

Arriving at the postmodern medical consultation¹

The consultation is central to the practice of medicine and has been studied extensively since the 1970s. However, as Glyn Elwyn shows in this paper, our understanding of the consultation is evolving. This is partly because of an increased understanding based on research but partly on developments in our way of viewing the world.

Glyn Elwyn

The 1970s was a time to let hair go long, be free, declare love not war and experiment with drugs and new concepts. It was inevitable that this would have its impact on professional practice. With the benefit of hindsight we can now see that the interest in the medical consultation and the communication process was connected to the mood of that time. The consultation moved from being an accepted, almost invisible, feature of professional practice to being a process that could be objectified studied and, for where new models of professional practice could be presented, advocated and debated. The arrival of audio and visual recording techniques provided added impetus but the catalyst was the adoption of an exploratory curiosity about the medical consultation. Since the 1970s these interactions have been increasingly analysed, and with a wider range of tools and methods [1, 2]. This paper describes an overarching movement from the practice of paternalism towards the centrality of the individual autonomy and increasing multivocality. The paper argues that these two directions of travel indicate our arrival at the concept that could be known as the postmodern consultation, a feature of our postmodern condition [3].

The consultation

The first to describe an outline of the consultation were Patrick Byrne and Barrie Long in a landmark study by based on a recording of over 2000 patient-doctor interactions in general practice [4]. They published a descriptive framework (table 1): a forerunner of many similar descriptions that followed. Considered from today's vantage point it may appear as a simplistic chronological account. At the time, how-

ever, the sequential six-stage outline helped doctors to reflect on the consultation, and to think about the dialogue in new ways. They concluded that doctors have fixed ways of conducting consultations, and used the word "fossilised". They analysed hundreds of tapes, and in summary we can conclude that they had listened to "paternalism". There were, however, signals that they were anticipating changes in the way communication would be considered in the future. It seems that they were signalling their awareness that patients could, perhaps should, have greater roles to play. The use of the phrase "the doctor attempts to discover or actually discovers a reason for the patient's attendance" seems to predict the "prescribed" consultation models that followed shortly after Byrne and Long's work. They also noted that it was mostly the doctor alone who "considered the condition" and that doing this in a "shared way" was low in the "order of probability", and that the patients only very "occasionally" detail the treatment or further investigation. The language is almost prescient of future developments.

It was also a time when other disciplines were debating medical practice. Balint, influenced by the psychoanalytic tradition, was writing about the "doctor as the drug" [5], Kleinman, decades before the recent surge of interest in narrative, had recognised its central role [6], and Helman was emphasising the

Table 1. Byrne and Long's Consultation Framework.

The doctor establishes a relationship with the patient
The doctor attempts to discover or actually discovers a reason for the patient's attendance
The doctor conducts a verbal or physical examination or both
The doctor, or the doctor and the patient, or the patient (in that order of probability) consider the condition
The doctor, and occasionally the patient, detail the treatment or further investigation
The consultation is terminated, usually by the doctor

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importance of culture, context and health beliefs [7]. Medicine however was, at that time, as now, dominated by a reductionist approach. George Engel, a clinician scientist at the Rochester Medical School felt dominated by a technical biomedical approach. He argued for the usefulness of the “interview” as the clinician’s most important tool, and advocated an interaction to allow the patient “to speak of himself, his family, and his relationships as well as of his symptoms”. He crystallised and gained widespread recognition for his views by using the phrase – the “biopsychosocial” model [8].

Engel’s ideas were influenced by the work of Ludwig van Bertalanffy, a Northern American professor of theoretical biology who developed the theory of general systems during the 1960s [9], and who was nominated for the Nobel prize, but died before a decision was made. His work is still influential. He said that: “humans must learn to develop the knowledge needed to deal with every natural, psychological, social and cultural situation, taking into account how every situation is embedded in others, and bearing in mind that every scientific endeavour is biased by our standpoints” [9]. In other words, this is the prototype of the biopsychosocial model. He had a rounded view of science that recognised the complexity of multiple perspectives. Although the central tenets of the psychoanalytic movement were being rejected at the time, here was an attempt to get more balance in application of science to the human condition.

At the same time, the concept of patient centredness was emerging in the early 1980s [10]. Levenstein from South Africa visited Ian McWhinney and Moira Stewart in Canada. It was this Canadian group that developed the patient-centred method [11]. Another key text was the work of Schofield, Tate and Havelock who had teamed up with a psychologist named Pendleton [12]. Although expensive and cumbersome at that time, videotape enabled doctors to view their performance. The consequence of this feedback-enhancing technology should not be underestimated. As with Stewart, their text moved away from a descriptive to a prescriptive stance, and suggested that good practice should be based on achieving what came to be known as Pendleton “tasks” (table 2).

Looking back, it is clear that this is a heavily doctor-centred list of tasks, which is perhaps inevitable given the educational and professional development agenda of the authors. It is worth noting that the task of control time is given prominence, and when compared with Byrne and Long’s outline, the patient has an increasing role. Phrases such as “With the patient, choose an appropriate action” and “Achieve a shared

Table 2. The seven Pendleton “tasks”.

1 Define the reason for the patient’s attendance (ideas, concerns and expectations)
2 To consider other problems (continuing and “at risk” areas)
3 With the patient to choose an appropriate action for each problem
4 Achieve a shared understanding of the problems
5 Involve the patient in the management and encourage the acceptance of responsibility
6 To use time and resources appropriately
7 To establish a relationship which helps to achieve the other tasks

understanding” and “Involve the patient in the management” are illustrations of this shift. Yet, although this is a prescriptive framework, there is no detail about “how” the patient should be involved and what involvement entails for the clinical interaction. In a similar vein, the patient-centred clinical method (table 3) talks of the need to find “common ground” and of “enhancing the relationship”.

Table 3. The patient-centred clinical method [11].

Exploring the disease and the illness experience
Understanding the whole person
Finding common ground regarding management
Incorporating prevention and health promotion
Enhancing the patient doctor relationship
Being realistic

The two consultation models outlined here are chosen as exemplars, there are many other suggested frameworks for “improving” doctor-patient communication [1]. Yet despite having been influential in medical educational arenas there is little evidence that doctors employ these communication strategies in clinical contexts [13, 14]. Whilst not wanting to develop this point here, there is a need to acknowledge the theory-practice gap, to open up a debate between the “prescribed” and the “described” and the limitations of viewing the consultation as an episodic dyadic encounter rather than a longitudinal complex relationship governed by rules that are as yet unexplored. Suffice it to note that the patient-centred clinical method also takes a professional perspective. It is the doctor’s job to find “common ground”, “to be realistic”, to recognise again the tyranny of time.

The changing role of patients

At the same time, in the mid 1980s, Wennberg and Mulley were considering the consultation from a different perspective, debating how patient preference

and their understanding of the evidence around treatments was contributing to medical practice [15]. Jack Wennberg had done small area statistical work in America and had discovered a significant amount of variation in medical practice. He divided this variation into “unacceptable” and “acceptable” professional variation. It was felt that the unacceptable variety was largely attributable to doctors either failing, or for contextual reasons, being unable to, follow best practice guidelines [16]. A significant step forward was the conceptualisation that there can be “acceptable variation”, variation that is generated by patient preference, “preference sensitive” decisions as he called them, where patients need to have information about harms and benefits in order to participate in decisions, and explicitly voice their preferred option. This idea of active participation has been a tipping point for medical practice and the impact is not as yet fully appreciated. Wennberg and Mulley addressed the area by addressing the information deficit, and used the term patient decision aid to describe tools that were designed to address this gap. It is interesting to notice that these decision aids were being built before the concept of sharing decision was described in the communication literature [17]. During the 1990s the concepts of patient involvement in decision-making moved to centre stage [18] and the research into decision aids has grown rapidly, especially in North America [19]. Table 4 outlines a set of competences for the health professional to achieve shared decision-making.

Table 4. Competences of shared decision making.

Problem definition
Equipoise
Option portrayal
Checking understanding
Ideas, concerns, expectations
Role preference
Decision making
Deferment
Review arrangements

Although the model again is based on the acquirement of a set of professional skills, notice that the central assumption is around the exposition of “uncertainty” – that doctors should acknowledge the existence of multiple therapeutic options in most circumstances, and that they have a responsibility to portray these as accurately as possible. The pivotal part of the model is the concept of “equipoise”, from the French for “equal weight”, i.e. to be in balance. Medical equipoise is to do with accepting that what’s best for the patient is often uncertain, and that per-

sonal preferences will influence decisions. It follows therefore that patients have a legitimate part to play in the decision-making process and that the provision of detailed information about harms and the benefits is essential. When compared with earlier models it is clear that a significant change has occurred. There is an accepted role of the patient, and the professional’s task now is to ensure that patients are empowered to adopt an autonomous stance. In other words, a shift of power is taking place. Whether this shift was due to patients claiming, or professionals relinquishing, power is not clear and at this point it is useful to consider the work of Michel Foucault [20]. Postmodernism and the medical consultation Michel Foucault straddles the same period as Balint [5], Byrne and Long [4], Pendleton [12], Stewart [11], Tuckett [21] and others, yet not cited. He inhabited a parallel world of ideas, talking about “power” and the “claims” to power, the way that people interact, view and represent the world [20]. He noticed how doctors had become powerful members of institutions, hospitals, colleges and claimed special knowledge [22]. He also realised that this power is inter-subjective and the relationship between people is the source of the power. He noted how people claim power by their discourse, warning that power relationships are seldom as they appear, that power is often hidden and changes as relationships develop and institutions adapt. Power relationships are central to understanding postmodernism. One of the earliest exponents of the postmodernism was Jean Francois Lyotard [3]. Table 5 summarises his key ideas. Essentially, postmodernism suggests that society has given up the idea of a “grand narrative” of progress, rationality and authority as a dominant ideology. Unifying stories are no longer tenable as we encounter a world that is fragmented, diverse and subject to conflicting viewpoints, often superimposed and hybridised.

Table 5. Postmodernism (according to Jean François Lyotard) [3].

Defined as the death of the “grand narrative” – the end of the unifying story
The end of the “grand” story of the Enlightenment, of authority and rationality
The “promise” of science is no longer believable
“Meta narratives” have been fragmented by consumerism, television simulations, and the use of multi channel mass media
The death of objectivity, the triumph of the subjective, the supremacy of the autonomous individual

Medical practice has to address these ideas because, standing back, it is evident that tensions have emerged over the recent decades between different

interests in medicine, that power relationships are shifting to a point where the consultation has become a “contested” interaction. In society we can see the “triumph of the autonomous individual” but this shift has been difficult to accommodate in a professional mode rooted in 19th century value systems of a clinician as “expert” and “authority”. Unmodified, medical paternalism will perish in a global market-led economy where individual choice, autonomy and consumerism reign supreme.

The multivocal postmodern consultation

In our postmodern world of contested perspectives the need to influence the views of patients is a critical concern. A recognition of multiple agendas, consumerism, and the existence of large amount of diverse quality information provides many opportunities to steer the views of patients. Table 6 illustrates the increasing range of influences on the medical consultation, from the informal and unregulated supply of information on the Internet to an official formalisation of “evidence” by governmental bodies. Compared with the aggressive and well-resourced public relations campaigns of the pharmaceutical industry the voice of medicine is uncoordinated, passive and conservative. Institutions such as the Cochrane Collaboration and governmental bodies are not renowned for their marketing and influencing strategies which tends to tilt the balance towards medicalisation and intervention. Practitioners who wish to involve patients in decisions are trying to do so in short time frames, with little, usually poorly formatted, information about harms and benefits. This creates a tension that is seemingly irresolvable.

Table 6. A selection of the potential voices in the postmodern consultation.

The patient
The patient's family
The doctor
The doctor's social network
The continuing medical education system
Evidence-based medicine and guidelines
Independent consumer organisations
The pharmaceutical industry
Patient groups
The internet
Media (TV, magazines, newspapers)
Direct to consumer advertising
Medical technology industry: investigations, procedures, and “screening” lobby

Although many doctors seem to be stuck in the “grand narrative” of “expert practitioners of certainty” there is an increasing realisation that medicine has inherent uncertainties, especially when interventions are aimed at the margins, at the interfaces between wellness and illness. The debates about the use of antidepressants [23], about the supply of statin therapy over the counter, the lowered diagnostic thresholds for osteoporosis in the elderly, the use of prostate-specific antigen (PSA) as a screening test and so on, are examples of areas where uncertainty is openly debated. Note Medawar's concern about: “a chaotic system of drug evaluation, driven by the almost unquestioned assumption that health is the product of greater “disease awareness” and more new drugs” [23]. Attempted solutions have been twofold: to suggest a change in the way in which practitioners share decisions and communicate risk to patients and to develop tools that help with the most time-consuming part of involving patients – the exchange of information about harms and benefits and the exploration of personal value systems. An increasing literature is emerging in these areas. The leading centres are in Boston [24], Ottawa [25] and Wisconsin [26]. Perhaps the future is a further modification of these innovations, an electronic patient record that directly links an individual patient with personally specified and tailored decision support, where information could be viewed before, during and after consultations. It may also be necessary for medicine to accept that it has a responsibility to have a different relationship with the media, to market trustworthy sources of information, use new channels and the techniques of branding to legitimate and validate trustworthy sources, to go beyond dull public health campaigns to find novel ways of engaging patients.

For family doctors, this poses the greatest challenge of all – to accept that the “grand narrative” of medical paternalism has gone – we now need to play the multiple roles of problem solver, guide to the interpretation of symptoms, information navigator, and where relevant, facilitator of decision preferences in a complex multi-authored time space that we should see as the postmodern consultation.

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