Editorial

History taking: the only tool to the right diagnostic track

SLH Chiu

Inability to take an effective history is one of the worsening problems among the younger generation in our profession. In this era when there is always new high technology coming up everyday, our focus has been shifting to 'novelty is good, and so is sophistication'. Some may think that the basic clinical methods are somewhat outdated and old fashioned. Some may even argue that only the 'toys' and machines of new technology can satisfy our patients. We are too busy to refine ourselves on the most basic and fundamental skill and technique of history taking which is the only way that can guide us to build up perspectives. Armed with it properly, we can get along the right track to arrive at the right diagnosis. I am impressed by the conclusion drawn by the authors of the article published in this issue – ***a comparison of emergency department admission diagnoses and discharge diagnoses***, stating that history and physical examination remain the most important diagnostic tools in the Emergency Department.

When some doctors of the younger generation are unable to grasp the skill of the art and to handle the precious tool to take an effective history during consultation, they often stagger along their way to diagnosis. Very often, being too perplexed and at a loss, they tend to rely on ordering more investigations. However, many of which are not helpful at all to help the doctor in immediate decision making and management of the patient. I can still remember an article by Gerald Sandler in 1984 which concluded in a two-year combined retrospective and prospective study of 555 acute medical admissions to a district general hospital that 'the usual emergency tests were considered to have little to offer in aiding diagnosis and treatment'.[1] I think this statement is still true and valid today. Investigations, aimed at helping doctors for confirmation, are never meant to be the means to replace our history taking dialogue with patients which is the foundation of medical consultation, for diagnosis and subsequent management.

We cannot perform all the available investigations for our patients. Even if we can afford the manpower and resources to take all the blood tests and imaging as freely as we want, we still need time to have these tests done. Unnecessary investigations, though sometimes may please the patients or give the perplexed doctors a false sense of security and peace of mind temporarily, will only reflect to their peer professionals their lack of clinical sense and acumen and what they are practicing is defensive medicine. Defensive medicine with indiscriminate investigations carries us farther and farther away from the real art of Medicine. Indiscriminate use of tests after a poor history taking not only fails to help us in arriving at the right diagnosis, it also creates an increasing burden to the healthcare system. Defensive medicine may in some way protect the doctor, but it is at the patients' or the public's expenses. These tests, if not properly selected and interpreted with the understanding of their varying spectrums of sensitivity, specificity, false positives and false negatives, in the end, are not conducive to managing the patient properly. Bad history leads one to the wrong track, which in turn leads one to choose the wrong investigations. Wrongly chosen investigations reinforce the unskillful

Correspondence to:
Chiu Lai Hong, Simon, FHKAM(Emergency Medicine), FHKAM(Medicine), MHA(NSW)
Princess Margaret Hospital, Accident & Emergency Department, Lai Chi Kok, Kowloon, Hong Kong
Email: chiulh@ha.org.hk

clinician's uncertainties and, at the end, cannot help him or her out of the wrong track of thinking. These repeated daily negative reinforcements further push the unskilled doctor into a vicious cycle of perception of the 'uselessness' of history taking.

Man interacts with one another, as doctor interacts with patient in the process of history taking. History taking is the first encounter with the patient. Good history taking is to do the right thing at the right time and to do it right to get the clinician to the right diagnostic track. The root of the interaction is doctor and patient communication. This should always be a two-way process, involving talking and listening. Other than the spoken verbal language, we very often underrate the meaning communicated to us through the patient's conscious and subconscious body languages. Munro, in the Dr Sun Yat-sen Oration 2000, said that 'we must be prepared (and be able) to listen to what the patient is saying and interpret correctly what exactly is being communicated to us. The body language of the patient must be observed closely – facial expression, tone of voice, eye contact, etc.'.[2] He further emphasised that 'in many instances the body language of the patient is a more accurate indicator of their problem than is their verbal presentation'.[2] On many occasions, we are too impatient to let the patient talk, and we interrupt a lot with chorus of leading questions that are full of assumptions. We possess abundant medical knowledge, but we do not possess the skill to throw out the right verbal questions in the right sequence. We also lack the skill to interpret their verbal and nonverbal responses. We engage ourselves in writing case notes, reading on the X-ray box and typing on the keyboard of the computer. At the same time we take no interest in reading the face of our patients, and pay no attention to their tone of speaking or gesture. We fail to note how ready or evasive they are when telling their problems.

Experience is accumulative, as bad habits are. Bad habits result from the accumulation of our daily repeated minor bad practices. Bad habits, once built up and formed, are notoriously difficult to be corrected. This is especially true when ones' ego expands in parallel with seniority and has longer years of practice. Who would have the courage to correct senior peers? Therefore, the habit of taking a good history and learning to grasp this precious clinical tool must be formed when one is still a junior. As bad habits in history taking can result in bad clinicians with frequent erroneous diagnosis, these doctors, after being upset by the errors committed, may develop an even worse mind set of the nonproductive, unfruitful, and even harmful defensive medicine as mentioned above. Occasionally, we may see doctors writing down comments in the history note such as 'poor historian'. It is true that some patients, demented, with altered mental states, or depressed and withdrawn, may not be able to give a good account of his past and present health complaints to the doctors. In fact, very often, some doctors, though supposed to have completed five years of undergraduate and a few years of postgraduate training, remain 'poor historians'. They may be unable to ask the right questions to elicit a good account of the story of the patient's presenting symptoms as valuable clinical information. Thanks to our seniors in the days when we were still junior, we had the golden opportunities to be 'tortured' by the never contented seniors who demanded us to grasp the skill and art of history taking. Thanks should also be given for their willingness to put all their efforts, though tedious, meticulous and sometimes annoying and not welcome, to try to build up our minds in appreciating the art and skill of history taking, in learning to explore important details and in refining the arts of communication during a consultation.

Are we Emergency Physicians satisfied or contented with where we are, staying at this level of clinical expertise in the art of effective history taking, with the habit of a two-minute history taking, where there are lots of leading questions, assumptions, no eye contact with the patients, and failure to observe the nonverbal body language of our patients? Can we say that some of us do have little interest and initiative to take the trouble to explore the most appropriate diagnosis for our patients? Can we say that technology can replace tedious history taking? Many doctors told me that they had no time, because they were rushing after cases at work everyday. 'No time', though very often valid, has allowed us an excuse of not taking a good attitude to learn good history taking, and has

permitted us to accumulate in our daily practice the building up of uncorrectable bad habits, and worse still, to propagate the mechanical, stereotypical and ineffective way of consultation to our new generation of doctors. I would say that those who have built up his system of bad habits and always at a loss while taking the history will still be unable to reach the right diagnosis even if given more time to see a patient. Good experienced clinician knows which questions to ask, the sequences, the important negatives, where to explore and which parts to be omitted. History taking is not a cook-book questionnaire. It is an artistic skill that no other profession can replace. A good golf player does not need many hours to finish the 18 holes. What he needs is the skill, the right sense of the field, and to go ahead in the right direction and on the right track. By corollary, you do not start with blood tests and X-rays, as you do not start with the 'Put' when you are not yet on the 'Green'. Common pitfalls and handicaps frequently observed are shown in Table 1.

We, as clinicians, would not like to see the number of 'poor historian' doctors growing. Is it possible that we can have some remedy to secure or to further refine this art and skill when we are pressing the frontline doctors to meet the time targets everyday? Bedside history taking is always a bedside apprenticeship training that no lectures or slide shows with magnificent power-point presentations can replace. Bedside teaching means that we are teaching with a real human being with a real disease lying in front of us. Bedside clinical is the ability to elicit valuable information from real patients, instead of the well-prepared slides or pictures, or well typed-out and well-phrased clinical information. Do we have enough coaches or mentors to train our juniors at the bedside? Can we afford to allocate some time exclusively for bedside teaching? Are we good enough to take up bedside teaching? Are our intermediate and exit examinations ready to attach greater importance to this precious communicative and interactive tool which is unique to the medical profession and which means so much to our clinical sense and judgment? Junior young doctors will not ignore the importance if the specialty examinations put an emphasis on it. Finally, it is our attitude of genuine interest in patient's presenting complaints. A methodical and logical approach to such problems leads not only to an effective outcome to the consultation, but also generates much more professional interest, satisfaction, gratification and fulfillment.[2]

References

1. Sandler G. Do emergency tests help in the management of acute medical admissions? Br Med J (Clin Res Ed) 1984;289(6450):973-7.
2. Munro C. The consultation – reflections on 40 years in general practice. HK Pract 2000;22(6):300-5.

Table 1. Common pitfalls in history taking

1. Unable to go further into the chief complaint. Unable to throw out the right questions to probe further on the presenting symptoms.
2. Too hasty to throw out leading questions, and to suggest symptoms and answers for the patient.
3. Not allowing the patient to talk uninterrupted if the patient voluntarily gives what he thinks important.
4. If the patient is not willing to talk, or unable to give prompt answers like a candidate taking viva examination, he is labeled poor historian.
5. Unable to reconstruct the sequence of events relating to the chief complaint, and unable to reconstruct the whole story of the patient.
6. Absence of perspectives while getting along with questioning. Wandering doctor loses his direction.
7. Disregard the importance of negatives.
8. Disregard the importance of informants.
9. Unable to master the use of language: colloquial, written, tone of speaking; and interpreting unspoken language, certainties or evasive answers.