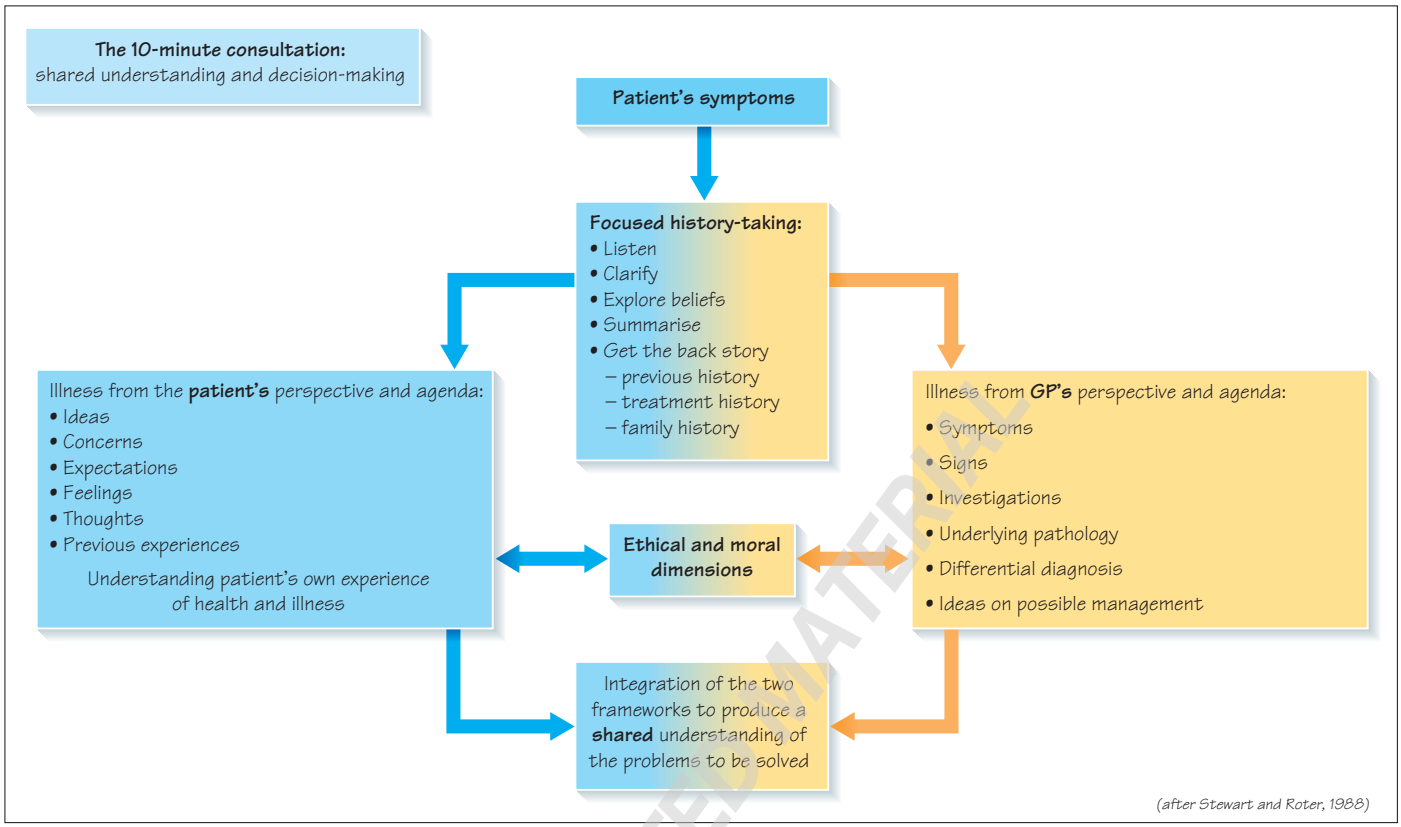
1 The 10-minute consultation: taking a history



At finals you could spend 20–40 minutes clerking your patient. So how can a 10-minute consultation in general practice produce an adequate assessment?

- Continuity of care means the patient and their history are often familiar.
- The 10-minute consultation is an average. A quick consultation, like a repeat medication request, saves time which can be spent on trickier problems.
- You don't need to do everything in one consultation. It can help to watch a problem develop over several visits.
- Making diagnoses is honed through practice, enabling GPs to recognise patterns of illness quickly. This is not 'taking short-cuts': it's about the expertise to focus on key areas.

As a student, don't rush to assess a patient in 10 minutes. Take the time you need to understand your patient's problem fully. Speed comes with experience.

What's the difference between a focused history and a traditional one?

- Traditional history-taking is useful when you first learn to interview patients as it teaches you a structure and a list of questions to ask.
- You'll notice senior doctors often ask surprisingly few questions, yet get a better view of the problem.
- This 'focused history' requires judgement about what to explore and what to set aside. Judgement is based on many things including knowledge and experience.
- Learning focused history-taking is an important transition between student and doctor. General practice is the ideal setting to practise this because you will see many undiagnosed patients on whom to hone your skills.

Focused history-taking in a nutshell

Listen

- *'What can I do for you today?'* Students often hope to save time by getting straight to the point with direct questions. The opposite happens. You get a better foundation for exploring the problem if you give the patient the time to tell their story from their perspective: start with an open question and then listen.
- The *'golden minute'* (give the patient a minute to speak without interruption) gives your patient time to frame their problem in their own way.
- *'Go on . . . tell me more . . .'* If the patient falters, encourage them to carry on. Use non-verbal encouragement through head nodding and eye contact.
- *'You were saying the pain is worse at night . . .' Reflection* can get help your patient going again.

• Don't fear *silence,* particularly in emotionally charged situations. Give the patient space to formulate their thoughts.

Clarify

• *'When were you last completely well?'* Establish the timetable of the patient's symptoms.
• *'Can you describe the pain?'* Analyse each symptom. Mnemonics can help, such as SOCRATES: Site, Onset, Character, Radiation, Associated factors, Timescale, Exacerbating/relieving factors, Severity.
• *'What do you mean by indigestion?'* Understand what the patient means, especially if they use medical terms. 'Migraine' often means 'bad headache', 'blood pressure' may mean dizziness, headaches or almost anything else.
• Ask *red flag* questions to detect serious underlying conditions. In back pain, ask about incontinence and urinary problems, history of cancer and TB.

Explore beliefs

• *'What are your thoughts about this?'* The patient may have a very good idea of their diagnosis, 'It's just the same as my aunt had.' Equally, they may have a very misleading idea, 'This website said it's typical of *Candida* infection.' Knowing your patients' **ideas** may help you diagnostically, or help your patients away from incorrect formulations.
• *'In your darkest moments what do you think this might be?'* Look for hidden agendas and explore your patients' **concerns**. Patients with headaches often worry about brain tumours or meningitis. They rarely volunteer this for fear of looking foolish, maybe because they're afraid they may be right. Your diagnosis and treatment may be spot on, but if you haven't uncovered these concerns and put your patient's mind at rest, you send away a worried patient.
• *'What are you hoping we can do?'* What are your patient's **expectations** for treatment. When you come to plan management, taking your patient's expectations on board will help you achieve **concordance** with your patient (see Chapter 2).
• Above all, don't try to guess what your patient is thinking. There's no point reassuring your patient about something that never worried them. Their real concerns (which might seem bizarre to you or to the next patient) may be life and death to them.

Summarise

'Let me see if I've got this right . . .' Once you have grasped the patient's problem, summarise it back. This checks your own understanding, and reassures the patient that they've been understood.

The past medical history

• The past medical history is essential background to the presenting problem. The GP may not need to explore it in a familiar patient, or if the records are to hand.
• *'Have you had any serious illnesses?' 'Have you seen a specialist or been in hospital?'* Don't list random diseases, ask general questions about the past, and . . .
• Ask specific questions relevant to the presenting complaint. Ask *'Ever had migraine?'* to the patient with headaches.

The treatment history

• *'Can you bring all your medicines to the surgery with you?'* Drug side effects and interactions cause huge amounts of iatrogenic illness and many hospital admissions. A secure drug history will allow you to spot current problems and prevent your own prescribing causing future ones.
• The drug history is a back door route to past medical history. You may only discover that your patient is hypertensive from the drug history.
• Ask about over-the-counter drugs and recreational drugs. Remember, the most important of these are alcohol and tobacco.

Family history

Enquire about illness in relatives rather than a list of conditions. Ask for anything that has come up as a possibility in the patient's history – like diabetes in the family of a patient presenting with thirst and weight loss.

Where next?

From the history you should now have a good idea of what's going on. If you haven't, sit back and think what else you need to fill out the picture. Use the history to make sure you find out all you need to help you make a diagnosis and plan management. If that takes time, it's time well spent. Remember 80% of diagnoses are made on the history and in many conditions (e.g. epilepsy, migraine) a secure diagnosis can only be made from the history, so use it well.