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How to conduct a clinical consultation in advanced practice

Authors Emma Mellors is lecturer advanced and specialist practice, and Vicky MacArthur is deputy programme lead advanced and specialist practice; both at Oxford Brookes University.

Abstract This article on clinical consultation is the first in a series on assessment and interpretation for nurses and other non-medics working at or towards advanced practice level. It discusses ways to recognise and capitalise on the opportunity offered by clinical consultation, how to incorporate and adapt consultation models for practice and the importance of communication skills as a driver for better consultation.

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Consultation is often viewed as the domain of the doctor or medic and many medical consultation models are traditionally designed for GPs. However, with the establishment of the advanced practitioner role, consultations are increasingly being led by nurses and other non-medics. This practical guide to consultation shows the value of this, both from a clinical skills perspective and in terms of modernising models of care, a theme at the heart of advanced practice (Health Education England (HEE), 2017).

Good assessment takes time, but investing this time up front has the potential to improve care, increase patient and clinician satisfaction and avoid further costs, both human and service, down the line.

Non-medics and advanced practitioners are often afforded more time to consult than is traditionally allocated to GPs, giving potential benefits in terms of optimising the consultation. Providing dedicated or high-quality time up front can allow an understanding of patients' long-term as well short-term needs, potentially slowing the 'revolving door' of healthcare. Non-medical professionals are ideally placed to challenge the existing healthcare paradigm through placing greater value on the clinical consultation.

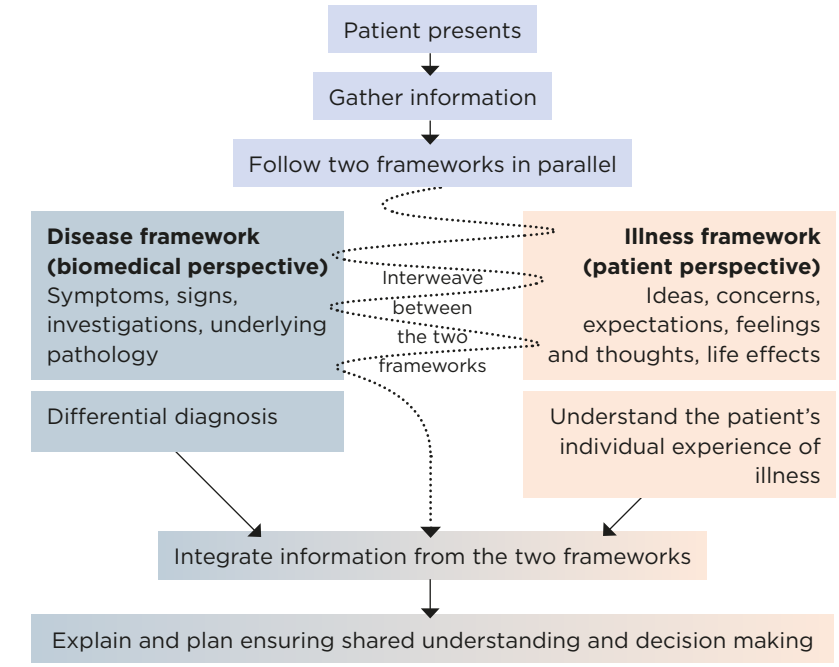
Consultation by an advanced practitioner may be distinct from that of a doctor. As well as clinical experience in their base profession, nurses and other non-medics bring extensive communication expertise and skill in building trusting and therapeutic relationships. Practising at an advanced level allows them to expand their scope of practice and push beyond traditional boundaries. There is also the opportunity to address patients' holistic needs early in the healthcare journey and effectively unlock, and quickly action, a pathway of care.

It is essential as an advanced practitioner that you work within your individual scope of practice and be open and candid with the service user, differentiating your role as a non-medic or advanced practitioner from that of a doctor's early in the consultation. Explain and clarify your role in the patient's journey. This can be achieved using education, a key pillar of advanced practice, early in the consultation to build trust and confidence and set realistic expectations.

Advanced practitioners

This series is aimed at nurses and midwives working at or towards advanced practice. Advanced practitioners are educated at masters level and are assessed as competent to make autonomous decisions in assessing, diagnosing and treating patients. Advanced assessment and interpretation is based on a medical model and the role of advanced practitioners is to integrate this into a holistic package of care.

Fig 1. **Disease-illness model**



Adapted from: Silverman et al (2013)

Consultation models

A consultation model can help bring structure to what is a pivotal moment in the

clinician-patient relationship. It can help you take that step into the unknown and assist with potentially stressful and challenging situations, as well as reassure service users. The path ahead may not always be clear, but the process can guide you on what to do next and show you and your patients what steps to follow to reach an optimal outcome.

Consultation models range from clinician-driven to patient-focused and task-orientated to those determined by clinician behaviours. Those discussed below are representative across the spectrum and most are used in practice today; their potential value is considered in developing a personalised consultation approach. Partnership working and person-centred approaches are at the heart of advancing practice, as evidenced by the capabilities in HEE's (2017) multiprofessional framework.

Traditional medical model

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

Physical, psychological and social model (Biopsychosocial or triaxial model)

This seeks to question beyond the biomedical, contextualising the presenting complaint by asking questions about the whole person to try to be more patient-orientated. However, it often only pays lip service to the psychological and social elements, asking a question on mental wellbeing or social history without more detailed context. Used on its own, it oversimplifies a person-centred approach and needs incorporating within a structured consultation framework (Mehay, 2012).

Patient-centred model (Helmann's folk model)

This model is truly patient-oriented, being all about the service user's perspective. It proposes the service user comes to the consultation with six questions, and it is the clinician's role to help the person find answers:

1. What has happened to me?
2. Why has it happened?
3. Why me?
4. Why now?
5. What would happen if nothing was done about it?
6. What should I or others do about it? (Helmann, 1981).

These questions seem almost philosophical, even though the answers could be enlightening and highly practical. One concern of clinicians is that this exploration is time-consuming and could fail to deliver the tangible outcomes expected from a traditional healthcare encounter. Although not comprehensive as a model to structure consultation, it does highlight service users' complex needs and agendas, which may compete with the clinician's.

Disease-illness model (Levenstein)

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

One of the most useful models in this respect is the disease-illness model, which integrates the clinician and patient perspectives (Levenstein et al, 1986) and is described by Mehay (2012) as sitting balanced between the two. It is a simple model that demonstrates the interplay between the needs and agendas of clinician and patient within a structured flow. Information gathering and decision making is done both within the context of the disease framework (biomedical perspective of a diagnosis) and illness framework (patients' perspective of their experience) (Silverman et al, 2013) (Fig 1).

One may be present without the other, but both need to be explored. For instance, there may be no medical diagnosis even though the person reports feeling unwell. Conversely, patients may be asymptomatic despite receiving a medical diagnosis (for example, hypertension).

This model can avoid too much focus on obtaining information toward a diagnosis without space for patients to express themselves. A shared understanding should be reached between clinician and patient, incorporating aspects of both disease and illness frameworks, and reflecting this in decision making.

Focus on clinician behaviours (Pendleton and Neighbour)

Models by Pendleton and Neighbour do not offer a fixed consultation structure but set out clinician behaviours for it to be effective (Neighbour, 2017; Pendleton, 1984).

Box 1. **Pendleton's consultation model**

1. Define the primary reason for the patient attending
2. Consider other problems that might be relevant, such as ongoing issues or potential risk factors
3. Work with the patient to choose appropriate actions
4. Achieve a shared understanding of the problem
5. Involve the patient in managing the problem and encourage shared responsibility
6. Decide how much time to allocate to the consultation in the context of the patient's immediate needs and the longer-term picture. Is it better to spend more time now to save time later or to just focus on what is necessary for the consultation?
7. Be mindful of the need to build and maintain a good working relationship with the patient

Source: Pendleton (1984)

Box 2. **Neighbour's consultation model**

1. Connect – build rapport with the service user to establish a working relationship
2. Summarise – use communication skills to find out the reason for a person attending and ensure shared understanding and logical identification of a potential diagnosis
3. Handover – return some control to the service user by engaging them in a shared management plan
4. Safety net – use prediction skills to set up a contingency plan with the service user in case things do not go to plan or new concerns arise
5. Housekeeping – attend to your own self-care, reflecting on your readiness for the next consultation and potential actions needed to re-set for it

Source: Neighbour (2017)

Both offer a pragmatic approach still relevant today with a logical flow of considerations. Pendleton's consideration of the patient's wider problems and the long-term value of investing time and resources up front is forward thinking. Neighbour focuses on building a good relationship between patient and practitioner, and clinicians practising self-care to create an

empathetic space for service user and clinician. The main considerations for each model are outlined in Box 1 and Box 2.

Structured model (Cambridge-Calgary)
Several models recognise the value of having specific steps to follow in navigating a consultation, which can be useful for the emerging practitioner. The 1996 Cambridge-Calgary model is considered the most comprehensive and evidence-based of these (Silverman et al, 2013). It incorporates elements of the disease-illness model in terms of the interplay between clinician and patient, but with an explicit focus on structure and flow and building an effective patient-clinician relationship (Silverman et al, 2013) (Box 3). In the development of this model, communication skills are recognised as crucial and are integrated into each step of the framework.

Communication process
Consultation can be viewed as the skilled application of everyday communication skills, which are as essential to the consultation as knowledge base, examination and problem solving. In this respect, how and when things are said are as important as what is said with the ability to influence the patient's journey (Silverman et al, 2013).

As with all skills, communication requires explicit acknowledgement, practise and refinement and any model is only as successful as the skill of the communicator. There will always be unknown and challenging issues encountered during a consultation and these cannot always be prepared for in a structured way. First encounters, follow-ups and routine reviews require a flexible approach; although the content will differ in each consultation, the same core skills and communication requirements apply.

Opening and closing the session with clarity is crucial. By approaching the consultation as a communication process, you can sensitively guide yourself and service users through any encounter.

Box 4 summaries key communication processes.

The art of listening
The art of delivering healthcare involves the ability to listen, which requires tact, skill and a willingness to hear (Green, 2011). However, paying attention to what patients say is sometimes easier said than done with competing demands on clinicians' time. Likewise, if patients feel they are being rushed, they may feel that they are not really being listened to. Even if this is not true, such a perception devalues the encounter and may make the person less willing to open up.

Neighbour (2017) identifies critical moments in the consultation where it pays to focus close attention:

- The curtain-raiser or first 15 seconds of the consultation, when you should not interrupt;
- A visible, internal search for information by the patient, which you should be able to identify;
- The patient censoring their own speech or saying nothing where a response might have been expected, which requires you to draw them out;
- Moments of turbulence in speech and body language, which can help you identify visible areas of concern.

"Listen to the patient, he is telling you the diagnosis" is attributed to Sir William Osler, a strong advocate for clinician-patient conversations (Sarasohn-Kahn, 2019). Never underestimate how much information can be gained from the patient before any physical examination or investigations are done. Gathering a thorough history can provide up to 80% of the information required to make a diagnosis, but listening carefully also contributes to a person-centred approach (Ospina et al, 2019). It is important to remember what you are trying to achieve and not allow procedure or routine to take over from your natural curiosity driven by your desire to help (Neighbour, 2017).

Narrative medicine
This encourages the patient to tell their story their way and is effective in putting the person at the centre rather than just focusing on the disease (Launer, 2022). In the diagnostic encounter the person's experience of illness is contextualised and meaning provided, allowing for greater expression of diversity. It also enhances empathy and shared understanding. Useful clues that might otherwise be missed are supplied freely and assist in the pursuit of holistic management (Greenhalgh and Hurwitz, 1999). This narrative approach embraces uncertainty without forcing the consultation down a linear pathway (Launer, 2018), potentially moving away from the idea of one central diagnosis and ideal treatment.

The seven Cs of narrative medicine are:

- **Conversation**: establish a genuine dialogue;
- **Curiosity**: come from a place of sincere interest and curiosity;
- **Context**: ask how the person is framing their story;
- **Complexity**: embrace the idea that there may not be a simple cause-effect;
- **Creativity**: can you help patients tell their story more clearly?
- **Caution**: be mindful it might not be needed for straightforward problems;
- **Care**: avoid taking it lightly as it requires your true engagement in the process (Mehey, 2012).

Clinicians may worry that this approach could be time-consuming in the

Box 3. **Cambridge-Calgary structured consultation**

1. Initiate the session – prepare, establish rapport, identify reasons for the consultation
2. Gather information – explore the problem from a biomedical and patient perspective, putting it in context
3. Physically examine the patient
4. Explain and plan – give appropriate information, ensuring shared understanding and decision making
5. Close the session – ensure appropriate closure and forward planning

Source: Silverman et al (2013)

Box 4. **Key communication processes in a consultation**

1. Greet the patient and initiate a relationship of collaboration and trust
   - Negotiate a shared agenda
   - Create an agreed structure for you and your patient to follow
   - Establish the patient's starting point, what do they understand?
2. Pay attention to what the person is saying
   - Assess the person's needs/wants
3. Pick up cues and read between the lines
   - Regularly check understanding
   - Encourage questions
4. Work out what to do next
   - Discuss options and perspectives
   - Allow time for the person to take things in
   - Provide support, advocacy and partnership
   - Explain and plan, relating this back to the patient's agenda
5. Arrange to meet up again if that suits
   - Provide closure by ending the encounter appropriately

Source: Neighbour (2017); Silverman et al (2013)

pressured healthcare environment. However, it could save time by getting to the crux of what really matters for the person, rather than trying to elicit this via closed questions that matter more to the clinician (Jones, 2022). On average, patients in a consultation are interrupted after 11 seconds, but without interruption find it easier to state their concerns in their own words, which takes far less time than clinicians anticipate (Ospina et al, 2019).

Incorporating a narrative approach could help focus the time patients and clinicians spend together, enhancing the relationship and optimising the outcome of any consultation. The concern that a narrative approach to consultation is time consuming can be addressed by first negotiating the agenda and signposting the patient through the process so that they are clear when the session is ending. Launer (2018) shows the practical steps to take when using a narrative approach, which can move the clinician away from taking a history towards building one (Box 5).

Be guided by clinical reasoning

People are more than a list of signs and symptoms, with individuals reporting problems that affect their lives. Asking patients to prioritise these problems in order of disruptiveness is useful for grouping multiple complaints in a way that makes sense to them. Using a timeline allows problems to be connected and elements of a narrative to be correlated into a bigger picture that takes into consideration the whole person.

People do not present like textbook cases and not everything will fit into a neat differential diagnosis. There could be more than one disease process even if there is only one illness narrative, so leave enough room to adjust your judgements as new information and findings come to light. Deal in theories not certainties.

Physical examination

This should seek to test theories formulated from a carefully taken history (Launer, 2018). Rather than applying tests blindly, they are used to give insight in building up a picture and correlated to form a reasoned judgement.

Planning

This does not require firm conclusions, only enough information to come up with a safe and holistic plan involving patients themselves and the wider clinical team. Ensure you have a low threshold for follow-up, taking into consideration continuity of care and safety netting (Morgan et al, 2014). As an advanced practitioner, you should be capable of addressing the patient's needs and providing practical advice and extending the scope of care where possible. Do not underestimate the power of patient information and reassurance.

Process versus content

Shifting the emphasis from only looking at the content of the problem to how it can be solved can unlock greater value compared with a content-centred model that frames the presenting problem as something the clinician uses their expertise to solve (Schein, 1989).

An emphasis on process also promotes collaboration in problem-solving, which is more likely to give an acceptable solution to service users (Rockwood, 1993), and enhance their independence and self-management skills for the future. The clinician can move between content and process consultation, according to what the situation requires in terms of their expertise (Schein, 1989). However, consultation is a chance to empower and upskill the patient, not just to investigate and inform. The process of storytelling and artful listening alone may provide healing and transformative healthcare experiences (Green, 2011)

Box 5. Using a narrative approach to gather a history

1. Start the encounter with an open question (What can I help you with today?)
2. Allow the person to tell their story uninterrupted for three minutes, signposting them or informing them directly of this
3. During this time, use non-verbal prompts to avoid interrupting the person's flow
4. After three minutes, follow with brief verbal prompts directly linked to their story to confirm certain points (for example: How long? Can you clarify what you meant by this?)
5. Having confirmed the relevant points, indicate you are moving the consultation on to gather other information
6. Complete the history by asking more directed questions to gather missing information and help formulate a differential diagnoses
7. Explain your initial thoughts and signpost to the next stages of examination, referral or follow-up

Adapted from Launer (2018)

Adapt and evolve

Consultation models, many of which have overlapping features and goals, offer clinicians insight, structure and guidance to help develop their consultation skills (Carter, 2018). Achieving optimal results from a consultation requires a strong focus on verbal and non-verbal communication skills, listening, signposting and artful questioning (Silverman et al, 2013) alongside the ability to flex and adapt in moving between models (Mehay, 2012) . A model is not a set of rules to be followed, but a tool with its own pros and cons, which you can draw on in different situations to meet varying requirements.

Most models are designed with face-to-face consultation in mind, but the convenience and opportunity of technology for remote consultation should also be embraced. Patients should be offered a personalised, flexible hybrid blend of in-person and remote options according to need and preference, available resources and consultation purpose (Hawley-Hague et al, 2023).

Patient-centred consulting models have moved on considerably and are preferable to clinician-focused and task-driven models. However, clinicians' needs are often not met in dealing with the stress of trying to keep time while staying calm and professional, keeping good documentation and ensuring they keep their patients safe.

Clinician wellbeing is inseparable from quality of care, and a shift is required towards clinician-sensitive consulting (Mirza, 2019) or relationship-centred care (Nolan et al, 2001) to ensure clinician resilience and longevity (Mirza, 2019). This requires a contextualised negotiation between service user and clinician needs, rather than one being sacrificed for another.

Communication skills are key to building trust and rapport. A transparent, collaborative approach is more productive and empowering for both patient and clinician. Thinking differently and embracing change is at the heart of evolving new models of care needed to meet the population's increasing comorbidity and complexity needs.

Service users and clinicians are seeking greater satisfaction from their clinical encounters and narrative medicine may be an untapped approach that is easier to incorporate than clinicians might imagine, although it may require a leap of faith to try it out in practice.

Successful consultation requires combining what works with personalised adaptations. It is also about having the confidence to be creative and innovative, knowing you are building the foundations for a person's onward care journey.

Box 6. **Overview and practical tips for a consultation**

Prepare
- Prepare for the consultation – mentally ready yourself
- Gather information about the person/context if possible

Structure/plan
- Decide on a model or outline structure to guide the process and create the flow in advance
- Be prepared to use it alongside the patient's agenda – get ready to be flexible and adapt

Greet
- First introduce yourself and explain your role in the person's journey
- Clarify how much time you have together, how it will work and what they can expect, but explain this is flexible based on their need and yours

Connect
- Decide to give someone your full attention in the limited time you have together
- Be curious
- Let the person speak uninterrupted for three minutes, explicitly demonstrating listening skills
- Allow room for silence for the person to say more
- Pay attention to clues in spoken and body language
- Ask open as well as closed questions

Follow a thread
- Be logical in your reasoning, linking and correlating what you find. Your thinking may change so be able to logically communicate this and explain your reasoning
- Build a picture for yourself and the service user connecting the whole

Manage the time, prioritise and adapt
- Decide what is most important, ensuring shared understanding and agreement of what needs to be done now and what can be followed up
- Ensure you know where you are heading with the consultation and signpost the direction of travel to the service user as you go
- Think about allocating a double appointment slot – do not be afraid to challenge the status quo
- Consider blocking out more time in advance and inviting patients back

Manage uncertainty for both clinician and service user
- Seek clarification
- Be transparent and explain uncertainty and complexity
- Be collaborative and encourage questions
- Seek advice from colleagues before, during and after the consultation
- Consider follow-up, safety netting and handover to others

Summarise
- Ensure shared understanding of the problem, options and the reasoning behind any potential plan
- Allow time for the person to take things in
- Encourage questions
- Summarise and explain the consultation is coming to an end but another consultation can be booked

Plan
- Be open to complexity and the requirement for follow-up
- Agree and negotiate actions, manage in partnership, set expectations

Close
- Use words that end the consultation appropriately and ensure the service user is clear on next steps

Reset
- Ensure you have time for yourself to set aside the last consultation before embarking on the next – consider how to action this if not currently available

Adapted from Morgan et al (2014)

Box 6 summarises practical tips for a consultation.

Conclusion

Advanced practitioners are ideally placed to challenge the existing paradigm of the clinical consultation. Consultation models can provide structure and guidance but ultimately a consultation is only as successful as the skill of the communicator. A balance needs to be struck between the different agendas of the clinician and patient to make for a more satisfying encounter. **NT**

- The next article in the series explores how to take a good patient history

Professional responsibilities

Only undertake this procedure after appropriate training, supervised practice and competency assessment, and following local policies and protocols

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