Achieving a patient-centred consultation by giving feedback in its early phases

Tony Hak, Peter Campion

Summary

The traditional medical consultation comprises history, examination, and investigations, followed by explanation to the patient of diagnosis and management. In the course of studying a series of tape-recorded consultations in a specialist medical clinic for chronic fatigue, we have observed a different structure. In some consultations, those categorised as more 'patient-centred', doctors introduced explanation and education into the early history-taking stage. This strategy is contrasted with the traditional approach, where the doctor only elicits information during the history, and gives an explanation later. The 'early feedback' strategy may result in patients with chronic illnesses achieving greater understanding of their symptoms. We discuss the implication of these findings for medical training.

Keywords: consultation; history-taking; training; communication

Empirical research on doctor-patient communication has for more than two decades described and analysed the ways doctors conduct their clinical interviews, or consultations.¹ The Toronto consensus statement,² which summarised this research, drew attention to the fact that only a low proportion of visits to doctors include any patient education,³ and that a surprisingly high proportion of patients do not understand or remember what their doctors tell them about diagnosis and treatment.^{4 5}

In listing the most important things that could be done to improve clinical communication, the consensus statement mentioned skills such as "the appropriate use of open ended questions, frequent summaries, clarification, and negotiation" and skills such as "giving clear explanations, checking the patient's understanding, negotiating a treatment plan, and checking patients' attention to compliance". It also noticed that "although a great deal is known about the early phases of the interview, less is known about information exchange and therapeutic strategies". This reflects the way doctors think about 'clinical competence' which is mainly, if not completely, defined as the competence to construct an appropriate differential diagnosis and to decide on an appropriate treatment. From our perspective of studies in communication in general practice⁶

and psychiatry,⁷ we expected that a clinic devoted to patients with chronic fatigue syndrome^{8 9} might be a particularly rich source of relevant phenomena. This expectation was based on the fact that there is a lively debate among both patients and professionals as to the nature of chronic fatigue syndrome,⁹ and patients referred to a tertiary clinic might be expected to hold well-constructed views of their condition and of treatment options, which might involve clinicians in considerable educational activity.

Using a qualitative approach,¹⁰ we carried out an exploratory, descriptive study of strategies used by doctors in the delivery of information and advice, and of strategies used by patients in response to this information, in a hospital clinic for chronic fatigue. In the course of this exploration we discovered that in 'patient-centred' consultations, information was introduced by doctors in the early history-taking stage, ie, when doctors usually elicit information from patients rather than give it to them. The aim of this paper is to describe this strategy and to demonstrate how this 'early feedback' is used as a resource in later stages of the consultation.

Patients and methods

In a secondary and tertiary referral clinic for patients with unexplained fatigue, staffed by two consultant physicians, two clinical assistants, and a registrar, we invited the doctors to allow us to study audiotape recordings of their consultations, obtained after written informed consent from the patients. All agreed, and we were able to make recordings of 12 consultations by four different doctors. These comprised a convenience sample, being the most we could obtain on the days we were able to record. There was no selection bias, insofar as no patients declined to be recorded, nor did any of the doctors. Consultations lasted between 30 and 60 minutes.

ANALYSIS

After the tapes had been transcribed, we categorised the consultations as either patient-centred or doctor-centred,^{11 12} using accepted criteria such as the relative number of open-ended (versus closed) questions and the presence (versus absence) of explicit inquiries by the doctor about whether the information was understood. We identified and categorised fragments in which doctors provided patients with information, and subjected these to a

Department of
Primary Care,
University of
Liverpool, Liverpool
L69 3GB, UK
T Hak

School of Medicine,
University of Hull,
East Riding Campus,
Hull HU10 6NS, UK
P Campion

Correspondence to
Dr Hak, Department of
Primary Care, University of
Liverpool, Whelan Building,
Quadrangle, Brownlow Hill,
Liverpool L69 3GB, UK

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qualitative analysis. This analysis was guided by the insight of discourse analysis¹³ and conversation analysis^{6,7} that a valid description of an interaction and its constituents (such as a consultation and what the doctor and patient say) must be sequential. In other words, we did not analyse types and forms of doctors' and patients' utterances in isolation but rather focused on how such utterances together constitute an ongoing activity (such as 'giving and receiving information').

Results

'Doctor-centredness' was defined in terms of a high number of closed questions, particularly in the earlier stages of the consultations, and a low number of explicit inquiries by the doctor into whether the patient had understood the information given. In contrast 'patient-centredness' was defined in terms of a high number of open-ended questions and a high number of explicit inquiries into the patient's understanding. When we observed the strategies in the later phases of the consultation, after the physical examination, doctors appeared to differ, according to their style. In doctor-centred consultations, the delivery of diagnostic news and treatment advice took the form of a monologue, whereas in more patient-centred consultations the same stage was characterised by an active monitoring of the patient's understanding. Some of these characteristics will be illustrated by examples below, but we would like to focus our discussion on an unexpected finding.

We observed that, in a patient-centred delivery, the doctor frequently referred to 'facts' that had been established earlier in the consultation, notably in the history-taking phase before the physical examination. By inspecting these early phases of the consultation, we discovered that, in patient-centred consultations, the doctor frequently provided the patient with information and feedback during the history-taking process.

THE DOCTOR-CENTRED CONSULTATION

In order to clarify what we mean when we refer to a 'doctor-centred' and a 'patient-centred' delivery of information and advice, we will first present an example of a doctor-centred delivery (box 1). This fragment immediately follows the physical examination. Parts of this extract have been omitted for reasons of space. In this example, the doctor, without any observable pause (though with some token 'alright's), delivers what can be described as a 'lecture' on the patient's condition. When he has arrived at the first part of the proposed treatment, 'an extremely small dose' of an antidepressant, the patient is able to ask a question which shows concern ("Are they addictive?"). This is followed by another lecture (shortened in box 1) which, again without pausing, is continued by the delivery of another part of the proposed treatment, an information pack. When subsequently putting forward a question on diet, the patient feels obliged to confirm that she 'obviously' accepts what the doctor has said her to

Extract 1

Doctor: Alright then, well what we'll say is we will do these blood tests now. I'll just fill in these forms, then I'll explain to you what we can do about it. We believe the problem is related to your sleep disturbance, there is evidence now that people who have a disturbed sleep pattern can have what we call non-restorative sleep, meaning that you are not fresh when you wake up in the morning or when you wake up after a sleep in the day and, as a result of that, you don't have energy to do things in the day time and you can have aches and pains because you don't relax your muscles properly during the time you are dreaming, or not dreaming rather, during the time you are not dreaming, which is non-rapid-eye-movement sleep. The net result is that this can go on and on and on. We've also done a systematic assessment of you on the anxiety and depression scale which comes out that you've got significant values for anxiety and depression. I think that that's important to recognise because that's treatable and we can also tie in the treatment of that with the treatment of your sleep disturbance, alright? So one aspect of the treatment is to deal with the sleep problem and the anxiety and depression, and the way to deal with that is to give you a tablet which will deal with the depression, anxiety and sleep all in one, alright? Now you take one tablet at night, I mean you need an extremely small dose of something called [name of the drug] and the dose, it's going to be given at a very low dose initially and will build up slowly over the course of a few weeks until you're up to a full antidepressant dose, alright?

Patient: Are they addictive?

Doctor: They're not addictive. It's been used for many years, it's not addictive. It does have some side-effects, which [Doctor gives information on side-effects and a further explanation of the dose]. Another problem is to change the way you think about yourself and to understand what the nature of your problem is in a different way. To that end we are giving you an information pack here which describes a bit about what the problem is, helps you understand that you are not alone in this.

Patient: Can I just I obviously accept what you are saying to do and how to go about it and I'll try anything that you would consider works. I don't know if you have any information with regard to diet, but I mean I read about carbohydrates and fats. I know, for example, the likes of people who do sport, they sort of have more carbohydrates in their

Doctor: I'll give you specific advice on that.

Box 1

do and that she will "try anything that you would consider works".

It will come as no surprise that the history-taking part of this consultation was characterised by a series of closed questions to which the patient's responses mainly consist of only the explicitly requested information. Box 2 presents a fragment from the beginning of this consultation. The first turn in this fragment is the patient's answer to the doctor's request to give a short description of her problem. This fragment is characterised by the lack of exploration of the information provided by the patient. A clear example is the doctor's remark "So that's your main problem", in which he does not specify what 'that' exactly is. It is this absence of summarising and explora-

Extract 2

Patient: I'm not able to cope with activity in anything like the same manner as I used to be able to. I don't personally put that down to age. I'm 28.

Doctor: You're 28 now?

Patient: Yes.

Doctor: So that's your main problem. Any other problems. Have you noticed any other symptoms, any aches and pains, problems with your sleep or anything else that you've noticed?

Patient: I've got two children and my sleep pattern isn't brilliant, but I'm getting broken sleep.

Doctor: I see. Anything else you've noticed?

Patient: Obviously I've got aches and pains.

Doctor: What have you got in that department?

Patient: A tiredness within my muscles. I am doing exercise to build my muscles up, but it's almost like the muscles are expanding if you like, but there's no strength within them. There's no energy there either. The aches and pains I feel are getting worse..... [part omitted]

Doctor: How long does it take to fall asleep at night?

Patient: A good hour.

Doctor: How many times do you wake up in the night?

Patient: I would say twice.

Doctor: Do you feel refreshed on waking in the morning?

Patient: Definitely not, no.

Box 2

tion that characterises doctor-centred consultations rather than the frequently discussed closed questions. Actually, in the extract in box 1, the doctor demonstrates his ability to use open-ended questions.

THE PATIENT-CENTRED CONSULTATION

An example of a patient-centred consultation is given in box 3. This fragment also begins immediately after the physical examination.

A patient-centred consultation is not defined or characterised by the absence of long stretches of monologue, but if such a monologue occurs it is achieved by *both* parties, doctor and patient. In box 3, it is clear that the patient feels free to interrupt the doctor (which she does twice at the beginning of this fragment). So the doctor's monologue later on is not something that the doctor just does but rather something that the patient gives him room for. Apart from the presence of interruptions by the patient, there are three main differences between the extracts presented in boxes 3 and 1. First, the doctor marks the end of his monologue by explicitly requesting the patient to give feedback ("Does that make sense?"). Second, the doctor not only refers to symptoms established in earlier phases of the consultation, such as sleep disturbance and fatigue, but also links these abstract terms to experiences and events described by the patient. These features of the patient-centred delivery of information and advice are ones we expect to find in a patient-centred consultation. They are exactly what doctors learn when they receive training in the ways they should deliver advice. But another, feature shown in box 3 has not been described in previous

Extract 3

Doctor: Everything there was completely normal. What I want to do is really take you through chronic fatigue as we understand it, because I'm quite sure that's what you've had and you've still got it to an extent because you've said that you're not 100%.

Patient: Yes, I mean I feel I've waited for this appointment because at the time I was in a real downer when I went to see my doctor and I literally had to say I didn't want to be told again that I had flu and I thought just tell me. I mean I've picked up an awful lot, but I hope you don't think that I'm wasting your time in any way.

Doctor: No, absolutely not, I was just saying to [other doctor] that for someone of your age to be spending days in bed.....

Patient: Well this week-end I was in bed on Sunday night at half past ten, last night I was in bed before nine, and that upsets me because everybody else is down at the bar.

Doctor: But you're still having some days when you're in bed during the day. You shouldn't be doing that, I mean you should be able to get better than that and what I would like to do is explain why you are like that so that you've got an understanding of it and then a way of getting better. We're going to give you the blue book, well we're going to give you all of those, but the blue book has got one of these in it and this is the sort of model of how this thing works as far as we understand it. There is some sort of trigger and glandular fever is just one trigger and there are lots of others. What you have got isn't particularly due to glandular fever, although the fact that you had glandular fever rather badly means that it was a fairly big trigger. What it does to anybody, but particularly to someone like you who is very, very active, very sporty and very driving, is that to not be able to do things is demoralising. I mean you said that yourself. OK, we've got depression as well.

Depression, demoralisation, it upsets your equilibrium. One of the results of that is that your sleep is affected and, as I explained, that makes your muscles ache and it makes you tired. The fact that you were falling asleep during the day was that you weren't sleeping at night. What is quite normal to do then is to rest. The trouble is, and this is the catch, that when you rest you get more fatigued and you can't do things. The best example that we can think of is the astronauts. Until they learnt about this the early astronauts, when they came out of their capsule, couldn't even stand because they'd been weightless. A simple example is if any of us had to go into hospital, say with a broken leg, and was in bed for a week and then stood up, you are terribly weak. Now for you it's been happening in a more gradual way, but every time you spend a day in bed you get more fatigued and this vicious circle goes on because you are still demoralised because you still can't do everything you'd like to do, and you're still not sleeping very well, and you've still got aching muscles. Does that make sense?

Patient: Yes it does, because even though I was in bed early last night and I slept, I woke up at two, I had a glass of water and I went back to sleep, I was up again at four, went to the loo, things like that. Today I find it really difficult, like I had lectures this morning, just to wake up.

Box 3

research and does not form part of extant communication skills training. This feature is illustrated by the following sentences: "Depression, demoralisation, it upsets your equilib-

Extract 4

Patient: I just didn't sleep at night, well I sort of did, but I would wake up at two, watch the telly until four, go back to sleep, get up, get down. I used to fall asleep in the common room, we had these lovely comfy chairs, and my friends used to just leave me there with a blanket, I had some great friends. Then at home, I would go home, fall asleep at four, wake up at midnight, awake all through the night.

Doctor: How long did that go on for, that pattern?

Patient: That pattern about 12 months and I was going back to the doctors and I was saying, this isn't right, I can't play sport, I can't do anything. What do I do? And he just kept saying, you've got the flu, you've got another virus, and he kept pumping me full of antibiotics.

Doctor: It's interesting, there's no doubt that the sleep disturbance is really at the heart of this chronic fatigue thing, we hear the same story so often from patients. You might think that you're a bit unusual in having this, but we see so many people with the same sort of thing. I'm terribly sorry to hear that, but I'm also not surprised. The interesting thing about the antibiotics too because you've probably realised they don't really play any part at all.

Patient: Yes, well the following summer I got a cold sore and then I infected myself, I had genital herpes and it came so badly that I passed out with the pain. I now look back and I think, was it the antibiotics that killed off my antibodies and lowered my immune system to be so susceptible?

Doctor: It's unlikely because antibiotics don't really have anything to do with viruses.... [part omitted]

Patient: I go to bed and I don't get up.

Doctor: Why do you do that?

Patient: I just feel awful when I get up. I get up and my head goes all dizzy. Even when I get out of a bath, if I go in a bath, relax in the bath, stand up, get out and I'm like ...

Doctor: Is that normal for you?

Patient: If I'm in a bath I just get a bit, like, you know

Doctor: It's something we quite often find.... [part omitted] When the morning comes, how do you feel?

Patient: Dead, and it takes me ages to wake up.

Doctor: This is what we call non-restorative sleep, absolutely characteristic. It's a key feature and it's related strongly to the feelings you have in your muscles, the pain and tiredness.

Box 4

rium. One of the results of that is that your sleep is affected and, as I explained, that makes your muscles ache and it makes you tired". "As I explained" refers back to an exchange between the patient and the doctor earlier in the consultation, which must have occurred before the physical examination. Obviously, the doctor quoted in box 1 could not refer to an earlier explanation because the history-taking phase in a doctor-patient consultation is characterised by the fact that only the patient gives information (and explanations if requested), not the doctor.

Box 4 presents a fragment from the history-taking phase of the same consultation from which extract 3 was taken. The behaviour of the doctor in this extract is not only very different from how the doctor treats the information provided by the patient in box 2, but also very

Extract 5

Client: I have a lot of difficulties with, things for myself, huh, yes, with really defending myself.

Therapist: You appear not to be able to draw a line somewhere, huh, to, you know, it's up til here and not further. Do you recognise this within yourself, that you, when people are requesting something from you, even if you don't know it any more, that you nevertheless will do it?

Client: Yes, I recognise that very clearly. I cannot say no.

Therapist: And this, this is a typical thing you know, this difficulty with defending yourself, with not daring to say no, so really you could say, you are subassertive, if you know what I mean?

Client: Yes.

Therapist: Suppose you could take part in an assertiveness training group

Box 5

different from what might be taught in a course on patient-centred interviewing. Such a course would be concerned with skills such as the appropriate use of open-ended questions, frequent summaries, and requests for clarification. It would not teach doctors to provide patients with an explanation of their symptoms and experiences in this phase of the consultation. This example, and its comparison to extract 2, demonstrates that the main difference between a doctor-centred and patient-centred consultation cannot be found in the types of questions (closed versus open ended) posed by doctors, but rather in the doctor's response to the information provided by the patient.

EDUCATING THE PATIENT

A study of intake interviews in psychotherapy⁷ found that the strategy which we discovered in patient-centred consultations in the chronic fatigue clinic is the central strategy by which therapists 'educate' their clients about what their symptoms 'mean', and hence secure their compliance with the proposed treatment. An example, from reference 5, is presented in box 5.

Initial interviews in psychotherapy are characterised by the joint construction of a mutually agreed interpretation of the client's condition. Typically this process consists of two steps, one in which the therapist demonstrates his understanding of the events as narrated by the client ("You appear") and a second step, after the client has actively shown his agreement with the therapist's summary, in which the therapist tells the client which (quasi) professional term is an adequate description of the client's condition ('subassertive').

A similar strategy has been observed in a study of the breaking of 'bad news' in an intensive care unit.¹⁴ In 'bad news' interviews with relatives of severely ill patients, a doctor asked them to first tell their story, while explaining to them that he would comment on it. He then gently interrupted them quite frequently in order to comment on the part of the patient's story that they had just told him. In this way he 'educated' the relatives comprehensively about

the patient's condition and about how the events experienced and observed by them fitted in the clinical picture. The typical result of such a consultation was that there was hardly anything left to tell when the relatives had completed their story. The relatives had 'discovered' the (bad) news themselves by being educated about the connections between the events they had reported.

Discussion

We have identified and described a strategy by which doctors achieve a patient-centred consultation by providing immediate feedback to the events and experiences as narrated by the patient. This strategy seems to be rather rare. We have seen it used by only two doctors, one in the chronic fatigue clinic and one in an intensive care unit. It has not been described in the literature and does not form part of communication skills training courses. In a search in transcripts and tapes from other research projects, particularly in general practice, we have not found other instances of this phenomenon. It can be asked, therefore, why bother? Why publish about such a rare phenomenon? The answer is that we think that this 'educational' strategy should be used more widely. This opinion cannot be based on the data we have collected in the chronic fatigue clinic because we have not measured the outcome in terms of patient understanding. Obviously such outcome studies can only be done if the strategy is used more widely or if it is explicitly introduced in the framework of an intervention study. In this discussion we want to make a case for the usefulness of such studies in future and, by implication, for the introduction of this strategy in actual practice.

Our main argument for expecting that patients will 'learn' more thoroughly about their condition and its management through the described educational strategy is its compatibility with contemporary educational principles. The doctor-centred approach to the delivery of information is very similar to the traditional lecture which is considered by educationalists as a less effective teaching method, whereas the 'early feedback' method and its use as a resource in the later stages of the consultation resembles the more 'student-centred' types of teaching and learning. As Hak and De Boer⁷ observe, clients in intake interviews learn

which behaviours and experiences are considered relevant by therapists and, more specifically, how they are connected from the professional point of view. Similarly, by being shown already in the history-taking phase of the consultation how narrated events can be explained medically, patients with chronic fatigue syndrome learn to be competent interpreters of their own experiences.

The 'early feedback' method provides patients with the opportunity to become experts on their own condition. This education could be achieved in other ways, after the physical examination, but this would require that reported symptoms and experiences are recalled again in this later phase of the consultation. As shown in box 3, this can be done much more effectively if the ground is prepared by a thorough discussion of the patient's symptoms and experiences in the history-taking phase of the consultation. It seems evident to us that this is exactly the kind of strategy that is desirable in (repeat) consultations with patients with chronic conditions, who must become experts on their own condition in order to be able to manage their illness successfully.

If, as we contend, the described educational strategy is desirable, in particular in consultations with patients with chronic conditions, a further question is, can it be taught, or learned? Obviously this question cannot be answered from our data. The fact that none of the doctors in our examples had been trained in using this strategy could be taken as an indication that training is not necessary, if other conditions apply. The patient-centred consultations in the chronic fatigue clinic and the 'bad news' consultations in the intensive care unit discussed above were all conducted by doctors who had been exposed to relatively intensive forms of communication skills training. It is likely that they had more or less spontaneously developed the 'educational' strategy as described in this paper by creatively making use of those skills that they had acquired.

It seems to us that the described 'educational' strategy is not inherently more difficult to teach and learn than the appropriate use of open-ended questions or, for that matter, strategies such as reflecting and summarising which are standard elements of communication skills training courses, and we therefore suggest that it be incorporated into such courses.

1 Epstein RM, Campbell TL, Cohen-Cole SA, McWhinney IR, Smilkstein G. Perspectives on patient-doctor communication. *J Fam Pract* 1993;37:377-8.

2 Simpson M, Buckman R, Stewart M, et al. Doctor-patient communication: the Toronto consensus statement. *BMJ* 1991;303:1385-7.

3 Waitzkin H. Doctor-patient communication: clinical implications of social scientific research. *JAMA* 1984;252:2441-6.

4 Ley P. *Communication with patients: improving satisfaction and compliance*. London: Croom-Helm, 1988.

5 Tuckett D, Boulton M, Olson C, Williams A. *Meetings between experts*. London: Tavistock Publications, 1985.

6 Greatbach D, Campion P, Heath C, Luff P. How do desk top computers affect the doctor-patient interaction? *Fam Pract* 1995;12:32-6.

7 Hak T, de Boer F. Formulations in first encounters. *J Pragmatics* 1996;25:83-99.

8 Royal College of Physicians of London. *Chronic fatigue syndrome: report of a joint working group of the Royal Colleges of Physicians, Psychiatrists, and General Practitioners*. London: Royal College of Physicians, 1996.

9 Wessely S, Hotopf M, Sharpe M. *Chronic fatigue and its syndromes*. Oxford: Oxford University Press, 1998.

10 Silverman D, ed. *Qualitative research*. London: Sage, 1997.

11 Byrne PS, Long BEL. *Doctors talking to patients*. London: HMSO, 1976.

12 Levenstein JH, McCracken EC, McWhinney IR, Stewart MA, Brown JB. The patient-centered clinical method. 1. A model for the doctor-patient interaction in family medicine. *Fam Pract* 1986;3:24-30.

13 Silverman D. *Discourses of counselling*. London: Sage, 1997.

14 Hak T. 'Text' and 'con-text': talk bias in studies of health care work. In: Sarangi S, Roberts C, eds. *Talk, work and the institutional order*. Berlin: Mouton De Gruyter, 1999; in press.