Doctor-Efficient Care

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Consultation Models

A Recap

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Balint (1957)

- 1957: Michael Balint's book 'The doctor, the patient and his illness'. :
  - Groups of GPs met and were encouraged to explore psychological aspects of their consultations.
  - In a very personal account, Balint described the most frequently used drug in general practice as the doctor himself ('the doctor as a drug').
- The work described and recognised emotional aspects of the relationship between clinician and patient.
- It described how attentive listening helped make patients feel better.
  - Balint described listening as a skill and held that 'asking questions only gets you answers'.

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Doctors talking to Patients by Byrne & Long (1976)

- Analysis of 2,500 tape-recorded consultations from over 100 doctors in the UK and New Zealand
  - Considered now to be very doctor-centred, as implied in the title.
  - Consultation style may reflect the personality of the doctor or the patient.
  - They recognised that doctors tended to use a narrow repertoire of consultation skills and that doctors who asked more open questions tended to see their patients less frequently.
- The six stages to the consultation are:
  - The doctor establishes a relationship with the patient.
  - The doctor attempts to discover the reason why the patient attended.
    - What is the patient's agenda? What are their fears and concerns?
  - History and possibly examination occurs.
  - The doctor, in consultation with the patient, considers the condition.
  - Treatment or further investigations are discussed.
  - The doctor brings the consultation to a close.

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

- This paper described four areas to be systematically explored each time a patient consults:
  - Management of the patient's presenting problem.
  - Modification of help-seeking behaviours.
  - Management of continuing problems.
  - Opportunistic health promotion.

Stewart and Roter (1997)

- Analysed consultations between over 100 doctors and 500 patients, using audiotape.
- They outlined a gathering of information about the patient's problem along two parallel pathways:
  - Patient's agenda, exploring ideas, concerns, expectations, feelings, thoughts and effects, culminating in an understanding of the patient's unique experience of the illness.
  - 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.

Calgary Cambridge (2000)

- An evidence-based approach to integration of the 'tasks' of the consultation and improving skills for effective communication. The consultation is divided into:
- Initiating the session (rapport, reasons for consulting, establishing shared agenda).
- Gathering information (patient's story, open and closed questions, identifying verbal and non-verbal cues).
- Building the relationship (developing rapport, recording notes, accepting the patient's views/feelings and demonstrating empathy and support).
- Explanation and planning (giving digestible information and explanations).
- Closing the session (summarising and clarifying the agreed plan).

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What’s the problem with consultation models?

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The Inner Consultation by Roger Neighbour (1987)

- This model describes an intuitive five-stage model:
  - Connecting with the patient and developing rapport and empathy.
  - Summarising with the patient their reasons for attending; their feelings, concerns and expectations.
  - Handing over or sharing with the patient an agreed management plan which hands back control to the patient.
  - Safety-netting or making contingency plans in case the clinician is wrong or something unexpected happens.
  - Housekeeping or taking measures to ensure the clinician stays in good shape for the next patient.

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What's different now?

- **Under-pressure GP: 'I'm so busy I don't have time to go to the toilet'**

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InnovAIT

- InnovAIT Volume: 12 issue: 1, page(s): 33-37
  - The need for new GP consultation models
  - Dr Deen Mirza
- Is it okay to consider Efficiency vs Patient Satisfaction?

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The doctor–patient power dynamic has changed.

There is less authority derived from the GP's position.	• Patients are less intimidated by the GP, many of whom are sessional and more transient than in previous eras.
Patients are also much more aware of their rights.	• Their expectations are further elevated by politicians who promote unrealistic slogans such as '7-day services'.
Patient culture today involves more complaints than before, leading doctors to modify their behaviour to avoid complaints.	• Although we do not have as many medicolegal claims for malpractice in the UK as there are in the USA, the numbers of such claims are slowly increasing.

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Increased complexity of the consultation

- An ageing population with multiple morbidity and complex treatment algorithms means the GP needs to know more and manage more within a consultation.
- The pressure on services means that patients are more likely to bring multiple problems to be dealt with in one appointment, not all of which can be separated out cleanly and prioritised.
- "The computer's agenda", reminding the GP to carry out medication reviews and give smoking cessation advice, usually completely unrelated to the patient's agenda.
- Another factor, not so prominent 30 years ago, is the requirement for documentation.
    - The risk of being sued has increased the pressure on GPs to closely document each patient encounter.
    - This takes time to think and type, time which is not factored in after a patient has taken a full 10 minutes face-to-face.
- With all of this going on simultaneously, it can be difficult for the GP to focus on communication, as there is now even more to cover in the consultation than, for example, eliciting ideas, concerns and expectations.

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Cultural changes affecting the consultation

- Previous consultation models were derived from an essentially mono-cultural setting.
- This setting has completely changed and is now more dynamic, particularly in the many urban practices in the UK.
    - Patients from, non-UK backgrounds have different language and cultural issues to consider.
    - Their consultation behaviour often does not match the standard questions supposedly needed for MRCGP-style encounters.
- Patients often expect medical services to be provided instantly, putting more pressure on the consultation.
- Often patients come to the GP already prepared with information from the internet that can cause different challenges within the consultation.

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GP stress and emotional capacity

- When the first consultation models were written, GPs used to feel stressed at times, but now stress has become a way of life.
- When GPs are stressed and stretched thinly, they have less emotional capacity to deal patiently with confrontations.
- The premise of the last generation of consultation models was that we need to be wiser, more intuitive and more understanding when faced with difficult patient encounters.
- GPs need more practical consultation models that accept GPs as they are in the daily grind, not how they should be in an ideal world.

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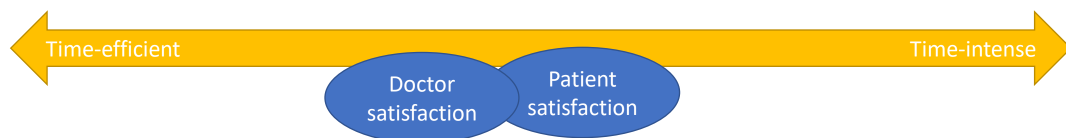
Patients v Doctors

Problem focussed	Empathy focussed
Doctor-centred	Patient-centred
Disease-specific	Holistic
Solution-driven	Person-driven
Rigid	Flexible
Tangible end-point	Scenic route



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Doctor-Sensitive Consulting

In the 20th century there was a paradigm shift from doctor-centred consulting to patient-centred consulting.

There is now a need for another paradigm shift to 'doctor-sensitive consulting'.

This approach takes account of the doctor's own needs within a consultation, needs often unmet.

- These include the need to:
  - be safe and not miss anything dangerous;
  - the need to keep to time and avoid getting stressed;
  - the need for good documentation, not least to protect against complaints and medicolegal actions;
  - the need to preserve emotional well-being in order to achieve resilience and longevity.

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Patient-centred but doctor sensitive

- I think [consultation models] have taken on an almost religious connotation in the minds of many people; if you disagree with them, then you are a heretic. *(Deen Mirza 2019)*
- We should work *outside* the consulting room to relieve the pressures on the profession, but in the consultation we should try not to let our reactions under stress overpower our attempts to consult in what we know is the best way *(Roger Neighbour 2019).*

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What is more efficient?

Practice A	Practice B
• "We'll text you your results" • One problem per appointment • Reception-based booking	• "Book an appointment to discuss your results" • 15 minute appointments • Full GP triage

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One Practice's Efficiency Plan

- Allocate appointments to the most appropriate healthcare professional
- Structure consultations to meet patients' needs effectively
  - Build a rapport
  - Stay focused, summarise, and set an agenda
  - Incorporate shared decision making, a management plan, and safety netting
- Follow up
- Make full use of the multidisciplinary primary care team
- Cultivate clear policies at the practice
- Adapt GP consultations to incorporate new ways of working

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How to do it all

10 minutes

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Tips from Fast Consulters

- Time Awareness
  - Articulate to patients
- Equipment
  - Check before starting, have things to hand
- Use technology
  - Synomnyms
  - Touch-type
- Problem focus vs Empathy focus

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