CLINICAL MEDICINE

Lecture Notes

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7th Edition

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Contents

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Preface to the Seventh Edition

History-taking and examination remain the essential tools of clinical medicine. However, the environment in which medicine is practised has changed since the first edition of *Lecture Notes in Clinical Medicine* in 1975. The seventh edition follows the format of previous editions of this book with two sections: Clinical Examination and Clinical Medicine. Each section has been updated to reflect the increased evidence upon which clinical practice is based and the more objective methods of assessment that are now used.

It is rewarding to discover how many readers have found the text useful for study, for revision and for the practice of clinical medicine. Please continue to let us have your views.

John Bradley
Mark Gurnell
Diana Wood

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Preface to the First Edition

This book is intended primarily for the junior hospital doctor in the period between qualification and the examination for Membership of the Royal Colleges of Physicians. We think that it will also be helpful to final-year medical students and to clinicians reading for higher specialist qualifications in surgery and anaesthetics.

The hospital doctor must not only acquire a large amount of factual information but also use it effectively in the clinical situation. The experienced physician has acquired some clinical perspective through practice: we hope that this book imparts some of this to the relatively inexperienced. The format and contents are designed for the examination candidate but the same approach to problems should help the hospital doctor in his everyday work.

The book as a whole is not suitable as a first reader for the undergraduate because it assumes much basic knowledge and considerable detailed information has had to be omitted. It is not intended to be a complete textbook of medicine and the information it contains must be supplemented by further reading. The contents are intended only as lecture notes and the margins of the pages are intentionally large so that the reader may easily add additional material of his own.

The book is divided into two parts: the *clinical approach* and *essential background information*. In the first part we have considered the situation which a candidate meets in the clinical part of an examination or a physician in the clinic. This part of the book thus resembles a manual on techniques of physical examination, though it is more specifically intended to help the candidate carry out an examiner's request to perform a specific examination. It has

been our experience in listening to candidates' performances in examinations and hearing the examiner's subsequent assessment that it is the failure of a candidate to examine cases systematically and his failure to behave as if he were used to doing this every day of his clinical life that leads to adverse comments.

In the second part of the book a summary of basic clinical facts is given in the conventional way. We have included most common diseases but not all, and we have tried to emphasise points which are understressed in many textbooks. Accounts are given of many conditions which are relatively rare. It is necessary for the clinician to know about these and to be on the lookout for them both in the clinic and in examinations. Supplementary reading is essential to understand their basic pathology, but the information we give is probably all that need be remembered by the non-specialist reader and will provide adequate working knowledge in a clinical situation. It should not be forgotten that some rare diseases are of great importance in practice because they are treatable or preventable, e.g. infective endocarditis, hepatolenticular degeneration, attacks of acute porphyria. Some conditions are important to examination candidates because patients are ambulant and appear commonly in examinations, e.g. neurosyphilis, syringomyelia, atrial and ventricular septal defects.

We have not attempted to cover the whole of medicine, but by cross-referencing between the two sections of the book and giving information in summary form we have completely omitted few subjects. Some highly specialised fields such as the treatment of leukaemia were thought unsuitable for inclusion.

A short account of psychiatry is given in the section on neurology since many patients with mental illness attend general clinics and it is hoped that readers may be warned of gaps in their knowledge of this important field. The

section on dermatology is incomplete but should serve for quick revision of common skin disorders.

Wherever possible we have tried to indicate the relative frequency with which various conditions are likely to be seen in hospital practice in this country and have selected those clinical features which in our view are most commonly seen and where possible have listed them in order of importance. The frequency with which a disease is encountered by any individual physician will depend upon its prevalence in the district from which his cases are drawn and also on his known special interests. Nevertheless, rare conditions are rarely seen; at least in the clinic. Examinations, however, are a ‘special case’.

We have used many generally accepted abbreviations, e.g. ECG, ESR, and have included them in the index instead of supplying a glossary.

Despite our best efforts, some errors of fact may have been included. As with every book and authority, question and check everything – and please write to us if you wish.

We should like to thank all those who helped us with producing this book and, in particular, Sir Edward Wayne and Sir Graham Bull who have kindly allowed us to benefit from their extensive experience both in medicine and in examining for the Colleges of Physicians.

David Rubenstein
David Wayne
November 1975

Part 1

Clinical Examination

Chapter 1

The Medical Interview

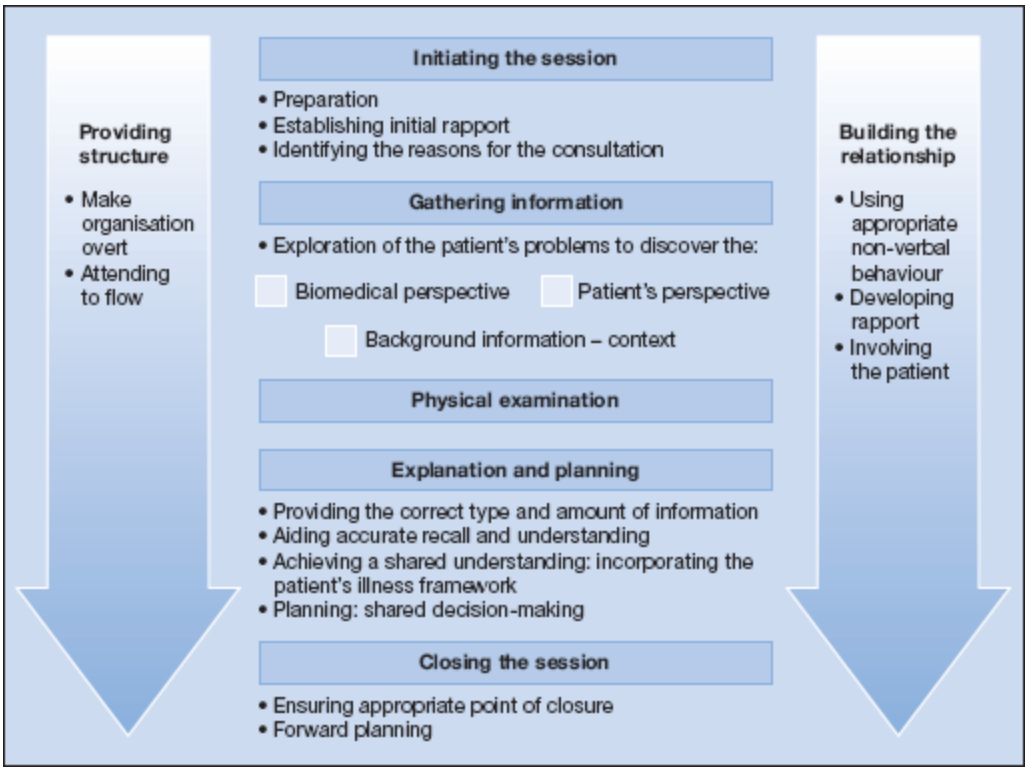
Good communication between doctor and patient forms the basis for excellent patient care and the clinical consultation lies at the heart of medical practice. Good communication skills encompass more than the personality traits of individual doctors – they form an essential core competence for medical practitioners. In essence, good communication skills produce more effective consultations and, together with medical knowledge and physical examination skills, lead to better diagnostic reasoning and therapeutic intervention. The term ‘communication skills’, when applied to medical practice, describes a set of specific skills that can be taught, learned and assessed. A large evidence-base shows that health outcomes for patients and both patient and doctor satisfaction within the therapeutic relationship are enhanced by good communication skills.

In this chapter the medical interview as a whole will be considered and then the way in which communication skills should be approached in different types of assessment encountered by students and trainees reviewed.

There are a number of different models for learning communication skills in use throughout the world. They are generally similar and all emphasise the importance of patient-centred interview methods. This chapter is based on the Calgary–Cambridge model (Fig. 1.1) which has been widely adopted in Europe and the USA and with which the authors are familiar as a means of teaching and learning and as a framework for assessment (Silverman et al. 2005). Like all clinical skills, communication skills can only be

acquired by experiential learning. This may take the form of small group learning with role play, the use of actors in simulated learning environments or, for more experienced learners, in recorded real consultations with subsequent feedback.

Figure 1.1 The Calgary–Cambridge Guide. From Kurtz, S., et al. (2005) *Teaching and Learning Communication Skills in Medicine*, 2nd edn. Radcliffe Publishing, Oxford.



Effective Consultation

Effective consultations are patient-centred and efficient, taking place within the time and other practical constraints that exist in everyday medical practice. The use of specific communication skills together with a structured approach to the medical interview can enhance this process. Important communication skills can be considered in three categories: content, process and perceptual skills (see Table 1.1); these mirror the essential knowledge, skills and attitudes required

for good medical practice. These skills are closely interrelated so that, for example, effective use of process skills can improve the accuracy of information gathered from the patient, thus enhancing the content skills used subsequently in the consultation.

Table 1.1 Categories of communication skills

Skill	Examples
Content skills	
What the doctor communicates	Knowledge-based: appropriate questions and responses; accurate information gathering and explanation to patient; clear discussion of investigation and treatments based on knowledge
Process skills	
How the doctor communicates	Skills-based: verbal and non-verbal communication skills; relationship building; organising and structuring the interview
Perceptual skills	
What the doctor is thinking	Attitude-based: clinical reasoning and problem-solving skills; attitudes towards the patient; feelings and thoughts about the patient; awareness of internal biases

Structure

Providing structure to the consultation is one of the most important features of effective consultation. Process skills should be used to develop a structure that is responsive to the patient and flexible for different consultations. Six groups of skills can be identified and each will be considered below.

Sequential in the consultation:

- initiating the session
- gathering information (including from physical examination)
- explanation and planning
- closing the session

Throughout the consultation:

- organisation

- relationship building

Initiating the Session

The initial part of a consultation is essential to form the basis for relationship building and to set objectives for the rest of the interview. Before meeting a patient, the doctor should prepare by focusing him- or herself, trying to avoid distractions and reviewing any available information such as previous notes or referral letters.

Initiating the Session

Establish rapport: greet the patient, confirm their name, introduce yourself and explain your role, attend to the patient's comfort.

Identify the reason for the consultation: use an appropriate opening question, listen to the patient, confirm the problem and screen for any other issues that the patient may wish to discuss.

Confirm an agenda for the consultation.

Physical Examination

Ask permission: gain the patient's consent for examination.

Ensure that the patient is comfortable: position them adequately for the examination; if doing a full examination, cover parts of the body not being examined actively.

Be clear and precise: explain what you are going to do in advance.

Be aware: the patient may be embarrassed or in pain.

Gathering Information

An accurate clinical history provides about 80% of the information required to make a diagnosis. Traditionally, history-taking focused on questions related to the biomedical aspects of the patient's problems. Recent evidence suggests that better outcomes are obtained by including the patient's perspective of their illness and by taking this into account in subsequent parts of the consultation. The objectives for gathering information

should therefore include exploring the history from both the biomedical and patient perspectives, checking that the information gathered is complete and ensuring that the patient feels that the doctor is listening to them.

Gathering Information

Ask the patient to tell their own story.

Listen attentively: do not interrupt; leave the patient time and space to think about what they are saying.

Use open and closed questions: clarify issues in the history; use clear, concise and easily understood questions; move from open to closed questions then back again.

Use verbal and non-verbal facilitation: silences, repetition, paraphrasing.

Pick up on patient's verbal and non-verbal clues: acknowledge them by checking.

Summarise at intervals: verify your understanding; allow the patient to correct or add to the history.

Encourage the patient to express their feelings: actively seek their ideas, concerns and expectations.

Further information is gathered from the physical examination. Establishment of a good rapport during the first part of the consultation will facilitate communication during the examination. An appropriate chaperone should be present during the physical examination.

Explanation and Planning

Explanation and planning is crucially important to the effective consultation. Establishment of a management plan jointly between the doctor and the patient has important positive effects on patient recall, understanding of their condition, adherence to treatment and overall satisfaction. Patient expectations have changed and many wish to be more involved in decision-making about investigation and treatment options. The goals of this part of the consultation are thus to gauge the amount and type of information

required by each individual patient, to provide information in a way that the patient can remember and understand and which takes their perspectives into account, to arrive at a shared understanding of the problem and to engage the patient in planning the next moves.

Explanation and Planning

Avoid jargon: use clear concise language; explain any medical terminology.

Find out what the patient knows: establish prior knowledge; find out how much they wish to know at this stage.

'Chunk and check': provide information in small amounts and check understanding; use this to assess how to proceed.

Organise explanation: develop a logical sequence; categorise information; repeat and summarise; signpost what is coming next; use diagrams or charts, written information or instructions.

Relate the information to the patient's perspective.

Respond to patient's cues: verbal and non-verbal; allow patient to ask questions or clarify information.

Involve the patient: share thoughts; reveal rationale for opinions; offer your opinion of what is going on and name it where possible; explore management options; take the patient's lifestyle and cultural background into account in the discussion.

Negotiate a mutually agreeable action plan: check that this meets the patient's expectations and addresses their concerns.

Closing the Session

Closing the interview allows the doctor to summarise and clarify the plans that have been made and what the next steps will be. It is also important to ensure that contingency plans are in place in case of unexpected events and that the patient is clear about follow-up arrangements. Continuing to foster the doctor–patient relationship in this way has positive effects on adherence to treatment and health outcomes.

Closing the Session

Summarise: review the consultation and clarify the plan of action; make a contract with the patient about the next steps.

Describe contingency plans: explain any possible unexpected outcomes; how and when to seek help.

Final check: ensure that the patient agrees and has no further questions.

Two essential parts of effective consultation skills run throughout the interview – organisation and relationship building. The way in which these two are used is shown in Table 1.2.

Table 1.2 Skills for organising the consultation and building the relationship

Organising the consultation		Building the relationship	
Summarising	Summarise the end of a specific line of enquiry; confirm your understanding; allow patient to correct; order information; reflect on what to do next.	Non-verbal communication	Includes eye contact, facial expression, posture, proximity, body movement, touch; use of time, your appearance, manner; the environment.
Signposting	Structure the interview overtly; draw attention to what you are about to say; introduce summaries; help patient to understand where the interview is going; ask permission to move on through the interview.	Rapport	Accept patient's views; empathise to show understanding of patient's views and feelings; support by expressing concern, willingness to help, acknowledge efforts to cope; be sensitive towards embarrassing or difficult issues.
Sequencing	Maintain a logical sequence to the interview; use flexible but ordered organisation by signposting and summarising.	Involve the patient	Share your thoughts to encourage patient interaction; explain your rationale for doing things; explain your actions during the physical examination.
Timing	Pace the interview; use other skills to achieve good timing.		

Organisation allows a flexible but ordered and logical process to occur within an appropriate time-frame. It encourages patient participation and collaboration and facilitates accurate information gathering.

Building a relationship with the patient involves a number of communication skills that enable the doctor to establish rapport and trust between themselves and the patient. It maximises the chances of accurate information gathering, explanation and planning and can form part of the development of a continuing relationship over time. It is

vital to patient and doctor satisfaction with the consultation process.

Special Circumstances

Certain circumstances demand a special approach to communication skills, such as breaking bad news, dealing with cultural diversity, using an interpreter, and consultation with the elderly, with mentally ill patients or the parents of a sick child. In essence, the core communication skills described here form the basis for any of the more difficult communication skills scenarios. Complex situations require the doctor to use basic skills to a higher level. Preparation and planning, listening to the patient, delivering information in small amounts with regular checking and allowing time for information to be assimilated and for questioning are paramount. Closure is also important, ensuring the patient knows what is happening and is clear about the next steps.