Revisiting Stott and Davis and the exceptional potential of the primary care consultation

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It is now well recognised that the consultation should be patient-centred. Roger Neighbour, in his book *The Inner Consultation*, categorises some of the current consultation models according to whether they are doctor- or patient-centred;[1] the Stott and Davis model falls into the doctor-centred category. However, one of the beauties of their model is its simplicity since it has only four areas, and allows some flexibility in consultation style.[2] The areas covered are:

1 Management of presenting problems
2 Modification of help-seeking behaviours
3 Management of continuing problems
4 Opportunistic health promotion.

However, with time the consultation models seem to have become more complicated (see Table 1 and Figure 1).

Table 1 The number of tasks needed for completion by the doctor in various consultation models

	Date	Areas
RCGP	1972	3
Heron	1975	6
Byrne and Long	1976	5
Stott and Davis	1979	4
Helman	1981	5
Pendleton *et al*	1984	7
Neighbour	1987	5
Calgary Cambridge	1996	6

The Pendleton model, for instance, much taught and used for the membership examination of the Royal College of General Practitioners (MRCGP), has seven stages, some with sub-stages, giving a total number of 13 tasks to consider.[3] Neighbour only has five, but is weak on health promotion, and risk factors are considered in Pendleton, but only as one subsection, whereas it contributes over 25% of the consultation in Stott and Davis (i.e. opportunistic health promotion). Given the current focus on health promotion this aspect of the consultation needs to be continually emphasised, which will not happen if its role is minimised as doctors concentrate on all the other stages.

Another current model is the Calgary Cambridge model with six areas but they can be split into 71 subsections.[4] GPs could face the problem of spending more time trying to remember the tasks of the consultation rather than actually connecting with the patient! This is especially true as we try to teach the consultation in a Ugandan setting where the doctor-centred approach has been taught from medical school onwards and patients seem to believe that the doctor always knows best. Simpler models are better even though the others contain all the necessary concepts.

At the International Health Sciences University (IHSU) in Kampala, when teaching consultation skills in our family medicine course, we took the above into account. Some other areas we considered included:

- the students are not used to the direct, to-the-point approach used in the Cambridge Calgary model
- the niceties at the start of the consultation are an integral part of the consultation in this culture, and this affects the opening gambits chosen. So even if the patient has many troubling issues, the starting point of 'How are you today?' is invariably answered by, 'I am fine, and how are you?' One therefore has to allow time for cultural greetings
- it was felt important to stress the positive points in the consultation. Going straight to 'what can be different?' as in Cambridge Calgary model, appeared to be too direct when discussing consultations. This could be related, in Ugandan culture, to the importance of maintaining relationships and also that reflective skills are not taught.

Taking these areas into account, we suggest getting back to basics whilst using elements of the Neighbour, Pendleton and Cambridge Calgary models. We have come up with the revised Stott and Davis model. Doing this we have managed to keep the patient at the centre of consultation, encouraged the use of ideas, concerns and expectations (ICE), and included safety netting along with health-seeking behaviour. We have expanded the health promotion section with patient-centred models of health promotion such as motivational interviewing, discussing health beliefs, and stages of change for lifestyle issues.[5,6]

Meanwhile, in this culture and when reviewing consultations using videos, we have tolerated the niceties at the start of consultation; stressed positive aspects of consultation; and also have looked at 'what could be done differently'. Meanwhile, this model puts the patient at the centre, as a reminder

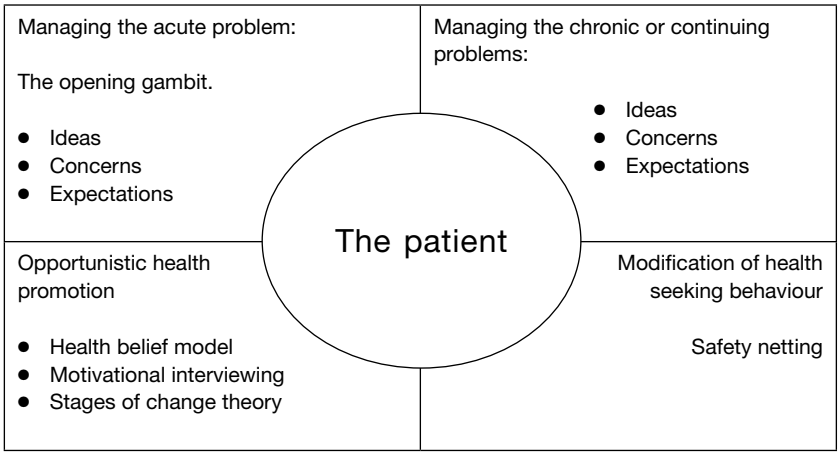

Figure 1 The IHSU consultation model

to consider him or her whenever the other four stages are being used.

References

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