The Consultation 1: Examples and theory

In this session we are going to observe some examples of real consultations filmed in the UK, and then examine their structure and characteristics.

Task 1

First watch the 17-minute video which has been posted at the following address:

https://youtu.be/XYFgF0DnBoA

(If you can't find it, search for GPs Behind Closed Doors on YouTube and watch any episode you wish.)

While you are watching it, observe three things:

1. What are the differences between the systems in the UK and in France?
2. What is the basic structure of a consultation?
3. What interpersonal skills do the doctors demonstrate?

Warning: the automatically generated subtitles are not 100% accurate

About the series

The series belongs to a genre that is sometimes termed "docu-reality" and films the day-to-day life in a medical centre, where GPs, nurses and other health professionals care for their patients. It was first shown in 2014, and the first two seasons only had a few episodes each. However, the series was so successful that it soon grew to forty or fifty episodes of almost an hour long over the course of the year. In 2020 season 7 aired, and it seems to be just as well-liked as when it was first launched.

For practical purposes and probably other reasons related to how to keep viewers watching, the filming location changes from time to time, but all the medical centres (or *surgeries*, as they are called in British English) are representative of local healthcare services.

Patients obviously are required to give consent to appear on the show, and several cameras are used so that it can be edited afterwards.

A short article written by three doctors who have taken part was published in 2014, and you can find it here : https://bjgp.org/content/64/625/412

You may have noticed…

In the series the consultations are very short compared to what we are used to in France, and this is unrelated to filming constraints. GP appointments were previously limited to ten minutes, and anything that was likely to require longer had to be booked in advance as a double appointment. However, the situation has evolved based on the observation that the average time needed was 12 minutes, and now GPs are allowed to be more flexible. Nevertheless, the doctors in the series seem to expedite their workload. According to a number of surveys carried out in the past 5 years, it usually takes two to four weeks to get an appointment to see a doctor.

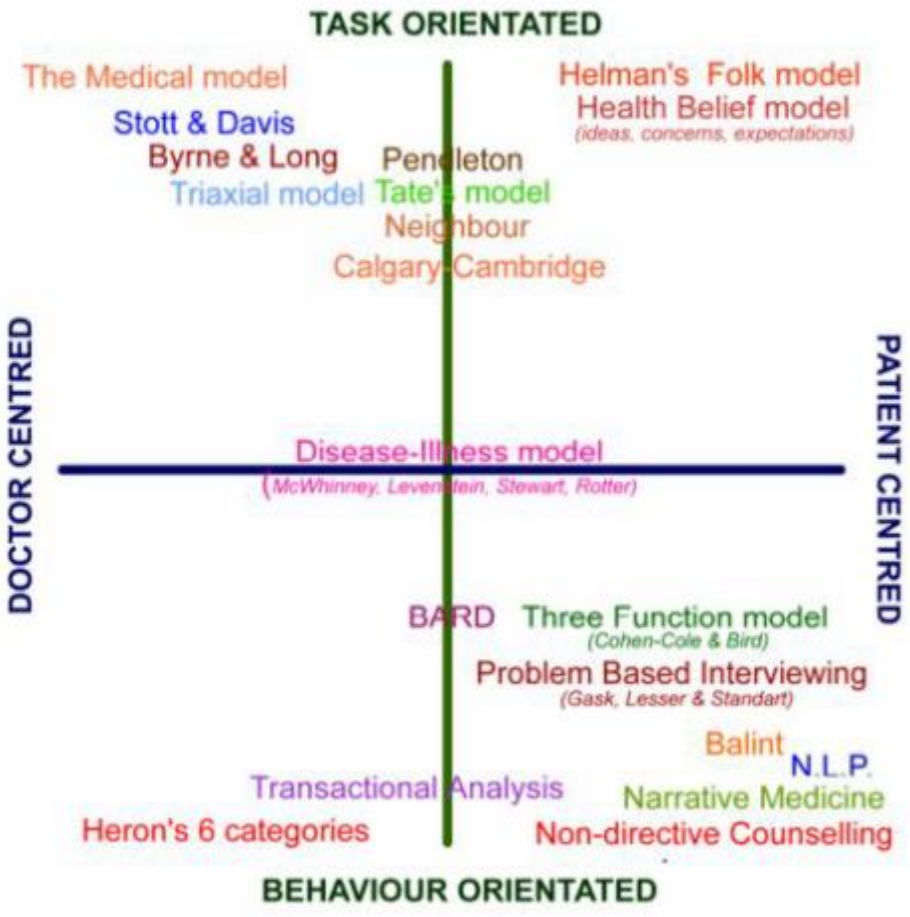
Another major difference between UK and French consultations appears to be the organisation of the rooms. In the series we note that there is a great number of patients (18 000 for Balham Park Surgery in London) and many doctors using shared consulting rooms to care for the population. Real estate has become such a problem in many areas of the UK too, so medical centres have to be organised

differently, with smaller consulting rooms. This means that the furniture has to be arranged differently, and in order to retain enough space for the treatment couch, should a physical examination be required (which you may have noticed is not systematic) the doctor's desk is often up against a wall and patients sit along the same wall, meaning that the patient is no longer sitting opposite the doctor. This subconsciously changes the relationship between doctor and patient, which in some respects can be a good thing, but in others it is an advantage to maintain a certain distance.

Structure

The basic structure that seems to emerge from the consultations observed in the series is similar to what we might expect in France. Generally speaking, the GP does not come to the waiting room to greet the patient, but does so at the door. There is an initial phase of questioning. If required, this is followed by a physical examination. The doctor will then give a probable diagnosis, and finally discuss treatment and tests, if needed. Then the GP will usually accompany the patient to the door.

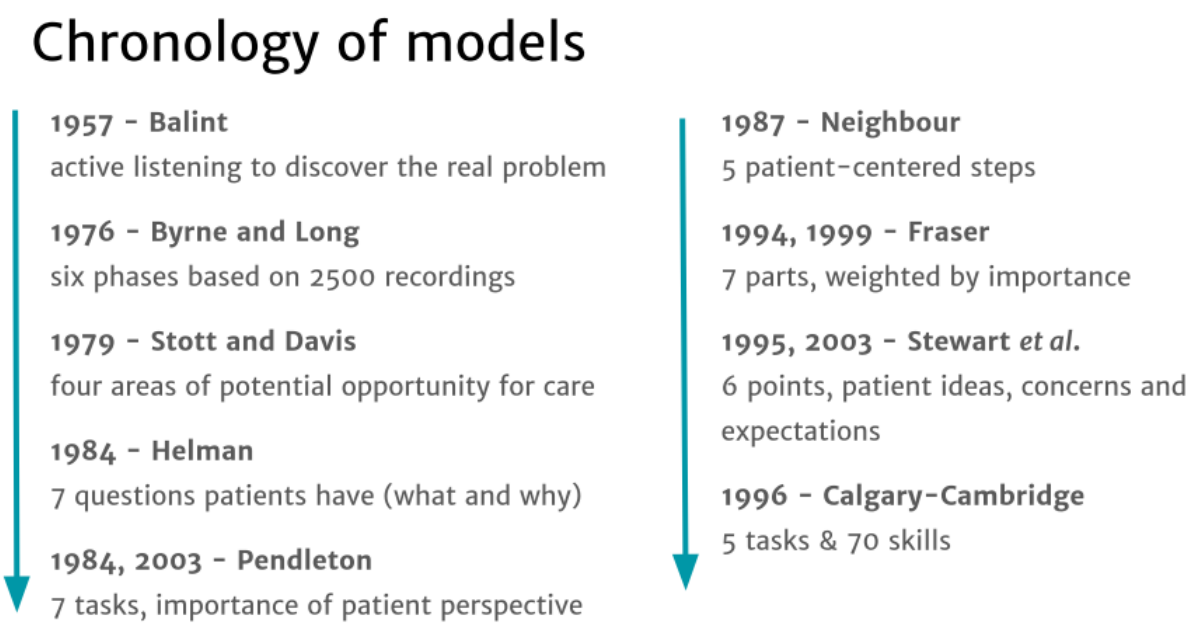
The structure of a successful patient consultation has been of interest in medical education and training for many years. As early as the 1950s researchers were attempting to gather data about best practice, and since then a number of models have been published.



In the illustration above there are no less than 20 different models which have been developed over the years. We'll take a chronological approach later on. For the moment note how the models are organised on two axes. The horizontal axis places the models based on whether the model is centred

more on the needs of the doctor or the patient. The vertical axis situates each model relative to whether the approach concerns what tasks need to be accomplished, or how each party behaves.

Some of the models bear the names of their creators, others the places in which they were developed, and others still use terms that have also been applied in other fields. For example, you will no doubt recognise "problem-based" as a term which is used elsewhere, particularly in education, and was pioneered in the sixties in a medical school in Canada. NLP, or neuro-linguistic programming, was created in the seventies in the US, and is a pseudoscientific approach to communication which still has a following among fans of self-help books. Transactional analysis is another model adapted from another field, which was invented by psychoanalyst Erich Berne at the end of the forties. It gave rise to a very popular book published in the sixties called Games People Play, about the psychology of human relationships, which also influenced other popular titles of the sixties and seventies.



In this diagram featuring just a few of the models we can see the general evolution of the topic.

In 1957 Balint pioneered an approach based on the idea that many people visit the doctor and describe one health issue while 'hiding' another perhaps less ordinary or socially acceptable issue. He contended that the GP use what he termed 'active listening' to discover what the patient had really come for.

In 1976 Byrne and Long used an empirical approach. They listened to a corpus of audio recordings and established the phases which were common to all consultations.

Stott and Davis developed a model based on opportunity. Their four opportunities were as follows:

1. The identification & management of the presenting problem
2. Modification of the patient's help-seeking behaviour, to help the patient better navigate the system according to his or her needs
3. The management of continuing problems, such as chronic illnesses like diabetes
4. Opportunistic health promotion, such as offering the flu vaccination when an elderly patient visits during the relevant period.

Helman came up with a model based on the idea that when patients come to see their physician they have a number of questions they are seeking answers to and postulated that a successful consultation would leave the patient with answers to all of them: What has happened? Why has it happened? Why to me? Why now? What would happen if nothing were done about it? What should I do about it?

Pendleton came up with a list of tasks to be accomplished, and he stressed the importance of patient perspective. Indeed, the overview above shows how progressively the patient has become more important in the equation as he ceases to be considered as a subject and becomes a fully-fledged human being.

Neighbour's model used five points, the first three of which correspond to the phases we have described earlier: connecting, summarising and handing over. He brought in two innovations: 'safety-netting' which sets up a plan in case things do not evolve as expected, and 'housekeeping' which refers to the practitioner's self-preservation, making sure that they are psychologically ready for the next patient. Neighbour is, to my knowledge, the only person to have included this vital step in a model.

Throughout the nineties other models continued to be developed, each trying to shed new light on the question, but there were so many that in 1996 a group met to discuss the question and they produced a model which is perhaps the best-known today, the Calgary-Cambridge model, which was an attempt to find a workable model for modern medical education. However, the list they came up with contained a manageable five tasks, but 70 skills.

In 2008 a UK group got together to produce a consensus on how communication for consultations should be taught, with the aim to produce a document that was relevant both in UK medical training, but also applicable abroad.

Task 2

Read the 2008 document which you can download on my website:

> Von Fragstein, M., Silverman, J., Cushing, A., Quilligan, S., Salisbury, H., Wiskin, C. and UK Council for Clinical Communication Skills Teaching in Undergraduate Medical Education, 2008. UK consensus statement on the content of communication curricula in undergraduate medical education. *Medical education*, *42*(11), pp.1100-1107.

Further information:

There is an updated version from 2018 which you can download via the university online platform

> Noble, L.M., Scott-Smith, W., O'Neill, B. and Salisbury, H., 2018. Consensus statement on an updated core communication curriculum for UK undergraduate medical education. *Patient education and counseling*, *101*(9), pp.1712-1719.