L3-Consultation Skills

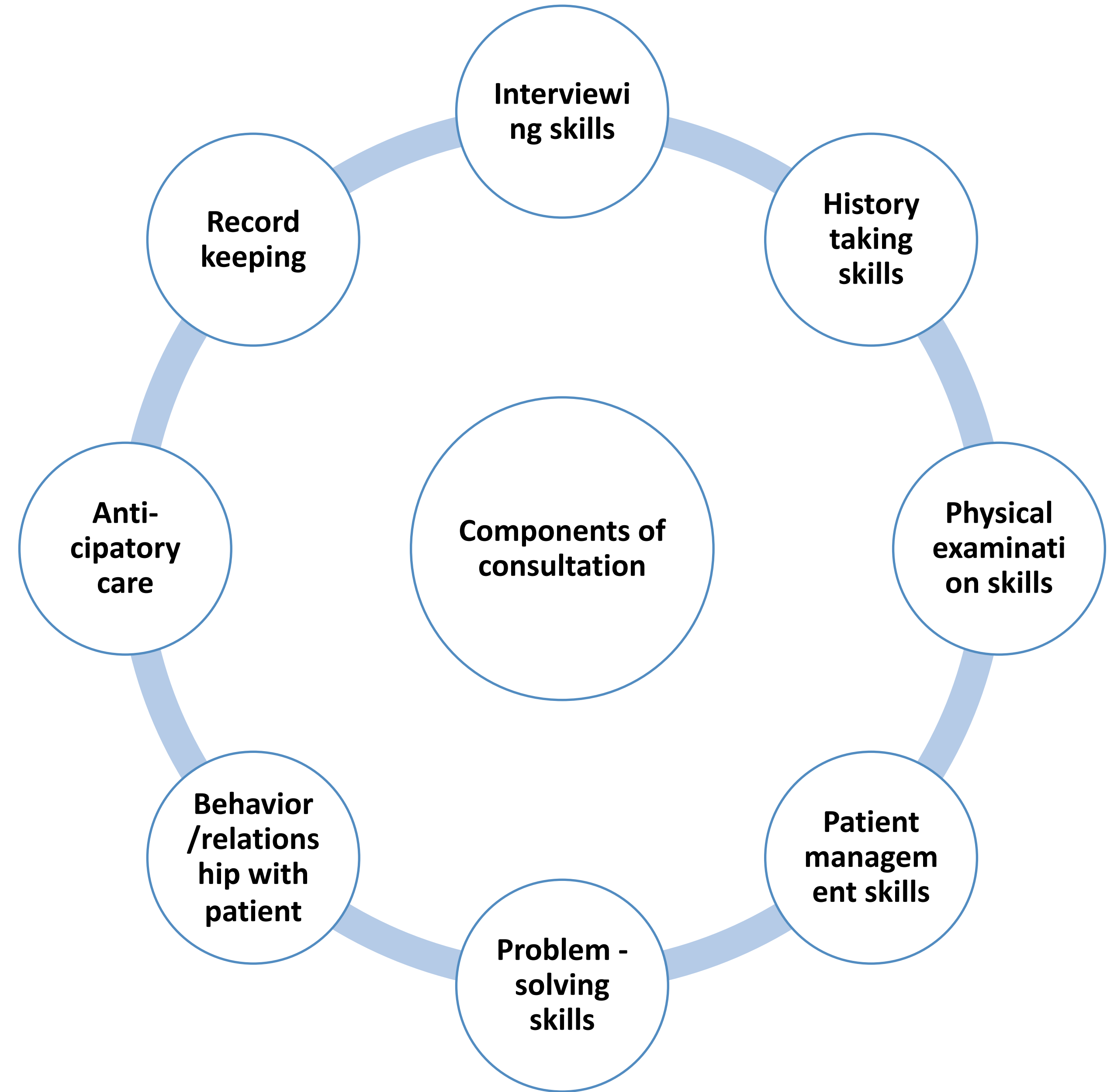
Objectives:

- Definition
- Component of Consultation
- Models of consultation
- Stott & Davis Model
- Pendelton Model
- Calgary-Cambridge model
- Approaches to consultation
- Key points

Definition& components of consultation

The essential unit of medical practice is the occasion when , in the intimacy of the consulting room, a person who is ill or believes he is ill, seeks the advice of a doctor whom he trusts.

Spence, 1960

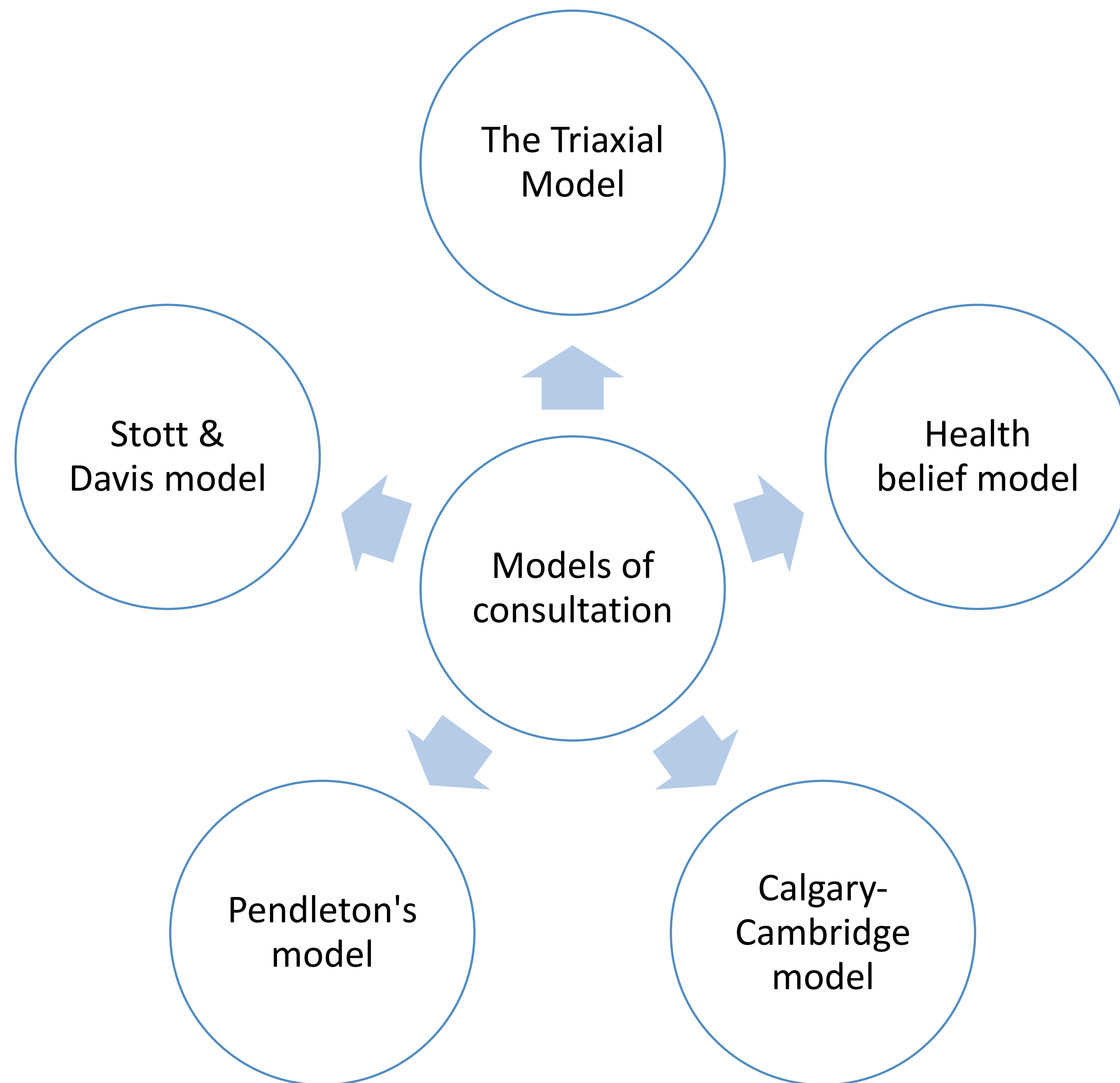


Models of Consultation

- The models described will provide a the range of approaches.
- there is no one correct model of the consultation – the approach is dependent on the context.
- Most of these models tell you what you need to achieve but not how you go about achieving.

Q1What is a model?

a hypothetical description of a complex process



*The doctor mentioned more but she said in the lecture we will only explain these 5 models.

1. The Triaxial model: physical, psychological and social

consider the patient's emotional, family, social and environmental circumstances that have a profound effect on health.

You look at the physical, psychological and social parts of the patient.

It's a holistic approach(خطة متكاملة شاملة للثلاثة أمور).

2.Health Belief Model (ICE)

This model focuses on the patient’s thoughts not just on the consultation but also about their attitudes to illness in general and how they see themselves as patients. By exploring the **(I.C.E.)** you get a true understanding of where the patient is coming from.
Patient’s **I**deas, **C**oncerns and **E**xpectations (I.C.E.).
Incorporating that information into your management plan improves patient compliance to abide by management plan.

باختصار نبي نعرف هو ايش يبي يطلع فيه حتى يتم إدراجها في الخطة العلاجية

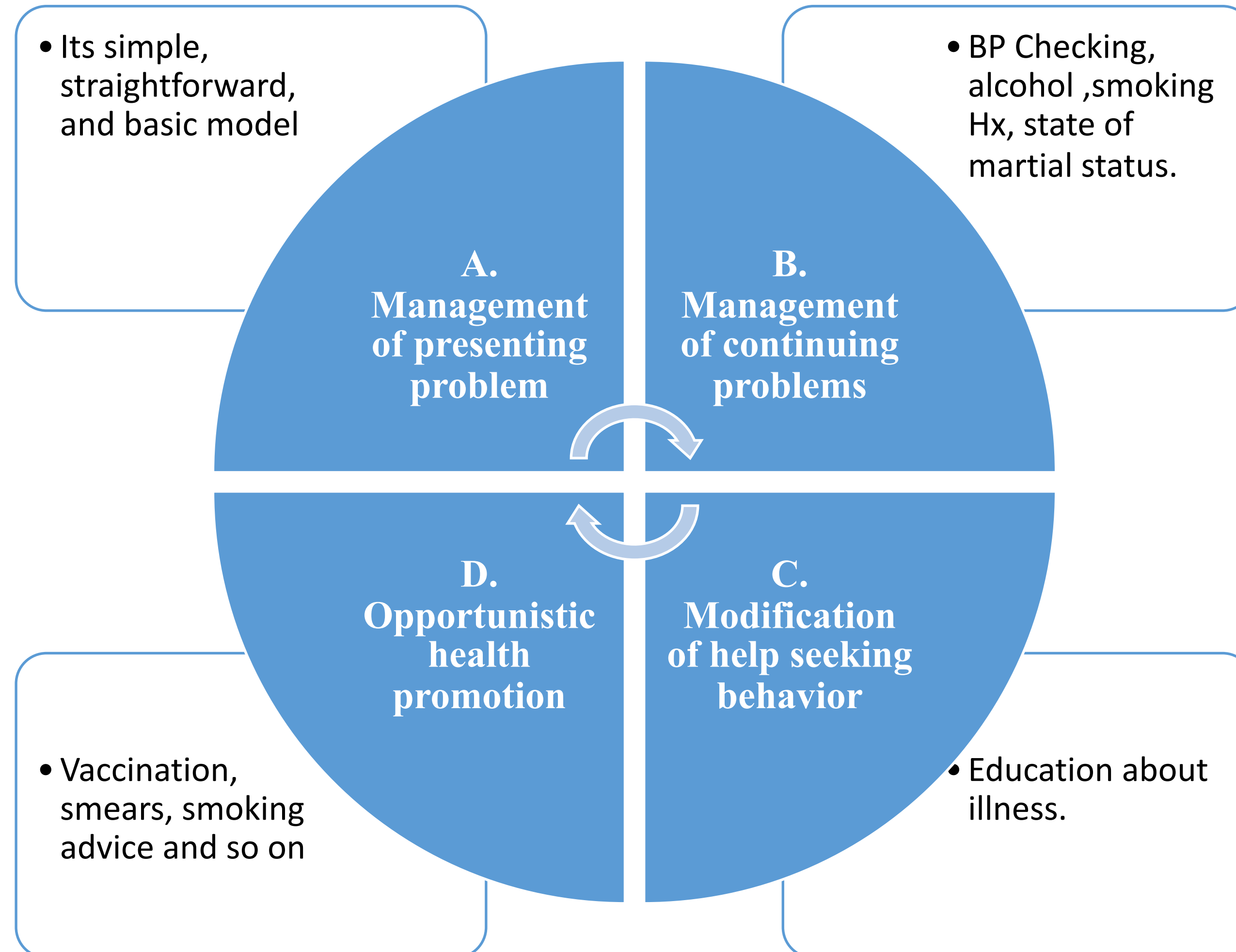
Patient’s ideas: Had you any thoughts about what might be going on?

Patient’s concerns: And what particular worries or concerns did you have?

Patient’s expectation: And what were you hoping that I might do for you?

3.Stott & Davis (1979) :

this suggests that four areas can be systematically explored each time a patient consults as shown bellow.



4.Pendleton's, schofeild, Tate & Havelock model: its more hard, used on more complicated situations due to it needing to dig in more into pt's agenda (it involves more of psychological complain than physical)

Pendleton, Schofield, Tate & Havelock (1984)

1) To **define the reason** for the patient's attendance, including:
   a) the nature and history of the problems
   b) their aetiology
   c) the patient's ideas, concerns and expectations
   d) the effects of the problems
2) To consider **other problems**: i) continuing problems ii) at-risk factors
3) With the patient, to choose an **appropriate action** for each problem
4) To achieve a **shared understanding** of the problems with the patient
5) To **involve the patient** in the management and encourage him to accept appropriate responsibility
6) To use **time and resources** appropriately: i) in the consultation ii) in the long term
7) To establish or maintain a **relationship** with the patient which helps to achieve the other tasks.

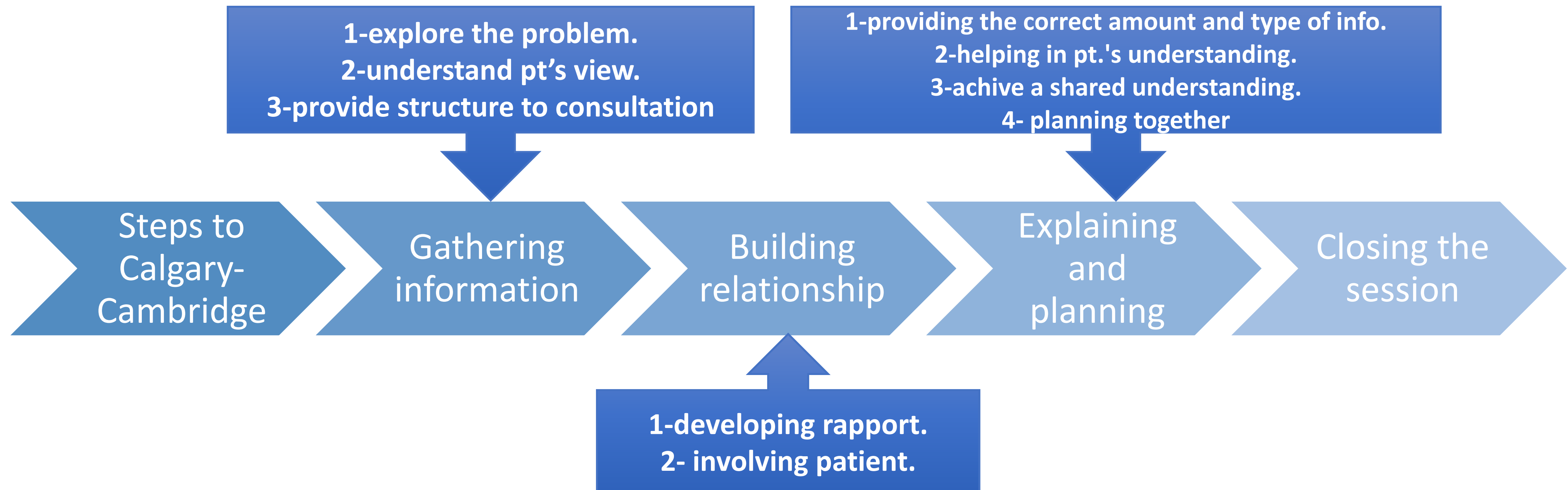
PATIENT'S AGENDA = 1c + 1d = ideas, concerns, expectations + effects of the problems

4.Pendleton's Model

- **To define the reasons for the patient's attendance:** (Nature and history of the problem, Their etiology ,Patient's ideas ,concerns and expectations, The effect of the problem)
- **To consider other problems**: (Continuing problems, At risk factors)
- **To choose with the patient 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.**
- **To establish or maintain a relationship with the patient which helps to achieve the other tasks.**

5. Calgary-Cambridge model

- Its new and its mostly used.
- In this model you start by building rapport (it's a relationship of mutual respect and interest between doctor & patient, العلاقة الجيدة بين المريض والطبيب). And then identifying the reason for consult.



THE ENHANCED CALGARY-CAMBRIDGE GUIDE TO THE MEDICAL INTERVIEW

Jurtz SM, Silverman JD, Benson J & Draper J. (2003)
Marrying Content & Process in Clinical Method Teaching: Enhancing the Calgary-Cambridge Guides.
Academic Medicine

*IMP-please read doctor went through it

Providing structure

Making organisation overt

Attending to flow

Initiating the Session

Preparation
Establishing initial rapport
Identifying the reason(s) for the Consultation

Gathering Information

Exploration of the patient's problems to discover the:
Biomedical perspective
patient's perspective
Background information- context

Physical Examination

Explaining & Planning

Providing the correct amount & type of information

Aiding accurate recall & understanding

Achieving a shared understanding incorporating the patient's illness framework

Planning: shared decision making

Closing the Session

Ensuring appropriate point of closure
Forward planning

Building the relationship

Using appropriate non- verbal behaviour

Developing rapport

Involving the patient

Other methods to do consulting:

is by using one of the following -which are approaches NOT models.

- **Balint (pronounced Bay-lint).**
- **Transactional analysis**

1. Balint: came up with multiple theories as follow

- **Attentive listening:** (listen to patient)
- **Entry ticket and Hidden Agenda :**(meaning they have hidden reason for coming in not what they actually presented with. Example: a new time mother bringing in her newborn child who is perfectly healthy and fine, while the real issue is with her having postpartum depression and trying to see if this physician is trustworthy to help her.)
- **Collusion of anonymity:** (the patient is passed from one specialist to another with nobody taking responsibility for the whole person)
- **Doctors have feelings**
- **The doctor as a drug:** (sometimes we as physicians can be helpful)

2. Transactional Analysis: in a certain situations doctors adopt roles(parent, adult, child) and the pt.'s also adopt a role(child , adult).

A. **PARENT – takes away autonomy and control off the other person**
B. **ADULT – tends to be logical, factual, calm and collected**
C. **CHILD – tends to emotional!**

Examples:

A. PARENT ROLE for physician:

- **Critical Parent – words and phrases**
- ***Critical Doctor***
- ✓ *'You must stop smoking.*
- ✓ *how bad your chest has become.*
- ✓ *You've only yourself to blame'*

- **Caring Parent – words and phrases**
- **Caring Doctor**
- ✓ *'Poor you. Your chest sounds dreadful.*
- ✓ *Let's see if I can make things better for you.'*

B. ADULT ROLE for physician:

- ✓ *What do you think?*
- ✓ *What are the choices?*
- ✓ *Shall we find out….*
- ✓ *Let's experiment..*
- ✓ *How can we move forwards from here?*
- ✓ *How can we handle it best?*

C. CHILD ROLE for physician:

- **Natural (Free) Child – words and phrases**
- ✓ *Yeah, that option sounds fab.*
- ✓ *I want that one please.*
- ✓ *Ugghhh.. I hate tablets. Can't you…*
- **Adapted Child – words and phrases**
- *I can't do that because…*
- *Okay, I'll give it a try but…*
- *Well, I hope that works*

Con. Examples:

A. ADULT ROLE for patient:

- **Critical Patient**

✓ *'I pay my taxes. Why can't I have antibiotics? This is just ridiculous'*

✓ *why haven't you…,*

✓ *you must never…*

✓ *right and wrong – should and should'nt*

✓ *always and never – must and mustn't*

- **Caring Patient**

✓ *'Not to worry doctor. You've tried your best*

✓ *Oh dear!, what a shame,*

✓ *please remember to,*

✓ *don't be afraid to,*

✓ *I'll help you,*

Key points:

- The primary task of the consultation is to establish the reason for the patient's attendance.
- A patient centered consultation style results in significantly improved health out come.

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