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Unit No. 2

THE EXTENDED EXAMINATION & EXTENDED INVESTIGATION

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2A. EXTENDED EXAMINATION

ABSTRACT

The medical consultation may be extended if and when needed to obtain more psychosocial data by extending the examination and investigations using tools. Psychosocial issues from the patient may be asked by direct questioning (invoke). However, tools remembered by the acronym "MIND" may also be used to evoke such data by the use of metaphors, ironies, nothingness, and disruptions of the mind processes. The methods have also been called active listening. To investigate certain issues further, the technique of investigations of the mind called Socratic inquiry may be used.

Keywords: Extended examination, Active Listening, Evocation, extended Socratic investigation

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INTRODUCTION

Directed by the history, the doctor performs a **physical examination** of the patient's body with his native senses of sight, touch, hearing, and smell using standardised clinical methods, augmented at times with further active manoeuvres to discover abnormalities of body structures and functions. The doctor may then proceed to clarify certain findings by using imaging and analysis of body parts to **investigate** his findings.

If and when psychosocial issues are needed, he may have to extend the consultation methods of the examination and investigations. The physical examination may be extended to understand the psychosocial issues by evoking the patient's responses using tools such as "MIND" (metaphor, ironies, nothingness, and disruption), adopted from psychotherapy practices. Socratic Inquiry tools with the acronym CAR-ACE can then be used to investigate identified psycho-social issues.

ACTIVE LISTENING TO EVOKE THE M.I.N.D

"The mind is like an iceberg; it floats with one-seventh of its bulk above the water."

– Sigmund Freud, 1856-1939

The extended examination is also known as **active listening** to evoke **the mind**. Here we have a set of tools to help us obtain information from the patient that might not otherwise be divulged during the consultation. This is different from invoking responses from patients by asking direct questions.

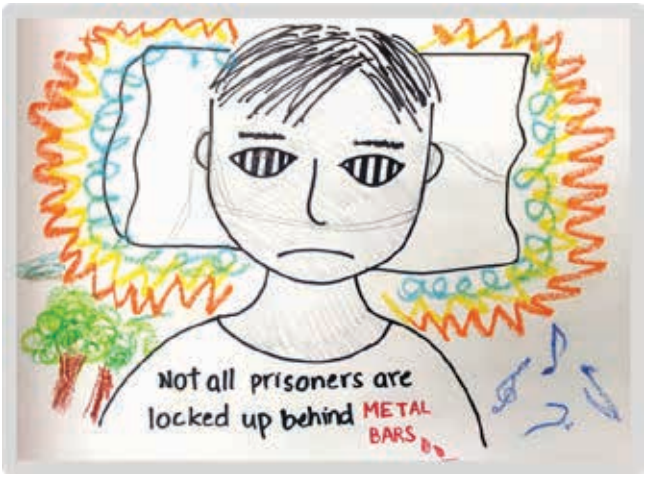
Think of our techniques of physical examination. We employ certain manoeuvres to yield certain signs. In medical school, we learn anatomy, physiology, and pathology and are taught structured ways to examine the human body. We do so by **"listening"** with our naked senses of sight, hearing, and touch.

When we identify signs, we might be prompted to **actively** introduce a manoeuvre and observe any changes to the sign. For example, when a mid-diastolic murmur is detected at the patient's cardiac apex, we follow up with the active step of instructing the patient to turn to the left and observe any change of sound. Another example is turning the patient to his right to tip the spleen.

The same discipline is followed in the extended psychosocial examination. We first "listen" to the patient, observing the body language, the spoken language, the thinking feeling, and behaviour of the patient in reflective communication. We can also actively use tools help us elicit additional information. Some of these active evoking tools can be remembered with the acronym "MIND".

We use **Metaphors**, **Ironies**, **Nothingness**, and **Disruptions** (MIND) to evoke more relevant information from the patient in an emergent pattern instead of examining the physical body in a reductive manner.

Figure 1. Social Isolation



Source: *The Extended Consultation* Second Edition, 2024: Page 46

Metaphors

Metaphors refer to the things that we compare our reality to. In other words, metaphors are used to describe an experience or understanding of something in terms of another.

Metaphors are often used by doctors to explain ailments and treatments to patients in simple terms, without using complex terminology or explanations (e.g., Frozen shoulder

is akin to a door hinge not moving and corticosteroid injections are a lubricant to encourage more movement).

Metaphorical comparisons can assist in clarifying the patient's understanding and uncovering his reservations or concerns, evoking more information surrounding his reason for encounter. If a patient is reluctant to take a course of antibiotics, taking antibiotics can be likened to using water to put out a fire that is consuming the body.

We also need to listen carefully to the patient's preferred metaphor of the moment, to see whether he uses visual, auditory, or kinesthetic metaphors to represent his feelings. If the patient says, *"I see no future"*, *"The impact was deafening"*, or *"I had to carry the burden"*, we should reflect it using the same representational system, i.e., visual, auditory, or kinesthetic metaphors.

This applies to carers as well. Consider the mother who brings her daughter to the clinic. She looks intensely at the physician and then at her daughter in turn as each speaks. By doing so, she reveals that she is a visual communicator.

It would be good to address her visually and to use visual imagery, for example, *"I see you are worried that your daughter will make a mess of her life"* and *"I have some suggestions to put the picture right"*.

Social isolation is a form of imprisonment. This might be the result of illness and disability, leaving the patient bedbound. He is physically isolated and consequently also socially isolated.

Irony

Irony is a rhetorical device where there is a contradiction or discrepancy between what is said and what is truly meant. In the extended examination, we point out the irony present in a patient's thought process. For example, *"You mentioned that you would like to see your grandchildren grow up. but you continue to smoke to damage your lungs?"* The patient's answer might shed light on the discrepant behaviour.

Nothingness

In this tool, we focus on the pauses and silence during conversations to prompt reactions from the patient. We can use this tool in two ways. First, we can use nothingness when directly addressing or conversing with the patient. Having a pause in between sentences, or maintaining silence after the patient has finished, might encourage him to continue talking/thinking and opening up further. The silence creates space for unspoken thoughts and emotions to surface, without the fear of interruption, as supposed to immediate and superficial reactions.

An example of **nothingness**, combined with both **metaphors** and **irony**, is used in the case study of conversation with a boatman. He was diagnosed with diabetes, and presented with his HbA1c levels increasing after every checkup. This was because he had not been consistently taking his medication.

The doctor asked about his job, to which he said he not only piloted the boat but oversaw its regular maintenance. He explained the importance of maintaining the boat, citing safety reasons and how the boat might stall if the boat was not maintained properly. The doctor listened intently and nodded. When the boatman had finished explaining, the doctor smiled at him but remained silent. The boatman responded with this epiphany, *"Doctor, are you trying to tell me to take care of my health?"*

Other than encouraging openness from the patient, such moments of silence or pauses might help patients reflect on the information discussed as well. Look at the statement *"Have you considered quitting smoking?"* The ensuing silence allows patients to dwell and reflect over the statement while giving them an opportunity to explain their current ideas, concerns, or expectations.

Second, we can also use nothingness by intentionally remaining silent or not directly engaging with the patient while addressing other individuals present, such as a nurse or family member. The silence towards the patient provides an opportunity for observation and reflection over the conversation with other persons in the room. Their reaction to the conversation can evoke more information in the process.

Other than just silence, it is essential to be aware of non-verbal communication cues both when using and not using nothingness. These cues include facial expressions, body language, gestures, and eye contact, all of which can convey subtle messages and influence the interaction.

Disruption

In recent years, Kahneman[1] suggested that we think in two ways, or systems. One system is the instinctive and emotional one, which reacts swiftly, and the other is the logical and deliberate one, which proceeds more cautiously.

The typical medical communication occurs between the patient's logical system (*"I have a headache and a cough today"*) and the doctor's logical system (*"Headache and cough – likely to be upper respiratory infection. Need to exclude red flags. Should be a simple case"*).

We want to recognise when we need to engage the patient's other instinctive, emotional system. For example, the patient's headache is mild but he is troubled by his upcoming prostate biopsy results. Without exploring beyond the surface, a prescription for paracetamol will not address his headache very much.

When we realise that we think both logically and instinctively, we also gain additional insights. We become more aware that certain phrases or topics can trigger a disproportionate emotional response.

Disjunctions and Discrepancies to Destabilise the Mind

For example, we can say, *"You seem to be very willing to be healthy, but you are still smoking. What do you think?"* This question to the patient is meant to confuse the patient a little, to break through his conscious mind and seek a deeper response from the patient.

This technique of using disjunctions and discrepancies to destabilise the mind has been called the Colombo technique after Detective Colombo in the American television series from the 1970s. Columbo would use two steps to get people to talk – first, he put them off their guard by engaging them in friendly banter or distracting activities, then he would slip in the real question as an ambush.

Destabilisation is sometimes achieved by orchestrating the situation. Aggressive sales pitches, for example, the marketing of timeshare apartments, can be preceded by a free, heavy lunch, followed by monotonous banter to lower the cognitive resistance in post-prandial, fatigued customers. The ambush is then sprung: *"Must sign up now for the good deals!"* The marketer hopes to gain from engaging his customer's instinctive desire not to lose out.

ADDITIONAL EXTENDED TOOLS

It is often said that up to 70 percent of information between people is transmitted through body language; verbal communication only accounts for 30 percent. Using the same gestures employed by the patient will help to create rapport.

The patient, a teenage boy, is brought in by his mother for insomnia. The boy persists in speaking to the doctor standing up, refusing to sit down despite doctor's invitation. He conveys the unspoken message, *"My mum is the problem, not me."* The doctor stands and continues the consultation with both the doctor and the patient (the boy) standing. His message is, *"I want to know you better. Tell me more."*

The spoken language is used to communicate thoughts. It can also be used to communicate the thoughts, feelings, and behaviours of both doctor and patient conveyed and received, or **reflected**, using the psychological skills of validation, tracking and pacing, showing empathy, sympathy, and affirmation, as well as mirroring and modelling.

Psychotherapists use other tools in their practice such as using tagged questions, adding presuppositions to assertive statements, use of deletions and substitutions, and framing suggestions based on the "Yes set" and "No set". These are described in the second edition of the book *The Extended Consultation*.

REFERENCES

1. Kahneman D. Thinking, Fast and Slow. Farrar, Straus & Giroux; 2011.
2. Lakoff G, Johnsen M. Metaphors We Live By. USA: The University of Chicago Press; 2003
3. Ménard L, Ratnapalan S. Teaching moment: reflection in medicine: models and application. Can Fam Physician. 2013 Jan;59(1):105-7, e57-9. PMID: 23341668; PMCID: PMC3555667.
4. Cialdini RB. Influence: The Psychology of Persuasion. Rev ed. USA: HarperCollins Publishers; 2007.
5. Zeig JK. Confluence: The Selected Papers of Jeffrey K. Zeig, Vol. 1. Zeig, Tucker and Theisen; 2006.

LEARNING POINTS

- **The discipline in the methods of physical examination of the body by active listening can also be used to examine the "MIND" to obtain psychosocial information.**
- **The patient is attentively "listening" by paying attention to the body and paralanguage, the phases of communication, and tracking, validating, mirroring, and modelling of the thinking, feeling, and behaviours. Further active tools can be used to evoke responses such as "MIND".**
- **MIND is a set of tools used to evoke the mind or for active listening. These tools need not be used in isolation but can be interwoven and employed simultaneously. They offer a deeper understanding of the patient's genuine thoughts and emotions, which is useful for understanding his reason for encounter.**

2B. EXTENDED INVESTIGATION

ABSTRACT

The aim of the extended investigation is to probe the mind for specific situations or issues that might help unravel the patient's problem. The tool is the mnemonic of CAR-ACE (clarifications, assumptions, reasons, alternatives, consequences, and relational experiencing). This disciplined inquiry brings information about feelings and thinking into the open, relating to the situation at hand. This is often used in problem work when troublesome situations are identified. It is used to uncover the Negative Automatic Thoughts (NATs) arising from cognitive distortions that triggered the emotions. It is also used in pattern work to investigate the salient situations linked by themes into stories. The themes and stories can then be investigated for consistency and content.

KEYWORDS: CAR-ACE; Clarifications; Assumptions; Reasons; Alternatives; Consequences; Relational Experiencing

INTRODUCTION

The CAR-ACE toolset offers a disciplined approach to questioning that goes beyond symptom clarification, delving into the patient's assumptions, reasons, and alternatives, consequences, and relational experiencing.[1]

EXTENDED INVESTIGATION BY SOCRATIC INQUIRY

"I know that I know nothing. The unexamined life is not worth living."

– Socrates, 470-399 BC

The Greek philosopher Socrates developed a systematic way of inquiry into issues that is now known as the Socratic Inquiry. For the extended investigation, the Socratic Inquiry process can be remembered by the acronym CAR-ACE. See details in **Table 1**.

Table 1. The CAR-ACE Framework of Socratic Inquiry

CAR	ACE
Clarification Length: Timeline and period Breadth: Relation to people, situation, environment, culture, and beliefs Height: Feelings, thoughts, actions, interoception (sense of the internal state of body), and scaling	**Alternatives/Possibilities** Viewpoints: What might be another way to look at this? Challenge: Are you implying that? What is the likelihood of that?
Assumptions What have you assumed? What can be assumed instead? Ideas, concerns, and expectations (ICE) of doctor & patient interactions	**Consequences (best, worst, and probable case scenarios)** Can we generalise? What is the outcome of each alternative? Is the result better/worse?
Reasons How do you know it is correct/true/valid?	**Experiences arising** Insight after awareness, scaling Circular/relational enquiry: Question-on-question and experience-on-experience
Source: *The Extended Consultation*, Second Edition, 2024: Page 61	

Many of us start and also stop at **clarification** of symptoms. We clarify the length (time relationship), breadth (relatedness and context), and sometimes the depth (severity, emotions, cognition, spirituality).

To probe into the patient's assumptions, we examine his ideas, concerns, and expectations, or ICE. Many doctors may consider the "ICE" in the encounter but only their own "ICE". At times, the doctor's ICE might be different and might conflict with the patient's ICE. Their respective ICE-ICE and how they interact (congruence and conflicts) needs exploration and might need resolution for a therapeutic understanding.

ICE: Not Just the Patient's!

Doing this helps us better manage our patient's medical conditions and helps us meet his expectations. Do we also explore our own ICE? At times, the patient's ICE might differ from ours, and this may need to be addressed.

Consider a consultation for upper respiratory tract infection (URTI) and a request for antibiotic prescription. The physician decides based on his training and clinical judgement. The patient has his own ideas about antibiotics; for example, *"I always get well faster with antibiotics,"* or, *"I never take antibiotics. They might lower my future resistance and have numerous side-effects."*

Based on ideas about antibiotic use and prescription, we have nine possible scenarios. Please refer to **Table 2**. Different sets of thoughts and feelings might arise from each scenario, in both the physician and the patient. As physicians, we should be aware of the possibilities that could arise.

Table 2. Physician's Ideas and Patient's Ideas on Antibiotic Prescription in URTI

Physician's idea of antibiotics	**Patient's idea of antibiotics**		
	I need antibiotics	I'll let the doctor decide	I do not want antibiotics
This patient needs antibiotics	1	2	3
I can prescribe, or I can observe	4	5	6
This patient does not need antibiotics	7	8	9
Source: *The Extended Consultation* Second Edition, 2024: Page 62			

When both physician's and patient's ideas are complementary, as in situations 1, 5, and 9, the relationship is harmonious. Situations 2, 4, 6, and 8 should not pose problems either. In situation 4, the physician might have to clarify the request and educate the patient. If the patient is worried because he is going on a trip and might not have access to regular medical services, then a prescription accompanied by clear instructions about when to start antibiotics might be reasonable.

In situation 3, however, we have potential conflict as the differing concerns and expectations of physician and patient come into play. Situation 7 is often encountered as well. Let's say a patient presents with a case of infectious mononucleosis caused by the Epstein Barr virus. From the physician's perspective, there is no need for antibiotic therapy, because it is not a bacterial infection and will not benefit the patient. This is the physician's ICE. The patient might feel that he requires antibiotics because of his experience of a loved one who had sepsis from a bacterial infection. Clearly, the ICE of the physician and ICE of the patient differ greatly. The physician needs to be aware of this discordance and their preceding assumptions before he can better manage the consultation.

With some training, we can ACE the inquiry by also exploring **alternatives** and possibilities. Physicians encourage the patient to consider the issue in a different time, space, or from another person's perspective.

While examining the **consequences** of expressed thoughts or scenarios, we can actively seed and facilitate the **elaboration** of thoughts, feelings, and beliefs. We can guide our patient to **experiencing** certain situations in a different time, with different people, and in a different space. This method encourages introspective thinking, which similarly facilitates a deeper understanding of one's emotions, responses, and values.

Here's another illustration. A 55-year-old cleaner visited the GP with acute chest pain, fearing that she might be having a heart attack. The GP conducted clinical examination and an ECG; they were both normal. The GP concluded that the chest pain was musculo-skeletal pain, and also attributed the pain to loneliness and fear of dying alone as her only child had recently migrated overseas.

In another case, a 30-year-old man complained of chest pain. As the attending doctor, we go through a structured set of questions. *When did the pain start? Is this the first time? How often do you get it?* This is clarifying the time relationship. *What were you doing when it started? Where were you?* These are questions to clarify breadth. *Did you sweat? Did you have to stop what you were doing?* These questions clarify the height.

Assuming this is not an emergency, we want to go further. (If it were an emergency we would stabilise the patient and call the ambulance!) Why does he look so worried? *"I feel it could be a heart attack. You never know. My colleague had a heart attack last week and died on the job."* Perhaps your impression is that this pain is musculoskeletal in nature. You could ask more. *"How old was your colleague? How old are you?"* If his respective answers are *"sixty"* and *"thirty"*, his awareness might be triggered. You could explore psychosocial issues after settling his biomedical ones.

Many of us face difficulty in using this open inquiry system because we are accustomed, as experts, to using directive and prescriptive language. Sometimes, however, it is more potent to let the patient arrive at a viewpoint by himself. We employ astute but respectful open questioning, rather than foist our viewpoint upon him. This would require us to be more patient and reflective, in a collaborative and not expert mode. Because time is a scarce resource in a consultation, this approach should be used judiciously.

Dorothy's CAR-ACE

Reproduced here is a conversation that Dr Lim had with Dorothy. It serves to illustrate how systematic questioning and using the toolset to CAR-ACE-ing the patient enabled Dr Lim to be able to elicit Dorothy's cognitive distortions and subsequently to suggest alternative thought patterns. This is an illustration of the problem approach.

For convenience, Dr Lim is referred to as "T" (for therapist) and Dorothy as "C" (for client). The extended history of Dorothy in the genogram and timeline are referred to in Chapter 3 of *The Extended Consultation* Second Edition.

Figure 1. "The Old Man in Chinatown" – A Transcript

T: How has last week been? **[Open question]**

C: *Bad. My dad asked me to accompany him to Chinatown to give some Chinese New Year presents to an old man in Chinatown. I was furious. He is still with the China woman. The old man in Chinatown is a friend of the China woman.* **[Cognitive distortion of "jumping to conclusions" based on the word *China*. The father's Chinese mistress had precipitated a family crisis, one year ago]**

T: How do you know that they are friends?

C: *He told the family during the discussion of his mistress that he got to know the China woman through a guy in Chinatown.* **[CLARIFICATION]**

T: Was the discussion recent?

C: *No, a year ago. Maybe my dad was not the one who mentioned it. I think it was my mother who told me.* **[Challenging the ASSUMPTION that she had heard her father telling them about this man]**

T: How did your mother know about the relationship?

C: *I do not know. I did not ask. But it is obvious – the old man must be the one who introduced him to his mistress. He could be the boss of a brothel or bar there.* **[Reason for the client's assumption. This is an example of the Socratic "vertical descent questioning" to identify the series of automatic thoughts]**

T: If there was this connection, why would your dad ask you to accompany him to visit the man?

C: *Don't know. Never thought about that.*

T: Did you ask your father how he knew the old man?

C: *Yes, but I kind of do not believe him. He said that he was shopping for Chinese New Year goodies in Chinatown; was caught in a thunderstorm. This old man had an umbrella and sheltered him to his car. He was touched. He found out where he lived.* **[Evoking ALTERNATIVES. Client disdained the positive thought that her father could indeed be touched by the gesture of this old man living in Chinatown]**

T: How could you ascertain if what your dad tells you is true?

C: *Go along with him.*

T: Yes, why not tell your dad that you will go along with him.

C: *Ok, will do.* **[Finding out the CONSEQUENCES or OUTCOME of pursuing alternatives. *In vivo* behavioural technique of experimentation and inquiry]**

Subsequently, Dorothy, her father, and her mother (who asked to go along) visited the old man in Chinatown. The story of how her father had met the old man on the rainy day turned out to be true. This was related during her next session with Dr Lim. Dr Lim went through Dorothy's thought record of the situation with her.

Source: *The Extended Consultation*, Second Edition, 2024: Pages 65-66

Table 3. Thought Record of Situation of "The Old Man in Chinatown"

Situation
Dad asked me to accompany him to visit old man in Chinatown. I was furious.
Clarification & assumptions of thought; feelings arising from NAT in assumptions
Assumption: The old man is a friend of dad's Chinese mistress. Dad must be meeting his Chinese mistress again. Thought: I believe it 100 percent. Feeling: I felt mad and sad (Scaled at 9/10)
Rationale (Evidence) to support the above thought
He told the family during the discussion last year that he had met his mistress through a man in Chinatown. Maybe it was mum who said that.
Alternative thoughts to situation
• When I asked him how he met the old man in Chinatown, he said that the old man had sheltered him with his umbrella to his car when he was caught in a downpour during his new year shopping. Dad said that he wanted to show gratitude to him when he was on his next shopping trip there. Maybe Dad loves the elderly and genuinely cares for them. • If the old man is really connected to the China mistress, why would dad ask me to accompany him to Chinatown? • What would you advise if your best friend were in your situation: Just go and find out. • What would you do now: I would go.
Consequences
Worst: If I do not accompany dad to visit the old man, dad thinks I am siding with mum. Best: If I do go, I might make a new friend and dad and I can bond, spend time together. Probable: At least I would know that my dad was not linking up again with the China mistress.
Experiencing after visit and finding no link between old man in Chinatown and the mistress
Negative thoughts of Dad: Scale 5/10 Negative Feelings: 3/10
Source: *The Extended Consultation*, Second Edition 2024: Page 67

This is how the CAR-ACE framework was used in "Old Man in Chinatown". See **Table 4**.

Table 4: Summary of how CAR-ACE was used in "Old Man in Chinatown"

Situation	Father wants Dorothy to accompany him to Chinatown to visit an old man.
Clarification (C)	She does not want to go as she thinks he is going to visit a friend of the Chinese mistress.
Assumptions (A)	He is going to visit a friend of the Chinese mistress.
Rationale (R)	During a discussion, the father told her family that he had met his Chinese mistress in Chinatown.
Alternatives (A)	Dad loves the elderly and genuinely cares for them.
Consequences (C)	Worst case: She will not accompany him. The father will break up the family. Best case: She will accompany him and make friends with the old man.
Experience (E)	Dorothy accompanied her father, who turned out be genuinely visiting an old man who was not related to any Chinese mistress in Chinatown.
Source: *The Extended Consultation*, Second Edition 2024: Page 68.	

In addition to using CAR-ACE inquiry, the table below summarises how Cognitive Behavioural Therapy (CBT) is used in the case of Dorothy's Negative Automatic Thoughts (NATs). These will be further explained in Unit 4, The Problem Approach.

Table 5. Summary of how Dorothy's NATs were disputed in "Old Man in Chinatown

Situation	Father asked her to accompany him to Chinatown to visit an old man.
Automatic thoughts	He is going to visit a friend of his Chinese mistress.
Meaning of automatic thoughts	He is going back to his mistress and will break up the family.
Emotions	Anger.
Behaviour	Not going to Chinatown with father.
Source: *The Extended Consultation*, Second Edition 2024: Page 68.	

REFERENCES

1. Gross R. Socrates' Way: Seven Master Keys to Using Your Mind to the Utmost. USA: Penguin Putnam; 2002.
2. Ménard L, Ratnapalan S. Teaching moment: reflection in medicine: models and application. Can Fam Physician. 2013 Jan;59(1):105-7, e57-9. PMID: 23341668; PMCID: PMC3555667.
3. Zeig JK. Confluence: The Selected Papers of Jeffrey K. Zeig, Vol. 1. Zeig, Tucker and Theisen; 2006.

LEARNING POINTS

- **The investigation is extended by open inquiry using the CAR-ACE framework.**
- **We explore the assumption by assessing patient's ideas, concerns, and expectations vis-à-vis the doctor to evoke more psychological information about the patient.**