

YEAR 1 CLINICAL CONTACT IN PRIMARY CARE SESSION
Thursday 1st February 2024 – am or pm - group B
Themes: Cardiovascular
Consultation skill: gathering

| Session plan | | Suggested timings: AM | PM |
|------------------------|-----------|-----------------------|---------------|
| Introduction | 30 min | 09.00-09.30 | 14.00-14.30 |
| Patient contact | 1 hour 20 | 09:30-10.50 | 14.30-15.50 |
| 10-minute break | | | |
| Debrief and discussion | 50 min | 11:00 – 11.50 | 16:00 – 16.50 |
| Close | 10 min | 11:50 – 12.00 | 16:50 – 17.00 |

The busy GP teacher will find all you need to know for the session in the first two pages. The format is the same as previous sessions. Please use this plan in conjunction with the GP teacher guide which can be found [here](#). The appendix below contains information extracted from the students' digital notebook (OneNote) and resources to enable you to help the students make links between the patients they see and their learning at the university. This includes the patient's lifeworld (relevant background factors), the concept of the iceberg and the acronym ICEIE to find the patient's perspective (Ideas, concerns, expectations, impact and emotions).

The consultation skill focus this session is on the information doctors gather, including finding out the patient's agenda and their ideas, concerns, and expectations. Please also consider with the students how we can remotely examine patients, and address and manage risk factors for heart and respiratory diseases.

Timings are approximate and flexible. Most important is patient contact with subsequent discussion and reflection. Patient contact ideally involves a mix of students observing/participating in consultations and meeting patients, in their own homes where possible. Please use your own clinical experiences to feed into the discussion. It doesn't matter if you don't cover everything, relevant alternative discussions or activities are fine. Any problems on the day, please email PHC-teaching@bristol.ac.uk or call 0117 4282987.

Central University teaching context

Case-based learning focuses on a male student who is training for a marathon. He is motivated by body image. He has considered buying anabolic steroids. He gets lightheaded getting out of the bath. Older members of his family have hypertension. He asks his GP for advice. These sessions are supported by lectures and lab-based practicals.

In **effective consulting labs**, the focus is on gathering information and taking a broad history in three domains: the medical problem, the relevant background, and the patient perspective. The students create their own patient scenario, they consider what questions doctors might use to gather information in these areas, and practise this.

Learning objectives

By the end of the session, students will be able to:

- Describe the risk factors for cardio-respiratory disease and the role of the clinician in health improvement and illness prevention
- Practise gathering information from a patient building on skills of active listening
- Explain the use of signposting and summarising in the clinical encounter
- Discuss how to manage emotion in the consultation
- Describe the importance of eliciting the patient's agenda and how the patient's ideas, concerns and expectations inform the health professional's understanding of the problem

GP advance preparation

- Read this guide: arrange a patient with a current or past cardiac condition to meet with half the students (at home or in the surgery).
- Arrange a short surgery (3/4 patients) for the other half of the students to observe. These consultations do not have to be linked to the system in case-based learning.

| | |
|---|--------------------------------|
| Welcome, catch-up and introduction (30 min) | 09.00-09.30 or 14.00-14.30 |
| <ul style="list-style-type: none"> • Welcome and check in • Pastoral check in, anything for you to be aware of? Offer support and one-to-one discussion if needed • Run through the learning objectives, session plan and timings for this session <p>You may wish to:</p> <ul style="list-style-type: none"> • Revise preparing and opening from the last session • Brainstorm the broad areas of the medical history • Consider the elements of the cardio-respiratory system that can be assessed clinically in GP e.g. pulses, O2 saturations, BP, heart sounds. Think about how these could be assessed remotely | |
| Patient contact (1 hr 20) | 09:30-10.50 or 14.30-15.50 |
| <ul style="list-style-type: none"> • Half the students interview a patient – ideally a home visit but can be at the surgery if needed • The remaining 2 or 3 students observe you consulting with 3 or 4 patients <p>You may wish to brief the students on the patients in advance. Whether they are interviewing a patient or observing consultations, the students should all introduce themselves to the patient by name and role.</p> <p>Patient interview. Ideally, this will be a patient with a current or past cardiovascular problem such as angina, previous MI or CCF. Students should take it in turns to lead the interview and be prepared to feedback to each other on consultation skills (see the GP Teacher guide for practical information about this and a patient letter).</p> <ul style="list-style-type: none"> • Discuss what information can be gathered from active, purposeful observation of patients • Try to gather a history in all three domains • Ask about symptoms and any known risk factors for heart disease • Reflect on how you or the person you observed facilitated rapport with the patient <p>Observing consultations. Ask the students to practice and observe communication skills, for feedback and discussion in the debrief.</p> <ul style="list-style-type: none"> • Verbal/non-verbal communication skills which help the patient tell their story/demonstrated listening • How did you encourage the patient to talk? Were there any silences? • Were there any difficult points in the interview and how did you deal with these? • Observe how the GP prepares for and opens the consultation (COGConnect template, available here) • Reflect on gathering information, the content and process and what questions worked well | |
| 10-minute comfort/toilet/stretch/tea break as needed | |
| Debrief and discussion (50 min) | 11:00 – 11.50 or 16:00 – 16.50 |
| <p>Ask one student to summarise the patient's story from the patient interview.</p> <p>Discuss and reflect on the patient's narrative — you may wish to use the reflective tool based on the 5C's of COGConnect to aid this — available here. Reflect on the experiences of having a heart problem and how these impact on patients' lives</p> <p>Students present the patients from observed consultations to the group: debrief, feedback and discussion around any issues that arise</p> <ul style="list-style-type: none"> • Discuss which communication skills and question types worked well in the patient encounters with specific focus on gathering the history and finding out the patient's ideas, concerns, and expectations • Discuss risk factors for cardio-respiratory disease and the role of primary care in health improvement and illness prevention • If not done already, discuss cardiorespiratory examination that can be done remotely (see p3 below) | |
| Close (10 min) | 11:50 – 12.00 or 16:50 – 17.00 |
| <ul style="list-style-type: none"> • Take home messages – share something learned/something that surprised them/ a learning goal etc. • Remind students about their reflective log/ePortfolio • Discuss what worked well/less well – anything to stop/start/continue for future sessions? | |

GP tasks after the session

- Make own **reflective notes** on the session if you wish (try to keep a record of which students interviewed patient/consulted).
- Prepare for and consider appropriate patient to invite to the next session (with your other group Thurs 15th Feb 2023, CBL fortnight: Respiratory. Cons skill focus: gathering information and formulating)
- Complete online **attendance data**

Any questions or feedback, contact phc-teaching@bristol.ac.uk or lucy.jenkins@bristol.ac.uk

Remote assessment of the cardiorespiratory system

Ask the students to think about what they already know about how a standard cardiorespiratory examination would be done in GP or hospital and consider which parts of this may be able to be done remotely? Consider the following:

- Observation around the patient. Look for clues like portable oxygen.
- General appearance via video. Do they appear to be in pain or breathless or unwell? Can you assess complexion?
- How much can you easily see by asking the patient to show you e.g. chest wall movements
- Can you count a respiratory rate in a video or telephone consultation?
- Show students the equipment that you use which some patients may have at home e.g. thermometer, home BP machine and oxygen saturations monitors (many have invested in these during the pandemic). Discuss any advantages and disadvantages of this.
- Discuss if and how can we teach our patients to take their own pulse and resp rate remotely.

Optional additional activities if needed (taken from GP Teacher Guide)

The session plans are reasonably full but sometimes patients cancel or there may be other circumstances when additional teaching resources are needed.

- Activity practising patient introductions – see [here](#)
- Discussing recent cases you've seen relevant to their learning
- Students could observe you telephone consulting or participate if the patient consents. They could use the observation tool in the appendix
- **Show and tell** with common consulting room equipment. E.g. thermometer, auroscope, sphyg, urine dip, swab, sats probe. Hold one up and ask students to tell you what it is, how to use, what is normal etc.
- Use <https://speakingclinically.co.uk/>. Watch together a clip of a patient describing a condition and then reflect on this as a group. Log in at <https://speakingclinically.co.uk/accounts/login/>. Use email as phc-teaching@bristol.ac.uk. Password: primcareGP1GP2
- Discussing significant events that have occurred recently at the surgery
- Role play as below

Role playing a simulated patient as a group

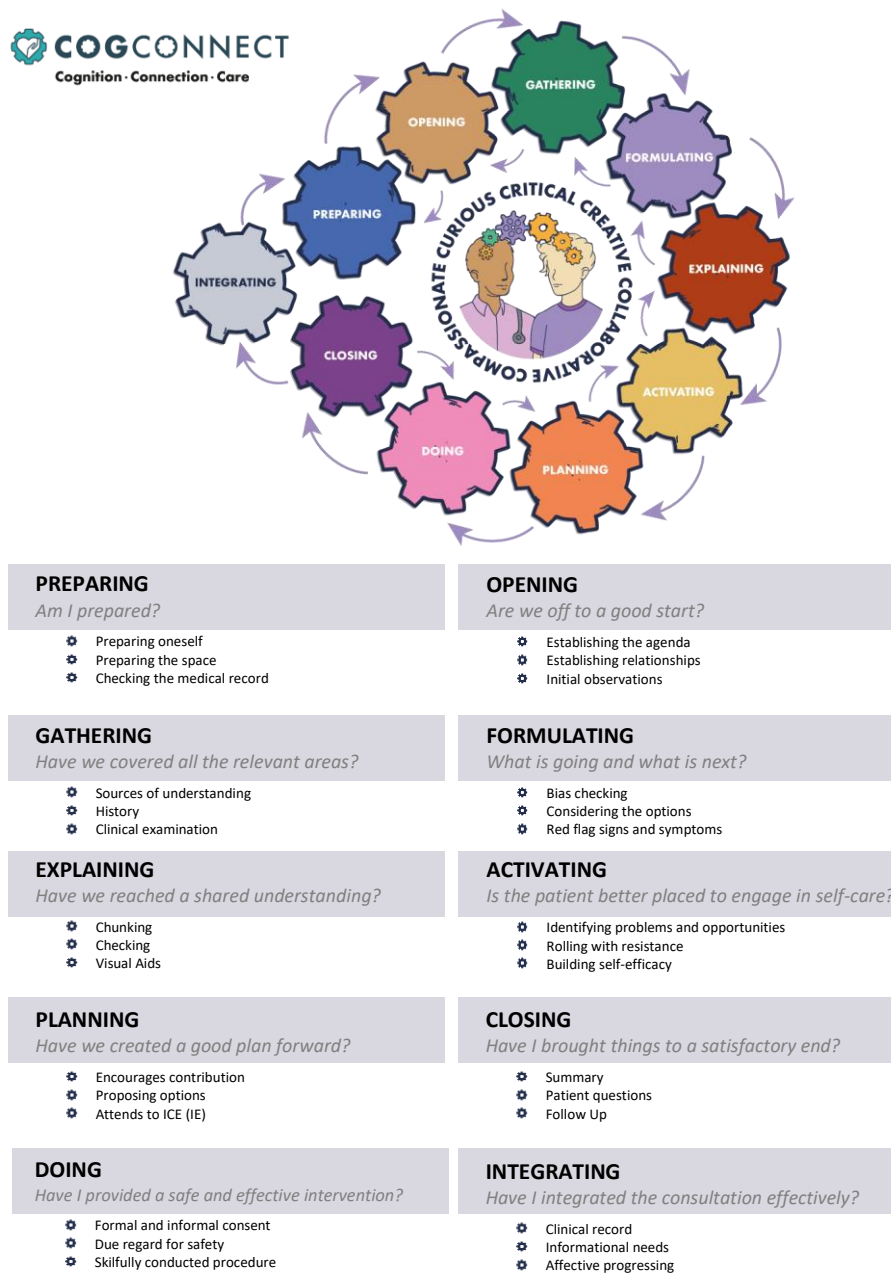
One student plays the patient, another is the medical student meeting the patient before their consultation. Please allocate the others specific areas to observe and give feedback on the role-play afterwards.

An example would be a patient who has recently had an MI who you suspect is not taking their newly prescribed secondary prevention meds. The patient's agenda is centred on fear that they will not be able to return to work/exercise/social life and they want to know about this.

APPENDIX 1

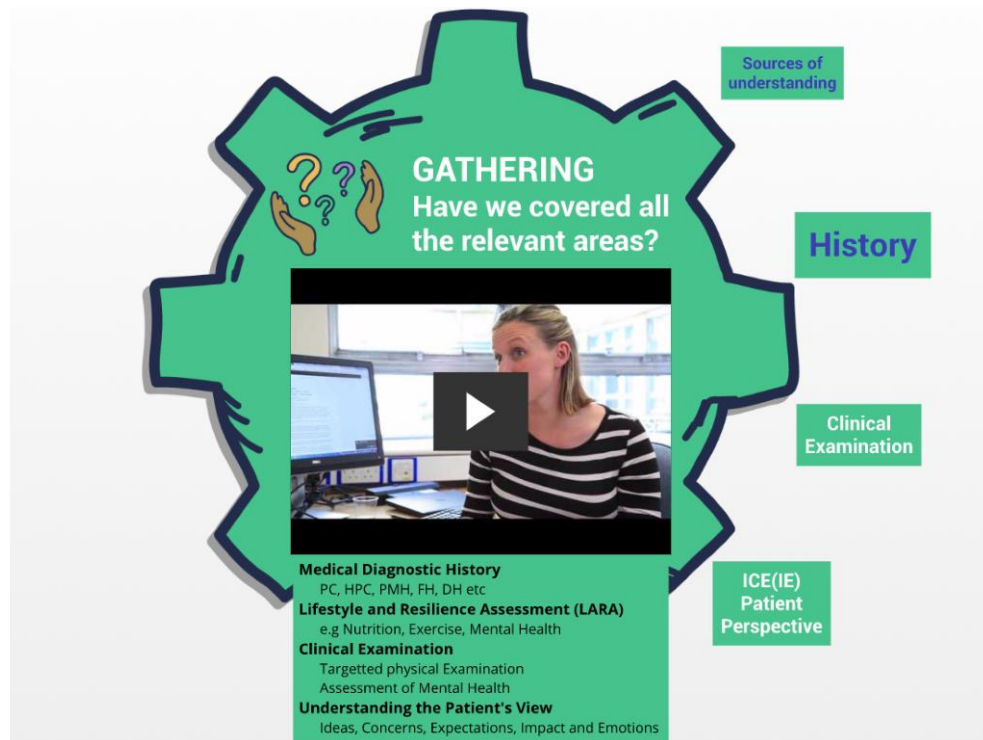
The following pages are extracted from the students' digital notebook (OneNote) and covers the relevant phase of COGConnect (toolkit for teaching and learning about clinical encounters). In this session they consider GATHERING, including sources of information, history, and examination. **GP TEACHERS DO NOT HAVE TO READ THIS BUT IT MAY FURTHER INFORM TEACHING**

In EC Labs, you will learn about gathering clinical (hi)stories: the bracket is there deliberately – at this stage, we want you to have clinical conversations with patients using your clinical communication skills to find out their story. You will develop specific 'history taking' skills over time.



The generic communication skills you need to develop in order to effectively gather clinical information include active listening, open questions, summarising, signposting, preparing, and opening well. These are all skills you have been introduced to in previous EC Lab Tutorials. You will also start to develop communication skills around gathering more specific and detailed information. For example: *how* you ask someone about their past medical history, *how* you ask someone about their lifeworld (the lived experience of the patient and their environment), and *how* you discover the patient's own ideas about what is happening. You will develop these through skills practice in the safe space of your EC lab, and then with real patients on the ward and in GP.

Describe the structure and components of a medical history.



You can watch the video on gathering information here: https://www.youtube.com/watch?v=YT2lv8_ID80&

In order to form a well-rounded impression of what's going on, you should be able to answer 3 questions:

1. What is the nature of the current medical problem?
2. What is the patient's perspectives on the problem?
3. What are the relevant background (lifeworld) factors?

As a medical student, you will learn how to gather information about the nature of the current medical problem, from your patients, in a structured way known as the "medical history." It is an important skill to learn because to be a doctor you need to find out all the relevant information you need from a patient in an efficient way to make a diagnosis or solve a problem, so that you can make a plan of what to do next.

The medical history is a structured assessment which, done well, helps to answer the first questions above and contributes to the other two. It includes:

- The patient's current health and health problems
- The patient's previous health problems
- Current and previous treatment
- Factors which might affect the patient's health and their response to treatment e.g. their perspective or risk factors, current lifestyle choices etc.
- The patient's family's health

The medical history is only a *part* of the medical assessment as useful information also comes from the clinical examination, and results from tests and investigations, and sometimes from other people (third parties). Making a diagnosis is not the only goal; to make an overall medical assessment (clerking) and form a plan you need to know the patient's perspective (what's important to them about their symptom and situation, how it impacts them, what they think is going on, what they are worried about and what they are hoping for or what their goals are.) Part of this is sometimes shortened to Ideas, Concerns and Expectations (I.C.E), although there is a broader picture to be gained. Be curious about your patient, their condition, their experience, and their circumstances.

Your goals as a medical student

- Understand, learn how, and then practise how to assess the medical history.
- Understand, learn how, and then practise how to do a clinical examination.
- Be able to gather enough information to define the problem to be solved.
- Be able to gather enough information to form a sensible idea of what might be going on.
- Give a clear presentation of the medical history, examination, investigation and test results and your differential diagnosis to your colleagues.

Learning to do this takes time, observation of more experienced peers and doctors and LOTS of practice. In Year 1 the focus is on health, not pathological symptoms. We do not expect you to learn to do a complete medical assessment just yet, that will be introduced in Year 2. But we do want you to think about the **broad areas** that a doctor can assess in a patient, and to be introduced to the concept and structure of the medical history.

The patient's current health and health problem ('presenting complaint')

This really means the main symptom/s the patient is seeking medical advice about; it helps define the problem to be addressed. This may or may not be obvious. A patient may tell you a clear symptom "*I've got chest pain*" or you may have to do a little more investigation to identify any symptoms. For instance, in your CBL case, Harry may start with: "*I've come for advice; I want to run a marathon, but I am worried about my health.*" Harry's presenting complaint is his symptom e.g. light-headedness. There is often more than one presenting complaint, and these may or may not be linked. In emergency situations where the patient is not able to articulate, the presenting complaint may be "collapse." In small children and babies, or in patients who are unable to articulate the problem, it may be expressed by a carer or witness "*they seem a bit breathless compared to usual.*" Sometimes the presenting complaints are not entirely clear until you've really listened to the patient and asked some clarifying questions.

Practising doctors often work with problem lists more than symptoms: in Harry's case, although his "*presenting complaint*" is light-headedness, it's not his only *problem*—he has come for advice on exercising, he is also worried about his risk factors for hypertension. Also, patients have their "*agenda*" (the things they want to discuss) and the doctor has theirs. In Harry's case his doctor would also want to address anabolic steroids with him and find out his perspective on body image. The doctor would need to gather information about all these problems in the same way that information is gathered about a symptom.

Medical students talking to patients who are describing past rather than current events often find it tricky to know what the presenting complaint is. You can tackle this in two ways; it really depends on what your purpose is. If you want to learn how to structure a history, practise forming a diagnosis and present a history to your tutors you can focus on a past event as if you were seeing the patient at the time. Consider the presenting complaint of the patient *at the time* they first sought medical advice. For instance, if you meet a patient with a pacemaker ask them about the events that led up to their diagnosis and treatment, they may describe how they noticed their heart racing and felt dizzy before they passed out. In this case palpitations, light-headedness, and collapse would be the presenting complaints.

The other way to structure a patient's history is to start with a *problem list*, which is what doctors in clinic often do. The patient visiting a cardiologist (heart specialist) may have come for a review of their medication and not need a diagnosis making. So rather than start with a symptom or symptoms, you start with key diagnoses and a problem list e.g. 1) Hypertension. 2) Depression.

Background to the current health problem ('History of the presenting complaint')

You can use open questions "*Tell me more about that.*" or "*Talk me through exactly what happened.*" For each symptom, there are a number of possible diagnoses, and in time you will learn the questions doctors need to find out the answers to help them decide what is going on.

- Before you ask more questions, clarify exactly what the patient means. What exactly are they experiencing?
- Remember to use open questions at first to let the patient explain in their own words. Later you can use more closed questions to clarify.
- To assess a particular symptom further you need to ask specific, often closed, questions about it. Does the symptom come on suddenly or gradually? How severe is the symptom, or what does it stop you doing? When and how often does it happen and what is it associated with? It's important to know the context in which the symptoms happen. What happens, where and when? Is there a clear trigger? What relieves the symptom or makes it better?

MacLeod's Clinical Examination chapter on history taking has a box of questions to further assess specific symptoms.

- Red Flag symptoms. You will also learn about specific symptoms for a presentation that may be serious or urgent that must not be missed. These are called Red Flags.
- What does the patient think about their symptom or problem? They will often have read about it or spoken to friends or family. They may be worried about what's going on, even if they don't really think it's serious, they may want to be sure. How is it affecting them? What are they hoping for? They might want an explanation, reassurance or advice, medication, or further investigation.

More about the nature of the patient's health: Systematic enquiry

When you are learning a medical assessment, this is often put at the end as a catch all "sweep" of all bodily systems in case you or the patient have forgotten anything. It's useful to practise these questions when you are learning. As you get more experienced you will learn to target the systematic enquiry to the presenting complaint and then it is more useful early in the medical history. MacLeod's Clinical Examination chapter on history taking has a useful table on the Systematic Enquiry listing all the cardinal symptoms for all different systems e.g. cardiovascular.

The patient's previous health issues ('Past medical history')

Here you want to consider the patient's other health problems current or in the past. Have they had any operations or serious illnesses?

Current and Previous Treatment ('Drug history' and other interventions tried)

For all medications (prescribed and non-prescribed) find out the name, the dose, the route by which they take it, how often they use it and for how long. Does the patient remember to take their medications or not? Patients may only mention prescribed medicines so ask about medication they've bought from a pharmacy, on-line, or herbal or homeopathic remedies. What have they taken in the past? Is there any medication they are known to be sensitive or allergic to?

The patient's family's health ('Family History')

You should ask general questions about the patient's family "Are there any illnesses that run in your family?" and then about relevant illnesses linked to the presenting complaint. It can also be useful to find out details about the family members. This will give you an indication of a patient's support network. It can be useful to draw a family tree including parents, siblings, and children.

Social history

This really is last but **very definitely not least**. **Here you want to really understand all about the patient's life, their lifestyle, and their circumstances.** This is the area of the medical history that often sheds light on the cause of the problem and holds the key to making a good management plan. There are many aspects you can find out about so consider what is relevant to the situation. In a patient who is at risk of blackouts or falls it's important to know if they live alone. A patient who has come with palpitations might be drinking excess alcohol or caffeine. There are a few areas to consider which are laid out in MacLeod's Clinical Examination "The social history" which includes diet, exercise, mood assessment, sleep, home life, occupation, finances, support and hobbies and interests. Alcohol, smoking and recreational drug use are often important, as are a relationship and sexual history if relevant. Again, being curious about your patient, their condition, their experience, and their wider circumstances will enable you to gather lots of relevant background and lifestyle information. More broadly, it will also help when making management plans: a patient with constipation might not be able to easily alter their diet based on your recommendations if they are only able to eat tinned food from a foodbank. A patient who is well supported by a community or family network might cope with a life changing health condition more easily than someone who is very isolated.

Risk Factors for Cardiovascular disease

Several factors increase the risk of a person developing disease of the heart, blood vessels or a stroke. These include:

- Smoking
- High blood pressure
- Blood lipids
- Other conditions such as Diabetes, Rheumatoid arthritis, Depression
- Older age
- Family history
- Stress
- Indian subcontinent or Afro-Caribbean ethnicity

As you can see, some risk factors are modifiable e.g. smoking, in other words the patient can do something about them such as stop smoking or take medication or change their lifestyle to reduce

their blood lipids and blood pressure. Other risk factors such as ethnicity, family or age are not modifiable. Doctors identify risk factors to help predict the likelihood of someone developing disease and focus on the modifiable risk factors to try and prevent disease occurring (primary prevention).

When you are meeting a patient on the ward, think about HOW you ask questions to get into these topics. Some of this will be part of your clinical history "do you smoke", some will be related to 'non-medical' aspects of lifestyle and others will be related to lifeworld (the experience of the patient and their environment – for example, adverse childhood events, poor housing, living in a 'nutritional desert'). HOW do you ask someone things like this? You will have practiced this in your EC Lab. Give it a go with real patients on the ward and in GP.

Top tips for medical students in gathering information

Help! The patient isn't giving me the information in the right order.

Medical students often worry that they are not finding out information in the same order that they document it, or present back to their tutors. Don't worry. Consulting with patients is a very different thing to writing up a medical history or presenting structured information about a patient to your tutor. When you are talking to patients, please don't get hung up at this stage about the order in which you ask questions or even asking "the right" questions. We just want you to have *conversations* with patients. We suggest you use the broad headings of the medical history as conversation prompts to remind you of areas to talk about. That's why in Effective Consulting we call this part of the consultation "Gathering Information." When you review and think about the information you've gathered and consider what might be going on (the stage we call "Formulating") or write up a patient's medical history or present it in a formal, structured way you will realise areas you missed or questions you wish you'd asked. The more you talk with patients in this way the more you will move towards a more structured conversation. If you realise you've forgotten to ask something while you are with the patient, you can always go back and ask it.

"Have you experienced any dyspnoea?"

"Excuse me?" As a medical student, you are learning a new language, and you will do so quickly. Medical terminology is known as "jargon" and it may be efficient, concise, and precise when it comes to writing up a history, but it shouldn't be a part of talking to patients. Be natural. Use the words you use every day, even better use the terminology and analogies that the patient uses. *"You said you're training for a marathon, have you noticed getting more out of breath than usual when you're running?"* Be careful with terms that can mean different things to different people e.g. asking about "drugs" when you mean medication. Also clarify any terminology the patient uses.

I can't ask that!

All sorts of questions may seem embarrassing to ask about when you start out. You may not be used to asking about people's feelings or their bowel habit. Remember to ask these questions in the same matter-of-fact manner as you ask the rest of the questions in the history. It can help to "signpost" a sensitive question or ask permission or explain why you need to know first. *"Tummy pain can come from the gut, so I want to ask you about your bowels."*

Write down phrases you hear doctors or colleagues use. Above all practise phrasing questions in a way that feels right for you and reflect on how they are working.

I can't remember all the questions (Warning: Do not simply rote learn lists of questions to ask).

When you are learning to gather information, it can be useful to have a list of questions to practise, or to fall back on when you get stuck. However, if you routinely run down a list of questions with the

patient you will exhaust yourself and them and end up with a lot of information that you don't know the meaning of. Try not to ask questions for the sake of it but think about what you need to ask and why. Every symptom has a number of different causes, think what those causes might be and what questions will help decide if a cause is more or less likely.

Assessing the cardiorespiratory system

You will be introduced to pathology and symptoms such as chest pain in Year 2. In Year 1 you are looking at how the normal cardiovascular and respiratory systems are structured (anatomy) and how they work (physiology). You will now be aware of that the processes of the heart, lungs, and cardiovascular system can be assessed clinically. What can we measure to assess the cardio-respiratory systems?

Traditionally doctors gather information through observation as part of the opening and throughout the consultation and through clinical examination. You will learn about this in secondary care and have opportunities to develop and practice these skills in future. In your GP session, you will consider how the cardiorespiratory system can be examined and assessed remotely, including observation on video consults and patients testing things at home.

Background information about GATHERING through (hi)stories

The students are given this information before their EC Lab tutorial to contextualise the idea of Gathering information through clinical (hi)story taking.

“The case history negates pain, distances the physician from the patient and thus sanitizes suffering. It is a highly useful, necessary tool, but it is a reductionist, “minimalist” reconstruction of a person's illness narrative.”

SOBEL, R. J. 2000. Eva's Stories: Recognizing the Poverty of the Medical Case History. Academic Medicine, 75, 85-89.

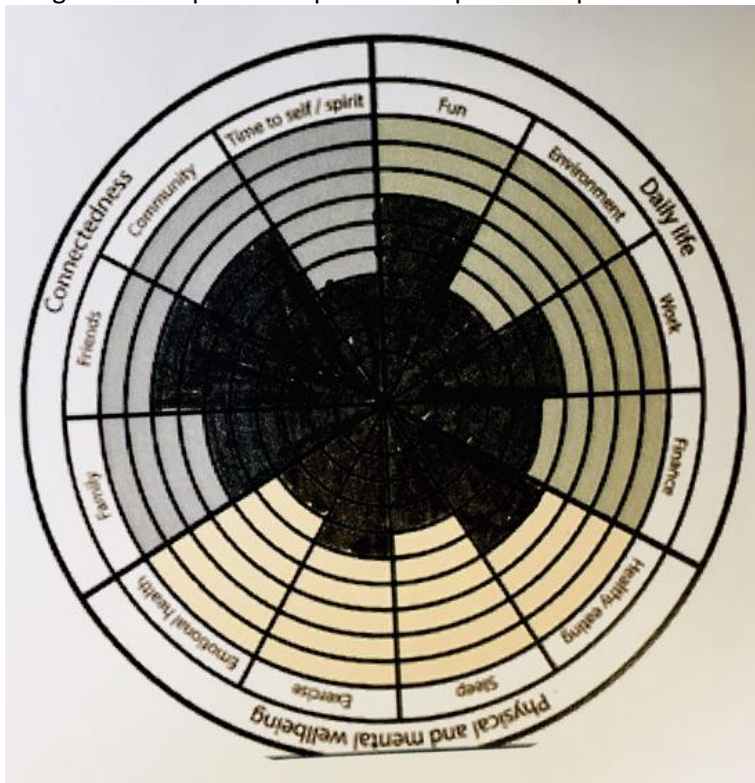
Our wish for you and your future patients, is that you will consult in a way which is genuinely curious about the person in front of you, their health, wellbeing and illness, the patient's own perspective on this, and relevant background and lifestyle information.

In order to do this, we are steering away from the traditional case history as a tool for *learning how* to gather clinical information in the first instance. You will come across this in clinical practice, and you will necessarily need to learn and use it yourselves in future. For now, however, we would suggest that you view this (the case history), the wellbeing wheel, and any other templates and tools as maps to guide you, rather than checklists to box you in. A checklist approach to healthcare can feel very disempowering for both you and patients.



Imagine the case history as a map of the landscape of the **patients' medical problem**, the wellbeing wheel which you were introduced to in Foundations of Medicine as a map of the **patient's background and lifestyle**, and ICEIE (ideas, concerns and expectations, impact, and emotion) as a map of the **patient perspective**.

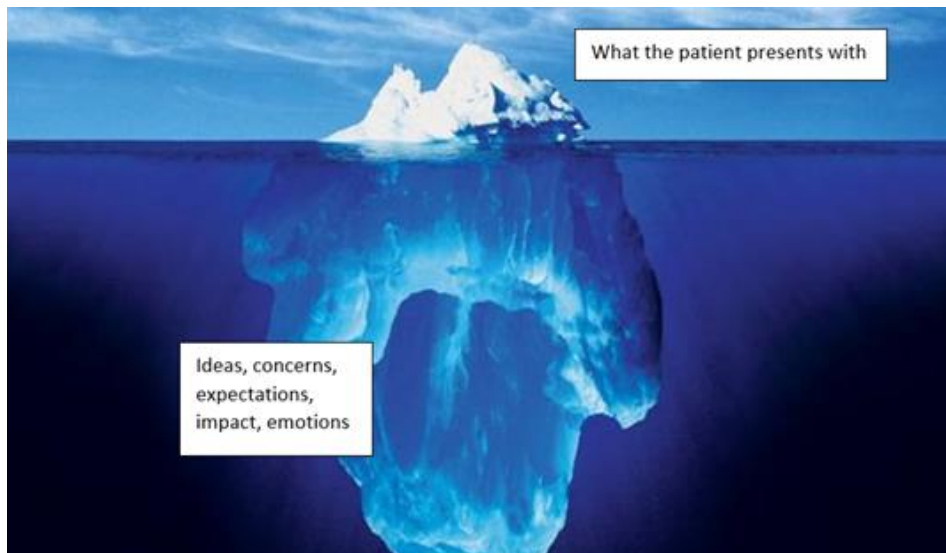
You may not cover all the points on the case history map in one go, or in a linear fashion. You may get to the same destination going different ways each time. The map will help you navigate, but don't follow it blindly like a sat nav. The **wellbeing wheel** is a pictorial representation of areas that can be explored in a patient's background and wider life. It's currently employed in some specific clinical settings and is often used for self-assessment (as you have done) or in coaching style relationships, but in day-to-day clinical practice many of your clinical tutors will not have come across this before. Our hope for you is that you will use this as a way to imagine the lie of the land in this particular area of the map it can show you the highs and lows, and how smooth or rocky things are for a particular person at a particular point in time.



ICE(IE)

- Ideas
- Concerns
- Expectations
- Impact
- Emotions

ICE(IE) can be visualised as the topographical representation of an iceberg, where much of what is really going on happens beneath the surface. People are often reluctant to express their worries, fears, hopes and expectations, and it's key that we find a way to elicit this information.



How does Gathering fit with a traditional medical history?

GATHERING is a deliberate phase of the consultation in which one GATHERS information from and with the patient. It is MORE than just another word for history taking/clerking.

In many ways it is a **bringing together of the process and content of history taking, clinical observation, clinical examination and the communication and practical skills that are required to do these things well.**

It acknowledges that there is more to patients than a collection of signs and symptoms: the patient perspective has equal prominence with the nature of the current medical problem and any relevant background. Relevant background includes 'lifeworld' which again is 'more' than just lifestyle (see the article on the next page for a summary). The wellbeing wheel is a good map of lifeworld issues and can be used to guide this part of information gathering.

For traditional 'history taking' we can see below the overlap of the 3 domains of:

1. Nature of the current problem
2. Background and lifeworld
3. Patient Perspective

GATHERING 'history' also includes obtaining information from notes, relatives, letters etc.

GATHERING will further include information from clinical examination. This will be guided by the information you have received during the (hi)story phase.

And finally, GATHERING includes information from bedside tests. You will cover this in your secondary care learning.

| | | | |
|---------------------------------------|--|---------------------------------|---|
| Nature of the current medical problem | | | Presenting problem |
| | | | Current health and current health problem |
| | | | History of presenting problem |
| | | | Background to the current problem |
| | | | Systems review |
| | | | More about the nature of the patient's overall health |
| | | | Past medical and surgical history |
| | | | Patient's previous health issues |
| | | | Drug and treatment history |
| | | | Current and past treatments and interventions |
| | | | Prescribed medication |
| | | | Allergies |
| | | | Over the counter meds |
| | | | Other interventions |
| | | Relevant Background / lifestyle | Social history |
| | | | Social history: occupation, smoking, alcohol, accommodation, etc |
| | | | Other background information |
| | | | Risk factors – modifiable, and non-modifiable |
| Patient perspective on the problem | | | Assessment of wellbeing, lifestyle and relevant background - Connectedness (family, friends, community, self) - Physical and Mental wellbeing (sleep, healthy eating, exercise, emotional health) - Daily life (finance, work, environment, fun) |
| | | | Ideas, concerns, expectations, impact, emotion (ICEIE) |
| | | | Ideas the patient has about their health and condition |
| | | | Things the patient is hoping to happen in the consultation today |
| | | | Concerns that patient has about the consultation, their health, their condition or anything else |
| | | | Impact that the patient feels this is having/ will have on their health, or more generally |
| | | | Emotions around the consultation (anger, fear, relief etc) |

As you progress through your medical degree you will be introduced to the concept of a 'medical history': the formalized way in which we clinically record and present information both verbally and in writing. P11-20 and 32-39 of McCleod's Clinical Examination (13th Ed) provide an outline of content and format.

You are not expected, nor encouraged, to have clinical conversations with patients in this checklist fashion. The template here is provided to illustrate how GATHERING information through history overlays with a more traditional clerking structure. Remember, Gathering is broader than just 'history' it includes other sources of information, previous results, examination findings etc.

How to use this template: use this as an observation and reflection tool. Did you, your peers or your GP gather this information? How was it obtained? What worked well?

What is Lifeworld and how is it relevant to healthcare?

Lifeworld is more than lifestyle (which implies an element of choice), it is a sociological concept which encompasses the lived experience of the patient and their environment. For example, it can include the effect of poor housing, living in a nutritional desert, difficult family circumstances, political realities etc. All the things that we in General Practice are well-aware can have a significant impact on our patients' lives and health.