

# Hints and tips on the medical consultation

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Whether you are seeing a patient in an outpatient clinic, the emergency department or in general practice, the ability to engage in a medical consultation is vital to clinical practice.

**The medical consultation is your basic tool and good communication is king.**

Throughout all modern Australian medical schools, the idea and skills of being a good communicator is drummed into students so I won't necessarily repeat skills that are obvious or self-evident. Rather, the following are some tricks and suggestions that may make you a better communicator.

A good way to think about the goals of a medical consultation is that it has three functions (1):

1. Build the doctor-patient relationship
2. Collection of data
3. To agree on a management plan

## The introduction

This step starts with calling the patient from the waiting room, to having them seated in your room. As the aphorism goes, "first impressions are the most important" - and this is true for both you and the patient.

If the patient perceives you as rushed, tired, stressed, or unhappy, it sets off the consultation on the wrong footing. At one end of the spectrum, some people may respond by not telling you all of their worries or symptoms so not to "burden" you any further. At the other end, some people may respond with anger or irritation as they perceive that your distress diminishes their own problems. Either way, it impairs the doctor-patient relationship and the collection of data.

As a corollary, you [should try to be mindful of your own emotional responses](#) when you lay eyes on the patient. What prejudicial or otherwise illogical assumptions have you made already?

When introducing yourself, call the patient by name. If you read around the popular media about these introductions, there is often an interesting quandary. Some people seem [offended](#) by being referred to by their first name (2). Others chaff that the formalism of being called by their salutation and surname to be anachronistic. Indeed a study in general practice seems to suggest that the majority of patients either prefer or do not mind being called by their first name (3).

A way around this is to use both: e.g., *"Good morning John, Mr Bloggs, I am ..."* and the patient can choose what they prefer.

## The patient angry with waiting

It is an unfortunate reality that patients may have an untimely wait before

they manage to see you. In some settings such as a busy emergency department, this may be the rule rather than the exception. For many junior doctors, the degree of anger directed at them can be confronting.

My approach to this is that the patient's emotions should be validated and accepted. Whether their wait is "unreasonable" or "excessive" is a matter of opinion but their emotional response is real. That being said, I take the position that we should not accept "blame" for something that is often entirely out of our control. Thus, I usually introduce myself to the patient when there has been a wait:

*"Hello Mr Bloggs, my name is Michael Tam, one of the doctors here. Thank you for waiting."*

If they are obviously angry or unhappy, I add, *"I understand that it can be frustrating."*

I find that this approach releases the tension as I've validated their emotional response. I rarely have to discuss this issue further and can go straight to the consultation.

Note that I say *"thank you for waiting"* as opposed to *"sorry about the wait"*. Most people respond to a compliment, "thank you", with appreciative deference while many people will respond to an apology as a vindication of their anger. Surprisingly, these linguistic tricks work which perhaps demonstrates just how much that the way we think is tied to language.

Avoid apologising and avoid being defensive (e.g., "we don't have enough staff", "someone really sick just came in") as it is often unhelpful.

Of course, remember your safety first. **If the patient is unreasonably aggressive or is abusive, you must leave the situation!**

Physical examination begins with observation and inspection, and both begin the moment you meet the patient. During the introduction, you can observe the patient's gait and mobility as they ambulate from the waiting room, whether they came with any family members, their body habitus, their "unobserved" behaviour and current emotional state, etc. With the handshake, you can observe the patient's upper limb co-ordination, hand strength and peripheral perfusion. If you are mindful and observant with your inspection, you will have gained much objective data before the patient has even passed through your door.

## DO

- Be mindful of your own feelings, emotions and appearance at the beginning of the consultation;
- take the opportunity to observe the patient during the introduction;
- follow the dictums of common courtesy; open the door for the patient, greet them warmly by name and shake their hand;
- acknowledge anger or frustration related to waiting times.

## DO NOT

- Project your tiredness, stress, boredom, unhappiness, etc., on your patients;
- appear to be the above (at least, try not in the first 30 seconds of the consultation);
- be defensive or ignore a patient's frustration or distress.

### Starting the interview - taking the history

Many doctors, junior or otherwise, fall into the trap of interrupting their patients during their opening statements. The first issue that a patient brings up is often not the most important. Furthermore, this interruption can give the patient the impression that they are being hurried or worse, that you are not listening.

My suggestion is, and certainly the research has demonstrated, that the opening statements should be listened to without interruptions. Not only will you pick up many clues, but you will have also develop a small general overview of the problem. For example, the patient may be coming in today with an upper respiratory tract infection for 3 days duration, but their real worry is that they haven't been well for 2 months.

Furthermore, most patients if left uninterrupted will "run out of puff" within 30 seconds (4). That time, however often seems much longer to the patient (analogous to how time seems to stretch when making an impromptu speech). I would propose that the doctors of patients who claim that "they didn't listen to me" probably interrupted the patient's opening statements early.

Contrary to the urge of impatience, interrupting the opening statement doesn't save much (if any) time and results in a poorer quality consultation and less satisfaction on the part on the patient.

### Active listening skills - adapted from Gask and Usherwood (1)

*Open ended questions* - questions that cannot be answered in one word require patients to expand: "tell me about this cough"

*Open-to-closed cones* - move towards closed questions at the end of a section of the consultation: "have you coughed up any blood?"

*Checking* - repeat back to the patient to ensure that you have understood: "when you said you were feverish, did you mean that you felt hot and cold and had sweats?"

*Facilitation* - encourage patient both verbally ("Go on") and non-verbally (nodding)

*Legitimising patient's feelings*: "it seems that you have an awful lot to cope with"

*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 problem and to control flow of interview if there is too much information.

Active listening skills are crucial and take time to develop. Many of the above may seem "obvious" but after having seen many doctors consult, I do not believe that these skills come naturally to everyone. You need to practice these skills and try to be actively mindful of what you are doing.

The question, "*is there anything else that I can help you with today*", should be asked early and often. If you only ask this at the end of your consultation, you may unleash a can of worms that you may not have time to deal with adequately (e.g., it is surprising how often a patient leaves a request for a Pap smear or an STI screen until the very end, especially if you didn't ask earlier). Having a general idea of the patient's agenda will help you plan your consultation, and furthermore, negotiate with the patient on issues of lesser priority that are perhaps best dealt with at a later date.

## Further history and examination

Given that communication is of utmost importance, try to avoid whenever possible using a family member to translate. More often than not, you will be wasting your time; you will be unsure of the history and you will be unsure whether the patient actually understands your questions. You must make an attempt to secure a clinical translator. The phone translator services are usually quite good.

I mentioned previously that observation and inspection begins the moment you meet the patient. This process should continue throughout the interview. The way that I conceptualise this is that you should be able to mostly complete a mental state examination by the end of the consultation. Where a psychological issue was not one of the main focuses of the consultation, you should still be able to comment on:

- **Appearance and behaviour:** e.g., dishevelled, garrulous, psychomotor agitation or retardation, fidgeting, aggressive, hostile
- **Speech:** e.g., rapid, slow, monotonous
- **Mood and affect:** e.g., anxious, depressed, high
- **Cognition:** including, level of consciousness, orientation, attention/concentration, memory.

With physical examination, do not be embarrassed to request that the patient sufficiently disrobes so that they can be examined properly. At the same time, preserve modesty by giving them sufficient privacy when changing.

**DO**

- Listen to the patient's opening statements without interruption;
- pick up and follow the verbal and non-verbal cues given to you by a patient;
- use and practice active listening skills;
- be "curious" about the patient;
- use a translator if you think it may be necessary;
- try to determine the patient's agenda (what they want to get out of the consultation) early in the consultation;
- continue with "observation" of the patient.

### **DO NOT**

- Make snap assumptions or judgements on why a patient has presented;
- move immediately into examination and management once you think you have a provisional diagnosis;
- assume that the current physical complaint or illness is the actual problem.

### **Management and the conclusion**

Agreement to a management plan is a negotiation between the doctor and the patient. You may have prescribed a medication or exercise regimen that evidence shows will "fix" the patient's problem but if they do not follow your management advice, it is not going to work. You need to "fit the evidence to the patient", and not the other way around.

Education, exploration of preconceptions, discussion of alternatives and at times, motivational techniques are all required.

Remember that at the end of the day, it is the patient's choice; though, you shouldn't be a nihilist either.

### **DO**

- Involve the patient in the management plan;
- ask how they perceive the plan;
- explore preconceptions that people have about certain therapeutic modalities and try to educate where appropriate;
- give patients an understanding of the aims and goals of therapy;
- think about the psychological and social contexts.

### **DO NOT**

- Force patients into confronting their denials - it is often unhelpful;
- avoid, trivialise or ignore a patient's worries or questions;
- give false reassurance;
- give in to unreasonable demands (e.g., prescribing benzodiazepines, or ordering an unnecessary test).

## References

- (1) Gask L., Usherwood T. ABC of psychological medicine - The consultation. *BMJ*. 2002;324:1567-9. [[Link](#) :: PDF 225 Kb]
- (2) Benton T. Don't call me Thomas. *The Chronicle of Higher Education*. 16 January 2006. [[Link](#)]
- (3) McKinstry B. Should general practitioners call patients by their first names? *BMJ*. 1990 October 6; 301(6755): 795–796. [[Link](#) :: PDF 337 Kb]
- (4) Rabinowitz I., Luzzatti R., Tamir A., Reis S. Length of patient's monologue, rate of completion, and relation to other components of the clinical encounter: observational intervention study in primary care. *BMJ*. 2004 February 28; 328(7438): 501–502. [[Link](#) :: PDF 102 Kb]

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