Consultation styles for pre-travel risk assessment.

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Objectives

• To realise that there is a range of consultation styles are based upon medical studies.

• These consultation styles do not individually reflect all of the skills required for a pre-travel consultation.

• To consider an adapted consultation style that reflects the wider range of skills required when completing a pre-travel risk assessment.
Importance of consultation and Risk Assessment (RA)

• The completion of an RA is only part of the patient/practitioner interaction with the remainder being the style of the consultation with the patient. (1)

• Many theoretical styles of consultation are published and documented. (2)

• These consultation styles are based on the traditional medical practice of the practitioner interacting with people who frequently deem themselves to be unwell.
Do the same consultation styles apply for pre-travel patients as non travellers?

• The Royal College of General Practitioners (RCGP) published in their statement (3) the changes that were needed to be made and understood with general practitioners were, “illness presenting in general practice requires a normality-orientated approach, as opposed to the disease-orientated approach in secondary care”.

• In the thesis by Wilcox, it is indicated that a travel health consultation is not linear and the rule-based models of Pendleton and Neighbour do not work with the social rules that govern behaviour and interactions (4).
Theoretical medical consultation styles

• Pendleton (1984)
• Neighbour (1987)
• Cohen-Cole and Bird (1989)
  • Launer (2002)
Pendleton, Schofield, Tate and Havelock (1984)

‘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.
Pendleton (1984)

Positives

• Considers other problems e.g. Risk factors
• Shared action with the patient

Concerns

• Defining reasons assumes the patient has a knowledge of the diseases for prevention or action.
• Achieving full shared action is unable to reviewed as compliance to malaria prophylaxis for example has no external patient measurement and the decision making surrounding the proposed vaccinations is subject to other influences e.g. cost.
Example 2 - Neighbour (1987)

Neighbour (1987) Five check points: ‘where shall we make for next and how shall we get there?’

• (1) **Connecting** - establishing rapport with the patient

• (2) **Summarising** - getting to the point of why the patient has come using eliciting skills to discover their ideas, concerns, expectations and summarising back to the patient.

• (3) **Handing over** - doctors’ and patients’ agendas are agreed. Negotiating, influencing and gift wrapping.

• (4) **Safety net** - “What if?: consider what the doctor might do in each case.

• (5) **Housekeeping** - ‘Am I in good enough shape for the next patient?’
Neighbour (1987)

**Positives**
• By summarising all the known points of the traveler and the destination then the safety net activity will only be partially effective as the patient will ultimately determine the final selection often through financial influence.

**Concerns**
• Establishing the rapport- this expects that the patient knows they need some prophylactic measure and that their itinerary will not be changing. A recent study (6) indicates that pre travel history does not adequately reflect what patients do.
Example 3- Cohen-Cole and Bird (1989)

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

• (1) Gathering data to understand the patient’s problems- eg. Open ended questions, summarising and eliciting patient expectations

• (2) Developing rapport and responding to patient’s emotion- e.g. Reflection, partnership, respect

• (3) Patient education and motivation- e.g. education of the illness, negotiation of a treatment plan, motivation of non-adherent patients
Launer developed the concept of narrative based medicine, where there is no definite answer to why has the patient attended for consultation, as this often raises more questions as expected (7).

However in a BMJ article, the evidence based clinicians held onto the importance of their expertise. Launer’s theory places the emphasis of the clinical assessment draws on narrative overlapping ideas and views told by patients, clinicians and patient representatives.

As clinicians we select the most appropriate prevention of treatment on clinical grounds and disassociation is experienced when occurs when we the narrative paradigm is abandoned. (8).
Summary

In other words the skills that help the patient's understanding require the Travel Health clinician to include:

• An appreciation that the pre-travel history may not adequately reflect what patients do.

• Clinicians, patients and patient representatives all need to have agreed overlapping views on proposed treatment.

• To be specific to the timing of appropriate questions and to the spirit of the eventual outcome (e.g. what may occur if these vaccinations or prophylaxis are avoided or not completed) rather than the production of clinical evidence.

• Clinicians will trend to select the most appropriate treatment based on clinical evidence when the narrative paradigm is abandoned.
Proposed consultation style for travel health

To reduce the subjectiveness but still maintain the patient right of choice then the proposed consultation model could be adopted for such consultations:

1. Connecting to establish rapport (Neighbour)
2. Gathering Data (Three Function)
3. Define the reason for the patient's attendance (Pendleton)
4. Education and motivation (Three Function)
5. Narrative based handover (to raise points of concern and negotiate behaviour change) circularity and co-creation
6. Narrative based safety net- curiosity, contexts, caution
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References


5. Evans, Proposed Consultation style for Pre-Travel clinic assessment developed from existing consultation models, British Global and Travel Health Association Journal vol XXII 2013, 61-63, www.bgtha.org

