CLINICAL COMMUNICATION SKILLS THEME

STAGE/LEVEL 3: 2011-2012

FOCUSED HISTORY TAKING & CLINICAL REASONING

FACILITATORS' PACK V.4 (17/7/2011)

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The Clinical School has pioneered the teaching of a comprehensive clinical method rather than "communication", and the integration of content, process and perceptual skills. We have set out our stall to combine traditional medical history taking with communication process skills so that the use of appropriate process skills are seen as the most effective way to obtain an accurate and efficient clinical history.

So 2 years ago we introduced this new course because of what at that time we considered to be quite a disappointing situation. There is no doubt that in the SCEE examination year-on-year, students in the history taking/clinical reasoning stations had been overusing certain communication process skills such as open questions, empathy, summarising and signposting. By overemphasising these, and by not concentrating at the same time on moving to appropriate directed and then closed questions about the clinical content, clinical communication was getting a bad name. And to my mind quite rightly.

I was so irritated by the students' lack of application of content in the SCEE examination two years ago, despite me telling them repeatedly how the exam was marked and what we were looking for, (which was effective process leading to a really good history and an ability to clinically reason) that I was sure we needed to give some serious thought about their training especially in stage/level 3. **And I'm delighted to say that the introduction of this course has changed things around and in the SCEE examination, the situation has markedly improved.**

(However, in this year's SCEE examination please note that some students, especially in more vague presentations, really failed to employ direct questions from the relevant systems review which we still cannot understand)

So what was the cause of all this? Firstly, this was not just a CCS teaching problem although we do have a responsibility here to get this right. Talking to several just qualified students 2 years ago, it would appear that they did not feel confident in taking a time-limited focused history in real life, and still basically took a complete long history. This is odd because the new final year which has been very successful does give them true responsibility for patients and they are working much more on the wards and acting as part of a genuine team.

Secondly, it could just be something that happened in the SCEE examination, and students were able to do this on the wards in reality. Some of the students thought they probably did do better in real life than they did in the examination, where they seemed to do some strange "examsmanship" history, and clearly we needed to do much better in explaining to them that the SCEE examination stations are meant to be real life situations and that they should cope with them as they would in reality, not in some strange way in which they are trying to predict (wrongly) what we want. However many clinicians have said in the past that when our new FY1 doctors start on the wards, they mostly work in long history format and have poor clinical reasoning skills.

Another perspective is that it is difficult to remember when people in our generation learned effective focused history and clinical reasoning skills and actually I rather suspect that we didn't achieve this until after qualification and that the SCEE examination just highlights a situation that has been going on for years. We asked clinical supervisors when they think they were able to achieve this and the majority felt this was after qualification. This may well of course be a matter of maturity and people reach this stage at different points. However, Helen Smith, the previous stage 3 coordinator, and myself thought about this at some length two years ago and decided this was an ideal opportunity to attempt to teach this vital element much more systematically to see if we can improve the skills of our newly qualified doctors.

We suspect that the issue here did not really lie just with CCS teaching, but with something more fundamental about the way students have been learning on the wards. They were simply not getting to grips with honing their short histories and clinical reasoning and we were not quite sure why that was. I certainly remember as a medical student myself being forced on teaching ward rounds in Oxford not just to present, but always answer the questions "what do you think it is, why do you think it is that, what else could it be, and how are you going to find out?". This seems to be a rare component of current students' education.

So what we introduced into stage/level 3 was to invent a set of approaches to be used throughout stage/level 3 of enabling students to hone their focused history taking, integrating content, process and clinical reasoning:

1. **An initial lecture/demonstration** introducing the issue and the rest of the clinical reasoning course during R & I week 9.

2. **Specific CCS teaching** as described here, using the format of a video interview with a simulated patient followed by a paired tutorial at the start of stage/level 3, so that students have a clear idea of what we are expecting them to learn during the next year in terms of focused history/clinical reasoning.

3. **The provision of e-learning material from the UK Council of Clinical Communication explaining the value of both open and closed questions, the relationship with focused history taking and clinical reasoning.**

4. **Changing the emphasis of clinical supervisions** both in Addenbrookes and in the region in stage/level 3 which are still at present predominately about clinical examination. We tried to make a specific emphasis in stage/level 3 supervisions on clinical reasoning, with students being regularly observed taking a history and intermittently interrupted to ask what they are thinking, how they are going to proceed with a history and why.

5. **We encouraged clinical teachers** when being observed by students to expose their thinking and clinical dilemmas as they proceed through the history rather than simply discussing the content at the end.

6. **We asked students to hone their clinical reasoning skills** by regularly getting them to take the first five minutes of history (basically the problems, the sequence of events and symptom analysis) on the ward and in the emergency room using really good process and content skills; then ask the patient if the student could take a two minute break to think about what's going on, and what the current differentials are and how they're going to proceed; and then return to the patient to nail the relevant systems review and relevant background information and specific questions to differentiate between their diagnostic list. Our theory was that what we are asking them to do in the two minute break is what we have learnt to do automatically and quickly as we move through the interview.

THE DANGER OF THIS COURSE

But there is a considerable danger in all of this. And that is that students will just concentrate on the biomedical content and forget about our teaching concerning the patient's perspective. And also that they stop using effective process skills altogether and move towards using only closed questioning. We have to guard against this at all cost or we will have lost all the ground that we have made and swing back to the original position we were in 10 years ago. So the particular focus that we are looking for in this session is crucial: it is how to enable students to look at how they are going to use effective process skills in a focused history to obtain the biomedical and patient's perspective accurately and efficiently and supportively.

And I would like to be very explicit about what we are and what we are not teaching here.

Firstly the focused history.

Focused interviewing is not abandoning the initial listening phase and the patient's perspective and moving quickly on to closed questions about the biomedical perspective only, as is sometimes thought by the students after having watched rather poor modelling. A good focused history is the normal application of the early part of the interview followed by the selective and judicial application of the background information component. guided by your clinical reasoning. So the only bit that changes in the content of the history is the more selective enquiries about the area in purple below. And the only bit that changes in the process is that the clinician makes a transition to open directive and closed questions perhaps slightly earlier than if you had a very long time period.

Patient's problem list

1.
2.
3.
4.

Exploration of patient's problems:

Biomedical perspective

sequence of events, symptom analysis, relevant functional enquiry

Patient's perspective:

ideas, concerns, expectations, effects on life, feelings

Essential background information

Past medical history

Family history

Personal and social history

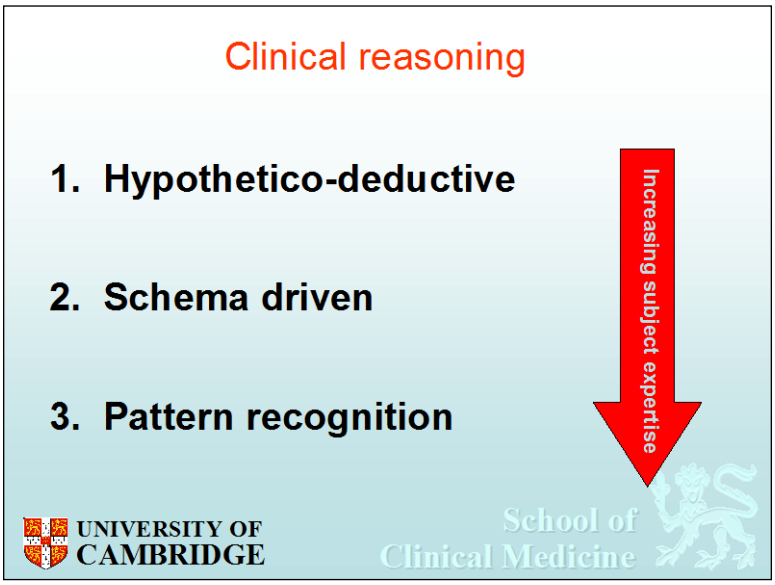
Drug and allergy

Functional enquiry

Secondly clinical reasoning.

We are not expecting the students to be able to clinically reason as experts. They will not at this stage be able to pattern recognise, and they well not be able to apply schemas in most circumstances. So what we are looking for here is **effective hypothetico-deductive reasoning**. They can aspire to schema and pattern recognition but we will not be particularly exploring these areas in these sessions.

Hypothetico-deductive reasoning is the least sophisticated method of clinical reasoning. When students first start, they use it to in a particularly unhelpful way. They take a full history, obtain all the information they are going to get without really engaging their brain and then stand back and think about what it might for me. In this method, clinical reasoning doesn't interfere at all with the interview process.



What we want them to be doing here is the second approach to hypothetico-deductive reasoning that can be used. Fairly early on in the interview (far too early when we doctors are often doing this in reality), several diagnostic hypotheses spring to mind. These hypotheses are validated or rejected by selective questioning as the interview proceeds and only appropriate background information is obtained to help with this process.

Just so you know, schema driven is an advance on this whereby the more experienced clinician uses a preformed schema or flow diagram to help solve the problem. By requesting specific information, the clinician can roll out large chunks of clinical possibilities at a time. But you need to know your area well to navigate quickly like this. Pattern recognition is what experts do within their subject area. When confronted with a problem, the clinician searches their "bank" of illness scripts searching for an illness that most fits what they are seeing. This is often pegged to a particular patient they have seen in the past. The clinician then tests their impression for goodness of fit. You have to have seen a lot of patients with the same condition to get this method right.

All we are after here is making sure that the students have progressed to the second more advanced approach of hypothetico-deductive reasoning. With all these methods, there is a single and considerable danger: the possibility of prematurely disappearing down the wrong rabbit hole if you move too early into this diagnostic mode. All the strategies are equally dependent on effective communication, on listening first so that you can get enough of the picture before you make your diagnostic list or attempt to fit what you are seeing into a pattern.

So without effective listening and open questions in the early stages of the interview, without screening and summary, and without attention to the patient's perspective, your clinical reasoning will suffer.

FORMAT OF STAGE 3 HISTORY TAKING/CLINICAL REASONING CCS TUTORIALS:

This teaching involves each student making a recording of a 10 minute history with an actor using a history taking/clinical reasoning scenario previously used in the SCEE examination. They will then be asked for a further 5 minutes to answer structured oral questions to camera. This is then followed later by a supervision in pairs giving specific feedback on their integration of content, process and clinical reasoning.

What has already occurred

R & I week 9: lecture for all students

- given by Dr Jonathan Silverman
- 1 hours 15 minutes
- introduction to the issue of content/process/clinical reasoning and the focused history
- demonstration of a video of a consultant with a patient doing a focused history in 10 minutes, broken up to look at process skills, content skills and clinical reasoning as we go
- description of the rest of the clinical reasoning course

Recording a simulated patient interview

- each student interviews a simulated patient for 10 minutes
    - all students see the same 'case', a genuine SCEE examination case we have used before about breathlessness
- this is then followed by a 5 minute structured oral delivered by one of the actors and recorded
- digital recording uploaded to MedPortal which students self-critique before the session - encouraged to review each other's video as well

And now:

Tutorial on simulated patient interview

- facilitated by yourself
- pairs of students
- 1 and a half hours per pair
    - both students' recordings reviewed and assessed by facilitator and pair of students using grids of process, content and structured oral
    - personalised feedback and focused recommendations for change given to each individual student
    - feedback not given particularly about how to pass the SCEE examination, which is the danger here, but how to do effective focused histories throughout stage/level 3 and that this will be the same as being examined in the SCEE examination
    - 'direct' feedback – supportive but definite suggestions for change
    - advice re how to improve focused history and clinical reasoning in stage/level 3

See next page for how to run tutorial

How to run tutorial

Introductions

Start with brief description and reiteration of the:

- Aims of the course as a whole
    - To help you with your focused history and clinical reasoning skills for stage/level 3
    - Make a clear point that this is not specifically about the SCEE examination although it will help you
    - To ensure that you are progressing in your ability to combine effective communication process skills, clinical content and clinical reasoning in a time-limited focused history (as you will soon be using in your day-to-day practice as a recently qualified doctor)
    - To ensure that you can put into practice the principles of an effective focused history:

❖ *effective listening/open questions/screening/narrative/summarising in first few minutes*
❖ *not coning down too soon until you have a reasonable overview of the whole picture*
❖ *ensure focus on both biomedical and patient's perspective*
❖ *then effective coning down to directive questions and eventually closed questions*
❖ *discovering sequence of events, symptom analysis and relevant systems review*
❖ *coning down driven by appropriate clinical reasoning*
❖ *selective relevant information obtained about background information*

    - it is not abandoning the initial listening phase and moving quickly on to closed questions as is sometimes thought; nor removing the patient's perspective; it is the normal application of the early part of the interview followed by the selective and judicial discovery of background information
    - To give you personalised feedback and suggestions for improvement

- Plan of tutorial
    - both students' recordings reviewed and assessed by facilitator and pair of students using grids
    - personalised feedback and focused recommendations for change to each individual student
    - 'direct' feedback – supportive but definite suggestions for change
- Roles and tasks of students
    - students should help each other in comparison and feedback
- Confidentiality between students, facilitator may feedback to CCS team if need extra help
    - formative not summative

Before watching first student's recording, start with the student's overall perceptions re the interview

Watch first recording in roughly 2 minute chunks, stop at an appropriate time

- ask the student how they think it's going so far, starting with process, moving to content and then perceptual.
- apply ALOBA - emphasise where they were trying to get to (**an outcome based approach**) and how they managed this. Ask them what **strategies** they were using. Later you can follow with "where do you want to get to next"
- use the flipchart to record your discussions

- use the wall charts to explore where they have got to so far
- then ask the student what was in their head at this point, what they were thinking about, what potential diagnosis they were considering already and why, what else they were considering or had already rejected, how they might proceed next
- look at process skills used so far
- look at information obtained so far
- **remember to cover both biomedical and patient's perspective**
- specifically look out for the overuse or inappropriate use of process skills and for the appropriate use of clinical reasoning guiding questioning
- involve the other student in these discussions as well

Use 2 grids on one page, one process, one content, combined just as we do in the examination. This to be only available to the facilitator to fill in. If the students see the content grid early while this tutorial is progressing, it will influence their clinical reasoning at each two minute stop**. Facilitator to fill grids in as they go and to show the student at the end but not give to the student. Grids with student and facilitator name on to be returned to the CCS office.**

At the first two minute stop, discuss their process skills, what limited information they have so far and what is in their head at that moment. We think that a student at this point should be considering that this might be respiratory or cardiovascular (i.e. have decided on some systems). If they start talking about individual diagnoses, that is okay, but do not start asking them how they would differentiate between these individual areas yet. Make sure that they realise that there is a danger here of going down the wrong rabbit hole and that they should stay open with screening or narrative.

At the next two minute stop, they should have found out the picture in outline and now it is worthwhile ask them what diagnoses they are thinking about. Also, what questions would be good differentiating ones to start to try to rule things out or add weight to their suggestions (such as diurnal variation for asthma).

Please ensure that they complete the symptom analysis and relevant systems review

Write-up on the flipchart the areas that they need answers to in order to help them in their clinical reasoning such as diurnal variation, swelling of ankles, smoking, chest pain, wheeze etc. Also discover what they still need to know about the patient's perspective. Then look at next two minutes.

See what has been covered now. It is perfectly all right if they have not covered their own suggestions as we are looking at this in retrospect and they may have gone down a different route. But if they don't cover them by the end of the consultation, then they are not working well in their clinical reasoning.

Personalised feedback and focused recommendations for change to each individual student. Use the filled in grid to summarise. **Be careful not to overload the student and think about how many teaching points they can actually take in any one time**

Watch the structured oral recording

- Explore their final clinical reasoning

- Remember this is not a particularly easy scenario for them to work through and they must be reassured that not getting the exact answer at this stage is not a concern. Even in finals, not discovering that this patient potentially has occupational lung disease is what we expect. Excellent candidates however might get to this being a restrictive lung disease.

Move on to the second student after 45 minutes - this might be quite difficult as there could be a lot of repetition and the exposition of clinical reasoning should have already happened. Uses positively to compare styles and approaches

Final recommendation:

- **Make it quite clear that if they can't do this clinical reasoning bit yet while taking a history, that is okay. We do not think that previous generations have ever been able to do this at this stage. Or indeed by qualification. So what we are doing now is just pointing out the area of difficulty for them so that they can engage in various ways during stage/level 3 to try to improve their skill at this**

- Ask students to hone their clinical reasoning skills by getting them to take the first five minutes of history (basically the problems, the sequence of events and symptom analysis) on the ward and in the emergency room using really good process and content skills; then ask the patient if they could take a two minute break to think about what's going on, and what the current differentials are and how they're going to proceed; and then return to the patient to nail the relevant systems review and relevant background information and specific questions to differentiate between their diagnostic list.

Please let us know on the feedback sheet if you feel any student is significantly underperforming. At the very least, they should be able at this stage to take an effective history using the skills we taught them in the introductory course and covering the symptom analysis and relevant systems review. If they cannot do this, we ought to know and we can look at the video to see if we should pick them up

The year group undertake these sessions in two halves, separated by a few weeks. Because of this, this year we have produced a completely new scenario for the second group of students so that any leakage about the scenario does not get in the way of students' practising clinical reasoning skills.

In the first group, the patient has been treated for heart failure by his GP and in fact the diagnosis is respiratory, probably asbestosis.

In the second group, a completely different younger female patient presents with breathlessness, probably due to pulmonary emboli.

Here we reproduce the scenarios and marking grids for both.

First scenario

Medical Assessment Unit – history taking

Instructions for focused history taking and clinical reasoning scenario

You have 10 minutes to complete the interview and five minutes for a structured oral

This scenario enables you to explore taking a focused history from a patient with breathlessness

You are:
A FY1 doctor in general medicine

Today you are seeing: Tom Parker **Age:** 60

Setting
You are in the Medical Assessment Unit, seeing patients referred to hospital as an emergency by their general practitioners

Task:
Mr Parker has been sent to the Medical Assessment Unit by his GP because he has been getting increasingly short of breath. His GP has treated him for heart failure but the breathlessness has not improved. It is proving a particularly busy take and your registrar has asked you to go and take a focused history from Mr Parker

Your task is to take the patient's history and to formulate a differential diagnosis. You are not required to take a full history, for instance taking a full systems review.

Time:
You have 10 minutes to complete the interview and 5 minutes for a structured oral with the examiner.

Simulated patient instructions

Title:
Medical Assessment Unit – history taking re breathlessness

Medical condition and communication challenge
Asbestosis. Need to take a focused detailed history of symptoms and of occupation

Name: Tom Parker **Age:** 60
Ethnicity: Any

Important social, cultural or behavioural characteristics of patient:
Builder, now self-employed

Setting
You are in the Medical Assessment Unit (MAU) having been sent up to hospital today by your GP. You are sitting next to a bed

Clinical details
You went to see your GP a week ago because you noticed you were becoming more short of breath. This is starting to affect your ability to work; you are a builder and your work is pretty physical. Your GP listened to your chest and prescribed 'water tablets' as she thought you had heart failure but there has been no improvement despite the fact that you have taken the tablets religiously. In fact you have only ever been short of breath on exertion; you have never woken up at night with breathlessness and you use 2 pillows as always. Looking back, the breathlessness has been slowly increasing over quite a few months, six months if asked. You can now only walk about 200 yards on the flat before stopping for a breath ('to get to the shop'), less if you are carrying anything ('couple of times back and forth to the truck, you know'), and are starting to notice difficulty climbing up stairs. You have also noticed an occasional tickly cough which occurs several times a day, which does not produce sputum. You have never coughed up blood, nor does it hurt to breathe (i.e. no chest pain). You have had no fever, chills or shakes.

Your only recent travel was to Spain last year. You have no pets, no allergies and your main hobby is looking after your garden and allotment.

Today, you went back to your GP, <u>as planned,</u> who said that she was surprised you were no better and that she would like a doctor at the hospital to see you – she was sure that at the very least you should have a chest XR.

Patient's perspective
- **ideas and thoughts**

what did you think might have caused your problem
what have they told you so far
You have no idea what might be causing this, but wonder secretly if your smoking might be related. Your GP Dr. Wheeler had told you it was heart failure but there has been no improvement with the treatment (but don't make this an issue; we don't want the students to get sidetracked here)

- **concerns**

what are you concerned about
any practical problems:
You are worried about your income if you become unable to work.
have you any underlying fears
You are worried that you might be seriously ill (specifically you are concerned it might be hard disease because of your father's death but don't really want to mention this).

- **expectations**

what are you hoping for
You want to be treated so that you can get back to normal activity

- **feelings**

how are you feeling about it all
You are worried, and a little annoyed, that the GPs treatment has not worked

Past medical history
Any previous operations: none
Any previous illnesses: nil serious

Medication
Any medication taken for this: Co-amilofruse 5/40 mg (one white tablet per day for 1 week) – this is a water tablet to make you pass more water - please learn the name of this drug
Are you on any other prescribed drugs: No

Family history
heart disease - father died of a heart attack aged 62
serious illness - no family history of chest disease

Smoking 20 cigarettes per day since 16
Alcohol 2-3 pints per night, but at weekends only

Social history
*Marital status***:** Married, no problems
Children: 2 − both left home
Occupation: Self-employed builder – mainly small jobs now, previously (25–30 years ago) you worked in much larger firm involved in refitting factories
Partner's occupation: Part-time shop assistant
Where do you live: Cherry Hinton
Type of housing: Own home
Social background Left home at 16, no further educational qualifications, worked as a builder ever since
Pets: nil

How to start role-play

- **patient's exact words in response to interviewer's first open-ended question**

'Well, I've been getting rather short of breath lately, and the tablets the GP gave me last week haven't helped at all and so she asked me to come up today to have some investigations and try and get it sorted out.'

- **what patient says when asked subsequent open questions:**

Unless asked to start from when all your symptoms first began, initially tell the story of going to see your GP a week ago because you have noticed you were becoming more short of breath (don't mention for how long) and that you are now pretty short of breath especially if you're carrying things or going upstairs. Mention that you were prescribed water tablets but they haven't really made any difference.

Don't at this stage say that it's interfering with your work and certainly don't say what you do. Do not divulge that you smoke.

If the student **either** starts by asking you to go back to the beginning when you first started to notice you were unwell, **or** if the candidate after the start in the paragraph above moves on to a further open question such as "can you tell me more about me breathlessness", say that looking back, the breathlessness has been slowly increasing over quite a few months and it's now quite clearly a problem for you ....

If the student was to pick this cue up, you could mention that it's interfering with work which is quite heavy but do not say what your work is unless asked.

- **what to divulge to screening questions - have you noticed anything else?**

Say you have also noticed a tickly dry cough (no wheezing) but do not spontaneously go into details and do not say overtly that there is no sputum.

If they ask you once more what else you've noticed, say “no that's it, it's just the breathlessness when I move about, it's fine when I'm sitting still"

- **what to divulge only to specific questions**

Tell the candidate the following in response to specific direct questions:

- you are a smoker
- how much you smoke
- how far you can walk - about 200 yards on the flat
- the lack of night-time breathlessness
- never breathless at rest
- no pain
- no sputum
- no blood
- no fever or chills or shakes
- that you are on no other medication
- that you have taken the diuretic tablets as prescribed
- your family history
- your occupational history
- your history of travel
- no pets
- your hobbies

Be very careful not disclose your occupational history unless asked. Then say that you are a self-employed builder

If asked the nature of your work it is mainly small building jobs. Only if asked whether this is what you have always done do you mention that you used to work for a larger firm refitting factories.

If asked specifically about asbestos, you do not know specifically whether you were exposed to asbestos but you did have to strip out fireproof walls and the like – there were no safety masks at the time. No family history of chest disease

- **how to respond to emotional subjects and questions**

This interview should be fairly matter of fact.

- **how to respond to questions about patient ideas, concerns and expectations about the problems**

You should state your need to get better and your worry that this illness may affect your income.

If asked further, you would admit to being worried that it might be something serious, and mention that you realise that you smoke. You would be reluctant to actually mention your concern about heart disease unless a sympathetic candidate leads you appropriately in this direction and then you would reveal this..

Simulated patient instructions:

Dress should be fairly casual (jeans and t-shirt). You are a pretty straightforward working man, prepared to answer questions honestly and succinctly. You want to get to the bottom of the problem.

If questions seem to come out of the blue, you look slightly askance before answering (the aim is to encourage the students to signpost or explain why they are asking particular questions.)

Process Grid - 40% of total marks	Good	Adequate	Not done/poor
Initiating the session			
Greets patient and obtains patient's name			
Introduces self, role and nature of interview; obtains consent			
Demonstrates interest and **respect**, attends to patient's physical comfort			
Uses appropriate opening question			
Overall Score for Initiating the Session			
Gathering Information			
Listens attentively, minimising interruption and leaving space for patient			
Encourages patient to **tell the story** of the problem(s) from when first started to the present			
Checks and **screens** for further problems (eg, so that's headaches, anything else you've noticed?)			
Overall Score for Problem Identification			
Uses **open and closed questions**, appropriately moving from open to closed			
Facilitates patient's responses verbally and non–verbally e.g. silence, repetition, paraphrasing			
Picks up and responds to verbal and non–verbal **cues** (body language, speech, facial expression)			
Clarifies statements which are vague or need amplification			
Periodically **summarises** & invites patient to correct interpretation or provide further information.			
Uses clear, easily understood language, avoids jargon			
Overall Score for Problem Exploration			
Actively **determines patient's perspective** (ideas, concerns, expectations, feelings, effects on life)			
Appropriately and sensitively **responds to and further explores patient's perspective**			
Overall Score for Patient's Perspective			
Building the relationship			
Demonstrates appropriate **non–verbal behaviour** eg eye contact, posture, position, movement, facial expression, use of voice			
Overall Score for Non-verbal Communication			
Acknowledges patient's views and feelings; is not judgmental			
Uses **empathy** to communicate appreciation of the patient's feelings or predicament			
Provides **support**: expresses concern, understanding, willingness to help			
Overall Score for Developing Rapport			
Providing Structure			
Progresses from one section to another using **signposting**; includes rationale for next section			
Structures interview in logical **sequence**, attends to **timing**, keeps interview on task			
Overall Score for Providing Structure			

Content grid - 30% of total marks	Yes	No
1. Co-amilofruse 5/40 1od		
2. SOB only on exertion		
3. no orthopnoea or PND		
4. slowly inc over few months		
5. 200 yds on flat, difficulty stairs		
Other symptoms		
6. cough		
7. non-productive		
8. no haemoptysis		
9. no pleuritic pain		
10. **no feverish symptoms**		
11. **no ankle swelling**		
12. **no wheeze**		
13. **no weight loss**		
Background information		
14. Spain last year		
15. No pets		
16. 20 cigs since age 16		
17. father died MI 62		
18. no FH chest disease		
19. no other medication		
20. always takes Co-amilofruse tabs		
Occupational Hx		
21. currently: builder, small jobs		
22. previously: larger firm refitting factories		
23. asks re contact with asbestos		
Ideas and thoughts		
24. smoking		
Concerns		
25. income		
26. serious		
27. heart disease		
Past medical history		
28. no PMH		

Student name: ***Facilitator name:***

Structured oral grid - 30% of total marks	Good	Adequate	Not done/ inadequate
1. Presentation *Please summarise this presentation – the principle features in 2-3 sentences only*			
2. Differential diagnosis *Would you like to have a stab at a differential diagnosis?* *Is there anything else you considered?* **Heart failure, angina, COPD (emphysema/bronchitis), asthma, pulmonary emboli, cancer, lung cancer, restrictive lung disease, lung fibrosis**			
3. Clinical reasoning *Which of the things that you have mentioned would you think more likely and why?* *Would you like to explain your thinking?* *Anything else you wish to say about this?*			
4. Investigation *Depending on the exam findings, what tests are likely to be relevant here* *Anything else?* FBC, electrolytes, CXR, sats, arterial blood gases, CT scan, PFTs			

Student name:	***Facilitator name***

Second scenario

The Medical Assessment Unit – history taking

Instructions for focused history taking and clinical reasoning scenario

You have 10 minutes to complete the interview and five minutes for a structured oral

This scenario enables you to explore taking a focused history from a patient with breathlessness

You are:
A FY1 doctor in general medicine

Today you are seeing: Judith Turner **Age:** 30

Setting
You are in the Medical Assessment Unit, seeing patients referred to hospital as an emergency by their general practitioners

Task:
Judith Turner has been sent to the Medical Assessment Unit by her GP because she has been getting increasingly short of breath. Her GP has treated her for asthma but the breathlessness has not improved. It is proving a particularly busy take and your registrar has asked you to go and take a focused history from the patient

Your task is to take the patient's history and to formulate a differential diagnosis. You are not required to take a full history, for instance taking a full systems review.

Time:
You have 10 minutes to complete the interview and 5 minutes for a structured oral with the examiner.

Simulated patient instructions

Title:
Medical Assessment Unit – history taking re breathlessness

Medical condition and communication challenge
Shortness of breath probably due to pulmonary emboli. Need to take a focused detailed history of symptoms

Name: Judith Turner **Age:** 30
Ethnicity: Caucasian

Important social, cultural or behavioural characteristics of patient:
Works as a local organiser for the Lib Dem party, a fairly low paid job with lots of responsibility organising newsletters and helping local councillors with election campaigns etc. You are fairly liberal in views and committed to the environment and local politics

Setting
You are in the Medical Assessment Unit (MAU) having been sent up to hospital today by your GP. You are sitting next to a bed

Clinical details
You went to see your GP a week ago because you were becoming more short of breath. This has been going on for three months but has been getting progressively worse. You had taken two months off work earlier this year as unpaid leave and had stayed with friends in the USA. A few days before your return, you developed a wheeze and thought you had a viral illness. You were a bit worried because you had been volunteering two days a week in a homeless hostel in California and thought you might have caught an infection. The wheeze continued on your return to the UK and you saw your GP two weeks later and had blood tests and a chest X-ray (all of which were normal). The wheeze seemed to settle down (after a 5-day course of antibiotics) but gradually you have got more and more breathless on exertion. The only other associated symptom is that in the last month you do feel dizzy (a faint feeling as if about to pass out) on exertion at times. There was also one episode that you can remember (a few weeks after the blood tests) in which you had a definite episode of increased shortness of breath associated with left-sided chest pain at the back which was definitely worse when you took a deep breath. It only lasted a few days. At that time, you coughed up a tiny fleck of blood which has never recurred.

You saw your GP for the second time last week. Your GP listened to your chest and prescribed an ‘asthma pump’ as she thought you might have asthma and asked you to record your peak flow recordings with a small peak flow meter at home. You went back today and there has been no significant variation in peak flow rate (around 200) over the day and no change immediately after using the inhaler. You have felt no better with the inhaler despite the fact that you have used it every four hours or so.

If asked by the candidate, you have noticed some ankle swelling over the last 6 weeks which initially seemed to be only in the right leg although it has definitely moved to both.

You have only ever been short of breath on exertion; you have never woken up at night with breathlessness and you sleep with one pillow. Looking back, the breathlessness has been slowly increasing over quite a few months, 3 months if asked. You can now only walk about 200 yards on the flat before stopping for a breath of and are starting to notice difficulty climbing up stairs. You have had to stop your weekly tennis.

Your only recent travel was to the States. You have no pets, no allergies, no eczema, no previous asthma and your main hobby is growing vegetables on an allotment.

Today, you went back to your GP, as planned, who said that she was surprised you were no better and that she would like a doctor at the hospital to see you – she was sure that at the very least you should have another chest X-Ray.

Patient's perspective

- **ideas and thoughts**

what did you think might have caused your problem
what have they told you so far
You have no idea what might be causing this, but wonder if you caught something in the hostel. Your GP Dr. Wheeler had told you it might be asthma but there has been no improvement with the treatment (but don't make this an issue; we don't want the students to get sidetracked here)

- **concerns**

what are you concerned about
any practical problems:
You really are beginning to feel unwell and at your age, this seems very unusual. You don't feel you are able to give your best at work now. You normally rush around everywhere on a bicycle and just can't do that. You do not own a car
have you any underlying fears
You are worried that you might be seriously ill - when you were at school, there was a boy with congenital heart problems and was breathless and became seriously ill and needed major surgery.

- **expectations**

what are you hoping for
You want to be treated so that you can get back to normal activity, but most of all you want a diagnosis

- **feelings**

how are you feeling about it all
You are worried that the GPs treatment has not worked and that the GP felt you needed to come to hospital today. You are beginning to feel anxious

Past medical history

Any previous operations: none
Any previous illnesses: nil serious, one termination of pregnancy aged 18, knee pains when you were a teenager for two years which stopped you doing gymnastics etc which gradually resolved without treatment (it had a long name which you cannot remember and your GP just reassured you)

Medication
Any medication taken for this: salbutamol inhaler
Any other medication: on Microgynon 30 oral contraceptive pill since aged 17yr

Family history
mother had breast cancer two years ago but has made a good recovery with surgery and radiotherapy
serious illness - no family history of chest disease

Smoking 10 cigarettes per day since 16
Alcohol social drinking when goes out
Recreational drugs: occasional cannabis only

Social history
*Marital status***:** single, long-term boyfriend, no plans to marry
Children: nil
Occupation: local organiser for the Lib Dem party
Where do you live: off Mill Road in Cambridge
Type of housing: rented accommodation
Social background studied political science at Bristol University
Pets: nil

How to start role-play

- **patient's exact words in response to interviewer's first open-ended question**

'Well, I've been getting rather short of breath lately, and the treatment the GP gave me last week hasn't helped at all and so she asked me to come up today to have some investigations and try and get it sorted out.'

- **what patient says when asked subsequent open questions:**

Unless asked to start from when all your symptoms first began, initially tell the story of going to see your GP a week ago because you have noticed you were becoming more short of breath (don't mention for how long) and that you are now pretty short of breath especially if you're going upstairs. Mention that you were prescribed "a pump" but it hasn't really made any difference. Don't mention the colour of the pump unless asked - then it is blue

Don't at this stage say that it's interfering with your work. Do not divulge that you smoke.

If the student **either** starts by asking you to go back to the beginning when you first started to notice you were unwell, **or** if the candidate after the start in the paragraph above moves on to a further open question such as "can you tell me more about me breathlessness", say that looking back, the breathlessness has been slowly increasing over three months and it's now quite clearly a problem for you ....

If the student was to pick this cue up, you could mention that it's interfering with work and explain what you do and that you cannot bicycle.

If the student asks you when it first started, explain the circumstances about going to the States for a break from work and that your symptoms started on return and

mention that you thought it was a viral infection at first and that you initially had a wheeze which resolved. Then say it has gradually got worse and worse over the last few months

- **what to divulge to screening questions - have you noticed anything else?**

Say you have also noticed that you feel dizzy (faint) on exertion at times

if asked again, mention you have had mild ankle swelling in both ankles over the same period which started initially on the right but then moved to both sides

If they ask you once more what else you've noticed, say “no that's it, it's just the breathlessness when I move about, it's fine when I'm sitting still”

- **what to divulge only to specific questions**

Tell the candidate the following in response to specific direct questions:

- you are a smoker
- how much you smoke
- how far you can walk - about 200 yards on the flat but you get breathless climbing upstairs
- the lack of night-time breathlessness
- you only sleep with one pillow
- if asked if you have had chest pain, mentioned that you had one episode a few weeks after this all started, of increased shortness of breath associated with left-sided chest pain at the back which was definitely worse when you took a deep breath. It only lasted a few days
- if asked specifically about blood, mentioned the episode above and the very small amount of blood associated with it
- no fever or chills or shakes
- no weight loss
- your family history
- your occupational history
- no pets
- your hobbies

- **how to respond to emotional subjects and questions**

you are beginning to get worried that you are seriously ill and start to look concerned

- **how to respond to questions about patient ideas, concerns and expectations about the problems**

firstly mention that you are worried you might have picked an infection up in the hostel in California. Do not mention the hostel unless asked about your concerns

if asked again, you are worried there might be something wrong with your heart in particular because of the boy at school as above.

Simulated patient instructions:

Dress should be fairly casual but stylish. You are friendly and engaging

Process Grid - 40% of total marks	Good	Adequate	Not done/poor
Initiating the session			
Greets patient and obtains patient's name			
Introduces self, role and nature of interview; obtains consent			
Demonstrates interest and **respect**, attends to patient's physical comfort			
Uses appropriate opening question			
Overall Score for Initiating the Session			
Gathering Information			
Listens attentively, minimising interruption and leaving space for patient			
Encourages patient to **tell the story** of the problem(s) from when first started to the present			
Checks and **screens** for further problems (eg, so that's headaches, anything else you've noticed?)			
Overall Score for Problem Identification			
Uses **open and closed questions**, appropriately moving from open to closed			
Facilitates patient's responses verbally and non–verbally e.g. silence, repetition, paraphrasing			
Picks up and responds to verbal and non–verbal **cues** (body language, speech, facial expression)			
Clarifies statements which are vague or need amplification			
Periodically **summarises** & invites patient to correct interpretation or provide further information.			
Uses clear, easily understood language, avoids jargon			
Overall Score for Problem Exploration			
Actively **determines patient's perspective** (ideas, concerns, expectations, feelings, effects on life)			
Appropriately and sensitively **responds to and further explores patient's perspective**			
Overall Score for Patient's Perspective			
Building the relationship			
Demonstrates appropriate **non–verbal behaviour** eg eye contact, posture, position, movement, facial expression, use of voice			
Overall Score for Non-verbal Communication			
Acknowledges patient's views and feelings; is not judgmental			
Uses **empathy** to communicate appreciation of the patient's feelings or predicament			
Provides **support**: expresses concern, understanding, willingness to help			
Overall Score for Developing Rapport			
Providing Structure			
Progresses from one section to another using **signposting**; includes rationale for next section			
Structures interview in logical **sequence**, attends to **timing**, keeps interview on task			
Overall Score for Providing Structure			

Content grid - 30% of total marks	Yes	No
1. blue inhaler		
2. SOB only on exertion		
3. no orthopnoea		
4. three-month history		
5. slowly inc over few months		
6. 200 yds on flat		
Other symptoms		
7. No cough		
8. No sputum		
9. One small haemoptysis		
10. One episode of pleuritic pain		
11. Associated dizziness on exertion		
12. Bilateral ankle swelling		
13. No feverish symptoms		
14. no weight loss		
Background information		
15. Worked in homeless hostel in California		
16. No pets		
17. 10 cigs since age 16		
18. Mother breast cancer		
19. no FH chest disease		
20. Oral contraceptive pill		
21. No allergies		
Occupational Hx		
22. Campaign manager		
Ideas and thoughts		
23. Picked up infection		
Concerns		
24. Not being able to work		
25. serious		
26. heart disease		
Past medical history		
27. Previous termination of pregnancy		
28. No previous DVT		

Student name: ***Facilitator name:***

Structured oral grid - 30% of total marks	Good	Adequate	Not done/ inadequate
5. Presentation *Please summarise this presentation – the principle features (positive and important negatives) in 2-3 sentences only*			
6. Differential diagnosis *Would you like to have a stab at a differential diagnosis?* *Is there anything else you considered?* **Pulmonary emboli, restrictive lung disease, lung fibrosis, TB, heart failure, asthma, cancer, anaemia**			
7. Clinical reasoning *Which of the things that you have mentioned would you think more likely and why?* *Anything else you wish to say about this?*			
8. Investigation *Depending on the exam findings, what tests are likely to be relevant here* *Anything else?* FBC, electrolytes, CXR, sats, arterial blood gases, d-dimer, CT PA , PFTs			

Student name:	***Facilitator name:***