CLINICAL SKILLS: TAKING A LONG STATION HISTORY

The 'long station history' is a station which some universities include in their OSCEs to allow a student to spend a longer period of time taking a history from a patient. The focus is usually on ensuring you can cover the important medical points as well as taking in any psychological or social issues that stem from the patient's medical journey.

Key points:

- Remember to fully introduce yourself to the patient and be polite throughout the whole discussion, even though you will be feeling the time pressure!
- The patient you will see will be clinically stable
- You may be asked to discuss their chronic illness, an acute-on-chronic presentation of their disease, or a new disease altogether
- This amount of time given to you can range from university to university. For my UCL finals, it was 5 minutes preparation time, a 20 minute history, and 5 minute discussion period where you should present your findings and answer any questoins that the examiner has
- In my opinion, the long station history is very different to the short station history. The main focuses of a long station history are two-fold:
    1. Ensuring you can take a comprehensive medical history and ask all the relevant points about their illness, including symptoms and management – just like you would in a short station history
    2. Approaching the patient holistically – I believe it is not enough to ask all the medical questions without really considering how it affects the patient as a whole. Without covering these bases, you aren't really showing an examiner that you understand disease in an bio-psycho-social way. I believe that you are given the extra time in this history to demonstrate just that
- Remember, these stations use **real patients** - it is vital that you treat them as such, and focus on being polite and creating a good rapport with them, just as you would aim to do when taking a patient's history on the ward
- Timing is an issue in all stations in Finals OSCEs, but even more so in the long station history. With around 20 minutes to take a full bio-psycho-social history of a patients long term and acute medical problems, you need to manage your time well. It is probably a reasonable starting point to aim to divide your time equally between: 1) the history of presenting complaint (ie the main medical issue), 2) the past medical history, drug history and family history, and 3) the social history. You should also try to screen for any other concerning symptoms that you didn't discuss in a systems review at the end of your consultation

Presenting complaint/history of presenting complaint:

- Ask **open questions** at first, for example, 'tell me about your main medical problems', or 'let's start from the beginning, when did you first notice something was wrong?' - the patient knows they are here to tell you all about their illness, so let them!
- Ensure you ask sufficient questions to establish a diagnosis, just as you would in a short station history. Additionally, think about asking the below:
- How does the patient feels about diagnosis/symptoms?
- What is the effect on their lives, for example; family, friends, employment, finances?
- Are they followed up, and if so, by which medical team?
- Does anyone else help them manage their illness?

- Do they feel they have enough support?
- Do they suffer from any complications of their chronic disease? For example, if a patient has diabetes, enquire about renal, ophthalmological, and neurological pathology
- If appropriate, screen for any concurrent mental illness - particular anxiety and depression
- Which of their symptoms or medical conditions bothers them the most?

Past medical history:

- Ensure you have a list of any other medical problems that they have experienced, and ascertain if these are active (ie causing ongoing symptoms) or quiescent
- Ask if they've ever had any operations, and if so what was the indication and outcome

Drug history:

- What medications does the patient take?
- Enquire about drug allergies (and what symptoms they get when they take the medication)
- Does the patient suffer from any side effects of their medications?
- Are they compliant with their medications? (a good way to phrase this is: "many people find it difficult to remember to take their medications regularly - how many doses would you say you missed in a week?")
- How do they manage taking their medications e.g.: do they use a dosset box? Do they require family members or carers to prompt them to take the medications?
- Ask if they take any over-the-counter, herbal or recreational drugs

Family history:

- Is there any family history of medical problems?
- Particularly relevant if the patient's main medical problem has any genetic component: e.g. familial cancer syndromes, autoimmune/endocrine/connective tissue disorder

Social history:

- Enquire about smoking, alcohol, illicit drugs
- Do they work, and is this affected by their medical condition?
- Is the patient independent in activities of daily living?
- Does the patient have carers? If so, what care support do they require? This could range from once-a-week visits to four times a day/sheltered accommodation/care home
- Do they have any other external support, for example meals on wheels?
- Do they have any family/friends who support them?
- Are they supported financially?

Systems review:

- As per any standard systems review, it is important to screen for symptoms that you didn't discuss in the history of presenting complaint. However, this needs to be carried out with consideration of the time pressures of the station, and remembering

that you should keep a good rapport with the patient (ie. attempt to avoid spending 5 minutes asking a list of closed questions about symptoms)

To conclude the consultation:

- Thank the patient for their time
- Spend 1-2 minutes collecting your thoughts and preparing to present the case to the examiner. Come up with a 'problems list' - e.g. the main medical diagnoses, the comorbidities, and the psychological and social issues that stem from this.