Proposed Consultation style for Pre-Travel clinic assessment developed from existing consultation models

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Background

Much work has been written on the importance and need for a pre-travel consultation following a pre-designed format and often described as a risk assessment (RA).[1,2]

However the use and completion of an RA is only part of the patient/practitioner interaction with the remainder being the style of the consultation with the patient.

Many theoretical styles of consultation are published and documented.[3]

These consultation styles are based on the traditional medical practice of the practitioner interacting with people who frequently deem themselves to be unwell.

In pre-travel consultation the practitioner deals with dominantly well patients who wish to remain well whilst traveling and this then raises the question should they receive advice and supply in the same consultation style as the former category of patients?

In the thesis by Willcox, it is indicated that a travel health consultation is not linear and the rule-based models of Pendleton and Neighbour do not work with the social rules that govern behaviour and interactions.[4] This is currently witnessed and evidenced in current practice where recommended vaccines can be refused or malaria prophylaxis abruptly discontinued.

In a web based search using the key words below there was no close web hit to specific consultation style for pre-travel RA and this was further supported with a review of the Royal College of Nursing (RCN) competencies on travel health nursing which does not mention consultation styles.[5]

By comparison the Royal College of General Practitioners (RCGP) published in their statement[6] the changes that were needed to be made and understood with general practitioners were "illness presenting in general practice requires a normality-orientated approach, as opposed to the disease-orientated approach in secondary care". The RCGP areas of competence highlight that person-centered care relates to

relating to patients as individuals and working in partnership with them.

Information and Resources

The basis of this article is that in the pre-travel RA model a different consultation style could be considered from an amalgamation of several other models. A brief review of the more popular consultation styles is listed below.

PENDLETON (1984)

PROs

Considers other problems e.g. Risk factors. Shared action with the patient.

CONs

Defining reasons assumes the patient has a knowledge of the diseases for prevention or action.

Achieving full shared action is unable to reviewed as compliance to malaria prophylaxis for example has no external patient measurement and the decision making surrounding the proposed vaccinations is subject to other influences e.g. cost.

NEiGHBOUR (1987) *PROs*

By summarising all the known points of the traveller and the destination then the safety net activity will only be partially effective as the patient will ultimately determine the final selection often through financial influence.

CONs

Establishing the rapport- this expects that the patient knows they need some prophylactic measure and that their itinerary will not be changing. A recent study[6] indicates that pre travel history does not adequately reflect what patients do.

COHEN-COLE and BiRD (1989)

This introduced the Three Function Model of gathering data, developing rapport, education and motivation; and describing the functions of the prescriber and the skills necessary to be used in each function.

LAUNER (2002)
Launer developed the concept of narrative based medicine where there is no definite answer to why has the patient attended for consultation as this often raises more questions as expected.[8] However in the *BMJ* article the evidence based clinicians held onto the importance of their expertise; however the clinical assessment draws on narrative overlapping ideas and views told by patients, clinicians and patient representatives. As clinicians we select the most appropriate prevention of treatment on clinical grounds and disassociation is experienced when occurs when we the narrative paradigm is abandoned.[9]

In other words the skills that help the patient to understand better (e.g. the need to have all selected vaccines rather then just self-select) are specific to the timing of appropriate questions and to the spirit of the eventual outcome (e.g. what may occur if these vaccinations or prophylaxis are avoided or not completed) rather than the production of clinical evidence.

Discussion

Any designed consultation model for use in a travel health assessment where a healthy patient presents themselves for travel abroad and wishes to remain healthy has an element of risk. The clinician can pro-vide the technical advice but the views of the patient (often subjective) can lead to some or all of the advice being disregarded and increasing the public health risk. These are more likely to occur in a private pre-travel clinic than a traditional GP surgery. To reduce the subjectiveness but still maintain the patient right of choice then the proposed consultation model could be adopted for such consultations:

1 Connecting to establish rapport (Neighbour)
2 Gathering Data (Three Function)
3 Define the reason for the patient's attendance (Pendleton)
4 Education and motivation (Three Function)
5 Narrative based handover (to raise points of concern and negotiate behaviour change) circularity and co-creation
6 Narrative based safety net- curiosity, contexts, caution

Further research

There appears to be a requirement for an adapted consultation model with behaviours for specialist private clinical service that has a higher risk element due to the patient financial considerations or their behaviours. Further study of determining how and when the timing of the appropriate questions with respect to the views of the patients during the consultation need to be completed.

Keyword data search

Medical, consultation, style, travel, clinic, pre travel, risk, assessment, patient, framework.

References:

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