# Introduction to clinical skills and examination

Introductory course

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# General history taking skills

# Managing clinical encounters

## 1-Reasons for the encounter

## Why now?

### 1.1 Deciding to consult a doctor

- Perceived susceptibility or vulnerability to illness
- Perceived severity of symptoms
- Perceived costs of consulting
- Perceived benefits of consulting

### 1.2 Triggers to consultation

- Interpersonal crisis
- Interference with social or personal relations
- Sanctioning or pressure from family or friends
- Interference with work or physical activity
- Reaching the limit of tolerance of symptoms

# The clinical environment

-Calm, private environment

-Layout of the consulting room

-Clinic vs. inpatient encounter

Always ensure privacy and dignity of patients

Sensitive questions

# Opening the encounter

## Establishing rapport with patients

-Greet the patient

-Introduce yourself (wearing name badge)

## Dress style and demeanour

-Smart, sensitive and modest dress

## How to address and speak to patients

## Asking open questions

# Gathering information

## Understanding the cause of illness (Diagnosis)

-History, physical examination and investigations

## Don’t use medical jargons

-Words with different possible meanings should be clarified

## Active listening

-Helps reveal concerns

## Summarizing

## Non-verbal communication

-Body language

-Signs of discomfort

# Handling sensitive information and third parties

-Confidentiality

-Patient's permission to share information to others (relatives, friends and carers, etc.)

# Managing patient concerns

-Understand the patient's personal experience of illness

-ICE (Ideas, concerns and expectations)

# Showing empathy

-Empathy vs sympathy

# Showing cultural sensitivity

-Eye contact, touch and personal space

-Appreciate and accept differences

# Addressing the problem

# Concluding the encounter

# Alternatives to face-to-face encounters

-Telemedicine

-Phone encounters, using email and other communication applications

# Personal responsibilities

-Don’t abuse your privileged position

-Be fit to care for patients

-Giving medical care to close persons

# Professional responsibilities

## 1.3 The duties of a registered doctor

### Knowledge, skills and performance

- Make the care of your patient your first concern
- Provide a good standard of practice and care:
  - Keep your professional knowledge and skills up to date
  - Recognise and work within the limits of your competence

### Safety and quality

- Take prompt action if you think that patient safety, dignity or comfort is being compromised
- Protect and promote the health of patients and the public

### Maintenance of trust

- Be honest and open, and act with integrity
- Never discriminate unfairly against patients or colleagues
- Never abuse your patients' trust in you or the public's trust in the profession

### Communication, partnership and teamwork

- Treat patients as individuals and respect their dignity:
  - Treat patients politely and considerately
  - Respect patients' right to confidentiality
- Work in partnership with patients:
  - Listen to, and respond to, their concerns and preferences
  - Give patients the information they want or need in a way they can understand
  - Respect patients' right to reach decisions with you about their treatment and care
  - Support patients in caring for themselves to improve and maintain their health
- Work with colleagues in the ways that best serve patients' interests

# General aspects of history taking

The importance of history taking

Preparation

-Settings, timing

Starting the consultation

-Open questions and closed questions

Don’t use medical terms

Terms that might need to be clarified

## 2.1 Examples of terms used by patients that should be clarified

| Patient's term | Common underlying problems | Useful distinguishing features |
|---|---|---|
| Allergy | True allergy (immunoglobulin E-mediated reaction)<br>Intolerance of food or drug, often with nausea or other gastrointestinal upset | Visible rash or swelling, rapid onset<br>Predominantly gastrointestinal symptoms |
| Indigestion | Acid reflux with oesophagitis<br>Abdominal pain due to:<br>Peptic ulcer<br>Gastritis<br>Cholecystitis<br>Pancreatitis | Retrosternal burning, acid taste<br>Site and nature of discomfort:<br>Epigastric, relieved by eating<br>Epigastric, with vomiting<br>Right upper quadrant, tender<br>Epigastric, severe, tender |
| Arthritis | Joint pain<br>Muscle pain<br>Immobility due to prior skeletal injury | Redness or swelling of joints<br>Muscle tenderness<br>Deformity at site |
| Catarrh | Purulent sputum from bronchitis<br>Infected sinonasal discharge<br>Nasal blockage | Cough, yellow or green sputum<br>Yellow or green nasal discharge<br>Anosmia, prior nasal injury/polyps |
| Fits | Transient syncope from cardiac disease<br>Epilepsy<br>Abnormal involuntary movement | Witnessed pallor during syncope<br>Witnessed tonic/clonic movements<br>No loss of consciousness |
| Dizziness | Labyrinthitis<br>Syncope from hypotension<br>Cerebrovascular event | Nystagmus, feeling of room spinning, with no other neurological deficit<br>History of palpitation or cardiac disease, postural element<br>Sudden onset, with other neurological deficit |

# Structure of history

Patient's profile
Chief complaint
History of presenting illness
Past medical/Past surgical history
Drug history
Systemic review (enquiry)
Family history
Social history and lifestyle

# Patient’s profile

-Name

-Age

-Gender

-Route of admission

-Date of admission

-Time of admission

# Chief complaint

## Usually, the main symptom

-Might use 2 or three main symptoms

## Duration of the complaint

-Acute vs chronic

## Generating differential diagnosis

# History of presenting illness

Analyzing the main symptom(s)

Identifying risk factors

Possible serious complications

Exploring the differential diagnosis

Recognizing patterns of symptoms

## 2.2 Characteristics of pain (SOCRATES)

### Site

- Somatic pain, often well localised, e.g. sprained ankle
- Visceral pain, more diffuse, e.g. angina pectoris

### Onset

- Speed of onset and any associated circumstances

### Character

- Described by adjectives, e.g. sharp/dull, burning/tingling, boring/stabbing, crushing/tugging, preferably using the patient's own description rather than offering suggestions

### Radiation

- Through local extension
- Referred by a shared neuronal pathway to a distant unaffected site, e.g. diaphragmatic pain at the shoulder tip via the phrenic nerve ($C_3$, $C_4$)

### Associated symptoms

- Visual aura accompanying migraine with aura
- Numbness in the leg with back pain suggesting nerve root irritation

### Timing (duration, course, pattern)

- Since onset
- Episodic or continuous:
  - If episodic, duration and frequency of attacks
  - If continuous, any changes in severity

### Exacerbating and relieving factors

- Circumstances in which pain is provoked or exacerbated, e.g. eating
- Specific activities or postures, and any avoidance measures that have been taken to prevent onset
- Effects of specific activities or postures, including effects of medication and alternative medical approaches

### Severity

- Difficult to assess, as so subjective
- Sometimes helpful to compare with other common pains, e.g. toothache
- Variation by day or night, during the week or month, e.g. relating to the menstrual cycle

# Past medical/Past surgical history

## Past medical history

-Chronic diseases

-Duration of illness

-Status of control

## Past surgeries

## History of blood transfusion

# Drug history

Regular/chronic medications

Non-medical therapies

Duration of treatment

Dosage

Frequency

Adverse effects

Concordance and adherence

Non-prescribed drugs

# Systemic review

## 2.10 Systematic enquiry: cardinal symptoms

### General health

- Wellbeing
- Appetite
- Weight change
- Energy
- Sleep
- Mood

### Cardiovascular system

- Chest pain on exertion (angina)
- Breathlessness:
  - Lying flat (orthopnoea)
  - At night (paroxysmal nocturnal dyspnoea)
  - On minimal exertion – record how much
- Palpitation
- Pain in legs on walking (claudication)
- Ankle swelling

### Respiratory system

- Shortness of breath (exercise tolerance)
- Cough
- Wheeze
- Sputum production (colour, amount)
- Blood in sputum (haemoptysis)
- Chest pain (due to inspiration or coughing)

### Gastrointestinal system

- Mouth (oral ulcers, dental problems)
- Difficulty swallowing (dysphagia – distinguish from pain on swallowing, i.e. odynophagia)
- Nausea and vomiting
- Vomiting blood (haematemesis)
- Indigestion
- Heartburn
- Abdominal pain
- Change in bowel habit
- Change in colour of stools (pale, dark, tarry black, fresh blood)

### Genitourinary system

- Pain passing urine (dysuria)
- Frequency passing urine (at night: nocturia)
- Blood in urine (haematuria)
- Libido
- Incontinence (stress and urge)
- Sexual partners – unprotected intercourse

### Men

If appropriate:

- Prostatic symptoms, including difficulty starting (hesitancy):
  - Poor stream or flow
  - Terminal dribbling
- Urethral discharge
- Erectile difficulties

### Women

- Last menstrual period (consider pregnancy)
- Timing and regularity of periods
- Length of periods
- Abnormal bleeding
- Vaginal discharge
- Contraception

If appropriate:

- Pain during intercourse (dyspareunia)

| | |
|---|---|
| **Nervous system** | |
| • Headaches<br>• Dizziness (vertigo or lightheadedness)<br>• Faints<br>• Fits<br>• Altered sensation | • Weakness<br>• Visual disturbance<br>• Hearing problems (deafness, tinnitus)<br>• Memory and concentration changes |
| **Musculoskeletal system** | |
| • Joint pain, stiffness or swelling<br>• Mobility | • Falls |
| **Endocrine system** | |
| • Heat or cold intolerance<br>• Change in sweating | • Excessive thirst (polydipsia) |
| **Other** | |
| • Bleeding or bruising | • Skin rash |

# Family history

Diseases that run in the family

Inherited diseases

-Autosomal dominant

-Autosomal recessive

-X-linked

Genetic predisposition

Document illness in first degree relatives

Family pedigree

# Social history and lifestyle

## Smoking history

-Calculate pack-years of smoking

## Alcohol intake

-Alcohol problems

## Occupational history and environment

## Travel history

## Sexual history if relevant

**2.8 Features of alcohol dependence in the history**

- A strong, often overpowering, desire to take alcohol
- Inability to control starting or stopping drinking and the amount that is drunk
- Drinking alcohol in the morning
- Tolerance, where increased doses are needed to achieve the effects originally produced by lower doses
- A withdrawal state when drinking is stopped or reduced, including tremor, sweating, rapid heart rate, anxiety, insomnia and occasionally seizures, disorientation or hallucinations (delirium tremens); this is relieved by more alcohol
- Neglect of other pleasures and interests
- Continuing to drink in spite of being aware of the harmful consequences

## 2.9 Examples of occupational disorders

| Occupation | Factor | Disorder | Presents |
|---|---|---|---|
| Shipyard workers, marine engineers, plumbers and heating workers, demolition workers, joiners | Asbestos dust | Pleural plaques<br>Asbestosis<br>Mesothelioma<br>Lung cancer | >15 years later |
| Stonemasons | Silica dust | Silicosis | After years |
| Farmers | Fungus spores on mouldy hay | Farmer's lung (hypersensitivity pneumonitis) | After 4–18 hours |
| Divers | Surfacing from depth too quickly | Decompression sickness<br>Central nervous system, skin, bone and joint symptoms | Immediately, up to 1 week |
| Industrial workers | Chemicals, e.g. chromium<br>Excessive noise<br>Vibrating tools | Dermatitis on hands<br>Sensorineural hearing loss<br>Vibration white finger | Variable<br>Over months<br>Over months |
| Bakery workers | Flour dust | Occupational asthma | Variable |
| Healthcare workers | Cuts, needlestick injuries | Human immunodeficiency virus, hepatitis B and C | Incubation period >3 months |

# Difficult situations

## Patients with communication difficulties

-Hearing or speech difficulties

-Different language

## Patients with cognitive difficulties

-? Dementia

-Obtain history from relatives or carers

## Sensitive situations

-Asking personal questions

-Examining intimate parts

## Emotional or angry patients

## 2.4 Typical patterns of symptoms related to disease causation

| Disease causation | Onset of symptoms | Progression of symptoms | Associated symptoms/pattern of symptoms |
|---|---|---|---|
| Infection | Usually hours, unheralded | Usually fairly rapid over hours or days | Fevers, rigors, localising symptoms, e.g. pleuritic pain and cough |
| Inflammation | May appear acutely | Coming and going over weeks to months | Nature may be multifocal, often with local tenderness |
| Metabolic | Very variable | Hours to months | Steady progression in severity with no remission |
| Malignant | Gradual, insidious | Steady progression over weeks to months | Weight loss, fatigue |
| Toxic | Abrupt | Rapid | Dramatic onset of symptoms; vomiting often a feature |
| Trauma | Abrupt | Little change from onset | Diagnosis usually clear from history |
| Vascular | Sudden | Stepwise progression with acute episodes | Rapid development of associated physical signs |
| Degenerative | Gradual | Months to years | Gradual worsening with periods of more acute deterioration |

Questions ?