Lecture 13

Editing file

PRIMARY HEALTHCARE TEAMWORK

# Enhancing The Consultation

## Objectives:

★ Not given.

## Color index:

Original text Important Doctor’s notes Golden notes Extra

# Consultation Models

## 1. The Biomedical Model

1. Take an accurate and relevant history.
2. Perform an accurate and relevant examination.
3. Make a provisional diagnosis (hypothesis).
4. Order and interpret the results of appropriate investigations (hypothesis testing).
5. Make a definitive diagnosis (deduction).

- Highly applicable in internal medicine.
- Advantages: Systematic approach Especially for beginner.
- Disadvantages: Time-consuming, requires experience, and it focuses mostly on the presenting problems regardless other important aspects of medical evaluation (Doctor-centred).

## 2. Byrne & Long (1976) Consultation Styles

1. **Doctor Centered:**
   - Dominates the consultation.
   - Asks direct, closed questions, it is bad when you start the consultation with it, otherwise it is acceptable.
   - Rejects the patient's ideas.
   - Evades the patient's questions.
2. **Patient Centered:**
   - Ask open questions.
   - Actively listens: SOFTEN: Smile,Open posture,Forward lean, Touch (consider cultural barriers), Eye contact and Nodding.
   - Challenges and reflects the patients' word and behavior to allow them to express themselves in their own way, Why? to summarize and understand all the details of the patient very well by asking open ended questions.

## 3. Stott And Davis Consultation Tasks

1. Identification and management of presenting problems.
2. Management of continuing problems.
3. Opportunistic anticipatory care.
4. Modification of the patients' help seeking behavior.

- Easy and simple but is doctor-centered.

| Presenting Problems | Continuing Problem |
|---|---|
| Opportunistic anticeptery care | Modify Patients' help seeking behavior |

# Consultation Models

## 4. Pendleton (1984) The Doctor's Tasks

1. Define the reason for the patient's attendance:
   - The nature and history of the problems.
   - Their aetiology.
   - The patient's ideas, concerns and expectations.
   - The effects of the problem.
2. Consider other problems. (Continuing problems, At-risk factors)
3. Together choose an appropriate action for each problem.
4. Achieve a shared understanding of problems.
5. Involve the patient in the management of problems and encourage acceptance of appropriate responsibility.
6. Use time and resources appropriately. (In the consultation, In the long term)
7. Establish and maintain a relationship with the patient which helps to achieve the other tasks.

- Pendleton defined seven tasks forming the aims of each consultation. These identify what the doctor needs to achieve and deal with the use of time and resources.

## 5. Neighbour (1987) Checkpoints

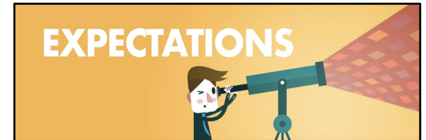
1. **Connecting:** Have we got rapport?
2. **Summarising:** Could I demonstrate to the patient that I've sufficiently understood why he's come?
   - The patient's reason for attending.
   - The patient's ideas and feelings, concerns and expectations are explored and acknowledged adequately.
   - Listening and eliciting.
   - The clinical process - assess, diagnose, explain, negotiate and agree.
3. **Handing over:** Has the patient accepted the management plan we have agreed?
4. **Safety-netting:** What if...?
   - General practice is the art of managing uncertainty:
     - Predict what would happen if things go well.
     - Allow for an unexpected turn of events.
     - Plans and contingency plans.
5. **Housekeeping:** Mindfulness, ablution, sick leave…
   - Am I in good condition for the next patient? - stress, concentration and equanimity

## 6. RCGP Model (1972)

- The Triaxial Model: 'Physical, Psychological and Social' (1972):
  1. Extend thinking beyond organic.
  2. Consider emotional, family, social and environmental factor.
- The RCGP model encourages the doctor to extend his thinking practice beyond the purely organic approach to patients, i.e. to include the patient's emotional, family, social and environmental circumstances.

# Consultation Models

## 7. Becker & Maiman (Health Belief Model)




1. **Ideas.**
2. **Concerns.**
3. **Expectations.**

- Becker and Maiman combined a number of patient beliefs and attitudes into a 'health belief model' which included:
    - The patient's interest in health matters, which may correlate with personality, class and social group.
    - How vulnerable the patient feels to a particular disease and how severe he feels the threat to be. (Perceived susceptibility & severity)
    - The patient's estimate of the benefits of treatment versus the costs, risks or inconvenience. (Perceived benefit & barriers)
    - The factors that prompt the patient to take action - such as developing alarming symptoms, advice from family or friends or reports in the media. (Cues to action)

## 8. Levenstein (Patient-Centred Model) (1984)

The six interactive components of the patient-centered process:

1. Exploring both the disease and the illness experience.
    - (Differential diagnosis , Dimensions of illness (ideas, feelings, expectations, and effects on function)
2. Understanding the whole person.
    - The "person" (life history and personal and developmental issues), The context (the family and anyone else involved in or affected by the patient's illness; the physical environment)
3. Finding common ground regarding management.
    - Problems and priorities, Goals of treatment, Roles of doctor and patient in management
4. Incorporating prevention and health promotion.
    - Health enhancement, Risk reduction, Early detection of disease, Ameliorating effects of disease
5. Enhancing the patient-doctor relationship.
    - Characteristics of the therapeutic relationship, Sharing power, Caring and healing relationship, Self-awareness, Transference and counter transference
6. Being realistic in time, resources, team building.

## 9. Calgary-Cambridge Observation Guide (Kurtz & Silverman-1996)

1. **Initiating the session:**
    - Establishing initial rapport.
    - Identifying reasons for attendance.
2. **Gathering information:**
    - Exploring the problems.
    - Understanding the patient's perspective.
    - Providing structure to the consultation.
3. **Building the relationship:**
    - Developing the rapport.
    - Involving the patient.
4. **Giving information - explaining and planning:**
    - Providing the right amount and type of information.
    - Aiding accurate recall and understanding.
    - Achieving a shared understanding; incorporating the patient's perspective.
    - Planning; shared decision-making.
5. **Closing the session.**

- **This simple five-point plan follows the sequence of events that:**
    - Take place in everyday clinical practice. Within the plan, each task is expanded into a framework for identifying the individual skills of the consultation.
    - Doctors and patients tend to carry out the four tasks of initiating the session, gathering information, giving information and closing the session roughly in sequence while relationship-building is performed continuously during the other tasks.
- These tasks make intuitive sense, are easy to keep in mind and provide a basis for studying doctor-patient interactions and communication skills:
    - As it offers a true spectrum of common clinical conditions.
    - A less desirable place for students to glean the fundamentals of clinical care and problem solving than in the past.

## How To Communicate Well? SOFTEN

- **S**mile.
- **O**pen Posture.
- **F**orward leaning.
- **T**ouch (consider cultural variations).
- **E**ye contact.
- **N**oding.

## 10. MRCGP Video Criteria

- Doctor encourages patient's contribution.
- Dr. responds to cues.
- Dr. elicits appropriate details to place complaint in social & psychological context.
- Dr. explores patient's health understanding Merit.
- Dr. obtains sufficient info for no serious cond to be missed.
- Dr. chooses an appropriate examination.
- Dr. makes clinically appropriate working diagnosis.
- Dr. explains diagnosis.
- Dr. uses appropriate language.
- Dr. takes account of patient's belief Merit.
- Dr. confirms patient's understanding Merit.
- Dr. uses appropriate management plan.
- Dr. shares management options.
- Dr. uses appropriate prescribing behaviour.
- Dr. and patient appear to have established a rapport.

## 11. M Balint (1957) The Doctor, His Patient and The Illness

- Michael Balint observed in 1957 that a doctor's personality interacts with medical training to produce a unique way of dealing with patients. Doctors tend to avoid examining their own behaviour and so a fixed style develops.

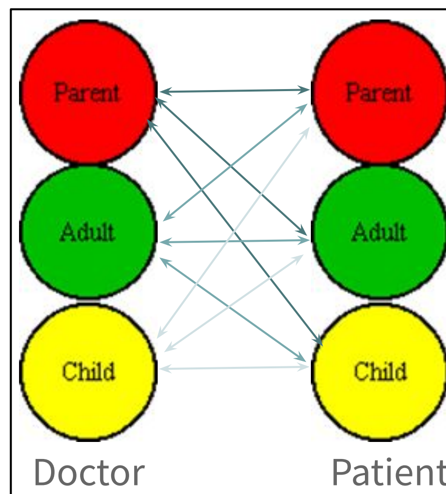
1. **The Apostolic Function:**
    - This incorporates the Dr's beliefs about how pts ought to behave when ill, how they should behave with drs and how they should cooperate in their cure.
    - A Dr personality interacts with medical training to produce a unique way of dealing with patients.
    - Drs a fixed style and avoid examining their own behavior.
2. **The Drug Doctor:**
    - Balint referred to the 'Drug Doctor' to describe the powerful therapeutic effect of drs as people, that is the effect of the dr's personality apart from the treatments they prescribe.
3. **The PT'S Sick Role:**
    - Traditionally, the patient adopts the Sick Role and hands over partial or complete responsibility for his well-being to the doctor.
    - This role allows the patient to drop out of other roles, such as that of breadwinner, and be treated in a dependent, cosseted way. The sick role also requires the patient to seek recovery; otherwise social disapproval and withdrawal of privileges may follow.
4. **The Long Consultation:**
    - **Balint promoted the use of the 'Long Consultation'** at a time when the average consultation took six minutes. He gave the patient an hour after surgery to explore the underlying psychosocial causes behind frequent attendances and repeated failures to resolve a problem.
    - A single long session can give insights to the doctor and enough support to the patient to lead to a new rapport and often a resolution of the problem.

# Consultation Models



## Berne (1964) Games People Play / Transactional Analysis

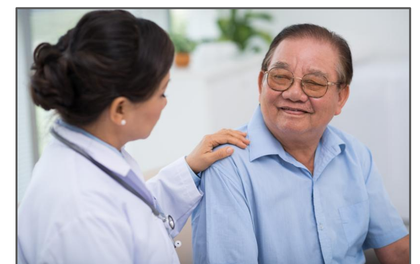
- Games doctor and patient play as a role during consultation is one of the following:
  - Parent or Adult or a Child
- At any given moment we are in one of three states of mind, one based on a rational assessment of our situation, the other two based on memories recorded mostly in early childhood.
- These states are named (critical or nurturing) Parent, Adult and (dependent or spontaneous) Child. The Adult is the thinking person, while Parent and Child are replayed memories of what happened to us (mostly at the hands of our parents) and of the feelings
  - We had as a small child.
- The two participants in a transaction are therefore each in one of these three states.
- Consultations conducted between a paternalistic (Parental) doctor and a submissive (Child-like) patient is seldom in the best interests of either but produces no conflict. Conflict will occur however if the patient doesn't accept this position and adopts either an authoritarian role back (Parent) or an unexpectedly questioning (Adult) stance. Best understanding is achieved by Adult to Adult consultations where the two parties respect each others' autonomy.
- Games are behaviours used in a bid to feel better by making someone else feel worse. Recognising a game and not playing it prevents the doctor from being manipulated into accepting responsibility for the results of the patient's own behaviour.
- For instance, in the game 'Poor Me - Yes, But' the patient presents a problem but always has reasons why proffered solutions are not acceptable. Thus the doctor is proved useless, the point of the game. Some games are deadly as some people will even commit suicide to hurt and 'win'.




## Delivering Bad News (Rabow & Mcphee (West J. Med 1999))

**Synthesized a simple mnemonic of ABCDE:**

- **Advance Preparation**
- **Build a therapeutic environment/relationship**
- **Communicate well. How?**
- **Deal with patient & family reactions**
- **Encourage and validate emotions**



# Consultation Models



## Patient-Centred Model

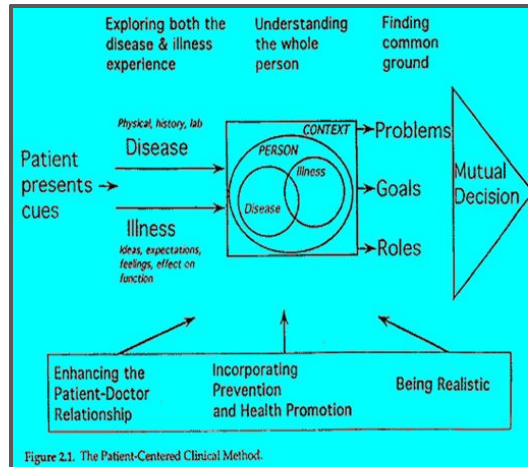
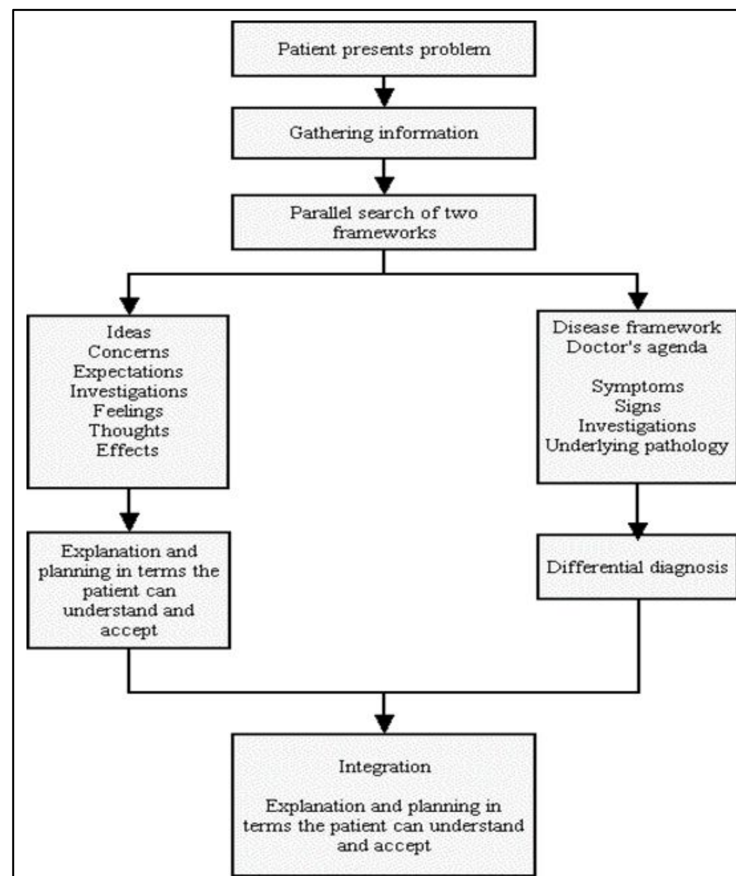


Figure 2.1. The Patient-Centered Clinical Method.

## Disease-Illness Model (1984)




- This was later developed by MacWhinnney et al. into the 'Disease-Illness Model' popular in the US.
- McWhinney and his colleagues at the University of Western Ontario have proposed a "reformed clinical method". Their approach has also been called "patient-centred clinical interviewing" to differentiate it from the more traditional "doctor-centred" method that attempts to interpret the patient's illness only from the doctor's perspective of disease and pathology.
- The disease-illness model below attempts to provide a practical way of using these ideas in our everyday clinical practice.

# Case Study & Notes

## Case Study 1:

A 35-year-old married woman with 2 children; during a visit to her family physician complains that she has fatigue, dizziness, insomnia, and headaches. Each day, she drags herself for work. Past medical: gestational diabetes, family history is insignificant her BMI is 44.

**What is the central or primary task of the physician in the consultation?**

A. Opportunistic anticipatory care
B. Management of continuing care
C. Identification and management of presenting problem
D. Modification of health seeking behavior

- It is Scott and Davis model.
- Doctor considered A correct as well but C is more important than A So you should consider opportunistic approach after identifying the presenting problem.

## Dr Notes:

- The worst to do in patients consultation is interrupting him/her unless necessary.
- Never abort patients ideas or judge him based on his behavior.
- Doctors should consider preventive measures, solving current problems and modifying patients behaviour.
- Don't be more strict with patients so consider sympathy and empathy and always look for safer and easily approachable solutions for patients problems and consider their preferences and values.
- Ventilation in consultation is letting the patient express his feelings and ideas freely and comfortably.
- Others: Dr has recommended this website: https://learnfm.ucalgary.ca

# Lecture Quiz

**Q1: Which of the following isn't a part of the six interactive components of the patient-centered process:**

A- Understanding the whole person
B- Being realistic
C- Finding common ground regarding management
D- Consider other problems

**Q2: In Byrne & Long consultation model which of the following considered doctor centered care?**

A- Ask open questions
B- Actively listens
C- Evades the patient's questions
D- Challenges and reflects the patients' word and behavior to allow them to express themselves in their own way

**Q3: "Am I in good condition for the next patient" define which of the following?**

A- Housekeeping
B- Connecting
C- Summaries
D- Safety-netting

**Q4: Which of the following refer to Stott and Davis consultation tasks?**

A- Opportunistic anticipatory care
B- Consider other problems
C- Achieve a shared understanding of problems
D- Understanding the whole person

Answers: Q1:D | Q2:C | Q3:A | Q4:A

# THANKS!!

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Send us your feedback:
We are all ears!