The consultation

Back to the future?

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Consultation[1]
1: council, conference
specifically: *a deliberation between physicians on a case or its treatment*
Her doctor called in a heart specialist for consultation.
2: the act of consulting or conferring
met with his physician for regular consultation *and examination.*

Does language matter? In recent commentaries, Pimlott[2] and Sandell[3] discuss the importance of language in describing the way that we as family physicians describe ourselves and our profession. How should we best describe what happens when family doctors meet patients in the clinic office? One term does come close: *consultation*, an expression historically used to describe this process and one that has fallen into disuse in Canada over the years. Other terms used to describe this encounter include *office visit*, *clinic visit*, *doctor-patient encounter*, *doctor-patient interview*, or *medical interview*.

Although deliberating over the term we use might seem like semantic hair-splitting, the description of what we actually do day-to-day has 3 important implications: it characterizes family medicine as a specialty; it impacts how medical educators name, teach, and assess the central construct in family medicine; and it affects how family physicians reflect on what they are doing when they meet their patients.

The consultation, whichever term we use, is what we "do" as family physicians. It is estimated that every day in Canada up to 500,000 meetings take place between family doctors and patients in their offices.[4] Silverman et al estimate that on average a family physician will conduct 200,000 of these encounters within their working lifetime.[5] Descriptors such as *office visit*, *encounter*, or *interview* carry an implication of functional or utilitarian problem-solving roles but none of these truly capture the essence of what is happening between doctors and patients. That essence includes the centrality of the doctor-patient relationship, affective (emotional content, empathy, patient-centred communication skills, etc) and cognitive (clinical reasoning skills, selectivity, time management skills, etc) components, and the work of "cocreation" that occurs within the meeting (ie, because both doctors and patients have their own agendas, narratives, objectives, and expectations during the consultation). As the full Merriam-Webster.com dictionary entry shows,[1] *consultation* is a word with multiple meanings. In North American clinical practice, *consultation* has come to mean the act of the primary care provider or generalist asking the secondary care provider or specialist for advice or help. As many of these "consults" between generalists and specialists aim to answer biomedical questions and are actually delivered in writing rather than in face-to-face interactions between clinicians, might the term *referral* be a more accurate way to describe the process? The word *consultation* can still have other meanings, but in the medical context let us revive this term for family physicians to describe the beating heart of what we do day to day.

Historical context of the consultation

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.

Sir James Spence[6]

Although the description of the consultation by Sir James Spence (who was actually a pediatrician) may seem somewhat clichéd, it does capture the essential elements of office visits to a family doctor: a personal doctor who can be trusted, a patient seeking help, and a meeting in intimate surroundings.[7] Other terms, such as *encounter*, *medical interview*, or *office visit*, fail to capture the sense of a doctor-patient relationship. *Encounter* suggests nothing of the personal nature of the meeting. *Medical interview* suggests a dry, 1-way exchange of biomedical information. Nor are we simply describing a venue where doctors meet patients, as implied in the term *office visit*—which also suggests a journey to a place, usually to the doctor's home turf, as housecalls become increasingly rare. The term *consultation* implies that there is a 2-way dialogue between the patient and the doctor, and that the meeting is about more than just information gathering on the part of the doctor, or even just a simple conversation. There is the concept of cocreation or, to put it another way, of working out what matters—to the patient and the doctor—and then of figuring out together the best way to achieve it. Usherwood,[8] citing Hart, describes the consultation as a "co-production"—with both patients and doctors having equal status as participants, and the consultation being the means by which both patients and doctors work together to enhance the former's health.

The decline of the use of the term *consultation* in Canada mirrors many of the changes in family medicine over the past 30 years. Erosion of the doctor-patient relationship is evident on many fronts. The role of generalism has been under threat by the increasing shift to specialization and subspecialization, even within family medicine itself, with many new graduates opting for focused practices.[9] Continuity of care, the bedrock of strong doctor-patient relationships, is threatened by workload, challenges in access, and the increased complexity of patient care models and large group practices.[10]

What is the consultation?

The consultation is the heart of family medicine and is, as Spence states, "the essential unit of medical practice."[6]

No matter where or how it is delivered—in person, by telephone, or via video link—the consultation remains the defining experience of all family physicians. The consultation is the primary tool of family physicians, the "thing" that they use day in and day out throughout their careers. In the same fashion that gastroenterologists use gastroscopes, gynecologists use colposcopes, and anesthesiologists use ventilators, family doctors use the consultation. Therefore, family physicians need to have a thorough understanding of the structure and dynamics of the consultation. This involves an appreciation of how consultations are structured, which can be as simple as a beginning, a middle, and an end. What matters within that simple framework is what goes on between doctors and patients at each stage, what skills and competencies need to be deployed at which stage, and, perhaps most crucially, how to recognize when consultations are not going according to plan and what to do about it when that happens.

Contexts of primary care and the consultation

Although all clinicians (generalists and specialists) consult with patients, the context of primary care also shapes the consultation, placing unique demands and responsibilities on family physicians.

As the first point of contact, family doctors must sift through undifferentiated and often multiple concerns, usually without recourse to much medical technology. The gatekeeper role adds complexity to the consultation because of the need to balance, on the one hand, care and advocacy for the patient within the health care system with, on the other, the doctor's responsibility to use resources wisely. Consultations by their very nature are time constrained, and the most precious resource of all that family physicians must ration is their own time. Using the time available to best effect is a major determinant of quality of care, and a key factor in why and how consultations succeed or fail. Managing, tolerating, and sharing uncertainty is an essential component when developing fluency in consultation skills in primary care. Promoting continuity of care (care by the same doctor on subsequent occasions) is key to developing effective doctor-patient relationships, which are essential for the work of cocreation that is carried out during each consultation.

The consultation and medical education

If the consultation is the primary tool of the family physician, then it needs to be deconstructed, examined, and understood. The consultation is a complex and multidimensional construct with many moving parts and requiring the application of hypothetical-deductive clinical reasoning and patient-centred communication skills within fixed time constraints. Family medicine residency programs are tasked with teaching the consultation formatively, and the College of Family Physicians of Canada (CFPC) is tasked with assessing the consultation in summative fashion.[11]

The learning, teaching, and assessment of the consultation requires attention to an appreciation of the concept of consultation models—how one describes the tasks, processes, and perspectives that arise during the interaction between family physicians and patients.[12] There is clear evidence that shows measured health outcomes are positively influenced by the use of patient-centred consultation models.[4,5,13] The terms *interviewing skills* and *history taking* do not convey the same appreciation of the complex, personal, multidirectional, and time-constrained nature of the interaction in primary care as conveyed by the term *consultation skills*.

The consultation in primary care has international recognition: it is the preferred term to describe the interaction between primary care providers and patients in jurisdictions where a commitment to patient-centred approaches is considered crucial to the processes taking place. The term *consultation* provides a common language, lens, and construct for describing the complex interactions and transactions that occur in a family medicine context. This common language is crucial for medical education and training of family physicians, and borne out in formal literature reviews of academic general practice and curriculum statements where consultation skills and consultation models are identified as essential components of family medicine training.[8,14-17]

The consultation and assessment

The axiom "assessment drives learning" is widely accepted as a fundamental principle in medical education[18] and the CFPC's primary summative performance assessment, the simulated office oral (SOO) portion of the Certification Examination in Family Medicine, reflects this. Training and assessment of family medicine residents in Canada should rightly focus on the meetings between doctors and patients as complex things that we can and should do well. The central construct of the SOO is to assess one's ability to conduct a patient-centred consultation, and is currently a universal rite of passage for family

physicians in Canada. The CFPC provides resource material to SOO candidates, describing the construct in part as follows: "The SOOs are designed to simulate an outpatient office-based setting in which family physicians usually provide care."[19] A more accurate way to describe the assessment, rather than emphasizing the sense of place, which the term *setting* implies (and which is further reinforced by referring to the assessment as an *office oral*), would be to state that "the SOOs are designed to simulate the consultation in family medicine." Clarity of the construct under scrutiny is essential to address the validity of any high-stakes assessment. Although patient-centred approaches are crucial for success in the SOO, the assessment is about more than that. It requires bringing all skills to bear—narrative competence, medical knowledge, clinical reasoning, patient-centred communication, and professional and ethical conduct—a complex, multidimensional set of tasks at the best of times. Conflating clinical method with context-free performance in assessment is an act of reductionism that academic family medicine needs to be continually mindful of, and to avoid.[20] The idea of the SOO and its attention to the consultation remains central to the identity of family physicians.

Conclusion

Language does matter. The consultation—both the term and the concept—is the tool that family physicians use daily, clarifies the construct for medical educators in the summative assessment of trainees, and characterizes the nature of the discourse between doctors and patients. It is more than a visit, an encounter, or an interview. The decline of the term *consultation* suggests a lessening and an erosion of the meaning and the importance of the doctor-patient relationship, and all that is happening when patients meet doctors in a primary care setting. As we move toward a reevaluation of assessment practices, describing the outcomes of training in family medicine,[21] and an extension of residency training in Canada, concepts such as the doctor-patient relationship, patient-centred care, and continuity of care need strengthening and renewal. Let us think about the consultation as the central construct of what we do as family physicians. As a result of the COVID-19 pandemic, these interactions are occurring face to face, by telephone, and over video calls, but the general principles of trust, empathy, curiosity, and the doctor-patient relationship remain, regardless of the mode of contact. Until someone thinks of a new word, we should revive not only the use of the word but also the idea of the consultation.[22]

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