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DISSECTING THE CONSULTATION

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Observations from a Clinician

The following notes are a road map for an unorthodox exploration of the clinical consultation. The lecture examines medicine as performance, focusing on the processes of clinical care rather than the scientific knowledge which underpins it. To highlight the performative and improvisational aspects of medicine I share the platform with a leading close-up magician in an unscripted conversation which explores the common ground between apparently unrelated fields of expertise and asks how medical education can be enriched by cross-disciplinary interaction.

The first lecture in this series set out the proposition that clinical practice is one of many instances of expert performance, and that the acquisition of expertise can be framed as an extended journey which falls into recognisable stages. Starting with the traditional trajectory from apprentice to journeyman to master, I examined aspects of expertise that develop and mature over time. To do this I introduced examples of experts I've been working with for many years - a bespoke tailor, a hair stylist and a potter - whose practice sheds light on clinical learning. For all of them, the process started with 'doing time' and 'learning to see'. Newcomers acquire the basic skills of their craft through this extended immersion, whether in medicine, music or masonry. These initial stages also lead to a fluency in the language of touch, where learners become familiar with the materials they work with and recognise the limits of their own bodies.

This second lecture turns to the consultation, that central act of clinical care where two or more people, held in a relationship of care based on trust and integrity, come together to address a problem. Traditionally, medical students approach the consultation from a 'disease' perspective, viewing medicine from a practitioner's point of view and fitting patients into diagnostic categories and approaches to treatment. As students, a lot of time is devoted to acquiring knowledge and skills relating to bioscience. Medical students are taught to gather information from patients by taking a history, performing a physical examination and arranging investigations, in order to make a diagnosis and propose treatment.

In this lecture I describe a shift I experienced when moving from surgery to general practice. Alongside the 'disease' perspective I had learned at medical school and as a hospital doctor, I became increasingly aware of my patients' experience of 'illness', of how their lives were affected by what they were going through.

The consultation was the focal point for these encounters. At that time, I was greatly influenced by 'The Inner Consultation' by Roger Neighbour, a pioneering GP and educator. This unpacked the consultation itself, showing its complexities and its underlying structures. Unlike other textbooks I was used to, Neighbour's book was not primarily about diseases and how to diagnose and treat them. It was about the consultation itself, and its pivotal role for exploring patients' experience of illness.

Neighbour set out five 'checkpoints' for navigating a consultation. *Connecting* involves establishing a rapport with your patient. *Summarising* requires you to check that you've understood why the patient has come to see you and that you have arrived at a plan that makes sense to you both. *Handing over* means checking that the patient is fully back in charge of what happens next. *Safety-netting* is about making sure you have anticipated all likely outcomes, even if things turn out differently from how you expect. *Housekeeping* is Neighbour's term for dealing with your own internal experience, making sure your mind is clear and that you're 'in good condition' for the next patient.

As a family doctor and later a GP trainer myself, I became fascinated by the complexities of the consultation. I recognised the art on which expert consulting depends, the performance which interweaves scientific knowledge with human interaction and empathic connection. Every consultation is unique and its outcome cannot be wholly predicted. Much depends on how clinician and patient interact, on how their conversation unfolds in the moment, and how each responds to the other. In this sense the consultation is an improvised performance.

Improvisation is an essential skill in medicine as elsewhere, though it sometimes has a bad name in the medical world. The word 'improvisation' can smack of unpreparedness, of putting things together on the fly, of not taking the trouble to plan. In this lecture I propose the opposite, asserting that improvisation is an essential and demanding skill that requires extensive knowledge and years of preparation. Improvisation requires the capacity to notice and respond to what is happening in the moment, not imposing your own intentions but recognising the concerns of someone else. Factual knowledge and component skill are necessary constituents but are not on their own sufficient.

In addition to that knowledge and skill developed over years of training and experience, successful improvisation requires a positive approach. The director Keith Johnstone, a specialist in improvisational theatre, famously said 'it's not the offer, but what you do with it'. Improvisation is a two-way street. One actor says something, another responds. The key is to respond with 'yes *and* …' rather than 'yes *but* …'. 'Yes *and* …' moves the conversation forward. 'Yes *but* …' shuts it down. Clinical consultation is like that too. Although the shape of the consultation is tightly framed (a fixed and usually short duration, a format that starts with a problem or symptom and aims at a satisfactory outcome), how it will unfold cannot be predicted. The more experienced and skilled the practitioner, the greater their ability to improvise.

Clinicians can learn much from expert performers outside medicine altogether. In recent years I have had the opportunity to work with leading magicians, including Will Houstoun. Their account of how they became expert in their field resonates with my own experience in medicine. Magicians describe spending years practising magic tricks in front of a mirror, learning to make cards and coins appear and vanish - their equivalent of learning scientific knowledge and component skills. And they point out that magic only happens when there's an audience. In close-up magic, the audience may be small - sometimes only one or two people. The magicians have to realise that the essence of magic takes place through performance, that dexterity on its own is not enough. They summarise it by saying 'It's not about you (the performer), it's about them (the audience)'. That summarises how I see the consultation. As a doctor my patients weren't usually interested in how many exams I'd passed or what I knew about medicine in general. Their focus was on what happened during the consultation and whether they left with a sense that what was troubling them had moved forward or been resolved.

Knowledge and physical skills will always be important. Magicians rely on sleight of hand to create a compelling illusion. For clinicians, dexterity has a different function, allowing them to examine patients and perform procedures. Both require the confidence and precision gained through years of practice. Although the purposes of clinical performance and magic performance are very different, they both depend on skill, integrity, trust and care.

Observations from a Magician

Almost exactly four years ago I met Roger Kneebone, in the company of a number of other magicians and academics, for the first conversation in what would develop into a fascinating exploration of the intersection between the worlds of conjuring and surgery. During the ensuing years we have had many interesting discussions, examining ideas of

expertise, embodied knowledge, and craft as they apply to our respective practices. But the two aspects of our work that we return to most often are manipulative skill and performance.

As a professional magician, my practical interest focuses on sleight of hand conjuring (the creation of magical effects that are achieved by dexterous, and often complex, covert manipulation). We have spoken at length about warm-ups, hand exercises and manipulations which your audience (or surgical patient!) are unaware of but which contribute to an effect they do perceive. Yet secret manipulation, or the other covert tools of the conjurer, are only a small part of what it takes to perform a piece of magic.

It is a fundamental characteristic of a magic trick that it requires at least two parties to take place. There must be a performer, who provides information in such a way as to mislead someone into thinking something impossible has taken place, and an audience (of at least one, though they could be a thousand strong) who make the assumptions the performer leads them to and end up experiencing something seemingly inexplicable. Without an audience a magician may be able to practice their trick so that they believe it will be deceptive, but it is not until someone else sees it that it becomes magic.

In conversation with Roger, I learned that the fact that magic can only happen in the collaborative space between the magician and the audience makes it similar to the clinical consultation, which can only exist with a collaboration between the physician and patient. In the consultation there is a clear imbalance of power in favour of the doctor. The patient will often be there for an experience that involves discomfort. Similarly, in the performance of magic, there is an imbalance of power - the magician, after all, is at least light-heartedly claiming supernatural abilities and their performance is predicated on other people not knowing how it was done - and the audience are often not sure quite what their experience will be. The similarity between the consultation and conjuring performance has made it interesting to consider how a magician shapes an audience's experience, particularly in an intimate setting, and how those ideas might be applicable to the physician.

One of the most important skills for a magician is being able to make a connection, both with an audience as a whole and specifically with its individual members. A fantastic tool with which to do this is eye contact. Looking at someone makes it clear that you are doing something for them, but how do you avoid mechanically staring for longer than you ought to? And how do you make eye contact with a room full of people? The Spanish master magician, Juan Tamariz, offers a solution in a book of performance theory for conjurers. He suggests imagining that there is a network of threads that extend from you to each and every member of your audience. Over time those threads gradually slacken but, by looking at someone, you can pull their thread taught. Your goal is to never let them get too slack, but also to avoid over-stretching them, something that can only be achieved by shifting your gaze from one section of your audience to another. This technique allows a performer to imagine their eye contact as a tool in a world of loosening and tightening threads, and ensures that they look at everyone yet never at one person for too long.

Another tool that a conjurer uses to put an audience at ease is naturalness, or, more precisely, lack of perceived unnaturalness. A magician largely wants to avoid unnatural movements, as they will pull an audience's attention from something you do want them to focus on, to something you would rather they did not. The obvious solution seems to be to do everything in a natural way, but this is actually insufficient. For example, two people talking might sit directly opposite each other facing towards one another. That would be natural but, if they were being watched by an audience (as Roger and I were for our conversation) they would shut people out and remove the possibility for communication beyond the edge of the stage. A better solution to actual naturalness is a performed naturalness, sitting at a 90-degree angle to one another with both chairs at forty-five degrees to the audience. This allows the people on stage to converse but also makes them open to the audience, allowing them to engage the entire room with little more than a turn of the head. It may not be entirely natural, but it does not feel unnatural to those watching and ensures they have the best possible experience.

A final example of an essential skill for a magician that has clinical applications is improvisation. Of course, when you are showing someone a magic trick you should know what you are trying to achieve, how you intend to achieve it,

what you will say and so forth. But this script is simply an idealised version of what you will do. If, part way through your performance of a card trick, you discover the volunteer cannot see the card they have chosen without their glasses you cannot simply continue with your script. Instead you must deviate from it into an improvisation that acknowledges the situation (they can't see their card), resolves it (they are lent a pair of glasses by someone close to them) and then returns you to your plan (they know what card they have chosen, and the trick can continue). If you do not do this, but simply plough ahead with your script, any connection that has been built with the audience will be destroyed as it becomes clear that you care little for them or their experience. It is particularly important to note that 'improvising' in this context does not mean making it up as you go along, but rather is a tool that can be used in conjunction with a well written and rehearsed performance to ensure the best experience possible for an audience.

People often think that the main skill of a magician is to be adept at sleight of hand, or perhaps simply to know how a trick is done, but remain largely unaware of all of the other skills and factors that underpin a successful performance for an audience. Similarly, one might think that a physician's principal skill is an encyclopaedic knowledge of diseases and their cures, rather than the ability to quickly build a relationship which creates a mutually satisfactory experience. This final parallel between the two practices, the difference between the perceived and actual skills involved, has provided the basis for fascinating conversations in the past, as I hope it will have done tonight and, perhaps, in the future.

Further reading

Neighbour, R. (1987). The Inner Consultation. Dordrecht: Kluwer Academic Publishers.
Johnstone, K. (2007). Impro : improvisation and the theatre. London: Methuen Drama.
Tamariz, J., & Lehn, D. B. (2007). The five points in magic. Seattle, WA: Hermetic Press Inc.
Macknik, S., & Martinez-Conde, S. (2010). Sleights of Mind What the neuroscience of magic reveals about our everyday deceptions. New York: Henry Holt and Company.

Podcast

Roger Kneebone's fortnightly podcast *Countercurrent* (http://apple.co/2n5ROy1) features Will Houstoun in his current conversation. Richard McDougall, another close-up magician, features in the podcast released on 16 October 2016.