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A competency history

An additional model of history taking

Background

Taking a medical history is an effective way of finding out important information about the patient and their presenting problem/s but this approach may inadvertently be disempowering for the patient. An increased sense of agency can increase the likelihood of behavioural change, so facilitating empowerment of the patient in the context of a medical consultation is an important challenge for general practitioners.

Objective

This article describes an alternative or additional model of history taking – the 'competency history'. It describes its theoretical base, components and appropriate use, and gives examples of how a competency history can be used in general practice.

Discussion

A competency history uses strength based empowerment approaches and is especially appropriate with patients who have a poor sense of agency. The core elements of a competency history include an understanding of the patient's past and current context, respect for the patient's expertise and strength based interventions, including alternative narratives and solution focused conversations. Another important aspect of this approach is to allow the patient to take the initiative in making a change in their behaviour, and to take responsibility for their health. Taking a competency history is a useful additional skill for GPs, and may be a valuable addition to undergraduate medical training.

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Taking a medical history is centred on a presenting problem and includes assessing and describing the problem according to a learned protocol.[1] After an examination, the next step is usually for the doctor to suggest solutions. In many cases this process is very successful. However, if the solution requires behavioural change, other factors can come into play, affecting the likelihood of change.

In some cases, a medical history based on 'critiquing' and 'deficits' may be counterproductive and undermine the likelihood of change. This is especially the case in patients where disempowerment leads to a poor sense of 'control' or 'agency' over current or future events and an inability to embrace preventive healthcare measures.[2,3] This can be particularly evident when low socioeconomic status is combined with social marginalisation, as is the case with patients who have serious mental health problems,[4] and with many indigenous patients.[5,6] This lack of a sense of agency may lead to the patient being vulnerable and a passive recipient of life, and may enhance the possibility of welfare dependency with its associated poor acceptance of responsibility.[7]

Empowerment and strength based approaches to behavioural change have been studied across multiple disciplines including social science, therapeutics and community development. Empowerment may be defined as a process by which individuals, groups and communities gain increased control over their lives.[8] Strength based approaches draw from narrative and solution focused therapeutic traditions. They aim to improve a person's self esteem and sense of personal strength, as well as to increase their sense of agency and ability to take responsibility.[9] The challenge is to find ways to incorporate such approaches within the contextual constraints of a medical consultation.

Given that the standard medical history approach may be disempowering, an alternative history based on empowerment and strength based approaches may be helpful. I suggest the term 'competency history' to describe this alternative style of history taking.

The competency history

The competency history is focused on detecting signs of competence, resilience, autonomy, self reliance and survival and aims to encourage the patient to describe achievements that have been made 'despite the odds'. It sets a tone for the consultation that is patient focused. The core elements of a competency history include an understanding of the patient's past and current

context, respect for the patient's expertise, and strength based interventions including alternative narratives and solution focused conversations. Another important aspect of this approach is to allow the patient to take initiative in making a change in their behaviour and to take responsibility for their health. Such a history needs to be adapted to the time constraints of a medical consultation.

Strength based approaches play an important role in managing physical conditions where behaviour change is necessary, and in managing mental health issues. While many general practitioners refer patients with major mental health problems to a registered psychologist or allied health counsellor, some may prefer to perform some aspects of counselling themselves, or to continue to support their patients while they are seeing a trained mental health professional. In these cases, strength based approaches can be extremely helpful.

Understanding past and current context of the patient

It is important for GPs to understand the cultural and socioeconomic background of patients that might be different to their own. Coming to understand this can take time, and the information may come from patients, their families, senior colleagues, other health workers, and from the literature. Acquiring this understanding gives a better insight into the constraints to change, why the obvious doesn't happen and how significant it is when something does change. For example, the dispossession, social marginalisation, racism and welfare dependency of Indigenous Australians has had a marked impact on their lives.[6] The impact of these past experiences can lead to a disempowering sense of victimhood. Any moves by a patient from this position to take more responsibility for their health and make changes to their lifestyle becomes more significant knowing this background. It is worth noting that in some cases a sense of embarrassment or shame of an unhealthy physical state can be a barrier to attending a consultation, and this sense of shame may worsen if the GP focuses on these problems.

Respecting patient expertise

It can be more respectful and produce better outcomes if the GP takes the attitude that most people are aware that obesity, smoking, an unhealthy diet and a lack of exercise are risks to longevity, and that there may be other reasons to explain why knowing this has not led to behavioural change. The important challenge for the GP is to understand what these reasons are in an individual patient. If the GP is unsure about the extent of patient knowledge, it can be helpful to ask, 'do you know what your target weight might be? Is it something you would like to know?' Importantly, the patient will know what has worked or hasn't worked for them in making lifestyle changes in the past. However, the patient may assume the GP's health knowledge is superior to their own and therefore not offer their opinion.

Alternative personal narratives

People develop a sense of self through the narratives they and others tell about their lives.[10] In some cases these narratives can be unhelpful and disempowering, especially if they highlight problems, deficiencies, a lack of self respect, and accept that past traumas define a person's future. Those who have been marginalised and disempowered often have a habit of blaming themselves and being their own worst critic. There is a greater possibility of change if this internalised oppression is overcome.

When a GP listens to a person's story, they construct a sense of meaning from the narrative.[10] This construct depends on the person listening, and will be shaped by the lens they use. The lens that focuses on problems and deficits may well meet patient expectations of a medical consultation and align with the training and medical language for the GP. It may well be a necessary first step so that the patient feels that they have been heard and that their complaint is being addressed.

An alternative 'competency narrative' has a different purpose in mind and is equally valid. A competency narrative is intended to be consistent with a process of empowerment, which is more likely to provide the energy to make lasting lifestyle changes.[8,9] This narrative may highlight events that defy long held negative descriptions of the patient's lives. These exceptions to the 'rule' are the cornerstone of narrative approaches.[10] For example, instances in which patients have taken responsibility, shown the capacity to run their lives, cared for their children, not given up and survived against the odds are noted and highlighted in the history taking process (see *Case example 1*).

Case example 1

Ellen, 23 years of age, presents with her three children, two of whom have school sores. All three find it hard to sit still and begin to explore the consulting room. Ellen tries to get them to behave but without much success. She slumps a little and appears to be tired and on edge. She apologises. I wonder whether she feels embarrassed by the children having school sores, as this can be seen as a sign of neglectful parenting. I ask how long the sores have been there and she says only a few days. I ask whether she has had to deal with school sores before and she says that she has several times. One time she 'let them go for a while and they got much worse, really out of hand, and took much longer to improve with treatment'. Since then she has tried to get in earlier. She used to hope that salty water washes would do the trick but now she figures that it works best when combined with antibiotics.

I begin to organise some scripts but by this time the children are becoming a handful. Ellen continues to try to exert some authority but they ignore her. I suggest to the children that they need to settle down so that I can talk to their mother. Because of the tone of this stranger's voice they settle but I am aware that this may further undermine Ellen's sense of parental competency. I ask her how she handles three such inquisitive children. She says it isn't easy as she is on her own and their father has little input into their upbringing. I mention to her that the children seem well dressed and well fed so she must be doing something right, and suggest that I don't think I could do what she does day in and day out. I ask how she manages. Ellen says that this is what you do when you are a mother. I suggest that it must be tough when you are only 23. She says it is tough but she can be tough. She can also call on her mother for help at times. I reflect that this all sounds good but if she does want any assistance at any stage to let me know. I write scripts for the children and recommend continuing the saline washes and that she should return if improvement is not rapid.

Medical narratives often inadvertently depersonalise a patient. The 'person' becomes the problem, such as in a hospital when doctors might refer to a person with kidney disease as 'the kidney in bed three'.

Descriptions such as 'the schizophrenic', 'the smoker', 'the alcoholic' or 'the obese patient' suggest that the person's identity has been eclipsed by their problem. The effect of this is that they lose sight of themselves, especially their strengths and personal attributes that may be useful in tackling the problem. For this reason, one of the first steps toward a new narrative is to call the problem 'the problem' rather than characterising the problem as a feature of the patient's personality. The language then changes from 'the alcoholic' to 'the person with an alcohol problem'. Separating the person and the problem allows the patient (and in some cases their family) and the GP to join forces against the problem or medical condition rather than against the person. This 'externalising' of the problem can have a powerful impact on the patient.[5]

Serious mental illness has a particular tendency to dominate a person's narrative of their life. The impact of mental illness can be so pervasive that the patient frequently feels they have lost the person they were before the onset of the illness, along with their previous positive attributes. They may also have lost any sense of the future and any chance of regaining such attributes. In a competency history examples are highlighted where a patient has broken the grip of the longstanding negative impact of previous events or illnesses. These examples raise the possibility that the patient may be beginning to regain their former self. It may indicate that the patient has begun to define their future rather than having it defined by the events of the past. The GP might ask whether the patient wants to continue this new direction, and what the patient considers to be the next step.

Another strategy to help a patient to change a negative life narrative is to place the problem in the realm of the patient's expertise. For example, a patient may not have personal experience in tackling low self esteem but they may understand that they have a habit of putting themselves down. Labelling longstanding behaviours as 'habits' puts the behaviour into a form in which most patients have personal expertise. Many will have broken a habit at some stage in their lives. What we know collectively is that habits can be hard to break and therefore require a lot of determination and effort. They have a tendency to sneak back just when you think you have them beaten. So one has to expect that they will re-emerge at times and be prepared to break them again, before they exert any influence. As a patient begins to make behavioural changes they may begin to see themselves as a 'habit breaker'. This puts the patient into the realm of determining their own future rather than the future being dictated by the habits of the past.

Solution focused questions

Solution focused questions are another important aspect of a competency history. This approach accepts that continually focusing on the problem and then retrying unsuccessful efforts to change is futile. Asking questions about what *isn't* working gives the patient little new information because they are already an expert in this. However, questions about solutions that highlight what *is* working for the patient now, what has worked for them in the past or what life would be like without the problem,[11] elicit new information for the patient.

The medical model includes a detailed description of the problem with standard questions about 'duration of symptoms', 'location of symptoms', and 'what makes symptoms better or worse'. The same curiosity may be applied to solutions in order to make the alternative, more positive narrative, more difficult for the patient to ignore (*Table 1*, see *Case example 2*).

Case example 2

Robyn, age 28 years, feels that her anxiety is getting out of control. Anxiety has been a part of her life ever since she can remember. It has affected her school career, work career and relationships. Now it has worsened and she is confined to her house. She is overweight, she feels ashamed and defeated. She is clearly in a difficult situation, and describes how unpleasant the anxious thoughts are and her constant fear of having a panic attack. Her only company is her dog. I am curious to know not only what Robyn can't do, but what she can do. How is she able to take the dog for walks? How is she able to occasionally go to the shops for supplies? How is she able to make it to my surgery?

We have a brief conversation about how she is able to defy the overwhelming anxiety for a brief time to do these exceptional things. I ask her what she can learn from these exceptions. I want to help her build a new meaning about herself so I ask her questions that will lead her to realise positive things about herself: 'What does it say about you that you haven't given up and you continue to fight it in some ways? Do you prefer this image of yourself as a fighter?' Other questions which highlight this strength based alternative story, instead of the failure story, might be asked at the next visit.

Another way to pose solution focused questions is to direct the questioning to a time in the future when the solution has already occurred. The GP could ask, 'what would it be like? How would life be different? How would you feel different? How could others tell that things were different?' These questions place the patient in the positive light of being someone who has made efforts to address health issues, perhaps with varying success, and who may make future attempts.

Who owns the problem?

The question of who owns the problem is seen as a key issue in the process of change[10] and yet it is frequently not addressed in standard medical

Table 1. Solution focused questions relating to giving up smoking

- Have you given up smoking before?
- What is your record off the smokes?
- How did you give up?
- What worked for you?
- Have you got a track record for breaking old habits?
- What have you learnt from the past about breaking old habits?
- Given it is such a hard habit to break, how did you make the persisting effort to succeed?
- Did you surprise yourself or did you know that you could do it?
- Where do you get your determination not to give up from?
- Did you inherit this strength?
- As you know, bad habits have a tendency to try and sneak back; what did you do to prevent this?
- How would you know when it is time to have another go?

practice. Empowering processes facilitate the patient's ability to become part of the solution and be involved in their own health outcomes. The traditional role of the medical practitioner has been to mount arguments to support the wisdom of the patient making a change. Some patients respond by doing what was suggested. Some may use the doctor's instructions for change as a way of explaining their shift in behaviour to peers, using the argument 'the doctor says I need to...' Others take a more passive approach, which invites the GP to make more forceful arguments for change. If this pattern continues, GPs may get immersed in the medical details of the consultation and become unable to step back and consider who owns the problem.

Taking a position of neutrality initially, without an assumption that lifestyle changes are the patient's preferred option, allows the patient to clarify whether or not they want to be involved in change. The GP can suggest that some people wish to 'eat, drink and be merry for tomorrow I might die', or take the attitude 'what happens, happens' and that others have an interest in 'hanging around longer for the sake of the kids'. Then the GP can ask whether the patient has a preference given that the option of working toward good health may be a tougher task. The GP might ask 'Are you sure you want to make the effort?' By doing this the patient is being asked whether they wish to put themselves in the driver seat of their own change process (see *Case example 3*).

Case example 3

Bill, 42 years of age, presents with a recent purulent cough. He is a smoker.

Doctor: How many cigarettes do you smoke per day?

Bill: About 20.

Doctor: Is that about the right amount for you or would you rather less or more?

Bill: I would like to cut it back as it is not good for me, and I have certainly been told that but it is not so easy.

Doctor: Have you ever been able to cut it right back or even cease?

Bill: Yes, once before.

Doctor: What is your record?

Bill: About 3 weeks.

Doctor: What worked?

Bill: I just got sick of it and went cold turkey. Well not quite as I did also use the gum.

Doctor: Was it too hard a task or do you ever think you might have another shot?

Bill: Yeah, maybe.

Doctor: How will you know that it is time to try again?

Bill: It's been on my mind, especially getting these chest infections, so maybe I will at least try to cut back a bit.

Summary

A competency history is a strength based, empowerment approach that highlights patient's strengths and encourages a greater sense of agency. Strength based approaches have been useful in countering the negative effects of many of the social determinants of health.[3,12] A competency history shares certain commonalities with both patient centred medicine[13,14] and motivational interviewing.[15] Common factors include a recognition that merely telling patients what to do does not always work, and therefore there is an attempt to understand the culture of the patient and their constraints to change and to meet their individual needs by helping them acquire the skills to manage themselves. However, both patient centred medicine and motivational interviewing are more problem based, whereas a competency history is an adjunct that may enhance the likelihood of change via such approaches. A competency history sees empowerment as a fundamental intervention that is often overlooked. It can be particularly helpful in cases where there is a distinct lack of a sense of agency with subsequent lifestyle changes required for preventive healthcare, as occurs in significantly disadvantaged patient groups.

In many presentations the standard medical consultation is appropriate and effective. However, in all presentations, having respect for a patient's individual knowledge and strengths is useful. Time constraints may be perceived to limit the use of a competency history in general practice. However, it is a flexible model where only aspects of the competency history may be required. It can be incorporated into ordinary history taking simply by orienting the intention of the questions toward empowering the patient. This approach is respectful to patients and can be a more enjoyable experience for both the patient and the GP. With practise, this approach becomes more refined and the questions more familiar. Taking a competency history is a useful additional skill for GPs and may be a valuable addition to undergraduate medical training.

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