History Taking in the CSA- An 'Open' Forum for Discussion or A Case 'Closed'? –

Part 1 : "Tell me more!"

This article will be split into 2 parts – the first will look to deconstruct the statements which belong to the following domains

GLOBAL

Reasons for failing:

1. **Disorganised and unstructured consultation**

DATA GATHERING

Reasons for failing:

4. **Does not identify abnormal findings or results or fails to recognise their implications**

Before considering the approach one should look to perfect in gathering data in the CSA, it is worth reflecting on how the CSA differs from a COT.

The equivalent statements in a COT would be:

Discovers the reasons for the patient's attendance
Encourages the patient's contribution
Defines the clinical problem
Includes or excludes likely relevant significant condition

One of the biggest challenges I observe on my course is the appropriate use of open questions and when to start focusing on specifics through closed questioning. When analyzing and reflecting on a COT there is often an emphasis on the use of open questions to help facilitate patient contribution and the 'golden minute of silence'. In everyday general practice this often works well and is of course part of establishing a rapport. However with that said imagine the patient who when given the opportunity to talk will do so without restraint and may not give you information pertinent to the issue at hand. Or recall the patient who is simply not a good historian and needs guidance through specific questioning to be able to give a narrative to their problem. More often that not, candidates finding difficulty with the data gathering domain rely too heavily on the use of open questions, and do not display structure to their line of questioning. Unfortunately repeatedly asking "Tell me more" will not get you far in the CSA and after a minute of silence, one will realize quickly that in the exam situation there will be little coming back in terms of information from the role player. A typical COT and a CSA case are very different in this respect. So instead recall that patient in real life who has difficulty in giving a history or requires guidance when telling a narrative.

How would you actively extract the information you require in such situations?

Let's talk through an example.
A patient comes to see you with chest pain. In both the CSA and in a COT one might open the consultation by asking the patient to "Tell me a bit more"
However what if the patient in both situations simply replies by saying "Well it is a bad chest pain, I am not sure what is causing it and that is why I have come to see you".

Which one of the following questions would you follow this up with?
1. What were you expecting me to do for you today?
2. What are you worried about?
3. How is this affecting you?
4. When did the pain start?

In real life I doubt many of us would actually ask question 1 and 2 from the outset and out of context. Generally speaking and certainly when I have been a patient and seen my own GP, I 'expect' when I make an appointment for the doctor to take a history, examine me, share his findings and involve me in the decision making process taking on board what has surfaced in terms of my health beliefs and possible expectations during the narrative between us. Yet time and time again, I observe the first or second question asked immediately from the outset by rigid and nervous registrars who when faced with diagnostic uncertainty fall back on an equally rigid elicitation of ICE as if it is a tick box exercise which they can then subsequently forget about. If it does not generally work in real life, then why should it work in a CSA? Additional questions asked out of context also surface early such as "Who lives with you at home?" or "What do you do for a living?" which are some how meant to reflect question 3 and the impact of the presenting complaint from a psycho-social context. Well imagine a patient replying by saying "I don't work and I live with my cat." – Has that helped you or given you any information relevant to the chest pain? Such questions will do little to facilitate a functional narrative between you and the patient. Active extraction of relevant information is what is being assessed for in the CSA. Do not assume open questions will establish rapport; it is sincere acknowledgement on the doctor's part that is needed to gain momentum in a narrative. Contribution can still be encouraged through use of specific and focused questions. So rather than just saying "Tell me more", pre-empt that you are being assessed on active extraction and get to the focused questions quicker. Try instead the following "Let's talk more about your chest pain. Could you tell me when it started?" which represents question 4 and then be specific in asking about associated symptoms. It is not enough to ask "Any other symptoms?" – How is a patient to know what symptoms you are worried about? Certainly from a CSA perspective this will not get you far. The role player will only give the relevant information if specifically asked. It is your job to screen for red flags and stratify risk. So again be specific, ask about associated shortness of breath, nature and duration of pain, precipitating factors specifically asking if the pain is exercise induced and relieved with rest, cardiovascular risk factors etc.

IF YOU DON'T ASK, YOU WON'T GET!

This is the essence of global statement 1 and data gathering statement 4.

We will end part 1 with the following Chinese proverb:
"Let not the opportunity pass, for it may not return."

In part 2 of this article I will look to cover statements 2, 3 and 5.

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