

Insecurity and risk in the consultation

Standing in reception recently I overheard the following discussion: 'I left the doctors' surgery went home and 6 hours later had meningitis.'

The patient's friend replied 'I can't believe it, sounds like a terrible GP, I would see them in court!'. The patient looked surprised and replied 'no need, my GP did their best.'

Intrigued by this comment I interrupted and asked a few questions. They told me the doctor had taken time to listen, seen things from their perspective and taken them seriously. The patient had understood the risks of a high fever and headache. They realised that things develop over time and actually felt grateful that the doctor had raised the issue of serious infections, even saying, 'When I was ill that night I could hear the doctor over my shoulder, so I called again.'

Ask doctors about risk and uncertainty in the consultation and they will mostly talk about how to communicate risk in a rational way with statistics and graphical displays. Ask patients and they will mostly talk about themselves and issues such as 'Will it affect me today?', 'Will I get to work?', or 'Am I like my dad?'. Doctors sometimes do not appreciate that rationality is not the only component in decision making about risk.¹ Furthermore, doctors who explain what to expect in discussion and take time to explore the human side, soliciting patients' opinions, checking understanding, and encouraging patients to talk are found to have less malpractice claims.²

In a day-to-day consultation the risks seem to revolve around the uncertainty of diagnosis and the way illness develops. At the beginning of my career in general practice it certainly felt like it was all about what will happen to the patient when they leave the consultation, tonight or next week.

Uncertainty causes a lot of anxiety for patients as well as doctors. When we are newly qualified there is less knowledge and experience to draw on and many

Table 1. Windows of risk.

	Risks known to doctor	Risks not known to doctor
Risks known to patients	A Mutual understanding	B Doctor's blind spot
Risks not known to patient	C Patient's blind spot	D Unknown risks to doctor and patient

doctors fear litigation after missing a diagnosis. Furthermore, in out-of-hours care the doctors' threshold for risk is a factor in determining hospital referral rates,³ and defensive medicine can lead to inappropriate referrals and sometimes worse care. Current thinking for the nMRCGP curriculum recognises the skills needed to help: 'Negotiating a shared understanding of the problem and its management with the patient, so that he or she is empowered to look after his or her own health.'⁴ My purpose here is to present a way to see what is happening in this crucial skill of a good doctor.

The way illness develops is something that doctors know only too well, but it remains a blind spot for many patients. One of my objectives in the surgery is that when a patient leaves the room they are empowered to handle problems as they develop. The way to do this is to expand their own understanding of the illness which not only involves some of the physical signs and symptoms but also how things can change with time. This is more than simple safety netting. Changing the patient's understanding will mean witnessing their present narrative and then expanding it with the doctor's knowledge of risks. Furthermore to understand the patient we need, as the philosopher Gadamer explained, to be a critically alert participant and not simply an objective analyst or detached observer.⁵ We will be contributing new material for a new chapter in their narrative so that the risks are shared.

I find a good way to visualise the risks involved in a consultation is to use my windows of risk table (based on the Johari Window) (Table 1).

Along the top are risks known and unknown to the doctor. Down the side are those of the patient. The ideal is for doctor and patient to move their understanding to part A: Mutual understanding.

B refers to the 'doctor's blind spot'. The patient expresses their ideas of risk through their narrative and the doctor needs to understand them. With this knowledge it may be possible to make careful changes. The doctor can explore this by listening but also asking questions such as 'what do you think might happen next?' or 'To help me understand, tell me what your worries are here?' The story may need careful alteration: 'Well actually a worsening fever doesn't mean you are "sweating it out", it normally means things are getting worse especially if there is vomiting or a bruising rash.' Or for another case: 'You say you have diarrhoea and have stopped drinking for 2 days to stop it, actually fluid replacement sachets will make you feel better and slow the diarrhoea.' Alternatively they might describe something that the doctor wasn't aware of. Even educate the doctor!! Happens to me a lot, Google™ is a popular patient tool and helps to populate my learning needs.

Part C of the Table is the 'patient's blind spot', the doctor aims to share their clinical knowledge and fit it into the patient's narrative. Change the story if required. The patient might describe something which is probably wrong: 'My dad had a rash a bit like this and he ended up with leukaemia.' Explaining that this is unlikely and providing an explanation that the patient can understand would help here. The patient may have no idea that vomiting blood is potentially serious, or

having problems swallowing is serious. Another situation might be 'You tell me that a work colleague said chest pain like this will be indigestion but I think we need to consider your heart. If you get that tightness lasting half an hour you must seek urgent help.' If we actively listen we can really find out where the education is needed and importantly how to explain it in a way which can change their story. In this way the patient's understanding in a specific situation can be moved into part A.

For part D: 'unknown risks' to patient and doctor, we have the most challenging but crucial area. Here we are faced with risks unknown to both doctor and patient. Our object here is to make the patient realise that we cannot always know the answers and that there are unpredictable outcomes and rarities. The patient's narrative may go along the lines of: 'You're the doctor, you should know.' We need to admit and share our inadequacies and 'be honest about what we know and about what we do not know'⁶ to empower the patient, something which I think the medical profession is often reluctant to do. Some careful phrasing can introduce this idea into the patient's thinking: 'You know it isn't always possible to know how things will develop.' 'If you become worried and things are getting worse please call again.' With experience consultations become easier but I still face consultations where I feel really perplexed and struggle to make sense of things and where it will lead. This is where the doctor needs to really empower the patient: 'This is an unusual problem which doesn't quite add up to me. This means we both need to be a bit more cautious. So if things get worse please come back.' Or in another situation: 'I know you don't have left-sided chest pain now but you did earlier and although the heart tracing is normal I think we should look into this. I do wonder about your heart. Please seek help if it returns.'

In this way even the issues in D can be pulled into A 'Mutual understanding.' The

patient leaves better equipped to deal with the natural history of illness. What about when things do go wrong? Well, maybe like the patient in the waiting room they will understand that we cannot always know the answers and accept we listened, took them seriously and perhaps most importantly, we tried to help and we did care.

Six months into one of my registrar's year they were going through a few problem cases and said 'I feel so much more confident now I share the risks with the patients, and you know what, they thank me for it as well, even if things don't go exactly how we might like'. This is expressed succinctly by the mathematician John Allen Paulos:

*'Uncertainty is the only certainty there is, knowing how to live with insecurity is the only security.'*⁷

Living with insecurity is a skill which is helpful to patients and doctors. It is reassuring for the new registrar and can mean a career with greater satisfaction and less litigation which we would all prefer.

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