Inside the routine general practice consultation: an observational study of consultations for sore throats

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Objectives. The aims of this study were to examine how GPs manage the consultation for upper respiratory tract infections (URTIs) and the prescribing of antibiotics, to understand what skills and strategies are used in managing URTIs without antibiotics, and to note evidence of pressure on doctors to prescribe and whether there are signs of overt disagreement about prescribing in the consultation.

Methods. A qualitative analysis of audiotaped consultations was carried out. The setting was a general practice in South Wales and the subjects were five GPs and 29 parents presenting children with URTIs over a 2-week period. The main outcome measures were skills and strategies identified from audiotapes of consultations.

Results. This group of GPs used a set of readily identifiable consulting skills for managing the consultation without prescribing. Their consultations had a highly routinized quality. There was little evidence of either conflict or overt pressure from parents to prescribe. The word ‘antibiotics’ was seldom mentioned. Clinicians did not elicit patient expectations for receiving antibiotics.

Conclusions. Doctors use a set of readily identifiable skills in managing the URTI consultation. Avoiding the prescribing of antibiotics is not necessarily a simple and straightforward matter. Since patients apparently want antibiotics less than anticipated, eliciting expectations might be a way of reducing prescribing and broadening the approach to meeting patient needs. Whether doctors can adjust their routinized consulting patterns in the time-limited context of general practice remains an open question.

Keywords. Antibiotics, consultation, general practice, upper respiratory tract infections.

Introduction

The consultation for upper respiratory tract infection (URTI) is one of the commonest in general practice and is surrounded by controversy. Concerns about the limited effectiveness of antibiotics for URTI and the consequences of overprescribing apparently are matched inside the consulting room by discomfort about decision making and a perceived need to respond to the expectations of patients for antibiotics. Doctors are aware of these issues, yet point to the difficulty of reconciling public health concerns with the circumstances of the individual consultation. Despite exhortations from the public health and scientific communities, significant overprescribing still takes place. Patients apparently do not want antibiotics as much as doctors think they do.

The failure to explore patients’ ideas about drug treatment is clearly associated with misunderstanding about medication use. While numerous questionnaire and interview studies have targeted these common consultations, very little attention has been paid to a basic description of what happens inside them.

In response to these concerns, having elicited the views of doctors and patients, we set out to develop a
training programme to reduce unnecessary prescribing and enhance patient self-care. Whether it is possible to achieve this goal through change in the doctor's approach to the consultation remains an open question. Our first task, reported here, was to understand the language, skills and strategies used in everyday URTI consultations, particularly those deployed in managing the consultation without prescribing. To this end, a researcher (CS) not connected to the training programme was used to bring a fresh eye to what goes on in the consultation, hopefully to provide a platform for developing new approaches to the URTI consultation in training seminars with clinicians.

Subjects and methods

All consultations with children with URTI aged 10 and under, involving five GPs from a single practice in the South Wales valleys were, with parents' permission, audiotaped over a 2-week period, and then transcribed. One parent refused consent to audiotape, and during one surgery a doctor chose not to collect data because he was running late. The characteristics of consultations collected are given in Table 1. The relatively low rate of prescribing was not entirely anticipated (28% of consultations). The GPs were chosen because they said they would like to participate in training to reduce prescribing. They did point out, however, that they believed that they had begun to make progress in reducing their prescribing.

A analysis of transcripts involved listening to the original tapes closely, and repeated readings of transcripts in order to identify verbal moves used by the doctors. The analysis was broadly informed by knowledge of conversation analytic (CA) techniques in which close examination of talk generally reveals unacknowledged skills. CA techniques typically gain force from a detailed look at a small amount of material, to discover what phenomena are possible in a particular setting.

<p>| TABLE 1 Prescribing across 29 consultationsa |
|-----------------------------|-----------------------------|</p>
<table>
<thead>
<tr>
<th>GP</th>
<th>Antibiotic prescribed</th>
<th>Not prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1</td>
<td>5b</td>
</tr>
<tr>
<td>B</td>
<td>1</td>
<td>4c</td>
</tr>
<tr>
<td>C</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>D</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>E</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Total consultations</td>
<td>8</td>
<td>21</td>
</tr>
</tbody>
</table>

a Excludes a 30th consultation where the tape quality was too poor for meaningful transcription.
b Includes one where a 'topical' medication containing an antibiotic was prescribed, rather than an 'oral' antibiotic.
c Includes two where the child was already taking antibiotics.

Results

Routine nature of URTI consultations
The most striking feature of these consultations was their routinized nature. All 29 involved an opening greeting that doubled as an invitation to explain the reason for the appointment, for example, “Hiya how are you, right... so what is the problem?” This was normally followed by an account of past events from the parent, arranged so that the present consultation appeared inevitable. Typically, the doctor monitored this with brief acknowledgements and occasional questions to the parent, and then proceeded to a physical examination, during which there could be occasional reporting of what was being seen, heard or felt. Treatment would then be discussed, and the consultation would then end with an “OK then, take care then, so long.” Thus there was a sense of ‘business as usual’ about these consultations, suggestive of a standard repertoire of routinely available skills.

Managing without prescribing
It became clear that this standard repertoire did not include the option of ‘just saying no’ (as in “It’s viral, you don’t need antibiotics, go away”). The decision not to prescribe was preceded by a number of pre-announcements. To begin with, however, the initial task for doctors was to address parents’ need to justify the consultation with a story of extreme or abnormal events.

A typical example is:

“He is coughing and he sounds very rattly you know and it kept him awake most of the night last night and he has been really feeling tired, sleeping on and off all day today... It didn’t start yesterday it started Saturday but I thought it was just you know a cough but it seems to be getting worse with him and his nose is running... I came in from work and I literally brought him straight down, I just came out...” (Dr D/2)

This presents a crescendo of events, involving abnormalities such as being awake at night and asleep in the day, progressing through a realization that ‘just a cough’ would not suffice to explain events, ending in an urgent and obvious need for the parent to drop everything and come straight out to the surgery. Other such extreme accounts included, “real red cheeks and this high temperature all the night”, “we are up to our neck in towels” and “I’ve had the doctor out twice... twice on one night... he was very ill... his temperature was up in the hundreds.”

The standard pre-announcement strategy employed by doctors who did not prescribe was to ‘minimize’ these extrematized concerns, often with the aid of a physical examination. The doctor in the example above (involving the ‘very rattly’ cough) used minimizing words, not only to reassure a worried parent and to reduce the
intrusiveness of the physical examination, but also to introduce the idea that the problem was not that serious:

“O.K., right oh, yes, lets just check his neck now, yes, his glands are a little bit swollen there, right have a quick look in his ears I tell you what whilst he is tilting back we’ll try and have a little look in his throat as well ... H ey O K won’t be a second now ... Yes, that’s fine, right probably just a viral infection that has just made him cough and splutter like this a bit ... A nd he has the cold symptoms now starting up as well you said ...” (Dr D/2)

Other consultations, conducted by all the GPs in the sample, contained references to tonsils that were just ‘a little enlarged’, an ear that was ‘a bit waxy’, a chest that had ‘nothing collecting’, a throat that was ‘a bit inflamed’ as well as the view that the child has ‘had a bit of a cold’, to convey in similar fashion that there is minimum cause for concern. This minimizing strategy could also involve emphasizing the normality of what parents had presented as dangerously abnormal, part of the general reassurance that doctors commonly see as an important function of such consultations, for example, “This is how I’d expect him to be with this infection” or “so there’s nothing to worry about there, he’s recovering from it obviously now”.

A further aspect of pre-announcements was what could be termed a ‘pre-emptive move’, in which a decision not to prescribe theoretically was signalled to anyone knowledgeable enough to hear it this way. Examples include “probably just a viral infection”, “more than likely a viral infection”, “the problem with coughs and colds is that we can’t actually speed them up” and “I’m not sure that I can magic this away”. We found examples of this strategy in transcripts of all the GPs in the sample.

Making ‘no’ mean ‘no’

While this pattern of preliminary moves served as warning of the final delivery of the doctor’s decision, aspects of the delivery itself and its aftermath served to pre-empt counter arguments and ensure that the ‘no saying’ was secure. For example, 61 alternative treatments for symptom relief were discussed in the 21 consultations where antibiotics were not prescribed (an average of 2.9), in contrast to only five such alternatives in the eight consultations where they were prescribed (an average of 0.6). The ‘consolation prize’ status of many of these discussions is suggested by the fact that most occurred after the ‘no’ decision was revealed and could involve things such as issuing a prescription for Calpol. Clearly parents could then leave feeling that something could be done for their child. Additionally, doctors introduced these discussions in a way that assumed an existing level of parental competence in this area: Doctor: “if you find that he does get warmer still despite the paracetamol you know what to do don’t you.” Patient: “Y es yes” Doctor: “L uke warm bath and so on” Parent: “Y es”. (Dr E/4)

During the delivery of the decision not to prescribe an antibiotic, it was evident that doctors made further appeals to existing parental competence and knowledge, evaluations which parents willingly acknowledged. This is evident in the following example of a ‘no’ delivery that begins with a pre-emptive move and continues with a minimizing reminder before the final delivery.

Doctor: “Y es, that’s fine, right probably just a viral infection that has just made him cough and splutter like this a bit.”

Parent: “I s it?”

Doctor: “A nd he has the cold symptoms now starting up as well you said.”

Parent: “Y es, y es”

Doctor: “Y es, O K , no point in giving him antibiotics of course for this, as you know I am sure it’s not going to do very much at all for it, what are you giving him so far, are you giving him paracetamol?” (Dr B/1)

The first comment from the doctor introduces the concept of a viral infection, whose connotations (antibiotics are irrelevant) it might be hoped were obvious to the parent. If this were not the case, it is spelled out in the final comment from the doctor, who incorporates the patient in this knowledge with an “as you know”, without in fact allowing any pause for the patient to indicate assent. No problems occur when the doctor moves the conversation off this topic and on to the matter of symptomatic relief. The parent is thus placed in the difficult position of implicitly admitting to an embarrassing level of ignorance should they oppose the decision, thus making acceptance considerably more likely.

The rapidity with which doctors deploy these skills can be quite remarkable. The exchange below (Dr A/4) reveals all three components (pre-emptive move, assumption of parental knowledgeability, delivery of ‘no’ decision) almost in a single utterance from the doctor:

Doctor: “O K , um, so this is more than likely a viral infection.”

Parent: “R ight.”

Doctor: “A s you know there is no point in giving antibiotics for that sort of thing.”

The effectiveness with which this decision not to prescribe is secured is revealed in the continuing sequence from the same consultation, even when the parent challenges the decision:

Doctor: “A s you know there is no point in giving antibiotics for that sort of thing.”

Parent: “S he had antibiotics just recently anyway.”

Doctor: “D id she?”
Parent: “For a cough.”

Doctor: “Did they work?”

Parent: “Yes, they did.” (laughs)

Doctor: “Sometimes they do, OK, but with this sort of thing I mean basically cold type symptoms with a sore throat that’s invariably viral anyway, the ear ache is because of deferred pain from the throat going up to her ears, and really it’s only a matter of what you are doing already I am afraid um which you know will . . .”

Parent: “Shall I keep her away from school?”

Doctor: “Um, yeah probably worth it for a day or two anyway just to let her settle down a bit.”

Parent: “OK.”

Doctor: “Probably won’t last that long this sort of illness”

Parent: “Yes”

Doctor: “So yes paracetamol four times a day, cough medicine is fine, there is nothing collecting on her chest there so it’s worth while suppressing the cough and that’s it.”

Parent: “A bright thank you very much O K.” (Dr A /4)

Even the apparently direct challenge by the parent to the effect that antibiotics ‘worked’ previously (accompanied by an apologetic laugh) cannot reverse the ‘no’ decision agreed upon earlier.

These strategies are very effective in gaining assent to the decision not to issue a prescription. The above example is the only occasion in the 21 ‘no’ consultations in which the doctor’s decision is challenged. The remainder revealed no evidence of disagreement.

Pressure to say yes
The eight consultations where antibiotics were prescribed were examined carefully for evidence of pressure from parents for this outcome. No requests were made, either directly or indirectly, with the exception of a single mention of antibiotics having been prescribed for a brother of the child in question, which might be ‘heard’ as a hint in this direction.

Offering choice
Evidence of offering the patient choice came from two consultations, both from the same doctor (Dr E). In the first example, the outcome was an antibiotic prescription, and demonstrates the consequences of half-hearted ‘no saying’. In its early stages, this consultation (with Dr E) displayed little difference from those where prescribing did not take place, when the following occurred:

Doctor: “. . . got an infection there so we will have to treat that. Will you open wide for me. A h—tongue out at me. L ovely that’s healthy, tonsils are healthy. So the ear infection—um funny enough we now know that ear infections do go even if you don’t treat them but they do take probably a little bit longer to go if you don’t treat them so its entirely up to you if you want to treat them then that’s fine.”

Parent: “I would prefer to because he was crying and then if it gets any worse . . .”

Doctor: “Distressed and obviously you are giving him Calpol which is the main thing—keep going with that. Is he allergic to anything?”

Parent: “No.”

Doctor: “He is very good isn’t he—had a bit of a wait today. O K there you go then.” (Dr E/1)

The initial “we will have to treat that”, in retrospect, opens the door for the mother’s decision. There is no pre-emptive move, such as a statement that it is “probably just a viral infection”. There is no appeal to parental knowledge about the ineffectiveness of antibiotics; rather this is presented as if it were ‘news’ to the mother with “funnily enough we now know”. The invitation to ‘treat’ is then repeated towards the end of the doctor’s first statement and is duly taken up by the mother.

In the second example, the doctor was able to present the choice in a way that militated against a ‘yes’ decision. On this occasion, “I’m not sure that I can magic this away” served as a pre-emptive move, and the later offer of a choice was accompanied by a reiteration of this move and advice in favour of a ‘no’ decision, which was duly taken by the mother:

Doctor: “I’m not sure we can do anything to speed it up, to be honest. It’s just a lot of catarrh that’s causing the problem and I can’t really speed up catarrh. It’s up to you, its obviously been going on quite a few weeks and if you wanted to try another course of antibiotics then you’re welcome to but I just wouldn’t recommend it, because I don’t think it’s actually going to speed things up.”

Parent: “No, no.”

Doctor: “You know, there’s no sign that it would do.”

Parent: “No.” (Dr E/7)

Uncommon skills
The skills described thus far—normalizing and reassuring in the face of parental anxiety, pre-emptive moves, invocations of parental competence, provision of consoling advice and treatment for symptom relief after a ‘no’ decision—appear to be a part of these doctors’ standard repertoire of skills. More exceptionally, some special skills were deployed, and these included the kind of things doctors will mention when asked to describe how they say ‘no’, as was revealed in our earlier study.4
These include the ‘easy access for review’ and ‘delayed script’ strategies. The former was evident in five out of 21 consultations where prescribing was avoided, for example, “If you’re worried you ring us and we’ll check her again”, while the single example of the delayed script strategy was, “it’s probably worth giving it a few days without antibiotics to start with”.

Additionally, Dr A, in two consultations, asked the parent after the initial presentation of reasons for the consultation, what was worrying them: “OK, right. What worries you most about what’s happening to him at the moment?” and “What was worrying you so much?”; the first of these involved a child who was on antibiotics already and resulted in a story of how the child refused to take his medicine and an eventual referral to the health visitor for advice on this. The second elicited a story of concern about the possibility of meningitis, about which the doctor was then able to reassure the mother.

Conclusion

The results demonstrate the existence of a standard repertoire of skills for managing without prescribing among five GPs working in a single practice. We believe many doctors will find this kind of talk familiar, yet the taken-for-granted nature of several of these routinely available skills means that they are rarely a topic for explicit discussion and reflection. We make no claims about the prevalence of the phenomena we describe here, but simply point out that these are things that GPs evidently can do, as a matter of everyday routine. Whether they apply to other doctors and patients, in other settings and cultures, remains unanswered.

These doctors appeared able to conduct many of the consultations without prescribing, in a polite, ‘business as usual’ kind of way, with little evidence of conflict. The word ‘antibiotic’ was seldom mentioned. Patient expectations and their reactions to the doctor’s decision were not elicited.

Under pressure to reduce prescribing and conduct consultations that are more satisfactory to both parties, one might ask what else needs to be done in the consultation beyond what was observed here? The impression of consultations free of conflict, in which patient assent is skilfully gained, does not mean that doctors feel no pressure, or that patients and doctors are satisfied with these encounters. One obvious missing ingredient is the eliciting of patient expectations and reactions. The benefits would not just be confined to meeting patients’ needs more readily, but doctors might realize that fewer patients than expected would actually want antibiotics and potential conflict could thus be avoided.

Whether it is possible for doctors to adjust their highly routinized consulting patterns, and approach shared decision making in URTI consultations remains an open question. If prescribing is to be reduced in some instances, and self-care enhanced, simply saying ‘no’ might not be as viable as common sense suggests; enhancing consulting skills which avoid conflict and make agendas explicit might prove to be more fruitful.

Acknowledgements

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