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GP

GP consultation skills: The 10-minute consultation

By Dr Pipin Singh on the 18 August 2015

How GPs can structure their time in consultations to effectively meet patients' needs.



Having a structure can help consultations (Photo: iStock)

The foundation of general practice is the relationship that we have with our patients. These relationships develop over time through effective and efficient consulting.

Effective consulting is an art involving listening to a unique story, extracting useful biopsychosocial information and formulating a safe and effective management plan tailored to the individual.

Currently within primary care, GP contracts recommend a minimum consultation length of 10 minutes. Each practice may differ in how they offer this.

Postgraduate RCGP exams are designed to reflect the ability to consult within 10 minutes. Whether GPs agree or disagree with this length of consultation time, a 10-minute consultation on average is the normality of today's general practice.

One of the main consultation models taught in medicine is the Calgary Cambridge model. Most UK medical graduates will be familiar with this style of consulting and anyone undertaking RCGP exams will be familiar with this in order to acquire MRCGP.

Structuring a 10-minute consultation

Initiating the session will depend on how well you know the patient and the context of the assessment. This will differ if you are meeting the patient for the first time, reviewing a set of symptoms after an intervention, discussing results, or if you have known the patient for months or years.

Assuming you have never met the patient, a warm introduction and a nice open question will get the ball rolling. For example:

- 'What are we doing today?'
- 'How can I help?'
- 'What's brought you in today?'
- 'What can I do for you today?'

Occasionally silence can be effective and nothing needs to be said but that will depend on a few factors, such as an already established relationship with the patient.

Avoid interrupting early on and let the patient talk. Most of the information you need will probably emerge within 90 seconds. Remember patients have been rehearsing their 'speech' in the waiting room.

When the patient has finished, an empathic response may be appropriate, followed by a small internal summary of what you have heard, then agenda setting to ensure the patient does not have multiple problems they wish to discuss. If multiple problems are crucial to the consultation, then negotiate with the patient about how you may wish to progress.

I structure the initial part of the consultation as follows:

1. Empathic statement (if relevant). 'I'm sorry to hear you have felt like that'.
2. Summarise
3. Agenda set

Patients by this point may have already volunteered their ideas, concerns and expectations, therefore it will not be necessary to explore further.

However they may have only dropped subtle hints and used verbal cues such as 'I was worried' or 'I feel something is wrong'. It will be important to pick up on these cues either here or at the

end of your line of closed questioning.

There may also be non-verbal cues that need to be acted on. These can be more difficult to spot.

If a patient has not volunteered their ideas, concerns and expectations, then it may be an opportunity to explore them at this point or at the end of your closed questions. Either way, it is imperative to establish them early on in the consultation in order to formulate a management plan that is tailored toward the patient's beliefs.

Finding out why the patient is presenting now in particular may also be relevant to understanding the complexity of the problem.

Progressing the consultation

At this point try to signpost the patient to how the consultation will progress. For example, 'I need to ask you a few more questions, examine you (if appropriate) and then we can decide how to take things forward'.

Closed questions may be appropriate here to include or exclude serious pathology. The depth of questioning will be determined by how well you know the patient and whether it is in a setting within their own practice (where you have the full record) or a walk-in centre or out of hours where obtaining basic information such as past medical history, drug history, allergies and so on is crucial.

Finding out how the symptom is affecting the patient at work or at home will also be crucial within this data gathering section.

This whole process should last five minutes in an 'ideal' consultation and at this point it may be appropriate to perform a focussed physical examination lasting around 90 seconds.

Decision making and safety netting

All the information gathered should now allow you to explain to the patient what you think the problem could be and integrate this with their beliefs on what it may be. Try to be clear, concise and avoid jargon.

Allow time for the patients to digest information and opportunity for questions. This should take around 30-45 seconds and then this is the point at which the management plan should be discussed. Shared decision making is becoming increasingly widespread and offering patients options allows them to be involved with the decision making process and hopefully lead to a more satisfying consultation.

The final 30 seconds should involve providing patients a safety net - what to do if symptoms worsen or explaining red flag symptoms to look out for. You may wish to book a review appointment for the patient.

Summary

The ideal consultation is an art and requires a series of communication skills to ensure all aspects of a patient's problem are covered.

Time pressures are increasingly common in primary care and 10-minute consultations are becoming more and more challenging. However having a structure as set out by the RCGP based on the Calgary Cambridge model, can hopefully improve efficiency within your own day-to-day practice.

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