THE EXTENDED CONSULTATION

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Many models have been developed over the course of time to extend the consultation from a biomedical focus on the human body to include an integration of psychosocial perspectives.

In 1979, Stott and Davis1 proposed that in every consultation, 4 areas represented by the mnemonic "ABCD" — for issues of acute presentation, behavioural issues, chronic continuing care and disease prevention — be addressed. In 1984, McWhinney's disease-illness model[2] extended the disease focus of the doctor to the illness experience of the patient.

In 1987, Roger Neighbour[3] believed that the external consultation of the doctor with the patient had to be extended by the "inner consultation" of the two "heads" within the doctor — the "rational head" and "intuitive head".

In 1999, Stuart & Liebermann[4] proposed "The BATHE technique", an algorithm of incorporating counselling and psychotherapy into everyday management by pacing the background, affect, troubles, and handling of the current situation, followed by an empathic response.

In the 2010, for the Sreenivasan Oration[5] of the College of Family Physicians, A/Prof Cheong spoke on "Re-defining the Art of Consultation". Subsequent to this, together with his colleagues, A/Prof Goh Lee Gan and Dr Ong Chooi Peng of the Division of Family Medicine, National University of Singapore, A/Prof Cheong explored ways to introduce brief counselling into the usual consultation where there is a need for this to be part of the extended consultation. Such a model was proposed in a book by the three authors, Counseling Within the Consultation.[6] Doctors taught using this model found it challenging to apply counselling in their practice for various reasons, the chief of which were: how to fit counselling activities into the consultation in the limited time available; and how to fit counselling techniques into the consultation.

Undaunted, they persisted in learning from the medical students and doctors how such extended skills can be taught and used. The paradigm thus shifted from conducting counselling de novo to just extending the already familiar tools, namely, history, examination, and investigations into the consultation as and when these were needed. The workflow of using extended tools to selectively access psychosocial information followed by work after assessment (formulation) is easier to implement. This new model of extending the usual consultation is written up in a second book, The Extended Consultation: Talk matters! [7]

A paper in this issue 'Case vignettes in the extended consultation' based on six cases the authors encountered in their practice illustrates how the framework of extended consultation is used in practice[8].

The contents of the extended consultation model have been organised into 6 units in this Family Practice Skills Course on the Extended Consultation.

Unit 1 — This overview presents the usual and extended forms of history taking, examination, and investigation. Extended consultation involves examining the thought processes, feelings, and behaviours of the patient with regards to the problems presented as reasons for encounter. Usual and the extended investigations involve investigating the patient's thought processes using the mnemonic of CAR-ACE (clarification-assumptions-rationale-alternatives-consequences-rational experiencing). This leads on to formulation of the problem and management.

Unit 2 — The details of the extended examination, paying attention to communication modes, use of words, and reflections, are presented in this Unit.

Unit 3 — This Unit describes the CAR-ACE framework of extended investiagation in some detail.

Unit 4 — This Unit formulates the information collected into a list of issues relevant to the patient in the form of predisposing issues in the patient's response to his problems, precipitating issues which created the present problem, perpetuating issues which keep the problem alive, and protective issues which balance out the negative issues. This unit also describes the 4P's of intervention — problem work, pattern work, presence work, and positive work.

Unit 5 — This Unit describes when problem work and pattern work can be used, and the tools for the tasks. References to everyday applications of problem work and pattern work are provided for chronic insomnia, smoking cessation, chronic obstructive airway disease, diabetes management, cardiometabolic risk reduction, and shared decision in antibiotic use.

Unit 6 — This Unit describes what is presence work, and positive work. There may be a need for presence work to focus the patient to the here and now, in time and space, vis-a-vis the anxiety that he is experiencing. Positive work forms the basis for learning to be pleasant, engaged, and finding meaning in our daily lives.

ORIGINAL ARTICLE

In this issue of the SFP, we have an original article – Evaluation of a hybrid undergraduate dermatology training workshop during family medicine clerkship by Dr. Shah Mitesh, A/Prof Tan Ngiap Chuan and Ms Eileen Koh, who studied the acceptability and perceived effectiveness of the Hybrid Model of dermatology training during Family Medicine (FM) clerkship in a Singapore primary care institution. The 4-hour Hybrid Model covered description of cutaneous morphologies, photo illustrations of common diseases by the faculty, student presentations and a slide quiz. Responses from 994 medical students from 2010 to 2016 were

analysed. The study found that students' ratings on its usefulness had risen from 85.8 percent in 2010 to 94.0 percent in 2016.

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