ADDITIONAL MATERIAL FOR YEAR 1 CLINICAL CONTACT IN GP

05/2/26 – am/ pm - group B

Theme: Cardiovascular. Consultation skill: gathering information

The following pages are extracted from the students' digital notebook (OneNote) and cover the relevant phase of COGConnect toolkit. In this session they consider GATHERING, including sources of information, history, and examination. Thus includes information about risk factors for heart disease as part of the cardiovascular history. It also includes, ICE, the concept of the clinical iceberg and the patient's Lifeworld. **GP TEACHERS DO NOT HAVE TO READ THIS BUT IT MAY FURTHER INFORM TEACHING**, with some student observation tasks and some GP teacher tips.

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.

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PREPARING
Am I prepared?
- Preparing oneself
- Preparing the space
- Checking the medical record

OPENING
Are we off to a good start?
- Establishing the agenda
- Establishing relationships
- Initial observations

GATHERING
Have we covered all the relevant areas?
- Sources of understanding
- History
- Clinical examination

FORMULATING
What is going and what is next?
- Bias checking
- Considering the options
- Red flag signs and symptoms

EXPLAINING
Have we reached a shared understanding?
- Chunking
- Checking
- Visual Aids

ACTIVATING
Is the patient better placed to engage in self-care?
- Identifying problems and opportunities
- Rolling with resistance
- Building self-efficacy

PLANNING
Have we created a good plan forward?
- Encourages contribution
- Proposing options
- Attends to ICE (IE)

CLOSING
Have I brought things to a satisfactory end?
- Summary
- Patient questions
- Follow Up

DOING
Have I provided a safe and effective intervention?
- Formal and informal consent
- Due regard for safety
- Skilfully conducted procedure

INTEGRATING
Have I integrated the consultation effectively?
- Clinical record
- Informational needs
- Affective progressing

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Describe the structure and components of a medical history.

You can watch the video on gathering information here: https://www.youtube.com/watch?v=YT2Iv8_lD80&

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).

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.

Background information about GATHERING through (hi)stories

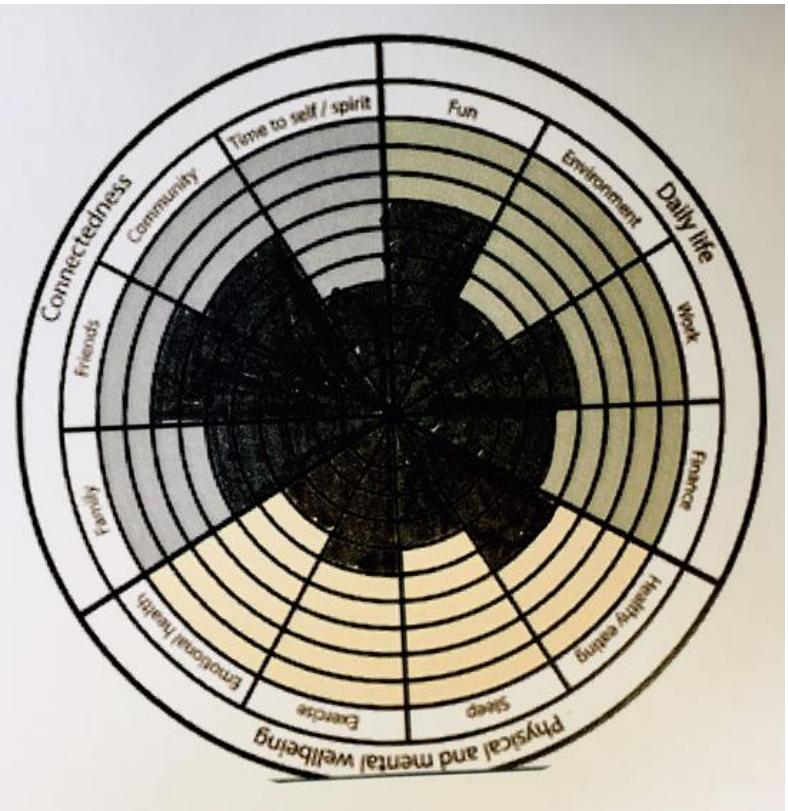
The students are given this information before their EC Lab tutorial to contextualise the idea of Gathering information through clinical (hi)story taking.

"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**.

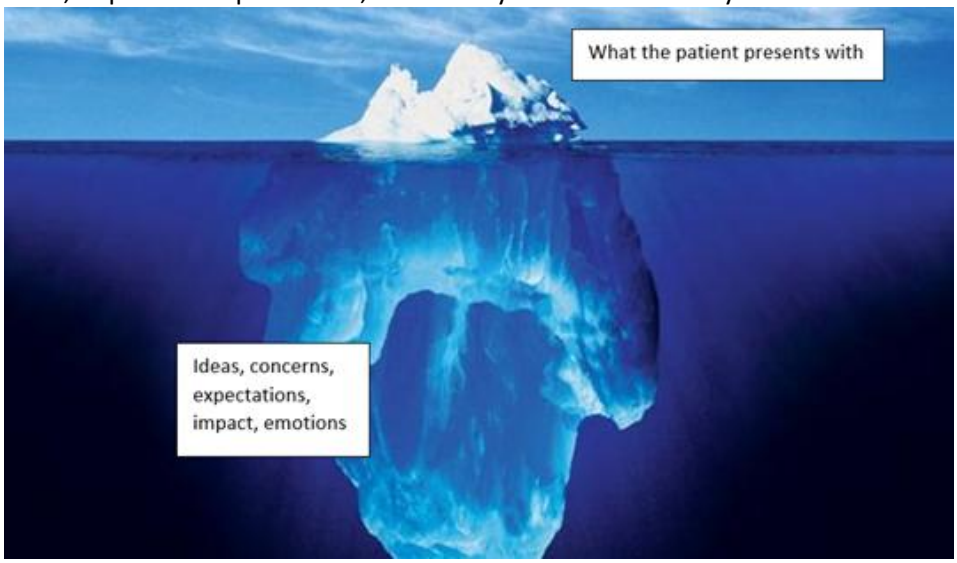
You may not cover all the points on the case history map in one go, or in a linear fashion. You may get to the same destination going different ways each time. The map will help you navigate, but don't follow it blindly like a sat nav. The **wellbeing wheel** is a pictorial representation of areas that 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 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.