The exceptional potential in each primary care consultation

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SUMMARY. A four-point framework is described which has been found to be helpful for general practitioners who try to achieve greater breadth in each consultation. The framework has also provided a useful stimulus in undergraduate and postgraduate teaching, because it provides a nomenclature to identify four major components of clinical practice which are particularly relevant to primary care.

Introduction

'COMPREHENSIVE primary care' is an attractive concept with a growing descriptive literature but the principles involved are still difficult to present in a succinct and practical way. Even the students who appear to have understood the principles of comprehensive care often fail to apply them in the consulting room and the five 'areas' described by the Royal College of General Practitioners (1972) in *The Future General Practitioner* provide a conceptual framework of the content of primary care rather than an aid to individual patient care which can be applied simply and quickly. A rift still exists between our understanding of the theory and practice of primary care and this has serious implications for teachers, patients, and students.

What appears to us to be missing is an acceptable concept of the practical potential in every single consultation in primary care which can be easily memorized, understood, and used. The basis of such a concept should be intimately related to the decisions which can face every primary care physician, whatever his or her educational background and within whatever system of care he or she operates.

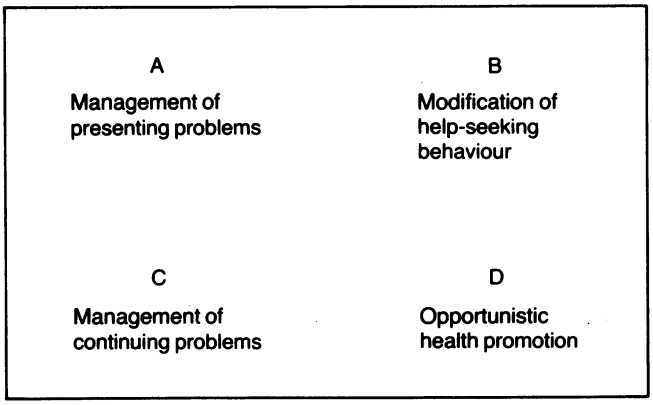
We present such a clinical framework which is designed to reveal the practical potential in each doctor/patient contact by highlighting four large areas, each of which embraces many skills which the primary clinician can use to his patient's benefit. The junior undergraduate can be expected to learn the basic outline, which is subsequently elaborated by the acquisition of appropriate knowledge, skills, and maturity.

Postgraduates can also be encouraged to consider the clinical decisions they take in every consultation against the framework because it clarifies the practical implications of many of the concepts and ideas which have been described in *The Future General Practitioner* (RCGP, 1972) and by the Leeuwenhorst Working Party of European Practitioners (1977) in 1974. The objectives of the framework are:

1. To provide a theoretical base from which a practitioner can develop the full potential in any primary care consultation.

2. To highlight some unique features of good primary care.

Figure 1. *The potential in each primary care consultation—an* aide-memoire.



3. To provide a basis for teaching in primary care which is simple enough for the undergraduate but equally valid for the postgraduate when more detailed knowledge and skills are included in the same basic structure.

4. To allow the philosophy, principles, and research achievements in comprehensive care to be discussed within a simple patient-centred framework.

The clinical framework shown in Figure 1 is not another classification of knowledge, skills, and attitudes. It is used to reveal potential skills which can be used in each doctor/patient contact and to be complementary to existing classifications of the content of primary care.

Use of the clinical framework

Realization of the full potential in each consultation depends on the clinician's ability to communicate with his patients and on the organization of the primary care services (Zola, 1973; Doyle and Ware, 1977). No clinical framework can be a fully successful *aide-memoire* if either of these general aspects of the primary physician's work is impaired.

The skill of active listening is much more than conventional history taking and it is appropriate that primary care is becoming the laboratory of many who have the vision to research into and teach interview skills (Byrne and Long, 1976; Verby, 1976; Alexander *et al.*, 1977).

However, primary health achievements are also partly dependent on individuals or agencies other than the doctor, and the World Health Organization is showing growing interest in innovative community health projects which have demonstrated that effective teamwork between clinicians, paramedical workers, and lay leaders can create new potential for health promotion (Newell, 1975; Barr and Logan, 1977). This widening of the primary care role is still little evaluated but it is probable that the primary consultation will become an important motivating instrument towards schemes which can be organized by the lay public, or by other professionals, and which operate beyond the confines of the clinic (Stott, 1976).

Our framework (Figure 1) deals with the clinician's potential actions and comprehensive care is a blend of the four inter-relating areas A, B, C, and D. This allocation of letters to the four areas aids recall and provides a convenient shorthand, but in this presentation A and C will be discussed first and B discussed last to avoid repetition which would otherwise be necessary.

Areas A and C. The management of presenting and continuing problems

At the centre of every consultation is the patients problem or problems which have been brought to the clinician and most medical time is spent dealing with these presenting problems (Area A). Indeed, most traditional clinical teaching is focused on the diagnostic and therapeutic processes and the evolving discipline of primary care has emphasized the importance of combining clinical acumen with insight into human behaviour and development in the comprehensive assessment of patients' problems (RCGP, 1972). The integrated physical and psycho-social formulation is relevant to every specialty but it is exceptionally important in primary care because techniques which are increasingly used by the trained family doctor depend on this widening of the diagnostic process.

The systematic supervision of continuing problems (Area C) has never been as attractive as Area A but the increase in chronic disease and the remarkable efficacy of some medical treatments have forced clinicians into their present position of having to treat and monitor diseases which can persist for many decades.

At every consultation the primary care worker has to ask himself the question: What continuing problems are there to be dealt with while the patient is with me? For example, a four-year-old girl with a past history of a squint presents to the general practitioner because she has earache. She has been seen only twice for minor ailments during the past three years. The doctor may deal with the acute otitis media alone (Area A) or take the opportunity to review or arrange to review the child's vision, even though her mother did not come to the doctor with this in mind (Area C).

The importance of primary care workers being willing to think in continuity terms (Area C) has to be stressed repeatedly because many students and young doctors find it irksome to widen the consultation deliberately from the presenting problems (Area A) to the often asymptomatic continuing problems (Area C). It demands a more comprehensive view of the patient and it can be time-consuming, so the time allocated for each consultation can have an influence on how successfully Area C is practised.

In the affluent nations there has been an attempt to develop computer recall systems to guarantee continuity of care for conditions such as hypothyroidism. Elegant as these systems are, they can cater only for a fraction of the problems requiring the clinician to be aware of Area C in every consultation. Other conditions which often exemplify this principle are: hypertension, anaemia, contraception, psycho-sexual problems, deafness following recurrent ear infections, antenatal care in the poor attender, and indeed any patient who is on regular therapy (repeat prescriptions). In the UK, where the average general practitioner sees 90 per cent of his patients every three years, the potential for unobtrusive attention to the continuing causes of disability is enormous and proper use of the primary care team will make this process even more efficient.

Knowledge of the family and its environment is often helpful when forming management plans for continuing problems and the most obvious tool to help skill in applied continuity is a good medical record; but even in

the absence of a record, the clinician who has been trained to be aware that continuity is necessary to deal with some clinical problems will use time, investigation, prescribing, and referral more appropriately.

High-risk groups are those who suffer hardship through discontinuity or who enjoy using discontinuity of care to gain drugs or episodic attention. It is too easy to treat each presenting problem but to fail to perceive the manipulations or cries for help which lie behind successive acute episodes of minor illness. The existence of a personal doctor does not necessarily provide continuing care because he too can be deaf to what the patient is saying, or fail to recognize the signs revealed by the medical record, or be blind to how much is hidden by a lack of records in a clinic which is too busy for methodical record keeping.

Sometimes continuity of care breaks down because of excessive demand, patient numbers, population mobility, shared care, or poor organization. The appropriate strategy to overcome these problems will vary from place to place, although it seems likely that additional time per patient and improved skills in primary care will need to be coupled to a review of the clinic or practice organization. This review will often lead to improvement of medical records and greater use of ancillary staff to reduce the load on clinicians (Stott and Davis, 1975; Marsh and McNay, 1974).

Area D. Opportunistic health promotion

One of the most exciting and controversial components of every consultation is the opportunity it provides for both the promotion of healthy life-styles and early or pre-symptomatic diagnosis. The former extends the traditional content of the illness interview to include helping the patient to identify one or more aspects of his/her life-style which could be changed in the interests of better adaptation to his/her environment before disease develops; for example, dietary changes, appropriate exercise, attitudes to interpersonal relationships, or habit modification. The latter embraces the vexed question of pre-symptomatic diagnosis and treatment in patients who attend the clinician for some other reason and educationalists face a challenge to decide which diagnostic procedures are justified by their outcome (RCGP, 1972). For example, blood pressure measurement in the 40-and-over age group.

Modern understanding of disease pathogenesis has shown that many of the current major causes of morbidity and mortality have their origins in the life-style of individuals. Every student of medicine should appreciate the unique potential of the illness interview for health promotion because the patient and relatives are often very receptive to advice from the doctor or nurse at this time (Russell, 1971; Truax and Mitchell, 1971; Stott, 1976; Eiser, 1977). Furthermore, methods which involve individual teaching—one-to-one discussion—are widely recognized as the most successful strategies in producing health-related behavioural changes (MacQueen, 1975).

There is also abundant evidence that future improvements in the major causes of mortality and morbidity in most parts of the world are more likely to come through modification of personal life-style than through legislation (Belloc, 1973; Committee on Child Health Services, 1976; DHSS, 1976).

Unfortunately, many doctors, largely as a result of their training, are reluctant to use their influence to encourage health-promoting behaviour in the absence of disease whereas they have no difficulty in offering advice about diet, exercise, habits, or relationships once a diagnosis has been made which can be attributed to illness-inducing behaviour and when it is often too late for the behaviour change to be effective. A caring profession should not withhold its knowledge and influence to help patients make appropriate life-style choices if this will reduce the likelihood of later ill health.

However, the objective of Area D can be only to ensure that the patient leaves better able to make informed choices. The clinician can try to develop methods which help the patient to grasp the practical issues but he should not allow the patient's response to modify his caring role in future disease episodes. This implies mutual adult respect and a change of the traditional attitude towards patients who reject the advice proferred by the physician.

The application of Area D to every consultation will involve the question: Is it appropriate to try to help this patient to modify his/her life-style in the interests of long-term health? When the answer is in the affirmative the clinician can be assured that he is well placed to use his influence by advice alone, but other strategies may enchance the likelihood of practical acceptance.

The well organized 'referral chain' extending outwards into the local community from the initial motivation by doctor or nurse is an example of a wider technique to help the patients step from 'knowledge' to 'behaviour change' (Stott, 1976), and self-help groups or clubs can also be utilized if informed leadership exists locally. Much more research is needed into Area D methods but the principles which have undergirded the development of a 'referral chain' into the community merit careful consideration by more affluent societies.

Area B. Modification of help-seeking behaviour

Area B embodies the assumption that each consultation may in some way influence the patient's future help-seeking behaviour and that recognition of this fact should lead to better patient care. The most straightforward illustration of this principle is Marsh's (1977) demonstration that a practice policy to stop prescribing for minor ailments coupled to a programme of patient education will lead to a lower demand for medical care for such illnesses. The incidence of coryza is not

changed but the expectation for medical treatment may be altered and patients can begin to be more realistic about what doctors can or cannot treat effectively.

In Britain the implications of the medicalization of many social and trivial problems has been provocatively presented in *The Health Care Dilemma* in which the Office of Health Economics (1975) calls for a fresh philosophy and attitude towards ill health in the population. Similar views have been expressed by Crombie (1974), Illich (1977), and others and illustrate the rapid evolution of the theory and practice of Area B. However, consideration of the clinician's role in determining help-seeking behaviour embodies both inappropriate under-use of medical services and their over-use.

An objective of the framework in Figure 1 is to highlight the need for every clinician to consider whether his management plans take cognisance of future help-seeking behaviour. Kaolin for diarrhoea, antihistamines for colds, codeine for coughs, or aspirin for aches . . . each is sometimes justified, but each is much more than a symptomatic prescription; it is also a ticket to reinforce the patient's belief that the doctor has a solution for such minor ailments. Thus patients' expectations are set and the waiting room becomes so full that the practitioner has little time to explain what he is treating, or to ensure that the child with a urinary infection is adequately followed up, or the woman with a recurring dysuria has a proper psychosexual history taken, or that the child with iron deficiency anaemia or kwashiorkor is perceived as the clear indicator to a need for nutrition education in the home rather than a problem which can be cured relatively easily by traditional methods.

In Africa the phrase "the revolving door of malnutrition" has been coined to describe the failure of traditional medical services to overcome the high incidence of recurrent malnutrition because children are healed in hospitals and returned to the social conditions which caused their illness initially. A comprehensive sociomedical approach has been shown to stop the revolving door in Africa (Stott, 1976) and so similar principles may be worth serious consideration to slow the revolving doors of the health care dilemma in Britain. Our experience suggests that we will be one step nearer to that objective if for every patient seen the doctor asks himself: What influence have I had on the future help-seeking behaviour of this patient and his/her family? When that question is posed thousands of times every day, primary care workers will probably begin to identify that they need fresh strategies which involve reaching out into the community, not just in terms of home visits as suggested by Pereira Gray (1978) but, more importantly, in terms of the establishment of realistic attitudes to the physical, mental, social, and spiritual development of our patients and their families. A major task ahead for the personal community health services is to give greater recognition to the methods which will encourage the realization of this potential and to have more insight into the activities which erode it.

Discussion

The framework described in this paper is complementary to existing analyses of the content of primary care, because it starts from the decisions and actions a doctor takes, rather than the underlying educational concepts or methods. This essentially practical approach is an extremely useful teaching aid because it widens the scope of every consultation by encouraging the clinician to consider the patient in a broad and practical way. One effect of this process is a growing awareness in the doctor of the limitations of short-term clinical solutions to many problems—particularly those that have their origin in human expectations and behaviour. For example, a young child with a dietary iron deficiency anaemia can be treated by giving iron therapy and diet advice (the traditional approach). However, as this anaemia is the product of faulty feeding habits, the family can learn more about the relationship between food and health by bringing their child back to health with judicious food choices alone. Furthermore, the child is less likely to become anaemic again if practical information rather than prescriptions are issued by the clinic (Area B).

The wisdom of this comprehensive approach extends well beyond the child's management because the process of maternal diet education has a potential impact on the whole family, by shifting the emphasis from a medicine bottle to food choices. The growth and development of siblings, grandmother's constipation, and perhaps even parental ischaemic heart disease risk factors could be modified by the skilled use of this child's consultation to motivate the mother to consider new food choices (Area D). Field experiments have shown that even semi-literate communities can benefit greatly from this approach if practical demonstrations of appropriate food choices and food preparation are developed to support the clinician's initial explanations to the patient (Stott, 1976).

An alternative strategy to prescribing is equally necessary to help many patients with problems involving anxiety, unhappiness, dyspepsia, loneliness, self-destructive habits, family conflict, and other common disorders. However, the example of the child with anaemia given above illustrates principles which may be difficult for the average practitioner to implement because he lacks the support of a nutrition education unit which has proved so successful in Africa. He may also be limited in his knowledge of alternative strategies and by the time he has with each patient. The goal of patient education may be unattainable without paramedical or lay support.

Nevertheless, the primary physician has an unequalled opportunity to balance long-term health

needs against short-term clinical pressures. He can practise from a broad clinical base by integrating the psycho-social and biological components of each illness (Area A). He can implement applied continuity of care to a defined population by learning to use the skills and aids which are required to achieve this (Area C). He can also make maximum use of the opportunities for health promotion (Area D) and thereby begin to discover the need to modify the traditional clinical approach. Finally, he can permit his growing knowledge and skills in the modification of help-seeking behaviour (Area B) to influence his clinical decisions, his practice organization, and his relationship with his patients. The larger number of patients coming to primary care, the nature of their problems, and the relationship they may have with their doctor—all reinforce these opportunities in a way not usually possible for other specialties.

Clinicians who feel nihilistic about Areas B and D are usually unwilling to concede that comprehensive care works on a much longer time-scale than traditional medicine and that our understanding of this young discipline is leading towards greater recognition for the need to have major re-orientation of our primary clinics and the relationship they can have with the community.

We have much to learn and test about the way in which we organize primary care and the relative emphasis placed on the four areas in Figure 1 will vary according to the availability of skills and resources; for example, in under-developed parts of the world, with severe under-doctoring, it is appropriate that the curative services should be seen mainly as a spearhead to primary prevention, although this is seldom achieved.

A nation's ability to afford an expensive curative medical service does not, however, guarantee a comprehensive approach, because episodic care remains more common than continuing care and reluctance to ask the questions of Area B is as common as destructive negativism to Area D, often because medical education and clinic organization have lacked these qualities and secondary care has dominated health service planning.

We believe that the potential in every consultation should be taught to undergraduates and postgraduates, so the next generation of doctors will begin to expect the skills and structures required to carry the special responsibilities of each primary care consultation and then organize their services accordingly.

This framework is intended to be an *aide-memoire* which encourages the primary physician never to forget the potential of each consultation, even if he cannot realize it fully owing to personal or organizational restraints.

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