L’examen oral comprend 3 à 5 minutes de préparation suivie d’une présentation orale de 10 minutes. Les 3 types de cas cliniques tombables sont : chest pain, abdominal pain et headache. Le contenu sera noté sur 8 points et le langage sur 12 points, la prof nous conseille donc de faire très attention aux temps utilisés. La grille d’évaluation détaillée est disponible sur Moodle. Les oraux sont, pour l’instant, prévus pour la semaine du 21 janvier mais cela reste à confirmer. Une séance d’entraînement aura lieu en décembre, la prof nous notera à titre indicatif, cela ne comptera donc pas pour la note finale.
I/ Video “Building efficiency and effectiveness through patient-centered interviewing by Auguste H. Fortin”

1) Theoretical advice for a medical interview
2) Assess the patient’s psychosocial situation
3) Explain the symptoms/medical history of the patient

II/ How to build a medical encounter

1) The 8 steps of taking a medical history
   1. Introduction, patient’s details
   2. Presenting complaint and history of present complaint
   3. Past medical and surgical history
   4. Medications, drug history and allergies
   5. Smoking and alcohol history
   6. Social, occupational and family history
   7. System review
   8. Conclusion and closure

2) Rappel sur les temps
I/ Video “Building efficiency and effectiveness through patient-centered interviewing by Auguste H. Fortin”

1) Theoretical advice for a medical interview

First, the doctor **introduces himself** and **welcomes** the patient. He gives the patient the outline of the interview, sets the agenda so that the patient knows in advance what to expect: “First, I’m going to ask you some questions about your issue. Then I’m going to ask you some more detailed questions and then I’m going to examine you.”

- The first part is “patient centered”, that is to say the doctor allows the patient to lead the interview by asking **open-ended questions** and then just listens without interrupting the patient. The aim of the “patient-centered” interview part is to put patients at ease, build trust and make the doctor aware of their psychosocial background (emotional state and support system), observing verbal and non-verbal communication.

- The second part is “doctor centered”, questions are **targeted** and necessitate a medical background.

- The last part is called “education”, the doctor **recaps** what he has understood and asks the patient if he has something to add. If the doctor has the diagnosis, he explains it and prescribes the treatment. If he doesn’t have a diagnosis, he prescribes further tests and refers the patient to another doctor.

2) Assess the patient’s psychosocial situation:

- Single mother
- Raises the kids alone
- Stressed out about leaving the kids alone
- Exhausted (talking in a low voice)
- Complains about insomnia and irritability (signs of depression)
- Snaps at the kids, crabby \Rightarrow Snap at sb: parler sèchement à qqn
  
  *Crabby: grincheux*

3) Explain the symptoms/medical history of the patient:

- It started with a cold 2 weeks ago.
- She has been coughing up phlegm.
- Since yesterday, she has been coughing up blood.
- She drove alone to the hospital (she has no support)
- She feels a tight, pressure-like pain on the right side of the chest
- She has lost her voice (hoarse voice: *voix enrouée*)
- She has been diagnosed with pneumonia.
II/ How to build a medical encounter

The 4 parts of a medical encounter are:

- History (8 steps)
- Examination
- Investigation (complementary tests)
- Management (treatment)

1) The 8 steps of taking a medical history

1. Introduce yourself; patient’s details
   - Name, age
   - Marital status: “Can you tell me about your marital status?”
   - Occupation: “What do you do?”

2. Presenting complaint and history of the present complaint
   - Commencer par une question ouverte et laisser le patient parler sans l’interrompre
     “What has happened to bring you to the hospital?”
   - Puis poser des questions ciblées sur le motif de consultation. La douleur doit être évaluée en détail (important pour tenir 10 min)
     - **Exact site/location of the pain**
       “Could you show me where exactly you feel the pain?”
       “Does it come from the inside or is it superficial?”
       “Does it radiate somewhere?”
     - **Nature of the pain**: 
       “How would you describe the pain?”
       “Is it sharp (vif), dull (peu intense), stabbing (intense), burning, throbbing=pounding=pulsating, griping (à type de colique)?”
     - **Onset (beginning) of the pain** (use the past simple)
       “When did you first feel the pain/recognize the symptoms?”
       “Did it happen suddenly?”
       “Was its onset gradual/insidious?”
     - **Severity of the pain**
       “Could you assess your pain on a scale of 0 to 10?”
     - **Duration of the pain**
       “How long have you been feeling this pain?”
       “How long does an episode last?”
       “Could you assess the length (la durée) of an episode?”
     - **Progress, frequency and timing**
       “How often do you feel the pain?”
       “How often does it reoccur?”
       “Is it a constant or an intermittent pain?”
     - **Aggravating and relieving factors, previous occurrences**
       “Have you ever felt this pain before? On what occasion?”
       “What eases/ alleviates/relieves/makes your pain disappear?”
       “What do you think causes/aggravates/makes your pain worse?”
o **Associated symptoms**
  “Do you experience anything else when the pain occurs?"

o **Who noticed the symptoms?** (Patient, a relative, caregiver, health professional…)
  “Was somebody with you when you first felt this pain?”

o **What initial action was taken by the patient?**
  “Did you take any medication when you first felt the pain?”
  “Did you do anything to ease the pain/to alleviate symptoms?”

o **Did the patient seek medical attention? When? Why? Where?**
  “Did you see/consult a doctor about your symptoms?”
  “When did you seek medical attention?”
  “Who treated you? Which hospital (ward) did you go to?”

o **What action was taken by the health professional?**
  “Did he prescribe you any medication/any treatment?”
  “Did he suggest any further investigation?”
  “Did he keep you in hospital for further assessment?”
  “Have you had any episodes since then? How often have you experienced the symptoms since then?”
  “Have you consulted your physician since then?”
  “Have you received any new treatment since then?”
  “What investigations have been undertaken?”
  “Are there any investigations planned?”

o **What do the patients know about their problem?** (patients don’t necessarily remember or understand the diagnosis)
  “Do you remember the doctor’s diagnosis? What did your doctor tell about your illness?”

3. **Past medical and surgical history**
  “Have you had any serious illnesses?”
  “Have you ever been admitted to hospital/hospitalized?”
  ⇨ Si la réponse est oui, continuer avec le past simple car l'hospitalisation est finie.
  “Have you ever had any operations?”

4. **Medications, drug history and allergies**
  “Do you take any prescription drugs/prescribed medication?”
  “Do you take any over the counter treatments?”
  “Do you ever take any recreational/illegal drugs?”
  “Have you got any allergies?”
  “Are you allergic to any drug?”
  “Do you follow any treatment for your allergy?”

5. **Smoking and alcohol history** (present simple for habits ≠ to know how long (duration): present perfect)
  “Do you smoke? How many cigarettes a day do you smoke?”
  “How long have you been smoking?”
  “When did you stop smoking? How long had you been smoking before you quit?
  “How much alcohol do you normally drink on a weekday/at the weekend?”

Page 5 sur 6
6. Social, occupational and family history
“If you don’t mind, I would like to ask you some questions about your family/parents.”
“Have you got any children? How old are they? Have they got any chronic illnesses?”
“Have you travelled abroad recently?”
“Has anyone got a chronic illness/the same illness in your family?”
“At what age did he/she develop the symptoms?”

7. System review (cette partie est souvent oubliée, donc bien y penser pour ne pas perdre de points)
It concerns questions linked to the most relevant system.
On est à la fin de l’entretien, on suspecte donc le système en cause. Il faut interroger le patient sur ce système. Par exemple, si on pense à un problème au niveau de l’utérus, on pose des questions sur les cycles menstruels (periods), saignements, pilule, etc.
Pay attention to use layman’s terms (compréhensible pour le patient) or to explain medical terms.

8. Conclusion and closure
Thank you for your cooperation. Is there anything else you want to add?
May I summarize my understanding of your case?

Don’t forget to:
- Ask patients how they would like to be called
- Ask the patients about their physical comfort
- Tell them you will treat all information confidential
- Tell them they may end the consultation “If any time you wish to end the interview, please let me know”.

2) Rappel sur les temps

|                   | Pour exprimer une durée | How long have you…?
|-------------------|------------------------|-----------------------
| Present perfect   | Pour exprimer le passé sans date précise | Since yesterday, she has been coughing up blood.
| Preterit (past simple) | Pour un événement avec une date précise | Have you ever…?
| Present           | Pour les habitudes     | When did you start…?
|                   |                        | Do you exercise regularly? 
|                   |                        | Do you smoke?

Page 6 sur 6