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**1. 'Physical, Psychological and Social' (1972)**

The RCGP model encourages the doctor to extend his thinking practice beyond the purely organic approach to patients, i.e. to include the patient's emotional, family, social and environmental circumstances.

**2. Stott and Davis ( 1979)**

"The exceptional potential in each primary care consultation" suggests that four areas can be systematically explored each time a patient consults.

- (a) Management of presenting problems
- (b) Modification of help-seeking behaviours
- (c) Management of continuing problems
- (d) Opportunistic health promotion

**3. Byrne and Long (1976)**[Back to top](#)

"Doctors talking to patients". Six phases which form a logical structure to the consultation:

- |           |   |
|-----------|---|
| Phase I   | The doctor establishes a relationship with the patient  |
| Phase II  | The doctor either attempts to discover or actually discovers the reason for the patient's attendance            |
| Phase III | The doctor conducts a verbal or physical examination or both  |
| Phase IV  | The doctor, or the doctor and the patient, or the patient (in that order of probability) consider the condition |
| Phase V   | The doctor, and occasionally the patient, detail further treatment or further investigation                     |
| Phase VI  | The consultation is terminated usually by the doctor.   |

Byrne and Long's study also analysed the range of verbal behaviours doctors used when talking to their patients. They described a spectrum ranging from a heavily doctor-dominated consultation, with any contribution from the patient as good as excluded, to a virtual monologue by the patient untrammelled by any input from the doctor. Between these extremes, they described a graduation of styles from closed information-gathering to non-directive counselling, depending on whether the doctor was more interested in developing his own line of thought or the patient's.

#### 4. **Six Category Intervention Analysis (1975)** [Back to top](#)

In the mid-1970's the humanist Psychologist John Heron developed a simple but comprehensive model of the array of interventions a doctor (counsellor or therapist) could use with the patient (client). Within an overall setting of concern for the patient's best interests, the doctor's interventions fall into one of six categories:

- (1) **Prescriptive** - giving advice or instructions, being critical or directive
- (2) **Informative** - imparting new knowledge, instructing or interpreting
- (3) **Confronting** - challenging a restrictive attitude or behaviour, giving direct feedback within a caring context
- (4) **Cathartic** - seeking to release emotion in the form of weeping, laughter, trembling or anger
- (5) **Catalytic** - encouraging the patient to discover and explore his own latent thoughts and feelings
- (6) **Supportive** - offering comfort and approval, affirming the patient's intrinsic value.

Each category has a clear function within the total consultation.

#### 5. **Helman's 'Folk Model' (1981)** [Back to top](#)

Cecil Helman is a Medical Anthropologist, with constantly enlightening insights into the cultural factors in health and illness. He suggests that a patient with a problem comes to a doctor seeking answers to six questions:

- (1) What has happened?                      (2) Why has it happened?
- (3) Why to me?                              (4) Why now?
- (5) What would happen if nothing was done about it?
- (6) What should I do about it or whom should I consult for further help?

#### 6. **Transactional Analysis (1964)** [Back to top](#)

Many doctors will be familiar with Eric Berne's model of the human psyche as consisting of three 'ego-state' - Parent, Adult and Child. At any given moment each of us is in a state of mind when we think, feel, behave, react and have attitudes as if we were either a critical or caring Parent, a logical Adult, or a spontaneous or dependent Child. Many general practice consultations are conducted between a Parental doctor and a Child-like patient. This transaction is not always in the best interests of either party, and a familiarity with TA introduces a welcome flexibility into the doctor's repertoire which can break out of the repetitious cycles of behaviour ('games') into which some consultations can degenerate.

#### 7. **Pendleton, Schofield, Tate and Havelock (1984)** [Back to top](#)

'The Consultation - An Approach to Learning and Teaching' describe seven tasks which taken together form comprehensive and coherent aims for any consultation.

- (1) **To define the reason for the patient's attendance, including:**
  - i) the nature and history of the problems
  - ii) their aetiology

- iii) the patient's ideas, concerns and expectations
- iv) the effects of the problems

**(2) To consider other problems:**

- i) continuing problems
- ii) at-risk factors

**(3) With the patient, to choose an appropriate action for each problem**

**(4) To achieve a shared understanding of the problems with the patient**

**(5) To involve the patient in the management and encourage him to accept appropriate responsibility**

**(6) To use time and resources appropriately:**

- i) in the consultation
- ii) in the long term

**(7) To establish or maintain a relationship with the patient which helps to achieve the other tasks.**

**8. Neighbour (1987) [Back to top](#)**

Five check points: 'where shall we make for next and how shall we get there?'

- (1) **Connecting** - establishing rapport with the patient
- (2) **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.
- (3) **Handing over** - doctors' and patients' agendas are agreed.  
Negotiating, influencing and gift wrapping.
- (4) **Safety net** - "What if?": consider what the doctor might do in  
each case.
- (5) **Housekeeping** - 'Am I in good enough shape for the next  
patient?'

**9. The Disease - Illness Model (1984) [Back to top](#)**

McWhinney and his colleagues at the University of Western Ontario have proposed a "transformed clinical method". Their approach has also been called "patient-centred clinical interviewing" to differentiate it from the more traditional "doctor-centred" method that attempts to interpret the patient's illness only from the doctor's perspective of disease and pathology. The disease-illness model below attempts to provide a practical way of using these ideas in our everyday clinical practice. [View powerpoint slide](#) of model

**Patient presents problem**

**Gathering information****Parallel search of two frameworks**

**Disease framework**  
**Doctor's agenda**  
 Symptoms  
 Signs  
 Investigations  
 Underlying pathology

**Illness framework**  
**Patient's agenda**  
**Ideas**  
**Concerns**  
 Expectations  
**Feelings**  
 Thoughts  
**Effects**

the **Differential diagnosis** **Understanding patient's unique experience of illness**

**Integration of the two frameworks**

**Explanation and planning:**  
**shared understanding and decision making**

**10. The Three Function Approach to the Medical Interview (1989) [Back to top](#)**

Cohen-Cole and Bird have developed a model of the consultation that has been adopted by The American Academy on Physician and Patient as their model for teaching the Medical Interview.

- (1) Gathering data to understand the patient's problems**
- (2) Developing rapport and responding to patient's emotion**
- (3) Patient education and motivation**

**Functions****Skills**

- |    |                |    |                      |
|----|----------------|----|----------------------|
| 1. | Gathering data | a) | Open-ended questions |
|    |                | b) | Open to closed cone  |
|    |                | c) | Facilitation         |
|    |                | d) | Checking             |
|    |                | e) | Survey of problems   |
|    |                | f) | Negotiate priorities |

- g) Clarification and direction
  - h) Summarising
  - i) Elicit patient's expectations
  - j) Elicit patient's ideas about  
aetiology
  - k) Elicit impact of illness on  
patient's quality of life
- 2      Developing rapport
- a) Reflection
  - b) Legitimation
  - c) Support
  - d) Partnership
  - e) Respect
- 3      Education and motivation
- a) Education about illness
  - b) Negotiation and maintenance of a  
treatment plan
  - c) Motivation of non-adherent  
patients

# **11. The Calgary-Cambridge Approach to Communication Skills Teaching** [Back to top](#) (1996)

Suzanne Kurtz & Jonathan Silverman have developed a model of the consultation, encapsulated within a practical teaching tool, the Calgary Cambridge Observation Guides. The guide is continuing to evolve and now includes Structuring the consultation. The Guides define the content of a communication skills curriculum by delineating and structuring the skills that have been shown by research and theory to aid doctor-patient communication. The guides also make accessible a concise and accessible summary for facilitators and learners alike which can be used as an aide- memoire during teaching sessions

The following is the structure of the consultation proposed by the guides:

- (1) Initiating the Session
  - a) establishing initial rapport
  - b) identifying the reason(s) for the consultation
- (2) Gathering Information
  - a) exploration of problems
  - b) understanding the patient's perspective

c) providing structure to the consultation

(3) Building the Relationship

- a) developing rapport
- b) involving the patient

(4) Providing structure to the interview

- a) summary
- b) signposting
- c) sequencing
- d) timing

(5) Explanation and Planning

- a) providing the correct amount and type of information
- b) aiding accurate recall and understanding
- c) achieving a shared understanding: incorporating the patient's perspective
- d) planning: shared decision making

(6) Closing the Session

## 12. Comprehensive Clinical Method/Calgary-Cambridge Guide Mark 2. (2002)

This method combines the traditional method of taking a clinical history including the functional enquiry, past medical history, social and family history, together with the drug history, with the Calgary-Cambridge Guide. It places the Disease-Illness model at the centre of gathering information. It combines process with content in a logical schema; it is comprehensive and applicable to all medical interviews with patients, whatever the context.

### Gathering Information

process skills for exploration of the patient's problems  
(the bio-medical perspective and the patient's perspective)

- patient's narrative
- question style: open to closed cone
  - attentive listening
  - facilitative response
    - picking up cues
      - clarification
      - time-framing
    - internal summary
  - appropriate use of language
- additional skills for understanding patient's perspective

content to be discovered:

the bio-medical perspective the patient's perspective  
(disease) (illness)

sequence of events ideas and concerns  
symptom analysis expectations  
relevant functional enquiry effects  
feelings and thoughts

essential background information

past medical history  
drug and allergy history  
social history  
family history  
functional enquiry

### 13. BARD 2002 Ed Warren Update 5.9.02

The BARD model attempts to consider the totality of the relationship between a GP and a patient and the roles that are being enacted. The personality of the doctor will have considerable influence on the doctor-patient encounter, as will the doctor's previous experience of the patient. The model attempts to include how the doctor's personality can be used to best effect, and looks specifically at the doctor and patient roles in the medical encounter. It aims to "encompass everything that happens during a consultation" and encourage reflection. It is important that GPs play to their strengths, and use their role and personality and behaviour positively for the benefit of the patient.

The four proposed avenues for analysis are:

Behaviour  
Aims  
Room  
Dialogue

#### Behaviour

A doctor has many alternatives in how they present to a patient, and these choices will reflect the needs of the patient and the personality of the GP. It includes non-verbal and verbal skills as well as confidence, "lightness of touch", and behaviours which feel "just right". The key is for the doctor to choose the most appropriate behaviour with each patient in front of them

#### Aims

It is important for the aims of a consultation to be clear in order to help the doctor and the patient to head in the right direction. However not all the aims will necessarily need to be achieved in one consultation, and priorities have to be clarified.

#### Room

The consultation will be affected by the environment in which the doctor works, as well as for example, where the doctor sits, or whether a side room is used for the examination.

#### Dialogue

How you talk to the patient is crucial. Tone of voice, what you say, language, the ability to confront or challenge needs thought. How can you be sure that both you and the patient are talking the same language?

### 14. Balint 1986 [Back to top](#)

Michael Balint and his wife Enid, who were both psychoanalysts, started to research the GP/patient relationship in the 1950s, and over many years ran case-discussion seminars with GPs to look at their difficulties with

patients. The groups' experiences formed the basis for a very important contribution to the general practice literature; The doctor, the patient and the illness. In exploring the doctor-patient relationship in depth, Balint helped generations of doctors to understand the importance of transference and counter-transference, and how the doctor himself is often the treatment or drug. Balint groups are still popular, and are usually run on psychodynamic lines and often one of the group leaders is a psychotherapist. Balint's tenet was that doctors decide what is allowable for discussion from the patient's offer of problems, and that doctors impose constraints on what is acceptable to explore in the consultation, often unconsciously. This selective neglect or avoidance is often related to something in the doctors life which is threatening. For example a doctor may not wish to explore alcoholism in a patient if he or she either drinks to excess themselves, or someone close to the doctor has an alcohol problem. If the patient is also reluctant to discuss the issue then this can lead to collusion.

Balint groups begin with "has anyone a case today?" A doctor then tells the story of a patient who is bothering him and the group will help the doctor to identify and explore the blocks which are constraining exploration and management of the patient's problem.

## 15. Narrative-based Medicine

### Launer J (2002)

Narrative studies explore the way people tell stories. The modernist approach had been to be attentive to these stories and the particular approach described in this book is a specific one, developed by a team of teachers at the Tavistock Clinic in London. In primary care we have an option not only to reflect on these stories, we can respond to and even challenge them. Thus the post-modern and more radical view would be that a clinical interaction is one in which two parties bring their own individual contexts and preferences, to create what is a unique and developing conversation. For example, in the context of the consultation between a patient and the GP, there is often no "ultimate truth" to the answer to the question "why has the patient attended", or what the patient is hoping for from the doctor, because in an attempt to explore these important questions, even more important questions and ideas will emerge.

1. Skills which help the patient to understand better what is happening to them not only include the basic skills of listening, and empathising. Question style is crucial; appropriately timed questions asked with respect and in the spirit of caring about the eventual outcome for the patient can be used with great effect in contexts where the clinician is trying to help the patient look at a problem from a different point of view, and encourage behaviour change. They might be compared with Socratic questioning, and form the basis of narrative-based interviewing and originally come from family systems therapy.

The six key concepts are:

- conversations
- curiosity
- circularity
- contexts
- co-creation
- caution

Some examples:

"When you get home, what do you think your husband might say when you tell him what we have been talking about?"

"Who in the family thinks you are depressed as well as your husband?"

"If we can't get to the bottom of your problem, what do you think you might do next?"

Constructing a genogram with the patient is a good example of one of the other techniques used in narrative-based medicine.

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