

## Revisiting Models of the Consultation

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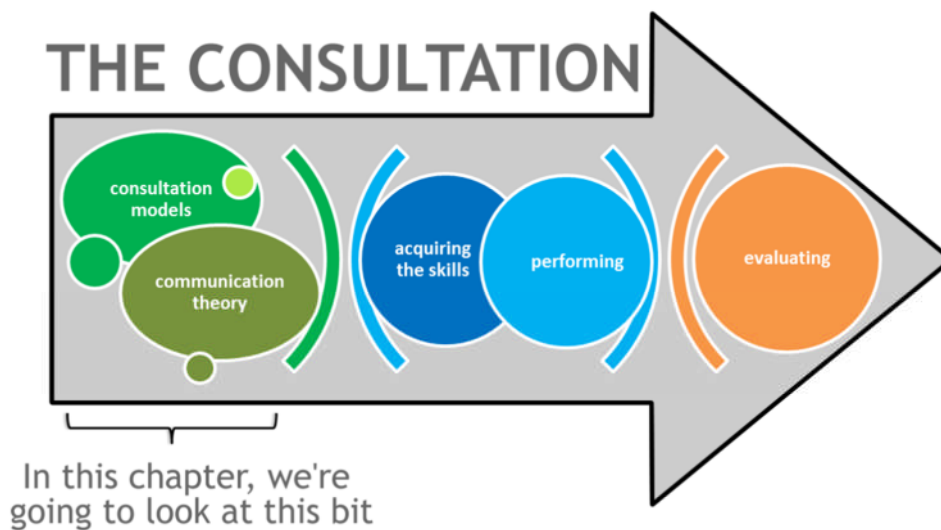
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### How to read this chapter

This chapter is provided as a source of reference rather than as a 'unit' to be read from start to finish. However, if you want to do that then that's fine but you may find it a bit too intense, overwhelming and exhausting – especially if a lot of the material is new to you.

We hope this chapter will invoke thought, interest and 'relight your fire' through material and models that you may not have come across before. And whilst we've tried to capture the essence of each model, remember that there is no substitute for the original source.

### What we're going to look at today



### Do I need to know about all these models?

No you don't. We've provided a comprehensive list so that you can:

- Copy it to your trainee to provide an overview on consultation models.
- Refer to it as a reference resource in case your trainee comes back to you asking for help in applying a particular model to a particular consultation scenario.
- Develop your own consultation skills by exploring models which are new and interesting to you.

## Why consultation models?

The consultation remains the main and basic tool of general practice and as Pendleton eloquently put it: 'it's the central act of medicine which deserves to be understood'. And it is consultation models that can help us (and our trainees) to *understand* the GP consultation and therefore *consult* better. Consultation models also help to add structure to a consultation – preventing it from going into all sorts of directions and deteriorating into a chaotic mess.

For example, a consultation model can help us manage a consultation where we are finding it difficult to make a diagnosis or where the patient doesn't like the sound of the management plan. It can also bring to the 'open arena' hidden agendas and significant concerns a patient may have.

### Why learn about consultation models?

- We subconsciously make models for anything we do regularly.
- By studying other people's models, we can make our own.
- Consultation models help us *understand* the patient's perspective.
- Better understanding means better concordance and less complaints.
- Consultation models make us more thorough and therefore safer.
- Consultation models help teachers teach on the consultation.

Finally, the framework of the models can help us to help our trainees perform better in some of the MRCGP assessment tools – namely the Consultation Observation Tool (COT) and the Clinical Skills Assessment exam (CSA).

## First things first – what is a model?

There are different types of models and therefore different definitions. The one that we're interested in is that which is:

*'a hypothetical description of a complex process'*

and not

*'a person who poses for a photographer or painter or sculptor'!*

The hypothetical description usually serves as an exemplar - something to be imitated because we know it will give the outcome we desire.

A model can come in many shapes, sizes, and styles – and you'll see this reflected in the different consultation models summarised below. Different trainees will take to different consultation models but the important thing to remember is that a model is **not the real world** but merely a human construct to help us **better understand real world** systems.

No matter what model you look at (whether mathematical, scientific or medical), they all have three things in common:

1. **An information input**

*Rapport (Neighbour), Data Gathering (Calgary Cambridge), Ideas-Concerns-Expectations (Health Belief Model), What's happened? (Helman).*

2. **An information processor**

*Merging doctor's and patient's agendas (McWhinney), Why me-Why now-What if I do nothing? (Helman), Doctor +/- patient consider the condition (Byrne & Long), Providing Structure (Calgary Cambridge).*

3. **An output of results**

*Shared understanding (Pendleton), Prescriptive-Informative-Cathartic-Catalytic-Confronting-Supportive (Heron), What should I do? (Helman), Explanation & Planning (Calgary Cambridge), Safety Netting & Housekeeping (Neighbour).*

So, whilst different consultation models place emphasis on different bits, they all have large degrees of overlap when you look at them in terms of input, processor and output.

**Some interesting things famous people have said about models:**

- 'All models are wrong but some are useful.' George E.P. Box (an eminent statistician)
- 'Make your theory as simple as possible, but no simpler.' A. Einstein

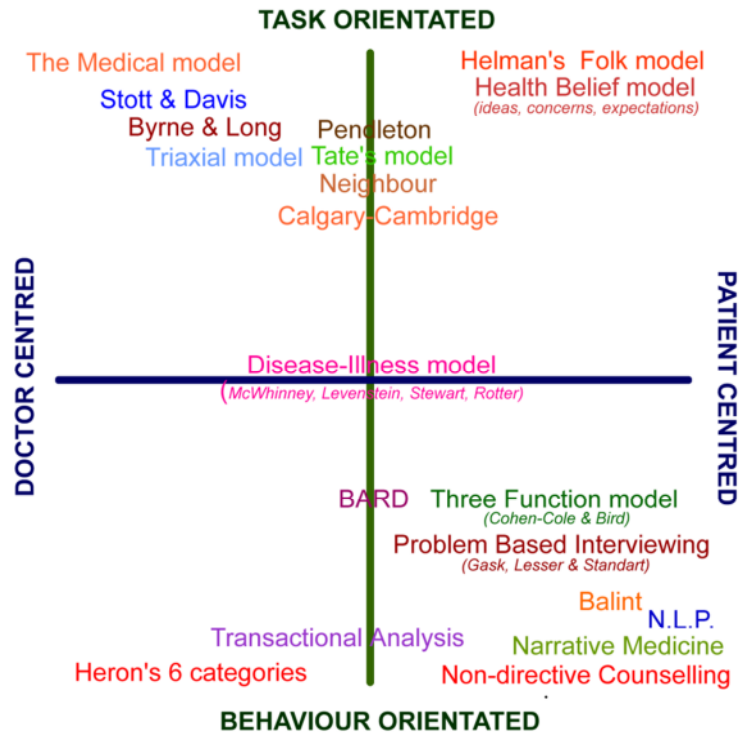
## Comparing consultation models

All consultation models include the taking of a (medical) history but they differ in their emphasis - some place more emphasis on diagnosis of the patient while others focus more on discovering what the actual patient ('consumer') wants. On the whole, consultation models differ from each other in three main ways:

Some are **conceptual frameworks** – telling you what needs to be achieved (aims) but not how to actually achieve them (implementation methods). Others concentrate more on implementation without a solid conceptual framework. Some (like the Calgary Cambridge) do both pretty well.

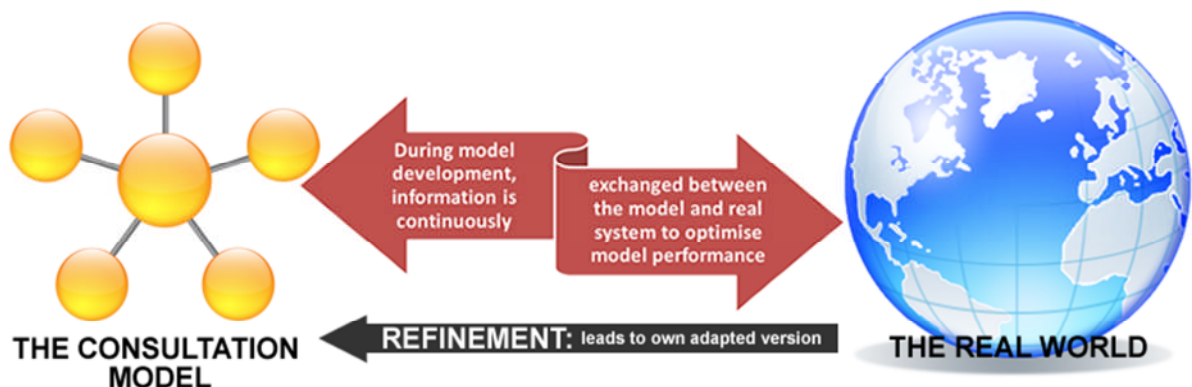
They also differ in terms of **doctor versus patient centredness**: the extent to which the consultation's agenda, process and outcome are determined by the doctor or the patient. Doctor-centred models describe the doctor's aims or behaviour whilst patient-centred models focus on the patient's.

The final difference is in the degree to which they focus on the tasks to be achieved (or a checklist of points to be covered - **task orientated models**) as opposed to the range of behaviours needed in the consultation (**behaviour orientated models**). Another way to think of this axis is to see the task orientated models as looking at the content of the consultation whilst the behaviour orientated ones focus on the process.



### How trainees adopt a consultation model

We said earlier that different trainees will be attracted to different models. They often start off with playing around with two or three - finding one that works best for them (and/or fits in with their 'personal style'). Even when they've found a model, they don't just blindly follow it – they'll continue to play and tweak it until their own adapted version of that model is born and internalised. As a GP educator, you can start your trainee off on their journey – help them find their model of 'enlightenment'!

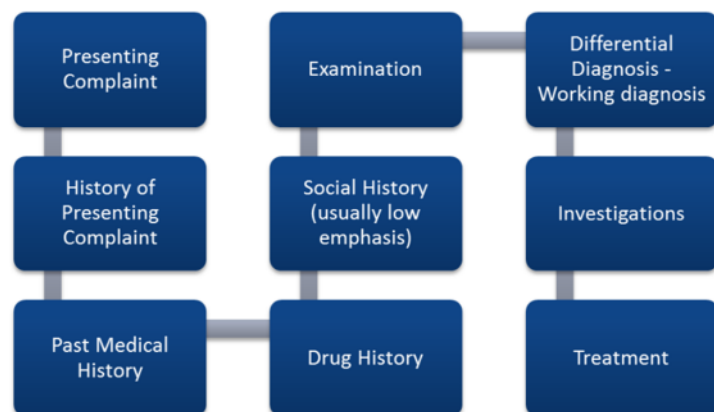


## ONTO THE CONSULTATION MODELS...

The models described below will provide a taste of the range of approaches. Remember - there is no one correct model of the consultation – the approach is dependent on the context. Most of these models tell you what you need to achieve but not how you go about achieving it – that being left to the doctor's own free will or experience. Consider the cliché 'to skin a cat', a model tells you that at the end of the day - you need to skin that cat. How you do that is up to you and your personal style. If one of these models captures your interest, please remember that this condensed version is not a substitute for reading the original publication.

### Model 0 – The Medical Model (*the benchmark*)

Before we try to understand what the other models are trying to achieve, we must start off the one which was instilled in us from our medical school days. It will give us a benchmark for comparing other models. It's called the 'traditional medical model' and it's by no means a dead model - most trainees still use it when they're in hospital posts. It is a purely organic approach to managing patients – where the disease and diagnostic process are of central importance. It's not interested in what patients think or feel or in what might be going on for them back in their own lives. It's purely a functional model to do the main job of sorting out the problem, not necessarily the patient.



*Timothy Lee is a 48 year old taxi driver who presents to A&E with central crushing chest pain. The Medical on call team take a history, examine him, do various tests and come up with the diagnosis of an Acute Myocardial Infarction. He is thrombolysed, put on a cocktail of heart drugs and then discharged a few days later. He is advised not to drive for 6 weeks. They've clearly followed the Medical Model.*

*But Tim doesn't know what he is going to live on while he's off for 6 weeks. Statutory sick pay won't meet the mark and monthly prescription charges will financially wreck him. Actually, he's thinking of stopping his meds and he doesn't like tablets in general anyway.*

*He went to see his GP who explored all of this in some detail. Over a couple of consultations, the GP was able to help Tim see the importance of not driving especially with regards to the safety towards others. He also found out that Tim was scared of heart tablets because he had heard from others about erectile dysfunction. His GP encouraged him to try them and see and he agreed. As for the prescription charges, the GP decided to issue 2 months prescriptions at a time to help with Tim's costs – Tim agreed that it would make things a lot easier.*

We hope you can see how the Medical Model is not interested in the patient's illness (effect of the disease on the patient's life). It's only interested in sorting out the problem (the

disease). But in this case, if it wasn't for the more patient-centred approach used by the GP, Tim would have stopped his medication, probably have had a fatal MI at some point – prematurely leaving behind a young family. If this had happened, what would the medical model have truly achieved? Illness is personal and unique, disease is impersonal and general.

Pros	Cons
<ul style="list-style-type: none"><li>• Sorts the main problem out</li><li>• Medically comprehensive</li><li>• Is structured</li></ul>	<ul style="list-style-type: none"><li>• What if you can't come up with a diagnosis?</li><li>• Disregards the psycho-social context of a presenting complaint. Every complaint can be placed in a psycho-social context (RCGP)</li><li>• It disregards the patient as a person (who has feelings, concerns and an agenda too). Patients don't function simply as machines!</li><li>• Disregards the doctor as a person (who has feelings). Doctors don't function simply as machines!</li><li>• Not an effective use of time – covers areas which may have little relevance.</li></ul>

### **Model 1 – The Triaxial Model: *physical, psychological and social***<sup>1</sup>

This model was proposed by a working party of the RCGP back in 1972<sup>1</sup> and said 'A *doctor should be encouraged to extend his thinking and practice beyond the purely organic approach to patients*'. In other words, to consider the patient's emotional, family, social and environmental circumstances, all of which can have a profound effect on health. Although most of us now do this religiously, it was only fifty years ago when many of these questions would have been considered as irrelevant or prying by patients.

Pros	Cons
<ul style="list-style-type: none"><li>• Covers the patients agenda</li><li>• Places the presenting complaint in a psycho-social context</li></ul>	<ul style="list-style-type: none"><li>• An over simplification of a patient-centred approach.</li></ul>

### **Model 2 – Health Belief Model (1975)**<sup>2</sup>

This model focuses on the patient's thoughts – not just on the consultation but also about their attitudes to illness in general and how they see themselves as patients. By exploring the patient's **I**deas, **C**oncerns and **E**xpectations (I.C.E.) you get a true understanding of where the patient is coming from. And if you go one step further and incorporate that information into your management plan, you're more likely to improve patient concordance.

- Patient's **ideas** – '*Had you any thoughts about what might be going on?*'
- Patient's **concerns** – '*And what particular worries or concerns did you have?*'
- Patient's **expectation** – '*And what were you hoping that I might do for you?*'

The model came about by a group of American psychologists in the 1950s who were trying to fathom out what factors encouraged people to participate in a health promotion programme to identify and eradicate TB. The came up with 6 things:

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** e.g. costs outweighing the benefits
5. **Internal factors** such as worrying about symptoms, and **external factors** such as media campaigns, advice from family and friends. These triggers that make a patient seek help are called '**cues to action**'.
6. Whether they have a strong **internal or external controller**.  
Patients vary enormously in the way they accept responsibility for their health. Those with a strong internal controller control their own health destiny – perhaps the demanding 'Guardian reading' patient? They see the doctor merely as an aid to achieving the treatment, prescriptions or referrals that they need. They have a firm idea of their own diagnosis and an equally definitive expectation of what the doctor should do for them.  
Those with a strong external controller are more 'fatalistic' – that their likelihood of developing illness is totally out of their control and they cannot do anything about it.  
There's another group who are a bit like this last 'fatalistic' group but what sets them apart is that although their health destiny rests externally to them, it can be influenced by particular individual – the GP for instance. They're the ones that 'do as they are told' and the locus of control rests with the powerful influential other.

### **So what! How does all of this help us?**

Exploring I.C.E. will help you:

- Gauge whether an individual has a general interest in his or her own health matters – which might correlate with personality, social class and ethnicity.
- Appreciate how vulnerable the patient feels to a particular disease and who severe a threat they feel that disease poses.
- Understand the patient's estimation of the benefits of treatment weighed against costs, risks or inconvenience of treatment.
- Understand the factors that prompt an patient to take action, such as the development of alarming symptoms, or things said by the family, friends or the mass media.

It's a particularly useful model when dealing with the worried well, the hypochondriac, the non-compliant patient, the helpless, the hopeless and patients who frequently miss their appointments. The model helps you to 'walk a mile' in the patient's shoes and see things from their perspective for a change.

### Model 3 – Six Category Intervention Analysis (1976)<sup>3</sup>

In the mid-1970's, John Heron, a psychologist working at the University of Surrey in conjunction with the GP VTS day release Course Organisers, developed a simple but comprehensive model of the array of *interventions* a doctor (counsellor or therapist) could use with the patient (client).

When a patient comes to see their doctor, in that brief time, the doctor can influence the patient's life journey by intervening in 6 ways:



- **A note on cathartic interventions:** another way we've seen this expressed is helping the patient to 'vomit their emotions' in the consultation so that they feel better.
- **A note on catalytic interventions:** non-verbal examples include creating a sense of trust and security, listening well, showing genuine interest, the effective use of silence. Verbal examples include things like reflecting or repeating the last word of a patient's sentence or asking open questions.

You should view this list of interventions as different tracks a doctor may take - the first three in the list are authoritative (or doctor-centred) and the last three are facilitative (or patient-centred). Do remember that in any one consultation you will see a number of these interventions come into play. Heron believed that *each* category has a clear function within the total consultation and that each will affect the *process* and *outcome* of the consultation. For example, a welcoming gesture might precipitate tears and therefore be cathartic.

Which interventions are used depends on where the energy lies in the consultation. You need to be able to identify the required intervention, perform it, and know when to stop and/or change track. Choosing a wrong intervention can ruin everything that has gone on before. Follow the patient's verbal and non-verbal cues – it will help give an early indication if you're barking up the wrong tree – enough time for you to switch to something else.



Pros	Cons
<ul style="list-style-type: none"> <li>Ideas which will last you a life time.</li> <li>One of the few models that is responsive to the patient's behaviour rather than the 'tasks' you have to achieve.</li> <li>Reminds you of what you can do as the doctor (esp. with difficult or heart-sink patients)</li> </ul>	<ul style="list-style-type: none"> <li>High stakes – if you go down the wrong path, you can ruin everything!</li> </ul>

## Model 4 - Byrne and Long (1976)<sup>4</sup>

Byrne and Long (one of whom was a GP and the other a psychologist) spent three-and-a-half years examining over 2500 audiotapes of consultations from over 100 GPs in New Zealand and the UK (video was in its infancy and expensive). They formulated a framework of six tasks or 'areas to be covered' for any consultation:

### The 6 Phases of the Consultation

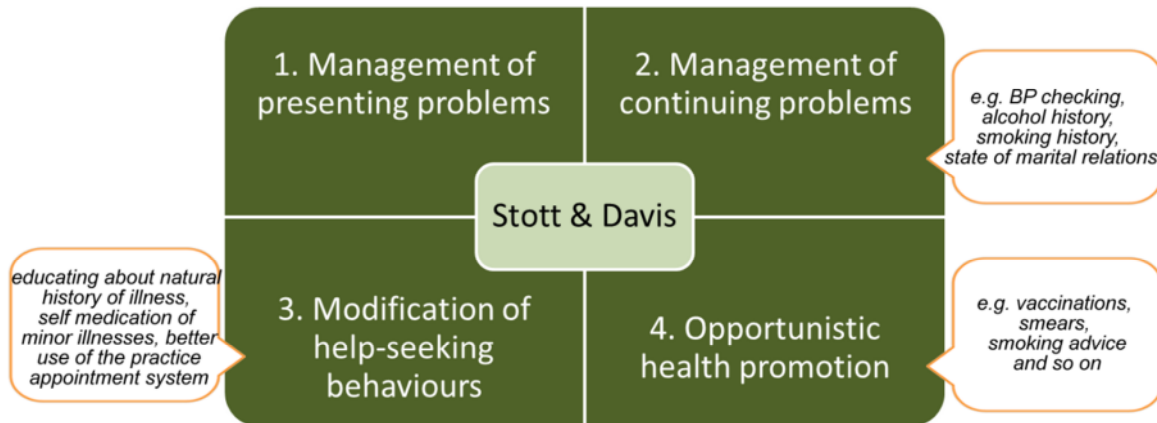
<b>Phase I</b>	<i>The doctor establishes a relationship with the patient.</i>
<b>Phase II</b>	<i>The doctor either attempts or actually discovers the reason for the patient's attendance.</i>
<b>Phase III</b>	<i>The doctor conducts a verbal or physical examination or both.</i>
<b>Phase IV</b>	<i>The doctor, doctor and patient, or the patient (in that order) consider the condition.</i>
<b>Phase V</b>	<i>The doctor, and occasionally the patient, detail further treatment or further investigation.</i>
<b>Phase VI</b>	<i>The consultation is terminated usually by the doctor.</i>

- Theirs was the first consultation to consider explicitly the task of introducing and finishing the consultation.
- Again, for the first time the task of considering the problem with the patient was described.
- They discovered 4 distinct styles of consultation and 7 distinct prescribing styles. They noted that sometimes the style of the consultation reflected the personality of the doctor and other times it was that of the patient. Sometimes consultations were doctor-dominated (where the patient said little) to a virtual monologue by the patient (where the doctor became a passive listener). More detail on the distinct consultation and prescribing styles can be found in a 'Byrne and Long' document on our website (along with some useful checklists).
- They also postulated that dysfunctional consultations resulted as a lack of attention being paid to Phases 2 (not discovering reason for attendance) and 4 (not considering the condition with the patient). And doctors who asked more open questions tended to see their patients less frequently!
- Later on, they described Phase VII, called the **Parting Shot** - where the patient reveals the real reason why they have come just as they are about to leave.

Pros	Cons
<ul style="list-style-type: none"> <li><i>Starts</i> to include the patient's thoughts</li> <li><i>Starts</i> to move the focus of the consultation towards illness</li> </ul>	<ul style="list-style-type: none"> <li>But the 6 tasks are still predominantly doctor-centred.</li> </ul>

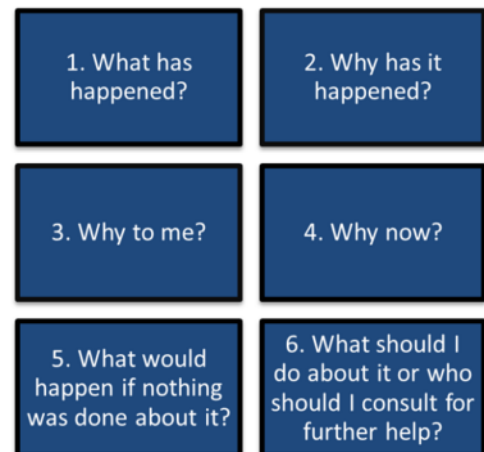
## Model 5 - Stott and Davis (1979)<sup>5</sup>

Professor Nicholas Stott & R.H. Davis suggested that four areas can be systematically explored each time a patient consults:



## Model 6 - Helman's 'Folk Model' (1981)<sup>6</sup>

Cecil Helman is a medical anthropologist, with constantly enlightening insights into the cultural factors in health and illness. He suggests that a patient with a problem comes to a doctor seeking answers to six questions:



Pros	Cons
<ul style="list-style-type: none"> <li>• Patient centred – in fact, it's all based around the patient's agenda</li> <li>• Hence, few patient complaints.</li> </ul>	<ul style="list-style-type: none"> <li>• Can be time consuming</li> <li>• Difficult to apply to some problems – what do you say to severe mental health problems like acute schizophrenia?</li> </ul>

## Model 7 – Pendleton, Schofield, Tate and Havelock (1984)<sup>7</sup>

David Pendleton, a social psychologist, wrote his PhD thesis was on the analysis of consultations. He worked with a number of GPs in the Oxford region and was the person who pioneered the use of video (a new medium at the time) in the analysis of consultations. Subsequently, he developed safeguards for the use of video which forms the basis of the current recommendations. In addition to the use of video, he also formulated 'Pendleton's rules for feedback' and 'Pendleton's model of the consultation'.

In Pendleton's model, the personal and psychological aspects of the illness are further developed. The model describes 7 tasks: the first 5 tasks are concerned with what the doctor needs to achieve and the final two deal with the use of time/resources and creating an effective relationship.

### Pendleton, Schofield, Tate & Havelock (1984)

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

**PATIENT'S AGENDA = 1c + 1d = ideas, concerns, expectations + effects of the problems**

Most of the performance criteria in the Consultation Observation Tool (COT) are taken from this model. Therefore, it's worth reading the book! The second edition of their book, called 'the new consultation', includes the relevant research evidence. The book is divided into two sections – the first part which looks at the consultation and their model, and the second part which is concerned with teaching effective communication skills.

Pros	Cons
<ul style="list-style-type: none"><li>• Patient's thoughts assume an important role in this model.</li><li>• It encourages patient responsibility</li><li>• It's the framework which is used in the MRCGP Consultation Observation Tool</li></ul>	<ul style="list-style-type: none"><li>• Although set out in logical sequence, not all consultations will follow this order.</li><li>• Not particularly appropriate for acute settings like emergencies.</li></ul>

## Model 8 – Problem Based Interviewing (1985)<sup>8</sup>

Problem Based Interviewing, or PBI for short, places heavy emphasis on the detection of psycho-social distress. It consists of two big skill sets – problem detection and problem management.

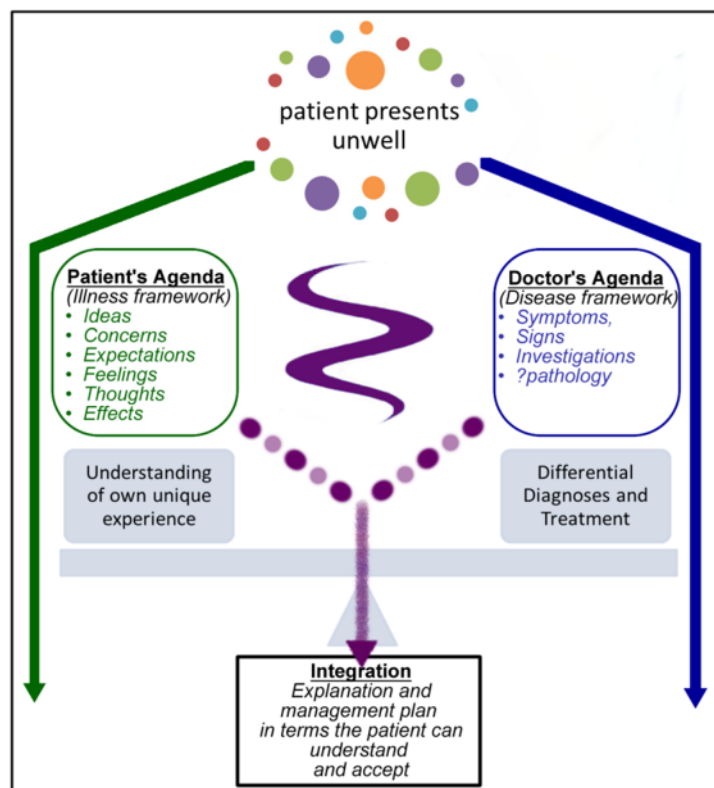
Problem Detection Skills	Problem Management Skills
Generally, this bit of the consultation is about:	Generally, this bit of the consultation is about:
<ol style="list-style-type: none"> <li>1) <i>problem sensing</i></li> <li>2) <i>problem detection</i></li> <li>3) <i>problem description &amp; clarification</i></li> </ol>	<ol style="list-style-type: none"> <li>4) <i>problem assessment</i></li> <li>5) <i>problem treatment</i></li> <li>6) <i>evaluation</i></li> </ol>
Specifically, to do it, you need to:	Specifically, to do it, you need to:
<ul style="list-style-type: none"> <li>• Begin the interview</li> <li>• Pick up verbal cues</li> <li>• Respond to verbal cues</li> <li>• Pick up non-verbal cues</li> <li>• Respond to non-verbal cues</li> <li>• Demonstrate empathy</li> <li>• Explore health beliefs</li> <li>• Control the pace of the interview</li> </ul>	<ul style="list-style-type: none"> <li>• Allow the patient to ventilate</li> <li>• Negotiate with the patient to initiate change</li> <li>• Problem solve (like directive counselling)</li> <li>• Re-attribute symptoms</li> <li>• Give information</li> <li>• Special skills(special therapies)</li> </ul>

## Model 9 – McWhinney's Disease-Illness model (1986)<sup>9, 10, 11, 12</sup>

We urge you all to become familiar with this model by reading Patient-centred medicine by Moira Stewart<sup>12</sup>.

This simple model can transform the way your 'new' trainee approaches the GP consultation (especially those who've just come out of hospital posts).

After qualifying, most doctors are more concerned with getting the information they want to make a diagnosis rather than what the patient might want to express. This doctor-centred model, where only the doctor's agenda matters, is often referred to as the 'Disease Framework' (represented by the blue arrow in the diagram).



In 1984 McWhinney<sup>9</sup> and his colleagues at the University of Western Ontario proposed a 'transformed clinical

Method'. Their approach, later revived in 1997 by Stewart and Rotter, has also been called 'patient-centred clinical interviewing': they say that whilst the doctor's agenda is important (blue arrow in the diagram), so too is the patient's (green arrow). Therefore, they suggest a consultation where the doctor weaves to and fro between his agenda and that of the patient's (purple arrow). In this way, a management plan is formulated which satisfies the patient's ideas, concerns and expectations (and thus helps them make sense of what is happening to them) whilst at the same time conforming to good clinical practice.

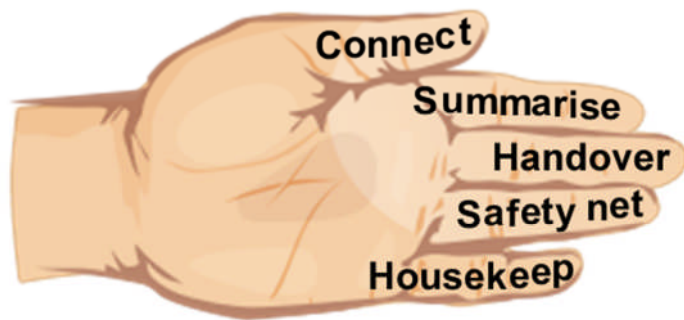
This model helps you realise that **disease is the cause of sickness** whereas **illness is the unique experience of the sickness**. Patients can have illness without disease – for example, a patient who complains of 'Tiredness All The Time' for which no medical cause can be found. And it can be the other way around too – where patients can have a disease without illness, hypertension being a prime example. We hope you can see how different diseases can cause different illnesses (i.e. experiences) in different patients. Therefore, the doctor has the unique responsibility to elicit two sets of 'content' of the patient's story: the traditional biomedical history, and the patient's experience of their illness.

*You see Mrs. Templeton who comes in with abdominal pain for the eighth time. It's getting no better. All the tests haven't shown anything and there are no alarm symptoms. Despite reassurances, she just keeps coming back. Three months later, she comes back to see you about her 'cough and cold'. She says that her tummy pain seems to have miraculously settled down. You see from the notes that after your last consult with her, she saw a colleague who explored her ideas, concerns and expectations and found out that she was particularly worried about gastric carcinoma – her mother had it at around her age and had a rapid and awful decline thereafter. It's clear that he empathised, validated her feelings and reassured her.*

*You see a patient with low back pain for 1 week following a recent bout of painting and decorating. You spend 15 minutes going into detail about an explanation of the diagnosis and the management plan. As you move towards the end of the consultation, the patient says 'Can I have a sick-note?' Reflection: The patient probably realised it was muscular and just wanted a sick note! Was that level of explanatory detail really necessary and could you have saved time?*

Pros	Cons
<ul style="list-style-type: none"><li>• Provides a balance between satisfying both doctor's and patient's agendas</li><li>• Both patient and doctor happy</li><li>• Nice simple practical framework</li></ul>	<ul style="list-style-type: none"><li>• Takes a little extra time and commitment.</li></ul>

## Model 10 - Neighbour (1987)<sup>13</sup>



Roger Neighbour, a GP from Watford, developed this model after working with his local Trainers' Workshop. This model provides a journey with 5 intuitive check points for answering the question: *'Where shall we make for next and how shall we get there?'*.

- **Connecting** with the patient; establishing a working relationship through empathy and building rapport. → **Rapport Building Skills**
- **Summarising** the reasons why the patient has come having discovered their ideas, concerns, expectations. This makes sure that both of you are on the same track and allows for corrections. This enables one to formulate a diagnosis and initial management plan. → **Eliciting Skills**
- **Handing over** is returning patient control and responsibility for some aspects of their health through a shared management plan, negotiating and gift wrapping. → **Communication Skills**
- **Safety netting** is making a contingency plan in case things do not go according to plan. Safety netting considers *'What If...?'* scenarios – worrying symptoms or signs that should make the patient return or seek urgent opinion. → **Predicting Skills**
- **Housekeeping** is looking after yourself between patients. Answers the question: *'Am I in good enough shape for the next patient?'* It recognises the need to attend to fatigue, boredom, stress, lack of concentration, distraction and other powerful emotions – for example, the need to vent off to a colleague about a patient who has upset you. → **Stress Management Skills**

Pros	Cons
<ul style="list-style-type: none"> <li>• Empowers the patient by ensuring the doctor hands back responsibility</li> <li>• The first model to recognise the importance of safe doctoring (safety netting) and being a healthy doctor (housekeeping).</li> <li>• The 5 checklists are easy to remember. A good starter for new GP trainees.</li> </ul>	<ul style="list-style-type: none"> <li>• Is a bit doctor centred at times</li> <li>• The style of the book is a bit like Marmite – you either love it or hate it. Flick through it before you buy!</li> </ul>

## The Doctor's Two Heads

Neighbour also describes the two different heads of the doctor in the consultation. One is called the **Organiser**. This *doctor-centred* head is busy trying to:

- manage the organisation of the consultation,
- asking questions and deciding to examine
- planning and negotiating clinical management
- time keeping – like slowing and speeding consultations
- and making records.

The other is called the **Responder**. This *patient-centred* head tries to make sure that you are:

- Being attentive through listening properly
- Taking time to think and process information
- Creating and testing ideas
- Being empathic.

*The skilled doctor needs to find a fine balance between Organiser and Responder modes whilst journeying through the five tasks of the consultation. It's a bit like driving a car whilst talking to a passenger. Your Organiser pays attention to the steering wheel, pedals and gears whilst the Responder maintains the conversation. In heavy traffic or at the traffic lights, your Organiser will take over and you temporarily stop engaging with the passenger. But when things are calm and easy again, the Organiser will relax allowing the Responder to come back in and maintain the conversation. The Organiser continues to lurk in the back ground, keeping an eye on the road, in case it's needed again at short notice. The journey within a GP consultation follows something similar.*

Later on, you will come across Balint, who described 'the doctor as a drug' – a metaphorical drug that patients 'take' to make things better. Neighbour's model sees the **doctor as a catalyst** rather than a drug – who facilitates problem solving or change by revisiting awareness raising questions like Who, What, Where, When, How? For example, 'Where is the patient now?', 'What do they need to do next?', 'Where shall we make for next?', 'How shall we get there?'. Some of these questions will be shared with the patient whilst others may simply reside in the doctor's head. Now you will understand why Neighbour describes the consultation as a journey (not a destination) in which there is 'reflective conversation with the situation'.

**Balint's Doctor as Drug** (the doctor fixes things):

*Side effects: addiction/dependency on the doctor, withdrawal when doctor moves on, potential for practitioner burnout unless he/she recharges self.*

**Neighbour's Doctor as a catalyst** (the doctor facilitates problem-solving/change):

*Practitioner emerges unscathed, with occasional contamination.*

By the way, Neighbour has a second book called 'The Inner Apprentice' which uses a similar style as 'The Inner Consultation' but focusing on *teaching* communication skills instead.

## Model 11 – Tate’s Model (1994)<sup>14</sup>

Peter Tate is a retired GP and former Convenor of the MRCGP examinations - he’s the one who introduced the MRCGP video module in 1996. He also helped co-author Pendleton’s original model. He continued to develop some of the themes from that model (particularly the importance of the patient’s ideas, concerns and expectations) to come up with a scheme that is now used in his book.

New trainees (especially those who have come out of hospital posts practising the ‘traditional medical model’) will find this book most insightful. Like Pendleton’s model, it covers a number of the competencies on which the MRCGP Consultation Observation Tool (COT) is based. He also outlines useful strategies and skills as well as succinctly reviewing how consultations have changed with the advent of the internet and the availability of information. It’s the one to read if you haven’t the time for any of the others and is dead easy to read.

### Discover reasons for attendance

- Encourage patient’s contribution
- Observe and use cues
- Obtain relevant social and occupational information
- Explore patient’s health understanding

### Define the clinical problem(s)

- Sufficient info not to miss any serious condition
- Reasonable examination
- Appropriate working diagnosis

### Explain the problem(s) to the patient

- Explain diagnosis, management, effects of treatment
- Use appropriate language
- Use the patient’s health understanding
- Check their understanding

### Manage the patient’s problem

- Make sure the plan is appropriate for the working diagnosis
- Share the management options

### Make effective use of the consultation

- Use time appropriately
- Prescribe appropriately
- Develop and use your relationship
- Give opportunistic health advice

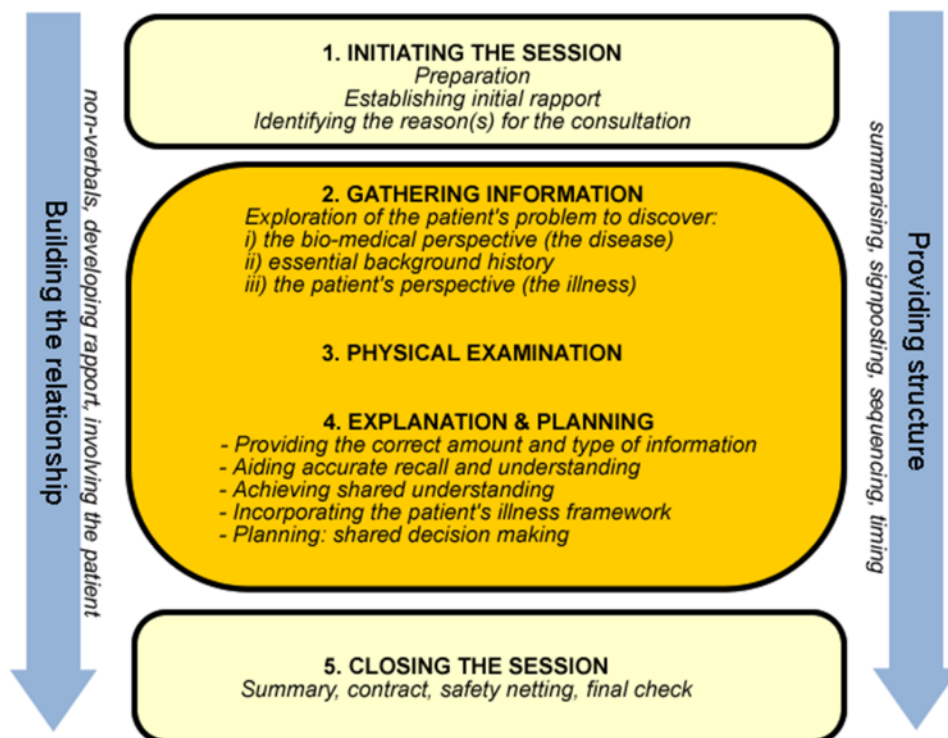
Pros	Cons
<ul style="list-style-type: none"><li>• Patient centred</li><li>• Easy to read, follow and implement</li></ul>	<ul style="list-style-type: none"><li>•</li></ul>



## Model 12 – The Calgary Cambridge Model (1996)<sup>15</sup>

We think this is currently the most favoured model in the UK (and no doubt in Calgary too!). It's the only comprehensive model which marries each of its components with the available research evidence on the skills that aid doctor-patient communication.

Basically, it outlines 5 steps each consultation must go through. These 5 steps capture both the disease *and* illness frameworks illustrated in McWhinney's Disease-Illness model. It combines process with content in a logical schema – emphasising the continuous need to provide structure to the interview and to build the relationship with the patient whilst journeying through the 5 steps.



The model also identifies the *skills and behaviours* required in each of these 5 steps. We've listed a few in the diagram below to give you a taster. Across the whole 5 steps, 71 micro-skills have been identified – you can now understand why trainees become all anxious and apprehensive when they see this list for the first time. However, if you take some time to read the 71 skills, you will come to realise that

- It isn't rocket science - most of them are things you probably do in day to day communication with your family and friends
- The authors don't expect you to remember them all. Instead, they suggest you see the 71 skills like the tools in an electrician's tool box. The electrician doesn't use every tool in his/her box to do a particular job – only the ones that are required. Likewise, you're not expected to use every one of those 71 skills to do a consultation – only the right ones for the job.
- Actually, if you tot up the skills that you're *unfamiliar* with, you'll probably find that they're only a handful.

Pros	Cons
<ul style="list-style-type: none"> <li>• Comprehensive – covers both disease and illness frameworks (i.e. it is doctor and patient centred).</li> <li>• It is comprehensive - applicable to all medical interviews with patients.</li> <li>• The only model that is evidence based</li> <li>• Two separate books are available – one for learning and one for teaching on it.</li> </ul>	<ul style="list-style-type: none"> <li>• The 71 micro-skills puts people off</li> <li>• Probably best read after having read one of the other more introductory ones first (like Tate's Doctor Communication Handbook or Neighbour's Inner Consultation).</li> </ul>

### **Skills (behaviours) in the Calgary-Cambridge Model**

1. Introduction & Orientation	<ul style="list-style-type: none"> <li>• <i>Greetings</i></li> <li>• <i>Introduction - self, role, nature of interview, requests consent</i></li> <li>• <i>Respect - demonstrates interest, concern and respect, attends to patient's physical comfort</i></li> <li>• <i>Opening question to identify problem that patient wishes to address</i></li> <li>• <i>Listening without interruption</i></li> <li>• <i>Screening - checks if other problems patient is concerned about</i></li> <li>• <i>Agenda setting negotiates agenda taking both patient's and physician's needs into account.</i></li> </ul>
2. Gathering Information	<ul style="list-style-type: none"> <li>• <i>Encourages patient to tell story chronologically</i></li> <li>• <i>Question style open to closed</i></li> <li>• <i>Listening attentively, not interrupting, allowing patient time</i></li> <li>• <i>Facilitation – use of encouragement, silence, repetition, etc.</i></li> <li>• <i>Cues</i></li> <li>• <i>Clarification</i></li> <li>• <i>Summarisation to patient - at intervals to check own understanding</i></li> <li>• <i>Language</i></li> </ul>
3. Understanding Patient's Perspective	<ul style="list-style-type: none"> <li>• <i>Ideas/Concerns/Beliefs/Feelings</i></li> <li>• <i>Effects</i></li> <li>• <i>Expectations</i></li> <li>• <i>Picks up on cues</i></li> </ul>
4. Providing Structure	<ul style="list-style-type: none"> <li>• <i>Summarising</i></li> <li>• <i>Signposting</i></li> <li>• <i>Sequencing – logical sequence</i></li> <li>• <i>Timing &amp; keeping to task</i></li> </ul>
5. Developing Rapport	<ul style="list-style-type: none"> <li>• <i>Non-verbal behaviour</i></li> <li>• <i>Appropriate level of note taking</i></li> <li>• <i>Not judgmental</i></li> <li>• <i>Empathy &amp; support</i></li> <li>• <i>Sensitive</i></li> </ul>
6. Involving the patient	<ul style="list-style-type: none"> <li>• <i>Explaining thinking/rationale</i></li> <li>• <i>Explaining examination</i></li> </ul>
7. Explanation	<ul style="list-style-type: none"> <li>• <i>Comprehensive &amp; appropriate information according to each patient's needs.</i></li> <li>• <i>Correct type, amount &amp; level of information</i></li> <li>• <i>Clear information – avoid jargon</i></li> <li>• <i>Timing of information</i></li> <li>• <i>Avoiding premature reassurance</i></li> </ul>
8. Aiding Recall and Understanding	<ul style="list-style-type: none"> <li>• <i>Emphasis and use of aids</i></li> <li>• <i>Prioritising information</i></li> <li>• <i>Asking patient to restate</i></li> </ul>
9. Achieving a Shared Understanding	<ul style="list-style-type: none"> <li>• <i>Explanations linked to patients' views, problems &amp; requests for information</i></li> <li>• <i>Invites questions</i></li> <li>• <i>Sensitive to patients' signs of puzzlement, overload, etc. – picks up cues</i></li> <li>• <i>Asks how patient feels about information</i></li> </ul>

10. Planning	<ul style="list-style-type: none"> <li>• Shared decision making</li> <li>• Negotiates, offers choices, encourages patient to contribute ideas and preferences, checks patient's acceptance and decisions</li> </ul>
11. Closure	<ul style="list-style-type: none"> <li>• Summarises, Agrees next step, Any final questions</li> </ul>

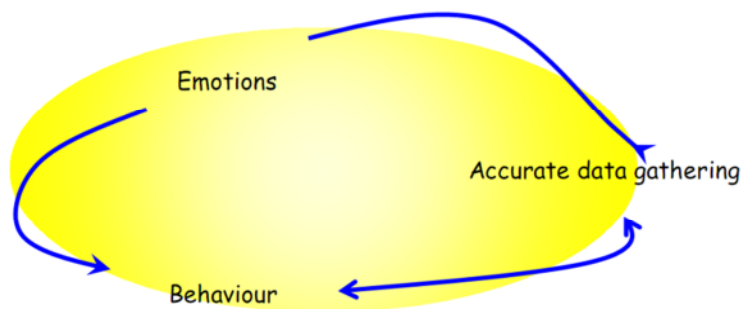
*Some of these skills will be second nature to you, some will be self-explanatory and others will need further explanation.*

### Model 13 - The Three Function Model (2000)<sup>16</sup>

Cohen-Cole's book<sup>16</sup> has some really interesting and useful chapters – understanding the patient's emotional response, managing communication challenges, overcoming cultural and language barriers, troubling personality styles and somatisation – just to mention a few!

The central concept in this model is that the interview has three primary functions

1. Gathering data to understand the patient's problems.
2. Developing rapport and responding to the patient's emotions.
3. Patient education and motivation (and thus behaviour).



Each of these is served by a particular set of skills. Clearly this is a deliberate simplification but provides a framework for analysis.

Function	Skills
<p><b>Data Gathering</b>  <i>To understand the patient's problems. This must be accurate and appropriate to elicit all relevant biological and psychosocial data. This is crucial not only for diagnosis but also for understanding personal and social context so that treatment planning can be realistic.</i></p>	<ol style="list-style-type: none"> <li>1. Attentive listening</li> <li>2. Open-ended questions</li> <li>3. Open to closed cone</li> <li>4. Understandable terms – simple language</li> <li>5. Facilitating</li> <li>6. Checking</li> <li>7. Survey/Scanning of other problems</li> <li>8. Negotiate priorities</li> <li>9. Clarifying and directing</li> <li>10. Summarising</li> <li>11. Elicit patient's expectations</li> <li>12. Elicit patient's ideas about aetiology</li> <li>13. Elicit impact of illness on patient's quality of life</li> </ol>
<p><b>Emotions</b>  <i>Developing rapport and responding to patient's emotion. In other words, handling the emotional and relationship component of communication to promote a positive relationship between doctor and patient. In this model, there are five types of empathic responses a doctor can give (expressed verbally or non-verbally).</i></p>	<ol style="list-style-type: none"> <li>1. Reflection – state the observed patient emotion. This communicates a deep sense of understanding and thus facilitates empathy = ↑ Rapport.</li> <li>2. Legitimation – a sense of the understandability of the emotion. Validating the patient's feelings leads to trust and rapport.</li> <li>3. Support – provide emotional support</li> <li>4. Partnership - collaborative doctor-patient</li> </ol>

<p><b>Education &amp; Motivation (Behaviour)</b>  <i>Motivating and educating patients to develop a clear and shared understanding about the nature of the problems, what needs to be done about them and a shared commitment to carry this out.</i></p>	<p><i>relationships are generally more effective than authoritarian relationships.</i></p> <ol style="list-style-type: none"> <li>5. <i>Respect - think about commenting on what the patient is doing well. Need to be genuine.</i></li> <li>1. <i>Eliciting patient's existing views and knowledge</i></li> <li>2. <i>Education about illness – readily understood advice, giving rationale, checking understanding</i></li> <li>3. <i>Negotiation and maintenance of a treatment plan</i></li> <li>4. <i>Motivation of non-adherent patients – reinforce common ground and partnership</i></li> </ol>
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### Model 14 – BARD (2002)<sup>17</sup>

The BARD model focuses on the relationship between GP and patient and the roles each is playing out. This model understands that the personality of the doctor and his/her previous experience with that patient will affect the consultation. In doing so, it tries to raise our awareness of the different roles being enacted and thus help us identify ways in which the doctor's personality and behaviour can be used to best effect. Warren says BARD aims to 'encompass everything that happens during a consultation' with reflection continuously streaming in the background.

<b>BARD summarised:</b>	
<b>Behaviour</b> <i>(verbal &amp; non-verbal)</i>	<i>How patients behave depends on how doctors behave – and we can change the way we behave! Being aware and making effective use of our behaviour at the 'just right' points (the use of touch, for instance) will have a profound influence on the direction of the rest of the consultation.</i>
<b>Aims</b>	<i>The aims of the consultation need to be teased out and be made very clear. Both patient and doctor need to have a shared understanding. If you don't know where you are heading, how will either of you know when you have arrived?</i>
<b>Room</b>	<i>The environment will also influence the doctor-patient interaction – for example, the seating arrangements.</i>
<b>Dialogue</b>	<i>How you talk to the patient is crucial – your tone of voice, what you say, how you say it. Does your dialogue marry with your behaviour?</i>

## OTHER APPROACHES TO THE CONSULTATION

### 01 – Balint (pronounced Bay-lint) (1957)<sup>18</sup>

Michael Balint, the son of a GP, was born in Budapest in 1896. He came to Manchester in 1939 together with his wife, Alice, who unfortunately died soon after. He remarried shortly after to Edna, but that didn't last long either – ending in divorce. He then moved to London in the late 40s and together with his *third* wife, Enid, started groups for GPs in the 1950s at the Tavistock clinic. Enid played an instrumental role in Balint work but unfortunately never seems to get the credit she deserves.

Anyway, they described an approach rather than a model. The GP groups engaged in case discussion seminars about their difficult patients. If you read the book, you'll realise that many of those 'difficult' patients are what we call today 'heartsinks'. The format eventually settled into something like this:

#### Format of a Balint group discussion:

- The group are reminded that the doctor-patient relationship is the central focus of Balint group discussions. They are not there to problem-solve but to explore the dynamics between the doctor and the patient.
- Balint groups begin with the phrase *'Has anyone a case today?'*
- A doctor then tells the story of a patient who is bothering him.
- The group then discuss the case to help the doctor to identify and explore the blocks which are obstructing the exploration and management of the patient's problem.

Balint groups are still popular today. Doctors should be encouraged to form and participate in Balint groups because they are a powerful way of learning - one is studying and evaluating one's own experience and performance rather than analysing it in terms of an academic or theoretical framework.

In their work with Balint groups, Michael and Enid developed a number of ideas and philosophies which have significantly aided our understanding of the GP consultation. We will describe the main ones below.

- Patients cannot be divided into **physical, psychological and social categories** because the three always co-exist. Psychological problems can manifest with physical symptoms and organic disease can have psychological consequences. Doctors should therefore try and understand the whole picture rather than colluding with patients in medicalising their psychosomatic complaints.
- **Doctors can develop the skills** necessary to explore psychological problems. It used to be thought that whether a doctor explores the psycho-social domain depended on his or her personality. Actually, it simply depends on using the right micro-skills.

For example, **attentive listening** helps patients open up and feel better. Balint described listening as a skill and held that 'asking questions only gets you answers'.

- Watch out for the simple '**entry ticket**' – there may be something deeper lurking behind. Balint suggested that we pay close attention to those patients who present with a simple, discrete and easily fixed problem, like a cough and cold. Some of them may be assessing the doctor's approachability and whether they feel comfortable enough to disclose the 'real' problem. He coined the term '**hidden agenda**' for this real problem and urges us to go look for it when things appear too simple and straight forward.
- Take control, otherwise no-one will and there will be a **collusion of anonymity**. A GP needs to take overall responsibility for a patient with physical complaints as a result of emotional distress (i.e. the somatising patient). Otherwise, that patient can end up being referred and then be passed from specialist to specialist as each one investigates and investigates before bouncing it to another department when they come to realise that the problem has nothing to do with their specialty. This is not good for anyone – the patient becomes more anxious, the hospital departments more overstretched and a waste of NHS (taxpayers') money.
- **Doctors have feelings** and those feelings have a function in the consultation. An awareness of those feelings might lead to insights which might help the doctor to become more sensitive to the patient.
- '**Selective attention**' and '**selective neglect**' – whilst patients might reveal all their cards on the table, what issues get carried forward is often decided by the doctor. Doctors impose constraints on what is acceptable to explore in the consultation, often unconsciously. For example, a doctor may have 'incidentally' picked up that a patient has a problem with alcohol but veers away from exploring this because his father died from similar problems and the feelings remain quite raw. The patient might not be particularly keen either and that can lead to collusion.
- **The doctor as a drug** refers to the doctor as a metaphorical drug that patients take periodically to improve their health. The most powerful *therapeutic* tool in the consulting room is the doctor – an effect over and above anything the doctor actually does. Doctors who listen to their feelings can use this to powerfully influence the patient's thoughts and hence their total health – without even writing a prescription! But be careful - the doctor, like a drug, may be therapeutic but can also have adverse effects and invoke dependency.
- **Mutual Investment Fund** – It's important for GPs to invest in their patients through spending time building relationships, sharing experiences and gaining trust. With time, this creates a powerful bond that can be used to encourage patients to try interventions which they previously would not have anticipated.
- **The apostolic function of the doctor** – All of us have core values and beliefs. In the consultation, a doctor can often transmit some of his core values and beliefs onto patients – things like how they expect patients ought to behave and so on. Sometimes this is done overtly but other times it is more subtle or implied.

- **The Flash** is that point in a series of consultations where you've suddenly fathomed out what might be going on. During the flash, the doctor usually becomes aware of his feelings in the consultation which he then feeds back in a way that can give the patient some insight into the problem. *Example: Dr Turner sighs as he sees Maude Temple, a miserable and negative 64 year old on his list. He can feel her grating on him. But wait! After all those consultations, he has a flash... He wonders if she grates other people too. Perhaps people have divorced themselves from her. He also wonders if he's the only person she has. As he walks down the corridor to call her into his room, he ponders on how he is going to explore this with her.*

## 02 - Transactional Analysis (TA) (1964)<sup>19, 20</sup>

Many doctors will be familiar with Eric Berne's (an American psycho-analyst), 1960's model of the human psyche as consisting of three 'ego-states' or states of mind - Parent, Adult and Child<sup>19</sup>.

- Every single one of us has each of these three states. Berne said that at any given moment, each of us is in a state of mind where we think, feel, behave, react or have attitudes like that of a Parent, Adult or Child. Try and see each state like a video tape: which one we 'play' at any given moment depends on the circumstance.
- The one we play the most often, is our predominant ego state.
- Two individuals who come together might interact well or badly depending on which ego state each one is in. Some ego states are more successful at interacting than others. The most successful consultations happen when both patient and doctor play their Adult tapes.
- Hence, TA helps us to look at consultations by focusing on the ego state the doctor and the patient is in. If we (the doctors) can change our ego state, we can influence which ego 'tape' the patient then decides to play.
- TA is particularly useful for looking at difficult consultations with unsatisfactory outcomes.

The three ego states are briefly defined here:

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### **PARENT – takes away autonomy and control off the other person.**

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*The foundation for this state comes from your experience of life with your parents and teachers. The parent ego has two sides – the controlling, disciplining, restricting parent and the caring, loving, helpful patient. The controlling parent is the one who scolds when their child comes home late for supper after school. The caring parent is the one who is happy they arrived safely home. When we feel, think, talk and behave in the way we remember our parents did, then we are playing our parent tape. It's usually the tape we play when we're involved in any sort of evaluative process.*

#### **Critical Parent – words and phrases**

*Critical Doctor 'You must stop smoking. Look how bad your chest has become. You've only yourself to blame'*

*Critical Patient 'I pay my taxes. Why can't I have antibiotics? This is just ridiculous'*

Others

#### **Caring Parent – words and phrases**

*Caring Doctor 'Poor you. Your chest sounds dreadful. Let's see if I can make things better for you.'*

*Caring Patient 'Not to worry doctor. You've tried your best'*

Others

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- 
- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>• <i>that's the limit,</i></li><li>• <i>why haven't you...</i>,</li><li>• <i>you must never...</i></li><li>• <i>right and wrong – should and should'nt</i></li><li>• <i>always and never – must and mustn't</i></li><li>• <i>good and bad - sensible and careless</i></li></ul> | <ul style="list-style-type: none"><li>• <i>Oh dear!, what a shame,</i></li><li>• <i>take care to,</i></li><li>• <i>please remember to,</i></li><li>• <i>don't be afraid to,</i></li><li>• <i>I'll help you,</i></li><li>• <i>Oh Poor you.</i></li></ul> |
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### **ADULT – tends to be logical, factual, calm and collected.**

*The adult ego state is logical, rational and says things based on common sense. It is the mature and deliberating part of your personality. As a result, your actions will be sensible and well considered. The adult ego collects information, evaluates it, works out probabilities, tackles and solves problems, all in a logical, calm and collected way. An adult ego asks questions and clarifies to seek 'the truth'.*

#### **Words and Phrases**

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• <i>What do you think?</i></li><li>• <i>What are the choices?</i></li><li>• <i>Shall we find out...</i></li></ul> | <ul style="list-style-type: none"><li>• <i>Let's experiment..</i></li><li>• <i>How can we move forwards from here?</i></li><li>• <i>How can we handle it best?</i></li></ul> |
|--|--|
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### **CHILD – tends to be emotional!**

*This ego state represents the child you once were. It reacts emotionally with the feelings and instincts of childhood. Like the parent state, there are two subdivisions of the child state. The natural (free) child is primitive, impulsive, instinctive, undisciplined and demanding – that healthy uninhibited part of us that is up for having fun, being playful and created. The adapted child 'does as he is told' and gives rise to guilt, rebellion, disobedience and compromises. The adapted child lacks natural spontaneity and can be petulant or sulky!*

#### **Natural (Free) Child – words and phrases**

- *Yeah, that option sounds fab.*
- *I want that one please.*
- *Ugghhh.. I hate tablets. Can't you...*

#### **Adapted Child – words and phrases**

- *I can't do that because...*
  - *Okay, I'll give it a try but...*
  - *Well, I hope that works*
- 

Many general practice consultations are conducted between a Parental doctor and a Child-like patient. Although a Parent doctor can work effectively with a Child patient, this transaction is not always in the best interests of either party. The ultimate goal is to achieve an Adult-Adult type of consultation because we know it works the best. For example, if you make a contract with the patient on Adult-Adult terms:

- There has to be something in it for both parties – it is never one way.
- The contract has to be equitable – mutual win if kept and mutual loss if broken
- Breaking the contract needs to be stated in terms of consequences not punishment
- It has to be renegotiable – if it is not working it could be because people or situations have changed.

The key to understanding TA is to be able to identify which ego state the patient is in and to decide whether it is a helpful or unhelpful state for them. If unhelpful, the doctor would actively decide to use an ego state that would encourage the patient to play his/her adult one instead.



The 'chronically sick' or the 'worried well' often assume an unhelpful adapted child state. Look at this example to see how the doctor can change all of that.

- **Patient:** *Oh doctor, those tablets, didn't do a thing. In fact, they made things worse. Oh, never again. (Adapted Child)*
- **Doctor:** *In what way did they make you feel worse? (Adult – seeks facts)*
- **Patient:** *Uggh... they didn't agree with my stomach. Please, don't ever do that to me again. (Adapted Child)*
- **Doctor:** *Okay, had you any thoughts about how we can move forwards from here? (Adult)*
- **Patient:** *How about a different set of tablets? (Adult)*
- **Doctor:** *The thing is we've already tried 10 different sets of tablets and you've tried other things with other doctors. Does that say anything to you? (Adult)*
- **Patient:** *Mmmmm.... Another tablet isn't going to make a difference is it? We're barking up the wrong tree. (Adult)*
- **Doctor:** *Mmmm. I think you might be right. So where do we go from here? (Adult)*
- **Patient:** *Mmmm, sounds like I'm going to have to learn to start living with it. (Adult)*
- **Doctor:** *What would help you do that? .....(Adult)*

The patient started off playing her Adapted Child tape. The doctor persisted with playing his Adult tape and in doing so, eventually got the patient to play her Adult tape too. We hope you can see how a familiarity with TA introduces a welcome flexibility into the doctor's repertoire which can help us break out of the repetitious cycles of behaviour (or what Berne called 'games') into which some consultations can degenerate.

### Ego state profiles – how to recognise which state your patient is in

Parent Critical	Parent Nurturing	Adult	Child Natural	Child Adapted
<b>WORDS THEY USE</b>				
Never	Good	Correct	Fantastic	Can't
Should	Nice	How	Fun	Wish
Ought	I love you	What	Want	Try
Must	Splendid	Why	Won't	Hope
Bad	Tender	Results	Hate	Please
Always	Poor thing	Practical	Scared	Thank you
Good	Don't worry	Alternative	Hi!	Sorry
Ridiculous	There, there	Quantity	Super	Ought
Do	Let me	Where	Mine	Excuse me
Don't	Be careful	Objective	Secret	After You
<b>TONE OF VOICE</b>				
Critical	Loving	Even	Free	Whining
Condescending	Encouraging	Confident	Excited	Defiant
Sneering	Comforting	Inquiring	Loud	Manipulating
Disgusted	Sympathetic	Calm	Giggling	Apologetic
<b>GESTURES/EXPRESSIONS</b>				
Closed	Open arms	Thoughtful	Uninhibited	Pouting
Points fingers	Accepting	Alert	Loose	Sad
Frowning	Smiling	Open	Spontaneous	Helpless
Rigid	Caressing	Straight	Flirtatious	Immobile
Angry	Consoling	Interested	Wide-eyed	Sullen
<b>ATTITUDE</b>				
Judgemental	Understanding	Open	Curious	Agreeing
Moralistic	Caring	Level	Fun-loving	Compliant
Authoritarian	Giving	Evaluative	Changeable	Ashamed

### 03 - Neurolinguistic Programming (NLP), (2002)<sup>21</sup>

In its basic form, NLP is a model based on determining how another person's brain handles information by observing their verbal and non-verbal signs. If you can pick out patterns and match them then you are more likely to successfully influence them (i.e. getting onto the same wavelength).

By *looking* at a patient, *hearing* what they are saying and *sensing* what they are feeling, you should get some idea of

- a) what a patient does inside their head as they think and
- b) how they code information using their sensory systems - their internal representation system.

Tapping into the perceptual system they use to 'view the world' will help you to 'connect' better with them.

There are three main types of internal representation, modal or perceptual systems:

- **(V)** Visual (seeing),
- **(A)** Auditory (hearing) and
- **(K)** Kinaesthetic (feeling).

#### **How can I tell if a person is predominantly visual, auditory or kinaesthetic?**

NLP is more interested in *how* a person expresses something rather than the *content* of that expression (i.e. process over content). The golden rule of NLP is therefore to *watch, listen and feel* the form and not to get too bogged down by the content.

#### In General:

**Visual people** *see* the world predominantly with their eyes. They memorise things by seeing pictures and are often good spellers. They would rather read than be read to. They tend to be organised, neat and orderly. They may even dress well – either flamboyantly or carefully colour matching their dress code. They tend *not* to be distracted by noise and prefer visual instruction over verbal instruction (for instance, when giving directions). Give them too long an explanation and their minds will wander off. They use phrases like: *see* you later, let's *look* at this, I *see* what you mean, that *looks* great, let's be *clear* about that, keep an *eye* on it and so on.

**Auditory people** *sound out* the world with their ears. For instance, when talking to them, they might repeat some of your words. They learn by listening and will prefer hearing someone speak as opposed to looking at their PowerPoint slides. Unlike Visual people, they *are* distracted easily by noise (they need peace and quiet in order to revise!). Be careful with what you say – they will respond to the set of words you use and the tone in which you say them. They use phrases like: hope to *hear* from you soon, let's *sound* that out, I *hear* what you're saying, that *sounds* brill, we need to keep our *ears* firmly on the ground...

*If a person talk to him or herself (as if they're in a conversation with themselves) they are more likely to Auditory Digital than Auditory.*

**Kinaesthetic people** make *sense* of the world through feelings and emotions. They stand close to people and physically interact with them. In fact, they're often physical themselves – of athletic build and always seem 'on the go'. They learn things by doing, practising or playing – for instance, they'll often dive in and start playing with a new electrical gadget rather than read the instructions. They use phrases like: keep in *touch*, let's get a *feel* for what it would be like, I *sense* that what you're saying is, that *feels* brill, we need to keep our *fingers* firmly on the pulse, she needs get a *grip*....

### Listen carefully to what people say

The words people use help construct the life they lead. From the general descriptions above, we hope you've noticed how the words tell you what sort of internal dialogue they use and how they see the external world. If you listen carefully to their words, you should be able to identify whether a person is V, A or K. For instance, if you explain something to somebody and they now understand your point of view:

A **visual** person would say 'I **see** what you mean'  
An **auditory** person would say 'I **hear** what you're saying'  
A **kinaesthetic** person would say 'I'm totally **in touch** with you' or 'I know the **feeling**'.  
(More examples of phrases to differentiate the three modal systems on our website.)

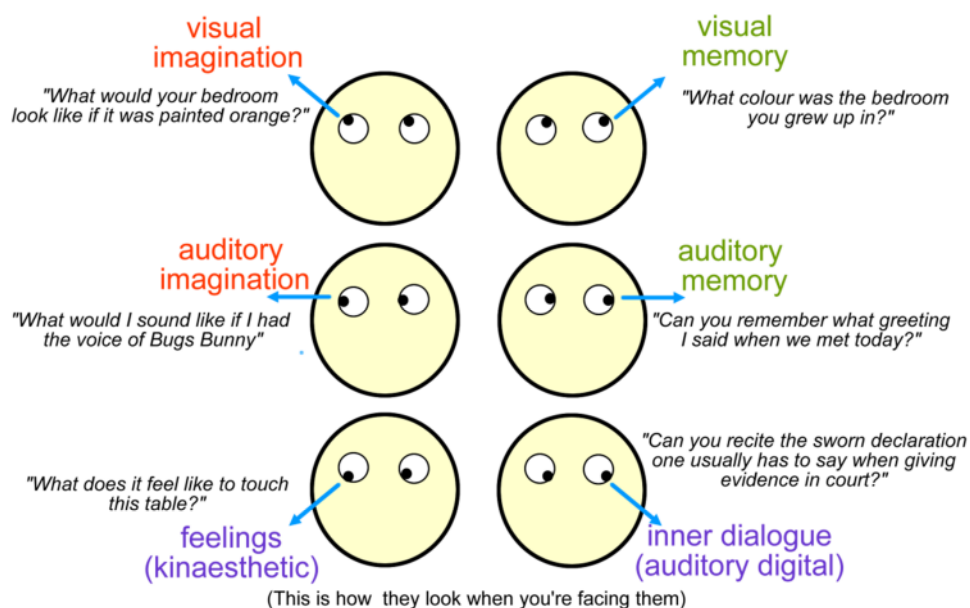
In the context of the GP consultation:

### Listen carefully to the patient's use of words

- Then try doing the management and explanation using words from the patient's primary modal system.
- You might use pictures and diagrams to explain something to a visual patient, give clear verbal instruction to the auditory patient, and demonstrate and get the patient to have a go for the kinaesthetic.

### Look into their eyes...

- You can also figure out what modal system a person is in by following their eye movements



- Visual imagination – seeing into the future, constructing visual fantasies
- Visual memory – seeing the past
- Auditory imagination – hearing the future, constructing sounds and words
- Auditory memory – hearing the past, remembered sounds and words.
- Feelings – current feelings – both tactile (touch, temp etc.) and emotional (happy, sad etc.)
- Inner dialogue/Auditory digital – making sense of what is going on, self-talk (often people who talk to themselves – engage in the dialogue within).
- Eyes defocused, looking straight ahead: quick access of sensory data, usually visual

In some cases (for example *some* left handed people), these visual accessing cues are opposite – e.g. visual imagination is where visual memory would normally be and vice versa. Ask some of the questions in the diagram above to see if they match.

The next time you have a conversation with someone, pay attention to their eye movements. However, watching their eye cues does not tell you *what* they are thinking. Instead, it tells you which *representational system* they are thinking – V, A or K – are they remembering or constructing something or are they in a conversation with themselves (self-talk). Also remember that the power to influence others depends on you moderating your external dialogue to match (or accommodate) their predominant 'modal' style.

#### Hey, try this...

- **The next time you go to the dentist, look up and visualise something.** Why? Because looking down is where your touchy-feely sensitive and emotional side is – and if you do that, you will intensify your focus on the drilling and grinding.
- **If you're feeling a little miserable today, look upwards.** Why? Emotions are connected with looking down (feelings).
- **If you ask someone a question and they look down before they answer you... beware of the truth in the response.** Why? Looking down means they had a conversation with themselves before deciding on what to say to you.

#### Pace, Pace and Lead

Another (one of many) NLP technique to influence people is pace, pace and lead. This involves match what the other person has just said (or what you expect they are thinking) and then leading them to a new, hopefully more beneficial 'answer'. In practical terms, this means stating two truisms that you know the other person will agree with before introducing your own statement of influence. For example, to a patient with depression you might say:

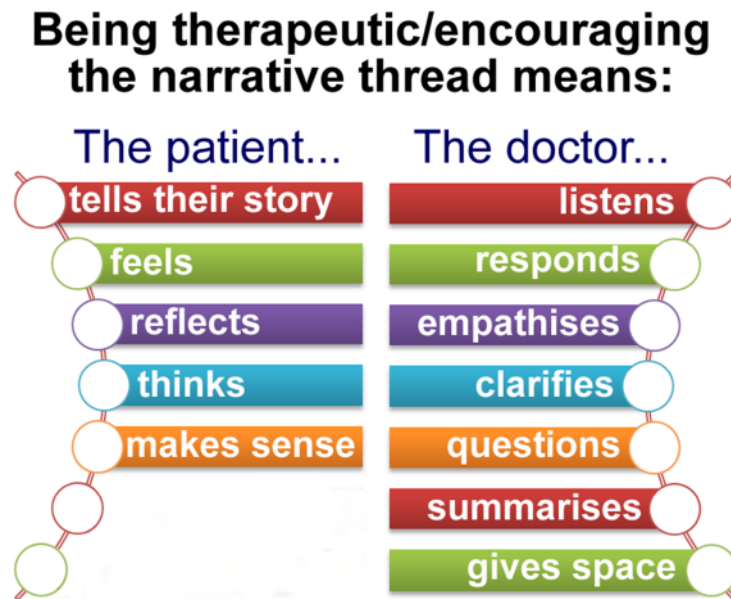
- *'I know that you've really had to pluck up the courage to come and talk to me today'* (she nods)
- *'And I know that you're a bit apprehensive about being referred to a counsellor'* (she nods)
- *'But sometimes you have to take chances and give things a try to be truly happy. Perhaps giving counselling a try?'* (she nods)

By adding your own statement to two things you know the other person will agree to, the more likely it is that they will *automatically* agree to the third statement and accept it as true.

NLP has become a sort of panacea treatment for 'everything' from anxiety and phobias to teaching and learning – just type in NLP into an internet search engine to get a flavour of all the things NLPists claim they can do! Lewis Walker's book<sup>21</sup> focuses on NLP techniques purely to improve communication with patients.

## 04 - Narrative Medicine (2002)<sup>22</sup>

Most of us consult by focusing and analysing the patient's behaviour – 'Mmm... she doesn't seem so upset by that. I wonder why that is. Is it because...'. A narrative approach encourages us to move away from this 'need to analyse' and instead concentrate, understand and become involved with the way a patient describes their story – for example, their experience of the illness. Narrative studies explore the way people tell stories and narrative medicine focuses on patients' histories as story-telling.



A narrative approach is not saying that you ignore the biomedical model. Nor is it saying forget about evidence-based medicine. At a basic level, all these frameworks are different ways of looking at the same thing. If you do the evidence based or biomedical bit without paying any attention to the narrative, then you are only exploring one aspect of the truth. Moving flexibly between the models will help you get closer to the 'real truth'.

A narrative approach is important because the way we all interact with people around us and the way we understand the world is based on 'shared stories' – and if we can help patients 'weave' new stories, perhaps we can change their view of reality.

*People using a narrative approach are not trying to peel away the layers of an onion, looking for the 'inner meaning' concealed at the centre. Instead, they see reality more like a tapestry of language that is continually being woven.*

John Launer, [www.johnlauner.com](http://www.johnlauner.com)<sup>23</sup>

## The Seven Cs of Narrative Medicine

John Launer<sup>23</sup> talks about the Seven Cs that are needed to help you get into the right frame of mind when you're contemplating on consulting in a narrative way.

- **Conversations.** A conversation is a true two way dialogue to help you both to understand things better and hopefully develop new insights (and not just to collate facts). And don't forget that the conversation process in itself can be therapeutic in its own right – getting people to think, reflect, reframe and redefine their stories.
- **Curiosity.** You have to get involved with the conversation and that means genuinely being interested and curious. Those queries you raise will help the other to think and reflect – and perhaps helping them to reframe and redefine their stories.
- **Contexts.** Conversations are nothing if they are not in context (i.e. in the context of their families, friends, community, beliefs, values and so on). Note the context in which the story teller puts his/her story. How have they decided to 'frame' their story? Be curious and clarify.
- **Complexity.** Life is not simple. So why do we (doctors) always try to fix life's problems with concrete and rigid solutions? Try and move away from that. Move away from 'cause and effect' mentality; simply go with the patient, his/her story and see where that interaction takes you. Don't worry too much about not knowing where you're heading.
- **Creativity.** Can you help patient's create a better account of what's going on for them? Can you help them make a better story? Better stories create better realities.
- **Caution.** Sometimes, patients come in with straightforward problems/questions for which they want straight forward answers. Don't hammer this approach where it just doesn't fit in.
- **Care.** You have to show genuine care for the narrative approach to work. That means being truly listening, showing respect, treating others as equal and showing a true genuine interest in wanting to help the person.

Pros	Cons
<ul style="list-style-type: none"><li>• <i>A different way of looking at things rather than the traditional 18<sup>th</sup> Century mind/body dual theories – is science the only truth?</i></li><li>• <i>Expands our own development and thinking – of cultures, our beliefs and of life.</i></li><li>• <i>Encourages patients to define THEIR own stories and lives (and take responsibility)</i></li></ul>	<ul style="list-style-type: none"><li>• <i>Patients have questions and most want traditional explanations.</i></li><li>• <i>Takes time – we work in a pressurised NHS.</i></li><li>• <i>How do you know you're not opening a can of worms? No-one should play post-modernist games with patients' lives.</i></li></ul>

## Getting trainees to think in terms of constructs and triads

Some trainees will find it useful to think in terms of constructs and triads because

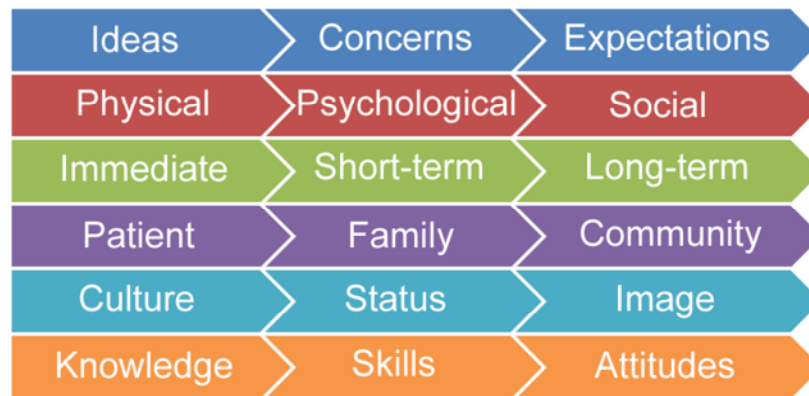
- They provide a framework for a particular situation
- In doing so, they encourage them to think more laterally
- They help uncertain situations become more certain.

### Constructs

Constructs are mental grids or frameworks that can help a trainee handle a specific situation.

<b>Management options (RAPRIOP)</b>	<b>Who can you involve in patient care?</b>
<p><i>Mr. Simons comes to see you regarding back pain. What are the options available to you?</i></p> <p>R Reassure A Advise (or Educate +/- leaflets) P Prescribe (or Carry out a procedure) R Refer I Investigate O Observe and follow up P Prevention and Health Promotion</p>	<ul style="list-style-type: none"> <li><b>Practice Staff</b> – practice/district nurse, HV, midwife</li> <li><b>Hospital</b> – consultant, physio, OT, etc.</li> <li><b>Social Services</b> – social worker, home care, meals on wheels, day centre, sheltered housing, residential or nursing care, respite care.</li> <li><b>Voluntary Sector</b> – CAB, CRUSE, Care groups</li> </ul>
<b>Breaking bad news (A KISS S)</b>	<b>Dealing with the angry patient (AFVER)</b>
<p>A Anxiety - acknowledge K Knowledge– what do they already know? I Information–how much info do they want? Keep it simple, avoid overload. S Sympathy + emotional management S Support – ask what would help S Summarise strategy and key points</p>	<p><i>Mr Trueman is furious over not being antibiotics over the phone. How would you manage this?</i></p> <p>A Avoid Confrontation F Facilitate discussion V Ventilate Feelings E Explore Reasons R Refer/Investigate</p>
<b>Conflict situations</b>	<b>Reattribution of somatising patients<sup>24</sup></b>
<p><i>What would you do with a patient who demands a specialist referral for something you consider trivial?</i></p> <p>D Disagree A Agree N Negotiate a compromise C Counsel E Educate R Refer to 3<sup>rd</sup> party</p>	<ol style="list-style-type: none"> <li>Feeling understood</li> <li>Broadening the Agenda</li> <li>Making the link</li> <li>Negotiating treatment</li> </ol> <p>Type the words 'reattribution gask' into Google if you want to learn more about this.</p>
<b>Ethical considerations (ABC+CDE)</b>	<b>Planning change (APRIE)</b>
<p>A Autonomy (patient) – be fair (Justice) B Beneficence - 'above all, do no harm' - 'do good where possible' - Moral theories (Aristotle) C+C Consent + Confidentiality D Do not lie (Honesty) E Everybody else (Society vs. Individual) - virtue, duty, utility and rights.</p>	<p><i>e.g. you're thinking of setting up a new sexual health clinic</i></p> <p>A Assess - consider all problem areas P Plan – decide what needs to be done. R Resource – availability, fund raising I Implement – who does what, when etc. E Evaluate - the service and fine tune.</p>

## Triads:



## There's too much. Just give me some recommendations.

For new trainees, encourage them to read one of:

- Roger Neighbour's *The inner consultation*<sup>13</sup>
- Peter Tate's *The doctor's communication handbook*<sup>14</sup>

For ST3 trainees, encourage them to read (both?):

- Silverman et al *Skills for communicating with patients*<sup>15</sup> (Calgary Cambridge)  
- really good in terms of tackling core generic skills common to all consultations.
- Liz Moulton's *The Naked Consultation*<sup>25</sup>  
- trainees find this book invaluable in terms of consultation skills for specific situations (which often come up in the CSA).

As a GP Educator (if you've read the above) consider reading:

- Salinsky and Sackin's *What are you feeling, doctor?*<sup>26</sup> (*Balint'esque*)
- Donovan and Suckling's *Difficult consultations with adolescents*<sup>27</sup>
- John Launer's *Narrative based primary care*<sup>22</sup>
- Lewis Walker's *Consulting with NLP*<sup>21</sup>

## Closing Statement

Having a wide array of models can be seen as either confusing or as adding richness. We've presented a comprehensive list of them because we see them as useful toys. Why limit yourself or your trainee to just one toy? By playing with several you will, eventually, find your personal favourite. Exactly how you play with your newly found favourite toy thereafter (= your consulting style) is entirely up to you.



## Other resources on our web

- Byrne & Long on the Consultation
- The Seven Cs of Narrative Medicine
- A model for working with somatisers – Reattribution

## Other chapters you should read

- In the book - Chapter 23: Road Maps for Teaching on the Consultation

## References

1. 'The Future General Practitioner - Learning and Teaching' by a Working Party of The Royal College of General Practitioners (1972)
2. Med Care. 1975 Jan;13(1):10-24.Sociobehavioral determinants of compliance with health and medical care recommendations.Becker MH, Maiman LA.
3. Publication: Six Category Intervention Analysis in British Journal of Guidance & Counselling, Heron (1976)
4. Publication: 'Doctors Talking to Patients' by Byrne PS & Long BEL (1976). A very detailed analysis and not very easy to read!
5. Publication: 'The Exceptional Potential in each Primary Care Consultation', Stott & Davis (1979) J R Coll Gen Pract. 1979 Apr;29(201):201-5.
6. Publication: Disease versus Illness in General Practice in J R Coll. Gen. Pract. vol 31 pp 548-62, Helman CG (1981)
7. Publication: The Consultation: An Approach to Learning and Teaching by Pendleton D, Schofield T, Tate P & Havelock P (1984). Second Edition is easy to read.
8. Publication: Problem-based interviewing in general practice: a model., Lesser AL., Med Educ. 1985 Jul;19(4):299-304.
9. Publication: JH Levenstein, EC McCracken, IR McWhinney, MA Stewart, and JB Brown, The patient-centred clinical method. 1. A model for the doctor-patient interaction in family medicine, Fam. Pract. 3: 24-30. 1986
10. Levenstein JH, Belle Brown J Weston WW et al (1989) Patient-centred clinical interviewing. In Communicating with medical patients (eds M Stewart and D Roter) Sage Publications, Newbury Park, CA.
11. Roter DL, Stewart M, Putnam SM, et al; Communication patterns of primary care physicians. JAMA. 1997 Jan 22-29;277(4):350-6.
12. Stewart M et al (2003) Patient-centred medicine: transforming the clinical method. Radcliffe Medical Press Abingdon Oxford
13. Neighbour R, The Inner Consultation: how to develop an effective and intuitive consulting style. Roger Neighbour (original 1987, 2<sup>nd</sup> Edition 2004)
14. Tate, P. The Doctor's Communication Handbook by Peter Tate (Original 1994, 6<sup>th</sup> Edition 2010)
15. Silvermann, Kurtz and Draper, Skills for Communicating with Patients by Silvermann, Kurtz and Draper (1996)
16. Publication: The Medical Interview: The Three-Function Approach by Cohen-Cole & Bird (2000).
17. Publication: An introduction to BARD: a new consultation model, by E Warren (2002)
18. Publication: The doctor, his patient and the illness. Michael Balint. First published 1957, update 1964.
19. Publication: Games People Play: The Psychology of Human Relationships, Eric Berne (1964). A difficult book to read – try looking for a modern version like:
20. T A Today: A New Introduction to Transactional Analysis by Ian Stewart and Vann Jones (1991) or I'm Okay, You're Okay by Thomas Harris.
21. Publication: Consulting with NLP by Lewis Walker (2002)
22. Launer J, Narrative-based Primary Care: a practical guide. John Launer (2002)
23. <http://www.johnlauner.com> accessed 18/02/2011
24. Reattribution by Linda Gask – the paper.
25. Moulton, L. The Naked Consultation: a practical guide to primary care consultation skills
26. Salinsky & Sackin. What are you feeling, doctor.
27. Donovan & Suckling. Difficult consultations with adolescents.