How this chapter should be used:
This chapter has been designed to be suitable for web based and face-to-face teaching. The text has been made to be as interactive as possible with exercises, Multiple Choice Questions (MCQs) and web based exercises.
If you are using this chapter as part of a web-based course you are urged to use the online discussion board to discuss the issues raised and share your solutions with other students.

Who this chapter is aimed at:
This chapter is aimed to the following types of people:

- Doctors, both in training and those wishing to be involved in some form of Continual Professional Development (CPD) programme
- Nurses who are just starting training as well as those undertaking advanced courses such as Nurse Practitioner training in the UK.
- Pharmacists both undergraduate and those undertaking courses to enable them to become Supplementary prescribers in the UK

I hope you enjoy working through this chapter.
Robin Beaumont
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1. Before you start

1.1 Prerequisites

This chapter assumes you have read and worked through the first chapter in this series ‘Basic Communication Skills’ at www.robin-beaumont.co.uk/virtualclassroom/comms/index.htm.

1.2 Required Resources

You need the following resources to work through this chapter:

- Active connection to the internet
- Optional ability to print out this chapter

2. Learning Outcomes

This chapter aims to provide you with the following skills and information. After you have completed it you should come back to these points, ticking off those with which you feel happy.

<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>Tick box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be able to discuss the concepts of professionalism, etiquette and power and their relationship to your own professional role</td>
<td></td>
</tr>
<tr>
<td>Be able to describe Argyle's two dimensions to interpersonal attitudes</td>
<td></td>
</tr>
<tr>
<td>Be able to identify the effects orientation and proximity have upon the power dynamics of the consultation</td>
<td></td>
</tr>
<tr>
<td>Be able to describe a variety of characteristics that Cruickshank 1985 suggested when describing the ideal doctor</td>
<td></td>
</tr>
<tr>
<td>Be able to consider the ideal characteristics that you believe defines your professional role</td>
<td></td>
</tr>
<tr>
<td>Be able to describe the main headings that form a medical history</td>
<td></td>
</tr>
<tr>
<td>Be aware of the additional aspects that the Royal college of General Practitioners suggested in 1972 should be considered in the consultation.</td>
<td></td>
</tr>
<tr>
<td>Be aware of the importance given to opportunistic health promotion in Stott and Davis's 1979 model</td>
<td></td>
</tr>
<tr>
<td>Be able to provide a summary of the work that Byrne &amp; Long carried out in the 1970's</td>
<td></td>
</tr>
<tr>
<td>Be able to provide a short description of the Doctor / Patient centred checklist developed by Byrne &amp; Long</td>
<td></td>
</tr>
<tr>
<td>Be aware of Heron's six Category Intervention Analysis</td>
<td></td>
</tr>
<tr>
<td>Be aware of Helman's Folk Model</td>
<td></td>
</tr>
<tr>
<td>Be able to describe the three ego state suggested in transactional analysis</td>
<td></td>
</tr>
<tr>
<td>Be able to describe the seven tasks suggested by Pendleton, Schofield, Tate and Havelock</td>
<td></td>
</tr>
<tr>
<td>Be aware of Neighbours 5 check points for the doctor</td>
<td></td>
</tr>
<tr>
<td>Be able to describe the main stages in the disease - illness model with it's emphasis on integration as the final stage</td>
<td></td>
</tr>
<tr>
<td>Be able to describe the three function model</td>
<td></td>
</tr>
<tr>
<td>Be able to compare the Calgary-Cambridge model to the other consultation models described</td>
<td></td>
</tr>
<tr>
<td>Be able to suggest a model that would fulfil your own personal and professional needs.</td>
<td></td>
</tr>
<tr>
<td>Be able to discuss the expert patient and Personal recovery concepts</td>
<td></td>
</tr>
<tr>
<td>Be able aware of the Neuro-linguistic programming concept</td>
<td></td>
</tr>
</tbody>
</table>
3. Introduction

This chapter is the second in a series to help you to learn more about communication and gain some relevant skills.

To give you an idea of where this chapter fits into communication and professional practice, the diagram below shows the main areas that need to be considered.

This chapter looks at the clinical/healthcare consultation at a high level, the focus is on different consultation models and their comparison. We will also look at the expert patient concept at this could be considered to be a very important factor in possibly suggesting new models for the consultation. Analysing consultation models also provides the basis for developing various methods of self assessment of performance in the consultation.

4. Professional conduct and Power

In the first chapter we looked at how we communicate in general and did not concentrate on how we adapt our communication style within our professional role.

In contrast in this chapter we will be concentrating on how one communicates as part of a professional role. Every professional role has a code of conduct defined by its governing body. For example if you are a Uk nurse you can find your code at, http://www.nmc-uk.org/aArticle.aspx?ArticleID=1658

For American organisations, ranging from the military to the religious, The Centre for the study of ethics in professions at Illinois Institute of Technology provides examples of many such codes, http://ethics.iit.edu/codes/

For a more global view you can consult the Professional Codes of Ethics and Related Chapters page on the Dalhouse university libraries in Nova Scotia at http://www.library.dal.ca/kellogg/Bioethics/codes/professions.htm

Chris MacDonald, an ethicist provides a good set of links at his web site including details of how to draw up a code of conduct for your organisation. http://www.ethicsweb.ca/codes/

Some sociologists argue that "Professionalism" is just the legitimisation of a closed club culture and is more concerned with gaining power for the individuals in the profession rather than serving the community at large in any altruistic way.
Exercise 1.

A) Please read the following quote:

"Professional codes tend to mix the two in a confusing way. Whereas etiquette is a guide to behaviour, it also responds to accepted conventions which are merely "custom and practice" rather than responses to fundamental principles. Etiquette tends to be centred more on the professional than on the client. Sometimes it frankly promotes the professional's interests rather than the clients!"

The above quote was taken from a web article by Dr Donald Portsmouth, a retired consultant physician, at: www.awselva.co.uk/ethics.pdf the link is unfortunately no longer available and I have been unable to trace a new one. A similar article is that by Kultgen, 1982 and 1988.


After reading the above it is clear why the Government in the uk, as well as other countries, has attempted to introduce independent organisations to monitor various professions. Also one can see why so many individuals in these professions feel threatened by such proposals, the action being akin to having some aspect of their professionalism stripped away from them. This is basically the issue of power, which we will consider next.

The following paragraphs have been taken and adapted from http://www.cultsock.ndirect.co.uk/MUHome/cshtml/nvc/nvc5.html, an excellent web site about communication written by Mick Underwood new version at: http://www.cultsock.org/.

According to Argyle one of the most influential psychologists in the late 20th century who unfortunately died in 2002, there are two main dimensions to interpersonal attitudes. He represents these as shown below, as you can see the power aspect is one of them:

Our attitudes can be anywhere within those ranges for example: the dominant, but reasonably friendly boss, the hostile, but submissive employee and so on. The evidence from a range of observations is that we use NVC to achieve more or less dominance and express more or less affiliation (i.e. friendliness).

A particularly revealing series of investigations was carried out by Mehrabian in 1972. He asked his subjects to talk to a hat rack. A pretty stupid sort of thing to do, I suppose, but by doing so Mehrabian was able to eliminate a number of intervening variables. What he hoped to do was to reduce the set of necessary signals to the bare minimum, so that he could concentrate mainly on those signs which appeared to be common to all the subjects when instructed to address the hat rack in a certain way.

His observations revealed the following:

<table>
<thead>
<tr>
<th>Bodily signal</th>
<th>Affiliation</th>
<th>Dominance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bodily contact</td>
<td>touches, strokes, holds</td>
<td></td>
</tr>
<tr>
<td>Proximity</td>
<td>1) is within normal range</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) closer proximity</td>
<td></td>
</tr>
<tr>
<td>Orientation</td>
<td>1) if mutual gaze, more direct</td>
<td>less direct</td>
</tr>
<tr>
<td></td>
<td>2) but intimate friends sit side-by-side</td>
<td></td>
</tr>
<tr>
<td>Gaze</td>
<td>more gaze, combined with smiles</td>
<td>less gaze</td>
</tr>
<tr>
<td></td>
<td>(especially males)</td>
<td></td>
</tr>
<tr>
<td>Eyebrow</td>
<td>raised rapidly in greeting and flirtation</td>
<td></td>
</tr>
<tr>
<td>Posture</td>
<td>1) lean forward</td>
<td>1) more relaxed</td>
</tr>
<tr>
<td></td>
<td>2) open arms and legs (by females)</td>
<td>2) head tilted back</td>
</tr>
<tr>
<td>Facial expression</td>
<td>smiles</td>
<td>3) hands on hips</td>
</tr>
<tr>
<td>Tone of voice</td>
<td>soft</td>
<td>loud, assertive</td>
</tr>
</tbody>
</table>

The important fact to take away from the above paragraphs is that in any relationship or interaction there is always an implicit power dimension.
Exercise 2.

Within your professional role consider your interactions with a variety of people and indicate in the space below where you think each sits in terms of power. I have started by giving the example of myself and my boss:

One common way that people display power is by how they arrange the furniture and themselves in space, called orientation, which we will now consider.

**Physical Proximity** is the distance between two people, and there are large cross-cultural differences - Arabs and Latin Americans stand very close, Swedes and Scots are the most distant (Lett et al., 1969 quoted in Argyle 1999 p.39)

**Orientation** is the relative positioning of the people and furniture in the scenario.

### 5. Orientation /Proximity

There seems to be an inverse relationship between proximity and orientation, except of course in intimate relationships. Orientation also changes naturally to suit the kind of interaction, roughly like this:

<table>
<thead>
<tr>
<th>style</th>
<th>competition</th>
<th>co-operation</th>
<th>conversation</th>
</tr>
</thead>
<tbody>
<tr>
<td>proximity</td>
<td>face-to-face</td>
<td>side-by-side</td>
<td>90 degree angle</td>
</tr>
<tr>
<td>orientation</td>
<td><img src="as_arranged_by_the_cleaners" alt="Diagram" /></td>
<td><img src="as_rearranged_by_the_staff" alt="Diagram" /></td>
<td><img src="as_rearranged_by_the_staff" alt="Diagram" /></td>
</tr>
</tbody>
</table>

Continuing to quote Mike Underwood:

I observe in my college staff room that the cleaners arrange the chairs neatly facing one another either side of a long table. As people get into conversation in the morning, so they naturally move the chairs into 90 degree angles.

As you can see from the diagram, the way that the cleaners arrange the chairs, though very neat, corresponds to the orientation we have described as being typical of competition. Naturally and unconsciously, staff who are engaged in conversation move their chairs around so as to achieve the ninety degree orientation which seems to be conducive to conversation. As you can see in the diagram, even if four people are in conversation together, two pairs will always be at a ninety degree angle; those who in a four-way conversation are opposite each other always adopt a slight off-centre position so that they are not directly facing each other.

Thus, an interviewer, whether for a job, or for a TV or radio interview, or in a counselling interview, would be making a mistake if (s)he set the chairs up facing each other, as that is conducive to competition. It could make for quite dramatic television in fact, but is actually unlikely to produce new information or revelations. In a job interview, it may help a possibly nervous interviewer to intimidate an interviewee, but it won't encourage him or her to spill the beans. If you want your interviewee to
be relaxed enough to start letting cats out of the bag, set them up in the ninety degree orientation which will make them feel comfortable to talk.

**Exercise 3.**

In a consultation where you are attempting to gain trust what do you think would be the best orientation of the chair?

So far we have just considered power which is just one human characteristic obviously there are other human characteristics that play a part in defining relationships, but possibly it could be argued that they all in some way contribute to the power relationship. We will now look at some other characteristics and see how they relate to what people perceive as the ideal doctor.

In the UK Pharmacists can now prescribe after having undertaken appropriate training, however anyone who goes into a pharmacist will immediately realise that issues of layout, space and human resources means that the actual layout of most pharmacies have recently changed in the UK to accommodate proper consultations rather than a few brief words over the counter with themselves or even sometimes via a intermediated counter assistant. The exercise below looks at this in more depth.

**Exercise 4.**

Please read through the article, Bellingham C 2002 Space, time and team working: Issues for pharmacists who wish to prescribe. The pharmaceutical journal 286  562-563 [27th April 2002]


You will need to register to see the paper alternatively your tutor may have a copy.

If you are doing this exercise as part of a web based course – post your comments on the forum/discussion board. If you are a doctor also consider what the article has failed to consider.

### 6. Characteristics of an ideal doctor

Cruickshank, 1985 identified a set of doctor characteristics that would help define what a particular patient felt amounted to an ideal doctor.

**Exercise 5.**

In a separate piece of paper list the characteristics that you feel would make an ideal doctor:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Please tick one box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thorough</td>
<td></td>
</tr>
<tr>
<td>Looking at you</td>
<td></td>
</tr>
<tr>
<td>Busy</td>
<td></td>
</tr>
<tr>
<td>Not listening</td>
<td></td>
</tr>
<tr>
<td>Unfriendly</td>
<td></td>
</tr>
<tr>
<td>Asking questions</td>
<td></td>
</tr>
<tr>
<td>Not explaining</td>
<td></td>
</tr>
<tr>
<td>Unsympathetic</td>
<td></td>
</tr>
<tr>
<td>Secretive</td>
<td></td>
</tr>
<tr>
<td>Indecisive</td>
<td></td>
</tr>
<tr>
<td>Convincing</td>
<td></td>
</tr>
<tr>
<td>Helpful</td>
<td></td>
</tr>
<tr>
<td>Paying attention</td>
<td></td>
</tr>
<tr>
<td>Slipshod</td>
<td></td>
</tr>
<tr>
<td>Not looking at you</td>
<td></td>
</tr>
<tr>
<td>Not busy</td>
<td></td>
</tr>
<tr>
<td>Listening</td>
<td></td>
</tr>
<tr>
<td>Friendly</td>
<td></td>
</tr>
<tr>
<td>Not asking questions</td>
<td></td>
</tr>
<tr>
<td>Explaining</td>
<td></td>
</tr>
<tr>
<td>Sympathetic</td>
<td></td>
</tr>
<tr>
<td>Not secretive</td>
<td></td>
</tr>
<tr>
<td>Decisive</td>
<td></td>
</tr>
<tr>
<td>Unconvincing</td>
<td></td>
</tr>
<tr>
<td>Unhelpful</td>
<td></td>
</tr>
<tr>
<td>Not paying attention</td>
<td></td>
</tr>
</tbody>
</table>

I wonder if your list looked anything like the one shown below that Cruickshank, 1985 finally came up with. Don’t worry if your characteristics are not included in the list below as many more where in the initial list which were dropped after statistical analysis.

The interesting aspect of the above research is that different patients have different views about the ideal doctor, in fact when you discuss this with most doctors who have been working for some years they say that they develop a instinct for second guessing what a particular patient wants and adapt their style accordingly. In the field of communication research an area of study called convergence theory investigates this aspect in detail.

Three very important references to consult if you are interested in patient satisfaction and the consultation are:

- Little, Everitt & Williamson et al 2001
- Williams, Weinman & Dale 1995
- Williams, Weinman & Dale 1998
Exercise 6.

Considering your own professional role (doctor, pharmacist, nurse etc.) prioritise those characteristics you feel are most important for you to display in the eyes of your clients. Notice that you may consider these characteristics as a form of 'window dressing' and not really important such as wearing a tie etc.

How much of this window dressing is culturally and socially dictated?

You probably realise that the characteristics you suggested in the last exercise says just as much about how you perceive yourself as what you believe your clients really do want from you.

Exercise 7.

If you have access to a forum/discussion board post up your result from the last exercise and also discuss your results in relation to what others have posted.

Now let's move onto considering the actual consultation process in more detail by way of looking at some models various writers have suggested for the consultation.

7. Consultation models

Whereas all consultation models include the taking of a (medical) history, the details of which have been included in an appendix to this chapter, the models present a difference in focus upon various aspects of the consultation, some place more emphasis on diagnosis of the patient while others focus more on discovering what the actual patient ('consumer') wants. The following descriptions will provide a taste of the range of approaches.

Exercise 8.

It is important that you are aware of the main headings that form a medical history, turn to the appendix and check to see that you know them.

7.1 Physical, Psychological and Social

The fact is that now the medical history, in much of western medicine, encompasses both social and psychological details is taken for granted, however this has not always been the case:

“A quarter of a century again, in 1972 a working party of the Royal College of General Practitioners proposed a model that would encourage the doctor to extend his thinking and practice beyond the purely organic approach to patients, in other words to include the patient's emotional, family, social and environmental circumstances, this has become so successful that it has become part of what most text books quote as part of the 'medical history' (see the appendix) yet less than fifty years ago many of these questions would have been considered as irrelevant or prying by patients.” (Adapted from: http://www.mita.soton.ac.uk/mita/forum/_forum/00000017.htm by Jonathan Silverman)
7.2 Stott and Davis

With the realisation that investigating and taking into account emotional and social factors was part of medicine it became clear that the patient should be encouraged to adopt health-promoting activities. In 1979 in “The exceptional potential in each primary care consultation” Stott & Davis suggested 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  

Adapted from: http://www.mita.soton.ac.uk/mita/forum/_forum/00000017.htm by Jonathan Silverman

7.3 Byrne and Long

Byrne & Long spent three-and-a-half years examining the consultation to produce their “Doctors talking to patients”. The book is as fascinating to read now, as it was when it was first published in 1976. Their analysis not only provided detailed descriptions of actual consultations but also provided ‘a set of instruments with which the solo learner may provide himself with feedback to facilitate his self-learning’ (p132). One single instrument they suggest is that the doctor ensures that he always uses the following 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.

They then divided the analysis of the ‘consultation’ into consultation and prescribing phases, discovering that there were 4 distinct styles of consultation and 7 distinct prescribing styles.

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.

Byrne & Long 1976, provide several checklists (‘instruments’) that the doctor can use to help access her/his degree of patient/doctor centeredness as well as their use of negative behaviours (p146). I have provided the lists of items below along with a typical scoring on the following page.
The Prescribing behaviours checklist can be found in the Diagnosis chapter.

<table>
<thead>
<tr>
<th>Doctor Centered Behaviour</th>
<th>Patient Centered Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offering self</td>
<td>Giving or seeking recognition</td>
</tr>
<tr>
<td>Relating to some previous experience</td>
<td>Offering observation</td>
</tr>
<tr>
<td>Directing</td>
<td>Broad question or opening</td>
</tr>
<tr>
<td>Direct question</td>
<td>Concealed question</td>
</tr>
<tr>
<td>Closed question</td>
<td>Encouraging</td>
</tr>
<tr>
<td>Self answering question (rhetorical)</td>
<td>Reflecting</td>
</tr>
<tr>
<td>Placing events in time or sequence or place</td>
<td>Exploring</td>
</tr>
<tr>
<td>Correlational question</td>
<td>Accepting patient question</td>
</tr>
<tr>
<td>Clarifying</td>
<td>Using patient ideas</td>
</tr>
<tr>
<td>Doubting</td>
<td>Offering of feeling</td>
</tr>
<tr>
<td>Chastising</td>
<td>Accepting of feeling</td>
</tr>
<tr>
<td>Justifying other agencies</td>
<td>Using silence</td>
</tr>
<tr>
<td>Criticising other agencies</td>
<td>Summarising to open up</td>
</tr>
<tr>
<td>Challenging</td>
<td>Seeking patient ideas</td>
</tr>
<tr>
<td>Summarising to close off</td>
<td>Reassuring</td>
</tr>
<tr>
<td>Repeating what patient said to affirmation</td>
<td>Terminating (indirect)</td>
</tr>
<tr>
<td>Giving information or opinion</td>
<td>Indicating understanding</td>
</tr>
<tr>
<td>Advising</td>
<td></td>
</tr>
<tr>
<td>Terminating (direct)</td>
<td></td>
</tr>
<tr>
<td>Suggesting</td>
<td></td>
</tr>
<tr>
<td>Apologising</td>
<td></td>
</tr>
<tr>
<td>Misc. Prof. Noises</td>
<td></td>
</tr>
<tr>
<td>Suggesting or accepting collaboration</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Negative Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rejecting patient offers</td>
</tr>
<tr>
<td>Reinforcing self position (justifying self)</td>
</tr>
<tr>
<td>Denying Patient</td>
</tr>
<tr>
<td>Refusing patient ideas</td>
</tr>
<tr>
<td>Evading patient questions</td>
</tr>
<tr>
<td>Refusing to respond to feeling</td>
</tr>
<tr>
<td>Not listening</td>
</tr>
<tr>
<td>Confused noise</td>
</tr>
</tbody>
</table>

The score value can be thought of as some type of weighting, notice the negative values for the undesirably behaviour and the high scores for the patient centered behaviour. I feel for day to day use just a tally of incidences of each behaviour is appropriate, remember they were doing a piece of academic research.

We will be revisiting this scoring approach in more detail another chapter.

Relating to one of the 7 prescribing styles p.103 - 111
7.4 Six Category Intervention Analysis

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.

Heron believed that each category has a clear function within the total consultation.

7.5 Helman’s ‘Folk Model’

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 seeing answers to six questions:

- What has happened?
- Why has it happened?
- Why to me?
- Why now?
- What would happen if nothing was done about it?
- What should I do about it or whom should I consult for further help?

7.6 Transactional Analysis

Many doctors will be familiar with Eric Berne's, 1960's, model of the human psyche as consisting of three ‘ego-states’ - 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.

7.7 Pendleton, Schofield, Tate and Havelock

‘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.

From: http://www.mita.soton.ac.uk/mita/forum/_forum/00000017.htm Jonathan Silverman
### 7.8 Neighbour

Neighbour in "The Inner Consultation" (1987) provides five check points answering '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?’

This checklist is very much written from the doctors perspective, I don't think any other model has anything equivalent to the last, but very important point. Having said that the model suggests eliciting information from the patient as well as negotiation so it does adopt a patient centered approach as well as considering the doctor.

Adapted from: [http://www.mita.soton.ac.uk/mita/forum/_forum/00000017.htm](http://www.mita.soton.ac.uk/mita/forum/_forum/00000017.htm) Jonathan Silverman

### 7.9 The Disease - Illness Model

In 1984 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.

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**Exercise 9.**

Can you think of specific concerns the patient's agenda might include?  
Similarly can you think of additional concerns the doctor may have?
7.10 The Three Function Model

The central concept in this model is that the interview has three primary functions each served by a particular set of skills, clearly this is a deliberate simplification but provides a framework for analysis. The functions and their related skills are:

**Emotions** – handling the emotional and relationship component of communication to promote a positive relationship between doctor and patient. Discussed further below.

**Behaviour** – Motivating and educating patients to develop a clear and shared understanding about the nature of the problems and what needs to be done about them and a shared commitment to carry this out. Education skills include eliciting patient’s existing views and knowledge, offering readily understood advice, giving rationale, checking understanding, and reinforcing common ground and partnership.

**Data gathering** – This must be accurate and appropriate to elicit all relevant biological and psychosocial data. This is crucial not only for diagnosis but also for understanding personal and social context so that treatment planning can be realistic. Data gathering skills include attentive listening, commencing with open questions and moving to focussed (specific) and then closed questions, use of understandable terms, facilitation, scanning for any other problems, clarification and summarising to check that all has been covered and understood.


**Reflection**

The first, and most important, intervention in dealing with the emotions of a difficult patient is **reflection**. Empathy is the ability to recognize someone's emotional reactions and communicate your understanding of these reactions. Our operational definition of reflection, which facilitates empathy, is "to state the observed patient emotion." For example, an angry patient could be told, "You seem quite irritated (or angry) about what's going on." The sad patient could be told, "You seem quite sad right now," or the doctor might tell the frightened patient, "You seem pretty nervous about your condition." While these straightforward reflective comments might at first seem oversimplified, obvious, or trivial, they actually can communicate a deep sense of understanding to a patient. Such understanding is usually very reassuring and facilitates deepened doctor–patient rapport.

Take, for example, the case of a 28-year-old woman with intractable abdominal pain and no apparent physical etiology after an extensive GI work-up. She became furious when her doctor asked her permission to request a psychiatric consultation, saying, "You really don't believe I have this pain. You think it's all in my head. Well, I'll just check out of the hospital and find a doctor who believes me!

You really don't believe I have this pain. You think it's all in my head. Well, I'll just check out of the hospital and find a doctor who believes me!

There are several reactions that doctors could have to this situation, ranging from defensive arguments like, "Well, go ahead and see someone else," to more explanatory statements such as, "I know you have pain, but I need the psychiatrist's help."

In our own teaching, we emphasize that a direct comment on any apparent emotion, as soon as it is observed, is usually the most effective way to calm an angry patient, or similarly, to reassure a frightened or sad patient. In the example discussed above, we suggest that the physician respond immediately to the patient's negative reaction, saying something like, "You seem to be very unhappy with the suggestion that I call a psychiatrist."
The patient is likely to respond with, "I sure am unhappy. Wouldn't you be? I go to you for some relief from my pain and you send me to the head-shrinker!" Thus, the doctor's reflective comment seems to permit the patient to express even more anger. While this may seem counterproductive at first, if the doctor can continue commenting on (and tolerating) the anger without "fighting back," most patients will not be able to maintain their angry position for very long.

The doctor can continue with more straightforward reflective comments like, "I see you are quite angry with me because I haven't been able to find the cause of your pain." The patient might typically respond, "That's right. You can't find the cause, so now you don't believe it's real."

The doctor can persist in making straightforward and effective reflective comments like, "You're upset because you think I don't really believe you're suffering." Such comments will quickly diffuse most patients' anger and allow a more calm discussion of the medical issues involved. When emotions run high, it is difficult or impossible for the doctor and the patient to hear each other clearly.

One of the most important yet most difficult concepts for physicians to learn is that communication of empathy is most effective through simple statements and not through questions. Doctors are so used to asking questions that their intuitive reaction to an emotion involves the asking of another question (e.g., "Why are you so upset?"). As exemplified in the case discussed above, effective doctor responses to an angry patient can be made by straightforward statements. Notice, too, that one statement is not enough. This is also very hard for doctors to learn. Once doctors have learned to make an effective reflective comment, they sometimes feel that the "empathy is through and something else needs to be done," as if one section of a review of systems has been completed and the next body system needs to be studied. Notice that at least three or four (or maybe more) simple reflective statements can be repeatedly made in an effective encounter with a patient who has a difficult emotional reaction.

Legitimation

Once a doctor has demonstrated his empathic understanding of the patient's emotion and has shown that he can tolerate that affect, it is often useful to express some legitimation, or sense of the understandability of the emotion. In the example given above, after several simple reflective comments, the doctor could point out,

I can certainly understand why you'd be upset. You came to me to find some physical cause for your pain. I couldn't find any problem and now I'm sending you to a psychiatrist. I might be upset also, if I were in your position.

This expression of understanding and legitimation of the patient's emotion is extremely reassuring to the patient. It usually prevents any real fight and is a powerful method for establishing trust and rapport between the doctor and the patient. Of course, the doctor must not just "say" that he understands if he really does not. In my experience, however, when doctors make a genuine attempt to understand a patient's emotion, from the patient's point of view, it is almost always possible to make an honest legitimating comment. I certainly would avoid any dishonest statements of pseudounderstanding.

Once the doctor has pointed out that he can understand why the patient seems so angry, the patient usually will not stay angry. The patient might sincerely wonder, "If you understand why I'd be upset, why are you calling the psychiatrist?"

At this point, the patient has shown a willingness to have an open discussion about the medical issues involved. The doctor can now give the patient a reasonable, straightforward explanation. In my view, when explanations are offered prematurely, before the emotion has been acknowledged, accepted, and legitimated, the patient is rarely able or willing to understand or accept the medical explanation. Only once the emotion has been faced can the doctor acknowledge, I do see that you're upset by the psychiatrist issue and I also want to make it perfectly clear to you again that I can understand why you'd be upset by my wanting to call the psychiatrist [repetition of reflection and Legitimation]. Let me try to explain my thinking and see if it makes any sense to you.

With this kind of approach to an angry patient, the doctor will almost always be able to gain some trust from the patient and establish enough rapport to develop some collaborative strategy with the patient for continued care. An explanation that might be acceptable to the patient described above could be,

I'm quite aware that your pain is real and that you are suffering. All our tests show that you do not have any serious or life-threatening physical problem. I don't know what's causing your pain and I don't know how I can help. Many patients have real pain without any apparent cause that doctors can figure out. Psychiatrists can't usually tell us what's causing the pain either, but they sometimes can help us figure out how to help you live with the pain. Sometimes medication, relaxation, stress-reduction techniques, or counseling can help patients cope better with unexplained pain.

Very few patients will refuse a psychiatric consultation presented in this manner.
Support
Doctors usually offer their patients a great deal of emotional support through intuitive relationship skills. I have found it helpful for doctors to learn explicitly to acknowledge this important dimension of the doctor–patient relationship. For example, with respect to the patient discussed above, a direct supportive comment like,

I want you to know that even though I've asked the psychiatrist to see you, I'm still your doctor and I will do everything I can to try to help you with your problem.

Doctors often forget how important they are to patients as sources of emotional support, and the direct acknowledgment of caring is often effective in difficult-patient-care situations.

Partnership
There is considerable literature that suggests that collaborative doctor–patient relationships are generally more effective than authoritarian relationships. When doctors are able to include patients in the decision-making process, patients are generally more satisfied as well as more likely to comply with doctors' advice. Statements of partnership, which provide explicit offers of a collaboration between doctors and patients, are often effective in troublesome-patient situations. For example, in the case discussed above, the doctor might say something like,

After you've talked to the psychiatrist, you and I can get together and review his recommendations. We can then decide together on the next step to take with respect to your stomach pain.

This explicit invitation for a partnership respects the patient's autonomous decision-making capabilities and also encourages a more adaptive doctor–patient relationship.

Respect
The fifth emotional-response skill, respect, requires the doctor explicitly to compliment the patient on whatever he or she is doing well. Again, this type of comment is made by many doctors on an entirely intuitive basis. In most difficult-patient situations, however, doctors do not automatically think about commenting on what the patient is doing well. More often than not, the doctor feels angry and defensive and uncertain about how to deal effectively with the patient. The interaction is tense and unproductive, and occasionally the patient gets labeled in the doctor's mind as a "turkey."

This unpleasant sequence can usually be avoided if the doctor is able to use the skills described above to reflect and legitimize the patient's feelings. An extremely effective and useful method to cope with the difficult patient is to try to focus on something that the patient does well. In very irritating situations with patients sometimes described as "hateful," the doctor needs to be somewhat creative when the patient seems to be coping poorly in many aspects of his or her life. However, if the doctor can reduce his or her own anxiety and irritation long enough to view the patient objectively, the doctor will usually be able to find something to compliment. It is extremely important for the doctor to be honest in these discussions because most patients will be able to detect lack of genuineness on the doctor's part.

For example, in the case discussed above, the doctor can point out,

I realize how much pain you've been having, and I'm impressed by how well you've been coping in spite of all the suffering you've been experiencing. You're still able to help with the housework (or go to work) and you're determined to get an answer to your problem. Those are good, positive qualities and I'm going to help you in whatever way I can.

[end of quote]
7.11 The Calgary-Cambridge Guide

Reference source: Kurtz SM & Silverman JD 1996.
The Calgary-Cambridge Referenced Observation Guides:
An aid to defining the curriculum and organising the teaching in communication training programmes.
Med. Education, 30, 83-9

Another Model is The Cambridge-Calgary Guide. This has become very popular in the uk, see http://www.gp-training.net/training/communication_skills/calgary/index.htm

This identifies five steps in a consultation. Running throughout these steps are the need to provide structure to the interview and the need to build the relationship with the patient. It identifies a number of specific skills (behaviours) a doctor uses to achieve these steps.

The Guide Identifies skills (behaviours) for each of the tasks in these steps the details of which are given in the table over the page.

The Calgary - Cambridge model presumes that what they call the 'Patient Centred Clinical Interview' presents a tension between two different agendas, that of the patient and that of the doctor, where the aim is to consolidate the two in an amicable way as in the disease illness model.

The developers of the model have also adapted it for paediatric (Howells, Davies & Silverman et al., 2010) and veterinary settings.
**Skills (behaviours) in the Cambridge-Calgary model**

1. **Introduction & Orientation**
   - Greetings
   - Introduction - self, role, nature of interview, requests consent
   - Respect - demonstrates interest, concern and respect, attends to patient’s physical comfort
   - Opening question to identify problem that patient wishes to address
   - Listening without interruption
   - Screening - checks if other problems patient is concerned about
   - Agenda setting negotiates agenda taking both patient's and physician's needs into account.

2. **Gathering Information**
   - Encourages patient to tell story chronologically
   - Question style open to closed
   - Listening attentively, not interrupting, allowing patient time
   - Facilitation – use of encouragement, silence, repetition, etc.
   - Cues
   - Clarification
   - Summarisation to patient - at intervals to check own understanding
   - Language

3. **Understanding Patient’s Perspective**
   - Ideas/Concerns/Beliefs/Feelings
   - Effects
   - Expectations
   - Picks up on cues

4. **Providing Structure**
   - Summarising
   - Signposting
   - Sequencing – logical sequence
   - Timing & keeping to task

5. **Developing Rapport**
   - Non-verbal behaviour
   - Appropriate level of note taking
   - Not judgmental
   - Empathy & support
   - Sensitive

6. **Involving Patient**
   - Explaining thinking/rationale
   - Explaining examination

7. **Explanation**
   - Comprehensive & appropriate information according to each patient’s needs.
   - Correct type, amount & level of information
   - Clear information – avoid jargon
   - Timing of information
   - Avoiding premature reassurance

8. **Aiding Recall and Understanding**
   - Emphasis and use of aids
   - Prioritising information
   - Asking patient to restate

9. **Achieving a Shared Understanding**
   - Explanations linked to patients’ views, problems & requests for information
   - Invites questions
   - Sensitive to patients’ signs of puzzlement, overload, etc. – picks up cues
   - Asks how patient feels about information

10. **Planning**
    - Shared decision making
    - Negotiates, offers choices, encourages patient to contribute ideas and preferences, checks patient’s acceptance and decisions

11. **Closure**
    - Summarises, Agrees next step, Any final questions
Exercise 10.

You have been presented with a large number of models and undoubtedly you will feel rather shell shocked, therefore the following exercises are designed to help you get to grips with the important aspects of the information provided above.

Look back at each of the models and try to write down a few words that would help you remember the uniqueness of each (assuming each is unique!)

<table>
<thead>
<tr>
<th>Name of model</th>
<th>Year</th>
<th>Key words from you</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Psychological and Social</td>
<td>1972</td>
<td></td>
</tr>
<tr>
<td>Six Category Intervention Analysis</td>
<td>1975</td>
<td></td>
</tr>
<tr>
<td>Transactional Analysis</td>
<td>1976</td>
<td></td>
</tr>
<tr>
<td>Byrne and Long</td>
<td>1976</td>
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<tr>
<td>Stott and Davis</td>
<td>1979</td>
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<tr>
<td>Helman's 'Folk Model'</td>
<td>1981</td>
<td></td>
</tr>
<tr>
<td>Pendleton, Schofield, Tate and Havelock</td>
<td>1984</td>
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<tr>
<td>The Disease - Illness Model</td>
<td>1984</td>
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<td>Neighbour</td>
<td>1987</td>
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<tr>
<td>The Calgary-Cambridge Guide</td>
<td>1996</td>
<td></td>
</tr>
</tbody>
</table>
Exercise 11.

All the models have a number of headings such as "Developing Rapport", "examination" or "prescribing" etc. See if you can come up with a common list of headings that most of the models say something about, possibly start with the three headings suggested in the previous sentence.

You may find in the end that whereas most models have a core set of headings each one also has a unique heading to itself. You will also come across instances of synonyms and homonyms.

Exercise 12.

Using the results from the previous exercise try to put them into some order of usage for a typical consultation, you may need to have several headings running simultaneously and probably the best way to show it would be to use some sort of diagram.
8. The birth of the expert consumer

Both the three function model and the Cambridge-Calgary model give more power to the patient and with this general trend the concept of the expert patient has developed. The idea that patients should be informed, involved in decision making and share the burden of responsibility (some would argue this is a form of personal blaming) has been slow to develop. Why is this? Important factors such as age, race and class all influence to degree to which patients are willing to take on this new role which is very different from the normal 'sick role behaviour'. The abstract below makes this clear.


The sick role is a concept arising from the work of the important American sociologist Talcott Parsons (1902–1979). Parsons was a structural functionalist who argued that social practices should be seen in terms of their function in maintaining order or structure in society. Thus Parsons was concerned with understanding how the sick person related to the whole social system, and what the person's function is in that system. Ultimately, the sick role and sick-role behavior could be seen as the logical extension of illness behavior to complete integration into the medical care system. Parsons' argument is that sick-role behavior accepts the symptomatology and diagnosis of the established medical care system, and thus allows the individual to take on behaviors compliant with the expectations of the medical system. Basically, Parsons defined the "sick role" as having four chief characteristics.

- First, the sick person is freed or exempt from carrying out normal social roles. The more severe the illness, the more one is freed from normal social roles. Everyone in society experiences this; for example, a minor chest cold "allows" one to be excused from small obligations such as attending a social gathering. By contrast, a major heart attack "allows" considerable time away from work and social obligations.
- Second, people in the sick role are not directly responsible for their plight.
- Third, the sick person needs to try to get well. The sick role is regarded as a temporary stage of deviance that should not be prolonged if at all possible.
- Finally, in the sick role the sick person or patient must seek competent help and cooperate with medical care to get well. This conceptual schema implies many reciprocal relations between the sick person (the patient), and the healer (the physician). Thus the function of the physician is one of social control.

Once again we have returned back to the discussion of power the above abstract indicated that the professional very much holds the power yet in several of the consultation models, including the patient centeredness check list, we have seen an attempt to move the focus of control away from the doctor towards the patient. To get more of a feel of patient centeredness and empowerment please work thought the activity below.

Exercise 13.

Please read through the following two articles, and listen to the radio program:

   At: http://bmj.bmjournals.com/cgi/reprint/318/7177/186

   At: http://bmj.com/cgi/content/full/326/7402/1279

3. You can find a link to the radio program at: www.robin-beaumont.co.uk/virtualclassroom/expertp/index.htm
For some unknown reason the references for Liam Donaldsons article above are missing from the pdf version so I have reproduced them below:


I think we will be seeing a lot more of the expert patient programme in the coming years in the UK, harnessing the knowledge they have to help develop support groups and make more effective use of resources I believe this will be a very important aspect of the NHS which has not been investigated so far.

There is also the possibility that the birth of the expert patient may encourage the development of new consultation models, Here are just a few possibilities:

- The inclusion of a patient expert as an additional member of the consultation (similar to how advocates and professional experts, such as stoma nurses, are used at present)
- Within the context of chronic disease management the development of pre-consultation interviews with an expert patient
- The more systematic use of resources produced by expert patients
- The possibility of creating locally based training schemes for such expert patients within each GP practice.

8.1 Personal Recovery

Whereas the focus in the expert patient program is that of the chronic condition, although this is changing and the ‘patient’ is beginning to be replaced with ‘person’, an alternative model for acute psychiatry illness is that of personal recovery which is only just beginning to be developed. The quote below is from the book Personal Recovery and Mental Illness: A Guide for Mental Health Professionals by Mike Slater OUP 2009

Recovery is a concept which has emerged from the experiences of people with mental illness. It involves a shift away from traditional clinical preoccupations such as managing risk and avoiding relapse, towards new priorities of supporting the person in working towards their own goals and taking responsibility for their own life. This book sets an agenda for mental health services internationally, by converting these ideas of recovery into an action plan for professionals. The underlying principles are explored, and five reasons identified for why supporting recovery should be the primary goal. A new conceptual basis for mental health services is described – the Personal Recovery Framework – which gives primacy to the person over the illness, and identifies the contribution of personal and social identity to recovery. These are brought to life through twenty-six case studies from around the world.

Exercise 14.

The radio program Freud & fund managers - fabricated or induced illnesses - the recovery model is available as a download at the radio 4, ‘All in the mind’ website at: http://www.bbc.co.uk/programmes/b00ktcb2

Select the program for 8/9 June 2009 if you are not already there, and listen to the last 10 minutes of the program, that is around the 20 minute mark, where they talk about the recovery model of mental health.
9. Neurolinguistic programming

This is a technique of assessing and 'enhancing' human communication and has been used as a modal for improving the quality of the consultation. There would appear to be no empirical study as to its effectiveness and there are both advocates and staunch sceptics to this technique. A non-critical article about it in the BMJ in 2003 caused a flurry of derogatory replies.

Exercise 15.

The original article in the BMJ

Walter J, Bayat A 2003 Neurolinguistic programming: the keys to success: verbal communication

The comments about the article: http://bmj.bmjournals.com/cgi/eletters/326/7389/S83#30563 and also a good review from a sceptics perspective in Robert Todd Carroll's the sceptics dictionary: http://skepdic.com/neurolin.html
You will need to register to see these articles.

10. Summary

Exercise 16.

This is the most important exercise in this chapter.

You have looked at a large number of consultation models and considered in depth various aspects of the consultation. The purpose of all this is to help you to find a model that suits you, both personally and professionally. You may feel that you need to adopt various aspects from several models or alternatively just choose one piecemeal. The important thing is to constantly re-evaluate your choice and work in a methodical manner.

If you are working through this chapter as part of an online course use the forum/discussion board to develop your ideas as a group, otherwise write down your initial impressions.

In this chapter we have looked at various aspects of the consultation, the most important thing is that you have managed to choose a model with which you are comfortable.

One important aspect of many of the models is their degree of patient versus doctor centeredness. Whereas in the past such an issue was considered to be quirky, but now with the increasing prominence of the 'expert patient' concept, it is no becoming a central consideration.

Unfortunately being a member of a professional organization, not to mention other external pressures, means that standards of care apply so the dual approach suggested by the Calgary-Cambridge model where there is an attempt at integrating both the patients and health care professionals desires is attractive.

I hope you have enjoyed working through this chapter and welcome feedback as to how I might improve it.

The next chapter looks in detail at the diagnosis, prescribing and recording aspects of the consultation.

Robin Beaumont 17/01/2012 12:52
11. References

Byrne P S  Long B E L 1976 Doctors talking to Patients: London HMSO
Cruickshank, P. J 1986 Patient rating of doctors using computers. Social Science & Medicine, Vol 21(6), 615-622
Heron J 1975 A Six Category Intervention Analysis: Human Potential Research Project, University of Surrey
Kultgen, J. 1982 The ideological use of professional codes. Business and Professional Ethics Journal I , 3 (Spring), pp. 61, 64.
Neighbour R The Inner Consultation 1987 MTO Press; Lancaster
Stewart Ian Jones Vann T A Today: A New Introduction to Transactional Analysis Lifespace Publishing 1991
Stewart M et al 1995 Patient Centred Medicine Sage
Working Party of the Royal College of General Practitioners 1972
12. Appendix A - The medical history

From www.mds.qmw.ac.uk/biomed/kb/year3/cmcsqguide/history.pdf authors name not given.

The aim of obtaining the patients medical history is to adequately define the nature and history of the problems. Below are listed the areas of enquiry you would follow and are presented in a logical order. This is not necessarily the order the patient will tell you them nor necessarily the order in which you would write them up. Note that as well as the biomedical information a history includes psychosocial information and the patient’s view of the illness.

A. History of Presenting Complaint (HPC)
   1. Characteristics of symptoms - for example in the case of pain the following information is required:
      - Site
      - Onset
      - Character
      - Radiation
      - Alleviation
      - Time (duration/past experience of symptoms)
      - Exacerbation
      - Severity
   2. Context - what were the circumstances of the onset of symptoms (physical, social, psychological)
   3. Response to symptoms - what the patient has done about symptom.
   4. Consequences - what do symptoms interfere with (physical, social, psychological)
   5. Patient’s understanding & own views about cause, implications and treatment. What have they been told.
   6. Concerns and worries

B. Review of Systems (ROS)
   Brief structured review of body systems which were not discussed in the HPC

C. Past Medical History (PMH)
   1. Medical
   2. Surgical
   3. Obstetric
   4. Allergies
   5. Medication

D. Family History (FH)
   1. Current health of parents, siblings, children
   2. History of significant illnesses

E. Social History (SH)
   1. Home environment -
      - living arrangements
      - who is resident
      - nature of relationships
   2. Support/secondary gains: how family and friends have responded to illness, sources of stress and support
   3. Sexual function: any difficulties
   4. Important losses: deaths, separation, divorce
   5. Work history/job satisfaction
   6. Other areas: Finance/interests
   7. Nutrition, diet e.g. dietary beliefs & meal patterns
   8. Smoking, alcohol, drug use

F. Mental Status Evaluation * (Including past psychiatric history, mood changes, changes in sleep/appetite, memory or cognitive changes, disturbing thoughts or ideas).

G. Treatment History (TH)
End of chapter