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

Part 2 : Eliciting ICE in context – Do you need to go fishing?

In the second part of this article I will look to cover the following statements:

GLOBAL

2. Does not recognise the issues or priorities in the consultation e.g. the patient's problem, the ethical dilemma
3. Shows poor time management

DATA GATHERING

5. Does not undertake physical examination competently, or use instruments proficiently

So what about the elicitation of ICE and asking appropriate psychological/social questions to place the problem in context?

These are of course very important and will help formulate your thinking around global statement 2, but a top tip is to ask these questions after you have taken a good focused history around the presenting complaint. By undertaking this, you will show a structure to your consultation, your patient will also feel that your line of questioning bears relevance to the presenting issue. Again the questions asked need to be in context and sound natural in order to complement your own style of consulting.

For example in eliciting health beliefs, after taking a focused history it is worth trying something like:

"Thank you for sharing with me what has been going on. Can you tell me if you had a particular worry or concern as to why this chest pain had suddenly happened?"

With repeated practice at this, health beliefs and patient expectations will surface naturally and through active listening, you may not need to repetitively look to extract ICE as it will be presented to you as the story unfolds. The challenge will then become how you acknowledge your patient's perspective and use this to consolidate your consultation. Don't go fishing rigidly for agendas - it is important to realize agendas are rarely 'hidden' in a CSA. The agenda will often be clear from the outset – if you strive to listen, it will be transparent. Sometimes the agenda is as simple as "I am worried about this chest pain, as I have never had it before and want to find out what is causing it." If the patient does not have a particular health belief, don't go fishing rigidly! For example if no specific health belief is elicited from a question such as "Was there a particular worry you had?", other than "I just hope it's not serious", don't push to find a hidden agenda. Don't ask questions out of context such as "Do you know anyone with chest

pain?" or "Are you sure you are not worried about your heart?" or "Why do you feel it is serious?". If it is serious enough for a patient to make an appointment to see you, then you need to acknowledge that and demonstrate self awareness, sincerity and structure to your consultation. So in response, acknowledge by responding sincerely- try something like "I appreciate you are worried, I will try my best to help you and find out what is going on."

DATA GATHERING

5. Does not undertake physical examination competently or use instruments proficiently

With regards to examination, this needs to be as focused as your history. As a general rule of thumb, any presentation which has a physical element to it will require a physical examination. There is little point in requesting a general examination of the patient as examination findings, just as the history will only be revealed if your examination is justified and relevant to the presenting issue. Fluency and confidence in how you examine is key with regards to how a patient and ultimately the examiner perceive you. For example if a patient presents with an eye complaint, do not immediately pick up the ophthalmoscope to look at the fundi. Remember that such cases require a systematic approach to examination starting with pupillary reflexes, visual acuity, visual fields, extraocular movements and finally fundoscopy. Do not look to the examiner for permission to examine, this is between you and the patient and if the examiner does not intervene you should get on and do it!

GLOBAL

3. Shows poor time management

Remember that every consultation will have 2 halves – you need to have a focus and perceived to be in control of both.
On my course I advocate a 6 minute, 4 minute time frame for dealing cases presenting with diagnostic uncertainty.
As we end this article, aim to cover the following using this structure, in the first 6 minutes:

FOCUSED HISTORY TAKING

- Open question firstly – 'What can I do for you?'
- Acknowledge the presenting complaint – show self awareness! It is a real person you are talking to! Show sincerity and sensitivity.

AVOID INITIAL WEAK QUESTIONS

E.g. what were you expecting me to do today?

YOU MUST APPEAR TO MANAGE UNCERTAINTY WITH CONFIDENCE

- Screen for RED FLAGS and BE SPECIFIC asking for associated symptoms
- REMEMBER YOUR BASIC HISTORY TAKING SKILLS!
- Questions must be justified and have purpose

- Ask about impact on daily living if appropriate

ELICITING AND ACKNOWLEDGING HEALTH BELIEFS AND EXPECTATIONS

- Acknowledge and Follow up cues : verbal / non -verbal
- Ask sensitively

'Had you any idea /thoughts yourself as to why this might have happened?'

SUMMARISE

- Before you examine : SUMMARISE to check you have not missed anything

APPROPRIATE USE OF MEDICAL INSTRUMENTS AND EXAMINATION TECHNIQUES

- Verbalise what you would like to do
- If the examiner does not intervene – get on and do it!
- Be gentle, show fluency and structure in your examination (e.g. EYES, ENT, JOINTS)

In the next article I will look to cover the 2nd half of the consultation and in the remaining 4 minutes how one should approach the Clinical Management Domain.

We will end here with another Confucian quote:
"Learn without thinking begets ignorance.
Think without learning is dangerous."

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