

Controlling the Consultation I - Setting an agenda and helping the patient to follow it

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This is the first in a series of three articles on controlling the consultation. They are aimed at Registrars but may be of use to others.

- The first addresses setting an agenda in patient centred consulting, and helping the patient understand and stick to it.
- [The second](#) will discuss what to do with new information that arises during the consultation and disrupts the agenda.
- [The last one](#) in this series will look at how interpersonal relationships can affect the doctor's control over the consultation.

As always with consultation skills, they need to be applied flexibly and may not fit the needs of every consultation. To illustrate these skills, this article concentrates on gathering the history, as the basic structure is common knowledge, whereas later parts of the consultation such as educating patients about their diagnoses, and sharing options are complex issues in their own right. A further article on closing consultations will follow at a later date.

Patient-centred does not equal patient-controlled

There is a common misconception that patient-centred consultations are patient-controlled. This should not be true.

The patient attends with a set of symptoms but they also have ideas, concerns and expectations (ICE as defined in Pendleton et al, 2003). Patient-centred consulting comprises a set of attitudes, tasks and skills that can be used to elicit a fuller history than doctor-centred approaches, while also addressing the patient's understanding and worries regarding their symptoms. This is often described as following the patient's agenda.

It is better to think of it as using the patient's medical, social, emotional and educational needs to inform the content of the consultation. It is the doctor's job to set the agenda accordingly. After all, few patients know which symptoms are important and fewer know the structure by which a model consultation should proceed.

Deciding on an appropriate agenda is a specific area of doctor expertise which can be developed for the benefit of both patient and doctor. Once this is taken on board, fears about the effect of patient-centredness on timekeeping should be reduced.

Achieving a good outcome - balancing wants and needs

When thinking about a good outcome from a consultation, it is important to think not only about the diagnostic outcome. Some other questions you might ask are as follows.

- Are other patients waiting over-long for their appointment?
- Is this problem of such significance that I need to run late to sort it out now?
- Does the patient understand what they are to do and why? - Do they agree? (Consider Helman's Folk Model of Illness)
- Have I jumped down one diagnostic road and missed other symptoms or failed to address some of the patient's worries?
- How much information can the patient really take on board in ten minutes?
- Would this be better as two or more consultations?
- Am I being pressured into taking on a role beyond what is appropriate?
- What effect will this consultation have on my patient's future behaviour and on our doctor-patient relationship?

- Why is this consultation making me feel stressed?

The list goes on, but it should be evident that a balance needs to be struck between the patient's wants, their needs and the needs of yourself and others. You will need to decide what needs to be covered, in what order, and whether it should be done today.

You are the expert, it is your consulting room and it is up to you to control the consultation to the best of your abilities to attain a good outcome.

The opening statement

To set your agenda appropriately, you will need to consider the issues, implicit in the questions above, such as available time and information overload. But you will also need a clear idea of what the patient has really come to discuss. Jumping in too early and following the wrong lead wastes valuable time and adds confusion when you find out mid way through the consultation and have to change direction.

Most patients have some plan of what they want to say before they come into the room. You can ask as open a question as possible to start things off (e.g, "How are you?", "What's troubling you?" "What's brought you in today?") or just allow the patient to start talking of their own accord. Then sit and listen.

Listen until the patient has finished, or the story has become repetitive or wandering. If you need to clarify something, make a note of it (mental or otherwise) to return to later, or if it is necessary to interrupt, try to put the patient back on their original track afterwards by saying: "*you were telling me about...*". Typically this takes 60-90 seconds.

When they have finished, you need to check whether there are any other issues they wish to cover. This helps to prevent major detours during the history, or nasty surprises nine minutes into the consultation.

This can also be a good time to explore ICE. There are two places in the consultation particularly apt for these questions. Here at the start of the history can be very useful – particularly if you don't feel you've quite got to the nub of their reasons for attending. You may also have picked up on some cues which will guide you into exploring their ICE.

Alternatively, you can leave ICE until you have finished the history and examination and have a clear idea of the possible diagnoses. This is particularly true when you pick up early cues suggesting concern about significant disease such as cancer, as it is much easier to field difficult questions once one has the beginnings of some answers.

Hopefully by the end of the opening statement section of the consultation, one should have adequate information to set an appropriate agenda. It will need to be flexible, but it's a start. The patient, however, does not know the agenda. You can rectify this by 'signposting' (see next section). You may also want to signpost for the patient what can and can't be covered in this consultation and how you intend to address other issues in future consultations.

For example you could say: "It sounds, from what you've told me, as if there are two separate problems here. I think we should deal with the palpitations thoroughly in this consultation and leave your foot pain until next week. Would that be okay?"

Signposting

Signposting is a means of making the structure of the consultation explicit to the patient.

- It helps establish the doctor's authority and control over the consultation
- It helps the patient understand how the consultation works, thereby reducing anxiety. (Anxiety can be the enemy of good consultation control)
- It can be used to control the flow of information from the patient.
- It can also be used to re-assure the patient that their concerns will be addressed, which also contributes to flow control.

"I'm going to ask you some questions about your sleep and then we'll move on to some of the other things you've mentioned" [indicating: "I am going to ask about this specifically but I have not forgotten about the other things. Please focus on this for now."]

"You asked me about the best treatment for this problem. Before I get on to that, I'd like to make absolutely sure about what is happening to you. Do you mind if I ask some more questions?" ["I acknowledge your concerns about this problem. Don't worry, I will give you an answer in due course. I take your problem seriously and the seemingly irrelevant questions I am about to ask may help me understand it and give you the best answer I possibly can."]

Questions

Most of us will have learnt about open and closed questions, but it is important to recognise that there is a continuum between the two absolutes. One could grade these open, wide, medium, narrow, closed.

A fully open question (e.g. "How are you") elicits the opening statement. This throws up a collection of symptoms and issues, and it is usual to then proceed to exploring each in detail. For each symptom, starting with a wide question and progressively narrowing is a logical and helpful progression.

Starting with:

"Can you tell me more about your backache?"

Is more likely to lead you to the information that the patient's big dog pulls on the lead all the time than the narrower question:

"Was there a specific incident which set this off?"

Furthermore, the first question can be easily combined with a bit of signposting to make the signposting feel more natural:

"I'd like to ask you a few questions about your backache – could you start by telling me a bit more about it?"

A narrower question might follow later:

"What sorts of things make it worse?"

This can lead to a lot of useful information in a short space of time, much of which would have been missed by closed questions. The early, wide questions provide most of the information, and make more sense to a patient than a string of oddly unconnected closed questions ("When do you get the palpitations?... How many pillows do you sleep on?...") Narrow and closed questions come in later to fill in the gaps where the patient has not volunteered information.

Of course, how quickly you narrow the questions will depend on how verbose the patient is, how much time you have, and how important the symptom seems. Quickly ruling out significant aspects of a minor symptom with closed questions before proceeding to the next symptom or issue can make a perfectly valid contribution to controlling the consultation. It is a matter of weighing the risk of missing something against the benefits of moving on quickly.

The extreme example of this might be a patient attending an emergency appointment with a non-urgent issue. Listening to the opening statement for 60 seconds or so, asking a couple of clarifying questions and then using closed questions to check for urgent problems, before acknowledging their concerns, safety netting and deferring the problem to a planned appointment should take very little time.

Returning to the structure

Throughout the consultation there are choices to be made about adhering to or deviating from our favoured structure. If we are to be flexible in using the structure, we must be able to deviate from it. When we deviate we risk missing something if we do not return to the right place. There is a skill to be developed – keeping a mental (or written) bookmark: "where had I got to".

The next article in this series will deal with this in more detail, but if you are to deviate, you can signpost the deviation: "That's interesting, let's talk about that for a minute, then we'll come back to this."

A way back to the original topic would be:

"Now, where had I got to before we started talking about your palpitations? (The patient may then tell you!)... Oh yes we were discussing your breathing..."

Thinking aloud “where had I got to” may be one way of doing of getting back to the planned agenda. Summarising is another.

Summarising

Summarising what the patient has told you fulfils a number of purposes. It allows the patient to rectify misunderstandings and to reiterate things that they think are important but have been missed. It also shows you've been listening. Summarising is invaluable when you have got 'lost' and don't know where to go next. It buys thinking time, helps clarify your thoughts and often illuminates the way forward. It also provides an excellent lead in to signposting the next part of the consultation for the patient.

SUMMARY POINTS FOR THE CONSULTATION AGENDA

- Use your expertise and experience to set an appropriate agenda after acquiring sufficient information, including assessing their ICE.
- Control the consultation, aiming for the best overall outcome, helping the patient to understand the structure of the consultation.
 - Signposting and summarising are a significant help in achieving this.

References:

This work is based on the author's own experience and ideas, combined with concepts from the following works (in which extensive references to the evidence base can be found):

Pendleton D, Schofield T, Tate P, and Havelock P. [The New Consultation](#). Oxford University Press, Oxford. 2003.

Silverman J, Kurtz S and Draper J. [Skills for Communicating with Patients](#). Radcliffe Publishing, Oxford. 2005

Helman C G. Disease versus illness in general practice. [J R Coll Gen Pract 1981; 31: 548-562](#).

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