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**Title page**

**Practical 'procedures' article on consultation models for Nursing Times**

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**Declaration**

I confirm that by submitting to the Nursing Times, this submission is the work of the authors and any additional sources of information have been correctly cited.

**Abstract (97 words)**

This article on consultation models is the first in a series on assessment and interpretation as part of a larger series on clinical advanced practice. It considers commonly used models, the importance of the patient's perspective and the centrality of communication skills. Understanding the art of listening, incorporating a narrative approach and collaboration have the potential to enhance the effectiveness and satisfaction of clinical encounters for both clinicians and service users. Successful consultation requires combining what works with personalised adaptations and having the conviction to be creative and innovative, building the foundations for a person's onward journey.

**5 key points of the article**

1. The advanced practitioner is in a key position to take the lead in challenging the existing paradigm of clinical consultation
2. Consultation models offer structure and guidance, offering pros and cons, beneficial to draw upon in different situations and requirements
3. The consultation is only as successful as the skill of the communicator
4. Narrative medicine could enhance quality of communication and be an untapped approach, easier to incorporate than anticipated

5. There is a balance to be found between the clinician’s and patient’s agenda during the consultation to make for more satisfying encounters for all

## Consultation models

This article aims to offer a practical approach to considering patient consultation for nurses and allied health professionals (AHPs) working at or toward an advanced level of practice. Consultation is often viewed as the domain of the doctor or medic and many models of medical consultation were traditionally designed for the general practitioner (GP). Much has been written in this context, but as demand for non-medics to lead consultation increases and with the establishment of the advanced practitioner (AP) role, there is great need for a renewed perspective that makes the most of their knowledge and experience.

### The opportunity of advancing practice

Consultation presents an opportunity to demonstrate the value of the non-medic practising at an advanced level, from both a clinical skills perspective and as a way to transform and modernise models of care (HEE, 2017), a theme at the heart of advanced practice.

Good assessment takes time, for which no apologies should be made. Current constraints of the system, including limited time allocation and resources are real, but that does not justify allowing insufficient time to take a thorough history. The value of the clinical consultation is immense. Insufficient focus and time in the name of efficiency, simply pushes costs, both human and service, down the line. If sufficient time is taken to do it well, the opportunity for improved care and satisfaction, for both service user and clinician, is significant.

Non-medics and APs are often afforded greater time to consult than that traditionally allocated to GPs, so an opportunity exists to be optimised. More dedicated or high quality time in the first instance has the potential for understanding not only the short term, but also longer term needs of service users, potentially reducing the revolving door of healthcare. Non-medical professionals are in a key position to take the lead in placing greater value on the clinical consultation and challenging the existing paradigm.

AP consultation may be different from that of a doctor. Professions are different, bringing added value from their base profession and should play to their strengths. As well as a wealth of knowledge built up over years of clinical experience in their base profession, non-medics bring extensive communication expertise and skill in building trusting and therapeutic relationships. In advancing practice, clinicians are able to push beyond traditional boundaries, expanding their scope and becoming increasingly integrated into an interdisciplinary team. There is an opportunity for being able to sensitively and comprehensively address patient needs early on in their journey and effectively unlock and quickly put into action a pathway of care.

It is essential to work within an individual scope of practice and be open and candid with the service user, differentiating the role of the non-medic or AP from that of a doctor early on in the consultation.

Explanation and clarity of their role in the particular service user's journey is paramount. As a key pillar of advanced practice, education can be applied early in the consultation to explain their role, giving service users confidence, building trust and setting expectations.

**Consultation models**

A model can help to bring structure at what could be considered a pivotal moment in the clinician-patient relationship. This is helpful in a potentially stressful and challenging situation for any clinician stepping into the unknown and for the service user experiencing distress and uncertainty. Exactly what to do to help may not always be clear, but the process can guide what to do next, reassuring both parties that there are steps that can be followed to reach an optimal outcome.

There is great variation in consultation models from clinician driven to patient oriented, and those driven by tasks to be achieved versus those determined by the behaviours needed to navigate each consultation. There are numerous theoretical models, of which a handful will be discussed in this article. The selection here incorporates models representative across the spectrum and the most commonly used in practice today. Their potential value will be considered in developing a personalised consultation approach. Partnership working and person centred approaches are at the heart of advancing practice as evidenced in the capabilities in HEE's multiprofessional framework (2017).

A **traditional medical model** is an example of a clinician driven, task-oriented consultation model and is dictated by the search for biomedical information using a closed questioning style. It remains a highly used, functional approach especially where time is of the essence. It is considered structured, efficient and medically comprehensive to move towards the central goal of diagnosis and a biomedical management plan (Mehay, 2012). A series of closed questions can, however, interrupt a person's narrative and fail to elicit their perspective (Ospina et al, 2019).

The **biopsychosocial or Triaxial model** (the traid being physical, psychological and social) seeks to question beyond the biomedical, contextualising the presenting complaint by asking questions about the whole person in an attempt to be more patient orientated. The psychological and social elements are often only given lip service by asking a question on mental wellbeing or social history without more detailed context. This approach alone over simplifies a person-centred approach (Mehay 2012) and should be incorporated within a structured consultation framework.

**Helman's folk model** (Helman 1981) is truly patient oriented, being all about the service user's perspective. It proposes that a person comes with 6 questions and it is the clinician's role to help them find answers. Helman's 6 questions;

1. What has happened to me?
2. Why has it happened?
3. Why me?

4. Why now?
5. What would happen if nothing were done about it?
6. What should I or others do about it?

These questions seem almost philosophical, although answers could be enlightening and highly practical. The fear is that allowing for this exploration is time consuming and could fail to deliver tangible outcomes expected from a traditional healthcare encounter. Whilst not comprehensive as a model to structure consultation it does highlight the complex needs of the service user and potentially competing agenda with that of the clinician.

Multiple models acknowledge that service users bring ideas, concerns and expectations (**ICE triad**) to the consultation (Van de Poel et al, 2013), the discovery of which must be practically incorporated, otherwise there is the risk that priorities of the consultation will not align with what matters to the person in question (Ospina et al, 2019).

The **Disease-Illness Model** (Levenstein et al, 1986) (figure 1) sits balanced between patient and clinician (Mehay, 2012) and remains one of the most useful. It is a simple model that demonstrates the interplay between both parties and their agendas within a structured flow. Information gathering and coming to conclusions is done in the context of both the disease framework as the biomedical perspective of a diagnosis and the illness framework as the patient perspective of their experience. The two don't necessarily need to co-exist, but both need to be recognised. For example, no medical diagnosis may be made yet a person can report feeling unwell and vice versa, for example a diagnosis of hypertension can be asymptomatic.

Its use can avoid overly focussing on getting information toward a diagnosis without making space for the patient to express them self. A shared understanding should be reached incorporating aspects from both frameworks with decision making that reflects this.

Figure 1: Disease-Illness model (Silverman et al, 2005). Copyright 2005 by Jonathan Silverman, Suzanne Kurtz and Juliet Draper.

**Pendleton's** (1984) **and Neighbour's** (1987) models do not offer a fixed structure, but set out behaviours for the clinician to incorporate in carrying out an effective consultation. Both offer a pragmatic approach still relevant today with considerations in a logical flow. Pendleton's consideration of a person's wider problems and the long-term value in using time and resources is forward thinking, whilst Neighbour's focus on the relationship and self-care create an empathetic space for both the service user and clinician.

**Pendleton's** 7 considerations (Pendleton, 1984);
*1 and 2*: Having defined the primary reason for attending, the person's other problems should be considered, such as ongoing problems or potential risk factors
*3, 4 and 5:* Choose appropriate action for the problems identified with the patient, ensure shared understanding and shared responsibility
*6:* The clinician should consider appropriate use of time and resources in the context of both the immediate consultation and the longer term picture - Is it appropriate to use more time now to save time later or to focus on the present only?
*7:* The clinician should keep in mind building and maintaining a working relationship with the service user

**Neighbour's** 5 considerations (1987);

1. *Connect*: First build rapport with the service user to establish a working relationship
2. *Summarise*: Use communication skills to find out the reason for a person's attendance, ensure shared understanding and logical identification of a potential diagnosis
3. *Handover*: Return some control to the service user, engaging them in a shared management plan
4. *Safety net*: Use prediction skills to set-up a contingency plan with the service user if things do not go to plan or new concerns arise
5. *Housekeep*: Attend to own self-care, reflecting on readiness for the next consultation and potential actions required to re-set for it

Several models recognise the value in laying out specific steps for the clinician to follow to navigate any consultation and can therefore be very useful for the emerging practitioner. The **Cambridge-Calgary model** (1996) (Silverman et al, 2013) contains elements of previous models reflecting the interplay between the patient and clinician of the disease-illness model and is considered the most comprehensive and evidence-based. There is explicit focus on providing structure and flow and building an effective relationship throughout (Silverman et al, 2013). Box 1 lays out its 5 steps.

Box 1: The Cambridge-Calgary structured approach to consultation (Silverman et al, 2013)

| **Step 1-5** | **Includes** |
|---|---|
| 1. Initiate the session | Preparation, establishing rapport, identifying reasons for the consultation |
| 2. Gather information | Exploration of the problem - biomedical, patient perspective, context |
| 3. Physical examination | |

| | |
|---|---|
| 4. Explanation and planning | Providing appropriate information, ensuring shared understanding and shared decision making |
| 5. Close the session | Appropriate closure and forward planning |

The full Cambridge-Calgary model details and integrates communication skills at each step, the framework by itself being incomplete without a strong emphasis on the importance of communication.

**Consultation primarily as a communication process**

Consultation can be viewed as the skilled application of everyday communication skills. These skills are as essential to the consultation as knowledge base, examination and problem solving. How and when things are said are as important as what is said (Silverman et al, 2013) with the ability to greatly influence the journey ahead. As with all skills, communication requires explicit acknowledgement, practise and refinement. Any model is only as successful as the skill of the communicator. The unknown and challenging issues encountered during consultation cannot always be fully structured or prepared for. First encounters, follow-ups and routine reviews require adaptation of approach, but whilst the content differs, the same core skills and communication requirements remain.

Box 2: Key communication processes

- **Greeting and initiating a relationship**
  - Negotiating an agenda
  - Create a structure to be achieved and signpost to the patient when moving on/through the process
  - Establish the person's starting point - what do they understand?
- **Pay attention to what they are saying**
  - Assess a person's needs/wants
- **Pick up cues, read between the lines**
  - Regularly check understanding
  - Encourage questions
- **Work out what to do next**
  - Discuss options and perspectives
  - Allow time for the person to take things in
  - Provide support, advocacy and partnership
  - Explain and plan, relating back to the patient's agenda
- **Arranging to meet up again if that suits**
  - Provide closure, ending the encounter appropriately

(adapted from Silverman et al, 2013 and Neighbour et al, 2017)

Opening and closing the session with clarity is crucial. Focusing on consultation as a communication process, the clinician can sensitively guide themselves and the service user through any encounter.

**The art of listening**

Paying attention to the service user is easier said than done with competing demands on the clinician's time and mind. A feeling of being rushed, from the patient's perspective, may translate to 'the clinician isn't really listening'. This might not be the case, but this in itself devalues the encounter and what the person is willing to impart. The art of delivering healthcare may be the ability to listen, requiring tact, skill and a willingness to hear (Green, 2011).

Attention truly focussed for a small amount of time can more easily elicit key moments in the consultation that say 'this bit matters' (Neighbour et al 2017). Critical moments include (Neighbour et al, 2017);

1. The curtain-raiser: the first 15 seconds of the consultation - don't interrupt
2. A visible, internal search for information - try to discover it
3. Censoring own speech or saying nothing where it would be expected - can you get them to elaborate?
4. Moments of turbulence in speech and body language - draw attention to their visible area of concern

'Listen to the patient, he is telling you the diagnosis', is a quote attributed to Sir William Osler, a strong advocate for clinician-patient conversations (Sarasohn-Kahn, 2019). Never underestimate what can be uncovered from the patient and before any physical examination or investigations are done. Gathering a thorough history can provide up to 80% of the information required to make a diagnosis, but listening carefully also contributes to a person-centred approach (Ospina et al, 2019). It is important to remember what is trying to be achieved during consultation and allow neither procedure nor routine to take over from a natural curiosity driven by a desire to help (Neighbour et al 2017).

**Narrative medicine** encourages the person to tell their story, their way, an effective approach for putting the person at the centre rather than just focussing on the disease (Launer, 2022). In the diagnostic encounter the person's experience of illness is contextualised and meaning provided, allowing for greater expression of diversity. Empathy and shared understanding are enhanced. Useful clues that might otherwise be missed are supplied freely, whilst assisting in the pursuit of a holistic management approach (Greenhalgh et al, 1999). It embraces uncertainty and is not about forcing the consultation down a linear pathway (Launer, 2018), potentially moving away from clinching one central diagnosis and ideal treatment.

The 7 C's of narrative medicine (Mahey, 2012) are;

1. *Conversation*: establish a genuine dialogue
2. *Curiosity*: come from a place of sincere interest and curiosity

3. *Contexts:* how is the person framing their story?
4. *Complexity*: embracing the idea that there may not be a simple cause-effect to be discovered
5. *Creativity*: can you help them tell their story more clearly?
6. *Caution:* some problems are straightforward and this approach may not be appropriate
7. *Care*: this approach cannot be taken lightly, requires true engagement in the process

Clinicians may worry that this approach could be time consuming in the pressured healthcare environment. In contrast it could save time by getting to the crux of what really matters for the person, rather than trying to elicit this via a series of closed questions that matter to the clinician (Jones 2022). Patients are, on average, interrupted after 11 seconds. Uninterrupted, someone can more easily state their concern in their own words and it takes far less time than clinicians anticipate (Ospina et al, 2019). Incorporating a narrative approach could help focus the time together and enhance the relationship to optimise the outcome of any consultation. A practical approach moves the clinician away from taking a history toward building one (Launer, 2018). The concern that a narrative approach to consultation will result in a time consuming encounter can be alleviated by initially taking time to negotiate the agenda and signposting the patient through the process so that they are clear when the session is ending.

Box 3: Practical steps in using a narrative approach to gather a history

- Start the encounter with an open question: What can I help you with today?
- Allow the person to tell their story for ***3 minutes***, uninterrupted - signpost/inform the person of this (this is longer than they would normally get to speak, it will not feel rushed)
- During this time, use non-verbal prompts to avoid interrupting the person's flow
- **After 3 mins**, follow up with brief prompts directly linked to their story to confirm certain points, e.g. for how long? Can you clarify what you meant by this?
- Having confirmed the relevant points from their story, indicate you are moving the consultation on to gather other information
- Complete the history with asking more directed questions where information is missing to help formulate differential diagnoses
- Explain your initial thoughts and signpost you are moving on to the next stage - examination, referral or booking a follow-up

(adapted from Launer, 2018)

**Being guided by clinical reasoning**

Individuals are more than a list of signs and symptoms. They report problems affecting their lives and can prioritise those which are most disruptive. Constructing a prioritised problem list is a useful way to group a multitude of complaints that makes sense to the person having them. Using a timeline, problems can be connected and elements of a narrative correlated to construct a bigger picture in the context of the whole person. People do not present like text books, so not everything will fit into a neat differential diagnosis. There could be more than one disease process, although only one illness

narrative and there should be room to influence judgement as new information and findings come to light. Deal in theories not certainties, as Osler as far back as the 19th century alluded to,

‘if it were not for the great variability among individuals, medicine might as well be a science and not an art’ (Olser, cited in Iohom et al, 2004, p440).

**Physical examination** should seek to test theories formulated from a carefully foraged history (Launer, 2018). Tests are not applied blindly, but reasoned to offer insight that builds on a picture and can be correlated toward a reasoned judgement.

**Planning** does not require concrete conclusions, but sufficient information gained to take informed action for a safe and holistic plan, involving the person themselves and the wider clinical team. Have a low threshold for follow-up with consideration of continuity of care and safety netting (Morgan et al, 2014). The practitioner at an advancing level should be able to address immediate needs, giving practical advice and extended scope of care where possible. The power of information and reassurance should not be underestimated.

**Process versus content**

A content-centred model frames the patient presenting a problem to the clinician for them to use their expertise to solve (Shein, 1989). A shift in emphasis from not only the content of someone’s problem to *how* it is solved can unlock greater value of the consultation. An emphasis on process promotes collaboration in problem-solving, more likely to result in an acceptable solution to the client (Rockwood, 1993) and enhancing independence and self-management skills for the future. The clinician can move between content and process consultation as appropriate for them to offer expertise (Shein, 1989), but consultation is an opportunity to empower and upskill, not just investigate and inform. If we take the process of storytelling and artful listening, this alone may provide healing and transformative healthcare experiences (Green, 2011).

**How do we choose which model to use? Adapt and evolve**

Consultation models, many with overlapping features and goals, offer insight, structure and guidance to help develop one's own consultation skills (Carter, 2018). A strong focus on skills involving verbal and non-verbal communication, listening, signposting and artful questioning (Silverman et al, 2013), alongside the ability to flex and adapt, moving between models is optimal (Mehay, 2012). No model is a rule, but a tool offering pros and cons, beneficial to draw upon in different situations and requirements.

Most models are designed with face-to-face consultation in mind, but the convenience and opportunity afforded through technology for remote consultation should be embraced. People should be offered a personalised, flexible, hybrid blend using in-person and remote options according to need, preference, available resources and consultation purpose (Hawley-Hague et al, 2021).

Patient-centred consulting models have moved care on considerably and are preferable to a clinician-focussed, task driven one. Clinician needs however, are often left unmet with escalating stress trying to keep time, remain calm and professional, keep good documentation and seek not to miss anything unsafe. Clinician wellbeing is inseparable from care quality, requiring another shift toward clinician-sensitive consulting (Mirza, 2019) or relationship-centred care (Nolan et al, 2001) for resilience and longevity (Mirza, 2019). It is not about sacrificing one for the other, but consultation should be a negotiation between needs of the service user and the clinician in context. Communication skills are the key to building trust and rapport leading to effective working relationships. A transparent collaborative approach is more productive and empowering for all parties.

Thinking differently and embracing change is at the heart of evolving new models of care to better meet the needs of a population with increasing comorbidity and complexity. Individual service users and clinicians seek greater satisfaction from their clinical encounters. Narrative medicine may be an untapped approach that is easier to incorporate than anticipated, simply requiring a leap to try it out in practice. Successful consultation requires combining what works with personalised adaptations and having the conviction to be creative and innovative, knowing you are building the foundations for a person's onward journey.

**Box 4: Overview and practical tips to consultation**

| | |
|---|---|
| Prepare | Prepare for the consultation - mentally ready yourself<br>Gather information about the person/context if possible |
| Structure/plan | Decide upon a model or outline structure to guide the process and create flow in advance<br>Be prepared to use it alongside the patient's agenda - ready yourself to be flexible and adapt |
| Greet | ***First*** introduce yourself and explain your role in the person's journey<br>Clarify the time you have together, how it will work, and what could be expected, but explain this is flexible based on both their needs and yours |
| Connect | Decide to give someone your full attention if only for this limited time together<br>Be curious<br>Let the person speak uninterrupted for 3 mins, explicitly demonstrate listening skills<br>Allow room for silence, for the person to say more<br>Pay attention to key clues in spoken and body language<br>Ask open as well as closed questions |
| Follow a thread | Be logical in your reasoning, linking and correlating what you find. Your thinking may change so be able to logically communicate this and explain your reasoning |

| | |
|---|---|
| | Build a picture for yourself and the service user connecting the whole |
| Manage time, prioritise, adapt | Decide what is most important, ensuring shared understanding and agreement of what needs to be done now and what can be followed-up<br>Ensure you know where you are heading with the consultation next and signpost to the service user as you go along<br>Consider allocating a double appointment slot - challenge the status quo<br>Consider blocking out more time in advance and bringing patients back |
| Manage uncertainty - clinician and service user's | Seek clarification<br>Be transparent, explain uncertainty and complexity<br>Be collaborative, encourage questions<br>Seek advice from colleagues before, during and after<br>Consider follow-up, safety netting, handover to others |
| Summarise | Ensure shared understanding of the problem, the options and the reasoning behind any potential plan<br>Allow time for the person to take things in<br>Encourage questions<br>Sum up and explain the consultation is coming to an end, but another consultation can be booked |
| Plan | Be open to complexity and the requirement for follow-up<br>Agree and negotiate actions, manage in partnership, set expectations |
| Close | Use words that explicitly end the consultation appropriately and the service user is clear on next steps |
| Reset | Ensure you have time for yourself to set aside the last consultation before embarking on the next - consider how to action this if not currently available |

(adapted from Morgan et al, 2014)

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