The Consultation

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Essential CME is a new section to the journal and will be a series involving a continuous self learning process in Family Practice for general practitioners, primary care physicians and generalist medical officers. With the introduction of the category "Family Physician" and the need for certification and recertification in the future, this series is aimed at the busy doctor to help him or her to update knowledge on broad issues in family practice by using different approaches. Some parts will be focused on helping the general practitioner to obtain certification as a "Family Physician" via postgraduate examinations.

There are five parts to the section.

***Part One** is called **BENCHMARKS FOR THE BUSY GP.** Instead of reading through a long article, a group of GPs will have extracted the important facts on the subject from a general practice perspective.*

***Part Two** will be on **SOUTH AFRICAN RURAL GENERAL PRACTICE.** It will deal with the issues arising from practice in remote rural clinics. It will be context related to practising in poverty stricken communities and problem orientated to the specific conditions arising from this context.*

***Part Three** is called **TEACHING OLD DOCS NEW TRICKS** and is a mock oral examination for a postgraduate degree in family medicine.*

***Part Four** is a self evaluation section by short Multiple Choice Questions (MCQS).*

***Part Five** is a selection of sources of information and resources for further reading.*

Throughout these sections family practice perspectives and theories will be integrated with the clinical aspects. Obviously this CME section cannot cover all that is "essential" in a prescriptive way but aims to help you revise, stimulate your interest and provide some guideposts.

This fourth one of the series is on
THE CONSULTATION

Part I

Benchmarks for Busy GPs

This section is not a comprehensive review but a short selection of abstracts to help you focus on important aspects of the subject partly in the form of reminders and memory joggers.

The most crucial feature of medical care, especially in general practice, is the consultation.

Consultation skills form the basis of good patient care.

It has been shown that consultation skills can be learnt and that to do so requires systematic training rather than just experience.

This teaching of interviewing skills has provided doctors with better means of understanding their patients.

The conventional or traditional medical consultation is classically conducted by an objective and detached doctor with questions and answers. The main purpose is to arrive at a physical diagnosis or exclude pathology.

The Patient-Centred Clinical Model retains the importance attached to the traditional medical agenda but also extends the consultation to include,

amongst others, an understanding of the context that the patient lives in and also an understanding of the meaning of the illness for the patient. It also aims at identifying who, in fact, has the illness (the presenting patient, spouse or relative etc) and the meaning of the illness for that person.

The Biomedical Model focuses on repairing the body as a "broken machine" and excluding physical pathology. These are necessary and important skills.

The Biopsychosocial Model (Engel, 1980) requires the doctor to consider and integrate information from several levels of the hierarchy of systems. These levels range from understanding the patient's inner world of values, fears and feelings to the understanding of the doctor's own reactions and feelings and also understanding the effects of the context and environment that surround both the patient and the doctor.

One of the core books in Family Medicine is The Doctor, His Patient and the Illness by Michael Balint (see resource section). This work explored the doctor-patient relationship, the dynamics of the consultation and the psychosocial aspects of general practice care. He suggested the following concepts :

The doctor as drug : This is the way in which the doctor, him or herself, is effective as a treatment. This implies that the doctor should know him or herself and the effect the doctor has on the patient. Self awareness is a key aspect.

The child as the presenting complaint when the patient may offer another person (such as a child) as the problem when there are underlying psychosocial problems.

Elimination by appropriate physical examinations is the sequence of events whereby traditional medicine attempts to exclude "physical" disease by examination and investigation. A good physical examination may be appropriate but conversely it may reinforce the patient's belief that his neurotic symptoms are in fact due to physical disease. The doctor thinks firstly of physical disease and then investigates with repeated investigation which perpetuate this cycle. This may prevent the reaching of a "deeper" diagnosis.

Collusion of Anonymity describes the spiral when referral reinforces this mistaken belief in the origin of the symptoms. The responsibility of uncovering the underlying psychosocial problems become increasingly diluted by repeated referral, with nobody taking final responsibility.

The Mutual Investment Company is formed by and managed by the doctor and the patient. "Clinical diseases" are episodes in a long relationship and represent "offers" of problems (physical and psychosocial) to the doctor.

The Flash

The Flash is the point in the consultation when the real reason of the "offer" is suddenly apparent to both the doctor and the patient. This forms a fulcrum for change and the consultation can now deal with the underlying basic "fault". It happens more easily when a good rapport is present and the patient feels safe and that the doctor is listening. (see Balint E, 1973 in references)

The Inner Consultation

This is the title of a book written by Roger Neighbour (1987, see reference section). He uses the following format for the consultation:

Connecting:	Rapport building skills.
Summarising:	Listening and eliciting skills.
Hand over:	Communicating skills.
Safety netting:	Contingency plans of what and when further action may be needed.
Housekeeping:	Taking care of yourself and checking that you are ready for the next patient.

Listening in the consultation (McWhinney, 1989, 99-102)

"The greatest single fault in interviewing is probably the failure to let patients tell their story."

"Listening to the patient with undivided attention is a very difficult discipline."

"Doctors, in general, are not good listeners. We frequently interrupt."

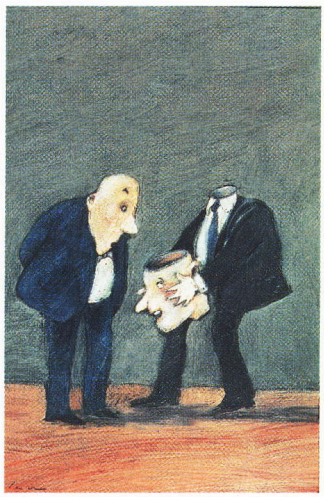
"One of the commonest errors in interviewing is asking a question, then providing the answer before the patient has time to respond."

"Open-ended questions encourage expression by the patient more than closed questions. There is a place for both types of questions: one is for getting very specific information about the problem, the other for reaching an understanding of the patient."

Reflections between Consultations

It is recommended to give some time for reflections between consultations. This gives one a short pause to consolidate the previous consultation, jot down the extra note, ask yourself how it went etc and prepare for the next encounter. It may prevent the carrying over of "contamination" from one consultation into another.

"When you wash your hands between consultations, wash your mind as well."



Next Issues are :

August 1994	Cardiology
September 1994	Contraception and HRT
October 1994	Diabetes
November 1994	Patient Centred Care
December 1994	Epilepsy

Part 2

South African Rural General Practice

This section presents a problem orientated approach in the context of rural practice.

Our context is the store at Pungulelwani, Northern Transkei. The roads to the clinic are difficult to travel on and may require a four wheel drive when it is wet. It is two hours drive from the nearest hospital at Mount Vernon, which is overcrowded and has only three medical officers.
It is a rural GP or government clinic treating low income or poverty stricken patients. There are no facilities for investigations, no x ray facilities etc. The constraints of poverty and unemployment dictate that medicines that are dispensed are generic and cost effective and may be based on the essential drug list (see Resource Section). Most patients that attend the clinic are illiterate and can only speak and understand their own vernacular language.

All consultations in family practice, no matter where, have the same core of principles and foundations.

This rural context is rich in divergent health beliefs, problems with trans-cultural communication and difficulties with language interpretation.

HEALTH BELIEFS

There is no single person without a health belief. It is present in all consultations. Health beliefs can differ between individuals, family members and cross-culturally.

They are those ideas the patient has about the causes and effects of disease, their sources of anxiety and their expectations of the doctor.

In this context the doctor may miss the patient's reason for coming or conversely misinterpret the symptoms as "real" rather than symbolic. (Two books, among many, on transcultural communication are *Living in Two Worlds* by Vera Buhrmann and *Body and Mind in Zulu Medicine* by Harriet Ngubane)

The Health Belief Model (see Maiman and Becker in references) is based on the theory that behaviour is determined by two main factors; the value placed upon a particular goal, and the estimated likelihood of a given action achieving that goal. This effects health seeking behaviour, attitude to the consultation and treatment compliance. The Health Belief Model thus looks at the patient's reasons for accepting or rejecting the doctor's opinion.

In this context the patient often presents as a result of a family decision and the event reflects the health belief of a family or significant person in the family.

The Interpreter in the Medical Consultation.

A common perception exists that interpreted consultations are inherently unsatisfactory, but research

literature provides little evidence for this (see Wood, 1993, in references).

In the clinic at Pungulelwani there is normally a third party in the consultation – the interpreter.

The triangular doctor-interpreter-patient relationship involves a variety of ways of performing a consultation.

The interpreter can be the interviewer via a protocol, act as an instrument of the doctor, act as an advocate of the patient, function as part of a team or act as a culture broker.

The most unsatisfactory interpreters are relatives or family members particularly when the interpreter is the child of the ill person.

Some disadvantages of interpreters are that they may display little sensitivity, interrupt the flow of a patient's response, omit, substitute, add, distort or condense the communication.

A common recommendation is for doctors to learn the language themselves but evidence is that language acquisition does not, by itself, solve communication difficulties.

Emotional content may be the component most easily lost when an interpreter is used but use can be made of the time that the interpreter is busy by reading non-verbal cues and responses and assessing the process of the consultation.

"SO LITTLE TIME, SO MUCH TO DO"

(Putatively Cecil Rhodes' last words)

The GP in the rural clinic and the medical officer in the rural outpatients has to contend with a number of competing priorities at the same time.

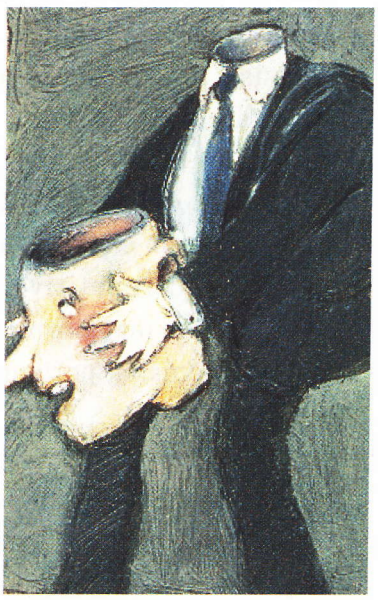
Quality of care, rationing of time and resources, costs etc are amongst these priorities.

"Every doctor has to decide what can be achieved for each patient in the time available. This involves a decision as to what is unimportant and may be omitted. All doctors work in this way and it is humbug to pretend that they do not." (McWhinney, 1969, p.17).

The average length of consultations in general practice in Britain is about 6 minutes. (see Balint and Norrell in references)

This is often too short even for a first world population. In the context of a rural African clinic much more education, explanation and discussion is needed. The potential for the consultation in this context is enormous for opportunistic health promotion, preventative care etc (see Stott and Davis in references).

Just one minute more spent in this area of the consultation makes a difference. (See Wilson et al in references)



THE RURAL NURSE/INTERPRETER/ DISPENSER/EDUCATOR

"Untrained", "Unassessed", "Unrecognised", "Unresearched", "Undefined". Is she all things to all men and women?

"The role of the rural clinic nurse or outpatient nurse in a rural hospital needs clarifying, defining and a job description with adequate training in the areas she is expected to function such as education, dispensing, interpreting etc."

"The importance of the interpreter is rarely emphasised, no formal recognition is given to nurses providing interpretation, and it is generally not remunerated." (from Wood, 1993)

THE "ONE OFF" OR "ONE CHANCE" CONSULTATION

In a rural hospital outpatients clinic or rural GP clinic, many patients are seen "blind" or "unknown" to the doctor because of the large numbers of patients and lack of time.

A different doctor may do the clinic each week or each month and the routine and repetitiveness of the presentations may prevent the doctor from recognising patients that have been seen before.

Continuity of care in this context – in the present health care structure – may have seemingly insuperable obstacles.

"Heavy work load", "No time available", "Overcrowded outpatients" "No facilities", "Inefficient record system" are universal abstracts from the rural doctor's conversation.

A "one off" or "one chance" consultation could be defined as a face-to-face meeting between a doctor and a patient with no previous or subsequent consultations within one year (that he is aware of). (adapted from Talmon, 1990, p.xv in resource section).

Most consultations in rural outpatients are brief, focused and practical. The main objective is to treat the presenting symptom.

Continuity of care is one of the principles of family medicine nevertheless, in this situation, many patients may accomplish what they intended from a single consultation with the doctor.

Continuity of care can be defined as continuity of person (where the same doctor sees the patient each time) and continuity of information (where the information from the previous consultations is available to the next doctor). Ideally both should be present and that requires good management and commitment. Continuity of information may be enhanced by patient – retained medical records. The system of giving the patient his medical records to keep and bring with him to the consultation rather than keeping the records at clinics or hospitals is well established in Lesotho and Swaziland. It is found that patients look after their records just as well as official administrators and feel more involved in their treatment. (see Van der Westhuizen et al, 1985 in references).

WE NEED YOUR HELP

Your comments on this CME Section are welcome:

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We need help to provide an ongoing education that is appropriate to practice. We invite you to make up MCQs or ideas on benchmarks, rural practice etc.

Please return to:

CME Editor.
SA Family Practice
Box 3172
Cramerview 2060

or Fax to 01213-92385

Part 3

Teaching Old Docs New Tricks

You are a general practitioner in your mid forties and have been in practice for fifteen years in a rural area of South Africa. You have attended some congresses but the work load of your practice and bringing up your family have left you with a need to update your knowledge. You decide to sit one of the postgraduate exams in family medicine.

You have written the papers and now go for the oral examinations.

The examiner explains that a revolution has occurred in family practice theory since you qualified and asks you the following questions:

Question One: What system or approach do you use routinely for your consultations?

Answer: You explain that you have a heavy clinical work load and use the orthodox biomedical clinical method of history, examination, investigations, diagnosis and treatment for most of your consultations.

This is accepted by the examiner who then asks: Are there any other approaches or systems you use?

Answer: You have used the problem-orientated medical records with SOAP which stands for Subjective, Objective, Assessment and Plan. (see Weed, 1968 in references)

Question Three: What other influences have affected the way you conduct your consultations?

You reply: that you have expanded your consultations in several ways.

Firstly, you are aware of expanding the consultation beyond the treatment of the presenting symptom into the areas of opportunistic health promotion, the management of continuing problems and the modification of health-seeking behaviour (see Stott and Davis, 1979 in reference section).

Secondly, you like to make a comprehensive assessment. One of the ways of making a comprehensive assessment is the concept of the three stage diagnosis or assessment which has influenced your way of practice in that you now assess patients on the three levels – clinical, individual and contextual. The clinical stage is the traditional medical model that you have always used, the individual stage finds out the patient's reason for consulting, his or her attitudes, fears, expectations, experience etc and the contextual stage assesses, amongst others, the influence of home, job and environment on the presentation (see McWhinney, 1969 and Fehrsen and Henbest, 1993 in reference section.). A comprehensive assessment is of value if it is followed by a comprehensive plan.

Thirdly, you incorporate the patient-centred clinical method (see the coming November's issue of Essential CME on this concept) with a holistic and systems approach to the patient and his relationships with others, ourselves and his environment.

Question Four: How did you know all of these answers?

Answer: Because you read Essential CME in South African Family Practice between Rotary lunch on Tuesdays and golf on Wednesdays.