**INTRODUCTION TO CONSULTATION GUIDE**

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Consultation models are learning aids. They describe ways in which you can analyse, understand and practise a complicated skill in order to get better at it.

Imagine sitting in with someone whose consultations you thought were effective, empathetic, efficient, focused, assured and ‘elegant’. Imagine then that you asked them to explain what they are doing so that you too could learn to consult in the same way. Their answer would probably come in the form of a ‘model’.

Models simplify complex performance into a manageable number of component ideas, principles or stages. They can underpin a programme of learning exercises.

When people learn, they first pass from a stage of ‘unconscious ignorance’ (not realising that there *is* something to learn) to ‘conscious ignorance’ – knowing there is something to learn, but not knowing how to go about learning it.

The next stage is acquiring the necessary skills in a rather painstaking, systematic and self-conscious way, like a learner driver preparing to take the driving test – the stage of ‘conscious skill’. During the learning process, the component skills may feel unfamiliar and look a bit ‘clunky’. But with practice and experience this gradually matures into the effortless ‘unconscious skill’ of the expert.

**Models**

Childhood – doctors and nurses, mom and dads – a basis for defining human relationships. Even dolls and toys are examples of miniature models of the real world. Play is a model of living and learning in safety.

Language – symbols used to convey or express something (feelings, situations, events or otherwise). A model for bringing the world under control.

Maps – models of the world to help orientate us and define boundaries. You don’t, of course, see the boundaries when you’re high up in the sky in a plane! Maps even help us to define properties of different parts of the world.

Recipes – model of a sequence of things to do to get a certain outcome eg ginger cake

Logic – a model of how to settle an argument

**Medical Model**

Lets apply the Medical Model to how we study medicine

Normal Health – defined in terms of bodily structure and function compatible with comfort and survival Studied in disciplines of anatomy, physiology and biochemistry

Illness – deviation from Normal ie function and/or structure not compatible with comfort or survival. Studied in pathology

Symptoms &Diagnosis – evidence of some malfunction. Studied in General Medicine, General Surgery and the specialties.

Therapy – to restore diseases process to or into the direction of the normal, thus curing or improving the patient’s illness. Studied in surgery, pharmacology.

**BUT IT DISREGARDS THE PATIENT AS A PERSON (FEELINGS)**

**Doctor just gets on with the job of diagnosing and treating! But this is not the only important facet of general practice. The Consultation is at the heart of general practice.**

**Purpose of ALL models**

They make sense of sensation – one of our basic human needs is to understand what is happening to us and around us. It doesn’t matter how concrete or abstract the model is – at the end of the day, it represents something we have experienced or real event.

We having been trying to make models of human relationships ever since child eg playing doctors and nurses, mom and dad.

**The Old Consulting Model**

Get participants to derive this model

What are the faults with it?

Identifying these faults may help to improve our consulting style.

Ticket of admission = symptoms

Patient gifts = donation of own bodily fluids for investigation

Clothing – Dr is symbolically robed in an expensive suit, enthroned behind a desk in an executive chair. Gives nothing away about his private thoughts and feelings. Patient symbolically naked, sitting on a hard chair, every part of his body and psyche potentially accessible to the doctor’s scrutiny.

Pitfalls

1. No account of patient ideas, concerns expectations **(Ideas, Concerns, Expectations)**
2. Sick role places the patient to actively display his/her symptoms (rather than dr. **picking up cues)**
3. Dr prescriptive – advice may not be taken **(Patient Involvement)**
4. Dr. Language – does the patient understand? **(Language & Checking Understanding)**

**Classification of Models**

**Doctor Centredness vs Patient Centredness**

The extent to which the consultation’s agenda, process and outcome are determined by the doctor or by the patient

Doctor Centred Models

Describe the doctor’s aims or behaviour

Patient Centred Models

Focus on the patient’s aims or behaviour

**Task vs Behaviour Orientated Models**

The degree to which they focus on the tasks to be achieved as opposed to the behavioural methods used in the consultation – ie content vs process

Task Orientated – consultation is viewed as an amalgam of separate definable tasks – a checklist of points to be covered.

In all these models, the methods to be used in achieving the various goals are not specified, being left to the doctor’s ingenuity or previous experience.

Behaviour Orientated – the consultation is viewed as the range of behaviours that are called for within it.

***Patient centred ones*** are based on behaviour which draws out the patient’s own problem solving capacity with minimum intrusion of the doctor’s agenda.

***Doctor centred ones*** – concerned with extending the doctor’s personal repertoire of consulting behaviours, which he can use to further the patient’s interests as he sees them

***Michael Balint (1957)***

1957“Balint” groups A Hungarian psycho-analyst

“Balint” groups, where GPs met to discuss their more difficult cases Reading the book suggests the cases were often the ones we now refer to as “Heart sink” Problems are never purely physical, psychological or social but a complex mix of all three.

Doctors have a apostolic function, the doctors ideas of what medicine is about, inevitably communicates to the patient Doctors have feelings during consultations which may provide useful insights Collusion of anonymity, where patients with physical complaints with psycho-social causes are passed from specialist to specialist with no doctor taking overall responsibility - “somatisation”

The “drug doctor”, the idea that the doctor may be therapeutic, have adverse effects, and invoke dependency Articulated the importance of the doctor / patient relationship.

**The RCGP (1972)** *The Future General Practitioner, Learning & Teaching*

Physical, Psychological & Social domains

Traditional consultation model: Active / Passive

Hypothetico-deductive model

Holistic Model of the Consultation

The effect of this very simple model is to extend the doctor’s thinking process beyond the consideration of the purely organic – and to include the patient’s family, emotional, social and environmental factors in the diagnosis.

If the doctor’s awareness is heightened, he/she is more likely to include them im his/her management.

**John Heron (1975)**

James Heron was a humanistic psychologist

A model which illustrates the range of interventions a doctor (counsellor or therapist) could use with a patient (or client). The overall aim is based on the patients best interests.

* Prescriptive – giving advice or instruction, 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

May use one or more of these interventions in a consultation.

**Byrne and Long (1976)**

Analysis of 2,500 tape recorded consultations by over 100 doctors Consulting styles

Doctor centred, Patient centred Doctors Talking to patients

6 “phases” forming a logical structure to the consultation.

* Establishing a relationship
* Why has the patient come
* Verbal and/or physical examination
* Considering the condition – the doctor, doctor and patient or the patient (in that order)
* Further investigation or treatment
* Termination

Dysfunctional consultations are particularly likely if phases 2 and 4 are skimmed over.

Phase 2 – reasons for patient attendance incompletely grasped (often resulting in door handle remarks like “by the way doctor”, “while I’m here” or “and another thing” which are often received negatively by the doctor resulting in a reduction in dr concentration and goodwill.

Phase 4 – patient can feel misunderstood if there are shortcomings in this phase (leading to dissatisfaction and poor compliance)

**Stott & Davies (1979)**

4 areas which could be systematically explored each time a patient consults

* Modify patients helps seeking behaviour – educating about natural history of illness, self medication of minor illnesses, how better to use the practice appointment system
* Review of long term problems – BP checking, alcohol history, smoking history, state of marital relations
* Opportunistic Health Promotion – vaccination, smears, smoking advice

**Pendleton (1984)**

7 tasks the Doctor should attempt in a consultation

Ideas, concerns and expectations

Effects of the problem in its physical, psychological, social, and spiritual consequences

The first 5 tasks – what the doctor needs to achieve

The final two tasks – deal with the use of time and resources and the creation of an effective doctor-patient relationship

Although set out in logical sequence, in any consultation, may not follow in this order.

The tasks (outcomes) are defined, but the behaviours to achieve those tasks are not – in otherwords the tasks can be achieved using many different approaches – “there are many ways to skin a cat”

1. Define the reasons for the patient’s attendance – the nature and history of the problems, aetiology, patient’s ICE, effect of the problems
2. Consider other problems – continuing problems & at risk factors

3 With the patient, choose an appropriate solution to each problem

4 Achieve a shared understanding of the problems

5 Involve the patient in the management and encourage the patient to take responsibility

6 Use time and resources appropriately (in the consultation & in the long term)

7 Establish or maintain the doctor patient relationship

**Roger Neighbour (1987)**

Connecting - Rapport building skills

Summarising - Eliciting skills

Handing Over - Communication skills

Safety Netting - Predicting skills

Housekeeping - Stress management skills

A very popular model.

**Summary**

Having a wide array of models can be seen as confusing or as adding richness. The latter in the sense that like toy models, you have so many consultation models you can play with. Like toys, you will pick your favourite, play with it and adapt it to your needs. That is the point of consultation models – not to prescribe you a consulting style but rather to help you develop one personalised to you.