but this is a long-term goal. In the short term montelukast offers the opportunity to refocus on the goals of asthma management as set out by the South African Childhood Asthma Working Group (SACAWG) (Table I).

Montelukast is not a panacea for asthma. Recommendation for its use, as a new therapeutic strategy, carries a huge responsibility. In order to meet this challenge certain guidelines are suggested for determining the ideal patient and for safeguarding both the patient and the reputation of the product (Table III).

We feel that the time is right for a shift in our recommendations for the management of young asthmatics and hope that this treatment approach will be adopted in future guidelines, but more importantly, improve the quality of life of our patients and reduce the enormous financial burden resulting from poor control of this common illness in young children.

### Table III. Indications for montelukast

<table>
<thead>
<tr>
<th>Indications for montelukast</th>
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<tr>
<td>1. Diagnosis: Chronic cough or wheezy response to a bronchodilator or 7-10-day course of oral steroids (prednisolone 1 mg/kg/day).</td>
</tr>
<tr>
<td>2. Response to montelukast as indicated by a significant reduction in symptoms or use of bronchodilators.</td>
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**Neurolinguistic programming in the medical consultation**

**Chris Ellis**

I am surprised you are reading this sentence. I would have expected the average doctor’s eyes to have glazed over on reading the title of this article and for him or her to have turned over the page in search of the locums-available-in-Australia column. As you are still with me let’s have a shot at defining what it is.

NLP (yes, it gets shortened into one of those ubiquitous acronyms) is about communication. It is about how we take in and process information from the patient and how we interpret it through our internal filters (that’s the ‘neuro’ part) and it is about how we use language, how we label things and how we talk (that’s the ‘linguistic’ part). We use all of this, and more, to improve our rapport with the patient and collect feedback from the patient so that we can flexibly adjust our actions, words, non-verbal gestures and approaches to the patient in order to achieve our particular goal, which in most cases is helping the patient change his or her health behaviours (that, in one long sentence, is the ‘programming’ part).

Now if you think neurolinguistic programming is a mouthful, hold on for the jargon that goes with it. For example, there is modelling, consulting flow states, meta-programmes, meta-models, break states, pacing, chunking and verbal reframing skills. These are all some of the skills that doctors who are good communicators have acquired over the years and that have not
been recorded or written about before. All techniques and conceptual frameworks have their gurus and NLP is no exception. It originated in the 1970s at the University of California in Santa Cruz when mathematician Richard Bandler and linguistics professor John Grinder became interested in how people change. They were interested in decoding the patterns of language that we use and how successful people communicate, respond and achieve their results. Another guru, much quoted, is the American psychiatrist Milton Erickson, also the founding President of the American Society of Clinical Hypnosis, whose legendary techniques helped patients with, among others, the pattern of communication called ‘conversational trance’.

So, if you are still with me, NLP is, in fact, of great importance to all doctors because it is based on what makes those doctors who are really good communicators different from the rest of us, who are muddling along, missing the clues and the cues. What is it that these doctors are doing differently that makes them stand out from all doctors because it is based on what makes those doctors who communicate at the intuitive level of depth psychology and judge our results.1 Another guru, much quoted, is the American management plan, or a ‘Yes’ which means ‘maybe’, or even a ‘Yes’ for any problem, or ‘No’ for any solution. One can assess how one is doing by what is called ‘yes-sets’.  This has now hopefully got you to a state of some shared understanding and agreement in the consultation. If one is then to go on and change behaviour patterns such as smoking, overeating, alcoholism or sexual behaviour one needs to go into the patient’s beliefs, perceptions and expectations. One attempts to find out how the patient ‘works’ and about his/her internal filtering-out processes and repetitive behaviour patterns. To do this one can begin one’s questions with ‘softeners’ rather than direct upfront questions. One can begin a question with ‘I was wondering . . .’ or ‘It’s interesting that . . .’ and lead into a conversational interview.

This then leads on to the setting of outcomes. NLP is not only the study of the structure of subjective experience (to give it one of its more scientific definitions) but it is also an outcome-focused, solution-centred technology.4

There are many ways of doing this. The one I particularly like is called ‘pacing’, which is playing back the patients’ beliefs to them even if you strongly disagree with those beliefs. Pacing is not agreement. It is simply acknowledging that many beliefs surrounding health are not logical or rational from a medical perspective but are true for the patient.

You can then run your story (called ‘lateral chunking’) along the lines of ‘I had a patient once, just like you . . .’ and then give your version of positive change or recovery. You can personalise the story according to your own experience, but be careful of your own unfettered beliefs. Constructing metaphorical stories or analogies to the patient’s perceptions and expectations can also be drawn from your previous experiences, condensing them into a short storyline. Even appropriate quotations are sometimes helpful. One is trying to install a solution outside of the conscious awareness of the patient.

My other favourite is ‘the miracle question’ which goes along the lines of ‘if I had a magic wand . . .’ or ‘imagine if you went to bed tonight . . . and you awoke and your problem had gone’. This helps the patient to verbalise or bring together in some form what he or she wants and at the same time brings the consultation into a lighter and more conversational mood. Like the British army officer serving in Northern Ireland during one of their conflicts who said that the Irish did not know what they wanted and would not be happy until they got it, NLP may help those patients who do not know where they are going and are about to land up someplace else.

All human behaviour, both the patient’s and our own, is often confusing. What is perhaps comforting is that confusion can only occur when you are learning something new.

If you wish to learn more about NLP I highly recommend the quoted book by Dr Lewis Walker, or contact him on lewis.walker@ardamp.grampian.scot.nhs.uk.