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General Doctor's Consultation Work Begins before Entering the Patient and does not End when Patient Comes Out

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Abstract

The consultation is the activity of meeting and communication between an individual and the doctor for the knowledge and solution of a health problem. In today's busy world of general medicine, constant demands for the general practitioner (GP) arise: she or he should not only make a diagnosis not only should make a differential diagnosis during consultation, but must also establish a good relationship, explore patient ideas, concerns and expectations and negotiate a management plan, taking into account limited resources, the quality framework and results, having Information technology skills, plus, the need to promote health during any consultation. Normally the GP has only 10 minutes to achieve all that, as well as to manage your own emotions, agendas and uncertainty. In this way, novice doctors may find it difficult to move in this situation of complexity, and they can also observe a gap in the literature that really guides them in practice. Rigorous preparation is the key to success for many endeavours. Some tips to perform an efficient and safe consultation work in general medicine are suggested: 1) Focus on the next patient; 2) Preparing the consultation before entering the patient, memorizing the patient's previous history; 3) Establishing a connection with the patient; 4) Remembering the elements that must be in each consultation (the current reason, update other previous processes, chronic diseases and continued attention, "case finding", health promotion); 5) Striking a balance between empathy and assertiveness; 6) Putting in writing and contextualized the clinical record; and 7) Making reflection-safety questions, learning questions, and preparation questions for the next visit. Rigorous preparation is the key to success for the general practitioner in every consultation. Think about these topics of the consultation before doing it, and after it, prepare the next consultation of that patient. All these things are force multipliers.

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Introduction

The best definition of the consultation was given by Sir James Spence Professor of paediatrics, Newcastle upon-Tyne in 1960. He said "The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it" [1].

The consultation is the activity of meeting and communication between an individual and the doctor for the knowledge and solution of a health problem. This activity can occur both at the request of the patient, or from the doctor as a "scheduled" consultation, that is, previously arranged by the doctor for follow-up or preventive activities, etc. [2].

When a person goes to a doctor with a "concern", it is also talk about consultation. The medical consultation is the time in which the patient is next to the professional in a certain space (the office or the home of the person suffering from the health problem), while the doctor gives his opinion and recommends the steps to follow. Medical consultations should be recorded in a document that has informative, scientific and legal value. This document, which is part of the patient's medical history, records the doctor's actions [3].

It is known that only the presence of symptoms is not the cause for the patient to consult with the doctor. All general practitioners (GPs) know that many patients consult with trivial symptoms, while others, with symptoms of potentially serious diseases, ignore them. Patients can consult their GP for many different reasons for having a diagnosis: seek support, discuss a personal problem, for being concerned about something, to repeat chronic prescriptions, to request changes in their treatment, to request leave of work for disease, to see if the doctor agrees with him on any decision the patient has already made, etc. In any case, once the decision to consult is made, the patient inevitably has certain expectations that he hopes to meet in the consultation. It is almost as important for the GP to know these expectations as to do a diagnosis about patient's disease [2].

Despite the enormous advances in the science of medicine, the interpersonal encounter between the patient and the doctor remains a cornerstone of medical care. Considerable research has explored several aspects of this relationship, including doctor-patient communication, difficult interactions with patients and what doctors consider significant in their work. These interpersonal aspects of the healing work can be considered the art of medicine. But, most research on the art of medicine have tended to focus on theory rather than specifying how doctors should act [3].

In today's busy world of general medicine, constant demands for the GP arise. Not only should you make a differential diagnosis during consultations, but you must also establish a good relationship, explore ideas, concerns and expectations and negotiate a management plan, taking into account limited resources, the ubiquitous quality framework and results, having Information technology skills, and the need to promote health during any consultation. Normally the GP has only 10 minutes to achieve all that, as well as to manage our own emotions, agendas and uncertainty. There are numerous consultation models, some of which were described decades ago, from more structured to more unstructured consultations, with their relative advantages and disadvantages [4, 5].

In addition, there is a conceptual bias about the "dyad" consultation type (doctor-patient). The health-patient relationship is actually triangular: doctor-patient-family (context). The GP is in contact with the patient for a few minutes, but the patient is related the rest of the time with his family. Therefore, the family must be counted as a primary element for treatment (hygienic measures, diets, taking drugs, exercise or rest ...). The GP is also related to the family: the degree of doctor-patient cooperation is related to the degree of doctor-family cooperation. The greater the complexity of the problem to be addressed, the greater is the need to work with the family group. It is necessary to think of consultations as triads instead of dyad [6-9].

In this way, novice doctors may find it difficult to move in this situation of complexity, and they can also observe a gap in the literature that really guides them in practice, before sometimes having to experience a long time, through trial and error, how to deal with many work situations in practice, so that consultation it

is more efficient and safe.

In this scenario, this article, which is a personal view, aims to, based on a selected narrative mini-review and the author's experience, to show, systematize and summarize fundamental concepts of the GP's consultation work, so as to give rise to practical guidelines. So, this article will not go deeply into the doctor-patient communication, but will focus on the practical elements of organizing the consultation for its efficiency and safety.

Discussion

The medical consultation is a meeting between the doctor and the patient that represents one of the oldest ways to solve health problems. The medical consultation as an object of complex analysis allows us to approach it from multiple perspectives; from the relational in terms of the encounter of subjects, from the intercultural to the diverse socio-cultural belongings of the doctor and the patient, from the communicational, etc. [10]. In planning the consultations of that day, the GP can see which patients will be the main problems and need more time, or will be difficult patients..., the ones that will be faster probably, the first visit who need to start with clinical record and genogram, etc. (Table 1) shows the suggested practices to perform an efficient and safe consultation work.

Focus on the Next Patient

If you feel rushed and tense or still think about your last patient, it is important to refocus before entering your next patient to consultation room. Take a moment to be aware of what is happening in your body, take a deep breath and get rid of the tension. Then ask yourself the following questions to prepare for your next patient [3]:

-What do I know about the patient?

-Where am I in terms of developing me relationship?

-What would I like to learn about this person I don't know yet?

-What is the theme of the meeting, if known, and how I could boost what needs to be achieved?

-If I do not know for sure the reason for consultation, what could be it be taking into account your previous history, your previous consultations, your health problems, your personality?

Preparing the Consultation before Entering the Patient, Memorizing the Patient's Previous History

We must have in our mind the patient's previous biopsychosocial history when he or she entering the consultation, so that we do not need to read computer screens, not written documents, etc. In this way, the GP can focus all his attention on patient. So, GP can integrate patient verbal and non-verbal communication, mentally in his previous clinical history, immediately, which will allow GP to be more effective, and will be understood by the patient as we recognize and remember him as a person and as a sick person (affective and cognitive competence of the doctor).

Before each patient goes into to the office, the GP has to concentrate and "position" himself in a suitable position to adequately "receive and respond" to the patient. Receiving the patient every time he comes to the consultation as a "new" visit and meeting the demand as a punctual visit, without any previous

Table 1. Suggested Practices to Perform an Efficient and Safe Consultation Work

1	-Focus on the next patient
2	-Preparing the consultation before entering the patient
3	-Establishing a connection with the patient
4	-Remembering the elements that must be in each consultation
5	-Striking a balance between empathy and assertiveness
6	-Annotation and contextualized clinical record
7	-Reflection-safety questions, learning questions, and preparation questions for the next visit

preparation, having to make very quick decisions, in a matter of minutes, implies a high risk of omitting data; and frequently the making inappropriate decisions. So, check the personal history or list of the patient's problems, their last visits with the GP (based on the continuity of care), and visits with other specialists, their treatments, their work and family situation, etc. After this, "almost", the GP can predict the reason for visiting to doctor in a large part of the patients [11].

Establish a Connection with the Patient

The first moments of the consultation are key and will give the "tone" to the rest of it. Greet the patient, possibly shaking hands -but this may change in the long term because of COVID-19 pandemic (and young people do not usually understand that gesture). Allow a few seconds for the patient to say the opening phrases he has thought before entering. The patient has his opening phrase prepared as in chess, and we should not interrupt it. It must be remembered that opening phrases are indicators of the patient's mental state, and it is important to be attentive to them. But if he doesn't say it, it is not convenient to ask "How are you?", but rather "What can I do for you?" or "What's wrong" or "I'm listening", "Tell me" ..., and focusing the theme of the visit [12].

When the patient is not known (for example, it is the first visit, or the doctor is the resident, or we are in hospital setting, the doctor will introduce himself and explain his purpose. Even if we know the patient's full name, could ask the patient how he prefers to be called: "I am Dr. Fernandez. I work with his doctor, Dr Smith, and I will take data on his illness." "How do you prefer to be called Mrs. Martin?"

Use the first minutes of the consultation to connect with the patient, before opening the electronic medical record. The connection occurs on at least two levels: interpersonal and intellectual. The interpersonal contact aims to develop a good relationship and generally begins by incorporating a brief and non-medical social interaction to open the interview. This is a good time to learn a little more about the patient. A good tactic is to refer to something mentioned in previous consultations as a way to strengthen the continuity of your relationship, such as "How is your child?" Or "How is your garden going?" When the patient responds, simply observe and listen and you will often find clues about his emotional state. Other aspects of interpersonal connection involve the effective use of assistive behaviors that show that you are listening, such as encouraging responses ("uhhuh"), eye contact and open body language. It is worth spending a small amount of time socializing and listening to the patient, as it has been shown to produce greater patient satisfaction than spending more time in consultation with the patient [3].

In any case, it is preferable to be natural and to get carried away by the style of each doctor, without resorting to a structured and cognitively imposed treatment that does not adequately marry the doctor's style, and does not sound false or theatrical.

You can quickly negotiate an agenda by sharing your understanding of the reason for the visit and then asking if there are other issues that the patient wishes to discuss today. If the patient answers affirmatively, continue asking until the patient no longer identifies problems to discuss. Having raised the concerns of the patients, prioritize them and negotiate a viable agenda for the time available. If necessary, ask the patient to schedule another appointment to address the remaining problems. This makes patients less likely to express concerns when trying to close the visit [14,15].

Setting an agenda early in the visit helps avoid late concerns that may be the most important problems for the patient ("by the way, I have been having these chest pains ..."). By not interrupting the patient's opening statement and using facilitating comments (also called "continuators", for example, "is there anything else" or "uh-huh"), instead of immediately looking for the details of individual symptoms, the GP will have better chance of discovering the full range of patient concerns. This process rarely takes more than 2 to 3 minutes. Understanding the reason or reasons for the visit ensures that it is addresses the heart of why the patient is in consulting room today [16].

The Consultation

The elements that must be in each consultation are [2]:

-The current reason

-Update other previous processes

-Chronic diseases-Continuity of Care

-"Case findings"

-Health promotion

The diagnosis and treatment of a patient's disease is the central clinical function. The first thing that GP must do if he want do his work right, is to understand "who is, and where is the patient" (its context), and then the doctor can move on to the topic of "what's wrong." To understand the health problem, from the point of view of the GP, the first thing is to know the "context of the patient". The clinic emerges, that is, it is perceived by the clinician within a framework that clarifies reality. The diagnosis is made by a mechanism similar to that of the painter when he manages to highlight a figure on a background: "when recognizing the edges by contrast". Thus, the same health problem takes different forms according to its background or context; so there are different diagnoses of the same health problem according to contexts. In this way, the clinical interview should be a "contextualized interview" [7].

Must be remembered that individual clinical circumstances are always "in context", and medical records should be records of patients' medical care in the context of their beliefs, family dynamics, psychosocial situation, disease experience and community culture, to become a real tool to make good decisions (with people in contexts). There is no disease with out a natural history of cultural and social factors. The main factor in the diagnosis and treatment of general medicine is to recognize the patient's relational experience and consider it completely [11], but it is also important to evaluate the patient's response to his illness and suffering. Patients commonly share clues about their experience with the disease, which they can be explored with a modest time investment. Listen to what the patient tells you; what he or she can no longer take for granted: for example, "It is difficult to climb the stairs, Doc" or "I can no longer spend the day without a nap"; and express your curiosity about it. This can reveal significant clinical information and is associated with a better resolution of patients' concerns [3].

The patient's suffering is more than just physical pain. It is "the state of severe anguish associated with events that threaten the integrity of the person." In other words, it affects patient personality. To assess a patient's suffering, ask questions such as: "How does your illness affect you personally?", "How do you find comfort when you are suffering?" And "Despite your suffering, do you feel hopeful about your future?." Patients may find meaning in their suffering or express a sense of hope, even if their condition is incurable, while others may feel despair and withdraw into their suffering. These latter patients will require more care and relationship building, and their plan management will be more effective if you address ways to find comfort in the face of illness and suffering [3].

A special section is the consultation with "shopping list patients" (which also relates to "patients with multi-morbidity", "difficult patients", frequent consultants, etc.). Further, the GP cannot assume that all of the patient's concerns will be raised early in the interview. Patients may talk about embarrassing or confidential problems when rapport and trust have been deepened. Not infrequently, the patient brings up important issues only at the end of the encounter by stating, "Oh, by the way, doctor..." [17].

A second group of difficult patients, next to the previous one or overlapping, are either those that have repetitive complaints, mainly without clear clinical significance, and strange unsolved complaints, Here we can also add a subgroup of patients for whom `everything hurts'. In this group, the visits last a long time, usually much longer than the average, and the patients tire out their doctors Some rules for acting with a poly-demanding patient have been published [18, 19]:

- Make a map of lawsuits and complaints.

- Negotiate the content of the visit.

- Give a follow-up visit.

- Maintain a proactive emotional tone.

- Distinguish the 'new' from the old demands or complaints etc.

A third group of difficult patients, also close to the previous ones or overlapping with them, are those who present disorganized symptoms or diseases. It must be admitted, to begin with, that patients of the GP do not fit adequately into the traditional diagnostic categories. In general medicine it is necessary to evaluate the "presentation of the symptoms", in addition

to the symptoms themselves. Symptoms are the result of an interpretation process. Most patients treated in general medicine have disorganized diseases: they are symptoms or problems that are not fully developed or open in the interview, and give the doctor a feeling of confusion, disorder, restlessness, uncertainty, insecurity with respect to the traditional diagnostic categories, and at the same time they give a sense of expectation. There is evidence, both statistical and anecdotal, that many major diseases are preceded by periods of unhappiness and disorganized disease. Patients' needs may not be expressed in words, and they have to be discovered by the doctor's diagnosis and even intuition. The vital role of the GP is in the interpretation of the unexpressed calls for help. To satisfy the patient is not simply to satisfy the expressed desires, but to meet the deepest, sometimes unconscious needs, and this requires complex and refined techniques [20, 21].

The reason for consultation expressed by the patient is a manifest content. The GP must transform or complete those ideas with which that are latent or initially hidden. The latent content of the symptom / problem / motive may be incomprehensible at the beginning. When the initial material or manifest material of the patient is translated by the GP, we have a more understandable expression. The GP, instead of performing the "clinical method of the detective," uses a "biopsychoanalytical" method or tool, that is the beginning of the diagnostic process, and which has at least 3 ways:

1) The GP acts by helping and avoiding disturbances in the patient's reflexive process

2) The GP try of knowing the latent material by means of "reading the manifest signs and symbols of patient". The messages of our patients contain "facts" and "feelings", and we must be attentive and understand the emotional messages. The reason for consultation / symptom / manifest problem that the patient initially expresses is a "symbolic representation" (with universal and particular symbols)

3) In addition, the doctor looks for what seems to be the cause of the patient problem in the doctor-patient relationship itself [22].

What is traditionally called individual, family and community care are elements of the same reality and cannot be separated. Here, genogram is an instrument or tool of the biopsychosocial model that gives information about the patient, their family and context, and that implies a prognostic value and useful information for the consultation. The biomedical family history means collecting problems of genetic transmission, but from the biopsychosocial point of view it can go much further: the elaboration of the genogram produces a therapeutic link with the family, implying a qualitative change in the relationship. The genogram gives rise hypotheses -in circular terms- about:

1. Patients' risks for family related illnesses or stressors, such as diabetes, hypertension, coronary heart disease, substance abuse, and depression

2. It allows developing a provisional explanation about how the family system is organized around a problem

3. It shows events of family life, transitions and turning points that mean opportunistic prevention and treatment moments

4. "Complex" genograms suggest families with psychosocial problems that can be expressed like biomedical problems

5. The genogram can be used as a screening system in all patients, at their first glance, regardless of the problem that motivates their consultation, to identify biological or psychosocial problems that would manifest themselves later.

It is advisable to make "feasible" genograms avoiding excessive information that paralyzes understanding and intervention. The genograms are a fixed photograph of the family at a certain moment, and the concept of "chrono-genogram" should be incorporated (evolution of the same genogram over time) [23].

Striking a Balance between Empathy and Assertiveness

It is important to show some empathy. It is described as "feeling the patient's world as if it were his own", without ever losing the nuance of "as if." This attempt to understand the patient's experience not only helps to establish a caring relationship but can also affect physiology. For example, patients with highly empathic doctors have been shown to have better glycemic control and LDL levels, and the cold symptoms last two days less than patients whose doctors are less

empathetic [24, 25].

Being empathetic usually involves making an explicit comment about the patient's feelings or experience. Examples of empathic comments are: "That must be very frustrating" (feeling) or "The stairs are really becoming a struggle for you" (experience). Patients cannot know if you have understood your experience and understand it as individual unless you indicate what you understand (feed-back phrases). By being explicit in its understanding, it communicates its receptivity to the patients' concerns, which can encourage the exchange of more personal and clinically important information [26].

However, empathy must be correlated with assertiveness: "the ability to defend your position without assaulting the other." Assertiveness implies having empathy before. A lot of assertiveness without much empathy is not adequate; But a lot of empathy without much assertiveness is not adequate either. Empathy and assertiveness are two axes (X and Y) of a same plane [27, 28].

Notes in the Medical Record. Contextualized Clinical Record

Patient-centered care requires a "context-focused medical record". One tip is that the GP always should record in the clinical history "as if this case he were going to publish it." The medical chronicles of the 19th and 20th century tends to be much more complete, more alive and richer in their descriptions than modern ones. Thus, by abandoning a purely descriptive period to enter a phase of research and active explanation, diseases are fragmented, and are no longer conceived as a whole. By studying the medical records of inpatients in nursing homes and in public hospitals during the 1920s and 1930s, we found highly detailed clinical and phenomenological observations, often presented in the form of accounts of wealth almost as in the density of a novel (such as the "classic" descriptions of Kraepelin and other authors at the end of the 19th century).

But, now there is contempt of the "hard" science towards clinical medicine, and especially towards specific cases (clinical histories). Freud himself wrote: "It continues to surprise me that the clinical histories I write are read as if they were stories, lacking, we might say, of the rigorous seal of science. I console myself thinking that this is due to the nature of the subject, and not due to my personal inclinations." It is evident that the clinical cases of Freud are rigorously scientific and embody a science of the individual as "hard" as the physical or molecular biology.

Let us avoid that this detailed and rich description of phenomena disappears and be replaced by brief notes that do not offer a real image of the patient or his world, but rather they reduce him or her and his/her illness to a mere list of diagnostic criteria. The contextualized clinical record must have the depth and informative richness of yesteryear, so that they are useful to realize that necessary synthesis between science and medicine.

The clinical encounter consists of stories within stories, and a "narrative reasoning" is carried out; each patient tells a story and the clinician intuitively uses patient' narrative cues for assistance. The patient is seen as "a page of a book of nature, a text to read". It is important to maintain the narrative rather than reduce its semantic richness and degrade the story by limiting it to short codes and phrases. Thus, the contextualized clinical record should be able to facilitate the clinician to easily take the narration. Clinical record is constructed and reconstructed as a sculptor sculpts a sculpture

The contextualized clinical record is like a puzzle that represents the totality of a person's life. The various pieces are completed as the patient's health biography is completed. They are added as time progresses and allow continuity of care. On the other hand, remember that every bit of information you obtain from patient history or physical examination that you do not record disappears and is irretrievably lost. The observation and recording of a certain sign or symptom at the initial visit, and days after the start, and even months later, can facilitate the recognition of the course, even aberrant, of a disease, helping a lot in decision making, for example on whether perform or not complementary tests [11].

Reflection-Safety Questions, Learning Questions, Preparation Questions for the Next Visit

At the end of the consultation, establish safety elements and write them down in the clinical record. Same of these elements are [11]:

1. "What will I do if the patient returns for the same problem?"

2. "What will I do if my therapeutic intervention is not successful?"

3. "If I was wrong what will happen?" "What will I do?" "How will I know?"

Conclusion

Rigorous preparation is the key to success for many endeavours. It is accepted that Abraham Lincoln said "Give me six hours to chop down a tree and I will spend the first four sharpening the axe." An axe is a force multiplier. You can be the strongest lumberjack in the world, but with an axe without an edge, you're in trouble! Rigorous preparation is the key to success for the GP in every consultation: think about the topic of the consultation, learn to learn, improve before doing the consultation, prepare the consultation in an integral way, etc. , all these things are force multipliers. You can work hard, hurry during the consultation to avoid delays in appointments, devote more hours to the consultation, etc., etc., but the magic happens when you intend to improve your skills beforehand. GP must be do emphasis is placed on planning and learning skills before entering the actual act. Better planning and learning can produce a better result.

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