Practitioner diagnosis and style

Lesson 5.1.2 | Health psychology

Core ideas

Diagnosis depends on collecting accurate information from symptoms, patient history, observation, tests and clinical reasoning.

A practitioner-centred style gives the practitioner more control over questions, decisions and the direction of the consultation.

A patient-centred style encourages the patient to explain concerns, ask questions and take part in decisions.

Practitioner style can affect how much information the patient shares, especially about sensitive or uncertain symptoms.

Diagnostic errors can happen when information is missed, assumptions are made too quickly or communication is unclear.

A good consultation style should balance medical expertise with patient involvement, time limits, safety and clear advice.

Key terms

Diagnosis: Identifying a health problem from symptoms, history, examination or test evidence.

Practitioner-centred style: A consultation style where the practitioner controls most questions and decisions.

Patient-centred style: A consultation style where the patient's concerns, preferences and questions are actively included.

Clinical reasoning: Using evidence and professional knowledge to judge what condition or action is most likely.

Patient history: Information about symptoms, past illness, medication, lifestyle and relevant background.

Practitioner diagnosis and style

Lesson 5.1.2 | Health psychology

Continued

Shared decision-making: Practitioner and patient discussing options and agreeing a plan together.

Diagnostic error: A wrong, delayed or missed diagnosis.

Compliance: Following medical instructions, often used when the practitioner directs the treatment plan.

Further detail and evidence

Key study: Savage and Armstrong (1990) compared directing, doctor-centred consultations with sharing, patient-centred consultations rather than assuming sharing is always preferable.

At one inner-London practice, 359 patients aged 16-75 consulting one GP were selected; four refused and five were excluded. Follow-up had substantial non-response.

Random allocation using face-down cards determined consultation style. Standardised prompts varied advice, treatment and prognosis.

Immediate and one-week questionnaires assessed satisfaction with understanding, explanation and perceived help; consultations were audiotaped.

Directing consultations generally produced greater satisfaction, particularly for physical problems and prescriptions; differences were not significant for every subgroup.

For physical problems, 34% rated the directing explanation excellent, compared with 15% in the sharing condition.

A false-positive diagnosis identifies a condition that is actually absent; a false-negative diagnosis misses a condition that is actually present. For example, wrongly diagnosing an infection is false positive, while overlooking an existing infection is false negative.

Patients' willingness and ability to disclose symptoms affect the information available for diagnosis. When presenting a diagnosis, practitioners should explain its meaning and uncertainty in understandable language and check the patient's interpretation. Communication style can affect satisfaction without proving that the diagnosis was correct.

Practitioner diagnosis and style

Lesson 5.1.2 | Health psychology

Continued

A false positive identifies a condition when it is absent; a false negative misses a condition that is present. Consequences can include needless anxiety/intervention or delayed care. Neither error is defined by whether the patient feels satisfied with the consultation.

Disclosure matters because embarrassment, fear, memory and the way questions are asked can change the information available. Presenting a diagnosis requires an understandable explanation, attention to uncertainty and an opportunity for the patient to respond.

Doctor-centred consultations are comparatively directive, with the practitioner controlling advice and decisions. Shared consultations involve the patient's concerns and preferences in discussion. Patient involvement is compatible with clear professional advice; it does not mean abandoning clinical expertise.

Applying the ideas

Savage and Armstrong changed consultation style within one GP practice and measured satisfaction. Greater satisfaction with the directing style for some physical problems challenges the assumption that every patient always wants the same degree of shared discussion. It does not establish better diagnostic accuracy or recovery.

Evaluation and connections

This concerns consultation fit and satisfaction, not demonstrated clinical recovery. Random allocation and a common GP support control, but one doctor and attrition limit generalisation.

Evaluate situational explanations, cultural expectations, satisfaction-scale validity and informed consent for recording.

Random allocation by prompt cards strengthens the style comparison; recording consultations helps check implementation. One GP limits practitioner generalisation, and follow-up losses may bias later responses. Separate patient expectations, satisfaction, disclosure, adherence and health outcomes when judging a consultation style.