

TALKING WITH PATIENTS

A CONSULTATION

HANDBOOK

Consultation Models

Hospital Clerking Model
Physical, Psychological and Social' (1972)
Byrne & Long
Stott & Davis
Pendleton
Neighbour
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Disease-Illness Model

Consultation Skills

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Intervention Categories
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Health Beliefs
Balint
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Medical Records

Bill Bevington

INTRODUCTION

The Challenge

Talking to patients can seem confusing. There seem to be so many ways of talking to our patients, all of them successful, that a newcomer can be left wondering where to start. Is one way better than another? The most revealing discussions sometimes seem to develop when the doctor strays from the history taking and talks to the patient about initially irrelevant non-medical matters. How does the doctor do this, make sense of it all, and still have time to record the consultation within the space of 10 minutes?

This short handbook has evolved from the Consultation Handbook for GP Registrars on the Guildford and Chertsey GP VTS Day Release Course. It introduces doctors to the study of the Consultation and provides perspectives for looking at consultations in many different ways.

The Consultation in general practice is the corner-stone of our work with our patients. The ways of analysing consultations and various aspects of consultations are laid out page by page. There is a brief accompanying description to clarify each list, but it is not intended to duplicate the text from which the summary has been drawn. References are given in each section, and a list of the consultation models is provided inside the back cover for easy reference and comparison.

There have been a number of helpful models of the consultation which have been produced over the last 30 years. Some are task-orientated, process or outcome-based; some are skills-based, some incorporate a temporal framework, and some are based on the doctor-patient relationship, or the patient's perspective of illness. Many incorporate more than one of the above.

Models of the consultation give a framework for learning and teaching the consultation; the toolbox is a useful analogy. Models enable the clinician to think where in the consultation they are experiencing the problem, and what they and the patient aiming towards. This is helpful in then identifying the skills that are needed to achieve the desired outcome. A particularly useful general book on Understanding the Consultation by Tim Usherwood (see the book list at the end of this document) describes a number of the models below in more detail, and also includes psychological concepts such as projection, transference and counter-transference.

Consultation Models

Consultation models are established lists of questions or areas to be explored, and provide a framework for a consultation. They can be useful, especially to those of us who like to think and learn in a structured or organised way, especially when developing a skill such as consulting with patients.

There is no suggestion that any one model is better than another, they are all valid and useful in their different ways. There is duplication between them, after all they are models based on the same fundamental activity, but with different emphasis related to their origins. Models are not intended to direct the doctor to move slavishly through the model from beginning to end,

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the doctor can select and use a part of any model and as skills develop can weave components of two or more models into the same consultation, a true pick'n mix selection.

As competence and confidence grow the models can become superfluous; an experienced driver no longer needs to say 'mirror-signal-manoevre' at every obstacle. However, a study of this book may indicate new areas to explore, and may help to answer questions about dysfunctional consultations.

Revisions since the first edition now include chapters about how we think while we are formulating diagnoses, the ramifications of patient-management, patient centredness, and a simple guide through the minefields of medical audit.

THE HOSPITAL CLERKING MODEL

HPC	History of Present Complaint
PMH	Past Medical History
DRUGS	Medication
FH	Family History
SH	Social History
DQ	Direct Questions
EXAM	Examination
Inx	Investigation
D	Diagnosis

This first consultation model is a list of areas covered in classical hospital clerking or history taking. Derived from the list with which we encountered our first patients as medical students it is intended to be comprehensive and takes us systematically through the whole medical history. The model concentrates on the disease and the final goal is the achievement of an accurate **diagnosis**.

This model is particularly helpful when learning how to carry out consultations whether in hospital or a general practice setting, and has therefore been renamed **the inductive method**. Unconstrained by time the student is trained by taking several histories in this way, developing the necessary communication and examination skills as experience grows.

In General Practice we have developed work patterns which usually necessitate much shorter consultations. We simply do not have the time to work systematically through such a comprehensive list of tasks during every consultation and so the doctor usually focuses on a selection of different aspects of the consultation which are often not disease-orientated as in the hospital model, but more often focused on **The Patient, The Illness, or The Problem**.

Reference:

Fraser RC 1987 and 1992 *Clinical Method - A General Practice Approach* Butterworth Heinemann ISBN 075061448X

A modern book written by Robin Fraser, Professor of General Practice in Leicester. Well balanced, covering many aspects of the consultation, problem solving, communication, the diagnostic process, ethics, in addition to his useful reworking of the hospital model as the "inductive method"

'Physical, Psychological and Social' (1972)

The RCGP model encourages the doctor to extend his thinking practice beyond the purely organic approach to patients, i.e. to include the patient's emotional, family, social and environmental circumstances.

BYRNE & LONG

“Doctors talking to patients”. Six phases which form a logical structure to the consultation:

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

This model is derived from work by a GP and a Psychologist working 25 years ago. Pat Byrne and Phil Long studied audio tapes of hundreds of consultations in General Practice and compiled their list of six tasks or 'areas covered' from the consultations they had recorded. The list is short but includes for the first time in this series of consultation models the tasks of **introduction and finishing**, and in the task '**considering the problem**' the patient is actively involved. Another distinction from the Hospital Model is that the Examination includes an examination of the patient's thoughts as well as physical findings. Compared with the Hospital Model, Byrne and Long's model moves the focus of attention on to the illness. Illness is personal and unique, disease is impersonal and general.

Byrne and Long's study also analysed the range of verbal behaviours doctors used when talking to their patients. They described a spectrum ranging from a heavily doctor-dominated consultation, with any contribution from the patient as good as excluded, to a virtual monologue by the patient untrammelled by any input from the doctor. Between these extremes, they described a graduation of styles from closed information-gathering to non-directive counselling, depending on whether the doctor was more interested in developing his own line of thought or the patient's.

Reference:

Byrne, P S. and Long B.E.L. (1976). *Doctors Talking to Patients*, RCGP Publications, London. ISBN 0 11 320652.6

A very detailed analysis. Not an easy read, but useful for us by providing this model.

STOTT & DAVIS

1. Management of Presenting problems
2. Modification of Help Seeking Behaviour
3. Management of Continuing Problems
4. Opportunistic Health Promotion

In 1979 Professor Nicholas Stott and RH Davis published a paper in the Journal of the RCGP entitled “The Exceptional Potential of each Primary Care Consultation.” In it they described a simple model to help us think of 4 tasks that can take place in any consultation.

A. Management of Presenting Problems

This is the commonest task carried out in a consultation. An example would be a consultation for an intercurrent infection.

B. Modification of Help-Seeking Behaviour

An example might be to suggest that someone who repeatedly presents within 24 hours of the onset of a sore throat might consider self medication for future episodes.

C. Management of Continuing Problems

After managing the presenting problem of the sore throat it can be a good opportunity to ask about ongoing problems such as diabetes or depression.

D. Opportunistic Health Promotion

Every consultation creates an opportunity to ask about and record such information, for example about smoking, weight, cervical smears, immunisation etc.

Reference:

Byrne, P S. and Long B.E.L. (1976). *Doctors Talking to Patients*, RCGP Publications, London. ISBN 0 11 320652.6

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PENDLETON

1. Reason for Attending
 - Nature and history of problem
 - Aetiology
 - Patient's ideas, anxieties, expectations
 - Effects of the problem
2. To Consider Other Problems
 - Continuing problems
 - At-risk factors
3. Doctor and patient choose an action for each problem
4. Sharing understanding
5. Involve patient in management, sharing appropriate responsibility
6. Use time and resources appropriately
7. Establish and maintain a positive relationship

This model was devised in 1984 by David Pendleton, a psychologist working with a group of GP trainers from the Oxford region. In this model there are specific areas involving the patient's thoughts and these assume an important role in this model. The new tasks of identifying the patient's **ideas, anxieties (concerns) and expectation** are specified, and identifying the **effects of the illness on the person** is incorporated as another new task. These four areas are often grouped together and called the **patient's agenda**. In this model the personal and psychological aspects of the illness and the importance of time management are further developed.

Reference:

Pendleton, D. et al. *The Consultation, An Approach to teaching and learning*. Oxford Medical Publications. ISBN 0 19 261349 9
A comprehensive book, describing the history of thinking about consultations. Readable and useful. Worth investing.

ROGER NEIGHBOUR

The Doctor's Two Heads

The Organiser

The Responder

The Five Activities

Connecting
Summarising
Handing Over
Safety Netting
Housekeeping

This model was constructed by Roger Neighbour, a GP from Watford, in 1987. Working with his local Trainers' Workshop he has simplified the list of tasks and so we have a totally new list. The structure is described in his book 'The Inner Consultation'.

The Doctor's Two Heads

His model is brief and therefore easy to remember and use in real consultations. He suggests that doctors are working in two radically different ways while carrying out tasks in the consultation. These are called the **Organiser** and the **Responder**.

As the **Organiser** we are managing the organisation of the Consultation, timekeeping, asking questions, deciding to examine, making records, slowing and speeding consultations, negotiating and planning the patient's management.

The other role is as **Responder**. By Responder he means the attentive doctor, listening, thinking, processing, creating and testing ideas and being empathic. The doctor-centred nature of the organiser and patient-centred style of the responder are obviously completely different and mutually exclusive. While being an active organiser it is difficult to be responsive and vice versa. The skilled doctor needs to balance his own roles as organiser and responder while carrying out the five tasks in the Consultation.

An analogy of this Organiser/Responder idea might be driving a car while talking to a passenger. The organiser has to do the driving and the responder listens and talks to the passenger - sometimes we have to stop listening and concentrate on the driving completely, and if the road is straight, wide and empty, with a minimum of distractions, we can concentrate as much as possible on our passenger, but without taking our eye off the road!

The Five Activities / Tasks

Connecting is established as an effective working relationship with a patient and obtaining information, developing empathy and rapport.

Summarising is drawing together the information gathered, making a diagnosis, checking it with the patient and formulating a plan for their care.

Handing over is returning the responsibility for some aspects of the disease and its management to the patient, agreeing a plan with explanation and reassurance.

Safety Netting is creating a contingency plan and procedures relevant to that patient, to ensure that the plan works out and that the patient is safe in any foreseen or unforeseen eventualities.

Housekeeping is keeping oneself, the doctor, well organised and in good condition, to be at ones most efficient and effective. It recognises the need to attend to fatigue, boredom, stress, lack of concentration, distraction and all the powerful emotions that can distract the doctor.

This model is different from all the previous ones because it seems to have moved on to include not only the clinical components of the previous models but now includes, for the first time, specific areas for safe doctoring (i.e. Safety Netting) and for being a healthy doctor (Housekeeping).

Reference:

Neighbour, R.H. (1987) *The Inner Consultation* Lancaster: MTP Press

An intellectually beautiful book which I found rather long winded for my liking. It is clever and erudite but you need to make real time for this one. A classic, but browse before you buy to see if it looks like a book for you.

CALGARY-CAMBRIDGE MODEL

STRUCTURE & FRAMEWORK

Initiating the Session

- establishing initial rapport
- identifying the reason(s) for the consultation

Gathering Information

- exploration of problems
- understanding the patient's perspective
- providing structure to the consultation

Building the Relationship

- developing rapport
- involving the patient

Explanation and Planning

- providing the correct amount and type of information
- aiding recall and understanding
- achieving a shared understanding - incorporating the patient's perspective
- planning: shared decision making

Closing the Session

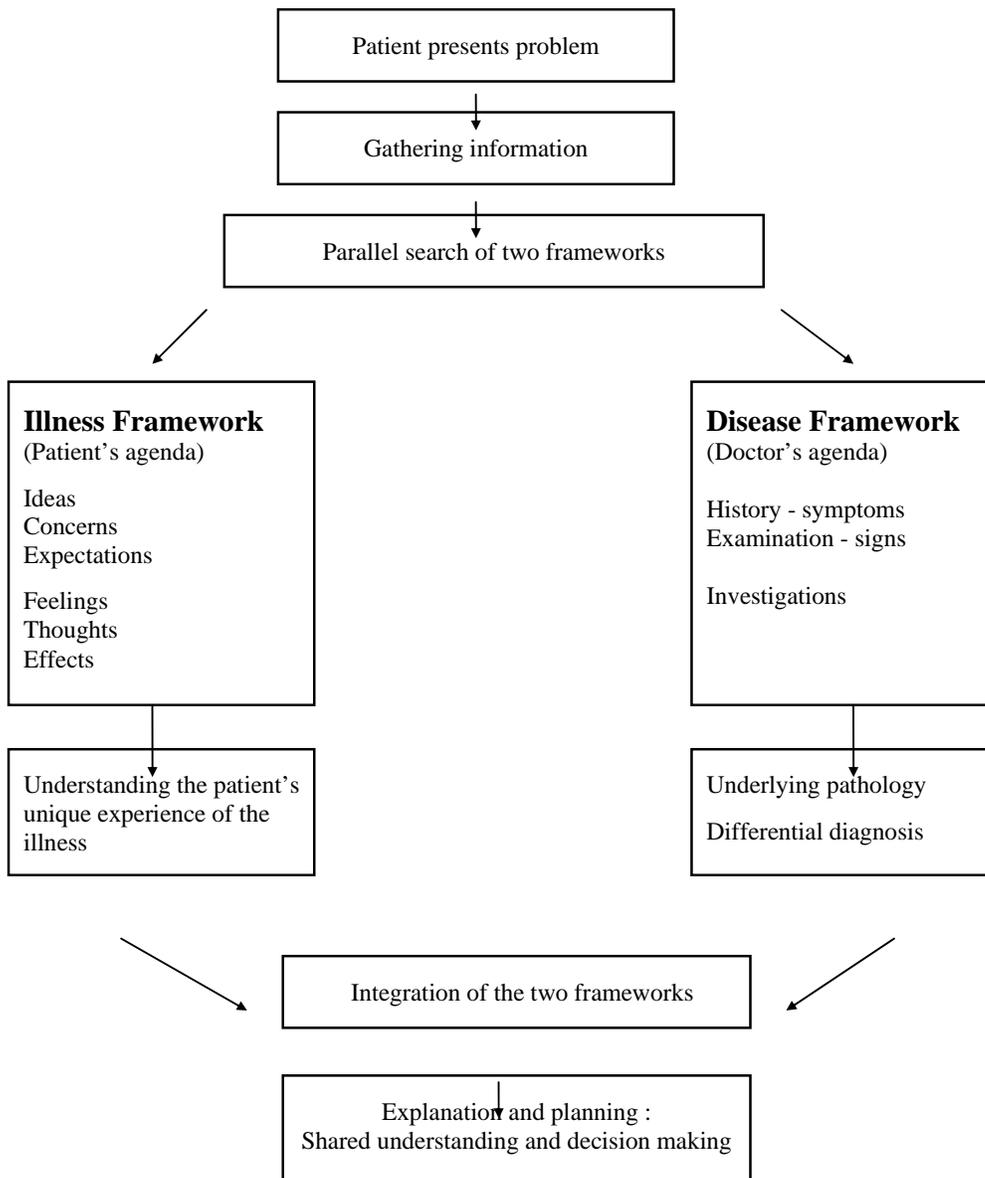
The Calgary-Cambridge Observation Guide to the Consultation.

This useful tool combines a standard consultation model with a framework for studying how we use skills within a consultation. Increasingly, it is being used in teaching and improving consultation skills and is particularly suited to structuring analysis of video consultations. The basic framework of the model is shown here. It reflects the changes in the later consultation models (Pendleton & Neighbour) with increasing emphasis on a patient-centred consultation. The main purpose of the model is in looking at the consultation skills that we use within each section of the framework. These are listed in more detail later, in the section on consultation skills.

DISEASE – ILLNESS MODEL

This model, (Stewart and Roter), shows the two parallel frameworks and the “tasks” in a consultation. It reinforces the importance of addressing the patient’s agenda. As a doctor, you can independently satisfy your own agenda and believe that you have conducted a successful consultation without exploring the patient’s agenda.

Does it really matter? Some examples. You see a patient with arm pain and invest 10-15 minutes with a full and clear explanation of tennis elbow, running through various treatment options, and as you move to close the consultation, the patient asks “Can I have a sick-note?” – all they wanted. This will happen many, many times! You see a young man on 4 separate occasions regarding chest pain and spend a lot of time reassuring and explaining why you believe it is non-cardiac pain. He keeps on coming back – his uncle has recently died from carcinoma of the oesophagus.



CONSULTATION SKILLS

On the previous pages we have looked at some of the established or seminal consultation models. These Task Models can be summarised as lists of areas to be covered, rather like stepping stones which one may choose to use, or not use, when making a journey across a stream. In the consultation they describe what we do.

Consultation Skills on the other hand do not tell us what to do but how we do it, i.e. how we get from one stepping stone to another. Skills in consultations are numerous and sometimes nebulous but developing them can improve the consultation. Using these skills can help us to think more effectively and explore many different ways of understanding how our patients think and behave.

The following pages briefly describe some of the consultation skills.

Communication Skills

Diagnostic Skills – Hypothetical-Deductive Model

Patient Management Skills

Intervention Categories

Patient-centred Consultation Style

Calgary-Cambridge Consultation Skills

Psychological Aspects of the Consultation

Health Beliefs

Balint

Transactional Analysis

COMMUNICATION SKILLS

Communication is a skill which we sometimes take for granted. Some doctors are much better natural communicators than others and in trying to improve our consultation skills it is worthwhile thinking about all the different ways in which we communicate. It is useful to identify the different methods or 'channels' of communication so that we can think about them in turn in order to develop more insight and awareness about how we do and don't communicate effectively. Here is a list of some of the different ways in which we communicate with our patients

A list of some important aspects of communication - how we communicate

- Non-verbal** Observation
 Reception
 Listening / free attention
 Non verbal cues
 Silence
 Eye contact / lack of eye contact
- Verbal** Questioning
 Reflection
 Confrontation
 Summarising
 Explaining

The Communication channels - ways in which we communicate

- Verbal and cognitive level
- Body sensation
- Emotions
- Sensory communication
- Body movement

1. **Verbal / cognitive** - this includes how we speak, the words and language we use, avoiding slang and jargon. It includes the sense of meaning that we transmit and the understanding that we receive from our patients. Who is doing most of the talking - us or the patient, or a well-meaning friend, relative or parent? Why?
2. **Body sensations** - if we focus our thinking upon our body we can think of all the following ways in which we ourselves 'feel' physically; hot, cold, dry, sweating, aching, pain, tension, comfort, butterflies, heart rate etc. We all have a blend or profile of body sensation and it can help to be aware of our own sensations, do they show, and what does it mean that we feel certain sensations during a consultation? Equally it is important to be observant for our patients body sensations, are they comfortable, do they look tense, are they in obvious pain, are they sweating etc? Can we spot how they are feeling, and what does that mean?
3. **Emotional communication** - this is sometimes self evident because of the other channels of communication which transmit emotions to us but we need to tune in to their mood and expression and to check out suspicions of sadness, depression, anger, anxiety, etc.

4. **Sensory channels** - touch, vision, hearing, smell, taste. Do our patients touch us a lot, do we touch our patients a lot? Can they see us clearly or is the window behind us? Is the light good for people with cataracts and impaired vision? Do they look at us at all, how much eye contact do we allow? None, enough, too much? Are they hearing us? Are we hearing them? Do we both try and talk at the same time? Are they deaf? Do we shout at foreigners? Do we smell OK? Do we react badly if our patients don't?
5. **Body movements** - in this channel we need to be aware of the concept of personal space. To understand the importance of posture and positioning of ourselves with respect to the patient, can we reach them and yet be at a safe distance for them, do we sit down to listen and do we understand postural echo? Do we allow our gaze to move around the desk, the computer screen or the room? Do we sit still? Do children fidget excessively and why? Other important and useful aspects of non verbal communication involve mannerisms and the use of our hands and arms, and body posture. Are patients comfortable lying on our couch, comfortable enough to be able to talk and continue telling us important pieces of information? Important history taking doesn't stop when the patient undresses, it is sometimes just starting.

IMPROVING COMMUNICATION

How can we improve the way in which we give and receive information and improve the effectiveness of our consultations?

- Raise free attention
- Clarify and reflect
- Work on the relationship
- Self disclosure

1. Free Attention.

One way we can improve our communication is by increasing our free attention. Free attention describes our ability to concentrate on our patient.

External Noise - Our natural ability and motivation to pay attention can be diminished by distraction, which can be divided into physical distraction or noise such as the telephone, traffic, an uncomfortable chair, poor lighting. This is external noise, i.e. outside our head.

Internal Noise - The other area of distraction is inside our head and consists of all the preoccupations that are on our minds while we are at work, inner voices that simply prevent us from concentrating totally on the patient in front of us, e.g. 'I must tax the car in the lunch hour' 'What shall I have for dinner tonight' 'I do hope my Mum's hospital tests are OK'

Free Attention = Attentive energy minus internal and external noise.

2. Clarify and Reflection

We can communicate better if we check that our patients have understood what we have said and if we check with them that we have understood what they said. Spelling it out and demonstrating that there has been mutual understanding can be very helpful.

3. Work on your relationship with your patient

If a consultation seems like hard work then accept responsibility for trying to make it work more easily for both you and your patient. Try and ask more *open questions* such as 'tell me about would like to know more about ...'. If we feel inwardly fed-up or even hostile towards our patients, especially if they go silent, seem to avoid the subject, argue or get confused with what we say, try not to argue back. Try and stay on the same side as your patient and perhaps go back to safe easy ground and build up a picture of their problem all over again starting with easy unthreatening areas for discussion. Try the following: 'Tell me something you think I may not have understood about you.' 'What do you need from me at this moment?' Remember too that most disgruntled patients have crossed transactions (see later section on *Transactional Analysis*) or an unfulfilled patient's agenda. Think therefore of the Pendleton Consultation Task List and in particular the Patient's Ideas, Concerns and Expectations and the Effects of the Illness upon the patient. Exploring these four areas one by one will often *expose the reason why patients seems to be disgruntled* and may help you to achieve a better outcome for the patient.

4. Self disclosure

This means being totally honest and open with our patients. Tell them how difficult and frustrating you find some problems that they present in the consulting room. Be honest and tell them if you don't know the answer to their questions. Sharing your reality as it happens can often increase a patient's comfort and not make matters worse.

In conclusion, it is often valuable to concentrate for a while upon one's ability to communicate. It is often difficult to sit down and do this on one's own but the video can be useful here, or inviting a trusted friend to sit in can often enable one to identify what is going on and in which "channel" of communication we are working, whether it is effective, and whether we might make any changes.

MAKING A DIAGNOSIS

HYPOTHETICO-DEDUCTIVE METHOD

DIAGNOSIS - definition - "Achieving knowledge through symptoms" (Greek)

Achieving an accurate diagnosis is the primary fundamental task of a consultation. Without it we are working with uncertainty and our management and prognoses are built on sand.

The Inductive Method

In hospital the diagnosis is sought out 'at all costs' and no stone left unturned until the truth is established. To achieve a diagnosis in the hospital context we use the **Inductive Method** to guide our consultations. The Inductive Model is systematic, indiscriminative and expensive in time and resources.

Prior knowledge - from memory or records

Presenting information - from patient

Early Hypothesis --> possibilities

Pre-diagnostic interpretation - PD1

Pivotal questions --> probabilities

Examination - to support diagnosis

Investigation - to clarify diagnosis

Diagnosis confirmed

Management decisions

The Triple Diagnosis

In General Practice the situation is totally different. For a start we seek diagnoses in any of the three areas:

- **Physical**
- **Psychological**
- **Social**

and there may be a working diagnosis or diagnoses in one or more of these broad areas. Diagnoses are presented in ill defined, vague, non-medical ways, often in the early stages and often blurred by the presence of more than one diagnosis. The illness is therefore often presented to a GP in a 'disorganised' form, compared to the 'organised' way in which we may refer to patient to a hospital with a clear description of a single problem.

The Hypothetico-Deductive Method

In General Practice we think differently during a consultation, initially listing the possible diagnoses or hypotheses, then listening carefully for important or pivotal symptoms which help us to prioritise our list of diagnoses and narrow the list down perhaps to one diagnosis. Only then, when we have a working diagnosis, do we progress to a selective physical examination to **clarify** the diagnosis. Next we may move on to investigate, again to clarify and confirm the diagnosis.

The factors which influence the prioritising of diagnoses are:

- probability
- seriousness
- treatability
- novelty. Novelty implies that the doctor may have recently made a rare diagnosis and think of it frequently when drawing up the list of diagnostic possibilities.

Practical Tips

Some practical tips for generating accurate diagnoses in a general practice setting might be:

- stay open minded i.e. be prepared to demote a diagnosis if questioning refutes it
- avoid the 'rule out syndrome' i.e. avoid reverting to the security of the Inductive Method which we sometimes do to avoid missing low probability diagnoses
- develop a Pre-Diagnostic Interpretation (PDI) i.e. the initial diagnostic favourite. Try to clarify this in your mind from **what the patient** is telling you before further questioning. E.g. 'It sounds like renal colic'
- use clarifying questions about pivotal symptoms if stuck try using diagnostic checklists
- remember the triple diagnosis
- common things occur commonly. Diverse symptoms and signs are often caused by a single disease entity

PATIENT MANAGEMENT SKILLS

RAPRIOP

Reassurance and Explanation
Advice
Prescription
Referral
Investigation
Observation
Prevention and Health Promotion

Reference: Robin Fraser *Clinical Method*

An excellent book based squarely on all aspects of the consultation. Clear. Readable. Usable. Affordable.

Having made a provisional diagnosis or diagnoses the main tasks in the Consultation can be collectively grouped under the title of patient management. In this context management is a broad area including many activities. Several are inter-related as is everything that happens during a consultation and the boundaries of the different management activities are often blurred and overlap.

For the sake of clarity the management tasks can be listed and considered separately. They are clearly described in Robin Fraser's book *Clinical Method* and make up the acronym **RAPRIOP**.

◆ Reassurance and Explanation

The most commonly used patient management activity, **Reassurance** requires high levels of skill to be really effective. Working well, reassurance can share or allay patient anxieties, using empathy and sympathy, and dispel false beliefs about diagnosis. Patients often have wide ranging and worrying ideas about their own diagnosis and prognosis. Reassurance therefore needs to be based on firm factual evidence of a diagnosis that the patient understands and agrees. There is overlap here with David Pendleton's Consultation Tasks and the support intervention from the 6 IVC's

There is evidence that good reassurance can influence Cooperation, Patient Satisfaction and even Health Outcomes.

◆ Explanation

Explanation is linked to Reassurance in the model but needs separate consideration. To explain things well we need to use clear, jargon-free language which is appropriate for our patients' level of medical understanding and intelligence. Explanation works best if there is a good doctor patient relationship in which the patient trusts and believes the doctor.

◆ Advice

Advice can be considered, like diagnosis, in the three areas of Physical, Psychological and Social problems. It needs to be appropriate and the style tailored carefully to each patient. Some patients and some problems seem to need a counselling or patient-centred approach, exploring the options together and negotiating the way forward. On other occasions a different style is needed and the doctor needs to be more prescriptive, changing the options for the patient and 'telling' them what must be done. The skill is to anticipate the most appropriate style for the particular patient or problem, and to develop a flexible range of skills.

◆ Prescription

In the context of this model Prescription means the prescribing of drugs. This chapter cannot include a full analysis of the wide range of factors related to prescribing but simply lists some key issues. What are the aims?

- therapeutic e.g. to prevent, cure, relieve symptoms
 - tactical e.g. to gain time, maintain contact, relieve doctor or patient anxiety
 - both
-
- **Will a drug really help?** Is there evidence to support prescribing, often at great expense.
 - **How effective will a drug be?** Will there be risks or side effects?
 - **Financial Cost Considerations**
 - generic v proprietary
 - types or groups of drugs
e.g. ACE Inhibitors v Ca Channel Blockers
 - **Contraindications and Interactions**
 - **Dosage and Duration** - is our advice accurate and evidence based?
 - **Compliance** – only 60% of prescriptions are dispensed & courses completed
 - **Ongoing supervision** - monitoring dosage etc.
 - **Information about drugs** - are patients informed or are they alarmed by the information they receive!!

◆ Referral

On average one in every ten consultations leads to a referral.

To whom do we refer?

- to Consultants
- to members of our PHC Team / attached team
- to ancillary healthcare workers
- complementary specialists
- Social Services

Why do we refer?

- for a second opinion
- for diagnosis
- for investigation
- for emergency treatment
- to access specialist therapeutic equipment
- for specific therapy
- for social reasons
- in response to patient pressure

The GP has an extended role over supporting a patient before and after referral, especially for serious and multiple problems, helping the patient to interpret and understand what has been said and done, and in coming to terms with it all.

◆ Investigation

Investigation is generally a blunt tool. On average only 1 % of screening investigations such as routine chest X-rays or cervical smears reveal a diagnosis. Even when focused and carefully selected the chances of success are still only 10%.

Why do we investigate?

- to confirm a diagnosis
- to exclude a diagnosis
- to monitor any treatment
- to screen any asymptomatic patients
- to impress something upon our patients

We investigate approximately every ninth patient we see in surgery, often at considerable cost, so we need to think and discriminate carefully, and minimise box ticking. The Hypothetico-Deductive Method suggests that we should use investigation to confirm and not make diagnoses.

Some questions about investigations

- Why am I ordering this test?
- What am I going to look for in the result?
- If I find it will it affect my diagnosis?
- How will this affect my management?
- Will this ultimately benefit the patient?

◆ Observation

In a General Practice context this means the long term management and use of time to watch over a patient and their illness. Most consultations are for self limiting conditions which simply do not require follow up. However about one quarter of our consultations involve the management of chronic illness and the key is to care, and not necessarily cure.

Inadequate follow up results in anxiety and risks for the patient. Excessive care can erode a patient's independence and foster an inappropriate dependency on the doctor. Frequent follow up makes great time and energy demands on the doctor, possibly blunting his powers of observation, creating inconsistency and overwork.

The following factors can improve our observation of our patients:

- flexible appointment systems
- disease registers
- accessible doctors
- follow up clinics
- protocols and guidelines

◆ Prevention

Anticipatory care is that part of our work which encourages Health Promotion and Disease Prevention. The skill here is to think of it. We all know several basic ways in which people could lead healthier lives but we so often fail to promote these ideas in our surgeries.

The explanation is that the patient usually comes for a specific problem or problems directly unrelated to chronic disease or factors influencing health. To improve our performance in these areas we need to remember to address these areas, albeit briefly, in as many consultations as possible. Having been trained in a disease-based problem-solving hospital environment it is not always second nature for GPs to promote health.

THE SIX INTERVENTION CATEGORIES

Doctor Centred:

Prescriptive

Informative

Confrontational

Patient Centred:

Cathartic

Catalytic

Supportive

The Six Intervention Categories, or IVC's as they are known, are well established and are relevant wherever two people meet in a negotiating or advisory context. For the purpose of their use in General Practice the IVC's were developed by a psychologist, John Heron, working at the University of Surrey in Guildford in the 1970's in conjunction with the GPVTS day release course organisers.

As an analogy the doctor's discussion with the patient can be thought of as a brief spell when the doctor accompanies and influences the patient on his or her journey through life. The IVC's are literally interventions by the doctor in which he is influencing the future course or direction of the patients' journey. The IVC's are divided into doctor-centred and patient-centred interventions depending upon where the energy lies in the interaction, in other words, is the doctor actively trying to modify the patient's thinking or behaviour, or is the doctor suggesting ways in which the patient may actively choose to behave or think differently?

The Doctor Centred Interventions:

Prescriptive - in this intervention the doctor makes an explicit recommendation, that the patient should do something at the doctor's suggestion. He may or may not have involved the patient in choosing and discussing the suggestion but the essential component of this intervention is that the patient is given specific advice about what to do, what to take, or perhaps what to think!

Informative - this intervention is involved with the doctor imparting knowledge or information. How relevant it might be in the patient's opinion is obviously important. Lack of information leaves a patient dependent upon the doctor, excess information can create anxiety and inhibit the patient from finding out things for him/herself. Is it understandable, is it relevant, is it too simple or too complicated?

Confrontation - in this intervention the patient is confronted by the doctor. In the analogy of the journey the direction that the patient is taking is challenged by the doctor and so his thoughts or actions are being questioned. To help the patient find a better direction in his illness or in his life, confrontation can at first cause upset and be uncomfortable. It therefore needs to be appropriate, caring, sensitive, well timed, and followed up!

Patient Centred Interventions:

Catharsis - in this intervention the doctor helps the patient to explore and express emotions. Many emotions are so powerful that they actually disable patients and prevent them from getting on with their lives as effectively and positively as possible. For example, suppressed fear can produce shaking, suppressed anger can produce shouting, suppressed sadness produces tears. To help a patient to bring out and expose these emotions can therefore release them from the strain of unresolved negative emotions and help them move forward.

Catalysis - means moving a patient on, encouraging them, and helping them to say more. The ways of achieving catalysis are often subtle and gentle and are often non-verbal. For example, creating the right atmosphere, a quiet environment, a sense of trust and security, listening well, and genuine interest. This can encourage patients to continue to reveal thoughts and feelings which may be sensitive and which they have perhaps never shared with anyone. To maximise our ability to catalyse our patients we therefore need to look systematically at all these various areas which together can make or break a catalytic intervention. There are also some specific catalytic phrases which can be most useful such as reflecting or repeating the last word of a patient's sentence, and asking open questions which invite the patient to contribute more to the discussion.

Support - the intervention of support sounds elementary and is indeed exactly what it says. It means helping and encouraging the patient to cope with the stress of illness and life crises. It is an enabling intervention meaning that it is the opposite to "leaving it to the doctor" and is an expression of actual or intended help offered to the patient so that he or she can cope more effectively with their problem. Supportive interventions affirm the worth and value of the patient, their qualities, their attitudes and their actions. They are making the best of what the patient has and encouraging positive thinking at a time when patients might naturally be gloomy or lose sight of their strengths.

Successful and Perverse Interventions

Using the strategies contained in this list of interventions can help patients to move on in their journey from sickness towards health, where they previously became stuck or ended up not achieving health because they went down the wrong path. It is necessary to identify the necessary required intervention, carry it out and know when to stop.

Choosing the wrong intervention, performing it ineptly or persevering inappropriately is called perverse intervention and can undo the good that has gone before. There are obviously millions of ways of getting interventions slightly wrong but don't worry, you will soon sense, verbally or non-verbally, when you are on the wrong track. A simple example would be to be very prescriptive and do a lot of 'telling' and 'instructing' a patient who does not want to be told, e.g. counseling a hardened drinker by 'telling' him to stop will not usually work unless he is first of all motivated to stop.

Reference:

Heron, J. Six Category intervention Analysis. Human Potential Resource Group. University of Surrey. ISBN 1-85237-045-9.

This small but specialised book is the definitive handbook on the 6 IVC's. If you are interested in this subject then buy it! Many useful ideas which will remain evergreen.

PATIENT-CENTRED CONSULTATION STYLE

Doctor Centred

Patient Centred

Task

Doctors agenda
What is the Diagnosis ?

Patient's agenda
What is the Problem ?

Thinking convergent on the diagnosis

Thinking divergently about illnesses & problems
Patient's ideas, concerns & expectations
How do the problems affect the patient

Interventions

Prescription
Interpretation
Evaluation

Catalysis
Catharsis
Support

Techniques

Closed questions

Open questions

Time

Controlling time

Allowing time to explore unknown aspects of problems

Control

Paternalistic, 'recommending' or
suggesting' management decisions.

Discussing options with the patient, which the patient
may or may not take up - a counselling style

Deciding for the patient

Decisions with or by the patient

Generally regarded as a 'good thing' this style consists of a general approach and specific skills which result in the focus of attention concentrating on the patient, and in particular what the patient thinks and feels about all aspects of all the problems which they bring to the doctor.

The Doctor-centred , or Paternalistic style, in contrast, is more concerned with the doctor's need to organise the process of the consultation, trying to confirm the diagnosis with carefully chosen specific questions - *closed questions*. As a rule it is easy to spot closed questions, they can be answered with 'yes', 'no', or one word answers.

For example the question 'Do you feel tense or stressed these days?' can too easily be answered with a simple yes or no, which tells the doctor so little.

The Doctor-Centred doctor is working to time, deciding what to discuss and what to say and do, and is in control. Working like this can be efficient, punctual, and least stressful for the doctor, but can sometimes leave problems unexplored and anxieties unresolved for the patient.

Patient-Centred consultations, by contrast, allow the patient time to explore matters more fully. The diagnosis or diagnoses may be considered in the physical, psychological, and social realms. From the patient's point of view they are often thought of as 'problems' rather than 'diagnoses'. For example a hypertensive patient may be much more preoccupied by the malaise and impotence of hypertension and its treatment, than the precise BP readings which so worry the doctor. To the doctor it can seem like a serious diagnosis, to the patient it is a hell of a problem which may affect every aspect of his life.

So how do we conduct patient-centred consultations to successfully explore these important problems and thereby help our patients more effectively.

Time Allow time to explore and listen. Switch off the 'speed up' driver in your head when appropriate. Switch it on again later or you will never get home !

Triple Diagnosis Remember that patient's problems may be social or socially triggered, and that social and seemingly minor psychological problems may be perfectly adequate justification to the patient to come to see you . Not every patient will have a dominant physical problem.

Interventions Try to develop your skills in catalysis, catharsis and support. These skills take up time and can be embarrassing and tricky to develop, but are the way into the patient's mind

Patient's Agenda Ask specifically about each of the components of the patient's agenda, especially if you are stuck not knowing what to make of the patient's symptoms

Patient's Ideas: 'What do you think is the cause of your problem?'

Patient's Concerns: 'What is it about this problem that worries you most?'

Patient's Expectations: 'What did you think I should do about your problem today?'

Effects of the problem: 'How is this problem affecting your life at the moment?'

Not every one of these questions will always be rewarded with an illuminating answer, but often they do create a flash of insight or understanding, enabling the consultation to move forward

Open Questioning Open questions demand an 'open' or descriptive reply. So instead of 'Do you feel tense or stressed these days ?' consider as an alternative 'You seem to have a lot going on. What is the most stressful aspect of your life at the moment ?' This kind of question might be stone walled with a monosyllabic ' nothing', but will usually encourage a helpful descriptive reply. So try questions which begin with the words:

What is the most difficult/worrying/depressing

Tell me about

It is important to stress that a patient-centred consultation style is not necessarily better than a doctor-centred style. Patient-centred consultations last longer, create more work, and are consistently more stressful for the doctor. They do however help the doctor to develop a greater understanding of his patients and their problems.

The ultimate skill is to be able to move gently from one style to the other, and back, the doctor gaining control of time and task in the one, allowing and making time to discuss and explore the patient's problems in the other.

CALGARY - CAMBRIDGE OBSERVATION GUIDE

INITIATING THE SESSION

Establishing Initial rapport

- Greets patient and obtains patient's name
- Introduces self and clarifies role
- Demonstrates interest and respect

GATHERING INFORMATION

Exploration of problems

- Patient's narrative
- Question style
- Listens attentively
- Facilitative response
- Clarification
- Internal summary
- Language

Providing structure to the consultation

- Internal summary
- Sign-posting
- Sequencing
- Timing

BUILDING RELATIONSHIP

Developing rapport

- Non-verbal behaviour
- Use of notes
- Acceptance
- Empathy and support
- Sensitivity

EXPLANATION AND PLANNING

Providing the correct amount & type of information

- Chunks and checks
- Assesses patient's starting point
- Asks patients
- Gives explanation at appropriate times

Achieving shared understanding

- Relates to patient's illness framework
- Encourages patient to contribute
- Picks up verbal & non-verbal cues
- Elicits patient's beliefs

CLOSING THE SESSION

- End summary
- Contracting
- Safety netting
- Final checking

Identifying reason(s) for the consultation

- The opening question
- Listening to opening statement
- Screening
- Agenda setting

Understanding the patient's perspective

- Ideas and concerns
- Effects
- Expectations
- Feelings and thoughts
- Cues

Involving the patient

- Sharing of thought
- Provides rationale
- Examination

Aiding accurate recall and understanding

- Organises explanation
- Uses explicit categorisation or signposting
- Uses repetition and summarising
- Language
- Uses visual methods of conveying information
- Checks patient's understanding of information given (or plans made)

Planning: shared decision making

- Shares own thoughts
- Involves patient
- Encourages patient to contribute
- Negotiates
- Offers choices
- Checks with patient

This is the daunting list of the 55 consultation skills that we use within the sections of the consultation framework. Some are almost second nature, some are self-explanatory, some needs further explanation. At the end of the handbook, there is an extended version of this list with further explanations. In general, you identify an issue in a consultation, for instance, achieving shared understanding, and then you examine the skills that you used, or could have used, within that section, to improve the consultation.

THE HEALTH BELIEF MODEL

- Motivation about health
- Perceived vulnerability
- Perceived seriousness
- Costs v Benefits
- Cues to action
- Locus of Control
 - Internal Controller
 - External Controller
 - The Powerful Other

Health Beliefs

This recently revived list is concerned with the beliefs that our patients have about illness and health. The list is not in itself proposed as an alternative model or structure to carry us through a consultation, but it is a direct development of the ideas contained in the Pendleton list and it fits in appropriately in this series of consultation models. Health beliefs focus in increasing detail on the patient's thoughts, not simply about the consultation, but about the patient's attitudes to illness in general and to themselves as patients. Asking ourselves and our patients about these issues can sometimes answer questions about the worried well, the hypochondriac, the non-compliant patient, the helpless and hopeless patient and the patient who repeatedly DNA's

During the 1950's a group of American psychologists tried to analyse the likelihood of individuals participating in a health promotion program, to identify and eradicate TB. The theory they developed argues that an individual's likelihood of taking up such an offer depends on several factors:

1. Whether they think they are **susceptible** to a particular illness
2. Whether the consequences of the illness could be **serious**, physically or socially.
3. Whether the 'treatment' would confer **benefit**.
4. Whether there are barriers where the costs outweigh the benefits, in physical, social or financial terms.
5. Internal factors such as symptoms or worry about symptoms, and external factors such as media campaigns and advice from friends can act as the trigger that makes a patient seek help. These are called cues to action.
6. Patients vary enormously in the way they accept responsibility for their health. Some patients feel that they control their own health destiny, and see the doctor merely as an aid to achieving the treatment, prescriptions or referrals that they need. They have a very well developed and firm idea of their own diagnosis and equally definite expectations of what the doctor should do for them. These are the demanding Guardian-reading patients who would be said to have a powerful **internal controller**.

Bill Bevington

Another group, by contrast, feel that their likelihood of developing illness or staying healthy is completely out of their control and that nothing that they might ever do such as modifying their lifestyle will really ever make a difference. These fatalistic patients have an **external controller**.

Yet another group of patients feel that their health destiny rests externally to them, as in the last group, but rests specifically with one particular influential person, perhaps the GP or a close relative. They often misunderstand advice unless it is dispensed in a very clear and often dogmatic fashion, when they will often co-operative by "doing as they are told". Their locus of control rests with a **Powerful Other**.

Reference:

Tate, P. *The Doctors Communication Handbook*. Radcliffe Medical Press.

For me the best, clearest and most readable book on the subject. In addition some excellent chapters on communications and consultations.

MICHAEL BALINT

Summary

1. Nearly all problems presented to the doctor have a psychological element to them and this needs exploring.
2. The doctor has feelings in a consultation. These need to be recognised and can be used to the benefit of the patient.
3. The general practitioner has a positive therapeutic role in all consultations, not only those with a defined disease process.

Michael Balint (pronounced Bay-lint) was a Hungarian psychologist who worked in London with a group of GP's in the 1950's and 1960's. The group met regularly for many years and discussed the doctors, patients and their consultations. They developed three philosophies which are particularly relevant in general practice.

1. It became evident that many patients who presented with minor physical complaints also had a psychological problem. Focusing on the psychological problem, which may be a 'stand alone' problem, or a problem directly related to or caused by physical illness often achieved greater success than working on the physical problem alone.
2. Michael Balint's second philosophy was that doctors have feelings and that these feelings can have an important influence on the Consultation. They need to be identified and used in the consultation. By highlighting the real importance of the doctors feelings and using them consistently in a consultation the term 'the doctor as the drug' was coined. This meant that a doctor can have a powerful ability to influence the patients' thinking and ultimately their total health, without necessarily writing a prescription.
3. The third philosophy drawn from Michael Balint's work was that doctors can develop the necessary skills to work effectively with psychological problems that patients present. Previously the concept had been that the doctor's skills were dependent upon the doctor's personality, and that personality dictated the likelihood of the doctor exploring the patient's psychological problems. Balint suggested that such success often simply depended on asking appropriate questions about psychological problems, and that doctors could therefore be taught to ask these questions and become more successful.

The Flash Technique

The Balint approach established that doctors have an active and not passive role in consultations. He showed that the doctor's feelings need to be identified and used within the consultation. Subsequent work by Balint and his wife Enid Balint described the flash technique where doctors become aware of their feelings in the consultation and sometimes interpret the feelings back in a way that can give the patient some insight into the problems that are presented. For example, if a patient angers the doctor it may be that other people will also be made angry by the patient. It might be appropriate to ask the patient about this.

Reference:

Balint, M. (1957) *The doctor, his Patient and the illness*. Tavistock Publications, London. ISBN 0272792063.

TRANSACTIONAL ANALYSIS

Transactional analysis (TA) helps us to look at consultations - often difficult ones or consultations with unsatisfactory outcomes - by concentrating on the state of mind, or ego state, of the patient and the doctor, and how they interact.

Ego States

The theory, described by Eric Berne, is based on the concept of the Ego States. At any one time all of us are said to be in one or other of three ego states which are described as:

Parent ego state	P
Adult ego state	A
Child ego state	C

The Parent ego state is the part of us which is preoccupied with parental thoughts and speech and can often be identified by containing the words 'should, ought, or must'. It is imprinted on us as children, by our own parents and other authority figures such as teachers, doctors, older siblings, police, and those in authority. The Parent ego state has two different components: One is the **Nurturing Parent**: e.g. 'You shouldn't go near the fire or it will burn you' The other is the **Critical Parent**: e.g. 'You simply must stop smoking now'.

The Adult ego state is principally concerned with thoughts and speech that are logical and factual. e.g. 'If you go near the fire it will burn you'

'If you smoke your asthma will probably become worse'

Note the logic in these statements and the lack of parental content expressed within them. They are often problem solving, looking for sensible and constructive compromise whilst still allowing the recipient to retain individual autonomy, i.e. making the patients responsible for their actions.

The Child ego state is the part of ourselves that is concerned with the expression of our feelings. This is the first to develop when we are very little and in many ways it controls the subsequent development of the whole person. As we grow we acquire a basket full of feelings as a direct result of our earliest experiences. Some of these feelings will be resolved, or fulfilled, but others will be unresolved and can continue to affect us throughout the whole of our lives. The child ego state is also divided into two parts, the free child and the adapted child.

The Free Child is the healthy uninhibited part of us that is involved in having fun, being creative, experimenting, playing and loving.

The Adapted Child lacks natural spontaneity. The thinking and behaviour is adapted or inhibited in response to other peoples expectations or to difficult circumstances. An Adapted Child ego state can result in unnatural or manipulative behaviour such as petulant or sulky behaviour.

Examples

At any one time each of us can be said to be using one or other of our ego states which determines how we think and feel and behave. This influences the way others will view us, and dictate 'what we are like'. To illustrate this point one could think of a patient who is ill and simply needs to know the diagnosis and to be cured. This is factual logical thinking and they could therefore be said to be 'in' their Adult ego state when they come to see us.

'I have a sore throat. I think it may be tonsillitis. Can you advise me what to do?'

By contrast, some patients are always demanding, nothing is ever right and they seem to have a perpetual axe to grind. They could be described as being in their Parental ego state.

'Tell the doctor my throat is very sore and he must visit me today.'

Again by contrast, some patients seem to always be emotional and unable to be logical or take responsibility for their illness. The helpless and hopelessly 'chronic sick' and 'worried well' could fit into this category and can be described as being in the Adapted Child ego state. They have adapted their behaviour to stand a good chance of eliciting a certain 'nice' response from the doctor, perhaps sympathy, comfort, a prescription, or a certificate.

'Oh dear, doctor, my asthma is so bad I don't know what to do. I am so worried about it. I have been completely unable to stop smoking like you said I should.'

The key to understanding TA is to identify which ego state your patient is 'in' or is 'using' and to be aware how appropriate or inappropriate it might be in the circumstances. Is each person content with their own and the other's ego state, and is that ego state the most appropriate to enable a person to make the best possible progress as a patient?

Interactions or 'Transactions'

The doctor and patient can interact in many ways. In most successful consultations they will both display **adult** behaviour, or sometimes a **parent** doctor can work effectively with a **child** patient. Providing they are happy with each other's ego state the consultation will probably succeed and they will be satisfied:

Doctor

How is your asthma?

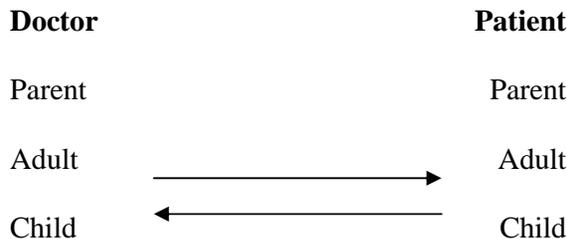
Patient

My asthma is still bad,
I haven't stopped smoking yet.

Do try and stop smoking, it really will help.

OK

All of this brief interaction is straightforward, factual stuff. The doctor's **adult** ego state has been communicating with the patient's **adult** ego state, i.e. a parallel, or complementary transaction that will probably be constructive and effective:



Crossed Transactions

Sometimes however the transaction can be crossed, for example the logical Adult doctor trying to reason with a drinker who is dependent on alcohol. The patient (Child ego state) feels the doctor is making unreasonable demands and being critical, and the patient will no longer 'work' with that doctor.

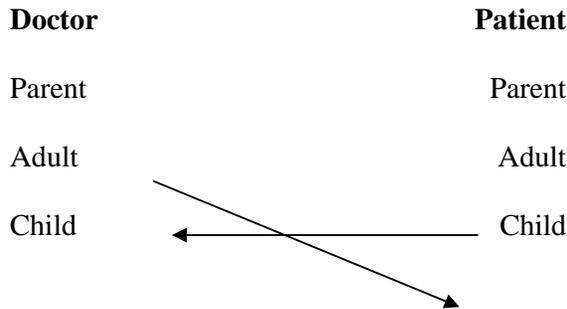
Doctor:

*Your liver enzymes are quite high
We must look at how much you are drinking.*

Patient:

You are always criticising my drinking,
just like by father did.

A crossed transaction, the consultation is going nowhere



Summary

Generally, individual patients tend to have a certain repertoire of thinking and behaviour. If, as doctors, we can recognise our patient's difficult or unproductive behaviour by using this model we can sometimes help them to develop insight and help themselves.

There are very many ways in which patients and doctors behave and interact. The many interactions and crossed interactions are described as 'games' and can be read about in the references given below.

References:

Eric Berne. Games People Play. Penguin Books
The man who devised and defined TA. Written in 1964.

Thomas Harris. I'm OK - You're OK Pan Books. ISBN 0-330-23543-5
Resume of TA., developing themes about TA.

Thomas Harris. 'Staying OK' Pan Books, ISBN 0-330-29136-X
And more. Includes excellent chapters on personal management. including time management.

Ian Stewart and Vann Joines. TA Today. Lifespan Books, ISBN 1-870244-00-1
An up-to-date book about TA and its modern use, including life scripts, drivers. rackets, stamps and games!
Probably the best one to buy.

MEDICAL RECORDS

Recording the events that take place in consultations is a complex skill.

Why do we make a record?

For the patient	who has a right to access the information in the notes.
For yourself	a) during the consultation - to record information we may otherwise instantly forget, e.g. blood pressure readings or symptoms; b) at the end of the consultation - when summarising and planning the management c) after the consultation - when writing a referral or reviewing previous consultations.
For our Partners	to find out what is happening in each other's consultations.
For administration	internally - e.g. recording cervical smears, immunisation etc.

The decisions about what to record and what not to record are difficult ones. The challenge is to abbreviate a hospital record keeping style (average hospital outpatient record = 87 lines of A4 per consultation) to a general practice record style (average = 4.5 lines per consultation on Lloyd George cards) without omission of important data and without recording worthless facts. This is, of course, an impossible task and by such vicious brevity we are risking omission and all the attendant dangers.

A study of GP notes invariably shows a smattering of all kinds of data, but almost invariably the information most often 'missing', which is often most useful retrospectively, is a record of diagnosis. Even if it is a 'soft' unsubstantiated diagnosis it is valuable to record, with question marks if desired.

There are many proposed models for record keeping. One that is quite a useful 'starting' model is known as 'SOAP', where one records something - even if only one word - in each of the four following categories:

S (Subjective)	Symptoms	c/o sore throat 7n
O (Objective)	Findings	o/e tonsillitis with exudates, glands
A (Assessment)	Diagnosis	Tonsillitis ? Glandular Fever,
P (Plan)	Management	Rx Pen V 250 7d. For IM Screen 10d

As one becomes more experienced the content will develop and different skills and recording methods will evolve.

Other factors to consider

Abbreviations

Disease Management Charts - held by the doctor
- held by the patient

Legibility.

Use of colour and diagrams.

Standardisation of recording

Summarising

What to keep and what to discard

Access to records

Recording home visits, emergencies, and telephone consultations

Using notes in an unobtrusive manner during consultations

Minimising time and maximising efficient use of time when using notes

Computerisation

The current trend is to increasingly record consultations and data on computer. The skill when using a computer is to try to develop the benefits of computer systems without losing any of the existing benefits of paper based notes.

The computer presents us with some new challenges of confidentiality, speed, size, flexibility, and general intrusion. All these problems are diminishing. In the meantime, the modern doctor needs to be increasingly computer literate and keyboard skilled.

CALGARY - CAMBRIDGE OBSERVATION GUIDE

INITIATING THE SESSION

Establishing Initial rapport

1. *Greets patient and obtains patient's name*
2. *Introduces self and clarifies role*
3. *Demonstrates interest and respect: attends to patient's physical comfort*

Identifying the reason(s) for the consultation

4. *The opening question:*
Identifies the problems or issues that the patient wishes to address e.g. "What would you like to discuss today?"
5. *Listening to the patient's opening statement:*
Listens attentively, without interrupting or directing patient's response
6. *Screening:*
Checks and confirms list of problems - e.g. "So that's headaches and tiredness. Is there anything else you'd like to discuss today as well?"
7. *Agenda setting:*
Negotiates agenda taking both patient's and physician's needs into account

GATHERING INFORMATION

Exploration of problems

8. *Patient's narrative:*
Encourages patient to tell the story of the problem(s) from when first started to the present, in own words (clarifying reason for presenting now)
9. *Question style:*
Uses open and closed questioning, appropriately moving from open to closed
10. *Listens attentively:*
Allowing patient to complete statements without interruption and leaving space for patient to think before answering or go on after pausing
11. *Facilitative response:*
Facilitates patient's responses verbally and non-verbally e.g. use of encouragement, silence, repetition, paraphrasing, interpretation
12. *Clarification:*
Checks out statements which are vague or need amplification e.g. "Could you explain what you mean by light headed?"
13. *Internal summary:*
Periodically summarises to verify own understanding of what the patient has said. Invites patient to correct interpretation or provide further information.
14. *Language:*
Uses easily understood questions & comments, avoids or adequately explains jargon

Understanding the patient's perspective

15. *Ideas and concerns:*
Determines and acknowledges patient's ideas (beliefs re cause) and concerns (worries) regarding each problem
16. *Effects:*
Determines how each problem affects the patient's life
17. *Expectations:*
Determines patients' goals, what help patient had expected for each problem
18. *Feelings and thoughts:*
Encourages expression of the patient's feelings and thoughts
19. *Cues:*
Picks up verbal and non-verbal cues (body language, speech, facial expression, affect); checks out and acknowledges as appropriate

GATHERING INFORMATION cont'd

Providing structure to the consultation

20. *Internal summary:*
Summarises at the end of a specific line of inquiry to confirm understanding before moving on to the next section
21. *Sign-posting:*
Progresses from one section to another using transitional statements, includes rationale for next section
22. *Sequencing:*
Structures interview in logical sequence
23. *Timing:*
Attends to timing and keeping interview on task

BUILDING RELATIONSHIP

Developing rapport

24. *Non-verbal behaviour:*
Demonstrates appropriate non-verbal behaviour e.g. eye contact posture & position. movement. facial expression. use of voice
25. *Use of notes:*
If uses notes or uses computer, does in a manner that does not interfere with dialogue or rapport
26. *Acceptance:*
Acknowledges patient's views and feelings; accepts legitimacy. is not judgmental
27. *Empathy and support:*
Expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self care
28. *Sensitivity:*
Deals sensitively with embarrassing and disturbing topics and physical pain, including when associated with physical examination

Involving the patient

29. *Sharing of thoughts:*
Shares thinking with patient to encourage involvement e.g. -What I'm thinking now is
30. *Provides rationale:*
Explains rationale for questions or physical examination that could appear to be non-sequiturs
31. *Examination:*
During physical examination. explains process, asks permission

EXPLANATION AND PLANNING

Providing the correct amount and type of information

- Aims: to give comprehensive and appropriate information
to assess each individual patient's information needs
to neither restrict or overload*
32. *Chunks and cheeks:*
Gives information in assimilatable chunks, checks for understanding, uses patient's response as a guide to how to proceed
 33. *Assesses patient's starting point:*
Asks for patient's prior knowledge early on when giving information, discovers extent of patient's wish for information
 34. *Asks patients*
What other information would be helpful e.g. aetiology, prognosis
 35. *Gives explanation at appropriate times:*
Avoids giving advice. information or reassurance prematurely

EXPLANATION AND PLANNING Cont'd

Aiding accurate recall and understanding

Aims: to make information easier for the patient to remember and understand

36. *Organises explanation:*

Divides into discrete sections, develops a logical sequence

37. *Uses explicit categorisation or signposting*

e.g. "There are 3 important things I would like to discuss. 1st
Now, shall we move on to"

38. *Uses repetition and summarising:*

To reinforce information

39. *Language:*

Uses concise, easily understood statements, avoids or explains jargon

40. *Uses visual methods of conveying information:*

Diagrams, models, written information and instructions

41. *Checks patient's understanding of information given (or plans made):*

e.g. by asking patient to restate in own words; clarifies as necessary

Achieving a shared understanding: Incorporating the patient's perspective

*Aims: to provide explanations and plans that relate to the patient's perspective of the problem
to discover the patient's thoughts and feelings about the information given
to encourage an interaction rather than one-way transmission*

42. *Relates explanations to patient's illness framework:*

To previously elicited ideas, concerns and expectations

43. *Provides opportunities and encourages patient to contribute:*

To ask questions. seek clarification or express doubts; responds appropriately

44. *Picks up verbal and non-verbal cues*

e.g. patient's need to contribute information or ask questions, information overload, distress

45. *Elicits patient's beliefs, reactions and feelings:*

Re information given, terms used; acknowledges and addresses where necessary

Planning: shared decision making

Aims: to allow patients to understand the decision making process to involve patients in decision making to the level they wish to increase patients' commitment to plans made

46. *Shares own thoughts:*

Ideas, thought processes and dilemmas

47. *Involves patient*

by making suggestions rather than directives

48. *Encourages patient to contribute:*

Their thoughts, ideas, suggestions and preferences

49. *Negotiates:*

Negotiates a mutually acceptable plan

50. *Offers choices:*

Encourages patient to make choices and decisions to the level that they wish

51. *Checks with patient:*

If accepts plans, if concerns have been addressed

CLOSING THE SESSION

52. *End summary:*

Summarises session briefly and clarifies plan of care

53. *Contracting:*

Contracts with patient re next steps for patient and physician

54. *Safety netting:*

Explains possible unexpected outcomes, what to do if plan is not working,
when and how to seek help

55. *Final checking:*

Checks that patient agrees and is comfortable with plan and asks if any corrections, questions
or other items to discuss

THE CONSULTATION TASK MODELS

HOSPITAL MODEL	BYRNE & LONG	STOTT & DAVIS	PENDLETON	NEIGHBOURHOOD MODEL
History of Present Attending Complaint	Establish Relationship Organiser vs Responder	Management of Presenting Health Motivation problems	Reason for	
Past Medical History of Connecting	Discover Reason for Perceived Vulnerability Attending	Modification of Help Seeking Behaviour	Nature & History Problem	Summarising
Medication	Physical and/or Verbal Examination	Management of continuing problems	Aetiology	Handing Over
Family History	Dr or Dr Pt Consider Problem	Opportunistic Health Promotion	Ideas, Concerns & Expectations	Safety Netting
Social History	Dr & ?Pt Detail Rx and Investigations	Internal or External	Effects of the	Housekeeping
Problem Direct Questions	Dr or ?Pt Ends Consultation		Continuing	
Examination Problem			At Risk Factors	
Diagnosis			Choose Action	
Investigation			Sharing	
Understanding Treatment			Involve Abet in	
Management			Sharing	
Responsibility			Use Time	
Appropriately			Maintain positive	
relationship				