MEDICAL HISTORY-TAKING IN THE MODERN ERA

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PART 1 of 3

It may not be fair to blame medical schools for the abysmal history-taking skills of many house officers. Blame at times must also lie with other factors: lack of time from too many inpatient admissions; too many outpatients at a single clinic session; the large number of old medical records; unavailable past medical records; and, the general complexity of some medical conditions. While all these factors can certainly impede "getting a good history," more often the problem seems to be *not knowing how*. And that problem, I believe, stems at least in part from not being *taught how*.

Traditionally students are taught that the medical history begins with eliciting the history of the present illness (HPI), then in succession the past medical history, the social and work history, and so forth. This may be the universal framework for taking a history, but seldom are students taught the art of history taking. Can "the art" be taught?

Like any endeavor, the physician has to *desire* a good medical history; this means having the right attitude and a natural curiosity about the patient. Despite all the lip service given to "getting a good history," many physicians (in and out of training) simply aren't interested in 'history taking.' After all, they may reason, that skill was learned long ago in medical school. I will make no value judgment about such an attitude. However, if *you* are interested, read on.

The "art" of history taking means getting the story in as complete a fashion as possible, so that you learn what is worth knowing. What is worth knowing includes: 1) the sequence of events that culminated in placing the patient before you; 2) an understanding of the patient's complaint, *and* 3) an appreciation of the patient as a human being. It does no good to learn every detail of the HPI if you are clueless about the patient's anxieties, fears, and perceptions. Similarly, you may be the most empathic, perceptive doctor around, but if you don't know who treated the patient last week and for what, or don't know the medications your patient is taking and why, you won't be very effective.

Both aspects are important the medical detail and what you can learn about the patient as a human being. To keep in mind the former, envision that you will be expected to retell the history to a group of your peers, other physicians who will ask all sorts of questions and in an informal way grade you on your knowledge. You surely will want to know what medications your patient takes, what recent tests he has had, who he has seen in the past for the same problem, and what therapy was given. You don't want to be ignorant of obviously relevant medical history. If something isn't known you want to be able to say to your peers, "That information is not known" because it isn't, not because you didn't ask or try to find out.

To keep in mind the latter aspect, envision that your patient will be asked by *his* peers "did your doctor listen to you?" Was he interested in you as a person. Patients *know* when doctors are listening, when they are interested. If you don't listen and attempt to learn what's truly bothering the patient, your lack of real concern will be noticed. Assuming the patient is the source of the history, you won't get a good history if you don't listen, if you aren't truly concerned. To quote Dr. Francis Peabody: "The secret of the care of the patient is in caring for the patient."

SUMMARY: The history should be logical, complete, and answer all questions the reasonable reviewer might ask. To learn what is bothering the patient, you must care about, and listen to, the patient.

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Medical schools seem to teach history-taking as if physicians were still in the 19th century. In the 19th, and much of the 20th century, practically everything you needed to know about the patient was obtainable from the patient, or if necessary from the patient's family. Thus the time course and nature of the patient's symptoms, as embodied in the "history of present illness," has long been taught as paramount. And so it is.

But there's a problem. History-taking, as traditionally taught in medical schools, presupposes a worried but alert and oriented patient sitting before you, ready to reveal all if you but ask the right questions and spend enough time. But what if the patient is confused, comatose, disoriented, or simply medically unaware and unsophisticated? What if the patient has already seen four other doctors and hasn't a clue as to what she was told by any of them? What if the patient is in some distress and simply can't get her breath to talk for longer than a monosyllable? What history-taking skills are necessary in these situations, which are very common (particularly in hospitalized patients)?

Unfortunately, the house officer's response in many situations is all too often, "The patient is a poor historian," a response that suggests it is the patient's *obligation* to render a well-organized, coherent history! In fact, labeling the patient a poor historian often signifies one thing only: the physician is not trained to assemble a comprehensive history.

Instead of blaming the patient for an inadequate history, emphasis should be on the vitally important "verifiable past medical history." Verifiable PMH covers events one can document, usually meaning specific past medical contacts (doctor, emergency room, pharmacy, laboratory, radiology department, etc.). Pity the poor house officer who, after spending an hour with a patient eliciting every nuance of her vague symptoms, has failed to learn of a recent complete evaluation at another hospital for the same complaints! (Oh? Then why didn't the patient say so? Simple: because the house officer didn't ask.)

It is amazingly common that patients we see in the hospital, the ER, or the outpatient clinic, have verifiable, recent medical history *pertinent* to their current problem(s): lab tests; x-rays; office visits to other physicians; pharmacy prescriptions; hospital discharge summaries; workers' compensation records; operative reports. It is also amazingly common

how often this verifiable history goes undetected by the treating house officer. Here are some true stories.

1) A slightly demented man was admitted to the ward with a complaint of shortness of breath. No family accompanied him. His chest x-ray showed a large right pleural effusion. Although the patient had an old medical record number, his previous records could not be found and he could not give any verifiable past medical history. A thoracentesis was performed and the results were non-diagnostic; cytology was negative for malignancy. On the third hospital day an infectious disease consultant was called; she observed that his hospital x-ray folder contained chest x-rays two months old, although chart records for that period were still not available. She went to the medical records department and demanded that the patient's old records be found. After a 10-minute search they were found in another physician's dictation box! These two-month old records revealed a hospital admission at that time for the same problem: shortness of breath and a right pleural effusion. While in the hospital a fiberoptic bronchoscopy had been performed, which revealed far advanced, inoperable lung cancer. The patient had been started on radiotherapy in the hospital, then discharged and lost to followup until readmitted two months later.

2) A 35-year-old woman was in the hospital for four days for workup of anemia, elevated sedimentation rate and joint discomfort. A series of tests had so far failed to elicit a unifying diagnosis. On the fourth day a medical student, just assigned to the case, talked to the patient and learned that she had been in another hospital a year earlier for the same complaints! To the student's surprise, no one else had elicited this bit of information. Later that day the other hospital's discharge summary was faxed over; it revealed a workup and diagnosis of lupus erythematosus. The patient had been lost to followup after discharge, only to reappear a year later when she was re-admitted to the second hospital.

3) A 67-year-old man was scheduled for thoracotomy for a suspicious lesion. The surgical note stated that there were "no old films." Indeed, in the hospital at the time there *were* no old films. But there were *plenty* of old films in another hospital, going back six years. They were obtained by a consultant and reviewed. The "suspicious lesion" was old and it had not changed. Radiologically it was clearly benign and did not need to be removed.

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The reason verifiable information is so often overlooked is because the physician a) doesn't know it exists (as in the above three cases) or b) doesn't work hard to obtain it. Given most hospitals' 19th century record-keeping systems, it may be difficult to obtain old information. But you surely won't succeed if you don't even know old records exist. To find out if they exist, the box below lists some of the questions you need to ask (and sometimes re-ask) of patients or family.

You will be amazed how often your patients have been treated and evaluated for the same problems you are treating them for; or how often they are taking medications pertinent to their current problem which they "forgot" to tell you about. When you learn that important verifiable information exists, take advantage of those modern medical tools the phone and fax machine and work to get the information.

Questions to Ask the Patient (&/or patient's family as surrogate) Regarding Verifiable Medical History

- What physicians have you seen in the past year? Where? What for?
- When was the last time you saw a doctor for any reason? And the time before that?
- Have you had any operation in the past 5 years?
- Have you spent the night in a hospital in the last 5 years?
- Have you visited an emergency room or urgent care center in the last 5 years?
- Have you seen a podiatrist, chiropractor, or psychologist recently?
- When was the last time you had a prescription filled? Do you remember what it was for?
- What drugs do you take? What else do you take? What else do you take when these drugs don't work?
- Where do you get your medicine? Where else do you get your medicine?

The task may not be easy. Say you've learned that verifiable information does exist, and you've requested it be sent via fax. How long should you wait for it to arrive? Not long. You can minimize delays by remembering three rules, listed below. (And when you do obtain fax'd records, treat them like found gold. Place them in the chart, note the principal findings in a progress note, and make other caregivers aware of their existence.)

Rules for Obtaining Records by Fax

Rule 1: Always record the name and phone number of the person you speak with, the one who agrees to send you the information.

Rule 2: Records mailed will never arrive in time to help an already-hospitalized patient. They must be faxed or, alternatively, important information relayed verbally over the phone.

Rule 3: Since record-keeping departments are often under-staffed and chaotic, the best intentions may not result in the records being sent to you. The record personnel may forget the request, or their fax machine may be inoperable, or the old records may not be found. After a reasonable wait (a few hours at most) call back: "Hello, this is Dr. Jones. I spoke with you earlier about records on my patient, Mr. Smith. We still haven't received those records. Have they been sent? Oh? Well, we need to make some important decisions; could you please fax them now?"

Summary: Don't blame the patient for an inadequate medical history. Always assume verifiable past medical history exists and work hard to find out what and where it is. If you need prior records, find out where they are and set out determinedly to obtain them. Be polite but aggressive.

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I have placed some of the blame on medical schools for not effectively teaching the art of history taking. There is another and perhaps even larger reason, which must be acknowledged: *No one pays for the time it takes to get a detailed, complete medical history.* As a direct result, there are few mentors in training programs with the time and skill to teach history-taking *by example.*

A practicing physician will be reimbursed the same fee for taking a 5-minute history or a 1-hour history, or for undertaking a 10-minute review or a 3-hour review of old medical records. Third-party payers, whether Medicare or commercial insurers, don't pay for a physician's time in taking a detailed medical history; they never have and they never will. That is why practicing physicians seldom take the time to plow through thick and jumbled medical records, or spend the time it might take to learn everything necessary about a patient's problem. This is not criticism, this is simply honest observation. It is reality, and the observation applies to all of us. Me. You. Everyone who sees and assumes responsibility for patients. The reality is that house officers emulate, sooner or later, what practicing physicians practice.

This observation also explains why, in any malpractice litigation, the involved lawyers will usually know far more detail about the patient's medical care than the treating doctors. The lawyers are paid for learning every detail about the case: either by the hour (defense lawyers), or via a large percentage of any damage award (plaintiff lawyers). Lawyers have a tremendous financial incentive to make sure they don't miss anything pertinent about the patient.

It's true that doctors in training usually spend a lot more time on history-taking than physicians in private practice. In fact, for a hospitalized patient, after the first day or two, the house officer will almost always know the patient's medical history better than the "attending physician of record." But the effort gradually wanes; the role models for obtaining a thorough, detailed history are simply not there. Eventually, of course, the house officer becomes the attending.

Summary: No one pays doctors for time-consuming, high-quality history-taking. Nonetheless, it stands to reason that the more thorough your history, the better will be your care of the patient.

The art of history taking

Miscommunication often occurs not because you didn't ask the right question but by HOW your asked it

see also The Unreliable historian

A word about patients (a cynical perspective)

They may give a misleading answer when:

- They don't understand the question
- They don't know the answer to the question
- They use non-conventional non-medical terminology e.g. My mother was treated for 'shock' at the scene and then sent home
- They want to make you happy
- They want to make their relatives happy
- They think it will get them what they want

Golden rules of history taking

- Don't assume the patient understands your question
- Don't assume patients uses words or descriptions in the way that you (or anyone else) would use them. Be sure you know what they exactly mean.
- Always question the patient's version or interpretation of events
- Always question any previous diagnoses the patient might have received (it might have been obtained on weak evidence)
- Translate the chain of events, causation and chronology of the problem into a plausible pathological process; not just a list of unordered diagnostic criteria. Patients may often jump backwards and forwards in the narrative and form their own relationships between events.
- Check for contradictions in the story

Problems with style

- Asking closed ended questions too early. Just encourage the patient to speak.
- Cutting the patient off before they can finish
- Leading the patient e.g. 'you don't drink alcohol DO you'?

Problems with language

- Not modifying your phrases in a way that the patient can understand. Only asking the question one way. Using jargon.

Problems with interpretation

- Don't take things at face value. Patient's can misinterpret their own symptoms or what they think the doctor has told them. Question a patient's diagnosis or the diagnosis they think they have been given. Question the conclusions that patient's have drawn from previous events or information given to them.
- Re-analyse the primary data. Were the symptoms, test results or treatment consistent with the diagnosis? Any diagnosis, condition or test that a patient claims should be viewed with a healthy degree of scepticism. Ask "why do you think that?" What "did they actually do?" e.g. A patient once had a 12 lead ECG which was normal so he believes that the doctors 'don't think

anything there is wrong with my heart'. 'I have migraines before' to describe an undiagnosed chronic recurrent headaches. "My doctor thinks I have stomach ulcers" (when they have never had endoscopic confirmation)
- Avoid using relatives to help interpret (multiple reasons for error). Engage professional services.

Problems with reliability

- A patient's history may be misleading for a variety of reasons
- If there are concerns about a person's memory then quickly perform a mini-mental screen before proceeding – it may save you a lot of wasted time asking questions they cannot answer
- Attempt to ask questions in several ways to check for inconsistencies or contradictions

Useful phrases

- *Chief complaint* – 'what was/were the main thing(s) that made you seek medical attention (especially if given a long list of symptoms), 'which of your symptoms most concerns you'
- *Character / Site / Location* – 'can you describe these symptoms further'
- *Time of onset* - 'so when did you last feel well?', 'when did things take a turn for the worst?', 'when did this current problem begin?
- *Onset* – 'what were you doing when you first noticed the symptoms', 'how did the symptoms change after that', 'when did they change'
- *Chronology* - 'and then what happened….' <patient answers> (repeat again and again), 'do the symptoms ever completely go away or diminish in intensity', 'how long do they last', 'how long between symptoms' or 'how often do they recur', 'are things same, better or worse',
- *Acuity* - 'was there point where your symptoms dramatically change', 'what made you decide to eventually seek attention'
- *Precipitant/Alleviating / Aggravating* – 'was there anything that altered the symptoms?', 'when or what brings it on', 'when or what makes it better'.
- *Associated symptoms* – 'did you notice anything else'
- *Severity* – 'how bad was it', 'did it affect what you could do', 'did it affect your sleep'
- *To encourage further description* - 'so then what happened?' and 'when did this happen'? (*repeat this phrase as many times as you need to*), 'tell me more about the (knee pain, swallowing problems)?'
- *Determining priorities or concerns* - 'what do you think might be going on', 'is there a specific thing you might be worried about having', 'do you know of someone else who had the same symptoms as you'
- *Final comments* -'is there anything else you haven't mentioned"?

BUT.....

A constant frustration and embarrassment to doctors is when the patient reveals a completely different story to a colleague or superior

You should be reassure that there are good reasons for this other than just poor history-taking technique:

- The patient's latter recollections were prompted by the initial assessment
- They required additional time to reflect on the question
- The patient is just unreliable and tries to construct a plausible narrative

Sometimes it is worth clarifying some points a little later after the patient has had time to 'digest' the questions.