Psychiatria Danubina, 2014; Vol. 26, Suppl. 1, pp 15–18 *Conference paper*

THE MEDICAL CONSULTATION AND THE HUMAN PERSON

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SUMMARY

The consultation has been described as the most important part of Medicine. The Doctor-Patient Relationship is considered to depend on the trust of the patient in the doctor. This paper seeks to explore fundamental requirements of the consultation by exploring empathy, integrity, and the understanding of the human self, using concepts taken from Neuroscience, Group Analysis, Philosophy and Theology. It then introduces a plan for a study aimed at assessing the impact of a specific form of teaching consultation on the patient.

Key words: *Doctor-Patient Relationship – empathy – integrity - Human Self*

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INTRODUCTION

The best definition of the consultation was given by Sir James Spence Professor of paediatrics, Newcastle-upon-Tyne in 1960. He said "The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it."

The effect of the doctor himself is crucial....one psychotherapist has advised doctors 'the first medication a doctor prescribes is himself'. This was Michael Balint, Author of 'The Doctor, the Patient, and the Illness'….Quoted during the present author's GP training by a GP trainer who was a member of one of the first Balint Groups, run by Balint himself (Balint 1957).

Advice reassurance and support from the doctor can have a significant effect on recovery. However what is called into operation in the consultation are deep issues related to the human person, or self.

But this raises very important issues:

- Who are 'ourselves' (The self)?
- How do human persons relate to each other?
- And how do we, as persons, have power to influence each other for good?

The answer to these questions goes beyond reductionist models of man and involves many specialities…..including also philosophy, anthropology and even theology.

Theology helps define the Human Self/Person, since for us to relate to 'the other', including God, we need to understand who we are ourselves, and this helps person-centered counselling.

The present author has been very influenced in his thinking by the theological writing of St. John of the Cross, and in particular by the book 'God is a Feast' (Sammut 1996), which a commentary on John of the Cross' teaching, and by 'Sign of Contradiction', by Pope John Paul II, written before he became pope (Wojtyla 1979), and also based on John of the Cross' teaching. John of the Cross spent most of his life as a councellor to Nuns, and has been described as an effective psychologist. Also, recently, and of relevance to the concept of the self, I have referred to Sarah Coakley's 'God, sexuality and the self (Coakley 2013)'.

In summary, the main argument of 'Sign of Contradiction' is that If an action you are considering is using another person then it is wrong. This implies that the human person is paramount in assessing the consequences of our actions. It also implies that we in our life are constantly making choices.

The self – or person - may be challenged when a diagnostic label is given and consequently the person is labelled ill. The self-or person- may reject the role of being an ill person. The self-or person- may become stigmatised because of the person's previous understanding of the nature of illness. These difficulties can be addressed by open and honest discussion with the patient about the nature of illness and its consequences.

My own understanding of the 'Consultation' does not begin with 'Consultation Analysis' but with my own personhood and my relationships with other persons, including my friends, family, and students in my Cambridge College, and hence with my relationships with other human persons, whoever they may be.

In Passing, the present author finds himself enthralled by having the opportunity to watch young persons grow in College and at the School of Clinical Medicine, and observing how they become, over the years, persons who can take on huge responsibility for other people. Two of his ex students have written a paper on how they changed in the first year in which they became doctors. Essentially they became more responsible, working beyond their allocated hours because there was a third person - the patient – who depended on them.

CONSULTATION ANALYSIS

Consultation Analysis is the present method whereby the skill of carrying out a consultation is taught. Medical students are taught to diagnose disease with the basic template of history, examination and investigation, but analysis of the consultation is intended to take a more profound view of why the patient came and what may have been achieved within the consultation. The consequence of consultation analysis by a number of notable pioneers is that it has led doctors to recognise and improve consultation skills. Furthermore, the widespread application of these methods through teaching (undergraduate and postgraduate) and professional development has disseminated wider knowledge, application and understanding of consultation skills.

The present literature on models for consultation analysis can be summarised thus:

- 1957: Michael Balint's book 'The doctor, the patient and the illness‘ (Balint 1957);
- 1972: 'The Future General Practitioner‘;
- 1976: 'Doctors talking to Patients' by Byrne and Long tape-recorded consultations (Byrne 1976);
- 1979: 'The Exceptional Potential in each Primary Care Consultation' by Stott and Davies (Stott 1979);
- 1984: David Pendleton Video recording of consultations for analysis (Pendleton 2003)
- 1987: 'The Inner Consultation' by Roger Neighbour (Neighbour 1987);
- 1994: 'The Doctor's Communication Handbook' by Peter Tate video module to MRCGP examinations in 1996;
- 1997: Stewart and Roter; Patient's agenda, Doctor's agenda…then bring together;
- 2000: The Calgary Cambridge method (Silverman 2000);
- 2002: John Launer, the use of a 'narrative-based' model of the consultation.(McDermott 2002);
- 2002: Lewis Walker, 'Consulting with NLP‘ (Neuro-linguistic programing).
- *Transactional analysis*; Eric Berne (three 'ego states' of Parent, Adult and Child)-games.

One can hilight a number of key steps in the development of consultation analysis. Stott and Davies in 1979, in 'The Exceptional Potential in each Primary Care Consultation' (Stott 1979) describe four areas to be systematically explored each time a patient consults:

- Management of the patient's presenting problem;
- Modification of help-seeking behaviours;
- Management of continuing problems;
- Opportunistic health promotion.

Roger Neighbour, 1987, in 'The Inner Consultation' (Neighbour 1987), describes an intuitive five-stage model:

- Connecting with the patient and developing rapport and empathy.
- 'Summarising' with the patient their reasons for attending; their feelings, concerns and expectations.
- 'Handing over' or sharing with the patient an agreed management plan which hands back control to the patient.
- 'Safety-netting' or making contingency plans in case the clinician is wrong or something unexpected happens.
- 'Housekeeping' or taking measures to ensure the clinician stays in good shape for the next patient.

Silverman et al. (2013) developed the Calgary Cambridge method of analysing consultations 2000, which is now used by a large number of medical schools in the UK. This method derives from Pendleton's approach and is an evidence-based approach to integration of the 'tasks' of the consultation and improving skills for effective communication. Here the consultation is divided into:

- Initiating the session (rapport, reasons for consulting, establishing shared agenda).
- Gathering information (patient's story, open and closed questions, identifying verbal and non-verbal cues).
- Building the relationship (developing rapport, recording notes, accepting patient's views/feelings and demonstrating empathy and support).
- Explanation and planning (giving digestible information and explanations).
- Closing the session (summarising and clarifying the agreed plan).

However, all that communication skills and consultation analysis teach us is actually technique. Patients are persons, and they see through technique, as also do medical students. Patients, and students, require assurance that what is offerred in the consultation is genuine. Integrity in doctors seems to be what is most required by Patients when they assess the impact of a medical consultation.

Empathy between doctor and patient seems essential to a successful consultation.

Interestingly there are neuroscience correlates to Empathy. Georg Northoff is a neuroscientist who uses philosophy to design his studies of the self, of Empathy and of the breakdown of these in Schizophrenia. His book on empathy is called ‘The search warrant for the ego’ (2009).

He shows that Cortical and subcortical midline structures help define the self. These Cortical and subcortical midline structures are related to Intersubjective attunement: “Basic relation” with “fungierende /operative intentionality” to other selves. Empathy is the sharing of emotional (and cognitive) states with others, and he could demonstrate a neural network for empathy. This Neural network for empathy appears to be the same as the Neural network for interoception: Hence there appears to be an Interaction between interoception

and empathy. There appeared to be a Neural network underlying empathy, and: Empathy was more likely to override Non-Empathy in healthy subjects. The Empathy network is Similar with strong overlap to the interoceptive network for body perception. Empathy is the Relationship between the self and the other, so was there a Positive or negative correlation between self and empathy? It appears that Empathy is the Embeddedness of the self in the world, and hence measures the Intrinsic relation of the self to the world. There appears to be an Intersubjective attunement or "Basic relation" to the world, which is operative Intentionality. This then affects Intersubjective relatedness: The higher the degree of self-relatedness, the higher the degree of empathy with the other, which leads to consciousness of the Self-Other relationship, which leads to consciousness of Embeddedness of the self in the world, and hence to a Constitution of Subjectivity. In Schizophrenia there is a loss of embeddedness of the self (in the world), hence a Loss of experience of subjectivity of the other, so that the Subjective experience of the other is seen as objective rather than subjective.

So, should it surprise us that there are neural correlates with empathy, and does this support a reductionist view of man? No. If we follow the philosophical model of Augustine, which is based on the neo-platonist model. Since we are animal, there should be a 'bodily' correlation with all of the functions of our material bodies, including empathy. Augustine (who was very influenced by Neoplatonism) was one of the first Christian ancient Latin authors with very clear anthropological vision. He saw the human being as a perfect unity of two substances: soul and body. In his late treatise On Care to Be Had for the Dead, section 5 (420 AD) he exhorted to respect the body on the grounds that it belonged to the very nature of the human person. Augustine's favourite figure to describe body-soul unity is marriage: caro tua, coniunx tua - your body is your wife (Wikipedia on St Augustine). This is very different from the model of Decartes, which so often is the basis of scientific thinking, which very strongly devides body from soul. Hence, if we change our model of humanity from the Carthesian one to the Augustinian one, then we do not need to be reductionist in our understanding of man - just a series of neurological and biochemical links - as suggested by Decartes, but instead an 'animal' in which all the neurological and biochemical links can be expected and predicted, but still maintaining its unique human character, as in Augustine. Simply changing the philosophical model changes our view of man with all his/her biological parts, including empathy, so that the model ceases to be reductionist, and instead becomes a fully integrative one. This accords with recent demands to develop 'Integrative Medicine' or 'Integrative Psychiatry'.

So, is it possible to teach empathy? The present author believes that empathy is real if one means what one says, and the other person can appriciate this, and that persons relate well to each other and gain from their relationship with their doctor if this is the case.

And another issue is Integrity. In the consultation a doctor must mean what he/she says….and people will realise whether the doctor does or not.

One thing which the present author enjoys, is watching young persons grow up over their university lives is watching them make choices, and affirming those choices. As they grow they learn to behave with integrity.

What the present author likes to do when interviewing a patient to make a diagnosis, especially when they have suffered a great deal - trauma of various kinds - is to offer some Positive Affirmation. This means being empathic and saying something which suggests that the doctor holds them in positive regard. But the other person needs to know that the doctor means it, for this to be effective.

Integrity enables people to support other persons by affirming them. One student commented to the present author about his handling of a consultation with a young woman with borderline personality disorder who had a history of having been abused; 'I see, so what you do is to be a positive male influence in their lives'.

The consultation is an issue of Assymetric Relationships, when one person in the consutation (the doctor) may appear to be be more powerful than the other person (the patient).

If the Doctor is firmly in control of the consultation, this may lead to a paternalistic consultation, while if the patient is most in control, then the consultation may become too 'consumeristic. It is important to achieve a mutuality where both parties feel satisfied and contributing to the consultation.

Doctor and patient may see the consultation as having different aims; For the doctor, the history examination, and investigation results in a differential diagnosis, while for the patient, expression of his ideas expectations and feelings results in an understanding of the patient's beliefs. An integration of both these viewpoints is necessary in the consultation.

The Doctor's consultation style is important; A Patient Centred consultation style is less authoritarian, it encourages the patient to express their own feelings and concerns, and uses Open questioning, because of the doctor's interest in the psycho-social aspect of illness, before going to closed questions to clinch the diagnosis. Thus, an intigrated approach to information gathering, seeking to identify physical psychological and social factors, Is likely to produce a better outcome.

Even how we sit affects how we project ourselves. If the patient is across the desk, and the doctor sits like a headmaster, then the consultation becomes more authoritarian, while if the patient and doctor are not separated by a desk, then the consultation is held on a more equal footing.

To conclude, a proposed project is introduced. It grew out of a teaching need, which was to teach senior medical students to take a psychiatric history while a senior doctor guided them. The consultation is carried out with two students; one to write, while one leads the

consultation and the doctor guides him/her. Add to these the patient and the patient's family, and the group end up sitting in a circle. This completely changes the dynamic. Add to this that the patient has agreed before entering the room that they will work with the students, and the group becomes a teaching/learning group where everyone shares information and learns,and tries to solve a common problem. Furthermore each consultation lasts an hour of allocated time. Feedback is very positive from both Patients, their Family, and the students.

Now one of my students has developed student and patient feedback questionnaires so as to be able to quantify the feedback and write this method up.

CONCLUSION

In the end this is all about persons believing that you care about them and that you wish to help them (and know how to do so!). In fact this is really no different from how we relate to the students in college, and how they relate to each other. Hence everything that we do in College prepares the students for acting with honesty, integrity, and caring in the outside world.

The consultation remains two persons who trust each other and wish to work with each other so as to deal with a problem. Trust and therefore care for each other remains the fundamental way in which people can work together to do each other good. Such good work was seen by neoplatonists such as Saint Basil as having infinite value - 'A good work is never lost'.

This takes us back to the value of our work as doctors, and the possibility of looking back, as the present author can do, over a career, to feel, as Saint John of the Cross remarked 'At the Evening of your life, you will be judged by Love'.

Acknowledgements: None.

Conflict of interest: None to declare.

References

1. *Agius M. Becoming a young doctor – Meeting Sophie Butler and Clare Holt. The Synapse 2012; 3:10-11.*
2. *Augustine On Care to Be Had for the Dead, section 5 (420 AD).*
3. *Balint M. 'The doctor, the patient and the illness'London: Churchill Livingstone, 1957.*
4. *Byrne PS, B.E.L. Long. Doctors Talking to Patients 1984.*
5. *Coakley S. 'God, sexuality and the self' Cambridge 2014.*
6. *Descartes R. La description du corps humaine (The Description of the Human Body), 1648.*
7. *Descartes R. Les passions de l'âme (Passions of the Soul), 1649.*
8. *Launer J. Narrative-Based Primary Care: a practical guide Radcliffe, 2002.*
9. *McDermott I, Duncan JS, Walker L. Consulting with NLP: Neuro-Linguistic Pr ogramming in the Medical Consultation, 2002.*
10. *Neighbour R. 'The Inner Consultation', 1987.*
11. *Northoff G.'The search warrant for the ego', 2009.*
12. *Pendleton D, Schofield T, Tate P, Havelock P. The New Consultation: Developing doctor-patient communication, 2003.*
13. *Sammut P. 'God is a Feast' Luton; New Life, 1996.*
14. *Silverman J, Kurtz S, Draper J. Skills for Communicating With Patients, Third Edition, 2013.*
15. *Stott NCH and Davis RH. "The exceptional potential in each primary care consultation", 1979.*
16. *Tate P. 'The Doctor's Communication Handbook', 1994.*
17. *Wojtyla K. Sign of contradiction 1979.*

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Consultation-related factors. The medical interaction takes place during a consultation in the ED. Emergency medicine is a unique subculture within medicine (Person et al. 2012, p. 1) and characterized by uncertainty, open-endedness and multiplicity (Chisholm et al. 2001; Eisenberg et al.Â Within a group of ratified hearers, a further distinction can be made between a â€œprimary addresseeâ€, the person whom the speaker focuses his visual attention on and to whom he expects to hand over the speaker role in the next turn, and the unaddressed ratified hearers, who are entitled to listen, but are not directly addressed. Consultation Analysis has become a routine part of teaching and learning. Find out more about Consultation Analysis.Â However, excessive external influences (for example, from target setting and the need to demonstrate efficiencies for political and financial reasons) can pose an extra challenge to the consultation and an agenda extra to that of the doctor and patient. Such influences may obfuscate the benefits to doctor and patient of developing and improving consultation skills. How can consultations be analysed? Consultation analysis is most often undertaken as part of teaching, learning or research. Human behavior has been described in terms of personality and behaviors in the consultation, both of the doctor and the patient, and the beliefs of the latter. These are factors that can modify the consultation. This approach includes verbal and nonverbal communication, and the clinical content of the dialogue [23].Â The doctorâ€™s attention in the process of taking the medical history confirms the patientâ€™s worth as a person who tells a story, shows interest, and lays the foundation of the therapeutic alliance [34]. It should be noted that, in general medicine, psychological problems often manifest with physical symptoms and physical illnesses have psychological consequences that need special attention. Doctors, nurses and other professionals in Human Medicine are probably one of the most important professions in the world. It is logical that behind this difficult and challenging profession there mus.Â Many future students choose foreign universities to gain access to the latest medical equipment and the opportunity to spend a year practicing abroad. One of the difficulties of medical education is that the norms and principles that are part of the system of medical education and health of one country can be not recognized in another country. Human Medicine programs structure and features. The structure of the program is very dependent on the specialization of medicine that you choose.