Consultation Models

• Why do I need to know about them?
• What is a ‘consultation model’, anyway?
• How do I learn how to use them in practice?
• Where do I find out more?

Why do I need to know about communication and consulting skills?

• Consulting well is a core skill: it’s essential to the practice of high-quality medicine
• Better communication means increased doctor and patient satisfaction
• Consulting models make consultations more effective and more efficient
• Good consultants receive fewer complaints
• “The consultation” is part of the RCGP Curriculum - you can’t pass the CSA without knowing about it

What does the RCGP say?

• The consultation is at the heart of general practice. It is the central setting through which primary care is delivered, and where the curriculum outcomes detailed throughout these documents are demonstrated.
• The general practitioner should be able to communicate clearly, sensitively and effectively with patients and their relatives, and colleagues from a variety of health and social care professions.
• The general practitioner must have a commitment to patient-centred medicine.
• The general practitioner who lacks a clear understanding of what the consultation is, and how the successful consultation is achieved, will fail his or her patients.

What is a consultation model, anyway?

• It’s a way of looking at, and deconstructing, what happens in the consultation.
• It might look at a doctor’s (and patient’s) behaviour in the consultation
• It might look at tasks the doctor can undertake
• It might consider parts of the consultation as stages in a journey.

The Models

• 1957 M Balint - The Doctor, His Patient and The Illness
• 1964 E Berne - Games People Play
• 1973 J Heron - Six Category Intervention Analysis
• 1976 Byrne & Long - Doctors Talking to Patients
• 1979 Stott & Davis - The Exceptional Potential in Each Primary Care Consultation
• 1981 C Holman - Disease vs Illness in Gen Practice
• 1984 Pendlestone et al - The Consultation
• 1987 R Neighbour - The Inner Consultation
• 1996 Kurtz & Silverman The Calgary-Cambridge Observation Guide to The Consultation
• 2002 Narrative Medicine
• Now: COT Criteria

• Patients don’t function simply as machines - they have feelings too
• Doctors don’t function simply as machines - they have feelings too.

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Models of GP consultation (but bear in mind...)

• Some are ‘of their time’
• They are often subjective
• Target-setting (like QOF) and political pressures can add an extra dimension that theory has not yet incorporated
• Some are more accessible than others (so pick a couple and get to know them)

The Medical Model

• There’s a state of normal health
• There’s a disease process
• The patient presents to the doctor
• The doctor diagnoses the disease
• Appropriate treatment by the doctor restores the patient’s normal health

Why we like the medical model

• It’s what we learn in medical school
• It stretches our intellect (doctors tend to have well developed intellects)...
• ...but doesn’t challenge our feelings too much (we’re much less sure of that)

What’s not so good about the medical model

• Its apparent disregard for the patient as a person (It’s not very patient-centred)

What I’m hoping to demonstrate

• That consulting skills are different from and supplementary to the traditional skills of diagnosing and treating that we learned at medical school
• That the consultation has been studied and analysed, and that consultation skills can be taught
• That there are some easy(ish) and not-so-easy consultation models that you can try out in practice
Michael Balint (1957)
‘The doctor, the patient and his illness’

- Michael Balint and his wife Enid were psychoanalysts, originally from Hungary, who worked with GPs in London in the 1950s and 1960s.
- Groups of GPs met and were encouraged to explore psychological aspects of their consultations. "Has anyone a case today?"
- Setting up of Balint Groups for discussion of consultations. Recognised emotional aspects of the relationship between clinician and patient.
- Not a model as such, but the first time someone had really studied what happens between a GP and his or her patient.

Some interesting Balint concepts
- Many patients with physical complaints have psychological problems too.
- The doctor as a drug - the doctor himself/herself can influence a patient’s thinking and behaviour, even without a prescription.
- The doctor’s apostolic function - the doctor’s fixed style of behaviour combined with the doctor’s belief about how patients should behave - doctors have expectations based on their own beliefs which they try to impose on patients.
- The entry ticket - patients present a nice simple problem which they use to assess the approachability of their GP as to whether they feel able to disclose the real problem. And the hidden agenda - this is the real problem they want the GP to address.
- Selective neglect (and collusion) - eg the alcoholic doctor who doesn’t ask his patient about their drinking habits.
- The mutual investment fund - All the shared experience and trust that doctor and patient accumulate over many years in general practice can be used to encourage patients to try interventions which previously they would not have considered.
- The ‘flash’ - moments of shared understanding.

The Doctor As a Drug:
mechanism of action

- The doctor can support.
- The doctor can inform.
- The doctor can listen and encourage the patient to talk (catharsis).
- The doctor can encourage.

The doctor as drug (ii)

- When might you prescribe yourself? (What’s the indication?)
- What sort of dose?
- What are your side-effects?

Prescribing the doctor - when?
To help tackle:
- Multiple problems (often insoluble)
- Multiple attendances
- Multiple referrals to no avail
- Multiple treatments (tried & failed)
- Heart sinks
- Persisting patient uncertainty or concern

Prescribing the doctor: how?
- Use your advanced consultation skills.
- Use active listening.
- Pick up and use cues.
- Build rapport.
- Utilise empathy.
- Explore Ideas Concerns and Expectations.
Prescribing the doctor: potential pitfalls

- If the doctor doesn’t realise they are the drug and therefore does not understand why the patient keeps re-attending
- Time constraints (long and sometimes multiple consultations)
- Differing agendas between patient & doctor

Prescribing the Doctor: Side Effects

- Encouraging doctor dependency
- Transference – negative emotions engendered in the patient being transferred to the GP
- Counter transference – negative emotions (expressed by the patient) are engendered in the GP and are reflected back by the GP to the patient

Transactional Analysis (1964)
Eric Berne: ‘Games People Play’
Parent-Adult-Child

- Model looks at the human psyche as consisting of three “ego-states” - at any given moment each of us is in a state of mind when we think, feel, behave, react and have attitudes as if we were either:
  - a critical or caring Parent,
  - a logical Adult,
  - or a spontaneous or dependent Child.
- Many general practice consultations are conducted between a Parental doctor and a Child-like patient.
- This transaction is not always in the best interests of either party
- A familiarity with TA introduces flexibility into the doctor’s repertoire which can break out of the repetitious cycles of behaviour (‘games’) into which some consultations can degenerate.

RCGP ‘The Future General Practitioner’ (1972)
‘Physical, Psychological and Social’

- The RCGP model encourages the doctor to extend his thinking practice beyond the purely organic approach to patients
- i.e. to include the patient’s emotional, family, social and environmental circumstances.

Heron (1975)
Six Category Intervention Analysis

- Prescriptive - giving advice or instructions, being critical or directive
- Informative - imparting new knowledge, instructing or interpreting
- Confronting - challenging a restrictive attitude or behaviour, giving direct feedback within a caring context
- Cathartic - seeking to release emotion in the form of weeping, laughter, trembling or anger
- Catalytic - encouraging the patient to discover and explore his own latent thoughts and feelings
- Supportive - offering comfort and approval, affirming the patient’s intrinsic value
Byrne & Long (1976)
‘Doctors talking to patients’
- The doctor establishes a relationship with the patient
- The doctor attempts to discover the reason why the patient attended. This might not be as transparent as it first seems. What is the patient’s agenda? What are their fears and concerns?
- History and possibly examination occurs
- The doctor, in consultation with the patient, considers the condition
- Treatment or further investigations are discussed
- The doctor brings the consultation to a close

Stott & Davis (1979)
The exceptional potential in each primary care consultation suggests that four areas can be systematically explored each time a patient consults.
- Management of presenting problems
- Modification of help-seeking behaviours
- Management of continuing problems
- Opportunistic health promotion

Helman’s Folk Model (1981)
The Patient’s Perspective
What the Patient Wants to Know
- What has happened?
- Why has it happened?
- Why to me?
- Why now?
- What would happen if nothing was done about it?
- What should I do about it?
- What can you do about it?
- How can I stop it happening again?

Pendleton/Schofield Tate/Havelock (1984)
- To define the reason for the patient’s attendance, including:
  - the nature and history of the problems
  - their aetiology
  - the patient’s ideas, concerns and expectations
  - the effects of the problems
- To consider other problems
  - continuing problems
  - at-risk factors
- With the patient, to choose an appropriate action for each problem
- To achieve a shared understanding of the problems with the patient
  - To involve the patient in the management and encourage him to accept appropriate responsibility
- To use time and resources appropriately:
  - in the consultation
  - in the long term
- To establish or maintain a relationship with the patient which helps to achieve the other tasks
I.C.E.

- Ideas
- Concerns
- Expectations

**Neighbour (1987)**

**The Inner Consultation**

The consultation is a journey with 5 check points:

- Connecting: establishing rapport with the patient.
- Summarising: getting to the point of why the patient has come using eliciting skills to discover their ideas, concerns, expectations and summarising back to the patient.
- Handling over: doctors' and patients' agendas are agreed. Negotiating, influencing and gift wrapping.
- Safety net: “What if?” consider what the doctor might do in each case.
- Housekeeping: “Am I in good enough shape for the next patient?”


Derives from Pendleton’s approach - an evidence-based approach to integration of the ‘tasks’ of the consultation

- Initiating the session (rapport, reasons for consulting, establishing shared agenda)
- Gathering information (patient’s story, open and closed questions, identifying verbal and non-verbal cues)
- Building the relationship (developing rapport, recording notes, accepting patient’s views/feelings and demonstrating empathy and support)
- Explanation and planning (giving digestible information and explanations)
- Closing the session (summarising and clarifying the agreed plan)

Launer: Narrative Based Medicine (2002)

- describes techniques to help understand the patient’s story
- Circular questioning or picking up patients’ words to form open questions and help patients to focus on meaning (originally came from family systems therapy)
- A focus on listening (for example avoiding note-making during the consultation)
- Exploring the context of the problem (may lie outside medical presentation in family, work or community).
- Using genograms and constructing a family tree to help understand the context of a patient’s problems.
- “When you get home, what do you think your husband might say when you tell him what we have been talking about?”
- “Who in the family thinks you are depressed as well as your husband?”

COT Criteria

- PC1: The doctor is seen to encourage the patient’s contribution at appropriate points in the consultation.
- PC2: The doctor is seen to respond to signals (cues) that lead to a deeper understanding of the problem.
- PC3: The doctor uses appropriate psychological and social information to place the complaint(s) in context.
- PC4: The doctor explains the patient’s health understanding.
- PC5: The doctor obtains sufficient information to include or exclude likely relevant significant conditions.
- PC6: The patient’s physical/oral examination should be conducted in an environment that could reasonably have been found. OR is designed to address a patient’s concerns.
- PC7: The doctor appears to make a clinically appropriate working diagnosis.
- PC8: The doctor explains the problem or diagnosis in appropriate language.
- PC9: The doctor specifically seeks to confirm the patient’s understanding of the diagnosis.
- PC10: The management plan (including any prescription) is appropriate for the working diagnosis, reflecting a good understanding of modern accepted medical practice.
- PC11: The patient is given the opportunity to be involved in significant management decisions.
- PC12: Makes effective use of resources in the consultation.

Resources

- ‘Games People Play’ - Eric Berne - parent-adult-child
- ‘The Inner Consultation’ - Roger Neighbour - connect/summarise/handover/Safety netting/Housekeeping
- ‘Skills for Communicating with Patients’ - Jonathan Silverman - Cambridge-Calgary - a great ‘toolkit’
- ‘The Doctor, His Patient & The Illness’ - Michael Balint - a classic