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Sreenivasan Oration 2010

"Re-defining the Art of Consultation"

22nd Sreenivasan Orator

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SREENIVASAN ORATION 2010
RE-DEFINING THE ART OF CONSULTATION

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ABSTRACT

The re-defined Art of consultation, beyond clinical instinct and hospitality can be put into practice in three ways to complement the scientific approach. Firstly, the healing ambit of the doctor-patient relationship can be extended with better relating and inquiry skills. The doctor can extend his role from an expert to that of a collaborator, from comforting to challenging, and from being detached to being engaged. Secondly, the totality of idiographic and nomothetic data so gathered in this extended consultation can be abstracted as a formulation of issues related to the reason for encounter to complement the usual list of diagnoses. Thirdly, specific skills from psychotherapy can be learnt to augment the potency of 'doctor as medicine'.

Keywords: Art, Consultation, Idiographic, Formulation, Psychotherapy

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INTRODUCTION

I have not met the late Dr. B.R. Sreenivasan personally but have read about his distinguished public career as the Vice-chancellor of the University of Singapore, President of the College, President of the Singapore Medical Council & President of the Singapore Medical Association. The late Dr. Wong Heck Sing, another of the College founding fathers told me that despite the high offices he held, he was at heart very much the passionate clinician practising general medicine in the community. The theme of this Oration given in his memory would honour that passion.

Two paradigms come readily to mind whenever the Art of consultation in medicine is broached. The first is that of Art as 'clinical instinct' and the other is that of Art as 'hospitality'.

The 'Art of Consultation' was also the title chosen by Dr. G.F. Abercrombie for the 5th James Mackenzie lecture given in 1958 at the Royal College of General Practitioners (RCGP)[1]. The Art in his view was akin to 'clinical instinct' and he quoted from Dr. Mackenzie's book 'The Future of Medicine' to define it. In 1923, Dr. Mackenzie wrote of "the curious knowledge which some physicians & general practitioners acquire after many years' practice. The knowledge is un-definable, and they are unable to express the reasons in language sufficiently clear for the uninitiated to understand." Art so defined is therefore the matured clinician's personal warehouse of heuristics from which mastery of practice emanates.

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The second paradigm of the Art of Consultation is that of hospitality. There are many salubrious attributes of this paradigm about according patients kindness and respect more so when they are sick and suffering. However, trends of commercialisation of healthcare pose a pernicious danger to morph the hallowed doctor-patient relationship to that of a provider-client relationship. Attributes like satisfying clients' wants and comfort and avoiding complaints from unhappy clients come to the forefront. Hospitality in such a relationship may then become just another commodity that is exchanged in the healthcare marketplace.

We need to move beyond these two paradigms of Art.

OF SCIENCE & ART

The practice of medicine is both Art and Science. Science is taught but the Art is left to be caught with time.

Doctors are scientifically trained to gather salient facts from the patient's history, clinical examination and laboratory investigations. Based on the knowledge of diseases and the constellation of pertinent facts gathered, the patient is then assigned to one or more disease groups, each defined by shared characteristics. The management of the patient then proceeds from the established guidelines of how such groups are best managed. This is the basis of the practice of evidence-based medicine.

Some doctor-educators have cautioned the over-emphasis on this disease-oriented approach and its preoccupation with generating labels. Dr. Y. Pritham Raj wrote a satire in the Annals of Internal Medicine, Nov 2005 titled 'Lessons from a Label Maker'.[2] He observed that medical students "quickly learned that navigating the world of medicine required an ability to correctly identify and label medical disorders" even when patients sometimes do not quite fit the requirements of the labels. He observed that inappropriate labels once adhered to "left gummy marks that could not easily be removed." The plethora of labels generated for a particular patient over time tends to obfuscate rather than clarify management of the whole patient.

A fixation on this scientific approach to consultation can inadvertently foster a culture of label-making and also fragmentation of care as disparate sub-specialists stake exclusive ownership of labels. At times, it can lead to medicalisation of social issues e.g. labelling usual sadness in life as depression.

A case has been made to re-define the Art beyond clinical instinct and hospitality that can complement the Science of consultation. Sir William Osler (1849-1919) exhorted doctors to 'care more particularly for the individual patient than for the special features of the disease.' Such a person-centred approach can be rooted in the Art of consultation to balance the disease-centred approach based on Science.

To understand this Art, we can revisit the two terms 'Nomothetic' and 'Idiographic', first coined by the Kantian philosopher Wilhelm Windelband (1848-1915) to describe two distinct approaches to knowledge, each one corresponding to a different intellectual tendency, and to a different branch of academe.

The Nomothetic approach is the tendency to generalise, to derive laws to explain objective phenomena in the natural sciences and is used to assign disease labels to patients with shared characteristics. On the other hand, the Idiographic approach is the tendency to specify as expressed in the humanities, to understand the meaning and qualia of subjective phenomena. This can be used to focus on the complexities and uniqueness of the individual and his/her bio-psychosocial environment. This latter approach has also been referred to as person-centred medicine or Narrative-based Medicine (NBM) for its focus on the individual and his/her story. The former, disease-centred or Evidence-based Medicine (EBM) focuses on diseases and its scientific evidences.[3]

We need both approaches to manage the whole person. (Figure 1) Albert Einstein (1879-1955) was reputed to have said, "Not everything that can be counted counts, and not everything that counts can be counted".

The challenge in the Art of consultation as a humanistic discipline is to seek understanding of how and what may be the varied issues confronting the individual. The issues can range from the obvious to an amalgam of psycho-social factors enmeshed with bio-medical diseases. Rigorous training in eliciting salient qualitative data, integrating the data and its interpretation in context, are skills needed in the Art. New perspectives to training and practice are needed so that the validity of such interpretations is anchored on the reliability of the data obtained and the plausibility, the 'Hows' to explain the problems in that individual. This is in contradistinction to the 'Whys' as ferreted out by reproducible evidences using the scientific method.

ART RE-DEFINED

In this Oration, three perspectives of the re-defined Art are examined. The first is an extended doctor-patient relationship requiring wider relating and inquiring skills. The second is Art as the added mental discipline to arrive at an explicit formulation of the reason for encounter (RFE) in addition to diagnoses. The third is Art as the special skills that can be learnt from psychotherapy to augment the potency of 'doctor as medicine'.

1. Art as the extended Doctor-Patient relationship

In practising the Art in consultation, there is a need to navigate between the dual roles of the doctor as expert and as collaborator, the stance of being detached and engaged, and also the comforting and empathic challenging of the status quo. Negotiating this new compact requires attention to clinical skills of relating and inquiry.

Doctor as both expert and collaborator

Traditionally, the doctor takes on the role of an expert in the healing relationship. Sir James Mackenzie advised doctors a century ago that "When the patient and physician come first together, it often happens that there is an unconscious struggle who is to be dominant. Many patients come full of ideas as to the nature and cause of their sensations and eager to impart their own opinions. Or they come with a bundle of notes, which they insist, on reading. This must be quietly and firmly repressed. The story of their life must be reserved until the examination is finished and their replies must be limited to the sense of the question asked."[4] The practice milieu has not changed. The inquisitive & assertive patient is not born with the advent of the Internet age.

However, with the increasing burden of chronic diseases and problems of functional impairment with longevity, Dr. Daniel Sands pointed out at an American Academy of Family Physician meeting October 2010 that 'participatory medicine' do improve

Figure 1: The Art & Science of Consultation

Art (Idiographic Approach)	Science (Nomothetic Approach)
Person-centred Medicine Narrative-based Medicine (NBM)	Disease-centred Medicine Evidence-based Medicine (EBM)
Specify - focuses on complexities & uniqueness of individuals	Generalise - assigns patients with shared characteristics to groups with labels
Validity judged by reliability of data gathered & plausibility of explanation	Validity in group can be tested by scientific method based on evidences
Seeks understanding of the 'how' & 'what' reasons for problems	Seeks explanation of the 'why' - causes of the diseases
Management based on person's unique story or narratives	Management based on EBM Guidelines of the labelled group

healthcare for both patients and physicians. "Doctors need to let go and admit they don't know everything. From the patients' standpoint, patients have to be comfortable taking more ownership and getting more engaged in their own care. Patients have to know that healthcare is not a spectator sport."[5] There is thus a need for doctors to be both expert and collaborator, the patient to be both patient and participant.

Detached and engaged

A consultation is a dynamic meeting of the mind and heart of the doctor and the patient for therapeutic purposes. Most times, doctors present a congenial persona but maintain varying emotional distance from their patients. Internally however, doctors should be aware of parallel processes at work. The first is the logical mind involved in nomothetic work and the other the intuitive mind in idiographic work. Both processes are not mutually exclusive. Clinical judgment at times arises from what is called valuing (emotional judgment) when only a certain subset of possible actions are considered because of unconscious emotions at work.

Patients also need to be emotionally engaged to be affirmed. Affirmation may be direct, indirect or self-affirmation. Doctors can overtly affirm their patients, directly or indirectly. In a collaborative relationship, the doctor can also seed recursive affirmation by the patient himself or herself by inviting the patient's perspective of how a positive unique outcome happened.

Empathy can be expressed in language or socio-symbolic gestures. A simple contextual statement like "That must be difficult/ heart-breaking/ painful" at an emotionally pregnant moment in time can be cathartic. At other times, the doctor's empathy is the unspoken mirroring of the patient's feelings in the flow of the consultation. It is a continuing challenge for those doctors burned out with heavy workload and besieged with the pain and suffering of their patients to remain congruent, genuine and positive. Peer support such as a Balint group is important to preserve these qualia.

Comforting and Emphatic Challenging

Comforting the patient always is the centerpiece of the famous aphorism of Ambroise Pare (1510-1590) "to cure sometimes, to relieve often, and to comfort always." However at times, patients need to be emphatically challenged instead of being comforted.

Emphatic challenge is an Art in consultation that can move the patient from an entrenched position, for example, a lack of motivation to stop smoking, to one that is more adaptive. The challenge need not be aggressive as in confrontation and should be issued at an appropriate time and setting. This can be presented as an invitation to stretch the possibilities in an affirmation of faith in the relationship concurrent with support to move on with life.

Relating Skills

Negotiating the new compact described above requires attention to the clinical skills of relating. The late Michael Mahoney, a pioneer constructive psychotherapist wrote that "we are born in relationship and it is in relationship that we most extensively live and learn".[6] He further observed that "Our language lacks words to convey adequately our social and symbolic embeddedness" and stressed the importance of cultivating 'the art of being humanly present to another person' in the here and now, in words, actions and spirit – being here and not there.

A system view can also be taken of the doctor-patient dyad. The terms, 'transference' and 'counter-transference' of the doctor & the patient are legacies of Freudian psychoanalytic traditions, and are best avoided as these terms may be enmeshed with the deterministic tenets of primordial instincts and needs. Dr. Eric Berne's Parent-Adult-Child (PAC) model of Transactional Analysis is easily understood. Dr. Jeffrey Young, the innovator of Schema Therapy, uses a more sophisticated model of schema interplay.[7] However, these models too are nomothetic.

Useful in negotiating this compact is exploring the idiographic precepts of 'Ideas, Concerns, and Expectations' (I.C.E.). It must be emphasised that the doctor and the patient each have 'I.C.E.' of a clinical situation. It is useful to explicitly understand each component and its interplay within the individual and interactivity within the dyad. The doctor can then decide to go for congruence, to roll with resistance or to accept the discordance so long as the therapeutic outcome is achieved.

Inquiry Skills

Negotiating the new compact also requires attention to clinical skills of inquiry. Dr. Michael Balint, who was renowned for his reflective 'Balint group' for doctors cautioned that "If the doctor asks questions in the manner of medical history-taking, he will always get answers – but hardly anything more."[8]

Many medical students first learn medicine by rote-learning sets of leading questions that are often asked in response to specific presenting symptoms or scenarios. They then imbibe the hypothetical deductive diagnosis model and so in consultation shuffle from one set of closed questions to another in search of associative diagnostic labels. Such an exercise may be expedient but not always effective. Important data that bear on management may be missed. Open questioning and active listening skills must be incorporated.

Two psychologists Joe Luft and Harry Ingham researching human personality at the University of California in the 1950's developed the so-called 'Johari Window Model' to understand the human mind. (Fig 2) An open question/gesture is one that when cognitively processed by the listener may not just elicit a direct associative response but generates in him or her

contextual questions or emotions that allows for expression from the patient's blind, hidden or even unknown windows. Although formal psychotherapy training hones the art of accessing these windows, doctors do intuitively acquire such skills from experience. Incorporating simple psychotherapy frameworks to link these rudimentary acquired skills are enabling.

An example of such a framework to facilitate open inquiry based on Socratic questioning technique is proposed (Fig 3). Many doctors start and also stop at clarification of symptoms. They clarify about the length (time relationship), breadth (relatedness and context) and sometimes the depth (severity, emotions, cognition, and spirituality). To open the Johari Windows wider, doctors may continue to probe into the assumptions the patients hold and the rationale (evidences) for them. With some training, doctors can 'A.C.E.' the inquiry by also exploring the Alternatives and possibilities, the Consequences of each expressed thought/ scenario and also the Experience(s) that arise therein. The doctor can actively seed, facilitate and sense such disclosures and elaboration of thoughts, feelings and beliefs.

Many doctors face difficulty in using this open inquiry system as they are acculturated as experts to use directive and prescriptive language. It is more potent to allow the patient to arrive at that same viewpoint by astute but respectful questioning rather than inserting the same viewpoint into them. This would require doctors to be more patient and reflective in the collaborative and not the expert mode. For sure, it could only be judiciously used, as time is a scarce resource in a consultation.

2. Art as Formulation of issues of Reason for Encounter (RFE)

Art is needed as the added mental discipline to arrive at an explicit formulation for the RFE in addition to the

Figure 2: The Johari Windows in doctor-patient consultation

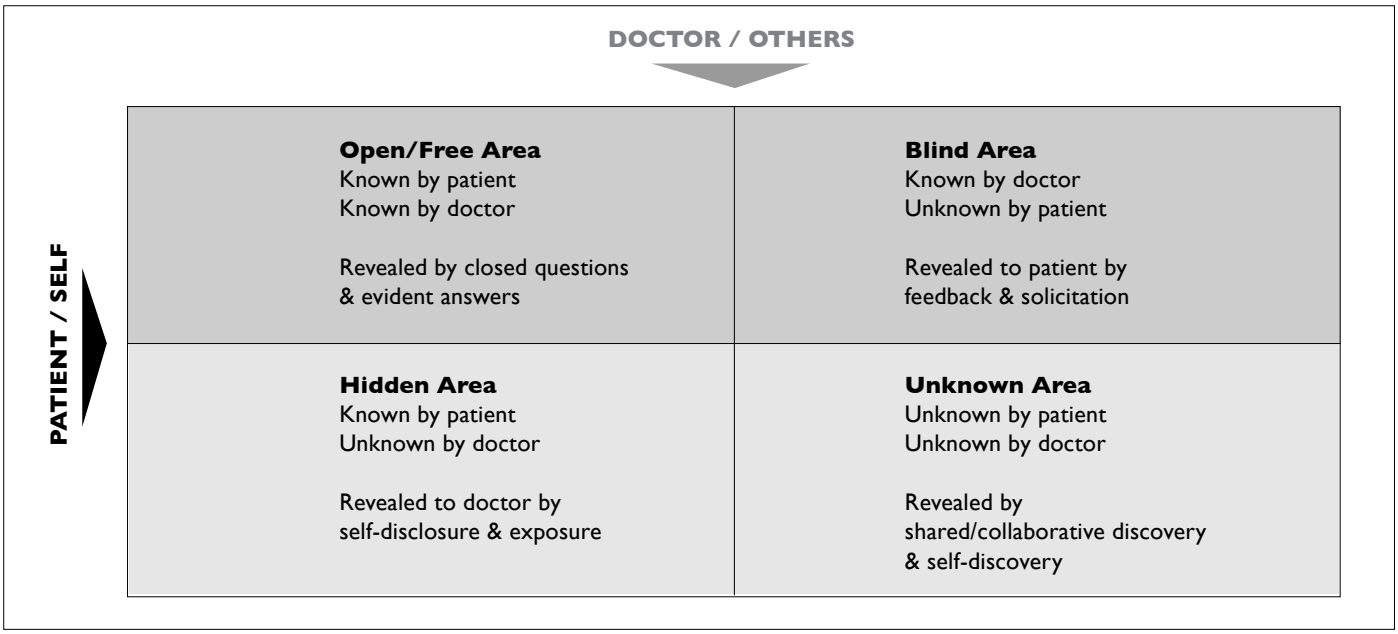

Figure 3: Techniques of open inquiry inviting self-generation of questions & contextual answers

Clarification Length: Time-line, period Breadth: Relation to people, situation, environ, culture, beliefs Depth: feelings, thoughts, actions, interoception & scaling	**Alternatives/Possibilities** Viewpoints: What may be another way to look at this? Confrontation: Are you implying that? Likelihood that?
Assumptions What have you assumed? What can be assumed instead?	**Consequences** Can we generalise? Outcome of each alternative Is result better/worse?
Rationale/Evidence How do you know? To be correct, true, valid	**Experience** Circular inquiry of question-on-question & experience-on-experience

diagnosis. In the disease-centred approach, the focus is on gathering evidences to arrive at nomothetic diagnoses. In the person-centred approach on the other hand, the focus is on conceptualising the salient bio-psycho-social issues into an idiographic narrative. Visual tools can be used to provide insight. The connectedness of family and significant others and their emotional bonds can be drawn as genograms. A time-line of significant life and medical events, work-life rites and putative stages of bio-psycho-social development charted.

The analogy of using various lenses to provide perspectives can be employed to make sense of the admixture of idiographic and nomothetic data so gathered. Expanding on his 1995 Sreenivasan oration 'Dare to Dream', Past President of College, Dr. Lee Suan Yew commented in a 2004 interview that 'GPs/ Family Physicians are best when they can use both lenses, that is, the wide-angle lens and zoom lens' in managing patients.[9] The wide-angle lenses provide the panoramic vista of breadth and linkages while the zoom lenses focus in and out to provide contextual substance & depth.

The doctor could then arrive at a formulation relating to the presenting problem structured as succinct statements (narratives that can be remembered as the 4Ps) as to what may have predisposed, precipitated, perpetuated the problem and also what could have protected it from getting worse. Most doctors do have tacit narratives of their patients. However, conceptualised as statements, the '4Ps' formulation can be used together with the list of diagnoses, impairments, disabilities and handicaps of that patient to provide an integrative view for management. (Fig 4) At other consultations where no definite diagnosis can be arrived at, the formulation per se can be used as the basis to manage the patient. There is no need to assign a label when there is inadequate evidence or when it is not useful to prematurely assign one.

3. Art as augmentation of 'doctor as medicine'

The third perspective of Art is the special skills that can be learnt from psychotherapy to augment the potency of 'doctor as medicine.' Dr. Michael Balint is best remembered for his famous aphorism 'The doctor himself/herself is a powerful medication'. Lessons from psychotherapy can be integrated into the art of consultation to augment this potency.

Figure 4: Bio-psycho-social Formulation of RFE & Diagnoses

Formulation of Reason for Encounter (RFE)	Diagnoses List
Predisposing Factors	Diseases
Precipitating Factors	Impairments
Perpetuating Factors	Disabilities
Protective Factors	Handicaps

Various doctors have introduced elements of psychotherapy into the medical consultation. Stuart & Lieberman's BATHE counselling method prompts the doctor to find out about the Background, the Affect, what is exactly Troubling the patient, how he/she is Handling it and then Empathising with the patient's predicament.[10] Dr. Roger Neighbour believes that there is an 'Inner Consultation' in the doctor's mind between two 'heads' he called the intellectual Organiser & the intuitive Responder. These two heads consult in parallel to the external doctor-patient encounter.[11]

Translating skills learnt from psychotherapy, an interest group (Prof Kua EH, Cheong PY, Goh LG, Voon & Wee ST) from the National University of Singapore has developed a programme called Brief Integrative Psychological Therapy (BIPT) to teach the application of basic psychological skills to help understand and formulate interventions to the life struggles of patients.[12] Viewing the encounter from a trans-theoretical stance, we proposed four areas of intervention (4Ps) viz. Problem Work, Pattern Work, Process Work and Positive Work to achieve psychological balance.

Briefly, Problem Work covers two areas – problem-solving skills and Cognitive Behavioural Therapy (CBT) skills. As to CBT, the principles of behavioural interventions are counter-conditioning (Pavlov & Wolpe) and contingency management (Skinner). Cognitive work involves the identification of negative automatic thoughts (NATs) arising from cognitive distortions (Beck & Ellis) and disputing them. (Figure 5) These interventions can be used in diverse clinical situations such as addiction management, engendering health-seeking behavior and ensuring continuing care.

Pattern Work deals with the Problem Saturated Stories (PSS) held by patients that impede healing. Narrative Therapy tools pioneered by Epston & White can be used collaboratively to re-author, re-member, re-frame such PSS and after re-construction into Preferred Positive Stories (PPS) re-tell them[13] Solution talk techniques developed by Shazer and Kim Berg can also be very useful to elicit unique positive outcomes to create the positive present and future story.[14] (Figure 6)

Process Work deals with psychological processes of mindfulness and polarities. Mindfulness anchors the person on the here-and-now, free from burdens of the past and anxieties for the future, and on the present without judgment or expectation. Work on polarities deals with awareness of the disparate & detached parts of self which need to be owned and managed.[15]

Positive Work anchors on the work of Positive Psychology (Seligman & Csikszentmihalyi) which "at the subjective level is about valued subjective experiences of well-being, contentment, satisfaction in the past, hope and optimism for the future, and flow and happiness in the present".[16]

Figure 5: Behavourial & cognitive principles of problem work

Counter-Conditioning	Contingency Management	Cognitive Therapy
A ⇨ B: Antecedent-Behaviour	 A ⇨ B ⇨ C (Consequence)	 A ⇨ Belief ⇨ B ⇨ C Disputing
Stimuli (Antecedent) Control Assertive Response (Behaviour)	Behaviour arising from antecedent strengthened or weakened contingent on consequence	Negative Automatic Thoughts (NATs) from cognitive distortions (Beliefs) pop up in response to A (situation)
Systematic Desensitization: graduated incremental stimulus (starting small) to overcome avoidance reaction	Behaviour strengthened if add positive or remove negative consequence.	Identifying & Disputing NATs to weaken maladaptive behaviour in response to antecedent (situation)
Reciprocal inhibition: Pairing stimulus that produced contradictory response with the original stimulus, thereby weakening response to original stimulus	Behaviour weakened if add negative or remove positive consequence. Operant (Skinnerian) Conditioning	Inquiry skills from Socratic questioning are used viz. Clarification, Assumption, Rationale, Alternative, Consequence & Experience. (C.A.R. A.C.E.)

Figure 6: Narrative therapies in pattern work (after Epston-White & Shazer-Kim Berg)

Narrative Therapy	Solution-focused Therapy
Problems because individuals construct meaning of life in Problem Saturated Story (PSS)	Solutions may have no direct relation with problems.
Replace PSS with co-constructed Preferred Positive Story (PPS)	Co-create present & future story by shifting focus from problem to solution.
Externalise, Elicit unique outcomes, co-construct preferred story by Four R's of Re-author, Re-member, Re-frame, & Re-tell.	Elicit Exceptions, go for small changes, scale, amplify & repeat.

Doctors can additionally learn 'externalisation' talk to metaphorically excise embedded problems, externalise them as transitional objects and then subject them to the collaborative attention of the healing doctor-patient dyad. For example, Mr. Tan who is diagnosed with cancer, should never be referred to as the cancer patient and the disease should not be referred to as 'your cancer' to embed it. Avoiding such 'totalising' language, Mr. Tan's problem should just be referred to as having a problem of cancer now being treated. Externalised, Mr. Tan's problem now has a separate identity. It is now subjectified and detached psychologically from his body so that the focus is not on Mr. Tan's self but the 'thing' by whatever name the doctor and patient choose to call it. This psychotherapeutic sleight of hand is useful.

Although in-depth psychotherapy training is needed to hone more complex skills, many psychotherapy interventions are intuitive and doctors with good people-handling skills and clinical presence can learn and apply the skills through brief training to this aspect of the Art of consultation.

CONCLUSIONS

In conclusion, the re-defined Art of consultation beyond clinical instinct and hospitality can be put into practice in three ways:

(1) The healing ambit of the doctor-patient relationship can be extended with better relating and inquiry skills. The doctor can extend his role from an expert to that of a collaborator, from comforting to challenging and from being detached to being engaged;

(2) The totality of idiographic and nomothetic data gathered can then be abstracted as a formulation of issues of the RFE to complement the usual list of diagnoses for holistic management; and

(3) Specific skills from psychotherapy can be learnt to augment the potency of 'doctor as medicine'.

Even though I have not met the late Dr. B.R. Sreenivasan personally, I believe that he would agree with this humanistic exposition of the Art of Consultation. Another President of our College, the late Dr. Koh Eng Kheng wrote in Dr. Sreenivasan's obituary (August 1977) that "He was a scholar in every sense of the word and his knowledge of the classics was greatly to be admired. His love of Shakespeare made him the complete physician." We would be honouring his memory by practising medicine as both Art and Science in that tradition.[17]

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FOOTNOTE: This Oration was delivered on 28th Nov 2010 at The Tanglin Club, Singapore. A copy of this oration with the powerpoint presentation will be available on the College website.