The Consultation Tasks and Competencies

Color Index	IMPORTANT	NOTES	GOLD	EXTRA

OBJECTIVES

- Explain the tasks of consultation.
- Interpret the consultation competencies.
- Apply patient centered consultation.
- Assess the consultation and health outcomes

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Sources	Drs Slides, Drs Handouts, Dr notes

Introduction

- "It is more important to know what sort of person has a disease than to know what sort of disease a person has" Hippocrates (circa ٤٠٠ BC).
- مهم جدا تعرفي مريضك كانسان من كل النواحي مو فقط المرض
- "The greatest mistake in treating diseases Is that there are physicians for the body and physicians for the soul Although the two cannot be separated" – Plato ٤٠٠ BC
- You can't separate your patient you have to look at him in a holistic way.

Consultation

- How do we define 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, ١٩٦٠.
- Extra explanation:
  - For good intimacy there needs to be a good patient-doctor relationship.
  - Patient could be physically, psychologically ill, he may be ill or may not be, may have other social or emotional problems.
  - There has to be trust so that the patient can open up to you.
- Components of consultation:
  - Interviewing skills (communication skills are very important)
  - History taking skills (should be focused on complaint and taking history relevant to complaint)
  - Physical examination skills
  - Patient management skills (investigations, treatment, and how to make patient comply to your plan)
  - Problem -solving skills (ex: if a patient came to you with marital or social problems you should know how to help her)
  - Behavior /relationship with patient
  - Anticipatory care (preventive care or **health promotional** care)
  - Record keeping

Models of Consultation

- Why are these models important? When you are with a patient you have to have a scheme that you follow or else you will be lost (مشتته). These models ترتب the structure of the consultation so that it helps you stay on track, and make this consultation the best and functional as possible.
- The models described will provide a range of approaches.

- No one correct model of the consultation – the approach is dependent on the context.
- ما في حاجه افضل من الثانية، كل حاله تحتاج نوع محدد يناسبها اكثر
- Models tell you what you need to achieve but not how you go about achieving it, so there is flexibility for you to do whatever you can.
- Models of consultation (they are important for the **OSCE**):
    ١) **The Triaxial Model**
    ٢) **Health belief model**
    ٣) **Stott & Davis model**
    ٤) **Pendleton's model**
    ٥) **Calgary-Cambridge model**
    ٦) Neighbor model
    ٧) Problem solving model
    ٨) Byrne-Long model
    ٩) Hypothesis setting model

١) The Triaxial Model

- Triaxial = Physical, psychological, and social. We call it the **biopsychosocial** model.
- *A doctor should be encouraged to extend his thinking and practice beyond the purely organic approach to patients'.*
- Consider the patient's emotional, family, social and environmental circumstances that have a profound effect on health. So we have to look at all the aspects of a patients life.

✓ **Pros**: covers the patient's agenda, places the presenting complaint in a psycho-social context.

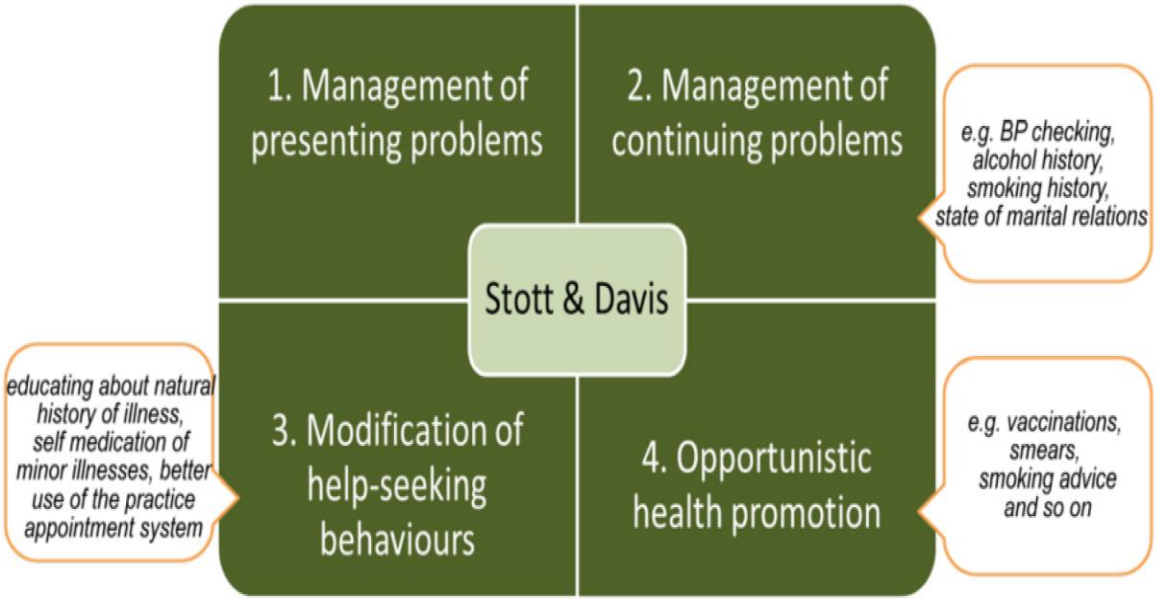
× **Cons**: an oversimplification of patient-centered approach.

٢) 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.
- You have to understand the patients thoughts so that if he has incorrect thoughts we can tackle that and explain it and correct it for him.
- Patient's Ideas, Concerns and Expectations (I.C.E.) you get a true understanding of where the patient is coming from.
    - 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?'
- If you go one step further and incorporate that information into your management plan, you're more likely to improve patient concordance and compliance.

٣) Stott and Davis

- We can use this model when we have a **straightforward** cases.
- Professor Nicholas Stott & R.H. Davis suggested that **four areas** can be **systematically explored** each time a patient consults:
    ١. Management of presenting problem
    ٢. Management of continuing problems
    ٣. Modification of health seeking behavior (educate the patient about when they need to see a doctor, ex: not to ask for antibiotic every time they have URTI)
    ٤. Opportunistic health promotion (anticipatory care) ex: if they need vaccine or screening, etc.



Case scenario

Fatima ٤٥ years old lady c/o epi-gastric pain for the last ٣wks.
She has a history of osteoarthritis of the knees for the last ٣ years and was taking NSAD on and off.
She smokes shisha and rarely practice any exercise.
Her BMI is ٣٥ kg/m٢.
On her way out she asks you for some antibiotics because she has a sore throat.

Let's apply the Stott & Davis model:

Epigastric pain ٣ weeks	Obesity, osteoarthritis, smoking
Asking for antibiotics for her sore throat	Healthy life style, stop smoking shihsha, screening for BP, BS, & lipids, cervical screening, mammogram if she has a family history

٤) Pendleton's model

- This model is more complicated and you have to go in depth and know more about the patient.
- In Pendleton's model, the personal and psychological aspects of the illness are further developed.
- The model describes **٧ tasks**: the first ٥ 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.

١. To **define the reasons** for the patient's attendance (this is the most important thing, a consultation may be dysfunctional if the doctor fails to find the real reason a patient came:

   a. Nature and history of the problem (look at it from a ٣-dimensional approach "biopsychosocial")

   > Example: patient with depression comes to you.
   > – Physical symptoms may be back pain, headache, etc.
   > – Psychological symptoms include lack of interest, anxiety, lack of concentration, problem with sleep, etc.
   > – Social: their marital relationship or relationship with their friends and family may be affected because he is becoming isolated.

   b. Their etiology (it is important to know etiology so that you can prevent recurrence)

   > Example: patient with ischemic heart disease → find the etiology in holistic way:
   > – Physical symptoms may be hypertension, diabetes, dyslipidaemia, smoking.
   > – Psychological: type A personality (very competitive always under stress, they are more prone to ischemic heart disease)
   > – Social: lifestyle (sedentary work, poor diet), if he has stress.

   c. Patient's ideas concerns and expectations (ICE) – patients perspective.

   > Example: patient with fatigue
   > – Ideas: she might think her symptoms are because of عين
   > – Concerns: she might say I think it could be cancer because her neighbour has the same symptoms and was found to have cancer.
   > – Expectations: she wants an MRI, I don't have to order it for her but I should at least know about her thoughts and discuss it with her, so that we have a shared understanding of the problem with the patient.

   d. The effect of the problem on her life, work, relationships, etc.

٢. To consider **other problems**:

   a. Continuing problems (chronic problems)

   b. At risk factors (ex: obesity, smoking)

٣. To choose **with** the patient an **appropriate action** for each problem: the patient has to be involved to make sure the plan is appropriate, and this will increase the compliance.

٤. To achieve a **shared understanding** of the problems with the patient.

٥. To **involve the patient** in the management and encourage him to accept appropriate responsibility, ex: patient can make tables and document his BP readings, نخلي المريض يحس انه مسؤول عن صحته

٦. To use **time and resources** appropriately (we can't do all this in one consultation we can tackle different problems in each consultation).
٧. To establish or maintain a **relationship** with the patient which helps to achieve the other tasks. It is very important to have trust between you and the patient.

✓ **Pros**: 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.
× **Cons**: although set out in logical sequence not all consultations follow this order, not particularly appropriate for acute settings like emergencies.

Case scenario

٥٠ years old Sudanese lady who works as a saleswomen. Married to a lab technician and has moved recently to Saudi Arabia. She left two sons studying in Sudan.
She presented with headaches, weakness and tiredness with no energy, she is experiencing early waking and loss of concentration and tearfulness for the last ٨ weeks. She lost interest in socializing and prefers to sit at home.
She has a very sick mother in Sudan and she is very worried about her.
She is diabetic on metformin ٥٠٠mg and has osteoarthritis.
Her BMI is ٣٨kg/m٢,
Her husband smokes ٢٠ cig/day

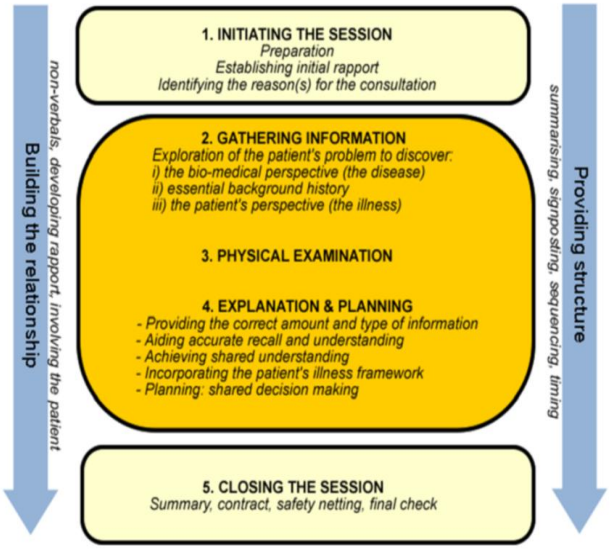
How would you proceed in this consultation?

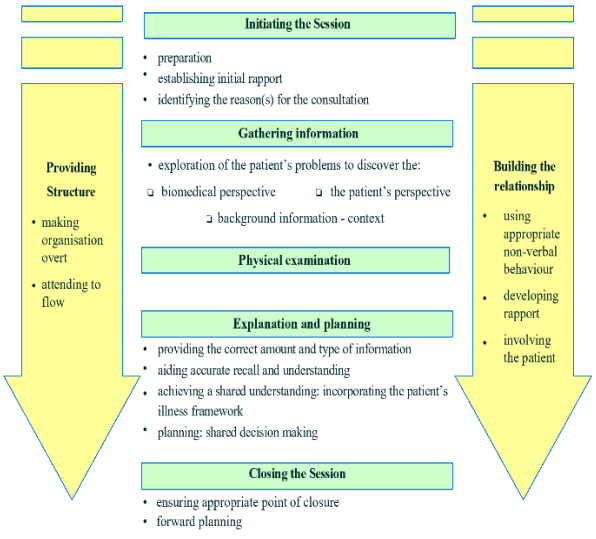
Let's apply Pendleton's model:
- Reason for attendance: she has headache, fatigue and tiredness.
- Nature and history of problem → to apply biopsychosocial:
  a. Physical: headache, fatigue.
  b. Psychological: loss of concentration, early awakening, tearfulness.
  c. Social: losing interest in socializing and prefers to sit at home.
- What do you think the etiology is? Homesickness, not coping with new changes, stress, and many factors.
- ICE:
  a. Idea and concern (what do you think the cause of your problem): my mother has been diagnosed with brain tumor and I'm afraid I have the same thing.
  b. Expectation (what are your expectations from me?): my mother had an MRI when she was first diagnosed and I want you to order an MRI for me.
- What is the effect of the problem? How has it affected her? Did it affect her work, can she still go and function? Is there any marital conflict or disharmony? Maybe she's not taking care of her house or cooking or etc.
- Consider other problems: she is diabetic (is it controlled or not? Did she go to the ophtha appointment?), obesity, osteoarthritis. Be careful if a patient has depression you have to manage it first then focus on these other problems in the next visit maybe. Because at this time she is not ready to take advice for anything else.

- Choose an appropriate action with the patient → what does she most likely have? Depression. So we have to explain to her that her symptoms are due to depression which is secondary to her homesickness which is very understandable. Continue to explain that depression is very common (٢٥٪) and it does not cause addiction. We can start you on SSRI and see you in ٨ weeks and accordingly plan the next step.
- If she still wants an MRI we can start explaining to her the difference between her headache and her mother's headache, and how hers started since she moved. We can also say let's start with our medication and give it a chance, if you don't see any improvement then we can consider further investigations.
- If she agrees we can start the next step = achieve shared understanding of the problem.
- Make sure to explain to her that there are other things we want to discuss with you next visit (diabetes, weight, etc..)
- Involve patient in management = If she comes next visit and she is improving, she is sleeping better, she can concentrate, she feels better. This means our diagnosis is correct and she has to continue the medication and she can't stop it without our advice. Then we start educating the patient about her other health concerns: "regarding diabetes and losing weight: do you want us to refer you to a dietician or can you do that at home with this flyer?" you can try on your own but if you fail in ٣ months we have to look at another option.
- Use time and resources appropriately and establish a relationship with patient

Model ١٢: Calgary-Cambridge

- This is the most recent model and is very comprehensive.
- This is the only comprehensive model which marries each of its component with the available research evidence on the skills that aid doctor-patient communication.
- It outlines ٥ steps each consultation must go through. These ٥ steps capture both the disease and illness frameworks illustrated in McWhimnney's Disease-Illness model.





- Initiating the session:
    - Preparation (before the patient comes to you, you have to be prepared, check report, vitals investigation)
    - Establishing initial rapport (introduce yourself and start socializing with the patient with some nice comments to break the ice)
    - Identifying the reason(s) for the consultation (same as before)
- Gathering information: you have to explore the problem: take history, examination depending on type problem
- Exploration of the problems:
    - Biomedical perspective
    - Understanding patient's perspectives = ICE + effect of the problem on the patient.
    - Providing structure to the consultation.
- Building relationship
    - Developing rapport.
    - Involving the patient.
- Explanation and planning
    - Providing the correct amount and type of information: first ask the patient what they know about the disease so that you know how much you need to explain and educate them about. Give the correct and right amount of education to patient.
    - Aiding accurate recall and understanding: after we finish we can ask the patient to repeat what we said to them to make sure they understood the instructions etc..
    - Achieving a shared understanding: incorporating the patient's perspective.
    - Planning: shared decision making.
- Closing the session
    - Summary: you can summarize what her problem is and the need for treatment and what to expect when she takes the treatment
    - Contract: you can also make a contract with the patient ex if you lost ١٠ kg I won't start you on insulin, etc..
    - Safety netting: tell the patient if you don't improve or have worse symptoms come back to me.
    - Final check

(click here for ٢ files the doctor sent with more details regarding the Calgary-Cambridge model)

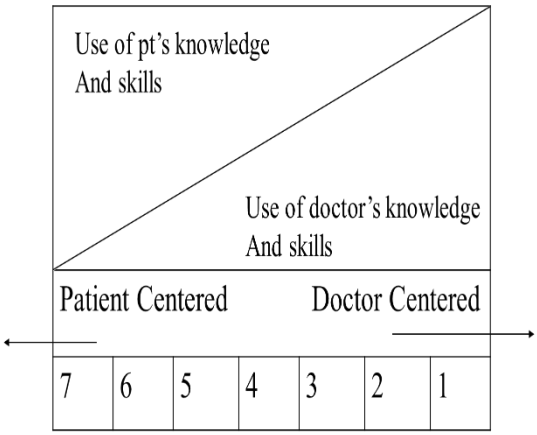
✓ **Pros**: comprehensive (covers both disease and illness frameworks, i.e, it is doctor and patient centered), it is applicable to all medical interview with patients, the only model that is evidence based, two separate books are available; one for learning and one for teaching on it.

× **Cons**: the ٧١ micro-skills puts people off, probably best read after one of the more introductory ones first (ex: Neighbor's Inner Consultation).

Video (Headache Consultation):
https://www.youtube.com/watch?v=VVGZkɛzDKZk&feature=youtu.be

٦) Byrne and Long

- Consultation style :
  - Doctor centered: authoritarian, paternalism (like a parent) → This is the kind of consultation where the doctor makes the decisions and tell the patient what to do. We should avoid this approach except in certain conditions like emergencies.
  - Patient centered: meeting between the experts → you are an expert in your medical field and the patient is an expert in his disease, this kind of consultation is more advised.



Other approaches to consultation

- Balint (pronounced Bay-lint)(١٩٥٧)
  - Balint groups, Michael and Enid developed a number of ideas and philosophies that aided our understanding of the GP consultation. Dr patient relationship.
  - Balint was the first to talk about the doctor-patient relationship and how it is important for the consultation.
- They found certain micro skills that help doctors get to where they want with their patients:
- Doctors can develop the skills necessary to explore psychological problems, ex: **attentive listening.** تعطيه فرصه يتكلم وممكن يعلمك اشياء ماكنت راح تعرفيها لو بس كنت تسألي
- Watch out for Entry ticket and Hidden Agenda[١].
  - Sometimes a patient may come with something simple and trivial, like a cough, you have to ask yourself why did he come? Is he trying to assess your approachability to see if he can confide in you. If he thinks he can then he might then start talking about the real problem he has "the hidden agenda".

[١] 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.**[٢] Some patients may present with somatization (physical symptoms due to underlying psychological cause) and they get dismissed and go from doctor to doctor and no one wants to take responsibility for them. This is collusion of anonymity so try to avoid it.
- **Doctors have feelings**; an awareness of those feelings might lead to insights which might help the doctor become more sensitive to the patient.
    - Example if a patient came and is angry at the end of the session the doctor will also feel angry/anxious because there is transfer of these emotions so you have to look into these feelings to diagnose or treat.
- **The doctor as a drug**: the most powerful therapeutic tool in the consulting room is the doctor.[٣] In some psychosocial problems if the doctor listens supports, and advices the patient the doctor himself may be like a drug "treatment" to the patient. But the doctor should be careful because there may be some sort of dependence on the doctor from the patient. So there should be a balance not too much or too little.

Pitfalls to avoid

- Common barriers to satisfactory consultation
    - Poor eye contact.
    - Over reliance on notes, we see this a lot now because of computers and systems.
    - Lack of clarification
    - Misinterpretation (تفسير الاشياء بطريقة مختلفه عن حقيقتها).
    - Insensitivities to language /cultural differences
    - Omitting to ask what the patient think of his illness

Videos:

Explaining and planning: https://www.youtube.com/watch?v=SSJFJpk·osU

Patient centered consultation: https://youtu.be/S٤wWClQhZaA

[٢] 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.

[٣] 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.

Key points

- Consultation is a fundamental event in clinical practice.
- A competent doctor needs to acquire a broad range of interpersonal, reasoning and practical skills.
- 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 outcome.
- The exceptional potential of every consultation in general practice needs to be recognized and appropriately acted upon.