



## ABC of psychological medicine: The consultation

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*ABC of psychological medicine***The consultation**

Linda Gask, Tim Usherwood

The success of any consultation depends on how well the patient and doctor communicate with each other. There is now firm evidence linking the quality of this communication to clinical outcomes.

*The dual focus*—Patients are not exclusively physically ill or exclusively emotionally distressed. Often they are both. At the start of a consultation it is usually not possible to distinguish between these states. It is the doctor's task to listen actively to the patient's story, seeking and noticing evidence for both physical illness and emotional distress.

*Involving patients*—Changes in society and health care in the past decade have resulted in real changes in what people expect from their doctors and in how doctors view patients. In addition, greater emphasis has been placed on the reduction of risk factors, with attempts to persuade people to take preventive action and avoid risks to health. Many patients want more information than they are given. They also want to take some part in deciding about their treatment in the light of its chances of success and any side effects. Some patients, of course, do not wish to participate in decision making; they would prefer their doctor to decide on a single course of action and to advise them accordingly. The skill lies in achieving the correct balance for each patient.

*A comprehensive model*—The “three function” model for the medical encounter provides a template for the parallel functions of the clinical interview. This is now widely used in medical schools.

**Starting the interview**

Research has shown the importance of listening to patients' opening statements without interruption. Doctors often ask about the first issue mentioned by their patients, yet this may not be what is concerning them most. Once a doctor has interrupted, patients rarely introduce new issues. If uninterrupted, most patients stop talking within 60 seconds, often well before. The doctor can then ask if a patient has any further concerns, summarise what the patient has just said, or propose an agenda—“I wonder if I could start by asking you some more questions about your headaches, then we need to discuss the worries that your son has been causing you.”

**Detecting and responding to emotional issues**

Even when their problems are psychological or social, patients usually present with physical symptoms. They are also likely to give verbal or non-verbal cues. Verbal cues are words or phrases that hint at psychological or social problems. Non-verbal cues include changes in posture, eye contact, and tone of voice that reflect emotional distress.

It is important to notice and respond to cues at the time they are offered by patients. Failure to do so may inhibit patients from further disclosures and limit the consultation to discussion of physical symptoms. Conversely, physical symptoms must be taken seriously and adequately evaluated. Several of the skills of active listening are valuable in discussing physical, psychological, and social issues with patients. These skills have been clearly shown to be linked to recognition of emotional problems when used by general practitioners.



Visiting the sick woman, by Quiringh Gerritsz van Breckelenkam (c 1620-68)

**Three functions of the medical consultation****1 Build the relationship**

- Greet the patient warmly and by name
- Active listening
- Detect and respond to emotional issues

**2 Collect data**

- Do not interrupt patient
- Elicit patient's explanatory model
- Consider other factors
- Develop shared understanding

**3 Agree a management plan**

- Provide information
- Appropriate use of reassurance
- Negotiate a management plan
- Make links
- Negotiate behaviour change

**Responding to patients' "cues"****Verbal cues**

- State your observation—“You say that recently you have been feeling fed-up and irritable”
- Repeat the patient's own words—“Not well since your mother died”
- Seek clarification—“What do you mean when you say you always feel tired?”

**Non-verbal cues**

- Comment on your observation—“I can hear tears in your voice”
- Ask a question—“I wonder if that upsets you more than you like to admit?”

**Aspects of interview style that aid assessment of patients' emotional problems****Early in the interview**

- Make good eye contact
- Clarify presenting complaint
- Use directive questions for physical complaints
- Begin with open ended questions, moving to closed questions later

**Interview style**

- Make empathic comments
- Pick up verbal cues
- Pick up non-verbal cues
- Do not read notes while taking patient's history
- Deal with over-talkativeness
- Ask more questions about the history of the emotional problem

**Active listening skills**

*Open ended questions*—Questions that cannot be answered in one word require patient to expand

*Open-to-closed ones*—Move towards closed questions at the end of a section of the consultation

*Checking*—Repeat back to patient to ensure that you have understood

*Facilitation*—Encourage patient both verbally (“Go on”) and non-verbally (nodding)

*Legitimising patient’s feelings*—“This is clearly worrying you a great deal,” followed by, “You have an awful lot to cope with,” or, “I think most people would feel the same way”

*Surveying the field*—Repeated signals that further details are wanted: “Is there anything else?”

*Empathic comments*—“This is clearly worrying you a great deal”

*Offering support*—“I am worried about you, and I want to know how I can help you best with this problem”

*Negotiating priorities*—If there are several problems draw up a list and negotiate which to deal with first

*Summarising*—Check what was reported and use as a link to next part of interview. This helps to develop a shared understanding of the problems and to control flow of interview if there is too much information

**Eliciting a patient’s explanatory model**

When people consult a doctor, they do so with explanatory ideas about their problems and with anxieties and concerns that reflect these ideas. They are also likely to have hopes and expectations concerning the care that they will receive. It is important not to make assumptions about patients’ health beliefs, concerns, and expectations but to elicit these as a basis for providing information and negotiating a management plan.

People’s health beliefs and behaviours develop and are sustained within families, and families are deeply affected by the illness of a family member. “Thinking family” can help to avoid difficult and frustrating interactions with family members.

**Providing information**

Doctors should consider three key questions when providing information to a patient:

- What does the patient already know?
- What does the patient want to know?
- What does the patient need to know?

The first question emphasises the importance of building on the patient’s existing explanatory model, adding to what he or she already knows, and correcting inaccuracies. The second and third reflect the need to address two agendas, the patient’s and the doctor’s. In addition, it is important for the doctor to show ongoing concern and emotional support, making empathic comments, legitimising the patient’s concerns, and offering support.

**Negotiating a management plan**

The ideal management plan is one that reflects current best evidence on treatment, is tailored to the situation and preferences of the patient, and addresses emotional and social issues. Both patient and doctor should be involved in developing the plan, although one or the other may have the greater input depending on the nature of the problem and the inclinations of the patient.

**Appropriate use of reassurance**

Reassurance is effective only when doctors understand exactly what it is that their patients fear and when they address these fears truthfully and accurately. Often it is not possible to reassure patients about the diagnosis or outcome of disease, but it is always possible to provide support and to show personal concern for them.

**Dealing with difficult emotions: denial, anger, and fear**

*Denial*—When patients deny the seriousness of their illness you should never be tempted to force them into facing it. The decision on how to address denial must be based on how adaptive the denial is, what kind of support is available to the patient, and how well prepared the patient is to deal with the fears that underlie the denial.

**Think family****When interviewing an individual**

- Ask how family members view the problem
- Ask about impact of the problem on family function
- Discuss implications of management plan for the family

**When a family member comes in with patient**

- Acknowledge relative’s presence
- Check that patient is comfortable with relative’s presence
- Clarify reasons for relative coming
- Ask for relative’s observations and opinions of the problem
- Solicit relative’s help in treatment if appropriate
- If patient is an adolescent accompanied by an adult always spend part of consultation without the adult present
- Never take sides

**Negotiating a management plan****Ascertain expectations**

- What does patient know?
- What does patient want?—Investigation? Management? Outcomes?

**Advise on options**

- Elicit patient’s preferences

**Develop a plan**

- Involve patient
- Tailor preferred option to patient’s needs and situation
- “Think family”

**Check understanding**

- Ensure that patient is clear about plan
- Consider a written summary

**Advise on contingency management**

- What should patient do if things do not go according to plan?

**Agree arrangements for follow up and review**

Reassurance is an essential skill of bedside medicine. (Hippocrates (469-399 BC), the “father of bedside medicine”)

**Anger**—If patients or relatives become angry, try to avoid being defensive. Acknowledge the feelings that are expressed and ask about the reasons for these. Take concerns seriously and indicate that you will take appropriate action.

**Fear**—Many patients are frightened that they may have some serious disease. It is crucial to ensure that you have addressed what a patient is really worried about as well as checking that the patient has correctly understood what you are concerned about.

### Motivation

Efforts to help people reduce alcohol consumption, stop smoking, and manage chronic illness have highlighted the importance of good interviewing skills in motivating patients to change their behaviour. This is not to say that patients no longer have the responsibility for such change, but doctors should recognise that they bear some responsibility for ensuring that patients get the best possible help in arriving at the decision to change.

### Making the link between emotions and physical symptoms

Particular strategies may be needed to help people who present with physical symptoms of psychological distress but who have not made the link between these and their emotional and life problems. However, it is essential that you do not go faster than the patient and try to force the patient to accept your explanation.

Ensuring that the patient feels understood is essential. It is crucial to get the patient on your side and show that you are taking his or her problems seriously. Start from the patient's viewpoint and find out what the patient thinks may be causing the symptoms, while at the same time picking up any verbal and non-verbal cues of emotional distress.

*Broadening the agenda* can begin when all the information has been gathered. The aim is to broaden the agenda from one where the problem is seen essentially as physical to one where both physical and psychological problems can be acknowledged. Acknowledging the reality of the patient's pain or other symptoms is essential and must be done sensitively. Summarise by reminding the patient of all the symptoms, both physical and emotional, that you have elicited and link them to life events if this is possible.

*Making the link* can involve various techniques. Only one or two will be appropriate for each patient, and different techniques may be useful at different times. Simple explanation is the commonest, but it is insufficient to say "Anxiety causes headaches." A three stage explanation is required in which anxiety is linked to muscle tension, which then causes pain. A similar approach can be used to explain how depression causes lowering of the pain threshold, which results in pain being felt more severely than it otherwise would be.

Once the patient and doctor have agreed that psychological distress is an important factor in the patient's illness, they can start to examine management options to address this. Even if the patient has significant physical disease, it is important to detect and manage psychological comorbidity.

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The ABC of psychological medicine is edited by Richard Mayou, professor of psychiatry, University of Oxford; Michael Sharpe, reader in psychological medicine, University of Edinburgh; and Alan Carson, consultant neuropsychiatrist, NHS Lothian, and honorary senior lecturer, University of Edinburgh. The series will be published as a book in Winter 2002.

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## Helping patients to change their behaviour

### Explore motivation for change

- Build rapport and be neutral
- Help draw up list of problems and priorities
- Is problem behaviour on patient's agenda?
- If not, raise it sensitively
- Does patient consider the behaviour to be a problem?
- Do others?

### Clarify patient's view of the problem

- Help draw up a balance sheet of pros and cons
- Empathise with difficulty of changing
- Reinforce statements that express a desire to change
- Resist saying why you think patient ought to change
- Summarise frequently
- Discuss statements that are contradictory

### Promote resolution

*If no change is wanted negotiate if, when, and how to review*

- Enable informed decision making
- Give basic information about safety or risks of behaviour
- Provide results of any examination or test
- Highlight potential medical, legal, or social consequences
- Explain likely outcome of potential choices or interventions
- Get feedback from patient
- Give patient responsibility for decision

## Key stages in linking somatic symptoms of emotional distress

- Helping patient to feel understood
- Broadening agenda to cover physical, psychological, and social issues
- Negotiating explanations for how physical symptoms, psychological distress, and social problems may be linked via physiological mechanisms

## Evidence based summary

- The style with which a doctor listens to a patient will influence what the patient says
- Effective communication between doctor and patient leads to improved outcome for many common diseases
- Patients' compliance will be improved if the management plan has been negotiated jointly

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