



Medical models of consultation

Andrew Millington begins a new series looking at aspects of clinical communication and how they may be applied to the optometrist's role

There is a whole raft of research into the role of the consultation in general medicine, but unfortunately there has been no specific research on the optometric consultation.

The optometric consultation differs from the GP consultation in a number of significant ways but there are enough similarities that we can apply the principles that have been learned in the last 30 years.

The most significant difference with the medical models is that they assume there will be an interview with possibly some minor investigation followed by a second appointment, often with a different specialist for further investigation or treatment; this is followed by a follow-up interview to discuss the results. Our consultations combine all these roles, but also give us the luxury of spending longer with the patient, allowing a deeper relationship to develop.

It is useful to consider what we mean by health and illness. The World Health Organisation defined health in 1948 as 'a state of complete physical, mental and social well-being and...not merely the absence of disease or infirmity'.¹

There is no easy definition of illness.² Our sense of health and illness is affected by our ideas on:

- How we normally feel
- How we could feel
- The cause of our present condition
- How we think other people feel
- How other people respond to us
- How our friends, family and culture describe our symptoms, behaviour and feelings.

Models of health

The Biomedical model has dominated Western medicine for the last 300 years.² It is an appealing model that assumes that the people are simply very complex biological machines. The medical professional simply observes the problem, diagnoses the fault and repairs, replaces or removes the damaged part.

The key parts are:

- Reductionism – reduce the explanation



Establishing a rapport with the patient is fundamental to both the GP and optometric consultation

of the illness to the simplest possible process. It will look for explanations in disordered cells

- Single factor causes – look for the cause of the disorder rather than a range of contributory factors
- Mind body distinction (Cartesian dualism). A separation is made between the nature of the body and the mind
- Illness not health. It deals with curing an illness rather than promoting good health.

This model promotes a 'Doctor knows best' approach from both the medical professional and the patient.

An alternative approach was proposed by George Engel in 1977.⁴ It has become known as the biopsychosocial model. He recognised that the concept of illness, that is the individual's experience of disease was lacking from the biomedical model. The concept of illness depends not just on the biological but also the psychological and social influences. This holistic approach to considering

the patient's experience of illness has led to a call for a more 'patient centred' approach. It also draws attention to the need to understand a patient's health-promoting or health-threatening activities, such as exercise, taking medication, or seeking a consultation, in the overall move towards good health.

Since investigations into consulting styles began in the 1970s, over 20 different models have been proposed. These range from a simple philosophy of the doctor patient interaction to a comprehensive list of tasks and achievements. It is worth looking at a few of them.

Helman's Folk Model²

Cecil Helman is a former GP and medical anthropologist specialising in the cross-cultural study of health, illness and medical care. He has looked at what motivates patients to seek medical help and has suggested that the patient seeks the answers to six fundamental questions:



Communication skills

- What has happened?
- Why has it happened?
- Why has it happened to me?
- Why now?
- What would happen if nothing were done about it?
- What should I do about it?

This is the checklist against which a person will test their 'illness' before deciding on the appropriate action. Obviously these questions may be answered without seeking professional medical advice and for the individual that is a valid viewpoint. A typical internal dialogue may be:

- I've got a cold (What has happened?)
- There's a lot going around (Why has it happened?)
- Everyone at work has had it. (Why has it happened to me?)
- I was sneezed on yesterday (Why now?)
- It only lasts a couple of day (What would happen if nothing were done about it?)
- I will take a day off work (What should I do about it?)

Helman's model was the first to acknowledge that there are alternatives to the simple doctor/illness equation. It allows for beliefs in alternative therapies and also peer group beliefs. His model is valid for people who seek healing through alternative routes such as homeopathy and crystal healing and also acknowledges that people will seek the advice of others in their peer group, before (or as well as) seeking professional help.

Byrne and Long studied over 2000 recordings of GP consultations.⁴ They analysed the roles of doctor and patient in each of them and identified six phases of the consultation:

- The doctor establishes a relationship with the patient
- The doctor attempts to discover or actually does discover the reasons for the patient's attendance
- The doctor conducts a verbal or physical examination or both
- The doctor and/or the patient consider the condition
- The doctor and the patient agree and detail further treatment or investigation if necessary
- The consultation is terminated (usually by the doctor).

This model looks at the flow of the consultation. It can be considered as a road map providing markers of good practice. It introduces the concept of a negotiated outcome. If we discuss the treatment options with a patient we are more likely to achieve a predictable and sustained outcome. In medical jargon

we would consider this patient to be compliant. Unfortunately too often what is meant in medicine by compliant is obedient.

In our case we need to discuss not just treatment regimes but also the use of spectacles, visual aids and the various dispensing options available.

In the case of a dysfunctional consultation, this model provides a useful tool to establish where an appointment went wrong and why the consultation went badly. It is a useful framework for reflective practice.

Roger Neighbour who is a GP also looked at the process of the consultation but took a different approach.⁵ He concentrated on the process from the doctor's perspective and considered the doctor listening to his 'inner voice'. He refined the consultation into five tasks under the umbrella question of 'where shall we make for next and how shall we get there?'

- Connecting – establishing rapport with the patient
- Summarising – getting to the point of why the patient has come using eliciting skills to discover their ideas, concerns, expectations and summarising back to the patient
- Handing over – doctor and patient agendas are agreed. Negotiating, influencing and gift wrapping
- Safety-netting – ensure a contingency plan has been made for the worst scenario – 'What if?'
- Housekeeping – clear the mind of the psychological remains of one's consultation to ensure it has no detrimental effect on the next – 'Am I in good enough shape for the next patient?'

Neighbour was the first to place an emphasis not just on the patient but also on the practitioner's well-being and also to consider the consultation as part of the continuum of consultations during the day. This is an important issue that is sadly often ignored. The well-being and needs of the professional can be as important as those of the patient.

There has been a move in recent years

away from 'doctor-centred' towards a more 'patient-centred' care. Perhaps the most perceptive model so far was from psychoanalyst David Tuckett who said that a consultation is 'a meeting of experts.'⁶ This challenges our normal perceptions. We are all graduates with post-graduate training and a professional registration and we all regularly complete professional development assessments. Surely we are the expert? However, we know very little about the patient and why they have presented. We have not been privy to the internal dialogue which, thanks to Helman, we know they have had. Are they in pain? How much pain? How is their change in vision impacting on their lifestyle? We need to acknowledge that the patient is the expert on their body and the effect of any condition on their lifestyle.

It is also useful at this point to consider a transactional analysis approach.⁷ Eric Byrne proposed a model of the human psyche that has three ego stages – parent, adult and child. These states are often represented as a set of traffic lights (Figure 1).

At any particular moment we will think, feel, behave, react and have the attitudes of either a parent, an adult or a child. The parent state can be further divided into either critical or caring and the child state into spontaneous or dependent. For instance, if we are feeling unwell and our partner put us to bed with a cup of hot chocolate, we are in the dependent child state and they are in the caring adult state. In any healthy relationship these states will change (often quite rapidly) but will always be complementary. That is adult to adult, parent to child or child to parent. Relationships become dysfunctional when the states become fixed or do not coincide.

The role of the medical professional is often seen as that of the caring parent, and this can lead to a fixed dysfunctional adult child relationship. The medical professional is not always the villain if they are stuck in the adult role. The role of child is an active choice and not a default position. Patients will often actively choose that role for themselves and we need to move them away from this position when appropriate.

We learn how to behave in social situations and behaviour in a medical setting is no different. 'Doctor knows best' is undoubtedly learnt in our early years. If a child hurts themselves they run to mum to kiss it better or if they have a cut they ask mum for a plaster to stop the bleeding. The adult becomes the dispenser of medical advice and treatment and this is a role that patients

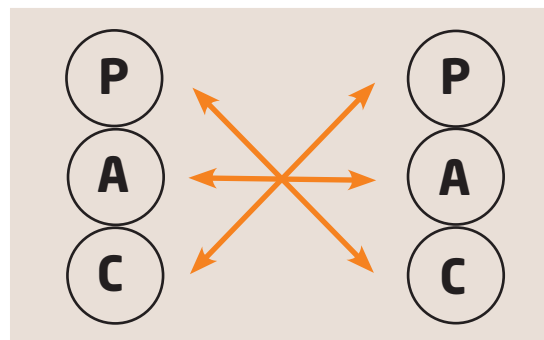
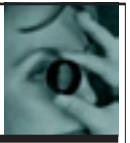


Figure 1 Traffic light representation of human psyche stages



can automatically slip back into during a consultation. In the same way as we learn to be the child in this relationship we need to teach our patients that they are equal partners in the wellness process. This education will start with the 'meet and greet' when we treat the patient as an equal.

There are two models which have recently taken a comprehensive approach to the consultation and have tried to combine the needs of the patient, the needs of the professional and the constraints of the situation.

In 1984 Pendeton, Schofield, Tate and Havelock published *The consultation – An approach to learning and teaching*.⁸ This model is arranged as a series of goals that need to be achieved during a consultation (Table 1).

The Calgary Cambridge Model proposed by Suzanne Kurtz and Jonathan Silverman is by far the most comprehensive model so far.⁹ The full version, which also discusses the teaching of the necessary skills, runs to two volumes and over 500 pages. The condensed summary lists 71 points to be considered during a consultation. In brief it considers that there are five tasks of the consultation:

- Initiating the session
- Gathering information
- Building the relationship
- Giving information – explaining and planning
- Closing the session.

The expanded framework goes into the five tasks in greater detail (Table 2).

In the next article a model of an optometric consultation will be introduced. ●

References

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- 7 Berne E. *Games People Play*. Grove Press 1964.
- 8 Pendeton D, Schofield T, Tate P and Havelock P. *The consultation - An approach to learning and teaching* OUP 2003.
- 9 Silverman J, Kurtz S and Draper J. *Skills for Communicating with Patients* Radcliffe Oxford 2005.

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TABLE 1


Pendeton, Schofield, Tate and Havelock Model	
<ul style="list-style-type: none"> ● To define the reason for the patient's attendance, including: <ul style="list-style-type: none"> – The nature and history of the problems – Their aetiology – The patient's ideas, concerns and expectations – The effects of the problems ● To consider other problems: <ul style="list-style-type: none"> – Continuing problems – At-risk factors ● With the patient, to choose an appropriate action for each problem ● To achieve a shared understanding of the problems with the patient ● To involve the patient in the management and encourage him to accept appropriate responsibility ● To use time and resources appropriately: <ul style="list-style-type: none"> – In the consultation – In the long term ● To establish or maintain a relationship with the patient which helps to achieve the other tasks. 	<p>These two points are the limit of investigation in a normal history and symptoms This acknowledges the patients expertise and the impact on their lifestyle.</p> <p>This is a long-term approach and an opportunity for patient education.</p> <p>Negotiate a care plan and educate the patient</p>  <p>'Housekeeping' attending to the welfare of the professional as well as the patient.</p> <p>A continuous process throughout the consultation.</p>

TABLE 2

The Calgary Cambridge Model	
<ul style="list-style-type: none"> ● Initiating the session <ul style="list-style-type: none"> – establishing initial rapport – identifying the reason(s) for the consultation 	<p>This recognises the need for both parties to feel comfortable. It allows the professional to establish an adult to adult relationship.</p>
<ul style="list-style-type: none"> ● Gathering Information <ul style="list-style-type: none"> – exploration of problems – understanding the patient's perspective – providing structure to the consultation 	<p>Explore the patient's theory of illness and effects on lifestyle.</p>
<ul style="list-style-type: none"> ● Building the relationship <ul style="list-style-type: none"> – developing rapport – involving the patient 	<p>This is a continuous process which starts with the patient greeting.</p>
<ul style="list-style-type: none"> ● Providing structure to the interview <ul style="list-style-type: none"> – summary – signposting – sequencing – timing 	<p>Uses the skill set of a facilitator.</p>
<ul style="list-style-type: none"> ● Explanation and planning <ul style="list-style-type: none"> – providing the correct amount and type of information – aiding accurate recall and understanding – achieving a shared understanding: incorporating the patient's perspective – planning: shared decision making 	<ul style="list-style-type: none"> – Establish the patient's information needs. Are they an information seeker? – Invite the patient to summarise back. – The professional understands the patient and the patient understands the professional.
<ul style="list-style-type: none"> ● Closing the session 	