Chapter 12

Consultation models

Dr Teresa Pawlikowska, Colonel Jonathan Leach,
Sqn Ldr Peter Lavallee, Dr Rodger Charlton and Dr Jo Piercy

This chapter has been a labour of love written mainly by Teresa Pawlikowska. It is an area where there has been a vast amount of research and is vital to any book which seeks to instruct its readers in the consultation. It is important to know the history and how the different models have arisen. Jonathan Leach and Peter Lavallee have also contributed to several of the consultation models. Rodger Charlton has written about the Leicester Assessment Package, evidence-based medicine and complexity in the consultation and Jo Piercy has provided a useful conclusion to a long chapter.

Communication skills are unlikely to be perfect and may deteriorate with time for the practising clinician. Effective communication is essential to the current practice of medicine. Over the last 15 years it has been increasingly recognised as a core skill for clinicians. This has had an impact upon their interaction with patients but, of no less importance, it has influenced their contribution to the healthcare team settings in which they work, and the medical community as a whole. A fundamental change in medical culture in this area has been the recognition and acceptance of the fact that the way in which health professionals communicate, on all levels, can be enhanced, irrespective of the innate and learned abilities they already possess. This has been illustrated in the last 10 years with the inclusion of communication skills teaching in all undergraduate education, and a complete change in the educational processes surrounding the teaching and observing of doctor–patient interaction.

> Interactions or interviews between doctors and patients are the cornerstone on medical practice.[1]

The aim of this chapter is to introduce the reader to a patient-centred approach to the consultation by describing various models of the consultation considering the biomedical and psychosocial approaches and how they have evolved. Ultimately everyone will develop their own flexible consulting skills and be able to use elements of these various approaches both when consulting with patients and analysing their interactions.

This chapter is divided into the following sections.

- Definition of the consultation.
- Background to consultation models.

- Individual consultation models:
  - Weiner (1948)
  - Maslow (1954)
  - Balint (1957)
  - Berne (1964)
  - Byrne and Long (1976)
  - Stott and Davis (1979)
  - Helman (1984)
  - Pendleton (1984)
  - Neighbour (1987)
  - Fraser (1994)
  - Stewart *et al.* (1995)
  - Kurtz, Silverman and Draper (1996).
- Other issues and recent influences:
  - empathy, empowerment and enablement
  - evidence-based medicine
  - neuro-linguistic programming
  - narrative
  - complexity and the consultation
  - summary.
- Conclusion.

Definition of the consultation

The medical consultation is a two-way encounter between a doctor or a practitioner and a patient. This may be initiated by a patient when they are ill or by a doctor when instituting preventive medicine or screening. There are many different models and potential structures for these interactions and some of these models are discussed in this chapter.

Practical point

There is no ideal consultation model, but the evolution of the various models over time is of particular interest as a practitioner develops their own unique consulting style.

Background to consultation models

There are several different approaches to the consultation or models. They are all ways of understanding the reality of our experiences. All of the ways of looking at the consultation have their strengths and weaknesses; because of this you will find some more applicable than others when you come to consider a particular type of consultation. For example, a first consultation with a teenager requesting contraception will involve relatively more health promotion than a first meeting with an elderly lady who complains of tiredness and you suspect may be suffering from depression. Take a look at all of the models discussed here before you decide which ones fit best with your natural consulting style. Equally relevant is to

consider any unsatisfactory consultations which have made you feel uncomfortable, inadequate or stressed and ask why.

When the human system malfunctions, one will have a biomedical framework, which enables one to hone down on the presenting symptom, e.g. chest pain, to the relevant system (cardiovascular, respiratory, upper gastrointestinal tract, musculoskeletal) by using a structured approach to the patient's history. One may even be able to determine which human system is malfunctioning, but will probably discover little about the individual human condition with this approach and how that condition is affecting them. Evidence is accumulating that, without exploring the latter, a management plan may not be successful or gain the patient's concordance, let alone the chance of them returning to seek your opinion in the future.

> Patients may define success differently from health care professionals, and increasingly the public expects to get its definition of quality and benefit recognised. (Neuberger 1998)[2]

At the beginning of the 20th century the dominant image of a doctor was as a species of 'applied scientist' or engineer.[3] By the end of the 20th century it was evident that science and technology could not always provide a solution to people's problems, and that patients' unquestioning trust in medical professionals had been undermined by enquiries such as the Bristol and Shipman. Social change and the explosion of public access to information and alternatives means that we need to develop a wider view in order to help those who consult us and provide improved access and choice.

The pivotal contribution of the patient's history to the final diagnosis (82%) was pointed out more than a quarter of a century ago.[4] McWhinney in Canada,[5,6] and the growing body of researchers and teachers whose work is discussed in this chapter, have repeatedly drawn attention to the importance of going beyond a biomedical diagnosis to define and address the patient's agenda, and developing a patient-centred clinical method of consultation. By considering different approaches to the consultation, this will help you to reflect on your own experiences so that you can develop an open and flexible method of consulting with patients.

Individual consultation models

The consultation is an exercise in complexity. A number of approaches have been developed to enable us to reflect on the huge variety we routinely encounter in our professional lives. These models of the consultation have been developed by people who bring to their analysis their own experience and vision (e.g. as psychologists or anthropologists), and so the emphasis of each model differs. As a result you may find that a particular model, or group of models, can give you more insight into the analysis of a consultation, e.g. modification of health-seeking behaviour may be important when a usually fit young adult consults with an upper respiratory tract infection wanting antibiotics, but less relevant when a person with diabetes attends for their check-up in a chronic disease clinic.

In comparison with the relatively simple process of written communication, verbal and non-verbal communication is considerably more dynamic and complex, with a cycling of transfer of messages between the two or more parties.

Practical point

These complex situations still reduce down to include the same basic principles once the complex structure of the encounter has been unfolded.

Many authors have written extensively on the structure of the consultation with patients. As you will see these models range from being doctor-centred, such as Byrne and Long (1976),[7] through to the doctor and patient having a 'dialogue' and a greater sharing of responsibilities, such as Pendleton, Schofield, Tate and Havelock (1984).[8] A more in-depth structure to the consultation is provided by the Calgary–Cambridge Guide to the Medical Interview (Kurtz, Silverman and Draper 1998).[9]

Overarching approaches, e.g. Maslow (1954)[10] and Berne (1964),[11] are important as they have a wide application. Balint's work (1957)[12] opened up thinking on consultation dynamics. Contemporary models such as Stewart (1995, 2003)[13,14] Pendleton (2003)[15] and Kurtz (1996)[16] offer detailed frameworks for analysis and quality improvement. Models are not best used as theoretical checklists learned by rote. This can stunt style and the consultation dynamic. Instead, look at the summary table (Table 12.1) and consider which models are most meaningful to you. Greater detail is then provided of each model or you can refer back to the original referenced source if you wish.

The models and approaches included here are not intended to be an exhaustive list. Many of these models have evolved from work in primary care as GPs routinely see people with undifferentiated problems, where consultation skills are key to making a diagnosis and developing a management plan. Individual models and approaches are summarised in tabular form in Table 12.1 and are ordered chronologically.

Weiner (1948)[17]

Communication in its initiation by the sender and interpretation by the receiver is a cognitive process. This means that active reflection on the process of communication is one of the first steps to improving skills. The Shannon Model (1948)[24] which was modified by Weiner (1948), who introduced the feedback loop, is still taught as the basic model of the communication process. Reflecting on this simple model we can identify a number of key stages in improving our communication (*see* Table 12.2) which can be easily applied in the clinical setting.

Maslow: a hierarchy of human needs (1954)[10]

At first glance this may not seem an obvious model for approaching a consultation, but it deals with the fundamental reason of why a patient may feel they need to consult a doctor. Maslow was an American psychologist whose thinking has influenced education, business, social studies and medicine. He recognised

Table 12.1 Individual models of the consultation

Model or approach	Key structure	Comments
Weiner (1948)[17]	Initiation by the sender Interpretation by the receiver	Key steps in improving communication: information source, transmitter, receiver, destination, feedback, clarification, reflection
Maslow (1954)[10]	Hierarchy of human needs	Overarching theory Basic needs (physical, safety, love) must be satisfied before higher level needs can be addressed
Balint (1957)[12]	Doctor–patient relationship	Bio-psychosocial view Doctor as a 'drug' Active listening Hidden agenda Apostolic function of doctor Analysed GP case history dynamics
Berne (1964)[11]	Parent = authority Adult = logic Child = intuitive Transactional analysis Consultation is a 'game' of social interchange	Over-arching theory Simple accessible model Crossed transactions are dysfunctional
Byrne and Long (1976)[7]	Six phases of the consultation: • establishing a relationship with patient • discovering a reason for attendance • verbal and/or physical exam • consider the condition • detail treatment or investigation • terminate consultation	Research based in general practice Doctor = product and prisoner of own medical education Identified many doctor-centred authoritarian styles compared with patient-centred ones
Stott and Davis (1979)[18]	A Management of presenting problems B Modification of help-seeking behaviour C Management of continuing problems D Opportunistic health promotion	Theoretical framework Bio-psychosocial model For GPs in consultation and teaching

Table 12.1 Continued

Model or approach	Key structure	Comments
Helman (1984)[19,20]	1 What has happened? 2 Why has it happened? 3 Why has it happened to me? 4 Why now? 5 What would happen to me if nothing were done about it? 6 What are its likely effects on other people if nothing is done about it? 7 What should I do about it?	Patient-centred and holistic Derived from patient's narrative Illness has social meaning Anthropological viewpoint Holistic approach Lay theories
Pendleton *et al.* (1984, 2003)[8,15]	1 Understand the problem 2 Understand the patient 3 Share understanding 4 Share decisions and responsibility 5 Maintain the relationship	Patient-centred amd partnership model Framework for detailed analysis and feedback Derived from research in GP
Neighbour (1987)[21]	1 Connecting 2 Summarising 3 Handing over 4 Safety netting 5 Housekeeping	Patient-centred Promotes partnership Follows GP consultation flow Links organiser (analysis) with responder (intuition)
Fraser (1994, 1999)[22,23]	1 Interviewing/history taking 2 Physical exam 3 Patient management 4 Problem solving 5 Behaviour and relationship with patients 6 Anticipatory care 7 Record keeping	Patient-centred Addressing patient's ideas, concerns and expectations essential to make progress Unable to reassure or advise if patient's agenda is unexplored Enables detailed assessment of performance, and feedback
Stewart *et al.* (1995, 2003)[13,14]	1 Exploring both the disease and the illness experience 2 Understanding the whole person 3 Finding common ground 4 Incorporating prevention and health promotion 5 Enhancing the patient–doctor relationship 6 Being realistic (time, resources)	'Patient-centred medicine' Holistic, partnership model for clinical method, education and research
Calgary–Cambridge Observation Guide (1996)[16]	Basic stages of a consultation: 1 Initiating the session 2 Gathering information 3 Building the relationship 4 Explanation and planning 5 Closing the session	Patient-centred and collaborative model Underpinned by a detailed framework of skills

Table 12.2   Key steps in improving communication

Step 1	**Information Source**	Consider what is the purpose of the communication. What is it that needs to be communicated? What is the content of the message to be created?
Step 2	**Transmitter**	What is the best format for the message to prevent misunderstanding? (The mouth (sound) and body (gesture, writing).) What is the best format for the receiver? Treating a message (spoken or written word) or making a signal.
Step 3	**Receiver**	Consider the other party in the communication (patient, manager, colleague). What barriers (noise) might you need to overcome to ensure effective receipt of the message (e.g. visual/hearing impairment)?
Step 4	**Destination**	Considering the other party, what barriers might you need to overcome to ensure correct interpretation of the message (e.g. language, cultural, emotional [depression, fright, stress], hidden agenda, intelligence, recall)? Noise – anything which obscures the message and can act at any stage to prevent the receipt and understanding of the message as intended by the transmitter.
Step 5	**Feedback**	Monitor for feedback – verbal or physical reaction that indicates understanding (e.g. smile, nodding) or misunderstanding (frown), poor reception (anger, withdrawal), etc.
Step 6	**Clarification**	Verbal checking that you have correctly interpreted the (non-verbal) feedback, e.g. was there anything about what I said that made you feel unhappy?
Step 7	**Reflection**	Reflect upon the communication – was it successful? Could it have been improved and, if yes, how?

the importance of a holistic approach: to emphasise the whole person, their culture and environment. He was able to integrate the views of behaviourists (that all things are learned), Freudian analysts (where instinct is paramount) and humanists.

He argued that all humans had needs, which were 'the essence of their lives'. These human needs can be classified as a 'hierarchy of needs' using a pyramidal concept where fundamental needs are at the bottom of the pyramid and must be fulfilled before a person can address fulfilment at the next level:

Self-actualisation
(true to own nature)
Esteem/self-respect
Love/affection/belongingness
Safety (security/stability/reduced anxiety)
Physical needs, for example, air, food and water

In the pyramid model higher needs are later evolutionary developments, and so they can develop later in an individual although their fulfilment creates greater happiness and individual growth and require a better external environment. Lower needs in the pyramid must be fulfilled. For example, a parent in temporary bed and breakfast accommodation who repeatedly presents their child with acute temperatures, coughs and colds (biomedically 'acute minor illness') may be unreceptive to self-management advice (which demands high self-respect and esteem to put into practice) as they are focused on concerns that basic physical needs (adequate food and warmth, etc.) and shelter needs (stable housing and finances) are not being met and may underpin the ill health of their child.

Communication, and consultation in particular, is a complex human interchange and Maslow's theory spans the many threads that make up our humanity. Maslow's hierarchy of needs remains a powerful overarching holistic approach to analysis in many fields, not least that of consulting with patients.

Practical point
Holistic medical care is an approach which considers all aspects of a person's health, including the physical, psychological, emotional, social, spiritual and cultural.

Balint: the doctor, his patient, and the illness (1957)[12]

This was a pioneering approach to the general practice consultation. Balint looked at transference and counter-transference in the consultation. Most importantly Balint commented that doctors have feelings and those feelings have a function in the consultation. He also highlighted that psychological problems are often manifest physically and even physical disease has psychological consequences.

Balint's work changed the landscape for consultation in primary care. He was a Hungarian refugee who worked as a psychoanalyst in London. He felt that a system based solely on biomedical diagnosis was inadequate for the task of the consultation. Balint, together with his wife, worked with a group of 14 GPs. They used case discussion and feedback to enable doctors to work with a dynamic bio-psychosocial view. They also created a training programme to enhance the capability of the GPs for 'practical brief psychotherapy' in consultation.

Balint gave us a better understanding of the emotional content of doctor–patient relationships.

- He emphasised the doctor's pivotal role in trying to make sense of undifferentiated illness (e.g. a patient who says, 'I'm tired all the time ...'). Balint stated that, 'Medical history taking means collecting answers to our well tried set of questions' and so '[The doctor] ... will always get answers – but hardly anything more', unless the doctor works from a wider **bio-psychosocial perspective**.
- He highlighted the importance of **active listening** (being sensitive to the patient's cues), to enhance understanding of the patient's view.
- The 'ticket of entry', i.e. the reason for attendance, might not be the symptom initially offered, when, with one hand on the door, as the patient is ostensibly leaving, they reveal a second problem which is the real source of their anxiety

('While I'm here, doc ...'). It is the doctor's response to this statement which can allow the patient to reveal their possible '**hidden agenda**'.

- Balint pointed out that advice and reassurance are the two most common forms of psychotherapy used by clinicians in daily practice. However, you can neither advise nor reassure the patient before you have found out what their **real problem** is.
- He described the '**doctor's apostolic function**': an expression of the doctor's individual way of dealing with his/her patients, and their unrealistic expectation of the patient based on their own values. For example, the patient presents with a problem, 'I've been off sick with a cold for a week and I'd like a sick note'. The doctor has a number of possible responses ranging from:
  a 'You can self-certify if you have had a minor illness, and you don't need to see a doctor' to
  b 'Tell me more about what happened and why you need a sick note.'
  In consultation (a) the patient has to accept the doctor's faith and commandments, and be 'converted' (usually superficial), or to reject them and argue, or go to another doctor (b) who is more flexible and will explore the patient's underlying need, instead of merely quoting chapter and verse.

Balint pointed out that avoidance of self-examination and apostolic fervour are often linked. All doctors have limitations and need to be aware of them. No-one is omniscient and the *Good Medical Practice* booklet (General Medical Council 2002) demands that we do not extrapolate beyond the bounds of our capability.

Practical point
How the doctor elicits the reason for a patient's visits and reacts is critical to determining the course of events.

In the 1950s, Balint, to some a prophet, to others the messiah, viewed the '**doctor as a drug**'. He said:

> no pharmacology of this important drug exists yet. No guidance whatever is contained in any textbook as to the dosage in which the doctor should prescribe himself, in what form, how frequently, what his curative and maintenance doses should be.

He went on to say that:

> there is a lack of any literature on the possible hazards of this kind of 'medication', the various 'allergic' reactions an individual may encounter and any undesirable side-effects.

A criticism of Balint's approach is that although it explores the doctor–patient relationship, it remains doctor-centred. Most doctors can identify with elements drawn from the case histories he analysed, and so this framework is of practical help. As students start their consulting career they may be quite doctor-centred and so widening their scope using this approach will be useful.

Balint also recognised that patients can arouse feelings in their doctors (e.g. of anger or despair) and if doctors acknowledge those feelings, they can be used in the consultation dynamic to benefit the patient:

> The patient is in real need of help, the doctor honestly tries his hardest – and still, despite sincere efforts on both sides, things tend obstinately to go wrong.

All patients 'offer' doctors their various needs, and doctors 'respond' to them. Balint's approach is to help doctors become more sensitive to what is going on, consciously or unconsciously, in the consultation. His legacy continues (nationally and internationally) in the form of Balint Groups, which GPs can join locally to explore their consultations using the framework he developed.

Berne: games people play (1964)[11]

This approach continues the application of psychoanalytical principles to the consultation. Berne used the framework of 'transactional analysis' to provide an overview of what is happening in the interaction between doctor and patient. He qualified as a doctor in Canada, and then became interested in psychoanalysis in the United States. He developed a theory of social interchange called **transactional analysis**.

When people meet, the options for interaction are (ordered in terms of increasing complexity):

1 rituals
2 pastimes
3 games
4 intimacy
5 activity (which may support any of the above).

Social interchange e.g. a consultation, usually takes the form of 'games'. The goal of each participant in the interaction is to obtain as many 'satisfactions', gains or advantages as possible from his or her transactions with others. According to Berne's theory the aim of any social contact is to achieve somatic and psychic equilibrium.

Practical point
A person's body language and the quality of conversation relate to a state of mind called an 'ego state': a coherent system of feelings, related to a coherent set of behaviour patterns.

Berne distinguished **three different ego states**, which could be inconsistent.

- Parent – authority figure. Critical and caring, can make some responses reflex but streamlines routine decision making, conserves time and energy.
- Adult – logical, autonomous, objective appraisal of reality. Essential for data processing and risk assessment. Regulates and mediates between the other two states.
- Child – relics of behaviour fixed in childhood: intuition, creativity, spontaneity and enjoyment.

At any instant a person will be acting as one of the above, but he or she will shift through the spectrum of each ego state in time, although individuals differ in their flexibility.

All three states are needed for survival, but problems are due to an imbalance, which can be dealt with by using this analytical model and restoring the equilibrium.

Practical point

At any given moment we think, feel and have attitudes as if we were either a critical or caring Parent, a logical Adult or a spontaneous/dependent Child. Many consultations are conducted with a Parental doctor and a Child-like patient, but this transaction is not always in the best interests of either the patient or doctor.

A conversation, such as a consultation, is a 'transaction' in this model. The person starting the conversation is called the 'agent' and their opening remarks the 'transactional stimulus'. This will provoke the 'transactional response' from the other participant. Using **transactional analysis** you can classify remarks, e.g.:

'Can I have something for my cold, doctor?'
The doctor prescribes.

These transactions are complementary: patient = child (make it go away), doctor = caring parent (fixes it) responses are as expected, and conversations can proceed smoothly, but possibly erroneously!

Conversely communication may be more challenging, when an adult-to-adult transaction occurs, e.g.:

'Can I have something for my cold, doctor?'
'Tell me more about it; what were you expecting from me?'
'I'm worried about re-organisation at work and I need to be on top form for a meeting tomorrow . . .'

The naïve child:parent interaction is transformed by changing the dynamics and asking the patient to give a more adult view of his/her needs, concerns and expectations, resulting in a more balanced adult:adult interchange where self-management and the role of antibiotics can be discussed in context.

Practical point

This analysis of the consultation can be very helpful when you find yourself getting uncomfortable and stressed by a particular type of interchange or patient.

You may assume that as a professional you are going to be the caring parent (on an authoritarian doctor-centred model), or an adult in an exchange of equals (on a patient-centred co-operative model), and it may be uncomfortable to find yourself as the 'naïve' child.

Berne's book offers a thesaurus of 'games people play' – examples from everyday life to the consulting room. The basic principles are easy to remember, and you may use some of them on a daily basis yourself.

Byrne and Long: doctors talking to patients (1976)[7]

Byrne was a professor of general practice at Manchester University; his collaborator Long was an educationalist. They analysed verbal behaviours in tape recordings of doctors in consultation with almost 2500 patients. They concluded that the doctor was 'both a product and a prisoner of his medical education' and authoritarian teaching and role-models fostered a predominance of doctor-centred behaviour, which did not enable doctors to deal with the psychosocial components of patients' problems. In this they echo Balint's findings of the 'Apostolic function' of doctors.

GPs seemed unable to engage with psychological disease or the psychological aspects of disease, and 'worked through a frame of reference which required both patients and illnesses to fit a pre-judged pattern ... which has a great deal to do with the ways with which doctors learn to cope with the diagnosis of organic illness', i.e. working solely from a biomedical model. They commented that few doctors at that time could reflect on the dynamics and process of the consultation: What are you doing? How are you doing it?

The study by Byrne and Long recognised six phases by the doctor in the process of consultation.

I   Establishes a relationship with the patient.
II   Attempts to discover, or actually discovers, the reason for the patient's attendance.
III Conducts a verbal or physical examination or both.
IV   The doctor, the doctor and the patient, or the patient (in that order of probability) consider the condition.
V   The doctor, and occasionally the patient, details further treatment or further investigation.
VI   Ending the consultation.

I   Relating to the patient

Usually this can be completed relatively quickly, e.g. 'Hello, Mrs Biggs, I'm Chris Edwards, a medical student sitting in with Dr Smith ...' Many doctors will use a similar form of words for most patients – you will need to develop your own which is informative, welcoming and professional. e.g. 'Hello, Mrs Baker, I'm Catherine Adams, a medical student working with Dr Holden. He has suggested that I talk to you before you see him – is that all right?'

II   Discovering the reason for the patient's attendance

Variable length: 0–8 minutes.

This is usually preceded by an open question, e.g. 'How are you? How can I help?'

The following variables influence the time a doctor spends in phase II:

- the degree to which the doctor is prepared to accept the first thing a patient says
- the degree of clarity with which the patient presents his or her symptoms

- the number of patients preceding, and waiting
- the degree to which the doctor is weighted towards organic illness
- the doctor's beliefs about him or herself and about his or her patients.

III   A verbal or physical examination

This varies according to the type of consultation but is a chance to clarify and enhance bio-psychosocial information, and the patient's ideas, concerns and expectations, flagged up in phase II. Time spent on the physical examination can be used to further the doctor–patient relationship by talking the patient through what you are doing and why.

IV   Consideration of the patient condition

This needs to be flexible and patient-centred and reaching a consensus at whatever level the patient requires. It is necessary to place before the patient the information that has been gained in this, and in previous consultations (personal experience or by looking at patient notes and computer records), along with other related information that the doctor may feel important. This will help to establish a consensual approach to the subsequent stages of the consultation and future management of the patient's condition. The study classified this phase as 'optional', i.e. it differed between patient-centred and doctor-centred behaviour.

V   Detailing treatment or further investigation

Ensure this is tailored to the patient and takes account of their health beliefs. Look out for the fact that in 8% of consultations this is the point at which the patient reveals their true agenda. 'Thanks for the antibiotics, doc; will they affect my periods as I'm a week late already and I'm worried I might be pregnant . . .', or 'While I'm here . . .'. This can create a feeling of frustration on the part of the doctor, who, just as s/he feels s/he is completing a successful consultation, needs to re-orientate and start again. It helps to be prepared for the inevitable. This phase showed the greatest variation between doctors.

VI   Ending the consultation

In 90% the doctor initiated this, e.g. saying goodbye, handing over the prescription and perhaps getting up. Again the doctor usually develops a personal routine.

Practical point

Byrne and Long comment that it was relatively easy to derive these steps but much more difficult to put them in a logical order. This is a common issue with both models and actual consultations. It stems from the natural ebb and flow of human conversation, which is not necessarily linear.

It serves to highlight the reasons why any of these models should not be used in the manner of a sequential checklist, which would lead to a rigid

inflexible consulting style. This chapter is trying to promote a review of potential approaches and adoption of those that feel appropriate and natural for the individual practitioner or lead them to review their present consulting style.

Byrne and Long also made a detailed analysis of consulting styles with transcribed examples, and developed a classification and scoring system for doctor-centred and patient-centred behaviour together with negative (rejecting or closing) behaviours. One should be able to identify with the origins of this framework rooted in the **biomedical model**:

- history taking
- examination
- diagnosis
- treatment.

Practical point

It is worth exploring a model further if you feel that model is one which you can recognise in terms of the way you consult.

In any consultation there are normally two parties – the doctor and the patient. Although the doctor has special skills and experience, it is wise to remember that the patient also has a unique pattern of knowledge and experience and that any consultation is made up of a mixture of the patient and the doctor.[7]

This detailed study described a logical sequence of medical procedures, and distinguished between 'doctor-centred' and 'patient-centred' styles. It provided the foundation from which later models were developed.

Stott and Davis: the exceptional potential in each primary care consultation (1979)[18]

Building on the theme of widening the brief discussed so far and promoted by evolving wider definitions of general practitioners, Stott and Davis, working in the Department of General Practice at the Welsh National School of Medicine, published a theoretical framework in which they described four areas that could profitably be explored in routine surgery consultations and also used for teaching.

A Management of presenting problems.
B Modification of help-seeking behaviour.
C Management of continuing problems.
D Opportunistic health promotion.

A   Management of presenting problems

This is the main activity, where the doctor seeks to define the 'reason for attendance' formulated in bio-psychosocial terms, the effect on the patient and the patient's ideas, concerns and expectations.

B Modification of help-seeking behaviours

Patients may need advice, information and support in managing some problems themselves, e.g. people with uncomplicated colds, parents with young children who develop acute viral illnesses. Doctors can teach patients 'to be more realistic about what (they) can or cannot treat effectively'. There is also a long-term agenda here of resource management.

C Management of continuing problems

For example, following up obesity and hypertension in a person who has ostensibly become focused on his diabetes.

D Opportunistic health promotion

'Offering advice about diet, exercise, habits or relationships ... to help patients make appropriate lifestyle choices', e.g. discussing contraceptive needs, smoking and diet when a mother comes for her post-natal check, or smoking, weight and cholesterol when checking blood pressure in a hypertensive. Stott and Davis note that this implies mutual adult respect (an 'adult to adult' interaction as in the Berne model, not a 'parent to child' one).

Practical point

Consider how you would broach the subject of smoking cessation using this information.

Stott and Davis recognised that B and D are often areas which are neglected by doctors, and suggested that they could be considered as working in a longer time frame, the end product of multiple consultations or **continuity of care**.

The virtue of this model is that it 'can be easily memorised, understood and used'. It is task-orientated to maximise the opportunity of a consultation to provide comprehensive care.

Helman: culture, health and illness (1984)[19,20]

Cecil Helman is a medical anthropologist and GP who came to the UK from South Africa. His book *Culture, Health and Illness* was first published in 1984 and focused on the contribution of anthropology to understanding health problems and their management in a variety of cultures.

'Doctors and their patients, even if they come from the same social and cultural background, view ill health in very different ways.' The success of the consultation depends on bridging these two positions.

Practical point

Anthropology is the study of human beings and their many different cultures. It is the holistic scientific study of mankind answering the question, 'What is man?'

Helman describes medical school students who are encultured into an applied science; they study the phenomena of sickness and health. Occurrences are subjected to rational objective measurement, and become facts, a 'biomedical consensus statement'. As 'all facts have a cause', the clinician's role is to discover the chain of causal events and so provide a diagnosis, prognosis and management.

Practical point

If this is not possible the problem is labelled **idiopathic** (science underdeveloped and as yet unable to provide an explanation) or **psychogenic** (driven by the mind, not the body, and beyond the remit of such clinicians).

Another layer of complication is that even within the medical profession there are huge differences in emphasis and approach between, e.g., GPs and public health doctors (the individual and the community), surgeons and psychiatrists (the body and the mind). In addition doctors, as members of society, carry with them their own baggage of assumptions, ideas and prejudices from their past personal experience which influence their practice, as discussed by Balint, and Byrne and Long.

Practical point

The **biomedical model** has difficulty accommodating the feelings, beliefs and psychosocial issues (as they are difficult to quantify) which colour the personal experience and meaning of health and illness.

Helman points out that the explosion of technology has made doctors **reductionist**, e.g. focusing on a group of genes that create disease.

Helman states that a patient's view of being **unwell** is more global. **Illness** is the subjective response of an individual and those around him/her to his/her being unwell; particularly how he/she and they interpret the origin and significance of this event. Also how it affects his/her behaviour and his/her relationship with other people; and the various steps he/she takes to remedy the situation. It not only includes his/her experience of ill health, but also the meaning he/she gives to that experience. As this is related to an individual's social and cultural background, together with their personality, the same disease may produce a completely different picture in people whose backgrounds differ.

Helman points out that the individual's response to 'illness' is one of a repertoire of responses to adversity, e.g. a burglary, and so has psychological, moral and social components.

Using this holistic approach, 'a person is defined as being ''ill'' when there is agreement between his/her perceptions of impaired well-being and the perceptions of those around him/her ... becoming ill is always a social process'. Contrast this with the narrower biomedical view. The consultation between patient and doctor needs to acknowledge these frames of reference, and the participants need to actively work to build on what they bring to the consultation to produce an integrated individualised outcome: **patient-centred medicine**.

Helman states that each culture will have its own language of distress, which integrates subjective experience, and social acknowledgement of ill health. The doctor needs to recognise the significance of verbal, non-verbal, somatic, or psychological cues within the consultation.

The doctor's way forward is to consider the **patient's story or narrative**, which may cover the following.

1 **What has happened?** The person organises their symptoms and signs into a recognisable pattern, and gives it a name or identity.
2 **Why has it happened?** This explains the cause of the condition.
3 **Why has it happened to me?** Attempts to explain the illness in personal terms, e.g. behaviour, diet, heredity factors.
4 **Why now?** Factual and related to life events, e.g. job loss, the anniversary of a relative's death.
5 **What would happen to me if nothing were done about it?** Considers likely course of events and possible outcomes.
6 **What are its likely effects on other people if nothing is done about it?** Strain on family, implications for work and income.
7 **What should I do about it?** Ranging from self-help, seeking the opinion of family and friend, or consulting a doctor.

Practical point
The pathway to a successful consultation requires negotiation between the patient's and doctor's models of the presenting problem, which provides a consensus on diagnosis, treatment and management.

Using this approach unsatisfactory/dysfunctional consultations can occur when:

● inappropriate emphasis is placed on the individual (when there is an underlying family problem)
● there is misinterpretation of the language of distress (emotion is equated with hypochondria by the doctor)
● patient and doctor models are incompatible
● there is disease without illness (treating a biochemical abnormality in a 'well' person
● there is illness without disease – the patient has ongoing symptoms but 'your tests are all normal'
● there are unrecognised and unresolved differences in terminology, treatment and context between patient and doctor.

Helman suggests the following **strategies for improvement**.

1 **Understanding the patient's meaning of illness** (in contrast to labelling the disease with a diagnostic category).
2 **Improving communication** – recognising the 'language of distress' of your patients.
3 **Increasing reflexivity** – be aware of where you are coming from (your culture, values, prejudices).

4 **Treating illness and disease** and also the patient not just the pathology.
5 **Respecting diversity** (there is usually an alternative model or explanation).
6 **Reflect on the context** – the patient's internal context and the setting of the consultation itself. What are the wider influences and where is the balance of power? Indeed should there be a balance of power?

Practical point

Helman promotes a holistic approach centred on the patient's narrative (see later) and emphasises lay theories of illness, which involve the individual, the natural world, the social world, and even the supernatural world in contrast to a purely medical one.

Pendleton: the tasks of the consultation and cycle of care (1984, 2003)[8,15]

Pendleton is a social psychologist working at the University of Oxford, and together with three GPs (Schofield, Havelock and Tate) have a complementary diversity of interests and experience. Pendleton set out to build on the above approaches, and develop a framework useful for both learning and teaching. This has resonated with advances in technology and teaching by analysis through both video and role-play. Although their work was originally published in 1984,[8] it is ongoing and this is why reference is given to the updated 2003 version[15] for a detailed account.

The 'Pendleton' model of the consultation

The seven '**tasks**' to be achieved in a consultation which originate from the patient's needs and the aims of the doctor are as follows.

- **Understand the problem** and so understand the reason for attendance in terms of the patient's problem and perspective through the doctor and patient having a '**dialogue**'.
  1 To define the reasons for the patient's attendance, including:
     i   the nature and history of the problems
     ii   their aetiology
     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 To choose with the patient an appropriate action for each problem.
- **Understand the patient**.
  4 To achieve a '**shared understanding**' of the problem with the patient.
- **Share decisions and responsibility.**
  5 To involve the patient in the management and to encourage and **enable** him or her to accept appropriate responsibility. Agree the actions and responsibilities for the doctor and patient in relation to targets, monitoring and follow-up.

  6 To use time and resources appropriately (both in the consultation and in the longer term).
  7 To establish or **maintain a relationship** with the patient which helps to achieve the other tasks and consider other problems not yet presented (a '**hidden agenda**'), ongoing problems and risk factors.

Practical point

Their original model moved away from an authoritarian biomedical stance, and emphasised that an effective consultation was one in which patient and doctor both worked co-operatively to define problems and their management.

This model has been developed to focus on both patient and doctor dynamics in the consultation. The essence of the consultation was not only to identify and meet patients' needs, but also to enhance their understanding and ability to manage their own health and so **patient enablement**.[25] Each consultation reinforced a '**cycle of care**'.

Doctors are encouraged to assess their own consulting style and develop insight into their feelings, attitudes, strengths and weaknesses – similarly, to be more aware of their mood, health, availability of time and organisational issues which may lead a doctor to react positively or negatively to a patient's issues. There are long-term outcomes for the doctor of job satisfaction, and those of the patient of adherence to a suggested management, satisfaction and a change in health.

To address **the issue that doctors do not always achieve a shared understanding**, Pendleton suggests the following.

1 **Before considering a prescription** always ask, 'Do you want me to give you something for this?'
2 **Before a prescription for an antibiotic** ask, 'What do you feel about taking/giving your child an antibiotic?'
3 **Before giving your diagnosis** ask, 'What thoughts have been running through your mind?'
4 **Before embarking on an explanation** ask, 'What do you understand about . . . ?'

Practical point

Since 1984 the development of this work has made a major contribution not only to analysis but also to teaching. Apart from defining the components of a successful consultation this approach explicitly supports a **patient-centred partnership model**.

Neighbour: the inner consultation (1987)[21]

This is a pragmatic holistic model developed by a general practitioner, trainer and examiner. It looks at what is going on within the consultation and doctor behaviours. The five stages are easy to remember and practise as they follow the natural flow of a good consultation.

1 **Connecting** – Have we got rapport? Establishing a rapport and getting on the same wavelength as the patient.
2 **Summarising** – Do I really know why the patient has come? Not only the reason for attending but also the patient's ideas and concerns regarding his/her problem and their expectations of what I can do about it.
3 **Handing over** – Sharing information. Has the patient understood and accepted the management plan we have proposed? Having assessed the problem and formulated a diagnosis (or problem list), and negotiated and agreed a management plan.
4 **Safety netting** – Have I anticipated all the likely outcomes? Manage uncertainty: anticipate likely outcomes and discuss them; look at probabilities and weigh up risks. Organise an appropriate time for follow-up.
5 **Housekeeping** – Am I in good condition for the next patient? Am I stressed? I need to be receptive to the next patient and in a position to offer 'a caring and compassionate state of mind uncontaminated with … personal preoccupations'. A doctor needs to be psychologically 'fit' for the next consultation and not transfer feelings from the previous one.

Neighbour identifies a pathway to improve your consultation skills by:

- **goal setting** – 'fixing in the mind at the start a clear idea of end point, the outcome, the result you are wanting to achieve'
- **skill building** – 'the process of anticipatory training in the repertoire of component skills you require to achieve the outcome'
- **getting it together** – 'well-intentioned and well-rehearsed, all that is needed is for you to rely on the adequacy of your preparation and give yourself over to the inspiration of the moment, trusting your intuitive and unconscious processes to function appropriately and automatically!'

Practical point

An unfortunate side effect of consultation skills analysis and modelling is to cause a mental distraction. You are trying to focus on the patient, but in parallel you are trying to discern what you should be doing 'in theory'.

Neighbour addresses this 'inner consultation' explicitly with the aim of freeing your intuitive input, to work in parallel with your knowledge to improve the consultation. The image Neighbour uses is of the doctor in consultation as having two heads – one labelled with 'theory', one with 'practice'.

The way that Neighbour's model reflects others can be summarised in a table referred to as the Health Belief Model and this can be viewed in Neighbour's book.

The Inner Consultation is short and easy to use. It provides a basis for understanding the dynamics of the patient–doctor interchange and the resultant internal dynamics of the doctor.

In Neighbour's book he also discusses, at length, how to identify non-verbal cues from patients during the consultation. These cues are certainly worth looking for as they can be the key to identifying the patient's hidden agenda or main reason for attending.

The Leicester Assessment Package (LAP)[22,23]

The LAP is an assessment model with seven prioritised categories of consultation competence as detailed below with the relevant weightings of each.

1   Interviewing/history taking (20%).
2   Physical examination (10%).
3   Patient management (20%).
4   Problem solving (20%).
5   Behaviour/relationship (10%).
6   Anticipatory care (10%).
7   Record keeping (10%).

In the undergraduate setting the LAP utilises the first five categories which have 35 component competences. Fraser *et al.*, who developed the LAP, state that to be able to cope with the varied tasks of a consultation and the associated challenges presented by patients, the clinician needs to master a broad range of skills within these categories.

The assessment of competence can be based on a systematic observation of performance. The seven categories of the LAP as an assessment tool and so a model for teaching and assessing consultation competences has been demonstrated to be valid, reliable and feasible in the setting of general practice (Fraser *et al.* 1994).[22]

This assessment process can be used as a model to teach the consultation through feedback which involves the generation, collection and interpretation of evidence which is compared with valid performance criteria. Such a comparison forms the basis of a judgement which infers competence or otherwise.

The assessment grades for the LAP are as follows.

- A grade – consistently demonstrates mastery of all components (80% or above).
- B grade – consistently demonstrates mastery of most components and capability in all (70–79%)
- C+ grade – consistently demonstrates capability in almost all components to a high standard, and a satisfactory standard in all (60–69%).
- C grade – demonstrates capability in most components to a satisfactory standard: minor omissions and/or defects in some components. Duration of most consultations appropriate (50–59%).
- D grade – demonstrates inadequacies in several components but no major omissions or defects (40–49%).
- E grade – demonstrates several major omissions or defects; clearly unacceptable standard overall. (0–39%).

In relation to calibration of this assessment tool, it can be argued as to what constitutes a 'major omission or defect', as opposed to a 'minor omission'.

The overall aim of the LAP is to help students and doctors further develop the consultation competences required to define and manage the health problems of patients.

Practical point
The LAP seeks to assist students 'to recognise, adopt and develop those clinical skills and values that are fundamental to the practice of rational and humane clinical medicine, whatever the clinical setting'.

For any of the models described they may be adapted for use in assessment and so like the LAP provide feedback to allow the student or doctor to further improve their consultation skills. However, it should be stated that it was Hager *et al.* in 1994 who wrote:

> There is no such thing as a process of assessment that is without its critics. Whatever efforts are made to improve assessment someone is bound to be unhappy with the process.[26]

Stewart et al.: *patient-centred medicine (1995, 2003)*[13,14]

This approach has evolved from the ongoing work of the Patient–Doctor Communication Group at the University of Western Ontario, Canada, in 1986. There has been a long history of research by members of the department into the patient–doctor relationship, which has informed the development of the '**patient-centred clinical method**'. McWhinney[5] drew attention to the fact that patients' problems had both breadth (bio-psychosocial elements) and depth (personal meaning). This holistic, patient-centred view is a cornerstone of the model[25] which is also explicitly co-operative. There are six components to the model where component 3 is central to the six components of doctor–patient interactions.[14]

1 **Exploring both the disease and the illness experience:**
   • history, physical, laboratory tests
   • dimensions of illness (feelings, ideas, effects on function and expectations).
2 **Understanding the whole person:**
   • the person (e.g. life history, personal and developmental issues)
   • the proximal context (e.g. family, employment, social support)
   • the distal context (e.g. culture, community, ecosystem).
3 **Finding common ground:**
   • problems and priorities
   • goals of treatment and/or management
   • roles of patient and doctor.
4 **Incorporating prevention and health promotion:**
   • health enhancement
   • risk avoidance
   • risk reduction
   • early identification
   • complication reduction.
5 **Enhancing the patient–doctor relationship:**
   • compassion
   • power

- healing
- self-awareness
- transference and counter-transference.

6 **Being realistic:**
- time and timing
- teambuilding and teamwork
- wise stewardship of resources.

The framework clearly addresses both the patient's agenda and experience of illness and the doctor's agenda (bio-diagnostic) and it has been widely influential in education and research. There are parallels with the Pendleton[15] and the Calgary–Cambridge[16] approaches which are contemporaneous.

The group also highlighted the need to find out why the patient was presenting at that time. Another way the patient-centred model can be summarised is as **ICEE** (Illness Framework) as follows where the doctor explores the:

- patient's **I**deas (I) about what is wrong
- patient's feelings/**C**oncerns about the illness (C)
- impact/**E**ffect of the patient's problems (E)
- patient's **E**xpectations about what should be done (E).

This is the same as ICE referred to throughout the book with an extra 'E' for the Effect or impact of the patient's problems.

Practical point
Patient-centred clinical method – the doctor should elicit and work through the patient's agenda and also be aware and careful of their own agenda and how this can influence the outcome of the consultation.

Kurtz, Silverman and Draper: the Calgary–Cambridge observation guide to the 'Medical Interview' (1996)[16]

This is an approach or structure to teaching and learning communication skills, which was developed jointly at these two universities by experienced educators to support both undergraduates and continuing medical education for qualified practitioners. The emphasis is on core communication skills, which then form a foundation for addressing attitudes and issues encountered in practice.

Riccardi and Kurtz (1983)[27] noted that accuracy, efficiency and supportiveness were goals that doctors attempt to achieve in consultations. Further work by Kurtz (1989)[28] identified generic principles for good communication:

- interactions
- reduce uncertainty
- planned outcomes
- recognise the dynamics of the consultation itself
- mutual interaction of the individuals involved.

The Calgary–Cambridge method is based on '**a patient-centred approach that promotes a collaborative partnership**'.[29] It explicitly seeks to move away from medical paternalism; however, because of the nature of the framework, this model 'concentrates on what doctors can do in the interview to facilitate their patients' involvement'.

There are five main tasks in this framework.

1 Initiating the session.
2 Gathering information.
3 Building the relationship.
4 Explanation and planning.
5 Closing the session.

Seventy individual skills are listed in the guide, but this is a summary of the actions covered in most consultations.

1 **Initiating the session:**
   - establishing initial rapport
   - identifying the reason(s) for the consultation.
2 **Gathering information:**
   - exploration of problems (including active listening, facilitation, and open questioning)
   - understanding the patient's perspective (covering ideas, concerns, expectations and effects on the patient's life)
   - providing structure to the consultation (summarising, sequencing, signposting and timing).
3 **Building the relationship:**
   - developing rapport (empathy, support and sensitivity)
   - involving the patient.
4 **Explanation and planning:**
   - providing the correct amount and type of information
   - aiding accurate recall and understanding
   - achieving a shared understanding incorporating the patient's perspective
   - planning: shared decision making
   - options in explanation and planning if:
     – discussing opinion and significance of problems
     – negotiating mutual plan of action
     – discussing investigations and procedures.
5 **Closing the session:**
   - including summarizing, contracting and 'safety netting' (Neighbour[21]).

The framework builds on previous models from a patient-centred stance. Each skill is discussed in terms of the evidence supporting it, and a variety of words and ways are discussed by which the goal of an effective consultation may be achieved. It is a model which makes the:

- what?
- why?
- how?

of communication with patients explicit.

Practical point
All of these models of approaches to consulting with patients are holistic. They aim to facilitate patient-centredness and partnership. Their structure and emphasis relates to the work and background of their originators.

Other issues and recent influences

More recently shifts in ideas and emphasis have occurred which will increasingly impact on consulting with patients.

Empathy, empowerment and enablement

Without an empathetic doctor none of the models above really work. **Empathy** is the ability to put yourself in the patient's place and act accordingly.

Practical point
Empathy is more than just an intellectual appreciation of the patient's situation; it is a blend of understanding and caring, which is evident to the patient in your actions and words.

Empathy supports the therapeutic relationship between patient and doctor. It is the cognitive and behavioural aspect of compassion and care. There is evidence that patients recognise and respond to empathy, that it improves satisfaction, diagnostic accuracy and outcomes.[30] Empathy involves engaging emotion, difficult when doctors are schooled in the application of objectivity, that can lead to a degree of professional 'detachment'. Empathy can be enhanced by training. It is a key component of a patient-centred approach.

Empowerment is a global movement. In the UK patient empowerment has been embodied in the NHS Plan (2000): '. . . patients will have a real say in the NHS. They will have new powers and more influence over the way the NHS works'. This includes advocacy, more representation, more information for patients and greater patient choice. Moving towards a patient-centred approach from an authoritarian/paternalistic one is required in the 'new' NHS.

Practical point
Most of the approaches above involve seeing a problem through the patient's eyes, addressing their ideas, concerns and expectations and mutually agreeing management.

However, a recent study in the UK shows this is often not achieved:

The sense of powerlessness that characterized many people's experience of the NHS was largely the result of a lack of information and knowledge about how things work. Participants talked of doctors and specialists using an 'alien language'.[31]

A shared understanding requires the use of language that can be understood by the doctor and the patient. A doctor should check that a patient understands the same by a medical term that they do, e.g. a medical term such as 'congestion'.

This study included patients in Europe[31] and reported an equal participation in a dialogue which leads to informed choice difficult to envisage, and there was also 'a reluctance to accept that sometimes there isn't always a straightforward answer ... – but instead a series of choices and trade-offs between less than perfect alternatives'. Doctors need to empower patients to cope with these complex decisions.

Patients consulting healthcare professionals expect to leave their consultation having made progress with their problem. The **Patient Enablement Instrument (PEI)** is a questionnaire that has been developed by Howie and colleagues from a patient-centred approach to reflect the quality of consultation outcome.[32]

Practical point

The theory behind **enablement** is that understanding, adjustment and coping are important influences on outcome for patients.

The enablement questions ask whether, as the result of consulting with the doctor, the patient felt more able to:

- understand their illness better
- cope with illness and life
- be confident about their health
- help themselves, and
- keep themselves healthy.

Enablement increases with a longer consultation time, continuity of care and getting a prescription when one is wanted. Doctors can be distinguished as being 'high' or 'low' enablers.[33] Empathy is strongly correlated with enablement,[30] and enablement shares some characteristics, but is distinct from patient satisfaction.[31] However, as we continue to define and evaluate patient-centredness, the nature of the processes which underpin it are the subject of current research.

Practical point

An **empathetic** doctor can **empower** the patient and **enable** them to 'move on' from their problem productively.

Evidence-based medicine

Development of evidence-based medicine (EBM) is heralded as the way forward. There is an evangelical fervour to convert all doctors to the advantages of this 'explicit and judicious use of current best evidence in making decisions about the care of individual patients' (Sackett 1996).[34] But does this approach always achieve a cure? What of the role of the doctor as a therapeutic agent, once loosely called 'bedside manner'?

Earlier in the chapter, it was discussed how the psychologist Balint viewed the doctor as a drug. Illness and disease are not synonymous and many ill people who consult a GP have no disease, but still have an illness that requires treatment. Thus, the application of EBM has severe limitations. Furthermore it is usually based on randomised controlled trials (RCTs) in secondary care where nearly all subjects have a disease and a different spectrum is seen. For example, only a small percentage of patients in primary care have the type of uncomplicated hypertension that can be managed by standard evidence-based guidelines. So why not have primary care RCTs? Because of ethical and practical concerns, a GP providing continuous personal care to an individual patient may perceive or worry that they are exposing the patient to a medication which is inferior to current treatment. With this come difficulties with recruitment and randomisation. Imagine a double-blind RCT, where the GPs prescribing drugs to patients realise which drug they are giving, and if they do not fully believe in the new product, the outcome will be influenced, whether by verbal or non-verbal cues.

GPs have a dilemma, for they draw on two bodies of knowledge – that of secondary care derived EBM and the insights of their individual experiences. In addition, there is their unmeasured and unrealised therapeutic effect. Hence, their own knowledge, skills and attitudes (or feelings) may have a profound effect on both the process and the outcome of treatment and in some cases an effect greater than any evidence-based treatment. Whether or not a person has a disease or is considered to have a disease, they have an illness.

Practical point

Where appropriate, **reassurance** is a powerful therapeutic tool which can lead to alleviation of an illness and associated symptoms, particularly where there is an absence of disease.

The practice of patient-centred medicine and evidence-based medicine are therefore not mutually exclusive, and should be seen as synergistic. Doctors in consultations should strive to deliver both effective clinical and interpersonal care.

Practical point

'External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision.'[34]

Evidence-based medicine can and should be integrated with patient-centred consultation and care where possible.

The art of medicine is how to apply the science. This is not the mystique of the 'Church of Medicine', but the role of the 'good doctor'.

Neuro-linguistic programming

Many models of consultation are derived from interpretive psychology. In contrast neuro-linguistic programming (NLP) is 'an outcome focused, solution oriented

behavioural technology'.[35] It started in the United States in the 1970s with studies into how people change. As such it provides a useful adjunct to the consulting skills models described. Both NLP and patient-centred approaches have the patient's subjective experience at their core. People interpret the world and their experiences uniquely: they have their own '*internal map*'. Every behaviour brings positive gain for the individual. NLP hones our ability to '*read*' people and, in understanding where they are coming from, we can better help them to move on from their problem. It enhances our knowledge and skills to detect and affect thinking patterns.

Narrative

> The effective practice of medicine requires narrative competence, that is the ability to acknowledge, absorb, interpret, and act on the stories and plights of others.[36]

Working with the patient's narrative is implicit in patient-centred approaches. Taking a history starts with actively listening to the patient's story, and under-standing its personal meaning. Agreeing on the management of the problem involves exploring the patient's ideas, concerns and expectations. Reassurance, advice and counselling will only be effective if they are framed from the patient's narrative. Launer highlights 'a tension between the complex narrative that a patient brings into the consulting room and a doctor's understanding of what is really going on as formulated in a diagnosis or an idea about pathology'.[37]

A patient's narrative tells us about their personal experience of being unwell. Understanding their narrative can help us to approach their problems holistically, and can point the way to solutions.

> To understand and accept a patient's moral choices, a practitioner must acknowledge that the illness narrative has many potential interpretations but that the patient is the ultimate author of his or her own text.[38]

> Narrative is fundamental as it 'deals with experiences, not with propositions'.[36]

> The consultation brings together the human experience of suffering and the paradigms of scientific medicine, with the general practitioner acting as an interpreter at the boundary between illness and disease, and a witness to suffering.[39]

(*See* Chapter 2 for further details.)

Complexity and the consultation

The models above have served to highlight the multi-layered nature of the consultation. A dialogue between a patient and doctor has a dynamic of its own as well as the complexity which the patient and doctor both bring to the interchange. There is a need to differentiate between the consultation models we have considered so far and those that may be aligned to what is referred to as complexity theory. Characteristics of the consultation models so far are:

- appropriate application of a scientific (probabilistic/linear) model
- the traditional scientific clinical method (biomedical medical) model
- pattern recognition or the hypothetico-deductive (probabilistic) model
- application of an often reductionist and perhaps not so patient-centred model
- evidence based (rules)/quantitative approach
- diagnostic certainties – diseases (deductive) model.

Some might say that these models endeavour to provide a scientific objective rigour to simplify what is exceedingly complex. They are based on Newtonian scientific reasoning, which assumes that complex situations may be explained by linear equations. These models may work well for simple situations – for example, myocardial ischaemia producing central crushing angina pain, diagnosed through history and an exercise ECG and treated by drugs reducing preload and afterload on the heart. However, situations such as depression will be more complex with psychological, emotional, social and relational factors which do not fit easily into such a linear framework.

> ... If things were simple, word would have gotten around. (Derrida 1988)[40]

Characteristics of complexity in the consultation are:

- narrative-based medicine/the illness story
- the unpredictable
- undifferentiated presentation of illness
- patient and illness inseparable – the so-called 'art of medicine'
- illness presentation is unpredictable (within boundaries)
- the approach is holistic appreciating the patient's environment (contextual)
- qualitative (no rules)
- diagnostic uncertainties (illness rather than a distinct disease entity)
- syndromes
- intuitive (heuristic)
- interpretive
- an inductive approach is required to unravel complexity
- outcomes will evolve or emerge over time (a feature of all complex systems)
- the 'butterfly effect' – small events may have vast effects (non-linear chaos).

Practical point
There is an argument to use the rigid structure of models or with experience to use those aspects that complement one's individual and developing consulting style.

Understanding the medical consultation as a complex system allows us to feel more comfortable with the potential **uncertainty** of how it will develop. It helps us understand the role of the doctor, not as an objective external observer, as suggested by traditional medical models of the doctor–patient interaction, but as an enquiring participant who seeks to influence change in a patient's condition for the better and so improving quality of life. This takes into account the WHO definition of health:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (WHO definition of health)

For many doctors, it is **uncertainty** in relation to problem solving and management that makes consulting with patients difficult and stressful. An excellent series of articles appeared in the *British Medical Journal* on the subject of 'complexity science' in relation to healthcare in 2001. The argument for uncertainty is illustrated by the following statement:

In complex systems, unpredictability and paradox are ever present, and some things will remain unknowable.[41]

How can a medical consultation be considered a complex system? Although many consultations can be successfully considered to only include the doctor and the patient, other influences act as agents within the consultation and will be particularly relevant in complex situations. These include the:

- themes emerging from the patient's narrative
- socio-cultural influences, e.g. religious, social or economic
- physical environment of the waiting room
- consulting room
- organisation of the practice
- constraint of time
- manager
- lawyer
- statistician
- journalist
- computer.

With this diversity of agents acting within a consultation there is the potential for the consultation to develop in many different ways. Free-flowing conversation is a process by which interaction occurs and possibilities can be explored. Structuring a consultation to limit the number of agents influencing the consultation limits potential developments and is insufficiently patient-centred. Complexity theory recognises uncertainty and helps us understand that it is intrinsic to complex systems including individuals and their health.

Human beings can be viewed as composed of and operating within multiple interacting and self adjusting systems (including biochemical, cellular, physiological, psychological, and social systems).[42]

What is a complex system? Take the example of a forest which is formed from many agents including the animals and plants. The agents are diverse in nature, they interact and they co-evolve. Changes emerge over time resulting from **non-linear** interactions, some having a minor and others a major effect on the evolving system. Change is constant resulting both from interactions within the system and external influences from the 'environment', but nevertheless the system can remain relatively stable over long periods of time. However, the state of the system is not entirely predictable in advance.

New conceptual frameworks that incorporate a dynamic, emergent, creative, and intuitive view of the world must replace traditional 'reduce and resolve' approaches to clinical care and service organisation.[41]

In relation to the individual doctor and their training, a skill is acquired to deal with the complexity of each individual encounter (patient consultation) and that is to be able to **integrate, synthesize and apply the knowledge** that they have received from teaching in anatomy, physiology, biochemistry, genetics and many other biomedical sciences and apply it in these clinical situations. (This theme is further explored in the next chapter in relation to Miller's Pyramid of Competence.)

Practical point

If one is to provide optimal and quality healthcare and keep up with the pace of change in the NHS, different consultation models should be considered when analysing the complexity of consultations and improving future performance.

Summary

More than 50 years ago Maslow[10] produced his overarching holistic theory of human need. It has been applied from business to medicine with varying degrees of success because it is difficult to operationalise completely. Through detailed analysis of the process of the consultation the influence of both patient and doctor on dynamics have been explored. The realisation that the application of 'scientific method' cannot always provide the answer to the ill-defined problems which distress people has led to the emergence of a wider perspective which embraces a more holistic approach. The recognition of the relevance of this broader perspective has led to the development of more patient-centred approaches which encourage learning and quality improvement through reflection and consultation analysis.

Practical point

Current views on the complexity of the interplay of influences on the consultation mean that further changes can be expected.

A successful consultation is the customised integration of technical knowledge and skill on the part of the doctor, together with competent interpersonal communication, which enables an understanding, and appropriate engagement of both the consulter and the consulted, to manage the problem.

Having considered these models, the reader will be able to identify approaches which are a better fit with their own intuitive consulting style, and which will help them analyse and build on it. Being a good communicator is not enough, and the latter part of this chapter has drawn attention to other important areas and influences, which one needs to explore and assimilate into professional practice.

Practical point
Models help us navigate a complex reality. They help us distinguish what is important; they increase our understanding, and provide a framework for action.

To reiterate, the WHO definition of health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Approaches to consultation should utilise this broad bio-psychosocial definition.

Communication is a generic skill, important for all healthcare providers. The GMC in their publication, *Tomorrow's Doctors*, in 1993, identified a range of skills that will be increasingly important to doctors in the future including the ability to work in a team, base decisions on evidence and communicate. Communication skills are an important part of professional expertise. The object of this chapter has been to alert the reader to different approaches to the consultation, and to provide an overview of a variety of models, which can be used to analyse and improve consultations with patients. Flexibility is vital. The consultation dynamic, together with one's professional dynamic, will inevitably undergo change during a lifetime of practice.

Practical point
'The theory and practice of medicine is strongly influenced in any era by the dominant theory of knowledge and by societal values. Medicine is always a child of its time.'[14]

Conclusion

There are very many 'models' of consulting styles. While one should not consult using checklists of tasks, it is important to be familiar with some of these consultation models. They can help to provide a structure and framework for your consultations.

Communication skills can be learned. This is best achieved using experiential learning techniques building on individual style. The following are some suggestions of important skills to incorporate flexibly into consulting with patients that may well aid effective communication. The number of texts written on the consultation is overwhelming as this chapter demonstrates. However, the following general points arise from the many consultation models described.

Establish a rapport

It is important to try and establish a rapport with all patients and develop an ongoing relationship. Try to connect with patients. Greet them with warmth and encourage them to talk early in the consultation. It is important to look interested and avoid stopping the flow in the initial stages.

Questioning style

Appropriate use of open, leading and closed questions. As a general rule, open questions are most appropriate at the start of a consultation followed up by

closed/leading questions later. Closed questions tend to increase doctor control and are useful to obtain facts. They are not good at eliciting the patient's beliefs and feelings and are generally answered with 'yes or no' answers.

Open question: 'Tell me more about . . .'. 'What is the pain like?'
Closed question: 'Have you lost weight?'

Active listening

This is demonstrated by appropriate open body language and verbal/non-verbal prompts (e.g. head nodding, smiling) Good eye contact is essential. Summarising helps demonstrate active listening to patient and aids clarity.

Empathy

This is trying to put yourself into the patient's position. Here are some examples.

'I can understand this must be a very difficult time for you.'
'This must be devastating news for you . . . I am so sorry.'

This is different to sympathy which is less effective

'I know how you feel . . . the same thing happened to me.'

Summarising

As mentioned in active listening, this can help clarify what the patient has told you. It is particularly useful to clarify the presenting complaint or agreed management plan.

Reflection

Reflect back a phrase or symptom that the patient has mentioned in order to explore it further. This is a good technique to use when trying to 'open' up a patient and again demonstrates active listening.

Patient: 'I've been feeling a bit out of sorts.'
Doctor: 'Out of sorts . . . tell me what you mean by this.'

Appropriate language

Medical terminology can frustrate and confuse patients. Jargon should be avoided wherever possible and explanations given in the patient's or lay language. It is important to be sensitive to the amount and kinds of words used with people from different social backgrounds and intellectual capacities.

Silence

Try to become comfortable with silence and allow pauses in the consultation. If you wait long enough, the patient will break the silence when they are ready.

Responding to cues

These cues can be verbal or non-verbal. 'You seem very upset/anxious . . .' is an example of responding to a non-verbal cue.

Patient's ideas, concerns and expectations

All patients have different health beliefs influenced by personal experience, media information or family/cultural beliefs. It is important to explore these during a consultation to enable a patient-centred consultation.

For example, a 45-year-old man presents with a six-week history of a cough. He seems very concerned and is requesting investigations.

If asked, 'Have you had any thoughts as to what this might be? Are you worried that this might be anything, in particular?':

- patient A might answer, 'TB', because he knows that someone a few doors down from where he lives has recently been diagnosed
- patient B might answer, 'Lung cancer', because he is a heavy smoker
- patient C might answer that he is particularly concerned because he was in Africa two months ago on a working trip and has never felt well since. He is worried he may have picked up some 'rare disease' from there.

Occasionally, if you ask the patient you may get the answer, 'You're the doctor, you tell me'. This should not deter you.

Some patients, at this point, will open up to their deeper fears. This can be the most revealing and important part of the consultation.

Sharing information

Patient-centred consulting means sharing information with patients and agreeing on a shared management plan. This respects that the patient through their experience is the 'expert' in their illness. When sharing information with patients, it is best to actively seek feedback throughout the consultation. Look for non-verbal clues that indicate non-understanding, e.g. facial puzzlement, lack of interest. It is not good enough to deliver all your information and then ask, 'Have you any questions?' It is better to check with the patient after each new piece of information is given. Possible phrases you might use are:

'Have you heard of that before? Does that mean anything to you?'
'How does that come across to you? Do you want to ask me anything about that?'
'I am not sure that I explained that very well. Is there anything you would like me to go over again?'

It is also important to use short words and sentences when delivering information. Give the patient the most important facts first. Do not worry about repeating important information. Check their understanding.

Social and psychological context

Where appropriate, it is necessary to explore these areas to establish a complete picture of the patient's presenting complaint.

For example, if the patient presents with back pain, it is likely to be relevant to ask about occupation; or if the patient is depressed, it is relevant to ask, 'How are things at home?' or 'How are things at work?'

Clinical examination

Some patients may require no examination at all but, if appropriate, clinical examination may help to confirm or refute a possible diagnosis.

Partnership

Consider using plural pronouns to make the patient feel part of a partnership: 'Where shall **we** go from here? What do you think **we** should do now?'

Honesty

Be prepared to admit uncertainty if you don't know exactly what is wrong with the patient.

Safety netting/follow-up

It is important for all patients to know when they should come back if their illness has not improved. This also can provide peace of mind for the doctor, especially in general practice where doctors are often faced with vague symptoms and signs. This is called '*dealing with uncertainty*'. It is often hard to know, when symptoms and signs are soft, whether the patient is presenting with a significant illness but at a very early stage, or whether their symptoms will settle.

By organising appropriate and realistic follow-up this allows you to monitor patients over time which can really aid diagnosis.

Housekeeping

Practical point
This means clearing the mind of the psychological remains of one consultation to ensure it has no detrimental effect on the next.

This might mean, in reality, having a few minutes to yourself to recover from an emotionally draining consultation.

Excellent communication skills alone are not enough

Good communication requires a combination of **knowledge**, **skills** and **attitudes**. It is important to be clinically competent with good diagnostic acumen. A professional attitude is also needed where the clinician is non-judgemental and

without prejudice. If these attributes are combined with good generic communication skills, then good doctor–patient consulting can occur.

Communication skills underpin virtually all the factors that either make a consultation successful or alternatively a disaster. While knowledge of a condition or being able to easily refer a patient to another practitioner is very important, this can amount to little, if the communication is poor.

Simple skills to improve communication are available to all clinicians, with a very rewarding outcome for both the patient and clinician in terms of communication, satisfaction and time management in the consultation.

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