The Clinical Consultation

DONALD LONGSON, MB, FRCP
Consultant Physician, Manchester Royal Infirmary

There is a resurgence of interest in clinical methodology, aided by a re-discovery of the importance of history taking. A satisfactory performance requires much skill and a sound knowledge of the clinical features and natural history of diseases. The promotion of the necessary skills is one of the most difficult tasks in medical education and the problem is exacerbated by the increasing number of students. There is probably no alternative to the traditional system in which the clinical tyro begins work with hospital in-patients since, in this setting, the conflict between teaching and service needs is at a minimum. However, there is a limit to the degree of skill attainable with this method because such patients organise their histories and the student can easily harbour preconceptions about the systems likely to display physical signs. Ideally, students should progress to dealing with new patients in an out-patient setting, but this poses organisational and clinical problems if carried out in hospitals on the required scale.

Video-recording has been shown to be a helpful aid in teaching interviewing skills, but, despite it, many students still have a defective understanding of what they are doing. Although skills are acquired only by practice, the performer needs a clear idea of the nature of the task, and enlightenment can be transmitted verbally to him. There are, no doubt, many ways of doing this, and I present in this article one method which, judging by the response of final year students, has useful explanatory power.

The text which follows is an edited version of a talk given to voluntary seminars (8 students); it is followed by a practical class during which partially undressed students examine each other. Important methods of physical examination are described and explained, and a demonstration is performed on each student, who is then able to comment on his peer’s performance. There are opportunities for giving examples of how the sequence and emphasis of the examination are conditioned by the patient’s circumstances.

I hope this approach will be of interest to others who face the same educational problem.

The Medical Consultation

A medical consultation demands a highly skilled performance by the doctor; the skills are acquired by practice and cannot be taught in the same way as factual knowledge; they are not a transmissible body of information. Hence the injunction to students to seek every opportunity to practise. They may not always appreciate that any conversation with a patient, or handling of the normal body, adds, in however small a measure, to the accretion of skills, and that this is the essence of clinical training. The teacher’s role is to influence the student’s performance by demonstration or advice, so that he understands what is to be done and becomes more critical of his own achievements; as a result it is hoped that he will do better next time and adjust his actions to the infinite variety of circumstances found in clinical practice. Textbooks of ‘Clinical Methods’ describe, in a most comprehensive manner, the kinds of information that assist diagnosis; there is, however, a world of difference between the ability to learn and recite the contents of such books and the skill required to use the information appropriately and purposefully.

The interview begins with a friendly greeting followed by a conversation during which the doctor tries to reconstitute in his mind what the patient has experienced. This is supplemented by information derived from examination of the patient’s body. The aim is to reach an explanation of these experiences, since this must precede any sensible attempt to improve the patient’s lot.

Patients tell doctors only what they have perceived or felt; more exactly, what they remember of the experience. These perceptions and recollections may be sharp or vague, remembered with ease or difficulty and are frequently heavily coloured by interpretations based on culture and past experience; they are, therefore, often so highly personal as to be unique. A skilled doctor can prompt the patient’s memory and partially disentangle fact from interpretation. The whole process is known as ‘history taking’; it is a complex process that repays close attention. Although it is a performance, not a body of knowledge, knowledge is essential for its effective execution. A history is not a document; it is the result of a purposeful interview with a patient; a written record is made as an aide-mémoire.

At the most elementary level the clinical apprentice asks all the questions he can think of, the range being determined by his knowledge of medicine and humanity; the result is a vast array of unweighted information. Few of the items elicited are evidently more important than others; the notes do not carry the reader to a rapid and clear understanding of the problem, and his confusion reflects the writer’s uncertainty. The result of these endeavours can be compared to a large number of jigsaw pieces without a guiding master picture and not even an indication of the number of puzzles to be assembled. Patients are, in fact, assemblies of puzzles, each repre-
senting physical and psychological pathologies or peculiarities, expressed in terms of their perceptions; these perceptions are coloured by the influence of culture and personality. It is a complex picture which is unlikely to be unravelled by near-random questioning, although it must be admitted that a particular pathology, emitting highly characteristic signals, may be discernible through the chaos (e.g. a classical duodenal ulcer).

It is an improvement if the facts are collected and ordered according to physiological systems since, in appearance at least, there is a logical segregation into sub-puzzles. Many symptoms, however, do not fall neatly into one system rather than another, and may be mistakenly classified; it is likely there will remain an amorphous mass of undifferentiated information. The improvement in technique is palpable but not great. The identification of the sub-puzzles remains laborious and prone to error. Evidently this is not how the skilled operator works. How then does he proceed?

His notes are shorter than the student’s, sometimes almost telegraphic in style, and the reader often senses the emerging diagnosis as he advances through the text. The work has proceeded by hunches and hypotheses. They are ideas about the nature of the problem, but not wild guesses. They are implanted in his mind by looking at the patient and listening to what he says—observations of appearance, demeanour, posture, behaviour and gestures, content of statements, emphasis and manner of delivery. Frequently these features assume additional significance because of the doctor’s knowledge of the patient’s past illnesses and his reaction to them, the family circumstances or the general socio-economic background. Even apparently trivial asides may assume great importance. As this moving picture develops before him, and is assisted by him, the doctor discovers the germ of ideas—clues; these ideas become conjectures or provisional assumptions about the cause of the problem, which are used as guiding norms until verified or disproved by evidence. Provisional assumptions are called hypotheses. But his thinking can develop on these lines only if he has the wit to ‘see’ the clues; “having the wit” is not merely a question of having intelligence and knowledge; it is also necessary to have skill, and skill is only acquired by diligent and enlightened practice.

The eagerness to perceive clues must be maintained from the moment the patient enters to the moment he departs; a non-verbal clue may be proffered as the door opens, or in a parting remark. While the doctor is pursuing one of the clues, the patient may say something that contains the basis for a further hypothesis; and the flow of clues does not cease because the patient is being examined physically; his off-the-cuff remark, made just as the stethoscope is applied to the chest, could contain a vital clue. It may be necessary to stop the examination temporarily and follow the new trail while it is still warm; not to do so might waste a golden offering by the patient and would certainly be discourteous.

So the range of useful ideas generated in the physician depends on his powers of observation, his imagination, his understanding of the culture of the patient, his breadth of experience, his ‘textbook knowledge’ and the diligence with which he has cultivated these attributes. Although the emphasis is on skills, there is no intention of depreciating the importance of factual knowledge of the kind found in textbook descriptions of diseases; we shall see that there is frequent need to refer to this pool of information as the interview proceeds.

Some of the clues are not specifically ‘medical’; they are of a general nature and for their perception require empathy, a sensitive disposition, imagination and a facility for understanding the patient’s point of view. Charles Dickens was better at this than most doctors but it is the essence of the good practice of medicine; the successful clues will influence not only the kind of advice proffered but, most importantly, the way in which it is proffered.

Other clues are more ‘technical’ but this is not a reason for granting them a higher status than the general clues; neither is pre- eminent. A few examples of the visual impressions that may be the bases of clues would include facial expression, colour, gait, posture, restlessness, aptathy, gestures accompanying statements, an anxious transfixing glance at the doctor, a bearded adult male face, cyanosis, jaundice, hyperpnoea, the rounded face of steroid toxicity, the protuberant abdomen of pregnancy— the list is very long. Clues may consist of a single item of information or be compound, i.e. apparently disconnect ed and individually trivial items may associate in the doctor’s mind to provide the idea. The latter complex associations undoubtedly demand more skill; the greater his facility for making such associations the more likely we are to say the doctor is clever, shrewd and able—all words used to qualify skills and not knowledge. He is doing something that cannot be learned from books but is acquired by practice; hence the repeated injunction to students to apply themselves to working with patients—the leitmotiv of this article.

Hypotheses are not solutions to diagnostic problems but tools which are useful because they can be tested. A hypothesis that survives testing is verified, i.e. likely to be true. It can be stated in the classical form, using the conditional sentence: If—, then—. For example, if the patient has diabetes mellitus he will have experienced some or all of the following: thirst, polyuria, weight loss (and will show hyperglycaemia). The more the patient conforms to the ‘then—’, the more likely he is to be a diabetic until, in this case, certainty is reached. Note that the full process of testing the hypothesis may end with the history but more usually extends to the physical examination and sometimes to the laboratory investigations. Logically, history-taking and examination belong to a single process. Each verbal test used in attempting to verify a hypothesis has been constructed from the doctor’s store of factual knowledge (textbook learning and experience of pathology, symptomatology and natural history of disease), but the use of the test is a clinical skill. A low level of skill with the correct test can lead to error. For instance, at a very simple level, the doctor may correctly wish to enquire about polyuria, to test the idea that the patient is diabetic, and may uncover the presence of frequency of micturition; he may fail to take the matter further and never establish the presence or absence of a large urine volume (the patient may have a bladder

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disorder). Scientific theories approximate closer to the truth the more they have survived attempts to prove them false, and the counterpart to this is seen in the clinical process. If we are considering diagnostic alternatives A and B we might find some evidence of A; but if we discover strong evidence of B, A is thereby equally falsified or weakened. Most people, of course, see this intuitively. ‘Testing’ must be interpreted generously. Sometimes, as in the above example concerning diabetes, it consists of close questioning to see if the patient matches the concept the doctor is using. Direct but not leading questions are permissible. Other examples will spring to mind, such as uncovering the classical symptom pattern of peptic ulceration, renal colic, etc. At the other extreme ‘testing’ means merely encouraging the patient to describe his symptoms in an informative way, aided by questions such as those which define the characteristics of pain (when? where? when to? what relieves? what aggravates?). In many circumstances the distinctions between the observation of clues, the formation of hypotheses and their testing, become blurred; all three events are telescoped and virtually simultaneous when, for example, the patient gives a short, precise and characteristic description of a well-recognised condition, such as classical migraine or sciatica. The testing of the hypothesis is then buried in the clue.

A common danger is that once the case has been seen in a particular light, certain hypotheses being foremost in the doctor’s mind, the formation of further hypotheses is partially blocked. The way in which the information is structured has a permanence and a pervasiveness that inhibit different ways of looking at the problem, but in a quick-flowing conversation there is limited time for reflection; opportunities must be seized as they present themselves. The difficulty is insoluble but even to be aware of it is an advantage.

In a written record of the proceedings the doctor assiduously notes the positive tests which have led him to conclusions and the negative features which made him reject important other possibilities (i.e. central chest pain brought on by exertion and relieved by rest; not related to posture or meals, not relieved by alkalis). It is this particular structure of the records which gives them the sense of direction and purpose alluded to earlier in this article, and which may be so obviously missing in the handiwork of the inexperienced. Naturally, there is a large element of judgement in deciding what to include in the notes, the reading of which will give some idea of the breadth of vision of the writer and the variety of possibilities his imagination has conjured up. There will usually remain a mass of unrecorded negatives which he regards as totally non-contributory. Others might see things differently—a point soon understood by those who present cases at clinical meetings.

If the account of the verbal interview ended here it would be woefully inadequate, a recipe for a deplorable standard of practice. The defect arises because: (1) from the point of view of physical diseases, no doctor is capable of consistently picking up all the clues offered to him and there is a danger of clues not being offered; (2) whether applied to physical or psychiatric disorders this technique yields a pathological lesion, a recognised disease or syndrome and no more or less than that; it tells us nothing about the patient.

There is a well-known aphorism which applies, with great force, at this point: ‘Il n’y a pas de maladies; il n’y a que des malades’. It draws our attention to the real business of our profession—to treat the whole patient. His suffering must be seen as something more than a pain caused by an ulcerated gastric mucosa; the common expression ‘so-and-so is ill’ shows that the common man understands clearly enough that the totality of the individual is suffering. In the circumstances of illness the ‘whole man’ includes the specific physical disorder and elements or colourings derived from his personality, fears, illusions, degree of introspection, previous experiences, level of information or misinformation, and social, cultural and economic backgrounds. If the doctor knows nothing about these matters he is acting merely as a technician; the professional approach has a much wider angle of vision and to be made better, the patient must be seen in that optical system. While the hypothesis-testing approach is legitimate and necessary, it is inadequate to elicit what concerns us here. Errors of thought and human problems generally are so infinite in variety and number that it is impossible to set up all the correct hypotheses. It is necessary to penetrate the privacy of the patient’s thoughts, concerns and circumstances and there is no excuse for omitting to do so. There will be great variations in the extent to which one can justifiably probe and some interest in these matters is always relevant. Even the simplest reassurance requires knowledge of the patient’s point of view and fears.

The cut-and-thrust forensic type of questioning, so essential in some parts of the interview, may discourage the patient from revealing and discussing these matters. What is needed is the ‘open’ type of conversation in which an unhurried, sympathetic, tactful, alert and well-informed doctor generates trust and guides the patient while he talks about himself. Prompting, encouraging, reassuring, questioning, approving, disapproving, commenting, commiserating and showing concerned interest, all describe the doctor’s role while he tries to see the world and the illness through the ‘eye of the patient’s mind’. Only then can he apprehend the complete problem. Those who might remark, sneeringly, that the product of such an effort is only ‘soft’ information, should reflect on the frequency with which it throws up new leads or clues in the sense used earlier in this article.

Two techniques have been described; they are mandatory, but a shifting emphasis to suit particular cases is not precluded; it is an attribute of the better doctor that he senses how far to go with each method. Some will interweave the methods with considerable subtlety; others will use them sequentially, allowing the patient free expression at first, then, in a gentle but firm way, concentrate on some features that have emerged. It is a matter of personal preference and opportunities. Quite often the pattern of a particular interview is determined not by a conscious decision of the doctor but by the personality of the patient, the facility with which he expresses himself, his initial assessment of the doctor’s
personality and the thoughts that are uppermost in his mind.

In each interview it is also necessary to take stock, at a particular moment, of the accumulated information and enquire into areas which have remained untouched or only partially exposed. Social, economic, occupational, drug and genetic histories are examples, but others will spring to mind; this set of features must not be neglected but the extent to which each element must be probed has to be determined by informed individual judgement.

The Physical Examination

Physical examination gives rise to a paradox which troubles students—the apparent conflict between the obligation to observe everything—miss nothing—and the manifest impossibility of performing, on each patient, all the manoeuvres described in textbooks in ‘Clinical Methods’. Where does one draw the line? To examine patients negligently might be expedient but is clearly reprehensible: it does not solve the paradox. No complete solution will be offered here but we hope to demonstrate that, by watching the trained person at work, the problem can be reduced to manageable proportions.

When a diagnostic hypothesis is put to the test there are several possible outcomes.
1. The hypothesis is so convincingly falsified that it is discarded. It is rarely resuscitated.
2. The verdict is indecisive: the idea remains plausible but not entirely convincing; further evidence is desirable but the likelihood of obtaining it verbally is deemed to be exhausted. However, if the ‘idea’ is correct, there may be certain physical signs; conversely the presence of those physical signs would provide strong confirmation of the ‘idea’. So that part of the examination which would provide the physical signs in question is ‘flagged’ or ‘marked’ for detailed scrutiny. The absence of those signs would help consign that idea to the discarded group. The testing of the original hypothesis is extended into the physical examination.
3. The hypothesis is strongly upheld by the verbal enquiry. Certain physical signs then become important because (a) they may further confirm the diagnosis; (b) they may locate the lesion or be a measure of its severity; (c) they may reveal the presence of complications (further ideas). For example, when diabetes is the diagnosis, examination of the eyes is important.

Thus, at the end of the history, a range of examination procedures has been elevated above the rest because of special relevance. There may be several groups of signs to be sought, each flowing logically from an item in the history. The examination is now seen as a simple extension of history-taking, using the same technique of hypothesis-testing. Of course, there remain ‘unflagged’ areas representing the unsolved residue of the paradox; they must be surveyed rapidly but systematically. The skill and judgement of the operator, so often referred to in this article, play an essential role in deciding which areas are flagged and how to deal with the residue. It is likely that in some cases the unflagged areas are, almost subconsciously, graded in importance but it is certain that during the examination doctors focus their attention on particular areas and that they have a reason for doing so. During the examination unexpected findings may be made and require an interruption and return to the history; thus the distinction between examination and history is blurred even more.

Close questioning, open conversation and physical examination are parts of a single process; those who concentrate almost exclusively on one of these techniques follow a defective methodology.

This article is not a substitute for the early chapters in books on clinical methods; they provide an inventory of the items of information which may be relevant and which the techniques discussed employ. It might be useful to remind readers that patients only give a ‘proper’ history once. On that occasion they perceive the way the doctor organises the information and will change their interpretation of the predicament. In an interview with a second doctor they may lead him differently; they have digested the information and may present it in an altered sequence or structure and with different emphasis. The doctor may consider himself completely free; in fact he is offered an organised substrate from which pre-formed ideas readily emerge, and he can be all too easily enmeshed, without knowing it, in the thoughts and imagination of his predecessor.

Reading this article will not confer skills on the reader, but it may help him to understand how to change his technique.

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