Analysis

Finding meaning in the consultation:

supporting the hermeneutic window in practice

INTRODUCTION

Consultation frameworks usually address only generic skills and largely ignore the extent to which a clinician is able to establish a human connection, to understand what an illness means to their patient, and to help them navigate through it, particularly in the face of uncertainty. We previously presented a model that sees biomedical and humanistic approaches as complementary and in which hermeneutics, the finding and creation of meaning by both patient and doctor, plays a key role. In the first of three articles, we introduced the ideas behind the model[1] and in the second we illustrated how it can work in practice.[2] In this third article we explore some of the systemic factors that have led to an undervaluing of hermeneutic approaches and illustrate ways in which a healthier balance may be restored, both for patients and practitioners.

THE HERMENEUTIC WINDOW

Our model of the GP consultation is represented as a two-by-two table with four related domains (Figure 1).

The hermeneutic window (Window 4) is where assumptions, meanings, and roles are interpreted in a way particular to the patient, doctor, and circumstances. This is often the area of greatest complexity and uncertainty, where questions about what it means to be a healthcare professional are asked, and relationships with individual patients are examined. It entails reflective practice in its widest sense. A hermeneutic stance may involve validation of a patient's experience, the triggering of a new insight (Heron's 'catalytic intervention'),[3] or helping someone to move on from a stuck narrative.[4]

WIDER INFLUENCES DISCOURAGING A HERMENEUTIC STANCE

Recent decades have seen a huge increase in regulation and governance. There has been more emphasis on demonstration of patient safety and achievement of quality standards. These changes have altered the nature of general practice, with more prominence given to output[5] — whether this is measured as points achieved in the Quality and Outcomes Framework (QOF), evidence-based prescribing, or adherence to referral pathways.

The nature of the consultation has also been affected, including the way in which clinicians approach patients, with the emergence of a 'sort, fix, or send' mindset,[6] where the presenting problem is triaged, managed in accordance with guidelines where possible, or referred if not. This disease-focused paradigm may have been encouraged by the depersonalisation ensuing from remote consultations. In a context where the disease and not the patient is given supremacy, the emotional availability, imagination, and empathy of the clinician are not valued.

Additionally, working in large, sometimes transient teams means that clinicians are less likely to develop longitudinal relationships with patients or to have a deep knowledge of their social and environmental context, which makes it harder to adopt a hermeneutic approach.

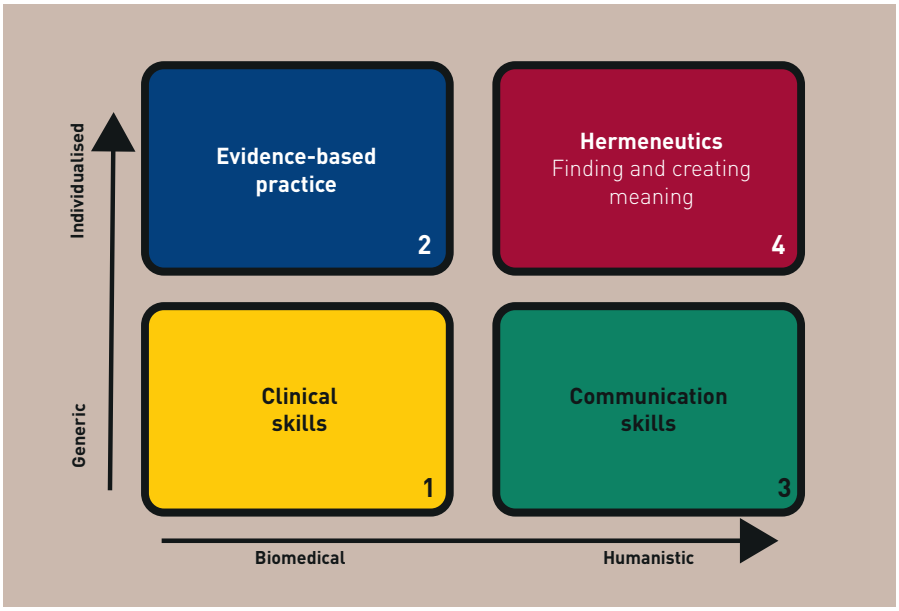

Figure 1. The Four Domain Model

We argue that, despite these contextual changes, the drift towards the transactional and measurable at the expense of the human and relational is not inevitable and can be redressed by making organisational changes to enable a cultural shift within practices.

ORGANISATIONAL INFLUENCES THAT CAN ENCOURAGE A HERMENEUTIC STANCE

There are many factors that determine whether a clinician adopts a hermeneutic approach — including personal values and past experience. However, in this article, we will concentrate on organisational influences.

The culture of a practice or organisation can have a huge bearing on what is most emphasised within consultations. Importantly, culture is not fixed, but is shaped by the multiple small interactions that take place over time among staff members, between staff and patients, and with external bodies.[7] It is possible to alter the nature of these interactions. The way in which the 'mental health' of a practice influences patient care has been described previously.[8]

Over recent years, there has been a growing body of evidence concerning the tacit way in which decisions are made in real life.[9] 'Mindlines' is a term that has been used to describe 'guidelines-in-the-head',

"The culture of a practice or organisation can have a huge bearing on what is most emphasised within consultations."

"Clinical leaders in general practice can make significant improvements to the culture of their organisations …"

which clinicians create for themselves over time, based on data from different sources, practical experience, and contextual factors. These mindlines are used to inform decision making — and may be as important as written guidelines in informing evidence-based practice. Longitudinal studies have shown that mindlines are influenced and changed by discussions with colleagues.[10] Therefore, if the conversations that take place between colleagues within an organisation validate a hermeneutic approach, there is likely to be a corresponding effect on patient consultations.

CASE STUDY

The Billinghythe Practice has run monthly cancer review meetings for many years. These have been mandatory in accordance with the requirements of a Locally Enhanced Scheme (LES). The meetings have historically centred around early detection of cancer and awareness of guidelines and local protocols. There has been little discussion of inadvertent harms.

Last year, the practice nurse and GP who lead on education and training decided to rethink the meeting. This followed discussion of several disturbing cases, including an 89-year-old man who had been referred under the 2-week rule because of a mild anaemia. His bowel was perforated during a subsequent colonoscopy and tragically he died of sepsis after a prolonged hospital admission.

Instead of focusing only on early detection and protocol, the meeting now incorporates discussion of the clinician's rationale for referral, the patient's journey through the hospital system, and the psychological effect it has had on them. The team talks about risk aversion due to medicolegal concern, as well as the extent to which personal engagement with the patient can mitigate this. A selection of patients who have been referred under the 2-week pathway are discussed, even if the eventual diagnosis was not cancer. On occasion, a patient is invited to join part of the meeting to talk about their experience of referral. The meetings have become increasingly well attended and one of the GPs has commented that they seem important and *'not the tick box exercise they used to be'*.

A similar approach has now been extended to other clinical meetings, including mental health and palliative care. A care coordinator liaises with patients on these lists prior to the meetings to check whether there is anything they would like the clinicians to be aware of, and to ask how the practice can best support them. Increasingly, it has also become usual practice for clinicians to meet daily over lunch to discuss cases and share their thinking about their clinical decision making.

Some aspects of this approach have now also been adopted by other local practices within the primary care network (PCN). When it becomes safe to do so from a COVID-19 perspective, plans are afoot to trial quarterly meetings within the PCN, which are to be loosely based on Schwartz Rounds,[10] to give clinicians the opportunity to discuss the emotional impact of certain cases.

CONCLUSION

Clinical leaders in general practice can make significant improvements to the culture of their organisations by making simple changes that encourage and support a hermeneutic stance among members of the practice team. From a practical perspective, the recruitment of allied health professionals and other staff (for example, the care coordinator in the case study) to primary care with the creation of PCNs offers an additional opportunity to rethink current approaches to practice. These benefits complement the recent emphasis on patient safety and evidence-based medicine, and can exert a ripple effect to others within the PCN, restoring greater humanity and countering the default position of 'sort, fix, or send'.

Rupal Shah,
Associate Dean, Professional Development, Health Education England, London.

Robert Clarke,
Retired GP and Educator.

Sanjiv Ahluwalia,
Regional Postgraduate Dean, Health Education England, London.

ADDRESS FOR CORRESPONDENCE

Rupal Shah
Health Education England North Central and East London — Faculty Development, Stewart House Russell Square, London WC1B 5DN, UK.

Email: Rupal.Shah@hee.nhs.uk

John Launer,
Director for Innovation, Health Education England, London.

Provenance
Freely submitted; externally peer reviewed.

Competing interests
The authors have declared no competing interests.

DOI: https://doi.org/10.3399/bjgp22X718493

REFERENCES

1. Shah R, Clarke R, Ahluwalia S, Launer J. Finding meaning in the consultation: introducing the hermeneutic window. *Br J Gen Pract* 2020; DOI: https://doi.org/10.3399/bjgp20X712865.
2. Shah R, Clarke R, Ahluwalia S, Launer J. Finding meaning in the consultation: working in the hermeneutic window. *Br J Gen Pract* 2021; DOI: https://doi.org/10.3399/bjgp21X716105.
3. Heron J. *Helping the client: a creative practical guide*. 5th edn. London: SAGE Publications Ltd, 2001.
4. Launer J. *Narrative-based practice in health and social care: conversations inviting change*. Abingdon: Routledge, 2018.
5. Shah R, Ahluwalia S, Spicer J. A crisis of identity: what is the essence of general practice? *Br J Gen Pract* 2021; DOI: https://doi.org/10.3399/bjgp21X715745.
6. Zigmond D. Human contact: do we need it in medical practice? *Br J Gen Pract* 2021; DOI: https://doi.org/10.3399/bjgp21X716933.
7. Spicer J, Ahluwalia S, Shah R. Moral flux in primary care: the effect of complexity. *J Med Ethics* 2021; DOI: 10.1136/medethics-2020-106149.
8. Launer J. The practice as an organisation. In: Elder A, Holmes J, eds. *Mental health in primary care: a new approach*. Oxford: Oxford University Press, 2002: 121–134.
9. André M, Borgquist L, Foldevi M, Mölstad S. Asking for 'rules of thumb': a way to discover tacit knowledge in general practice. *Fam Pract* 2002; DOI: https://doi.org/10.1093/fampra/19.6.617.
10. Gabbay J, le May A. Mindlines: making sense of evidence in practice. *Br J Gen Pract* 2016; DOI: https://doi.org/10.3399/bjgp16X686221.
11. Point of Care Foundation. Schwartz rounds. http://www.pointofcarefoundation.org.uk/Schwartz-Rounds/ (accessed 22 Oct 2021).