The Frankenstein consultation model

I've created a monster! I've always found it heartening that much of the essential skills and knowledge of our discipline of general practice centre on defining and describing our key tool — the consultation.

Having a varied set of models of the consultation was not just an interesting academic exercise, but was useful in seeing the many patients with problems not easily defined within a narrow biomedical window. These models were like having various maps of a country. In the same way I might use different maps to tell me about the terrain I found myself in — here were the roads I could take, here are the geological rock formations we walk on, here are the income gradients — models of the consultation might show me tasks I had to accomplish, or the psychological interactions playing out, or the cultural roles we were playing.

However, like Frankenstein, I've tried to create something more powerful, by stitching together parts of other consultation models. I've found particular parts of particular models more useful than others, which has led me to discard parts and try to reanimate my consultations with the parts of the models that give them life. Gone are the long lists of tasks and subtasks to be accomplished from the Cambridge-Calgary framework,[1] to be replaced with just two essential tasks — make sure the patient doesn't die in the car park; and make sure they have a reason to come back. I haven't memorised all of Cecil Helman's anthropological folk model,[2] but it does remind me that patients have their own agenda, and, in broad terms, it follows predictable patterns. David Pendleton,[3] on the other hand, reminds me that I might not be able to predict the patient's agenda, and I need to seek out their ideas, concerns, and expectations, even if I've forgotten his other tasks.

I do remember Eric Berne telling us about transactional analysis,[4] and that we can flip psychoanalytically between parent, child, and adult, though I usually remember this after clinic has ended. I do find myself using his ideas of repetitive patterns of behaviour — 'games' — especially the game 'wooden leg', where a patient's impediment is unconsciously used as a barrier to problem solving.

The monarch of all consultation models, Michael Balint,[5] gets to supply two body parts to my monster. Balint described *'the collusion of anonymity'*,[6] the phenomenon where a patient sees multiple providers for their care, none of whom take any responsibility for actually looking after the patient. Then he describes the Doctor as a Drug (*'The doctor herself/himself is the most frequently prescribed medication'*),[6] crucial in recognising that the interaction that we have and the person that we are has a therapeutic effect on the patient, even if we don't know the pharmacodynamics or toxic doses.

The final part of my creature comes from Roger Neighbour.[7] His use of mindfulness techniques to be fully present in the consultation is always useful, but many of you, like me, will journey through the consultation, ticking off his checkpoints on your fingers. However, whatever happens in the consultation, my day is always made better by making it to the fifth checkpoint, Housekeeping. This is the part between consultations where you look after yourself. When I'm running late, sometimes just knowing that one of our major text books says it's OK to go to the loo and grab a glass of water between patients can be very reassuring!

Like most monsters, mine lumbers around a bit, but hopefully it will turn out to be more helpful to me, rather than showing up my own infinite hubris.

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