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Hello, I’m Graham Easton. I’m a GP in west London and a senior clinical teaching fellow in the Department of Primary Care and Public Health at Imperial College in London.

Welcome to this first in a series of three modules where we discuss advanced communication skills. Here to talk to us, I’m delighted to say, is Dr Roger Neighbour, perhaps best known for his book *The Inner Consultation*. He is former president of the RCGP and he’s had a distinguished career in medical education. Roger, welcome, thanks for joining us.

Thank you Graham. Thanks for the opportunity of this conversation.

So Roger could you just talk us through the key steps, the key points in your model.
Roger: Yes certainly. Five of them, just so we know where we’re heading with this. The first one connecting, the second one summarising, the third one handing over, the fourth one safety netting, the fifth one housekeeping.

Connecting, the first point to aim for in a consultation. It usually doesn’t take very long, is just quickly building enough of a working rapport with a patient for you then to be able to take things further. That involves just setting the patient at ease and preparing the ground for effective communication.

Second checkpoint, summarising. Taking the sort of focused history, listening to enough of the patient’s narrative to get a feel of what today’s agenda is. Being able to confirm to the patient that you’ve got that gist of today’s agenda by being able to summarise it to them very succinctly. So that they can recognise in your summary the fact that you’ve understood what they’ve come for.

Thirdly, handing over. At some point in the consultation you reach a point where a management plan or a way forward has been discussed and considered and agreed between you. But you have to make sure that the patient is happy with that. That involves you, as the doctor, systematically taking steps to hand over, to the patient, the management plan in a way that they’re totally happy with it and understanding of it.

Fifthly, housekeeping. That’s to do with keeping oneself in good lick. Housekeeping means making sure that you don’t carry forward leftover feelings from one consultation to the next. Making sure that you’re in the right frame of mind. Looking after yourself to keep yourself both mentally, physically, and psychologically in good lick from one patient to the next. From one surgery to the next. From one week to the next.

So those five: connecting, summarising, handover, safety netting, housekeeping.

Graham: Do they necessarily have to happen in that order or can they be in any?

Roger: I think in general it’s best particularly when you’re learning the craft and, as I said, all models are essentially teaching aids. I think although situations may change things, in general, if one disciplines oneself to try to do it in that order. Firstly make sure the patient’s comfortable, secondly make sure I’m getting the point and showing that I’ve got the point. Thirdly make sure the patient is happy with the outcome. Fourthly make sure I’m thinking ahead. Fifthly am I okay with where this has left me?

I think, in general, taking that kind of trajectory does impose a structure which is, in the long run, helpful.

Graham: That’s a very neat summary, thank you, of the model. I think what we’ll be trying to do in these podcasts is to bring some of those ideas to bear on some of, perhaps, the more tricky, challenging,
scenarios that tend to crop up in general practice and see how we get on. Whether it triggers any ideas for helping busy GPs through those sorts of consultations.

Let’s look at the beginning, the sort of starting bits of the consultation to start with, why not? Presumably this is mostly about trying to connect, as you would put it, but perhaps some elements of summarising too there.

Let’s take a surgery, probably running late in my case. A middle aged woman comes in, sits down. You want to build some rapport, make a connection with her but of course she starts with a tirade of complaints. “I’ve been waiting for 20 minutes.” “Do you realise how busy I am?” I often get patients who talk about their experiences elsewhere, nothing to do with our reception. All sorts of complaints and gripes.

That’s challenging isn’t it? If you’re there trying to build a rapport and you have all sorts of feelings bubbling up inside you which are breaking rapport.

Roger: Yes and I don’t want to go down the trite line of suggesting that every threat is an opportunity. On the other hand what’s always seemed to me fundamental particularly about the first minute or two of the consultation, I wonder if I could perhaps just in brackets say that with most consultations I think if you get the first couple of minutes right the rest of it is easy. If you get the first couple of minutes wrong either off to a bad start or going down the wrong track it’s very hard to retrieve them. So I think that’s a very challenging and familiar and potentially quite disruptive situation presents you with actually encapsulates something that’s very
important which is to do with "What's the right mindset for the doctor to try to be in as the patient comes into the room?"

It’s my belief that if you could prescribe the right mindset, the right frame of mind for the doctor to be in as the patient enters the room it would be something like this. It would be genuinely curious to know what’s coming through, what person is coming through and what’s going to be said to you, genuinely curious.

Fully attentive or if we had antennae tuned with whiskers at maximum sensitivity as it were. One’s attention totally on the patient and so far as possible one’s mind as free as you can get it of disruption.

So that what the patient encounters when first coming in is a doctor genuinely hungry for all the information that you, the patient, can give. Now that’s easy to say and not so easy to do. But the chief barriers to it particularly in the first couple of minutes are the internal noise in the doctor’s head. This situation, of course, is guaranteed to turn up the noise inside the doctor’s head to deafening levels. Not only if the patient’s cross about running late. You don’t like running late either, that’s stressful.

Graham: You get anxious but also maybe a little bit angry.

Roger: You get angry. You probably got angry with the person a consultation or two ago who seemed to take longer than necessary. Maybe someone’s turned up late and insisted on seeing you. There are all sorts of things.
So this woman who arrives late and begins to start her 10 minutes with a tirade almost kind of focuses the difficulties acutely for you. I always wish I’d said, but never had the courage to say, when somebody said “I’ve been sitting around in the waiting room for ages.” I’ve always lacked the courage to say “Oh we better get a move on then.”

Graham: Yes that’s what you’re feeling.

Roger: That’s what you’re feeling. I suppose so far as is possible what can one say in that situation that might be helpful. I think the right response from the doctor under that situation ought to be to count to 10. Not to respond, to be content to receive whatever the patient wants to do for a while. There’s no point in going on and on being passive about it. It certainly doesn’t help for the doctor to say “Oh I know.” I call it the Sybil Fawlty school of counselling “Oh I know” because that actually, you know yourself if you’ve been angry and somebody immediately gets onto the back foot it actually winds you up more. So I think, so far as is possible, something along the lines of “Yes I do apologise it’s difficult for both of us when we have days like this.” By saying it’s a difficulty for both of us it starts to make the patient something of an ally. I’m not happy about it either.

I suppose one of the points which I hope will emerge from our conversation, where sometimes there can be a bit of a feeling that to be patient centred means that the patient is always right. That one shouldn’t try to structure things too much. I don’t accept that. I think part of being skilful about one’s consultations is knowing when and how to take control.
This case would be one of the . . . This situation would be one of them where so far as you can, if you can preserve that slight separation so that you can see what’s going on and take command of it the voice in your head ought to be saying to you “Don’t rise to this.” “Let the patient have their say for a while but don’t let it go on too long because you both need to move on from that” with a remark such as “It’s a really awful day, I’m really sorry about it.” “None of us like this situation if there are some problems you can tell me about them if you want to either now or perhaps when we’ve finished our consultation.” “But maybe we should just crack on and see if I can help for today.”

Graham:  Okay another similar example perhaps at the beginning and for me increasingly common, the idea of a patient starting with a demand. So in a way we’re getting into that what’s on the agenda. But this is a very clear demand “I’ve just come for my sleeping tablets.” “I just need some sleeping tablets” say and there’s a practice policy which says “We don’t do sleeping ta——.” or whatever it is.

I find this particularly challenging because one obviously wants to be helpful as you say. You want to be patient centred. But it does challenge you to be confrontational. If you say “No” at the very beginning there’s a danger the whole thing falls apart. If you imply that there may be a chink, maybe you’re being disingenuous. How would you approach that?

Roger:  There’s a saying, I think, in commerce or in sales training “The customer is always right.” I think there’s probably a medical equivalent something like “The patient is always right – to start
with.” As you rightly say, Graham, if one’s immediate response is “No you can’t or we don’t . . .” then you’re into a fight. No-one’s going to win from that.

On the other hand if you were to say “Certainly” then you’re on the back foot. How does one sort of re-establish some degree of control or rationality from that?

But if you try to put into action that general advice, accept that the patient is always right at least to start with. Some remark like “Yes of course if that’s the best thing to be doing.” Or “That’s a very simple question but I’m sure there’s a story beneath it.” “What’s the story beneath it?”

I think with a lot of these apparently difficult patients or difficult consultations no-one gets up in the morning and thinks “I know what I’ll do I’ll go down to the doctors and have an argument.” It’s usually because what they want is at some point in conflict with our assumptions. With most of these difficult situations, as with straightforward clinical situations there’s a story there to be heard which, if you understand it, at least makes some sort of sense.

In fact with the situation that you raise of the patient with a seemingly simple request for sleeping tablets there are two stories in that room at that point. There’s the patient’s story about why sleeping pills are necessary and why they seem to be the only possible solution. It would be quite interesting to know that. If you knew that it might actually make it much easier for you to either accede to the request if it’s reasonable or come up with some satisfactory alternative.

Likewise there’s a story in your chair about why you don’t like this. Maybe you’re trainer didn’t approve of it or there’s some kind of
practice policy that you may or may not agree with. There may be some kind of dictat that you may or may not agree with. But you’ve got a story there as well.

I don’t want to come across sounding as if we’ve got all the time in the world. That every time the patient wants a request there are two stories to be told at 20 minutes each, that’s daft. But even within the space of a few minutes some sort of remark like “Yes of course you can have some sleeping tablets if it seems like the best way to help.” “Now tell me the story that makes you need them.” That needn’t take many minutes. Then some reciprocal remark like “That’s a difficult request for doctors sometimes. Let me tell you why.” Some brief account of the situation.

Normally once people are listening to each other’s stories rather than making demands of each other then there’s room for dialogue there. It may well be that the patient will see things more from your point of view if you can explain your story clearly enough. It may actually be that you need to compromise and accept the patient’s story if that’s the right thing to do.

Graham: I’m interested how you feel about doctors being open about their own anxieties, perhaps which might expose them or show them to lack knowledge for instance. “I don’t know much about that drug.”

Roger: The more I think about this the more I think it’s an underappreciated skill if you like. Let me put it in terms of an extreme. If you’re put on the spot by a patient who wants sleeping tablets in circumstances that you want to say no to for whatever reason. That immediately sets you wrestling internally with all sorts of
things. If that wrestling inside your own mind, that tension, that argument inside one's own mind is conducted silently until it's resolved and is then expressed in the form of a response to the patient. So the patient says “I want some sleeping tablets.” You silently go “Struggle, struggle, struggle, argue, argue, argue” and then say “No.” That's very difficult for the patient to respond to because they don't know what's been going on inside your head. If the patient does get some sort of sense about what's going on inside your head you've at least got something to negotiate about.

I'm increasingly persuaded that a key skill for doctors to have in general practice is the ability to think their thoughts aloud. Not necessarily completely but to put into words something, taking the case that you've raised, something along the lines of, “That sounds like a very simple question but to me it's not quite so simple.” “It raises all sorts of things about whether it's the right way of helping.” “Whether these are the right tablets.” “Whether you're aware of all the downside of them.” “It's going to put me into some conflict with guidelines that we think we've established for very good reasons.”

To be able to say something of that out loud is helpful for the patient because they can then pick up on whatever is relevant to them. If the patient wants to say “Well I'm sorry but stuff your guidelines I want my tablets.” At least you know then where the negotiation is. If the patient says “Really I had no idea . . . I thought it was just a simple request, how very interesting.” Then you've at least got something to discuss. It takes a lot of courage.

Graham: Yes it does take a lot of courage doesn't it? Like showing your whole self, your thinking. In fact this is a perhaps this is the next scenario I've got for you might need some of that too. I find this
very common. “Doctor I haven’t been for ages I’ve brought nine things I’ve stored up for you.” Nine is my record. These are the problems ranging from ear wax to chest pain. So there is some negotiating to be done at the beginning. Immediately you have feelings as well of course. So maybe this is a place to show your thinking a bit.

Roger: Yes I think so. It’s also one where summarising is going to be extremely helpful as well. The patient who comes in at the beginning and says “I’ve got a list of things or nine of them.” That in a way is easier for the patient who keeps the list privately and only reveals that there are nine when you think you’ve dealt with the first one and taken 10 minutes over that. Then they say “There are eight other things.” That’s even more challenging.

Even the patient who comes in and right from the beginning makes it clear that there’s a list of things there are a couple of points there that need to be made. Firstly just briefly to recapitulate. Don’t immediately respond out of the emotionality. Don’t immediately say “Well I’m sorry you can’t” or “We have a policy one problem, one appointment.” Bite your lip, count to whatever it is. Don’t respond, think “Oh blow” if that’s what you need to but don’t say it out loud. I think particularly with a patient with a list - he who holds the list or she who holds the list is in a much stronger position to manage the process.

I think there are various tricks, aren’t there? I’m sure you’ve played them or gambits or manoeuvres that you’ve done. If the patient’s got a list on paper it’s really quite possible to lean across and say “Oh how helpful” take the list from the patient and grab it. I think although that may sound facetious it’s actually not. Just think about
it, part of what the patients expect from you is professionalism in managing the process of the consultation as well as the medical content. We’re not talking about the medical content today, we’re talking about managing the process.

Part of being professional about managing the process means knowing how to manage a patient who needs 20 minutes when they’ve only been allocated 10. That does mean to some degree you, the professional doctor, taking control.

If you contrast this patient with perhaps another one who comes in and silently sits down and weeps and you’ve no idea why. The right process for you to invoke at that stage is attention permissive. Allow that patient to open up.

This on the other hand is a situation where that is not the appropriate response. It is not appropriate for you with a patient who’s booked 10 minutes and says nine problems. It’s not appropriate for you to sit back passively and allow the narrative to unfold. That’s not going to be fair to you. It’s not going to be fair to the patients waiting. Ultimately probably not even fair to the patient who’s snowballing their time with you.

So I think under those situations I, personally, would say that it is okay to take control and say something like “Thanks for the list.” “If I could have a look at that it’ll help me to prioritise because, as you know, we may or may not have time to cover all these things in one consultation.”

Graham: “The thing is I haven’t been for years and I pay my taxes.” “I need resources because I can't take another day off work.”
Roger: Yes I think I prefaced earlier in our conversation by saying I’m not going to be able to come up with slick responses to every situation. This is one of them. But I think here’s a patient who is at least, in the response that you’ve just given, here is a patient who is at least alert to the possibility that there might be some further time needed. Then again you’re into negotiation. So I think at that point it’s okay to say “Well why don’t we just prioritise and see what the important things are.” “See how we got and anything we don’t have time for we can make some further plans.” “I take your point about not being able to take time off work.” “It may be that there are some other ways that we can deal with this if we don’t have time today.”

I think that’s important. Not least because, as we’re all well aware, quite often the patient with the list doesn’t necessarily prioritise either the problem that is most important to them as number one. Or indeed medically most important as number one.

We all know the classic cliché of the schoolgirl who comes in and giggles a bit and says “Have you got anything for spots.” If you think that that’s number one and don’t realise until minute nine that actually this needs to be a consultation about the Pill when she says “Giggle giggle, do you do the Pill?” We all know that what comes first isn’t necessarily what’s most important.

Graham: Are you in favour of the “Was there anything else?” after each . . . “I’ve come here to talk about my ears.” “Was there anything else?” To avoid the . . .
Roger: Thank you for that Graham. I think that’s a reminder that this idea of summarising can be a means, not necessarily with nine bits of agenda, that’s perhaps extreme. But with more than one piece of agenda that bit of summarising in the early phases of the consultation can be a means of doing that.

So even the patient who’s got a concealed list you know with some potentially late breaking news. It’s possible in the early stages of hearing the first part of the patient’s presentation to summarise and say “Okay so there was the pain in the knee and that was what brought you for today.” “So if we deal with the knee . . .”

Graham: That’s all we’ve got to talk about.

Roger: Yes indeed. At that point most patients will at least give you some kind of pointer. It’s a rare patient who will deliberately conceal the fact of a list . . . I suppose frankly if they deliberately conceal and you’ve given the chance then you’re a bit more entitled late in the consultation to say “That’s not fair.”

But if you look at most consultations that run late or indeed perhaps many doctors have this as a recurring feature of their daily work that they run late. Quite a lot of the reason for running late is to do with trying to solve the wrong problem. Either having missed the boat and misinterpreted what the patient wants. Or as in the case of the situation that we’re now discussing about the patient who’s got more than one problem and you hadn’t twigged. Most of the cues to the existence of that are there somewhere within the first couple of minutes if only you notice. Maybe it’s just a couple of deep breaths “Well yes . . .” then the first one. Or maybe there’s
the “Where shall I start, oh no it’s my knee?” Or even that remark “I don’t come very often.” We all know even if it’s not said that the rest of that sentence is probably “So I want my money’s worth today.”

If you’ve got your antennae really tuned in the first minute or two you can usually get some sense of that. Then, of course, as you suggest, it’s possible to free that into a kind of summary and say “So it was just the knee for today was it?” Or “So you’ve brought several problems and this is the first.”

Summarising, I think, I’m increasingly persuaded is an effective way of not only making sure that you’ve got the patient’s agenda. But also of signalling to the patient that it’s time to move on now.

Graham: Yes. So actually quite a good way of time managing.

Roger: I think so.

Graham: I feel people think of summarising as a sort of final step. Very often I catch myself using it at the end and thinking “Actually that would have been quite useful earlier on.”

Roger: A piece of advice I find myself giving very often is summarise early, summarise often, summarise early, summarise often. It’s never too early just to do a brief “Okay so it’s the knee today.” “So this pain you’ve had for two weeks.” “So it’s just the sleeping pills you’re here for today.”
Graham: Presumably not only a sort of item on the agenda in terms of a task to be done but also the old ideas, concerns, expectations type of agendas in there as well. “It was your knee which you think might be this and you’re worried might be that.”

Roger: Yes indeed so maybe this would be an opportune moment to think for a few minutes about how you do elicit the information that you need to get to that summary. I think in general practice there’s a kind of filter or a funnel effect. A funnel is a better image than the filter where when you've only got 10 minutes or so a lot of which the first three or four or almost five minutes ought to be spent in information gathering.

Paradoxically if you’re working to time constraints to start very generally and then focus in is actually much more effective use of time. To say in effect “Tell me the story” and sometimes it'll be focused. Sometimes it will be rehearsed, sometimes it'll be completely irrelevant. Sometimes it will appear bizarre. But it doesn’t have to go on forever.

We tend to interrupt the patient after somewhere between 10 and 20 seconds. If on contrast you don’t interrupt at all most patients run out of steam by about 30 seconds. Well the difference between 10 and 30 seconds is not very great. You can afford, I think, to let the patient have their free say.

Graham: Then have the summary.
Roger: Then of course to start in because as you’re hearing that and receiving unstructured, unprocessed information from the patient you’re already beginning to process that through your medical ears. Perhaps noticing things, picking up things, noticing facial expressions, latching on to certain words in the narrative that press medical buttons.

But I think an important message to get across about that early stage is to try to resist the temptation to make it medical too soon. I think if you can let the patient have free flow, open questions, “Tell me more about . . .” “What happened next?” “What was it like?” “What’s going on there?” Those sorts of open questions before we rush in to say “Well how long have you not been sleeping for?” “What did the rash look like?” “Did you try the cream?” Those focused questions.

Graham: Often, I’m afraid, sometimes still will say “What are your ideas, concerns, and expectations?” What sort of phrases do you like using?

Roger: That’s terribly important. That phrase ideas, concerns, and expectations, capital I, capital C, capital E all one word. It’s such a shame that it’s acquired the status of a cliché because the concept is entirely sound. It’s entirely relevant for the doctor to have a genuine interest in what the patient makes of all this. It’s entirely relevant to know what they’re half expecting from you whether it’s sensible or not sensible. It’s entirely sensible to know what they might be worried about that they haven’t told you about. Phrases like “You probably had some thoughts yourself about this.” Or “I’d
be surprised if you didn’t have some worries about this that you’ve maybe not told me about.” Or “I don’t know whether you’ve seen anything on the internet or in the press that you thought we might do about this?” Phrases like that.

Graham: I liked your my friend John idea which I once had a patient who thought that or . . .

Roger: Quite a lot of the things that patients are worried about, let’s just take sort of patients concerns as one of that triad of the cliché of ideas, concerns, and expectations. Patients’ underlying concerns, many patients have got more on their mind than they choose to tell you about. Either because it seems trivial to them or they think you’ll laugh at them. Or perhaps at the other extreme that it might be terribly worrying. The patient who comes in and says “I’m sure it’s indigestion” and probably it is only indigestion but “There was something on the telly last night about . . .” Maybe in one of the soap operas about somebody who had indigestion and it turned out to be cancer and they were dead in six months. “It’s only something I saw on the telly.” “I’m not going to tell the doctor that, that’s silly.” They might not want to come out with that.

So knowing, as we do, that many patients have got things on their mind that they find difficult to express how are we, the doctor, to elicit that? Because it’s highly relevant obviously in terms of how one might manage that situation. If you were to say to the patient “Did you have any particular worries that it might be . . .” The patient thinks “No” and you take that at face value then you’ve lost an opportunity.
So how else can you do it? You could ask a very direct question “Did you think this might be anything serious?” That might work. It might, it might not. “Did you think it might be cancerous?” “Oh my God.” If it hadn’t occurred to the patient there you’ve sown the idea. If the patient had thought it might be cancer and the doctor said “Did you think it might be cancer?” “Oh my God, I thought it might be, the doctor thinks it might be.”

So how else can you do it? I like my friend John. My friend John is some fictitious third party. Doesn’t necessarily really have to be a friend of mine or indeed called John but just some fictitious other person that we can talk about. So one might, in that situation, say “Lots of people get worried about things like this.” “Lots of people, my friend John amongst them get worried about things like this.”

So that if the patient happens to be in that group of the many people who are worried about things like that. It’s much easier for them to say “Well yes and I’m one of them.”

Graham: They don’t have to feel stupid.

Roger: They don’t have to feel stupid, no indeed. My friend John can be the person who’s worried about rationing in the health service. My friend John can be another sensible parent who’s worried about MMR vaccine. My friend John can be somebody who wants to give their child with a sore throat the best treatment and not necessarily the antibiotics. My friend John in his or her various guises is a very useful person for the doctor to know and be able to draw upon. It doesn’t have to be real.
Graham: Dr Roger Neighbour thank you very much. That really takes us to the end of the first stages of the consultation. In the second podcast in this series we’ll be looking at the middle bit, if you like, of the consultation. Perhaps looking more at summarising and the idea of handing over and some more clinical scenarios to challenge us.

To listen to the second podcast in this series and for more useful resources follow the links on the next page. Thanks for listening.

V/OVER: Thank you for listening to this audio module from BMJ Learning.

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