# PHC

## 432 Team

6

# Consultation & counseling in Family Practice


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# Objectives

1. To understand the concepts of consultation and counseling
2. To learn why consultation & counseling skills are important?
3. To learn the theories and stages of counseling
4. What are the possible barriers?
5. To know the benefits of good communication skills.
6. Identify why & when pts decide to consult.
7. Discuss the Model of consultation.
8. Identify how we can improve consultation skills.

Here are Two useful videos let us start with them:

https://www.youtube.com/watch?v=xrHgOoNBiWk

http://youtu.be/NH8sEpc_A9I

## Why Consultation/counseling Skills?

- ☒ Family Physicians may need to be bearers of the worst and best imaginable news.
- ☒ They have to arrange complex and often uncertain information into something understandable.
- ☒ They have to respond to differing needs of a hugely diverse range of patients and their families.
- ☒ *And* they have to do much of this when they are busy and under pressure.

## Consultation:

- ❖ Consultation is the entire process of interaction between a patient and a doctor in the privacy of a room.
- ❖ It includes from initial welcome to history taking, examination, investigation, assessment and management including **advice, follow up and referral** (if needed).

## Counseling:

- ❖ Counseling in Family Practice is very often a part of the management in the consultation process (helping the patient to help himself).
- ❖ It relates basically to an interaction between a doctor and a patient with the aim of helping the patient to understand the true nature of the problem so that he can play an active role in solving or managing it.

## What is Specialized Counseling?

- It is the skilled and principled use of relationship to help the patient develop self-knowledge, emotional acceptance and growth including personal resources.

- Counselors who offer warmth, genuineness and empathy are more effective.

## Theories of Counseling:

- **Directive:** Active or directive counselors tend to interpret, lead and direct their clients
- **Non-directive:** Non-directive, or reflective counselors tend to elicit and reflect, guide and support their clients

## Aims of counseling:

- To help people accept and come to terms with their difficulties and identify ways of coping more effectively and resourcefully.

- The counselor listens and asks questions until both counselor and client understand the way the client sees things.

- The counselor enables the client to clarify thoughts and feelings for better understanding of the problem.

## Stages of Counseling:

1. **Exploration:** Enabling the patient to explore the problem himself and then focus on specific concerns
2. **New understanding:** To see both, themselves and their situation in new perspectives and how to cope more effectively
3. **Goal setting.**
4. **Action:** Possible ways to act ; costs/consequences, planning, implementation and evaluation ; creative thinking, problem solving and decision making

**Stages of counseling – example:**

**Exploration:**

Patient- 'I want to kill myself '

Doctor: 'Why do you want to kill yourself?'

**New understanding:**

Patient - 'My girl friend left me for a more muscular man'

Doctor: 'Have you considered all other possible options?'

**Goal setting:**

Patient – 'I shall become more muscular'

**Action:**

Patient – 'I shall join a Gym'

## Consultation & Counseling Skills:

- If a joint understanding of the problem & its management plan (the patient understands, feels comfortable with, and is prepared to adhere to) is not made:

  Then the patient is not likely to follow the advice and all our efforts in assessment and diagnosis are wasted.

Consultation skills = Communication skills + Clinical skills

Communication skills (**Verbal** 40% and **non-verbal** 60%)

Clinical skills (Examination and procedure)

## Benefits of good communication skills:

- Diagnostic Accuracy
- Pts' understanding & Information retention
- Increase adherence to treatment
- Patients adjust better psychologically
- Allow patients to share in the decision making.
- Pts are more satisfied with their care
- Greater job satisfaction and less work stress
- **Effect on health outcomes:**
  - Reduction of anxiety.
  - Reduction of psychological distress.
  - Pain relief.
  - Symptom resolution.
  - Mood improvement.
  - Reduction of high blood pressure.

***Evidence Base: Individual Consultation:***

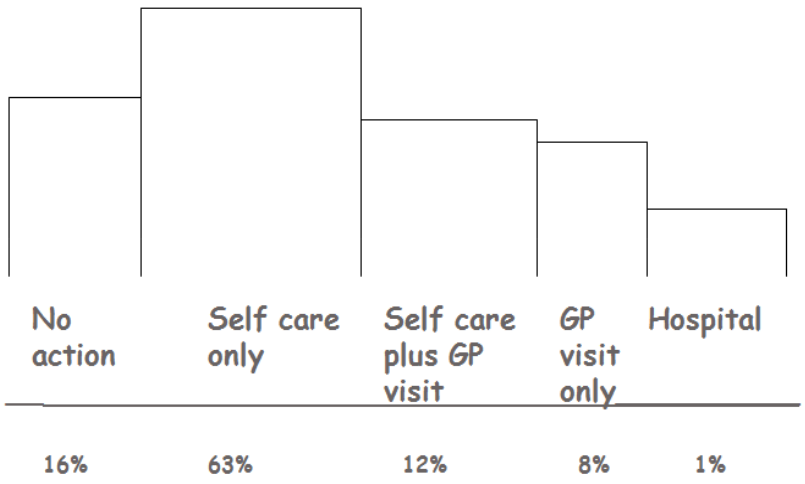
*For the doctor it is one of many routine encounters, something to be got through as fast as possible given the number of other patients waiting to be seen.*

*But for the patient, it may be the most important – and stressful – aspect of his/ her week….or the last six months, as they wait anxiously for the appointment and their chance to see the doctor…… "*

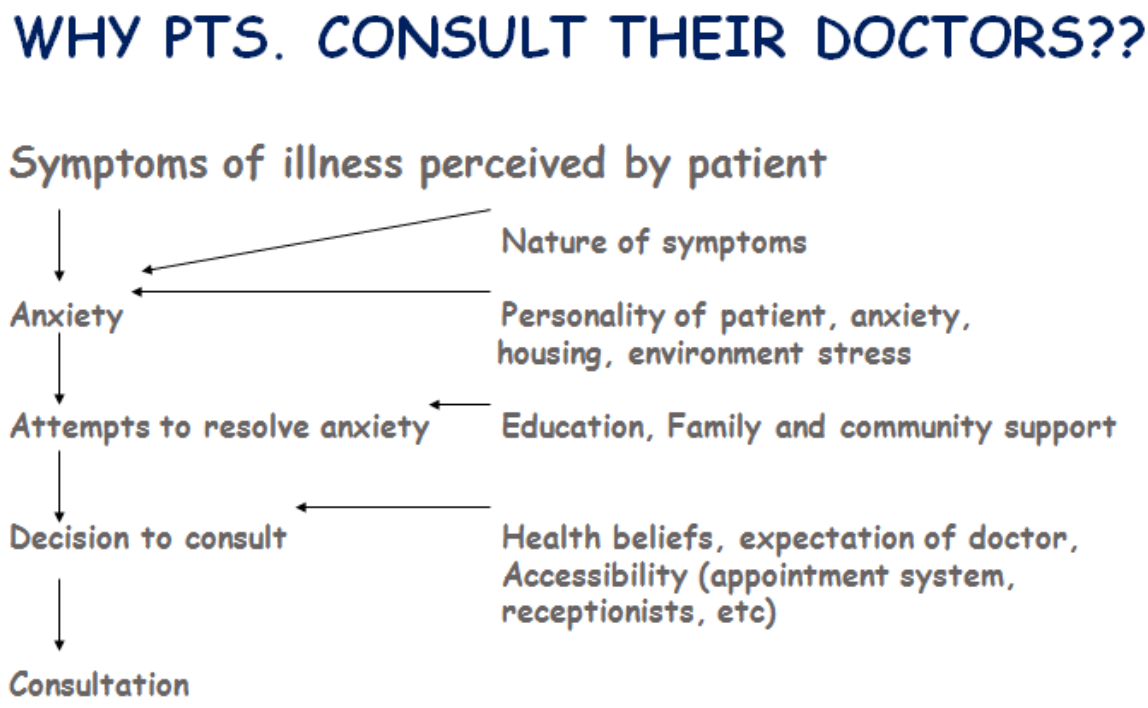
(Dr Julie Draper, an unpublished quote, Cambridge University Medical Training Workshop, December 2001)

- ☒ 54% of patient's problems & concerns not elicited.
  (Stewart et al, 1979)
- ☒ Doctors frequently interrupted their patients soon after their opening statement (mean time 18 seconds) so patients subsequently failed to disclose significant problems.

  (Beckman and Frankel, 1984)
- ☒ Failing to discover the patient's feelings and concerns led to dysfunctional consultations and counselling.
  (Byrne and Long, 1976)




**What people do about their symptoms??**




## Deficiencies in Communication & Counseling:

- Doctors may not obtain enough information about patients' perspective.
- Provide information in inflexible way.
- Pay little attention in checking how well patients have understood.
- Less than half of patients' psychological morbidity is recognized.

## Blocking Behavior of Doctors: (interruption)

- Offering advice and reassurance before the main problems have been identified.
- Explaining away distress as normal.
- Attending to physical aspects only.
- Switching the topic.
- "Jollying" patients along.

## Reasons for patients not disclosing problems:

- Belief that nothing can be done.
- Reluctance to burden the Doctor.
- Desire not to appear pathetic or ungrateful.
- Concern that it is not legitimate to mention them.
- Doctors' blocking behavior.
- Worry to confirm that their fears confirmed.
- Lack of confidentiality and trust.

## What is a failed Consultation/Counseling?

- No rapport.
- Using medical jargon.
- Not exploring the patients agenda.
- Not eliciting the actual problem.
- No contingency plan/ no safety netting.
- No summarization.
- Failing to clarify.
- Not exploring in socio-cultural & economic context.
- Not patient-centered.

## Problems & Limitations in Communication & Counseling:

- ☒ Shortage of time
- ☒ Language barrier – low literacy
- ☒ Firm misconceptions and myths
- ☒ Lack of Dr awareness
- ☒ Pts not ready to take responsibility for own illness
- ☒ Socio-cultural, economic barriers
- ☒ Fatalistic attitude (It's God's will)


## Barriers to Communication/Counseling in Clinical Practice:

- Personal Barriers.
- Lack of training: undergraduate/postgraduate.
- Undervaluing importance of communication.
- Focus only on treating diseases.
- Personal Limitations.
- Organizational Barriers.
- Lack of time.
- Pressure of work.
- Interruptions.

## Why Consultation & Counseling skills?

*When doctors use consultation & counseling skills effectively:*

1. Patients' problems identified more accurately.
2. Patients more satisfied with their care.
3. Patients more likely to comply with treatment.
4. Patients' distress & vulnerability to anxiety & depression are lessened.
5. Doctors' and patients wellbeing is improved.
6. Few clinical errors are made.
7. Patients are less likely to complain.
8. Reduced likelihood of doctors being sued.

***Good communication & counseling is good for doctors***

***good for patients and good for the health service***

## Improving consultation skills:

- ❑ Clinical reasoning & Problem Solving
- ❑ Constant Learning and Practice
- ❑ **Feed Back:**
  - Self monitoring/Peer review
  - Role play
- ❑ Audio-visual technique

## Moving from open to closed questioning: Imp in OSCE

***Open ended questions to explore the field***

***Mid-way questions – directional statements***

***Closed questions – used following information gathering to focus in***

**Open-ended questions: are ones that require more than one word answers.**

**Example: What do you have? Why you are here today?**

**Directional statements: to make you organized.**

**Example: Can you explain to me what do you mean by abnormal urination?**

**Closed questions: can be answered in only one word or very short phrase. (Yes/no)**

**Example: Do you have fever? Back pain? …etc**

# Models of Consultation

1- Stott & Davis
2- Roger Neighbour
3- Pendleton

## 1. Stott and Davis:

A. Management of presenting problems

B. Modification of help-seeking behaviors

C. Management of continuing problems

D. Opportunistic health promotion

## 2. NEIGHBOUR'S 5 CHECKPOINTS:

1. CONNECTING.
Achieving rapport & empathy.

2. SUMMARISING.
Demonstrate to patient you understand why he's come, hopes, feeling, concerns & expectations.

3. HANDING OVER.
Has the patient accepted the management plan we have agreed?
Negotiating, influencing & gift-wrapping.

4. SAFETY NETTING.
Predicting what could happen – what if?
Or have I anticipated all likely outcomes?

5. HOUSEKEEPING.
Clearance of any emotional responses to patients we have seen or to those, we are about to see. Am I in good condition for the next patient.

## 3. PENDLETON'S MODEL (Seven tasks):

1. Define the reasons for the patient's attendance:
    (i) The nature and history of the problems.
    (ii) Their etiology.
    (iii) The patient's ideas, concerns and expectations.
    (iv) The effects of the problems.

2. To consider other problems:
    (I) Continuing problems.
    (ii) At risk factors.

3. The choose with the patient 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.

7. To establish or maintain a relationship with the patient which helps to achieve the other tasks.

## Summary

- **Consultation is the entire process of interaction between a patient and a doctor in the privacy of a room.(seeking behavior)**
- **Counseling is the interaction between a doctor and a patient with the aim of helping the patient to understand the true nature of the problem so that he can play an active role in solving or managing it.**
- **Stages of counseling: Exploration, new understanding, goal setting & action.**
- **Theories of Counseling :**
  1. ***Directive:* Active or directive counselors tend to interpret, lead and direct their clients.**
  2. ***Non-directive:* Non-directive, or reflective counselors tend to elicit and reflect, guide and support their clients.**
- **One of important aims of counseling is to help people accept and come to terms with their difficulties and identify ways of coping more effectively and resourcefully.**
- **Barriers to Communication/Counseling: Page 9.**
- **Models of Consultation: Page 12**

**For OSCE exam:**

1) If you ask the patient you should stop talking after the Q and ask the patient if he understood?

2) Thy type of Q is important (start with open-ended, then directional ..) **one mark in the checklist.**

3) You should apply **ICE**: Idea, Concern & Expectation. (What the patient think, afraid of and expect)

3) At the end you should tell the patient the summary and ask him if he has anything to add.

# Communication & Consultation Skills (OSCE)

| Domains | A | B | C |
|---|---|---|---|
| **1. *Introduction*** <br>• Shake hands. Ask the person to sit down by indicating a chair. <br>• Smile and greet the patient by his names **(أبو فلان)**. <br>• Make eye contact ,introduce himself warmly <br>• Establish a rapport by asking a simple open- ended question , <br><br>**2. *Data Gathering:*** <br>(a) Patient's main problems; <br>(b) Patients idea, concern & expectation. <br>(c) Physical, emotional, and social impact of the patient's problems on the patient and family. <br>(d)Any ongoing problem? <br>(e) Appropriate physical examination. <br><br>**3. *Main Communication Skills*** <br>• Use a good mix of open-ended & closed-ended questions. <br>• Listen actively <br>- Pay attention to what he or she says, <br>-Do not interrupt. <br>• Maintain appropriate eye contact, <br>• Give verbal and non-verbal feedback to ease the flow of the exchange. <br>• Silences; allow thinking and reflection. <br>• Aim to encourage emotional expression <br>• Clarifying, paraphrasing <br>• Ask for clarification if he/she not sure, to guarantee shared understanding. <br>• Respect their views about the illness and develop a shared understanding upon which to base intervention. <br><br>**4. *Summary*** <br>• Summarize the whole plan of action <br>• Give a chance to ask <br>• Shared management plan <br>• Agree on a time for a follow-up. <br>• Opportunistic health promotion <br>• Thank and escort him to the door | | | |

**A**= Done well **B**= Partially done **C**= Not done

# Questions:

1) One of these reasons for patients is not disclosing problems?

a. Lack of confidentiality and trust
b. Doctors' blocking behavior
c. Reluctance to burden the Doctor
d. All of the above

2) Which of the following is considered as a failed consultation/ Counseling?

a. Using medical jargon.
b. Exploring in socio-cultural & economic context.
c. Eliciting the actual problem.
d. Contingency plan / safety netting.

3) Which type of questions the doctor should start with during taking the history:

a. Closed-ended.
b. Open-ended.
c. Directional.
d. None of the above.

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**Answers**:

1st Question: D

2nd Question: A

3rd Question: B