From the Editor

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The evolving clinical consultation

We had the experience but missed the meaning
(TS Eliot)

Both doctor and patient may miss the meaning in the clinical consultation. Listening and responding to patients, both essential elements of the consultation, are too often prone to misinterpretation. Even when we listen carefully, messages are often erroneously perceived and interpreted. Social, educational and cultural background affect the discourse, and in this issue of *Clinical Medicine*[1], the thoughtful article by John Mole reminds us that 'different cultures may use different intellectual tools to arrive at a conclusion. They can be misunderstood or misinterpreted…'. He describes the different ways of thinking which can create barriers to understanding and communication.

Understanding patients requires much more than the assessment of numerous laboratory tests and other clinical investigations[2]. Professor Rita Charon has recently reminded us that an understanding of patients unfolds over time[3], which may mean weeks, months or even years, as anyone caring for those with chronic diseases would know. Complete interpretation of the patient's malady needs not only an understanding of the natural history of the disease but also an unfolding of the patient's life history. The medical records, she writes, can 'capture individual human lives as they change and as they age, finding some meaning in the random events that happen in them'. We should read our 'patients'charts as if they were novels, looking for patterns and movements throughout a patient's life'[3].

New elements within the consultation now further confuse our established routes of communication. The millions of health-related web sites[4] confer on patients a newly acquired authority which significantly shifts the balance of expertise within the consultation. The 'expert patient' needs to be understood, though not perhaps employed in the user-led self management programs suggested by the Department of Health[5] and critically examined by Robert Tattersall in the last issue of *Clinical Medicine*[6]. In our new relationship with patients as partners in the consultation, particularly in the choices needed when handling chronic diseases, we need to understand that some patients vigorously want to lead, while others still prefer to be advised in the traditional didactic manner[6].

Many patients feel that they have received insufficient information and have not been properly involved in decision making. Communication back to the patient must show that we understand, while patients must in turn try to understand the dilemmas of uncertainty. Such communication comprises both words and gestures. Both spoken and written opinions need to be shared by all parties and reinforced by sight of the doctors' letter to the General Practitioner. While volumes have been written on communication, and educational courses may improve doctors' skills[7], inspiring confidence in the patient remains a gift which doctors cannot always acquire simply by reading. By whatever means, at the end of the consultation patients must feel that they have been heard and understood, and their self esteem should always have been enhanced. 'What is spoken of as a "clinical picture" is not just a photograph of a man sick in bed' wrote Francis Peabody in 1927. 'It is an impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joy, sorrows, hopes and fears[8].'

References

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Council for Research Integrity

Misconduct and fraud in research have gained increasing prominence over the past decade. While other countries such as the USA and Denmark have introduced systems to deal with the problem the UK academic community has been slow to respond, although funding agencies such as the Medical Research Council and Wellcome Trust have introduced guidelines and policies for those supported by them whilst the General Medical Council has recently published good practice guidelines.

A consensus meeting organized by the Royal College of Physicians of Edinburgh and the Faculty of Pharmaceutical Medicine recommended establishment of a Council for Research Integrity. A recent meeting of several major stakeholders in medical research agreed that such a body should be established in an advisory capacity. It would advise research institutions such as medical schools and NHS bodies on good practice and on investigation of suggested fraud. It could also recommend external individuals who would conduct rapid investigations when internal mechanisms suggested that there was a case to answer. It was also agreed that the Academy of Medical Sciences was the most appropriate body to oversee establishment of the Council.

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