Consultation Skills in General Practice

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Aims & Method

- What are we going to do today
  - To have an overview of consultation skills
  - Small groups and role play
  - Discussion

I hope that by the end of today's session you will be able to connect different models and have a good understanding of how to apply them in real practice

Why do we use Consultation Skills

- Best use of time
- Holistic
- Ensure patient compliance
- Cost effective
- To reduce uncertainty

Why talk about uncertainty?

- It is an important issue in General Practice
- Failure to cope with it can lead to “Physician’s Anxiety”
- Failure to cope with it can lead to over treatment, referral and investigation.
- It is a common question in MRCGP oral exams & CSA.

Aggravating factors, the doctor

- The “impostor syndrome”, being found out!
- WWW. Syndrome!
- Personality
- “The black hole”, I don’t know,what I don’t know
- The “health of the doctor”
- Previous experience, bad ones.

Aggravating factors, the patient

- A dreaded outcome, death or a complaint.
- Insoluble problems
- Triple Diagnosis in GP & Psychosocial factors
- Non disease or somatisation.
- The usual presentation or fear of it.
- Expectations that the doctor will always have an answer
- Unreasonable? Expectations

Aggravating factors, the consultation

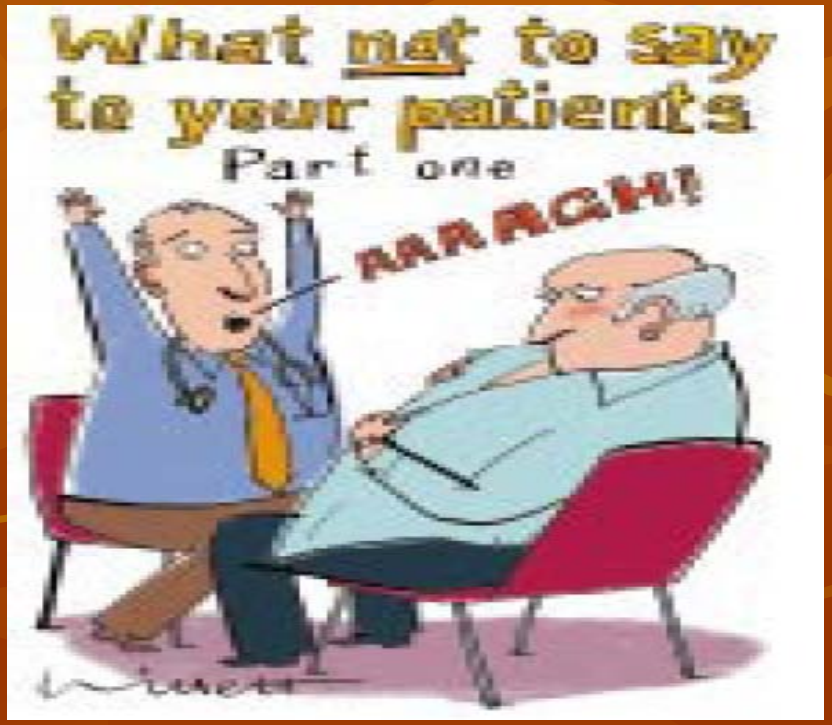
- The consultation style.
- The pressures of society.
- News
- Internet search.

Strategies within the consultation

- Safety netting.
- Negotiation in decision making.
- Sharing the responsibility of decision making.
- Patient centred communication.
- Communicating uncertainty??

- From BMJ BMJ 2004;329(7480):1419 (18 December), lifting the fog of uncertainty in the practice of medicine
- **Identifying relevant evidence**
- **Improving connectivity between data, information, and knowledge**
- **Training doctors for decision making under uncertainty**
- **Bold leadership is needed to inform the public about uncertainties**

Communicating Uncertainty



Its not good to say “I don’t know”!

- The current trend is to admit and share uncertainty.
- What doctors say might effect the confidence patients have in them
- Doctors need to be careful in hoe the communicate uncertainty

Rating of what GPs and patients thought were the words or behaviours most detrimental to patients' confidence

GPs	Patients
1. "I haven't come across this before"	1. "Let's see what happens"
2. "I don't know"	2. "I don't know"
3. Asking a nurse for advice	3. Asking a nurse for advice
4. "Let's see what happens"	4. "I think this might be..."
5. "I'm not sure about this"	5. "I haven't come across this before"
6. Used a book to find out about a condition	6. "I'm not sure about this"
7. Asked another GP for advice	7. "I need time to find out more"
8. "I think this might be..."	8. Used a book to find out about a condition
9. "I need time to find out more"	9. Used a computer to find out about a condition
10. Used a computer to find out about a drug	10. Asked another GP for advice

RCGP “In Safer hands”

- Diagnostic errors are rare, 5-8 per 100,000 consultations.
- Malignancies are the commonest area, breast being the most common.
- Advised good examination and history.
- Appropriate follow up.
- Effective communication.
- Marginalising Danger- Primary Care
- Marginalising Error- Secondary Care
- Six common errors in the diagnostic process are:
- Causes of error 1. Fixation on a hypothesis 2. Stop looking 3. Rule-out syndrome 4. Making very unlikely hypotheses 5. Retaining unsustainable hypotheses 6. Making unsupportable hypotheses

Diagnosis in general practice

Almost one million people visit their GP every day and making an accurate diagnosis can sometimes be difficult because of undifferentiated presentations. It is one of general practice's strengths that it does manage uncertainty and get it right most of the time when symptoms are inconclusive.

Whilst greater vigilance is needed, it is important not to routinely over-investigate or make inappropriate referrals. Marshall Marinker's[5] distinction between the task of a generalist and a hospital specialist is useful for understanding the diagnostic function in general practice. Marinker says the role of the GP is to tolerate uncertainty, explore probability and marginalise danger. In contrast, the role of the secondary care specialist is to reduce uncertainty, explore possibility and marginalise error.

The Models

Traditional Hospital Consultation

- History
- Examination
- Investigations
- Differential diagnosis
- Treatment
- Follow Up

Consulting in General Practice Patient-Centred Consulting.

- *Detection skills to marginalise danger*
- Patient's agenda
- Patients' ideas
- Listening skills
- Watching for non-verbal cues
- Exploring feelings (doctor and patient)
- clarification

Patient Centred Consulting

- *Management skills*
- Health beliefs
- Patient expectations
- How does the problem affect the patient
- Sharing examination findings
- Formulate a plan by negotiation with the patient
- Explanation
- Checking understanding

Avoid

- Being prescriptive
- Jargon words
- Valued judgements.

Gathering Information using parallel search of 2 frameworks

- Illness Framework
- Patient's agenda:
- Ideas,concerns,expectations,feelings,
- Thoughts, effects
- Understanding the patient's unique experience of illness

- Disease Framework
- Dr's agenda:
- Symptoms,
- Signs
- Investigations
- Underlying pathology
- Differential diagnosis

Integration of the 2 Frameworks

- Explanation and Planning:
- Shared understanding and decision making

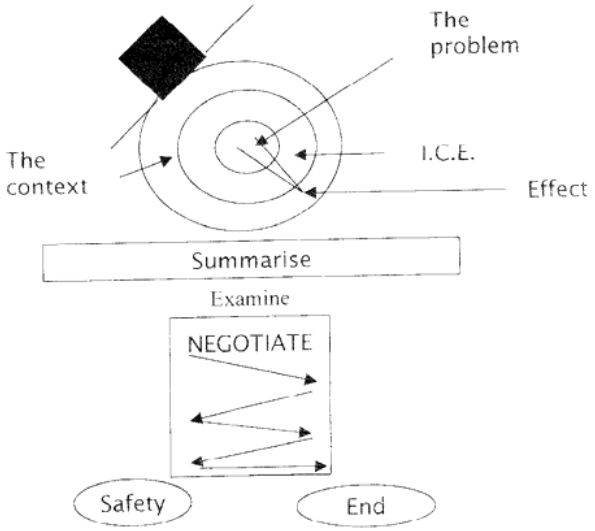
Evidence supporting Patient Based consultation

- History contributes 60-80% of diagnosis (Peterson et al)
- Patient centeredness and the perception of common ground means fewer follow-ups, investigations and referrals (Little et al 1997)
- 50% of patients in general practice presenting with chest pain had no proven cause after 6m (Blacklock 1997)This suggests non organic cause
- Up to 25% of patients presenting to hospital outpatients had no definable physical cause for symptoms suggesting non organic cause (Blacklock 1977)
- Duration of illness is improved by patient centeredness(Little et al 1977)
- Undiscovered discordance between the health beliefs of patients and physicians leads to problems in patient satisfaction, adherence and outcome (Kleinmann et al 1978)
- Joint Working Party Royal College of Physicians and Royal College of Psychiatrists concluded that underlying psychological issues were an important dimension in patients presenting to hospital (2003)

Video Man

Video

man



Just listen - first 90 seconds to the patient. Explore and clarify

Use patient's words and cues

Offer options or choices

1. Balint (doctor/patient roles)

the apostolic function

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.

Balint called this the 'Apostolic Function'. This incorporates the doctor's beliefs about how patients ought to behave when ill, how they should behave with doctors and how they should cooperate in their cure.

the drug 'doctor‘

the 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, cossetted way. The sick role also requires the patient to seek recovery; otherwise social disapproval and withdrawal of privileges may follow.

Balint/ continued

- **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**

2. Berne (Games People Play/TA)

- Eric Berne founded a school of psychotherapy based on analysing the transactions between people rather than looking for answers solely within the individual patient.
- Berne described how to recognise behaviours ('games') which patients may use to score points off their families, friends and others, including their doctors.
- Berne also developed a usefully simple model of the ego-states of Freudian psychoanalysis and applied it to the transactions between people. He called these states Parent, Adult and Child.

Games/ Berne

- 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.
- In the game 'Poor Me - Yes, But' the patient presents a problem but always has reasons why preffered 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'.

Parent, Adult and Child/ Berne Transactional Analysis

- 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.

3. Becker and Maiman (health belief model)

- Remember I.C.E.
- Becker and Maiman combined a number of patient beliefs and attitudes into a 'health belief model' which included:
- This model can be summarised as the patient's Ideas, Concerns and Expectations.

4. Heron (The 6 types of intervention)

- 1. Prescriptive - giving advice or instructions, being critical or directive
- 2. Informative - imparting new knowledge, instructing or interpreting
- 3. Confronting - challenging a restrictive attitude or behaviour, giving feedback
- 4. Cathartic - seeking to release emotion as weeping, laughter, trembling or anger
- 5. Catalytic - encouraging the patient to explore his own latent thoughts and feelings
- 6. Supportive - offering comfort and approval, affirming the patient's intrinsic value

6. Byrne and Long
The six phases of the consultation

- Description

1. The doctor establishes a relationship with the patient
2. The doctor discovers or attempts to discover the reason for the attendance
3. The doctor conducts a verbal and/or physical examination
4. The doctor, the doctor and patient, or the patient (in that order of probability) consider the condition
5. The doctor and occasionally the patient detail further treatment or investigation
6. The consultation is terminated, usually by the doctor

7. Stott and Davis (areas to explore)

the presenting problem

The main task of every consultation is to find and treat the reason for the attendance: the nature of the problem, the effect on the patient, the patient's ideas concerns and expectations and an answer to the question, Why now?

help-seeking behaviour

'Doctor' means teacher. Teaching the natural history of minor illness and about self-medication is an important part of a long-term strategy for making best use of practice resources. Patients may need to be reminded how to make appropriate use of the practice's appointment system or out-of-hours cover. Every doctor-patient encounter plants the seeds of future patterns of illness behaviour which will affect the over-use (and under-use) of medical services.

continuing problems

The GP, as the coordinator of the patients' health care, should consider reviewing any coexisting conditions at each consultation. The doctor's continuing interest in the patient's hypertension, diabetes, epilepsy or asthma is likely to produce better adherence to any management plans.

opportunistic health promotion

Health promotion can be improved by taking action when the patient attends for other reasons. Vaccination, cervical screening, blood pressure checks and enquiring and advising about smoking or drinking habits can often be done or at least suggested. The doctor should not, however, become overzealous and insensitive to the patient's needs and wants but it is usually possible at least to ask the patient back to see the nurse 'for a checkup' if a gap is spotted.

8. Helman (questions to be answered)

- Cecil Helman, an anthropologist, suggested that a patient with a problem comes to the doctor seeking answers to six questions:

1) **What has happened happened?** This includes organising the symptoms and signs into a recognisable pattern, and giving it a name or iidentity.

2) **Why has it happened?** This explains the aetiology or cause of the condition.

3) **Why has it happened to me?** This tries to relate the illness to aspects of the patient, such as behaviour, diet, body-build, personality or heredity.

4) **Why now?** This concern the timing of the illness and its mode of onset (sudden or slow)

5) **What would happen to me if nothing were done about it?** This considers its likely course, outcome, prognosis and dangers.

6) **What are its likely effects on other people (family, friends, employers, workmates) if nothing were done about it?** This includes loss of income or of employment, or a strain on family relationships.

7)**What should I do about it or to whom should I turn for further help?** Strategies for treating the condition, including self-medication, consultation with friends or family, or going to see a doctor.

9. Pendleton (the doctor's 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:
- **1. To define the reason for the patients attendance, including:**
- a) the nature and history of the problems
- b) their aetiology
- c) the patients ideas concerns and expectations
- d) the effects of the problems
- **2. To consider other problems:**
- a) continuing problems
- b) 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 patien patient in the management and encourage him/her to accept appropriate responsibility.**
- **6. To use time and resources appropriately**
- 1) in the consultation
- 2) in the long term
- **7. To establish or maintain a relationship with the patient which helps to achieve the other tasks.**
- These tasks might be paraphrased as: understand the problem, understand the patient, share the understanding, share decisions and responsibilities and maintain the relationship.

10. Neighbour(checkpoints)

- Neighbour - The Inner Consultation
- Neighbour proposed five checkpoints in the consultation:
- **1. Connecting:** have we got rapport?
- **2. Summarising:** could I demonstrate to the patient that I've sufficiently understood why he's come:
- **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:
- **5. Housekeeping:** Am I in good condition for the next patient? - stress, concentration and equanimity

11. Fraser (areas of competence)

- 1. Interviewing and history-taking
- 2. Physical examination
- 3. Diagnosis and problem-solving

For up to 50% of patients who present in general practice, a firm diagnosis based on pathology may not be possible. Where diagnosis at this level cannot be achieved, working diagnoses are often expressed at a lower level in terms of the patient's symptoms, signs or problems.

- 4. Patient management
- 5. Relating to patients
- 6. Anticipatory care (opportunistic)
- 7. Record-keeping

12. Calgary-Cambridge observation guide

- **A.Initiating the session**

i) Establishing initial rapport

ii) Identifying reasons for attendance

- **B.Gathering information**

iii) Exploring the problems

iv) Understanding the patient's perspective

v) Providing structure to the consultation

- **C.Building the relationship**

vi) Developing the rapport

vii) Involving the patient

- **D.Giving information - explaining and planning**

viii) Providing the right amount and type of information

ix) Aiding accurate recall and understanding

x) Achieving a shared understanding: incorporating the patient's perspective

xi) Planning: shared decision-making

- **E.Closing the session**

CSA "Model"

Data Gathering	Skills (how to do them)
History & Relevant information Past events (entries) Examination Drugs	Cues I.C.E. Health beliefs Red flags Agenda Open / closed questions Patient's understanding
Management plan	Communicating risk
Explain differential diagnosis Sharing management plan Appropriate treatment Follow up (explicit ie see in 5 days if no better) Safety netting Ensuring compliance & concordance	Sign posting Summarising
Interpersonal skills	
Connecting Rapport	

Small Groups

- Break to 4 groups
- Use one (ONLY) of the models to conduct your consultation
- Consultation to take no longer than 10 minutes
- We need a time keeper, doctor & patinet volunteers
- Other members of the group to write the description of what happened in line with the model they were using and present on behalf of the group