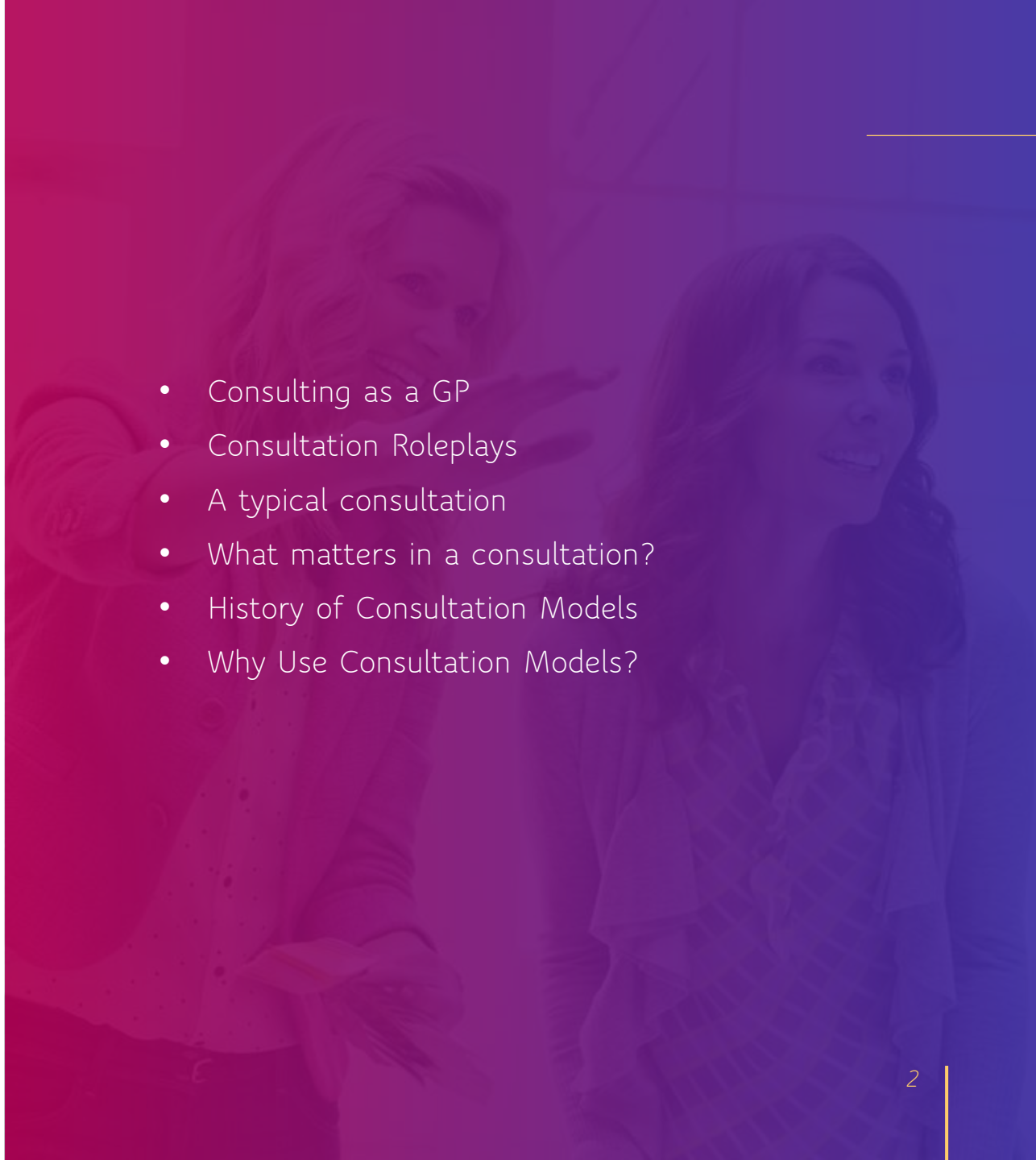
CONSULTATION MODELS

BOLTON GP ST3 - A

SESSION CONTENT

Consultation Models



- Consulting as a GP
- Consultation Roleplays
- A typical consultation
- What matters in a consultation?
- History of Consultation Models
- Why Use Consultation Models?

What is the point of GPs?

Masters of Consultation

GP: The Jack of all Trades

- Patients covered: from cradle to grave
- Medical specialities covered: neonatology to palliative care, skin rashes to heart failure, occupational health to endocrinology, learning disability to cardiovascular disease risk reduction
- Support staff: no junior clinical staff or dedicated PA/admin
- Consultation duration: 10-15 minutes (includes records review, writing notes and referrals)

Our specialism is the consultation

GROUP TASK 1

- Doctors A
- Doctors B
- Patients A
- Patients B

Keep your information in your group!

Patient Info Reshma/Rishi

Group Task 1

- "I've come basically to get some antibiotics for my chest, it's gotten bad and not improved over the past week".
- Reshma/Rishi, 36yo, with increasing cough and some sputum. Thinks has infection so attends for antibiotics
- PMHx: Asthma, on "brown inhaler" twice a day. Uses blue inhaler for exercise or when cough returns, like now. Works.
- Works in a call centre. No life changes. No one else ill. No recent travel. Negative COVID LFT. A home PEFR was 400, you usually get about 500.

- Only offer information if asked:
  - *If offered antibiotics, accept these. You'd prefer amoxicillin as doxycycline makes you feel sick.*
  - *You hadn't thought about steroids, but have had before and they work. You'd be reluctant to take more than 30mg OD for 3 days as it tends to affect your sleep.*
  - *You get hayfever and have noticed it's worse with lots of sore eyes and sneezing. You're taking OTC antihistamine (cetirizine)*
  - *Cough has been worse after work and you notice the AC is on a lot as it's been hot. The vents are dusty and the definitely feels dry.*
  - *You are going away to Dubai in 2 weeks and are worried the cough will ruin/prevent this (they are strict at UAE border about COVID). Your spouse has been working so hard and this trip is the reset you and 2 children (Inda ,9 and Arun, 11) need*

GP Info Reshma/Rishi

Group Task 1

- Reshma/Rishi, 36yo, "Cough"
- PMHx (last consulted): Asthma 2021, Appendicectomy 2001, Conjunctivitis 2014, Allergic Rhinitis 2019,
- Med Hx:
  - *REPEAT: Qvar 100 BD, Salbutamol PRN*
  - *ACUTE (last had): Fexofenadine 180mg (2019), Chloramphenicol*
- Allergy:
- Last asthma check October 2021: ACT: 24/25. PEFR 520L/min
- Non-smoker

Patient Info Andy/Andie

Group Task 1

- "I've come to ask if I can get some co-codamol as my back is playing up".
- Andy/Andie, 29yo, with increased back pain, and you couldn't see co-codamol on the NHS app to order and have run out – reception said need to have medication review. Naproxen most days
- Mood is fine, fluoxetine helps and better now pandemic over (was lonely over 2020/2021)
- PMHx: Ankylosing Spondylitis
- Works as a teaching assistant in secondary school. Enjoys job
- Lives alone, manages all ADLs

- Only offer information if asked:
  - *You like playing football and your back seems to manage but had a bad tackle at weekend which might have triggered this flare, but equally it does just sometimes hurt for no obvious reason*
  - *Life is good, you're going to start teaching training in February, you have good friends and social life and have holidays planned.*
  - *You don't want to start DMARDs/biologics because of the possible side effects and at the moment, naproxen works fine*
  - *You have had to take time out of work to attend and want to get back asap. It's annoying you've been asked to come in as you just need a prescription. You respect the GP so don't want to make a fuss – but also aren't interested in a long chat!*

GP Info – Andy/Andie

Group Task 1

- Andy/Andie, 29yo, "Low Back Pain"
- PMHx (last consulted): Axial Spondyloarthropathy (2022), Depression (2022),
- Med Hx:
  - *REPEAT: Naproxen 500mg BD, Lansoprazole 15mg BD, Fluoxetine 20mg OD*
  - *ACUTE (last had): Co-codamol 30/500 (July 2021), Gabapentin 100mg TDS (May 2018)*
  - *Last Medication Review: February 2018*
- Allergy: Tramadol
- Non-smoker
- Sees rheumatology annually for review. Not on DMARD/biologic as never felt pain bad enough to warrant but past letters indicate is a future option if wants

Group Task 1

Medical Student

- 10minute time limit
- Follow proforma/SOCRATES
- Goal of consult is to complete admission proforma

1950s GP

- 5 minute consultation limit
- Doctor centred, avoid open questions
- You won't need to write notes
- Goal of consult is to diagnose the medical problem and provide a management plan, and get patient out of door as quickly as possible

Counsellor

- No consultation time limit
- Patient centred, avoid closed questions
- You'll need to keep a record to remember certain phrases patient uses to share later
- Goal of consult is to find out as much about patient as possible, coming to a full biopsychosocial diagnosis.

GROUP TASK 1


How does it feel to be the clinician/patient in these scenarios?

Sir Lancelot Spratt

https://youtu.be/oVWjAeAa52o

? “nice” or modern consult

Stewart, 56

Presenting Complaint

- Cough for 2.5 weeks, started dry and now productive of green sputum. No haemoptysis.
- No coryzal symptoms or sore throat
- No SOB noted
- No headache, no fever, no facial pain
- No indigestion/reflux
- No weight loss
- Negative COVID-19 LFT at onset of illness

Background Information

- Ex-Armed Forces, served in NI and Bosnia
- Currently renovates houses/handyman
- BMI 29kg/m^2
- Lives with wife and youngest child still at home
- FHx: COPD in both parents, IHD/MI: father aged >60
- Substances
  - Smoker, 20-40/day
  - Alcohol, 28 units/week
  - Occasional cannabis, nil other drugs

Stewart, 56

What does Stewart **need** from the consultation?

What does Stewart **want** from the consultation?

Presenting Complaint

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Traditional Medical Model

History & Examination

- Presenting Complaint
- Past Medical History
- Family History
- Personal & Social History
- Drug/Medication History
- Allergy History
- Systems Review
- Physical Examination

Management

- Biomedical Diagnosis
- Investigations
- Prescriptions
- Advice
- Follow Up Planning

This doesn't meet the patient's needs or wants… Why?

What's Missing?

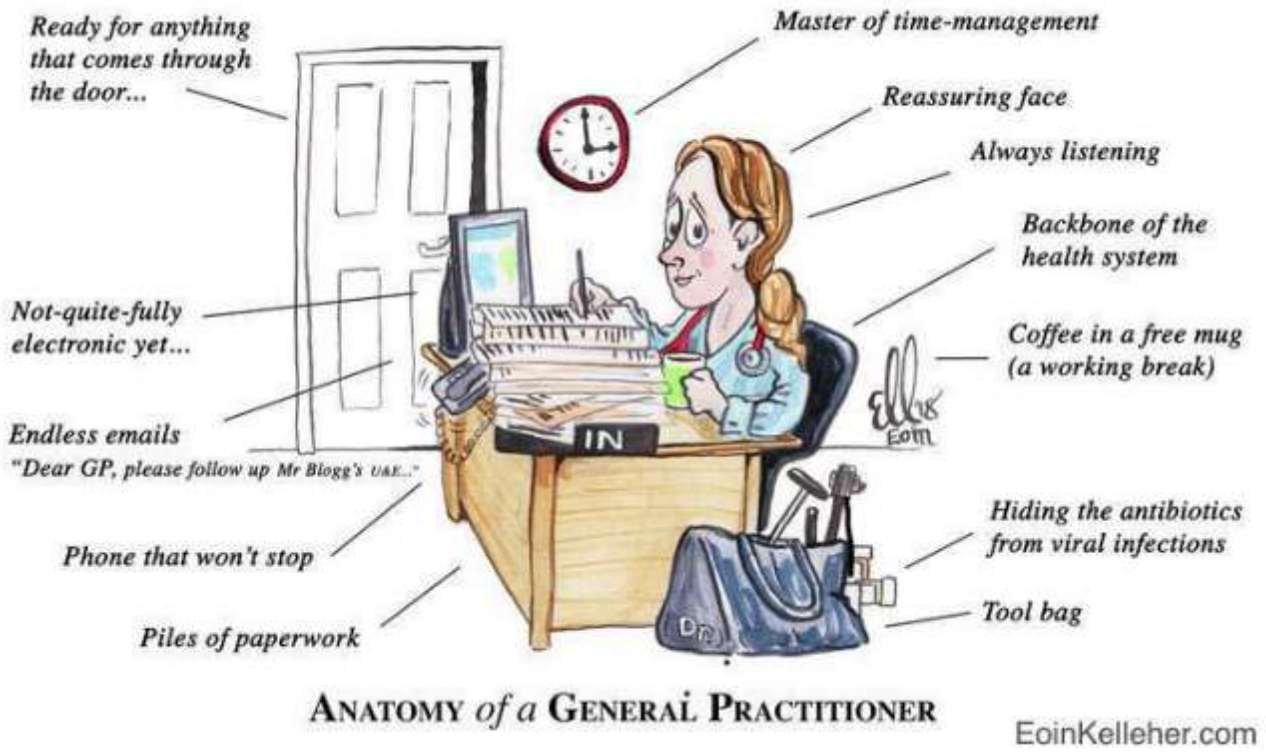
Patient

- Poor Satisfaction
- Unlikely to provide reassurance
- Poor Compliance
- Biological diagnosis – what?!
- Doable in 10 minutes?

Doctor

- Missing relationship
- Ideas, concerns & expectations
- True psycho-social assessment
- Time/Resource management
- Doctor's feelings

Break


Ready for anything that comes through the door...
Master of time-management
Reassuring face
Always listening
Backbone of the health system
Coffee in a free mug (a working break)
Not-quite-fully electronic yet...
Endless emails
"Dear GP, please follow up Mr Blogg's U&E..."
Phone that won't stop
Piles of paperwork
Hiding the antibiotics from viral infections
Tool bag
IN
ANATOMY of a GENERAL PRACTITIONER
EoinKelleher.com

Write a wishlist

WHAT MATTERS IN A CONSULATION?

Patients, Clinicians, Managers

WHAT ARE THE BARRIERS TO A GOOD CONSULTATION?

Patients, Clinicians

A History of Consultation Models

How we got here

Consider...

- What is your experience of using the consultation models presented?
- Which model do you prefer to use in your current consultations?

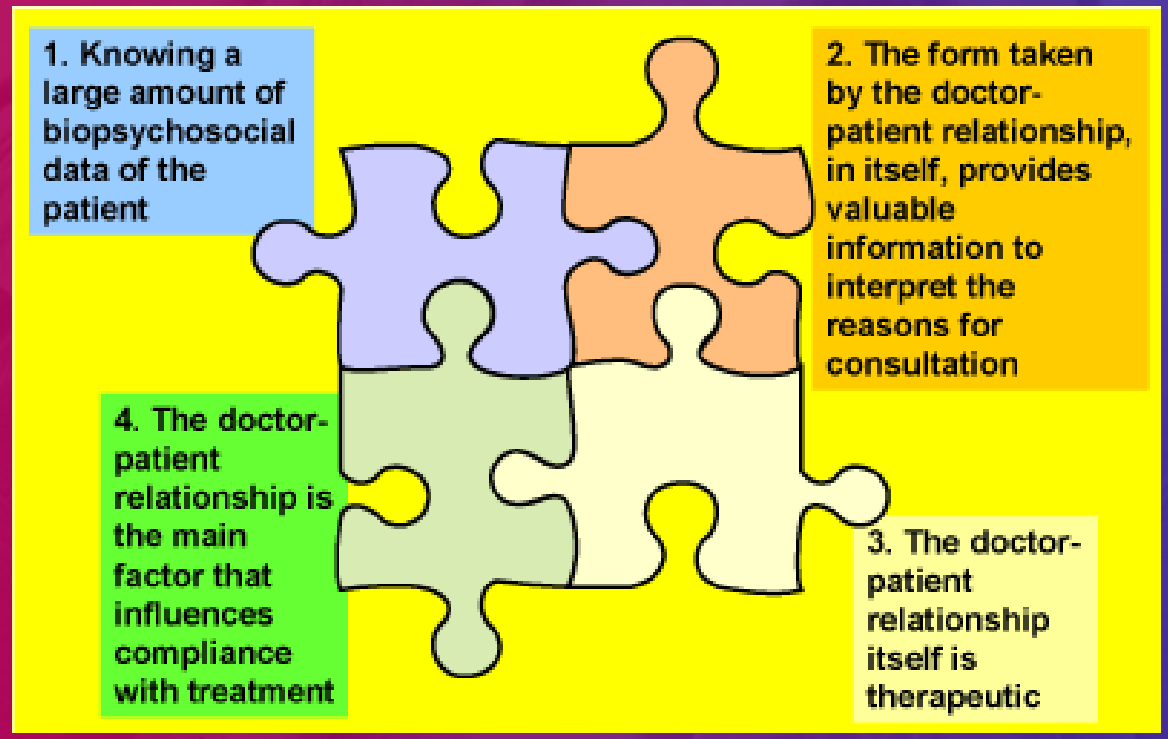
Old style GP

Paternalistic, biological model

Balint (1950)

Consultation Models

- The “doctor as a drug”



Six Category Intervention Analysis (1975)

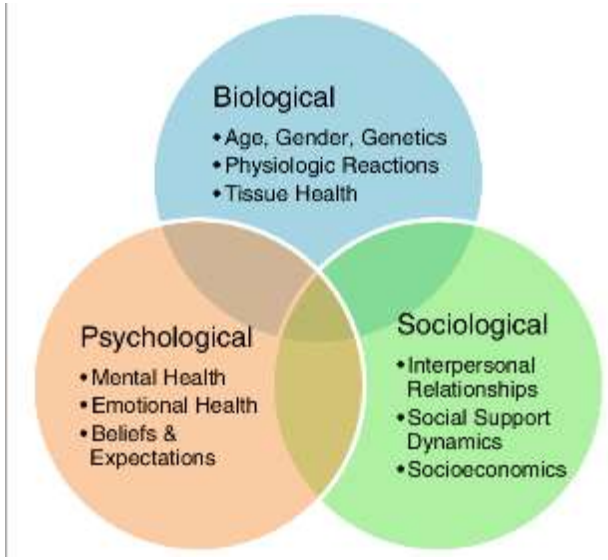
Consultation Models

Within an overall setting of concern for the patient's best interests, the doctor's interventions fall into one of six categories:

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 direct feedback within a caring context*
4. Cathartic
   - *seeking to release emotion in the form of weeping, laughter, trembling or anger*
5. Catalytic
   - *encouraging the patient to discover and explore his own latent thoughts and feelings*
6. Supportive
   - *offering comfort and approval, affirming the patient's intrinsic value.*

The Triaxial Model (1972)

Consultation Models



The RCGP highlights the need for doctors to address patient problems in

- physical,
- psychological and
- social terms.

The most contemporary thinking about the consultation assumes it must be analysed with respect to these three features.

The effect is to discourage doctors to think purely in organic terms and consider also the patient's emotional, family, social and environmental circumstances, all of which can have a profound effect on health.

Byrne & Long (1976)

Consultation Models

1.The doctor establishes a relationship with the patient.

2.The doctor attempts to discover or actually discovers the reasons for the patient's attendance.

3.The doctor conducts a verbal or physical examination or both.

4.The doctor and/or patient consider the condition.

5.The doctor and patient agree and detail further treatment or investigation if necessary.

6.The consultation is terminated (usually by the doctor).

The Exceptional Potential in each Primary Care Consultation by Stott and Davies (1979)

Consultation Models

- Management of the patient's presenting problem.
- Modification of help-seeking behaviours.
- Management of continuing problems.
- Opportunistic health promotion.

Helman's Folk Model of Illness (1981)

Consultation Models

- what has happened?
- why has it happened?
- why to me?
- why now?
- what would happen if nothing were done about it?
- what should I do about it?

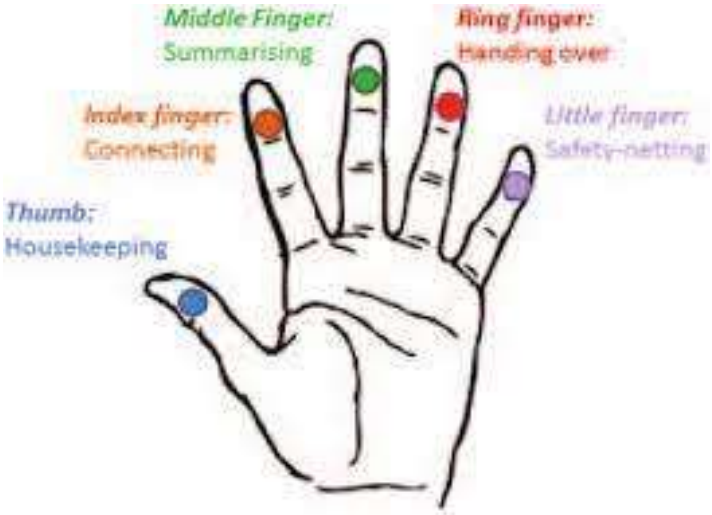
‘The Consultation – An Approach to Learning and Teaching’ (1984)

Consultation Models

1. To **define the reason for the patient's attendance**, including
    - *the nature and history of the problems*
    - *their aetiology*
    - *the patient's ideas, concerns and expectations*
    - *the effects of the problems.*
2. To **consider other problems**:
    - *continuing problems,*
    - *at-risk factors.*
3. With the patient, to **choose an appropriate action** for each problem.
4. To **achieve a shared understanding** of the problems with the patient.
5. To **involve the patient** in the management and encourage him/her to accept appropriate responsibility.
6. To **use time and resources appropriately**
    - *in the consultation,*
    - *in the long term.*
7. To **establish and maintain a relationship** with the patient which helps to achieve the other tasks.

Roger Neighbour's Inner Consultation (1987)

Consultation Models



1.Connecting – establishing rapport with the patient

2.Summarising – getting to the point of why the patient has come using eliciting skills to discover their ideas, concerns, expectations and summarising back to the patient.

3.Handing over – doctors' and patients' agendas are agreed. Negotiating, influencing and gift wrapping.

4.Safety-netting – ensure a contingency plan has been made for the worst scenario

- *"What if?"*

5.Housekeeping – clear the mind of the psychological remains of one's consultation to ensure it has no detrimental effect on the next

- *"Am I in good enough shape for the next patient?"*

The Three Function Approach to the Medical Interview (1989)

Consultation Models

Functions	Skills
Gathering data	a.Open-ended question b.Open to closed cone c.Facilitation d.Checking e.Survey of problems f.Negotiate priorities g.Clarification and direction h.Summarising i.Elicit patient's expectations j.Elicit patient's ideas about aetiology k.Elicit impact of illness on patient's quality of life
Developing rapport	a. Reflection b.Legitimation c.Support d.Partnership e.Respect
Education & motivation	a.Education about illness b.Negotiation and maintenance of a treatment plan c.Motivation of non-adherent patients

Calgary Cambridge (1996)

Consultation Models

1. Initiating the Session
   - *establishing initial rapport*
   - *identifying the reason(s) for the consultation*
2. Gathering Information
   - *exploration of problems*
   - *understanding the patient's perspective*
   - *providing structure to the consultation*
3. Building the Relationship
   - *developing rapport*
   - *involving the patient*
4. Explanation and Planning
   - *providing the correct amount & type of information*
   - *aiding accurate recall & understanding*
   - *achieving shared understanding: incorporating the patient's perspective*
   - *planning: shared decision making*
5. Closing the Session

Stewart and Roter (1997)

Consultation Models

1. Patient's agenda:
   - *exploring ideas, concerns, expectations, feelings, thoughts and effects, culminating in an understanding of the patient's unique experience of the illness.*
2. Doctor's agenda:
   - *exploring symptoms, signs, investigations and consideration of the underlying pathology and a differential diagnosis.*

The two frameworks are then brought together to give a shared understanding. This then allows for explanations, planning and decision-making.

Is there a point to consultation models?

USING CONSULTATION MODELS

- Consultation models provide a structure for the complex interactions that occur between patients and clinicians.
- An unstructured consultation can lead to failure to recognise the real issues raised by the patient and may also lead to an unclear shared management plan with the patient.
- There will never be a model that covers every eventuality within either a face-to-face or a remote consultation.
- The key principle when selecting a model to use is to consider the context and use the model that will achieve the best outcome for the patient.

RCGP Curriculum

The consultation between doctor and patient is at the heart of general practice.

It is the central setting through which primary care is delivered and from which many of the curriculum outcomes are derived.

The skills used in the consultation are transferable to other areas of professional practice.

For example, your communication skills and approaches with patients are transferable to how you work with colleagues, in leadership and in teaching.

Having highly developed communication skills is pivotal to all aspects of high quality patient care.

'Consultation skills' and 'communication skills' are often used interchangeably, but these are only a subset of the interpersonal skills, knowledge and attitudes required to consult effectively.

https://www.rcgp.org.uk/mrcgp-exams/gp-curriculum/professional-topic-guides#consulting

Attitudes, feelings and biases

- Feelings and intuition strongly affect the consultation behaviour of both the doctor and the patient.
- These less transparent thinking processes bring benefits and risks to the consultation. For example, while they can help you to establish rapport, it is also important to be aware of the potential impact of conscious and unconscious biases on shared decision-making
- Many patients will attend the same GP repeatedly during the course of their lives: this longitudinal relationship can influence attitudes, feelings, biases and processes within consultations for both patients and doctors
- Patients' views and perspectives may change during the course of their lives and even during the course of an illness
- Health beliefs, preferences, ethnic and cultural differences have an impact on the way that patients present with illness, their willingness to engage with health services, and their management
- Adopting a curious and open-minded attitude can help you gain insights into patients' perspectives
- Some patients may wish to approach health and illness in a non-scientific way. The reality for most people is that they make their own health choices on the basis of their own values and not necessarily on the health system's values. Understanding and responding to this can improve both the patient experience and concordance with agreed care plans
- Patients may sometimes prefer to delegate their autonomy to you as their GP, rather than accept this responsibility themselves, particularly at times of illness or distress. While being willing to take on this responsibility when appropriate, it is important to support patients in maximising their capacity for decision-making and encourage self-care.

The consultation process

- Clinical effectiveness and optimising whatever time you have to spend with the patient depend on effective consulting skills. To have an effective consultation, you need to navigate with the patient through the usual phases of the consultation in an appropriate sequence and at an appropriate pace.
- A working understanding of consultation models can greatly assist this process.
- For example, if you do not spend sufficient time discovering the reason for the patient's attendance and their expectations for the consultation, then your agreed management plan is less likely to be appropriate, and patient safety as well as satisfaction may be compromised
- Close observation of and interest in the patient are essential
- Person-centred consulting includes the choice of responses, both verbal and non-verbal, that you and the patient make
- It is important to be aware of your practice in real time, always seeing the patient as an individual reacting to their own unique context and taking this into account when formulating your responses.
- This real-time monitoring is essential for detecting when a consultation is not going as well as hoped, enabling appropriate steps to be taken to address this
- Consultations are usually time-constrained, although longer consultations tend to be associated with better health outcomes, increased patient satisfaction and enablement scores. Balanced against this are the competing demands of limited appointment numbers and reduced access to GPs
- Structured feedback on your consultation, with reference to evidence-based consultation and communication models, can help to improve your consulting skills.

The wider context of the consultation

•Consultations, along with episodes of illness, rarely impact on the patient alone

•It is important to understand the relationship between the interests of patients and the interests of their carers, in order to negotiate how relatives, friends and carers might become involved, while balancing the patient's rights to autonomy and confidentiality

•It is also important to identify and support people undertaking a caring role

•Consultations that work effectively from a patient's perspective require the doctor to understand that 'health' and 'illness' comprise more than the presence or absence of the signs and symptoms of disease

•Physical, psychological, socioeconomic, educational, cultural and community dimensions of health are reflected in every consultation

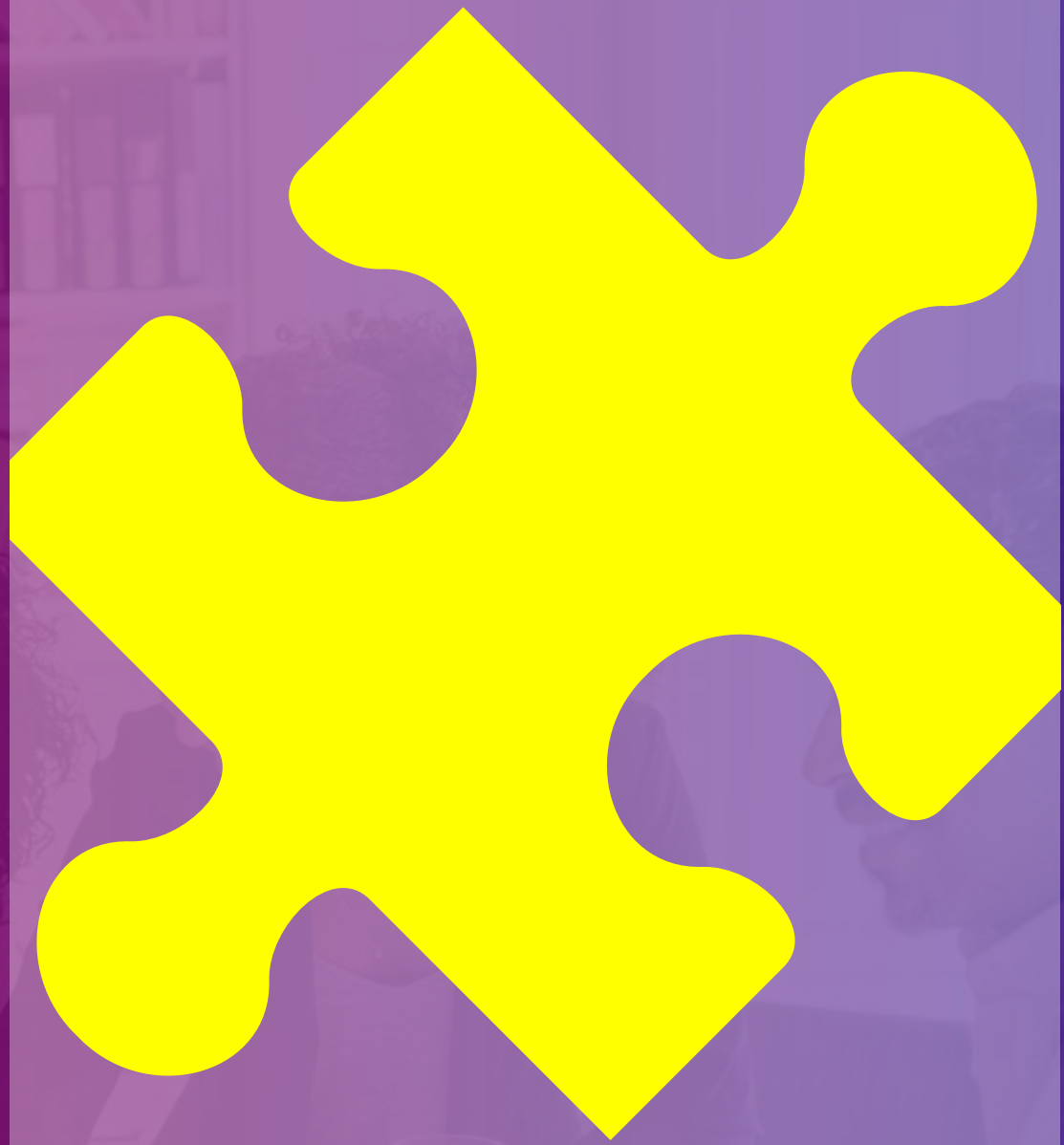
•It is important to understand the boundaries between professionals and other services with regard to clinical responsibility and confidentiality, particularly when working in teams and in care pathways that span organisations

•Each consultation provides a window to the local community.

•Cumulatively, these consultations can help you to understand the demography and diversity of your practice population, as well as provide powerful illustrations of unmet health needs and gaps in service provision. These experiences can be effectively combined with scientific data to inform the development of appropriate services for the community as a whole.

•It is also important to recognise the health needs of patients who are less able to consult.

JIGSAW TASK

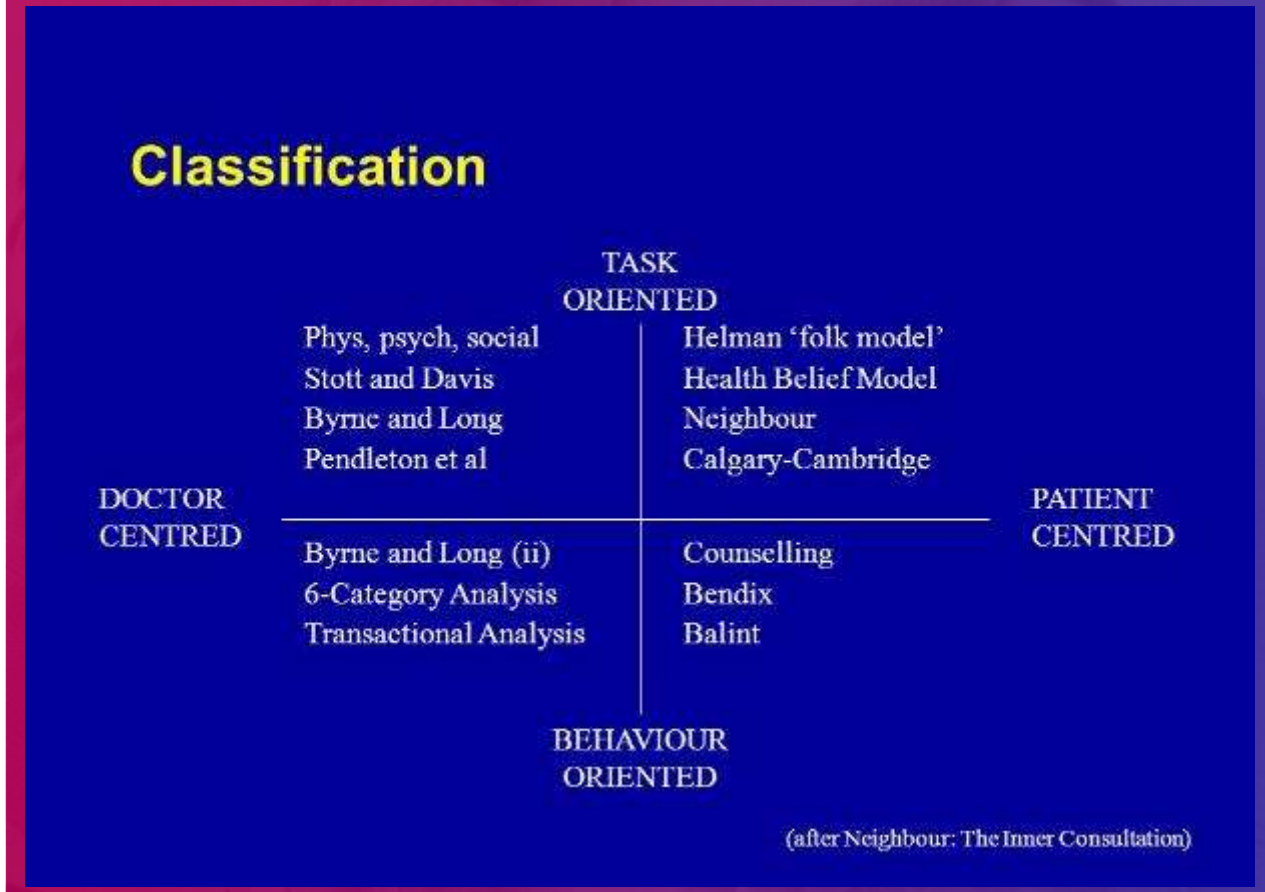


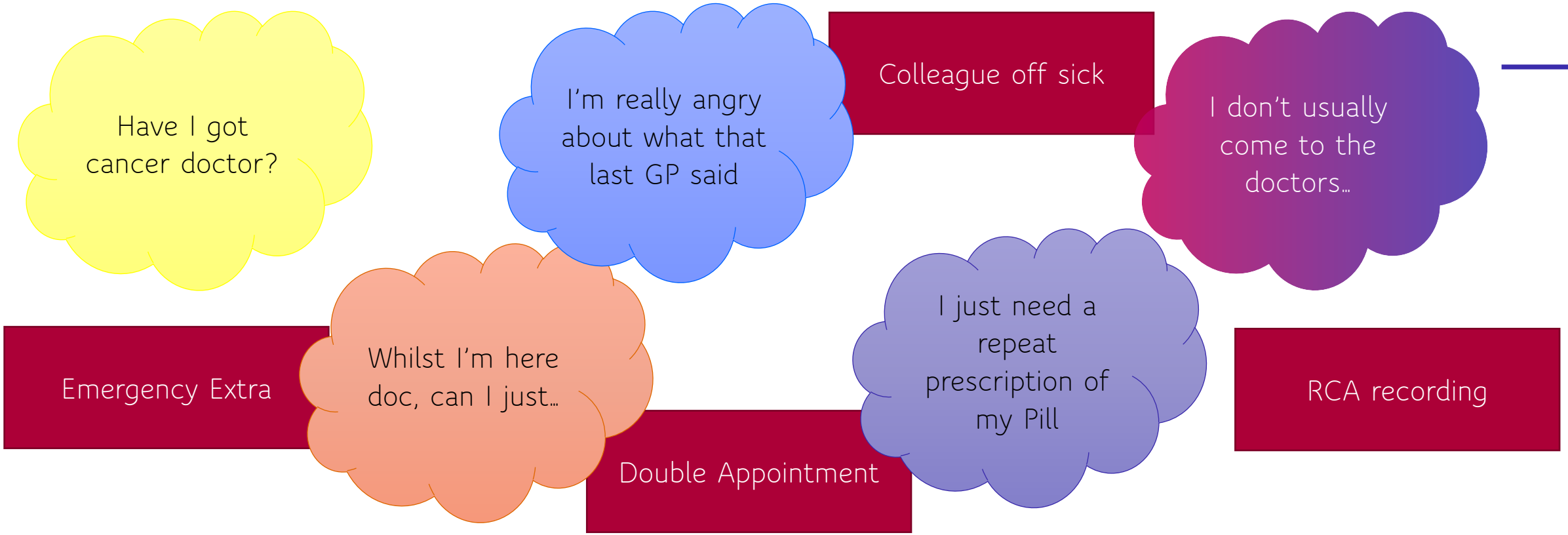
“Without foundations there can be no fashion”

Christian Dior

Which model to use?

If you know different frameworks, you can adapt to different scenarios





CONSIDER HOW TO CONSULT…

SUMMARY

Masters of Consultation

Patient Focussed

Doctor Focussed

Public Health

Consultation Modelling

Adaptability

THANK YOU!

Consultation Models