PRACTICE OBSERVED

Practice Research

Recording the consultation: model for assessment

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Abstract
A model has been devised that provides, at a glance, a summary of the relative importance of the physical, psychological, and social aspects of a patient's problem as assessed at the consultation. Its presence in the notes, alongside a medical diagnosis, allows treatment to be planned along recognised lines, while still keeping other aspects of the problem in perspective. It is suggested that this may lead to more appropriate management.

Introduction

The Royal College of General Practitioners states in its job description that "a general practitioner composes diagnoses in physical, psychological, and social terms."¹ In general practice it is much too restrictive to consider your patient's physical findings only. For a full assessment and understanding the patient must be viewed in a wider context so that any intervention that the general practitioner may consider may be applied appropriately. Balint highlighted this principle in *The Doctor, His Patient and the Illness and Treatment and Diagnosis*.²

But summarising and recording in the patient's notes this breadth of information "obtained during a consultation" remains a problem. Yet an assessment or diagnosis must be noted so that treatment may be logically initiated and reviewed. The medical terms used for this concentrate almost entirely on the physical aspects of a problem, which may lead to misplaced emphasis and the "medicalisation" of a patient's problem. Marinker referred to this when writing on the paucity of available ter-

minology for wider assessment of the patient: "failures of diagnosis are simply failures of language."³ The college has also suggested "a reconstruction of the medical record in order to help the recall of data vital to making the whole range of clinical hypotheses."⁴

I have designed a simple model to help general practitioners to record all the information obtained at the consultation in a "user friendly" manner, which also allows medical diagnoses to be used to plan treatment.

Methods

While carrying out a study to assess general practitioners' approach to repeat prescribing I devised a "reconstruction" to enable general practitioners to assess patients in physical, psychological, and social terms. The model that I produced obtained separate measurements of all three aspects (fig 1a). Each aspect was ranked by marking across the lines on a scale of increasing importance from the centre outwards. Figure 1b shows a completed model: the general practitioner considers that the physical aspect is important, and, although the psychological aspect is still reasonably important, the social aspect is not.

I presented the model in a questionnaire to 16 general practitioners

FIG 1a—Model to assess the three factors affecting a patient's problem

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in training practices around Bath and Bristol and asked them to complete it in my presence. For the study I had produced three case summaries of patients who required repeat prescriptions. These cases had been chosen from personal experience as ones needing to be dealt with in physical, psychological, and social terms, although the emphasis on each may have differed.

Case 1 was a 60 year old man with longstanding essential hypertension, which was just adequately controlled. He was unformed and uninterested, overweight, and continued to smoke. Diagnosis: essential hypertension.

Case 2 was a 52 year old housewife whose husband was an executive and she had two grown children. A history of "functional" disorders when she was young was followed by a history of severe headaches starting 10 years ago. The results of investigations showed no cause, but after repeated visits to her general practitioner she was given Caffeine suppositories, with immediate improvement. She continued to use these about four times a week, hardly ever needing to consult her general practitioner again. Diagnosis: migraine.

Case 3 was a 24 year old woman who had attended four weeks before with a sore throat, when examination showed some pus on her tonsils. She was, however, complaining of difficulty in breathing and of a lump in her throat. She was now on the telephone asking for more penicillin V, as that had worked within 16 hours and she could not get to the surgery that day. Diagnosis: tonsillitis.

Results

The model was readily accepted and used by all 16 general practitioners interviewed; only one was unable to complete the model fully for all three cases. In conversation the cases were considered under the diagnoses given above. It was noticeable that as soon as these diagnoses were in use the patient was "moulded" to fit them, undue emphasis being given to the physical component. It seemed that, to discuss the cases, we needed the short, acceptable label of a diagnosis, but yet the language "failed" and the overall view expressed in the model was lost in an "illness centred" approach.

I therefore decided to use a version of the model in my clinical notes (fig 2) to discover if I could summarise my consultations usefully

Discussion

Though I put this model forward for general consideration and, I hope, use, it is also possible to expand its uses. I have added a fourth limb to measure the quality of the relationship between doctor and patient from my point of view (fig 3), hoping that it will be a form of quality control over the rest of the model.

FIG 3—Model with fourth limb added to assess the doctor-patient relationship.

If all aspects of a patient's problem are open for consideration and assessment during a consultation a useful professional relationship of high quality should evolve between the doctor and patient. If there are hidden factors then relationships are often strained, difficult, and uninformative—of low quality. Therefore, if the relationship between doctor and patient is regarded as being of low quality the assessment obtained from the three other limbs of the model should be regarded as less reliable than if the relationship is considered to be of high quality.

There is an expression that "every picture tells a story." When words fail communication should not. I think that it is possible by using simple methods not only to obtain information about patients but also to record and use it.

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References

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- 3 Marinker M. Should general practice be represented in the university medical school. *Br Med J* 1983;286:455-6.
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FIG 2—Version of model used in clinical notes

The first noticeable difference was that the need to complete the model disciplined me to search for and weigh constructively all the factors that affected my patients. It was quick and simple to use, taking only five or 10 seconds to complete after short practice. My assessments

Rethinking Established Dogma

The team in general practice

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In the very early years of the National Health Service the complacency of the political and medical establishment was shaken by a report written by an unknown Australian called Collings. He had come to look at British general practice and its role in the newly created and much vaunted National Health Service and his report was extremely critical.¹ Contrary to what is generally believed, it was not an attack on general practice but rather an appeal to do something to save it before it was too late: "It is an appeal not to throw away what is good in general practice and relegate that part of medical care to the scrap heap, but rather to use, reinforce, and bring up to date practice as we know it could if we wished to be converted into general practice as we like to imagine it." At the end of his report Collings made some excellent recommendations for achieving this renaissance in general practice, among which was the development of health centres or group practices with doctors working together supported by ancillary and paramedical staff; a revolutionary idea for the "cottage industry" of general practice at that time.

Deaf ears

His message fell very largely on deaf ears, in so far as this meant positive action on the part of the profession or the government. When I first entered practice in 1958 general practitioners were supposed to finance any ancillary or paramedical staff entirely out of their own NHS income. The rest was of course that doctors could afford to employ only a minimum of staff to help in their surgeries. The slow erosion of morale that so many general practitioners experienced at that time led finally to an angry desperation that could have destroyed general practice. In fact it was saved by the steadfastness of our professional and political leaders who negotiated the so called Doctor's Charter. This agreement transformed the economic basis of general practice. The need for ancillary and paramedical support for general practice was recognised and appropriate financial arrangements were introduced to encourage its use. Inevitably, there was a time lag in the realisation by general practitioners of the immense change in the organisation of their work made pos-

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sible by the Charter. But over the next decade the pattern of practice changed progressively.

The employment of full time secretaries and receptionists was the first and easiest step. There had always been an informal working relationship between general practitioners and local authority district nurses, but the idea of the formal attachment of district nurses and health visitors to particular general practices was now encouraged. Schemes of attachment developed that varied in style and degree according to local factors. The possibility of general practitioners employing their own nurses or other paramedical staff was also now recognised. Some doctors found themselves with social workers and clinical psychologists working in their practices. The concept of the primary health care team has continued to develop, so that it is now obvious to everyone that the general practitioner is only one of many people with varying skills who are needed to work together if, in Collings's words, "General practice as we know it is to be converted into general practice as we like to imagine it."

It is interesting to speculate how the term "team" first came to be accepted as the collective noun for the trained staff working in or attached to a practice. It is heavy with associative ideas, but I suspect that the flavour of those ideas is often different for the different groups that constitute the "team." Not surprisingly, the idea held by Dr Average of what his team is tends to derive from models in his medical training. This is a leadership view of the structure of the team. The chief has his team—definitely there to serve his plan of action, and even if not to be directly commanded, at least to be accountable to him for decisions taken. Scratch a doctor deep enough and you will find an autocrat convinced of the final superiority of his own opinions. Perhaps we don't believe that any more, but many of our nursing and social work colleagues still feel that about us.

Interdependence

The word team also has in it the idea of interdependence and shared responsibility—the integration of the individual contributions of a group of people for the accomplishment of an agreed purpose. Such an idea of the team and the way it should work is much favoured by the other professionals who compose the primary health care team. If I were to try to express the rethinking of established dogma concerning general practitioners and the team I would see it in terms of this change from the leadership model characterised by the surgeon and his team to a team that is truly interdependent—a partnership of professionals. There are several directions in which I think this is already happening, and I see great hope for the achievement of "general practice as we like to imagine it" that Collings spoke of.

There will, of course, always be a special and important role for the doctor in the primary health care team. All members of the team recognise this and depend on his availability for medical knowledge and medical decisions when they are required. There will be times when such decisions are indispensable to other members of the team. This does not, however,

make him the leader of the team so that he is necessarily required to initiate or control all its actions. There are many important decisions relating to the work of the team for which the doctor's knowledge or assistance is not in fact required, and indeed may not be in his power to provide.

The doctor is primarily concerned with the diagnosis of disease and its treatment. We are expensively and extensively trained for that function and I see little sign that we will be other than fully exercising it. But the needs of our patients in general practice often require other kinds of help for which other people are often better trained than ourselves.

In preparing for this article I engaged in some revealing discussions with members of our own team. It was a genuine surprise to find how much work was going on, not only without the doctors being aware of it but without anyone thinking that it was necessary for us to be aware of it. Nevertheless, the knowledge that the doctors would be immediately available should the need arise was an essential element in the confidence that allowed other members of the team to make responsible decisions individually. This is one direction of change that I see as needing encouragement if the full potential of the members of the team is to be developed.

The next is related to it—namely, an increase in the use of cross referrals among all members of the team, not just doctor to different members, but, for instance, from district nursing sister to social worker, or health visitor to practice nurse. Such referrals may be informal but are effective. To make them successful the practice must be organised to provide a place, a time, and a method for different members of the team to communicate easily with each other, and if necessary to meet. This, of course, includes the medical staff. Doctors may be concerned that such cross referrals may cause them to lose control of what is happening to their patients. It may be argued that this sense of control is illusory in any case and the need to feel it is more the doctor's problem than anyone else's. Nevertheless, it is important that the team members, and particularly the doctors, define when they would wish to be concerned in or at least informed of decisions or actions taken by any member of the team and that in their experience is not so easy.

Time is perhaps the biggest problem for general practitioners. The nature of the open access contract seems to lead to a remorseless pressure on our time. As a group we appear to most people to be permanently over busy. Peremptory men making peremptory decisions" was how Julian Tudor Hart described

us. Even if we think that a bit hard most would agree that we nearly all find it difficult to find time to think and plan for the many new ways in which we hope to extend our role in the care of our patients. Preventive or anticipatory medicine, patient education, patient participation groups, support or therapy groups, paediatric assessment, and geriatric screening are all subjects which we feel we ought to be doing more about but never quite have the time. If these things are to become a real force in the medical care provided by the team then I think the initiative for such change needs to come not only from the doctor but from other members of the team as well. The doctors must create an atmosphere in which such initiative is not only possible but encouraged.

In our own practice, for instance, our attached social worker was the moving force in starting a group for patients who were socially isolated or suffering from phobic anxiety. It is known as the Open Door Group. It has been extremely successful, and although our social worker keeps us informed of its progress and often asks for information or advice about particular patients, none of the work of the group depends on the doctor. Instead, there has been an appreciable decline in the surgery attendance of several patients who attend the club. More importantly, patients have been helped in a way that was not possible before.

Such activities show a growing confidence in members of the community health team—a confidence in their own professional autonomy. Doctors need to respond to this with a sensitive appreciation of a subtle but progressive change in the relationship to the rest of the team. With this change will come a recognition that the leadership function will need to be assumed by different members at different times and in different ways. Yet a different kind of leadership is then required of the doctors. Above all we have to get better at sharing ideas and objectives and clarifying for all members of the team where independent action is to be encouraged and where and how information should be shared or joint decisions made. This is a kind of leadership from behind, like "That celebrated, cultivated, under-rated nobleman—The Duke of Plaza Toro." Who, as you know, "In enterprise of martial kind, when there was any fighting... led his regiment from behind, he found it less exciting."

Except that in our case I think that "leadership from behind" is going to be much more exciting for us and for the team.

Reference

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ONE HUNDRED YEARS AGO Cremation: Apart from sentiment and custom, which, however, in considering a question like this cannot be disregarded, the greatest objection to the adoption of cremation lies in the fact that it might undoubtedly render the detection of murders more difficult. There have been several instances within the last years where murderers were only suspected some time after the death and burial of the person murdered, and where unmistakable traces of poison were found when the body was exhumed. Such cases are no doubt the exception, and in the majority of cases of suspected poisoning an inquest has been held and examination of the body made before burial. Where that happens, it would make no difference whether the body was disposed of by cremation or by sepulture, as either way the necessary investigation as to the cause of death takes place first, and where there is reason to suspect foul play the necessary steps would in either case be preserved. But where there is no suspicion at the time, and a medical certificate of death has been given in the ordinary course, cremation would undoubtedly remove the means of verifying any suspicions that might subsequently arise, and might prevent murders being detected. Such a possibility is a very serious objection to cremation; and if the practice ever becomes established in this country, it may be necessary to alter our law as to the holding

of coroners' inquests, and to insist on them being held in many cases where they are considered unnecessary. Cremation is to be introduced, it will also be necessary to make laws to regulate it, so as to prevent public feelings being outraged, and to secure proper records being kept. In case of burial, these things are provided for by law, and their observance protected by making those who violate them liable to punishment. As cremation has never been practised in this country, there are no legal regulations applicable to it, except the rule of common law, which forbids it being conducted in such a place or manner as to cause a public nuisance. Mr. Price had selected the top of a mountain for his experiment, and that was held by the jury to be a place where no nuisance was created; but a man who burned a body in a populous neighbourhood, unless he did so in a manner different from that observed by Mr. Price, might very possibly be convicted, and if so would be liable to fine and imprisonment; at the direction of the court before which he was convicted. If cremation is to be practised in this country, it should be regulated by law, so as to secure the due observance of public decency, and safety from irregular or premature destruction of the corpse, and to give security from prosecution to those who properly conduct rites which are now seen to be not illegal. (*British Medical Journal* 1884;3:571.)