UNIT NO. 1

CONSULTING SKILLS

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ABSTRACT

In general practice, the reason for seeking a consultation with the doctor is more varied than seeing a hospital specialist. The problem can be a biomedical one, a worry or concern, or a problem of living. Furthermore, for each reason for consulting, the patient has his or her ideas, concerns and expectations that need to be understood and dealt with if the consultation is to be an effective and satisfying experience for both the doctor and the patient. A patient-centred consultation seeks out the patient's reason for encounter (RFE) and his ideas, concerns and expectations (ICE). The potential in each primary care consultation goes beyond the acute problem. Communication and decision-making skills are important consulting skills.

INTRODUCTION

In general practice, the reason for seeking a consultation with the doctor is more varied than seeing a hospital specialist. The problem can be a biomedical one. Such a problem is usually due to self-limiting minor illness but occasionally may be due to a serious problem at an early stage such that it can be difficult to differentiate from a benign cause. The reason for consulting could also be a worry or concern. Furthermore, for each reason for consulting, the patient has his or her ideas, concerns and expectations that need to be understood and dealt with if the consultation is to be an effective and satisfying experience for both the doctor and the patient.

In this unit of study, the learning objectives are the ability to describe:

- Consultation as a task
- Consultation models used to help us deal with the problems at hand
- Contribution of the models to the consultation
- Pitfalls to avoid in the consultation.

CONSULTING AS A TASK

The first and most important task is to understand why the patient came or the reason for encounter (RFE). A second and equally important task is to seek out his ideas, concerns and expectations of the RFE. What follow these two tasks will be the processes to sort out the problem and decide on its diagnosis, prognosis and action to be taken.

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Reason for encounter (RFE)

Patient can come to see the doctor for a variety of reasons. The symptom(s) given by the patient may be explicit of his reason for seeing the doctor or it may be the "*ticket of entry*" for something that troubles the patient but which he finds difficulty for some reason to express directly (the so-called *hidden agenda* of the patient).

It is easy to make wrong assumptions why the patient came:

- It may be assumed that the patient has come to the doctor because of the symptoms; but for every patient who presents there are many more who are coping with similar symptoms themselves and not seeking help. Thus, it is not sufficient to know what symptoms have been experienced; we need to know what sense the patient has made of the symptoms in order to know why he or she has come.
- It is often assumed that the patient has come for treatment, but what he is looking for may be an assurance that something more serious is not going on, simply because he has seen someone with a serious problem having similar symptoms. His concern is that he may have the same problem.

The following is one classification of possible reasons for encounter.

Pain or other symptoms: Most medical encounters would concern physical complaints. The patient presents because his limit of tolerance has been reached. The symptoms are causing pain, discomfort or disability. In the outpatient setting, there is a need for a high index of suspicion for serious problems and try to exclude serious causes first. Chest pain and abdominal pain are typical cases in point. Cardiac chest pain needs to be considered in the differential diagnosis in the former, and appendicitis for both gender and ectopic pregnancy in the female for the latter. Enough history and documentation, and the judgment call of watchful waiting and review or referral will need to be made in undifferentiated cases.

Accident and emergency: The physical nature will be obvious. In dealing with a specific emergency, the doctor adopts a different approach. Instead of taking a history and performing an examination in the usual way, he replaces this with a technique of rapid assessment and immediate management. You are expected to have knowledge about the patient's illness which gives rise to emergencies, but in addition will be expected to know the immediate steps on diagnosis and management which are required on the road side, in the home or consulting room. The anxiety and fear of the patient or close ones that may accompany the situation may require management.

Problems with living: These can masquerade as a physical symptom such as headache or backache. There may be multiple visits before the real reason for encounter is unraveled. Problems of living can arise as a result of:

- personality disorders e.g. hypochondriasis, alcoholism, drug addiction
- family related situations e.g. the empty nest syndrome, bereavement
- work related situations e.g. unemployment, shiftwork
- the community e.g. the problems of a minority race, immigrants, social delinquents.

Seeking of reassurance: Patients whose real need is reassurance frequently, if not usually, present their symptoms rather than express their fears. And in response to these symptoms, the physician may achieve a diagnosis and proceed to treatment without recognising the patient's major problem. Cartwright has shown that in Britain patients interviewed at the end of consultations had seldom received adequate reassurance, and many of them had found their experience of consulting the doctor alarming rather than comforting.

Need to legitimise sick role: Society has given doctors a statutory role in the certification of illness. The patients who wish to take up the sick-role are by no means confined to those who want to be excused from work; the school child wishing to avoid school and the housewife who desires to manipulate her environment are almost as common.

Continuity of care / Continuing care: A family physician has a role to play in both acute and chronic care. In an acute situation he may not be able to make a diagnosis on first encounter e.g. PUO. He may then extend his consultation by inviting his patient to return whereby the illness would undoubtedly unfold thereby enabling him to institute the appropriate management.

In the care of chronic illness such as diabetes, hypertension, asthma and epilepsy, the family physician has much to do in clinical management. He however also co-ordinates the activities of other members of the primary health care team e.g. nurse practitioners, DAC nurse, dietitians and therapists in providing holistic care for his patient.

Prevention of disease: The patient may request for some form of prevention in health such as (a) well person care e.g. well-child or well-woman clinics, (b) routine immunizations, (c) pre-employment/retirement checkups or (d) periodic health examinations. This may result in multi-phase screening. A point to note is that this request may have arisen out of anxiety and it is important for the family physician to pick this up. Opportunistic screening is another method which family physicians can adopt to detect disease at an early stage.

Ideas, concerns and expectations

The motivation to see the doctor is driven by the patient's ideas, concerns and expectations. The patient attaches a meaning to his symptoms which is coloured by what he has observed or learnt about the symptom from others around him. What is apparently trivial to the doctor may be of great worry to the patient. Our job as effective doctors is to elicit if the symptom has a special meaning and concern to the patient. Only then could we begin to help the patient. This is achieved by asking open questions. "Can you tell me about your headache...", "What else?", "What else?"[1]

CONSULTATION MODELS

The Pendleton's Patient-Centred Model (also called Pendleton's Seven Tasks in the Consultation)[2]

Much has been written about various consultation models and processes in the last 30 years. One useful model is the Pendleton's effective patient-centred consultation model which deals with the processes of consultation which he called them the seven tasks (Figure 1). Over the years, additional ideas have been added to the concepts. Thus, Moira Stewart et al[4], and other writers have further expanded the concepts within

Figure 1. Pendleton's Seven Tasks in the Consultation (1987)

(1)	Find out why the patient has come, also called the reason for encounter (rfe) and from there go on to take a history which covers the following: the nature and history of the problem, the patient's ideas, concerns and expectations, the effects of the problem on the patient and significant others;
(2)	Consider the other problems that the patient may have: continuing problems, risk factors,
(3)	Choose with the patient as appropriate action for each problem. In general practice, there is a need to prioritise the action to take if the patient has more than one problem.
(4)	Achieve a shared understanding of the problems with the patient,
(5)	Involve the patient in the management and encourage him to accept appropriate responsibility,
(6)	Use time and resources to good advantage,
(7)	Establish or maintain a relationship with the patient that helps to achieve other tasks.

Steps (1) and (2) together correspond to what we sometimes refer to as the approach to the problem and the remaining steps (3) to (7) correspond to the management of the patient and his problem. Note the steps (3), (4) and (5). These are crucial steps that form the cornerstone of the patient's compliance to the doctors' management plan.

Pendleton's patient centred model to give emphasis on the importance of seeking the reason for encounter, the ideas, concerns and expectations of the patient as well as elaborated on the importance of seeking common ground for action and managing the patient and his disease realistically. These additions to the concepts of patient-centred consultation become of value when we deal with patients who have multiple problems or have difficulties of resources and motivations for change of lifestyle and behaviour necessitated by the disease state e.g., diet, exercise, weight control, and use of alcohol or smoking.

Stott & Davis ABCD Model of the Aide Memoire of the Potential of the Consultation

The Stott & Davis ABCD Model of the aide memoire of the potential of the consultation is shown in Figure 2. Its usefulness is elaborated in the next section[3].

Figure 2. Stott & Davis Model of the Aide Memoire of the Potential of the Consultation

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

Bayer's 4E Consultation Model

The Bayer Institute for Healthcare Communication's Consultation Model puts the concepts of the patient-centred consultation model into an easy to remember framework of 4Es with an opening and a closing. The details of the 4Es are dealt with under in the next reading on communication as these involve communication skills.

Figure 3. Bayer's Consultation Model

- Opening – introduce yourself, greet the patient, welcome the patient, maintain eye contact
- Find it – Engage the patient, Empathise with the patient
- Fix it – Educate the patient, Enlist the patient's motivation
- Closing – summarise diagnosis, treatment, and prognosis; review next steps – future visits, phone calls, test results; say goodbye and express hope.

CONTRIBUTION OF THE MODELS TO THE CONSULTATION

Patient-centred consultation

Pendleton's model of patient-centred consultation and other later variations of this consultation model are useful in giving us a working model to deal with the consultation at the outpatient setting in a way that takes care of the varied reason for encounter as well as addressing the ideas, concerns and expectations of the patient. The later variations of the model provide further ideas to deal with consultations that deal with non-acute and non-communicable problems where acceptance of the diagnosis and self-care become the lynch pin of success or failure in patient care.

The many reasons of non-adherence to the doctor's advice come to mind when analysed with the patient centred consultation. We begin to have an explanation and therefore a strategy to deal with the underlying problem. The reasons for non-adherence could be:

- The advice may not fit in with the patient's lifestyle;
- The advice may be too complicated for the patient to bother to follow it; think of dosage regimens;
- The advice is related to a diagnosis that the patient is trying hard to reject. (It would be interesting to find out how much anti-hypertension medication is not taken because the patient cannot accept the diagnosis and the implication of incurable "illness", especially when he is experiencing no symptoms); and
- Other reasons e.g., lack of time or other resources.

Of these, the most significant point to note is that advice will be rejected when it does not fit in with the patient's own view of the problem. Time spent to test out if this is the problem with the patient will be of critical importance.

Caring beyond the acute problem

The Stott & Davis model is useful in understanding the potential that we could make to each consultation as well as the skills that we need to bring to the task areas besides Task A.

Task A – Management of presenting problems. Every consultation needs to address this area. Besides, dealing with the presenting problems, it is good practice to embark on the other tasks as far as time permits.

Task B – Modification of help-seeking behaviour. It may be necessary on occasion to change the help-seeking behaviour. For example, the patient may insist on antibiotics which are not appropriate. The modification of such behaviour needs due attention to ideas, concerns and expectations behind the help-seeking behaviour.

Task C – Management of chronic problems. There is a need to address the care of chronic problems whenever the patient visits. Time spent in this task will result in better compliance and reduce complications from chronic diseases.

Task D – Opportunistic health promotion. Much can be done to reduce the onset of disease related to adverse life-style. However, this is a challenging task because the adoption of healthy behaviours requires the change of life-long habits.

SKILLS IN MAKING THE PATIENT-CENTRED CONSULTATION WORK

Initiating the consultation

When your patient enters your consultation room, the first minute is very important.

- Make your patient feel welcomed, relatives included.

Greet all of them.

- Show him his chair, make him comfortable and make him feel at ease.
- Your opening remarks are also important. They are different depending on whether the patient is new, a recent follow-up patient or an old patient making a reappearance.
- Strike a good rapport.
- Eye contact is essential. Having a computer in front of you may be a distraction. Use it discreetly.
- Body language tells the patient your attitude. The patient can tell whether you have a sincere interest in him and his problems.

History taking

How much history should be taken? There is a need to take note of each symptom. Beyond that, the depth of questioning will depend on what is perceived to be the core of the problem. Symptom presentation in ambulatory care is often early and undifferentiated. Hence the doctor should develop a systematic approach to evaluate each symptom presented by the patient.

In ambulatory care, ninety percent of diagnosis is made on the basis of history alone. The meaning of the symptom will have to extend beyond biomedical possibilities. The value of the symptom as a marker of biomedical disease may also be different from that encountered in the hospital patient. It is important to include in the history taking, the effect of illness on the patient, his work and his family.

Selective Physical Examination

- How does the history guide the doctor on how much to examine?
- What do you see as the purpose of the physical examination in general practice?
- When should a comprehensive physical examination be conducted in the outpatient setting?

The answer is sufficient examination should be done to the confirmed clinical impression and to rule out surprise findings. Failure to examine the patient will be a shortcoming should anything missed become of medico-legal importance. The more undifferentiated the problem, the more extensive a physical examination will need to be carried out.

Selective investigations

- How is the decision made?
- How many investigations to order for the patient?
- What in-house investigations should be available?

It is a judgement call whether investigations need to be ordered or not. They should be ordered if they may change the diagnosis.

Management options

The following need to be considered in managing the patient:

Therapeutic interventions

- How would you attempt to convince the patient if you think that medication is not necessary? What would you do if the patient remains unconvinced?
- What surgical and medical procedures could be done in your clinic?

Patient education

- This should be given at the end of each consultation on the working diagnosis, an explanation on why the symptoms occur, the action that have been agreed upon to deal with the problem, as well as what self-care and monitoring the patient should do. The need to be seen again should also be clearly spelt out.

Follow-up and staggered consultations

A problem that is uncertain may need to use time as a diagnostic tool. Watchful waiting and frequent reviews may need to be considered. Where the problem is complex or multiple, staggered consultations to deal with the more urgent ones first will also need to be considered.

Family as a resource

The need of the family as a resource is often, ranging from social support to patient care and financial and time resources. These will need to be worked out with the family members.

Referrals

This may sometimes be necessary. There are several tasks that must be done:

- Explain to your patient and accompanying relatives your reasons for seeking a second opinion or for requesting a specific treatment.
- Prepare them mentally and financially especially when surgery is contemplated.
- Try to match the skill and expertise of the specialist to the condition, personality and financial capability of the patient.
- Do not refer your patient to a close friend or relative without the above consideration.
- Try to make the appointment for your patient.
- Write a good referral letter.
- Brief and to the point. Include relevant history, lab results, X-rays, ultrasound, CT scan results and treatment
- Give your opinion, ask specific questions
- Phone directly for urgent conditions and early appointments.

ACHIEVING SATISFACTORY OUTCOMES

Knowing the patient's concerns and expectations, the doctor will be in a better position to bring about outcomes they

want. At the conclusion of the consultation, we should like to have reduced the patient's concerns as far as possible, and to have explained matters sufficiently clearly for the patient to understand and remember all what has been said and be committed to the management planned.

PITFALLS TO AVOID

Common barriers to a satisfactory consultation process:

1. Poor eye contact
2. Over reliance on notes
3. Lack of clarification
4. Misinterpretation
5. Insensitivity to language/cultural difference
6. Omitting to ask what the patient thinks of his illness.

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LEARNING POINTS

- **A patient-centred consultation seeks out the patient's reason for encounter (RFE) and his ideas, concerns and expectations (ICE)**
- **The potential in each primary care consultation goes beyond the acute problem**
- **Communication and decision making skills are important consulting skills.**