Models of the Consultation

Prepare by

Prof AlJohara AlQuaiz

Why consultation models?

The consultation remains the main and basic tool of general practice and as Pendleton eloquently put it: 'it's the central act of medicine which deserves to be understood'. And it is consultation models that can help us (and our trainees) to *understand* the GP consultation and therefore *consult* better. Consultation models also help to add structure to a consultation – preventing it from going into all sorts of directions and deteriorating into a chaotic mess.

Why learn about consultation models?

- We subconsciously make models for anything we do regularly.
- By studying other people's models, we can make our own.
- Consultation models help us *understand* the patient's perspective.
- Better understanding means better concordance and less complaints.
- Consultation models make us more thorough and therefore safer.
- Consultation models help teachers teach on the consultation.

Model 1 – The Triaxial Model: *physical, psychological and social*[1]

This model was proposed by a working party of the RCGP back in 1972[1] and said *'A doctor should be encouraged to extend his thinking and practice beyond the purely organic approach to patients'*. In other words, to consider the patient's emotional, family, social and environmental circumstances, all of which can have a profound effect on health. Although most of us now do this religiously, it was only fifty years ago when many of these questions would have been considered as irrelevant or prying by patients.

Pros	Cons
• Covers the patients agenda • Places the presenting complaint in a psycho-social context	• An over simplification of a patient-centred approach.

Model 2 – Health Belief Model (1975)[2]

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 patient's **I**deas, **C**oncerns and **E**xpectations (I.C.E.) you get a true understanding of where the patient is coming from. And if you go one step further and incorporate that information into your management plan, you're more likely to improve patient concordance.

- 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?'*

Model 5 - Stott and Davis (1979)[5]

Professor Nicholas Stott & R.H. Davis suggested that four areas can be systematically explored each time a patient consults:

Model 7 – Pendleton, Schofield, Tate and Havelock (1984)[7]

David Pendleton, a social psychologist, wrote his PhD thesis was on the analysis of consultations. He worked with a number of GPs in the Oxford region and was the person who pioneered the use of video (a new medium at the time) in the analysis of consultations. Subsequently, he developed safeguards for the use of video which forms the basis of the current recommendations. In addition to the use of video, he also formulated 'Pendleton's rules for feedback' and 'Pendleton's model of the consultation'.

In Pendleton's model, the personal and psychological aspects of the illness are further developed. The model describes 7 tasks: the first 5 tasks are concerned with what the doctor needs to achieve and the final two deal with the use of time/resources and creating an effective relationship.

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.

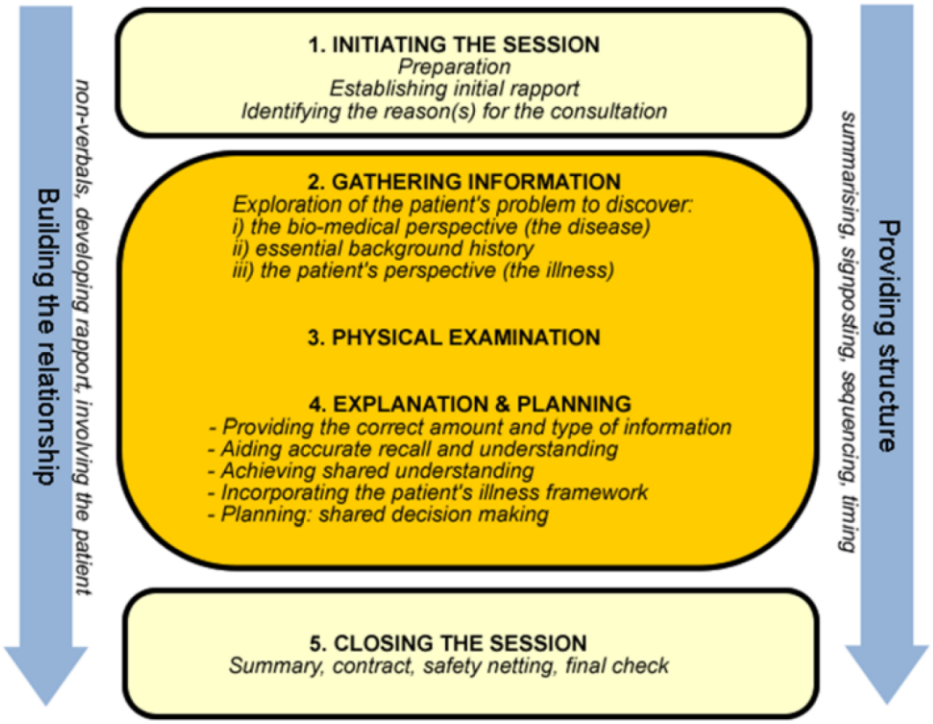
PATIENT'S AGENDA = 1c + 1d = ideas, concerns, expectations + effects of the problems

Pros	Cons
• Patient's thoughts assume an important role in this model. • It encourages patient responsibility • It's the framework which is used in the MRCGP Consultation Observation Tool	• Although set out in logical sequence, not all consultations will follow this order. • Not particularly appropriate for acute settings like emergencies.

Model 12 – The Calgary Cambridge Model (1996)[15]

We think this is currently the most favoured model in the UK (and no doubt in Calgary too!). It's the only comprehensive model which marries each of its components with the available research evidence on the skills that aid doctor-patient communication.

Basically, it outlines 5 steps each consultation must go through. These 5 steps capture both the disease *and* illness frameworks illustrated in McWhinney's Disease-Illness model. It combines process with content in a logical schema – emphasising the continuous need to provide structure to the interview and to build the relationship with the patient whilst journeying through the 5 steps.



Pros	Cons
• Comprehensive – covers both disease and illness frameworks (i.e. it is doctor and patient centred). • It is comprehensive - applicable to all medical interviews with patients. • The only model that is evidence based • Two separate books are available – one for learning and one for teaching on it.	• The 71 micro-skills puts people off • Probably best read after having read one of the other more introductory ones first (like Tate's Doctor Communication Handbook or Neighbour's Inner Consultation).

OTHER APPROACHES TO THE CONSULTATION

Balint (pronounced Bay-lint) (1957)

Michael Balint, the son of a GP, started groups for GPs in the 1950s at the Tavistock clinic.
In their work with Balint groups, Michael and Enid developed a number of ideas and philosophies which have significantly aided our understanding of the GP consultation.

- **Doctors can develop the skills** necessary to explore psychological problems. It used to be thought that whether a doctor explores the psycho-social domain depended on his or her personality. Actually, it simply depends on using the right micro-skills For example, **attentive listening** helps patients open up and feel better. Balint described listening as a skill and held that 'asking questions only gets you answers'.
- Watch out for the simple **'entry ticket'** – there may be something deeper lurking behind. Balint suggested that we pay close attention to those patients who present with a simple, discrete and easily fixed problem, like a cough and cold. Some of them may be assessing the doctor's approachability and whether they feel comfortable enough to disclose the 'real' problem. He coined the term **'hidden agenda'** for this real problem and urges us to go look for it when things appear too simple and straight forward.
- Take control, otherwise no-one will and there will be a **collusion of anonymity**. A GP needs to take overall responsibility for a patient with physical complaints as a result of emotional distress (i.e. the somatising patient). Otherwise, that patient can end up being referred and then be passed from specialist to specialist as each one investigates and investigates before bouncing it to another department when they come to realise that the problem has nothing to do with their specialty. This is not good for anyone – the patient becomes more anxious, the hospital departments more overstretched and a waste of NHS (taxpayers') money.
- **Doctors have feelings** and those feelings have a function in the consultation. An awareness of those feelings might lead to insights which might help the doctor to become more sensitive to the patient.
- **The doctor as a drug** refers to the doctor as a metaphorical drug that patients take periodically to improve their health. The most powerful *therapeutic* tool in the consulting room is the doctor – an effect over and above anything the doctor actually does. Doctors who listen to their feelings can use this to powerfully influence the patient's thoughts and hence their total health – without even writing a prescription! But be careful - the doctor, like a drug, may be therapeutic but can also have adverse effects and invoke dependency.