

The shared consultation: a necessity in primary care clinics?

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Abstract

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The shared consultation is a concept that differs from shared decision making and shared care. It involves two or more health professionals in the consultation of a patient during the same illness episode. Commonly, the health professionals are a primary-care doctor and a clinical nurse practitioner. On the basis of clinical experience, a number of models of the relationship in such situations are described, viz the consultant, the master-servant, the teacher-pupil and the teamwork models. Issues of communication within the consultation, the patient as a person, continuity of care, and clarification of roles and responsibilities are highlighted. More investigation is required to explore this further.

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Introduction

Many different types of consultation are described in family medicine literature. Any textbook of family medicine is likely to devote at least one chapter to this issue. One neglected concept, however, is the *shared consultation*, in the sense of a consultation that is shared between two health professionals.

The concept of shared *decision making* in the consultation, in which the patient is a full participant, is well known, with the stages and competencies needed in the process that have been spelled out,¹ and guidelines that have been written to help patients.² *Shared care* is another familiar concept, according to which family physicians and specialists, or different specialists, share in the ongoing care of a patient with a chronic illness. This is also commonly applied to obstetric care, where midwives, family physicians and obstetricians may all be involved in care. This kind of shared care may involve other members of the health care team and even lay workers. Models for and examples of these abound.³⁻⁷

However, a specific form of the *shared consultation* exists in the South African context of primary care in district clinics, and it often is the most common form of consultation that doctors working in primary care engage in. Yet, even South African literature, including the Handbook of Family Medicine,⁸ does not explore this issue. The only concept that approaches this is that of working with interpreters,

which is fairly well described in the literature.⁹ It is not surprising, therefore, that the shared consultation is often badly handled and that teamwork is not a strong feature of many of these interactions. We argue that an understanding and functional practice of the concept of shared consultation can contribute towards better teamwork and improved quality of patient care.

Defining the shared consultation

What is the concept of “shared consultation” in the context of primary care in South Africa? A shared consultation is one in which two or more health professionals are involved in the consultation of the same patient, either sequentially or simultaneously, during the same illness episode, in the same context and at the same level of care, with both taking responsibility for the patient’s management. The typical example of this in our South African context is the primary health care nurse practitioner seeing a patient together with a doctor. There are similarities with the process of specialist referrals from the family physician to another specialist, but the difference is that, in the clinic, the doctor and the nurse share responsibility for the care of patients, the same limited resources and the same burden of illness and number of patients. The shared consultation most commonly involves a clinical nurse practitioner, but may also involve other health workers, such as enrolled nurses working at community level, community health workers, or students. For the purpose of this discussion, we will focus on the consultation

shared between the clinical nurse practitioner or primary health care nurse (PHCN), and the family physician.

The shared consultation is influenced by the relationship between the doctor and the PHCN, as well as the workload and organisation of the clinic. A functional model of the consultation is described in terms of a juggling model of the consultation,¹⁰ and giving attention to the patient as a person, continuity of care and roles and responsibilities.

Relationship between the doctor and the nurse

The relationship between the PHCN and the doctor will dictate, to a large extent, the nature of the shared consultation. We have noted the following ways in which the relationship shapes the consultation:

1. *The Consultant Model:* The PHCN sees the doctor as a consultant and has no direct contact with the doctor. The PHCN simply writes a note to the doctor to request assistance, indicating what that assistance should be. This is probably the commonest form of the shared consultation, and is most like a specialist referral. This is functional where a simple administrative duty is required, but where it is an issue of diagnosis and management, the PHCN may learn from the process only from a written reply (uncommon) or by seeing the patient again the next time (by chance). This type of consultation is inevitable where the doctor visits a clinic only on certain days of the week and the PHCNs who have seen the patients are not on duty. Even when they are on duty, if they are not seeing the patient at the time the doctor is present a great deal of effort is required to ensure their involvement.
2. *The Master-Servant Model:* The nurse refers the patient to the doctor, but takes no further part in the consultation (except, perhaps, as an interpreter or nursing aide). This fits into the model in which medical and nursing students are taught, in teaching hospitals, where the doctor takes the clinical decisions while the nurse implements the treatment based on the doctor's decision. This common occurrence is unfortunate, as great opportunities for sharing and learning are lost. It is often difficult for both professions to get out of this mould.
3. *The Teacher-Pupil Model:* The PHCN presents the patient to the doctor, and the latter uses the consultation as an opportunity to teach the PHCN regarding the patient. This model certainly has a lot of benefits in that there is ongoing development of the PHCN throughout this process, which supports her in her role and allows her to become steadily more independent. At the same time, it negates the fact that the doctor can also gain many

insights from his nursing colleague about the patient. Also, the process requires sensitivity to ensure that the PHCN does not feel she is being slighted or scolded in front of the patient – a major complaint amongst nurses with whom we have spoken.¹¹

4. *The Teamwork Model:* The PHCN presents the patient to the doctor and they discuss the issues raised, deciding together, with the patient, the way forward. This is the ideal of the shared consultation: both health professionals, as well as the patient, are fully involved in the process; they learn from each other, they share the decision making (with the patient) and they share the responsibility. Dilemmas in diagnosis and management are shared, and the patient is included. This approach takes time and effort, and it requires doctors who are open and secure in their knowledge (or lack thereof) and PHCNs who are open and confident. Yet it is the most rewarding where it can be achieved. Adding complexity to this model is that, on many occasions, the nurse is still doubling as an interpreter in addition to working alongside a doctor in this teamwork model. This is another instance of the dual, or often multiple, roles of the nurse. This model requires a commitment from both parties. It seems, at least at present, that the initiative for implementing this approach will need to come from the doctor; nurses who have tried to assert themselves in consultations have described to us their negative experiences, with questions such as “Did I see you in my class at medical school?” and “Have you got an MBChB?”.¹¹ The teamwork model also means that the doctor will refer patients to the PHCN, not only the other way round. This can happen where the gender, age and culture of the patient will be better understood and managed by the PHCN and where counselling and patient education are needed. It is crucial that a relationship of collaboration, underpinned by joint knowledge creation, mutual respect for each other's roles and strengths and sharing of information, form the basis of the shared consultation.

The pre-existing relationship between the doctor and the nurse is important. A confusion of roles or outright conflict can have a serious effect on this consultation. The patient can pick up inconsistencies and conflict between the doctor and the nurse and, at worst, the patient becomes a medium of negative communication between the doctor and the nurse. We suggest that the doctor and the nurse be aware of the relationship issue, take responsibility for it, and manage it to the benefit of the patient. Mutual respect for each other, as well as for the patient, is crucial. It builds confidence and creates the basis for the shared consultation.

The context: patient load and clinic organisation

The context within which the shared consultation takes place is important in the understanding and development of the shared consultation. A heavy patient load puts increasing pressure on relationships and team work. It lessens time for mutual discussion and planning. It also increases frustration and negative emotions. Attempts to limit patient numbers are seldom countenanced by more senior managers because of the fear of being seen to turn patients away. As a result, many clinics are overburdened. However, this can also have a positive effect of forcing doctors and nurses to work together.

The patient profile, the composition of the team and their skills and the way in which the clinic is organised all have an influence on the possibility for functional shared care and shared consultations at the clinic.

Relationships with the community and patient preferences influence care at the clinic. Collaboration with community leaders and patients is important to developing a culture of respect and shared care at the clinic.

Adequate and available equipment and drugs are important. If drugs or equipment for certain diseases are not available to those needing them, the shared consultation process is more difficult, but it also becomes more important in helping the whole team to make the best use of the available resources.

Making it work: joint juggling

For the shared consultation process to be functional it is helpful if the doctor and the PHCN function with a similar understanding and practice of the consultation. The juggler model of the consultation describes the consultation as juggling three tasks throughout the consultation, namely facilitation, clinical reasoning and collaboration.¹⁰ In the shared consultation, the same model implies the juggling of these three processes by the two practitioners together. Initially the nurse will facilitate the patient's story, then do clinical reasoning by gathering information from the history and examination and make an assessment. Collaborating with the patient, she will share the assessment and offer the options for management by getting input from the doctor. The doctor's facilitation task now is to make sure that he/she understands the patient's complaints as well as the nurse's reason for referral. The clinical reasoning component draws on both the information given by the nurse as well as the doctor's own findings. In discussion with the nurse (and the patient), they come to a joint assessment. The options for

management will then be discussed by the doctor and the nurse and, in collaboration with the patient, a decision is made about a management plan.

Collaboration between the doctor and the nurse forms the basis of the collaboration between them and the patient and may be crucial to the patient's experience of collaboration in the consultation and his or her future participation in his or her own care.

For this to be possible the doctor and the nurse need to understand each other's roles and consultation styles. This implies that they need to communicate about these issues.

Collaboration in a shared consultation provides opportunities for further exploration – outside of the consultation, but arising from it – of quality issues, systemic problems and the learning agendas of both parties.

The patient as a person

The patient as person is central to the shared consultation. The doctor may respond more to the concerns of the nurse than those of the patient and neglect the person of the patient. The doctor and the nurse may also think that the other one will give attention to the concerns and expectations of the patient and, in the end, the patient's agenda and person are not addressed adequately. Often the doctor, nurse and patient will not share the same languages of communication. If the doctor and PHCN use a language that the patient does not understand, the patient may feel excluded and even dehumanised by being the object of a discussion he/she cannot understand. We suggest that the doctor and the nurse both be acutely aware of the different agendas and of the possibility of excluding a patient from their discussion, and make sure that the patient's agenda and person receive the necessary attention. Differences of opinion between the doctor and the PHCN about the patient and his/her management may cause difficulties for the patient if these differences are discussed in front of the patient. The doctor and nurse have to be sensitive and rather not discuss these differences in front of the patient.

Continuity of care

Continuity of care is a cornerstone of quality patient care. Through the shared consultation, a process of shared care can enhance the continuity of care by the team of the doctor and the nurse. Such continuity requires good communication and good clinical records. It is best if the clinical records of different clinicians appear chronologically in the same section of the clinical records. Also necessary for continuity of care are clear follow-up arrangements with the appropriate member of the team.

Roles and responsibilities

Who takes responsibility for decisions and actions needs to be clear to the doctor and the nurse as well as to the patient. The doctor and nurse as a team need to know the situation and each other well enough to be clear as to who is doing what. In good teams this may happen automatically, but at times the roles and responsibilities need to be clarified, and the patient especially must understand the process.

Clinical associates

In the development of the clinical associate (midlevel medical worker) profession, the shared consultation will be an important aspect of functioning between the doctor and the clinical associate, and between the PHCN and the clinical associate. The patterns and processes that are implemented at the inception of the profession will have a lasting effect on the future interaction between the clinical associate, the doctor and the PHCN. It is important that the teamwork model, in which the doctor and the nurse interact as equals, be extended to include a similar relationship with clinical associates.

Conclusion

This framework is a theoretical one, although it is based on our practical experience of working in primary care. The suggestions we are making are from experience and not from any evidence beyond the anecdotal. We have embarked on research to explore this further. Another step would be to record and analyse a series of consultations of this nature in order to develop a more complete understanding of the issues. Input from patients will be crucial. Specific outcomes

and intervention studies will be needed to test the different models and interventions. Once a fuller understanding of the shared consultation is reached, concepts need to be introduced into the teaching of both family medicine and primary health care nursing science.

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