The consultation: a juggler's art

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INTRODUCTION

Consultation skills are central to being a physician. Without competence in consultation skills, all the other skills of a clinician become almost irrelevant.[1] What happens between the doctor and the patient for that short time of the consultation dictates to a large extent the rest of patient care and illness outcome. For this reason, medical teachers are constantly challenged by the teaching and assessment of consultation skills.

Many models of the consultation have been described and are used, while new ones surface from time to time. This in itself may indicate the complexity of the consultation and how difficult it is to capture its essence sufficiently to teach and assess.

The purpose of this article is to describe a model of understanding, teaching and assessing the consultation in family practice that we have found useful.

We practise and teach in southern Africa, a context with a very wide variety of patients from different demographic backgrounds, ranging from sophisticated urbanites to traditional rural people. We have experience of a range of practice situations, in private and public healthcare, involving both doctors and nurse practitioners. There are often major cultural and language differences between the practitioner and the patient, and the time available for the consultation is always limited. The model has been developed in, and found to be relevant to, this context.

Our model uses the angle of process and interaction to describe the consultation. It divides the consultation into three processes that are active simultaneously. The three processes are termed:

- facilitation
- clinical reasoning
- collaboration.

The practitioner needs to be aware of and responsible for all three processes throughout the consultation.

We take the patient-centred approach to healthcare. Thus the wealth of literature about patient-centred care, its theory, practice and outcomes form the basis of our understanding. Each of the three processes can be linked to the concept of agendas highlighted by the patient-centred approach; each process requires specific skills and leads to particular expected outcomes (see Table 1). However, the greatest value lies in the interplay among the processes. The emphasis on process enables students and practitioners to become more aware of, and give more attention to, this aspect in the consultation.

The metaphor we use is a juggler who keeps three balls in the air at any one time (see Figure 1). To be able to do that, he has to be aware of each ball and can only keep juggling as long as all three are moving.

FACILITATION

The first ball the juggler picks up is facilitation. Facilitation is 'making something easier or less difficult'.[2] This is the process that aims at uncovering the patient's story, by making it easier for the patient to open up the problem with the doctor.

Facilitation has been described by Enelow and Swisher as a technique in basic interviewing, which involves encouraging communication by manner, gesture or words in a way that does not specify the kind of information sought.[3] However, we see it as something broader. It is an essential element of the consultation that enables

Table 1 Linking agenda, process, skills and expected outcomes in the consultation

Agenda	Process	Skills	Expected outcomes
Patient's agenda	Facilitation	• Rapport • Active listening	• Patient satisfaction • Relationship
Doctor's agenda	ıical reasoning	• Focused history taking • Physical examination • Comprehensive assessment • Focused investigation • Rational decision making • Hypothesis formation and testing • Evidence-based practice	• Cost-effective care • Quality care • Safety
ared agenda	aboration	• Explanation of assessment • Explanation of management options • Involving patient in decision making • Negotiation • Comprehensive plan	• Improved adherence • Patient satisfaction • Continuity of care • Improved disease outcomes
tegration ɜendas	Integration and synergy between processes	• Integrate processes • Use of time	• Integrated understanding by patient and doctor • Comprehensive patient care

patients to express their agendas, their fears, their expectations and their needs in respect of any aspect of their illness or life.

Figure 1 The juggler

Facilitation assists the patients to describe their problems in ways that they may not have thought about before.

Barry and colleagues ask whether qualitative research methods can assist doctors and patients to 'encourage patients to be more present'.[4] The method that we describe here has been influenced by our training and experience in conducting qualitative research interviews, where the main aim is to uncover and describe complex phenomena (see Box 1).

The first step in facilitation is to establish a rapport and connect with the patient. Rapport is achieved differently in different cultures and situations, but universally it is the process that ensures that a patient is at ease and is able to talk about the illness, issue or problem. The basis of rapport is recognising the patient as the most impor-

Box 1 Facilitation steps

1 Rapport
2 Open questions
3 Recognise cue(s)
4 Reflect cue(s)
5 Summarise patient's story

tant person in the consultation and showing unconditional respect towards them. The doctor aims to meet the patient wherever they may be, rather than drawing them into where the doctor is. How this happens depends also on previous encounters and an ongoing relationship.

Once rapport is established, the practitioner moves towards active listening. This starts with an open question, the nature of which depends on the individual practitioner, the patient, the culture and the language, e.g. 'What brings you here today?' or 'What is troubling you today?'. Then the practitioner waits for cues from the patient. A cue is any piece of information, verbal or non-verbal, which comes from the patient: a word, a sigh, a shrug, even a silence.

The safest response to a cue is to reflect it back to a patient in a neutral, non-judgmental manner, and then give time and space to go further with the story. In family medicine, particular care is given to recognising emotional cues, including those about fears, beliefs and expectations. The process in which cues are reflected back and discussed with the patient continues until the doctor thinks that the story is complete enough to proceed. Then they summarise the story for the patient to assess whether they have heard and understood the story correctly, or whether the story is different or incomplete.

CLINICAL REASONING

The second ball the juggler uses is clinical reasoning. This is naturally a process that starts very early in the consultation and is also triggered by a cue. Sometimes it may even start when the doctor sees the patient in the waiting area or the name on the appointment list or, more typically, when the patient enters the consulting room with a specific gait, facial expression or body language (see Box 2).

With clinical reasoning the doctor's agenda comes to the fore. The natural way to change the focus from facilitation to clinical reasoning is with a link statement such as: 'Now that I've heard your story, may I ask some specific questions and examine you to understand more?'. The doctor already has formed an idea or hypothesis. The aim of the focused history and examination is to fill the gaps in the information needed to develop and test hypotheses further, in order to reach a comprehensive assessment. The three-stage assessment or triple diagnosis are useful tools to include biological, psychological and social dimensions in the assessment. [1,5] The purpose of the comprehensive assessment is to lead to a comprehensive management plan.

Clinical reasoning may include the so-called 'routine search' (systems enquiry and physical examination). This aims to prompt alternative hypotheses by bringing to light cues that have not emerged in the directed part of the search, to collect base-

Box 2 Clinical reasoning steps (not in any specific order)

- Observe cues: verbal and non-verbal
- Hypothesis formation and testing (continuous)
- Focused history-taking
- Focused physical examination
- Focused investigation
- Rational decision-making
- Evidence-based practice
- Comprehensive assessment: biopsychosocial
- Work towards comprehensive management plan: biopsychosocial

line and background data on the patient and to screen for symptomless conditions.[6]

Clinical reasoning, which assumes the application of evidence-based medicine and rational decision making, is fundamental to sound medical practice. Decisions have to be made constantly throughout the consultation and these decisions need to be based on sound reasoning.[7] Successful facilitation is dependent on clinical reasoning, which gives substance to facilitation; without clinical reasoning, the consultation is no more than a conversation. We have found that an overemphasis in family medicine teaching on patient-centredness and listening can diminish the importance of sound clinical reasoning in the eyes of students. Clinical reasoning requires the doctor to know enough about the pathophysiology of the illness and its clinical course, as reflected in signs and symptoms to be able to evaluate the relevance of the information they obtain.[3] It requires the doctor to apply clinical skills expertly in order to elicit signs and symptoms that may be present.

Effective clinical reasoning enables effective management, which in patient-centred care means a mutual decision between patient and doctor. This is the next ball.

COLLABORATION

The third ball that the juggler keeps in the air is collaboration, which is an essential part of any productive process involving people and includes meaningful participation and enablement.

Ways to involve patients more in the consultation and in decision making are important concepts in the literature. Some of the terms used are participation, enablement, agreement, shared decision making and equipoise, partnerships and mutual agreement.[7–10] All describe the collaboration between the patient and the doctor. We choose the term collaboration as it communicates a more focused, outcome-based participation.

Collaboration can be built in from very early in the consultation. 'May I ask you some questions?' and 'Do you mind if I examine you?' already indicate that the doctor wants to work in a collaborative way. These questions can change an authoritarian consultation into a collaborative one (see Box 3).

The natural way to move the focus from clinical reasoning to collaboration is to make the assessment clear to the patient, in a way that invites comment and discussion. Once there is agreement about the assessment, the different management options are explained to the patient. The patient is drawn into the decision-making process towards a mutual comprehensive plan. This is where the different agendas become a shared one. The practitioner must be aware of what common ground exists between the patient's ideas and expectations, and their own ideas, plans and management goals. Mutual decision making involves a process of sharing management options with the patient and deciding together on the way forward, with both parties participating in the process.[12] It is also important for the practitioner to aim for the level of participation that the patient would prefer or is able to cope with.

The practitioner has to look out for differences in opinion, conflict or other complications in the relationship. The doctor's agenda and the patient's agenda may not overlap enough for mutual participation. Then the doctor needs to draw on negotiation skills. Negotiation is an important

Box 3 Collaboration steps

- Make the assessment (diagnosis) clear to the patient
- Agree about assessment (diagnosis)
- Explain management options
- Mutual decision making
- Aim for level of participation that the patient prefers
- Look out for differences between patient and doctor: do negotiation

aspect of successful collaboration. It is important not to confuse negotiation with convincing the patient. The currency of collaboration is information, whereas the currency of coercion is power. We teach negotiation as a specific skill, which may be essential to collaboration (see Box 4).

We teach negotiation skills as requiring a series of steps (see Box 4). Recognising the difference between the agendas is the first step. Missing the difference leads to a dysfunctional consultation. The second step is to recognise the value of the difference and learn from it. There is a lot of information in difference, and this may be the key to understanding and addressing the patient's problem. The third step is to verbalise and clarify the difference for both the patient and the doctor, and then to try to understand the difference. During this process, one looks for the areas of overlap in agendas between the doctor and the patient. Often, at the very least, both want the best solution to the patient's problem. Focusing on the area of agreement and trying to broaden that area often brings a solution to the difference. Agreeing to disagree is also an option. Agreeing to disagree and giving each other time to reflect may make an ultimate solution easier. Therefore it is vital for the doctor to maintain their relationship with the patient, while maintaining their own integrity. The last step is to make a specific plan for follow-up.

Fortunately most consultations do not need negotiation, but negotiation skills often make a major difference. The difference between an ordinary doctor and a successful one may lie in their negotiation skills. Good rapport and functional facilitation build the kind of relationship that can cope with differences and enable negotiation.

Collaboration is the most active process towards the end of the consultation and leads to a functional conclusion of the consultation.

Box 4 Negotiation steps

- Recognise difference
- Value difference
- Verbalise and clarify difference
- Understand difference
- Find areas of agreement
- Find solution
- Maintain relationship
- Arrange follow-up

INTEGRATION OF THE THREE PROCESSES

Integration is where the juggling metaphor is most useful. The success of the consultation depends on how the doctor can keep the three aspects in balance and active. The three elements carry equal importance but do not necessarily require the same amount of time. This will depend on the nature of the problem, the issues raised by the patient, the context of the consultation and the relationship between the doctor and the patient. Each consultation is different, and the art of the juggler is to know which ball to catch and which to throw up again, without ever losing focus on the interplay of the three balls. A patient may present with a 'straightforward' clinical problem, but if the doctor does not facilitate the patient to share their understanding of that problem, the evidence-based treatment plan may come to naught because the patient sees the problem in a different light. For example, a traditional Zulu patient presenting with pulmonary tuberculosis will not benefit from the doctor's clinical reasoning if their understanding of the illness as a kind of poisoning (*idliso*) is not explored and dealt with in the negotiated management plan.

We recognise, as noted by McWhinney, that there is no predetermined order in the consultation; it does not flow in a uniform fashion from history to presenting condition through to systems inquiry and examination, but is guided by the patient's presentation and the doctor's response.[6] The

image of the juggler keeps in tension the dynamic interplay of the various factors.

TEACHING CONSULTATION SKILLS

We find this way of understanding the consultation particularly helpful in teaching consultation skills to both undergraduate and postgraduate students. We often take three different coloured balls to a discussion with the students. Usually one of the students can juggle and that is then used as a metaphor for teaching the consultation.

The model brings together familiar concepts from everyday life for students and registrars, who discuss it easily in seminars and often come to a unique understanding of the concepts and processes, teaching us in turn. The concepts are open enough to allow discussion of other models and theories within this framework, and to integrate much of the theoretical basis of the consultation and relationships. Students also find it easy to grasp, practical to use and relevant to their experience.

Dividing the consultation into these processes makes it possible to teach and practise specific skills without having to do the whole consultation at a time. The student can first understand and practise the skills of facilitation (rapport and listening), stopping, for example, at the question: 'Now may I ask you some more specific questions?'.

Students find it helpful to see the difference between facilitation and clinical reasoning, including focused history taking. History taking is traditionally taught as interviewing, so that there is often confusion between the need to listen and the need to ask closed questions. In this model, the difference is clear, making it easy to understand when to ask open questions and when to ask closed ones. In the same way, clinical reasoning and collaboration can be taught and practised.

Practising negotiation skills in role-play is usually very intense, but can be great fun. For example, in role-plays we have used the story of a patient with a sexually transmitted infection who refuses to let his spouse be informed or treated. As long as the student tries to convince the patient, it leads to resistance, but going through the negotiation steps usually leads to uncovering important relationship issues, opening the way for much deeper understanding and involvement.

ASSESSMENT

The model provides a useful framework for assessment of the consultation. An easy scoring system allocates 30% for each of the components, highlighting their equal importance and value, and 10% for the integration. The different skills in each process are used as elements for assessment and feedback. (See 'Skills' column in Table 1.) The student is usually good in at least one of the three processes and thus can be encouraged, and then helped to master the other skills and processes.

Using a learner-centred approach to postgraduate training (which reinforces the issue of collaboration), this model enables registrars to identify specific areas of weakness and to develop learning plans to address these.

The 'P-R-A-C-T-I-C-A-L' framework for the consultation has been offered as an aid to understanding the different phases of the consultation and provides a checklist which can be used for assessing the consultation, but it is difficult to remember and arguably too cumbersome to use.[12,13] The Leicester Assessment Package is very logical and has been found to be reliable and valid, but it relates more to specific actions and competences than to processes.[14,15]

Describing the consultation in the juggler model also proves functional in interdisciplinary discussions on the consultation. Most specialist disciplines can identify with the clinical reasoning section, but nevertheless agree that the other two aspects are important. On the other hand,

a discipline such as psychiatry may place more emphasis on the process of facilitation without neglecting the others. Thus the allocation of marks in the assessment may vary in different disciplines.

CONSULTATIONS IN PRACTICE

We have found the model to be useful in our own practice. Thinking about these aspects throughout everyday consultations has helped us to be reflective in our work. While recognising that the consultation is complex and varied, this model provides a simple and logical framework for reviewing it. Very often when a consultation is dysfunctional, the problem can be found in one of the three processes.

CONCLUSION

The method that we describe offers a relatively easy way to understand and teach the complex processes and skills involved in a consultation while leaving space for other models and theories. The method needs to be systematically tested and to be compared with other methods in teaching, assessment and practice situations.

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