapy and cortisone injections so that you can make an informed choice about your own treatment."
THE JO-HARI WINDOW

Jo and Hari described their "window" in the 1970's. Working as therapists in the United States, they sought to classify the knowledge that client and therapist have in common and what is unknown during a consultation. Their window is a two-by-two table with 4 cells each containing a different category of information. Here the two people are referred to as doctor and patient rather than therapist and client.

<table>
<thead>
<tr>
<th>Cell</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>Information in this cell is known by the doctor and the patient (OPEN)</td>
</tr>
<tr>
<td>2)</td>
<td>Information in this cell is known by the doctor and not by the patient (BLIND)</td>
</tr>
<tr>
<td>3)</td>
<td>Information in this cell is known by the patient and not by the doctor (HIDDEN)</td>
</tr>
<tr>
<td>4)</td>
<td>Neither doctor nor patient is aware of this information (UNKNOWN)</td>
</tr>
</tbody>
</table>

Cell (1) contains information known to both parties and is often what the consultation is about at "face value" or "presenting symptom medicine". Sore throat, penicillin, next patient!

Cell (2) contains information known to the doctor which the patient does not know, for example what other family members may have said or the contents of a consultant's letter. It also includes some of the doctor's perceptions about the patient about which the patient may be unaware. Many forms of psychotherapy aim to increase the patient's self knowledge by using the doctor's perceptions of and feelings about the patient as a therapeutic tool. Feedback is used to promote the patient’s self discovery- in other words a catalytic intervention.

Cell (3) contains information which the patient for whatever reason chooses not to disclose. What is not said is often as important as what is said (like in a job reference about somebody!). When a relationship of trust develops, this hidden information may be revealed.

The ability to explore the patient's ideas concerns and expectations may shift crucial information from cell (3) to cell (1) during the course of a consultation.

Cell (4) contains information about which neither doctor nor patient is aware.

The fourth cell is very important. Things may be going on in a consultation about which neither party is consciously aware. This is the reason that many therapists are themselves supervised by another therapist: only some external person or event can make doctor or patient aware of such things. This is also a very good reason for sharing videos of one's consultations with others: by focusing attention on an important aspect of the consultation about which we may not have been aware, new light may be shed on subsequent consultations and new types of awareness developed.
HEARTSINK PATIENTS

This section is a summary of parts of a chapter in *Critical Reading for the Reflective Practitioner* (Clarke and Croft, 1998). Here the introduction and two key papers are summarised; one about different types of heartsink patient, the other giving helpful advice for somatising patients.

What is a heartsink patient?
The feelings induced in practitioners by their patients form a major theme in British general practice following the work of Balint. Many different terms have been used to describe patients perceived as difficult, but "heartsink" seems to be the most widely used, summarising as it does the strength of feelings in a way which is lacking in descriptions such as "problem patients".

Although the term heartsink patient implies implicitly that the source of the problem is the patient, and is pejorative because of this, it is essential to remember that problems arise from an interaction between practitioner and patient and that the contribution of both to the relationship must be acknowledged.

Pause for a moment and consider one or two patients you have seen recently who have made your heart sink.
- What was difficult about them?
- Can you think of other patients where similar difficulties have arisen?
- What feelings did you experience?
- How have you dealt with such feelings in the past?
- Can you identify anything about your approach attitude or life experience which may have made these consultations difficult?

Feelings
Heartsink patients are being defined by the effects they have on the practitioner and these can include feelings of:
- frustration, irritation, exasperation, anger, dislike, hatred
- sadness, hopelessness, inadequacy
- unprofessionalism because of the strong negative emotions felt

Ellis (referring to "dysphoria" induced by patients) describes the feelings as: "feelings felt in the pit of your stomach when their names are seen on the morning's appointment list" (Ellis, 1986). The range of emotions is wide as indicated above and may include particularly a sense of humiliating failure and disappointment in oneself for having such "unprofessional" feelings. Many different types of behaviour can induce such feelings; if it was only one type, you might expect that we would all have gone on a simple course to learn the appropriate coping skills.

There are a few patients who manage to antagonise every practitioner they see, but there are probably an equal number who just "get under the skin" of one particular practitioner and with whom other carers have no major problems. This raises the question of whose problem it really is. Some patients go through a difficult phase, often related to life events, when they appear to make enormous emotional demands on those providing care. When circumstances change, they may no longer make your heart sink.
Frequent attenders, somatisers and patients with lists
Heartsink patients may be hard to define but (like the elephant) you're pretty sure you know one when you see one. A heartsink patient is not the same as a frequent attender because many of the latter do not cause such strong antipathy. However, they do seem to consult frequently. They are also different from somatisers although some may have a tendency to somatisation. Similarly, the term dysfunctional consultation may apply to some interactions with heartsink patients but may equally apply on particular occasions to patients with whom one has a relationship which is not characterised by a sense of heartsink. It may be best to regard these other terms as overlapping concepts which commonly form part of a heartsink doctor-patient relationship but which do not necessarily define it. Some, but not all, patients "with a list" can cause a feeling of heartsink (Middleton, 1994).

Groves' four stereotypes of "hateful patients" (Groves, 1978)
Four stereotypes of "hateful patients" were described by an American psychiatrist (Groves, 1978). This paper is widely quoted and provides a simple classification of some of the main sorts of behaviour which reliably upset clinicians. It also emphasises the validity of the practitioner's feelings as diagnostic data: it is helpful to examine these feelings for managing the patient as well as for managing yourself.

Groves points out that negative reactions to patients "constitute important clinical data about the patient's psychology" and that emotional reactions "cannot simply be wished away, nor is it good medicine to pretend they do not exist." Rather such feelings can be used in an attempt to understand the patient and can facilitate appropriate psychological management. He confines his attention to patients who cause more than mild irritation: those "whom most physicians would dread to treat" and defines four stereotypes of "hateful patient". All have in common a great dependency on carers, an "insatiable dependency".

Summary of Groves classification:

a) Dependent clingers- will not take responsibility
b) Entitled demanders- dissatisfied with service, excessive demands: "I know my rights"
c) Manipulative help rejectors ("nothing has worked")
d) Self-destructive deniers (eg deny risk factors)

a) Dependent clingers
Clingers make repeated requests for reassurance, explanation, tablets and all sorts of care. They are "overt in their neediness" and see the physician as "inexhaustible". Early on such patients may express genuine gratitude, but to an extreme degree and the practitioner may feel powerful and special because of this. There may be flattery by the patient or even unconscious seduction. Later, when the demands for care are incessantly repeated, the practitioner may become exhausted. Groves uses the analogy of a mother's relationship with an unplanned, unwanted and unlovable child and points out that any attempt to refer the patient to a psychiatrist are usually interpreted correctly as rejection and doomed to failure. The best management is to inform the patient that the practitioner "has not only human limits to knowledge and skill but also limitations to time and stamina". In addition, it may help to take the initiative in arranging follow-up. The
practitioner "who begins to feel an aversion towards the patient should think of setting limits on dependency."

b) Entitled demanders
These patients may feel equally needy but they express their need in an overtly hostile way, using intimidation, threats of litigation, devaluation and guilt induction. This is perceived by the practitioner as either pathetic or repulsive and often induces a wish to counter-attack. It may be hard for the practitioner to realize that such behaviour may be a way of preserving the self "in a world that seems hostile or during an illness that seems terrifying". Attacking the patient by denying their entitlement may be harmful; it is better to acknowledge the entitlement but re-direct it towards the goal of good care. Groves points out that it is easy to get into fruitless debate with such patients and suggests the best approach is to assure the patient repeatedly that you will do your best to ensure that they get the best possible medical care.

c) Manipulative help-rejectors
"Unlike clingers, they are not seductive and grateful; unlike demanders they are not overtly hostile". Instead, they return repeatedly saying that the treatment or plan suggested has not worked. They seem quite satisfied by this, sometimes smug. The more efforts the practitioner makes, the more pessimistic are the patient's reports. If one symptom improves, another "mysteriously appears in its place". What is really sought by the patient, probably unconsciously, is "an undivorcible marriage with an inexhaustible caregiver". The practitioner starts out anxious that a treatable condition may have been overlooked, then becomes irritated by the repeated appearance of a pessimistic patient. Finally, the practitioner may begin to doubt herself and become depressed. Groves suggests that the correct intervention is to "share the pessimism- to say that the treatment may not be entirely curative". Regular follow up may be planned as a way of ensuring that the patient may begin to realise that if he loses his symptoms he will not necessarily lose his practitioner.

d) Self-destructive deniers
These are patients such as the alcoholic with oesophageal varices who continues drinking. They are profoundly dependent but "have given up hope of ever having needs met. Such patients seem to glory in their own self-destruction. They appear to find their main pleasure in furiously defeating the physician's attempts to preserve their lives." Groves points out that what one can do to help them is quite limited and that doctors usually respond with a wish that the patient will die "and get it over with". It may help the carers to recognise that the denier may actually wish to die. The wish to abandon the patient should be resisted and compassion found "just as one does with any other patient with a terminal illness".

Surviving the heartsink experience (Mathers and Gask, 1995)
The feeling of heartsink is often experienced as "angry helplessness" and practitioners often feel they do not know what to do when such patients consult. This often boils down to lack of control, called "helplessness in the helpers" by Adler (Adler, 1972). The solution may be in part to recognise that practitioners' "hearts often sink because they cannot control their patients, yet many patients… have a desperate need to be in control of something and the doctor patient consultation may be an easy target for those feelings." Rather than enabling the practitioner to
feel more in control, the authors wish to promote a "more balanced, open and realistic view of what has happened in the consultation".

A small one-day workshop was designed to give participants a greater understanding of the heartsink experience and to facilitate the development of coping skills. They describe a "heartsink survival pack" with four components:

<table>
<thead>
<tr>
<th>The heartsink survival pack (Mathers and Gask, 1995)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Skills for difficult consultations with a somatizing patient</td>
</tr>
<tr>
<td>2) General strategies for difficult consultations</td>
</tr>
<tr>
<td>3) Coping strategies</td>
</tr>
<tr>
<td>4) Goal re-assessment: a problem solving approach for group discussion</td>
</tr>
</tbody>
</table>

Here we will summarise just the first section on the somatising patient. For further details, read the original article, or the more extensive summary in Clarke and Croft (1998).

**Skills for difficult consultations with a somatizing patient**

The first stage is to make the patient feel understood by taking a full history including exploration of health beliefs, emotional issues and social and family factors. It is particularly important to acknowledge the reality of the symptoms and if you feel there may be a psychosomatic component, the most powerful question is to ask about the effects of the problem. Somatising patients will often answer this with graphic detail, while remaining relatively silent on “What do you think is causing the problem?”. A picture of the “effects” of the problem will often give details of sources of stress and unhappiness which may be relevant to the presenting symptoms.

The second stage is to "broaden the agenda" by giving honest feedback of the results of examination and tests, acknowledging the reality of the symptoms (crucial) and reframing the symptoms. This involves linking physical, psychological and life events in a tentative way leaving the patient room to negotiate. Thirdly, "making the link" by giving the patient a simple explanation of how psychological distress can cause physical symptoms and test to see if the explanation is accepted.

This could be viewed as a model with three essential components:

1) Acknowledge
2) Explain
3) Make the link
1) Acknowledge
Remember the pain is real even though you, as practitioner can’t make sense of it in terms of having a well defined biomedical cause; patients often feel doctors think they are imagining it or “putting it on”. Very, very few patients make up their symptoms.

2) Explain (“re-framing”)
For example, “the headache is caused by tension in the muscles- I can feel the knots” or “the pain in your tummy is caused by adrenalin which makes the bowel go into spasm; the usual cause of too much adrenalin is stress”.

3) Make the link
This is where all the information gained in asking about the “effects of the problem” can be used and “turned round” so that the patient may see the vicious circle so often created by stress. Stress causes real physical symptoms which leads to anxiety, distress and avoidance behaviour which in turn lead to unhappiness which causes further stress. For example, “You’ve told me about your husband being made redundant and how you’ve stopped going out because you have so many headaches; it sounds as though you’re stuck at home a lot. That in itself can be very stressful. I’m wondering if that’s why you’re getting so much muscle tension. It’s the muscle tension which is keeping the headaches going.”

Such an approach can frequently help with patients whose basic investigations are normal but who remain with:
- tiredness all the time
- constant headaches
- abdominal pain, bloating, (IBS)
- palpitations
- hyperventilation
- non cardiac chest pain
- globus

For each of the above, assuming that appropriate investigation reveals no organic cause and confirm your initial hunch that the symptoms are real but have a psychosomatic basis, try writing a brief explanation linking stress mechanistically with the production of symptoms. You may try using muscle tension or adrenalin as mediators or you may have other explanations which you have found helpful. Not all patients will want or accept a mechanistic explanation; for example, some might relate to an explanation of chest pain being due to a “broken heart” following bereavement. Try now to think of symbolic explanations for each of the above. It’s harder because we’re brought up with a mechanistic view of the world and a very mechanistic medical training!

References
APPENDICES

Appendix 1

Reading About The Consultation

The Doctor, his Patient and the Illness; Michael Balint
First published in 1957, much of it reads as if it might have been written yesterday. An enduring classic, with an undeserved reputation for being difficult.

Doctors Talking to Patients; Patrick Byrne and Barrie Long
An impressive analysis of audio taped consultations. Byrne and Long's consultation model remains useful and easy to apply.

The Inner Consultation; Roger Neighbour
The most often quoted book about the consultation amongst registrars. Includes an impressive and thoughtful analysis of other consultation models.

The Consultation - An approach to learning and teaching
Pendleton, Schofield, Tate and Havelock

Culture, Health and Illness; Cecil Helman
The anthropological approach. Not light reading.

Family Medicine; FJA Huygen and To Heal or to Harm; Richard Grol
These two books are additions to the general practice literature from the Netherlands which, of European countries, seems to have an approach to medicine quite like our own. Both are published by the RCGP.

The Doctor's Communication Handbook; Peter Tate
An excellent introduction.

Meetings Between Experts; Tuckett, Boulton, Olson & Williams
A study of over one thousand consultations which stresses the importance of exploring the ideas patients have about their illnesses.

The trainee's companion to general practice; Rosenthal, Naish and Lloyd
Chapter by Dick Savage "Communication in practice" is a superb short introduction and deals with areas not covered by many longer books e.g. consultations by telephone, dealing with an angry patient, and breaking bad news.

Problems with patients: managing complicated transactions. Norton, K. and Smith, S.
Cambridge University Press, 1994. pp. 1-174 This is an "advanced" book which takes further the concepts developed by Neighbour about housekeeping. It provides a very useful framework for analysing difficult consultations.
Appendix 2

PATIENT'S CONSENT FORM

Patient's name........................

Consent to Video Recording

• We are hoping to make video recordings of some of the consultations between patients and ......................... whom you are seeing today.

• The videos are part of the trainee practitioner’s education to help improve consulting skills.

• The video is ONLY of you and the practitioner talking together. No intimate examination will be done in front of the camera.

• The video will be seen only by other practitioners.

• You do not have to agree to your consultation being recorded. If you want the camera turned off please tell a receptionist - this is not a problem.

• But if you do not mind your consultation being recorded we are grateful to you. Work on consultation skills leads to a better service to patients.

• If you consent to this consultation being recorded please sign below.

Thank you very much for your help.

Signed:  ................................................................. Date:  ...........................................

Signature(s) of any accompanying person(s):.................................................................

After you have finished the consultation, please sign below to confirm that you are still happy to have the recording used.

Signed:  ................................................................. Date:  ...........................................

Signature(s) of any accompanying person(s):.................................................................