How to avoid ever having to write 'poor historian'

The primary importance of the history in the diagnostic process has long been acknowledged (Hampton et al, 1975). As Hippocrates said:

> **'The art of medicine consists of three elements: the disease, the patient and the doctor.'**

International consensus statements highlight the importance of doctor–patient communication in medical education (Makoul, 2001a). Training in history taking is based on well-established models of doctor–patient communication (Makoul, 2001b). These include the Calgary-Cambridge Observation Guide (Kurtz and Silverman, 1996) and the SEGUE Framework (Makoul, 2001b). The prevailing maxim is that good generic history-taking skills will circumvent many of the pitfalls of challenging situations in clinical communication (Makoul, 2001b; Breen and Greenberg, 2010).

Despite these generic strategies, medical students and junior doctors will frequently interact with patients who challenge their history-taking skills (Breen and Greenberg, 2010; Ranjan et al, 2015). Tailored higher level communication approaches can facilitate a more effective exchange of information (Kurtz and Silverman, 1996). While experienced clinicians are familiar with these challenging encounters, they are not always described in standard texts (Breen and Greenberg, 2010). Guidance on how to address these challenging encounters has been attempted, but only from the perspective of knowing the underlying diagnosis (Coulehan and Block, 2006). A gap in the training of medical practitioners and the need to avoid the term 'poor historian' has been identified (Fisher, 2016). Additionally, many factors may limit the exposure of students to these challenging encounters (Fisher, 2016; Nebhinani et al, 2016; Yon et al, 2017), thereby diminishing the development of important skills.

This article provides medical students and junior doctors with a framework and guidance towards developing skills to avoid the unhelpful clinical assessment or pejorative labelling of a patient as a poor historian. The authors' focus has been to describe the challenges that are likely to be encountered in a phenomenological construct without relying on having come to a diagnosis or characterization of the patient. This article highlights some potential explanations for these challenges and provides suggestions on how to facilitate ongoing efficient communication. In doing so it is important to recognize that the challenges being faced may be a manifestation of an underlying disease.

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Challenging encounters

Each challenging encounter is discussed below in terms of the nature of the challenge and strategies to facilitate meaningful doctor–patient communication. *Figure 1* provides a summary, including potential causes. As shown in *Figure 1*, the challenging encounters are broadly grouped into those with insufficient or inaccurate information and those where there is confounding of information provided.

The conversation is quiet

Patients who are quiet by nature may be unforthcoming with information which can impact on the detail obtained and hinder establishing rapport. The key to facilitating conversation is to make a personal connection with the patient (Makoul, 2001b). Practically, this involves showing a genuine interest in aspects of the patient's life (e.g. work, hobbies, sport). Take the time to use any information provided from the referral letter, personal items or collateral history to prompt a conversation and find common ground with the patient. It may be necessary to temporarily abandon the standard template for taking a history and spend time discussing broader personal matters through which important details of the patient's life and his/her medical history may emerge. This will assist in establishing rapport. In some circumstances this may take more than one encounter.

There is a lot of conversation

Some patients tell you everything, except for the answers to your questions. Alternatively, the conversation may be quite normal and appropriate, but just excessive. Finally, the conversation may be disorganized or go off on a tangent. While it is very important to allow patients to talk, there are limits and in some instances it is necessary to bring things back on track. This can be difficult to do without causing offence or losing rapport. It is important to reset the agenda by redirecting the conversation (Losh et al, 2005). As an example:

> **'Your Aunt Mary sounds like a fascinating woman, but earlier you mentioned that you sometimes get a pain in your stomach. I would like to know a bit more about that, can you tell me what it feels like?'**

If it is difficult to put together a clear picture, summarize to verify your own understanding and give the patient an opportunity to correct any misinterpretation or provide any further information (Silverman et al, 2005). For example:

> **'So you have had this chest pain on and off for the past 4 days and it sometimes hurts when you breathe in sharply or cough. Your "cold" started 2 weeks ago and went to your chest a week later. Is that right?'**

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Figure 1. Common challenges in history taking. See main text for descriptions of each type of challenge, underlying causes and strategies to address each challenge. Labels for each challenge are as follows: **Title** *Causes* Strategies.

There are no problems

Sometimes patients state that all is well and that they have no idea why they are here to see you. Commonly they have been brought to hospital or clinic by a family member. In these instances, a useful approach is to simply ask the patient more general questions about the patient's life and what he/she would do during a typical day. For example: 'What would you be doing if you weren't here?' Discovering that someone was a bank manager 12 months ago and is now needing help to find their way home from the shops is a sure sign that something is amiss.

While relatives may be keen to correct errors from the patient, it is important to get the patient's perspective on things. Explaining to relatives that you will seek clarification from them later will help to avoid this from recurring. Ultimately, the collateral history is vital in establishing the accuracy of the patient's story.

There are many problems

Some patients present with a multitude of symptoms. It is often difficult to obtain a clear picture of what is going on and a systems review becomes an exhausting affair as the patient reports that he/she has every symptom that you mention.

An important principle here is to prioritise the most troublesome symptom or symptom cluster. Ask the patient which symptom is the most bothersome. For example: 'You have a lot of symptoms and I am finding it hard to piece this all together. Which symptom is the one that troubles you the most?' Then signpost that you only want to talk about this symptom and none of the others until you have fully assessed that one symptom. If the patient mentions another symptom during this process, tell the patient that you will make a note of it and come back to it after you obtain a clearer picture of the most troublesome symptom. As an example:

> **'I'll make a note of that and we can come back to it later, but I still want to get a clearer picture of how your chest pain bothers you. Can you tell me some more about that?'**

This way the patient will be satisfied that you have addressed at least one of his/her symptoms fully.

Another approach is to focus less on the symptoms themselves and assess what impact the symptoms are having on the patient's day-to-day life. Examples include: 'How are all of these symptoms impacting what you can do day to day?', 'Are you still able to work?', 'How do you spend your day?'

If things still remain unclear it can be useful to ask: 'When were you last completely well?' and then try to build a picture from there. With this approach it is important to consider both symptoms and major life events.

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TOP TIPS

- It is important to identify the type of challenge early in the history-taking process.
- It should be recognized that challenges may result from disease-related factors, personal factors, situational factors or external factors.
- It is important to realize that the challenge being encountered may be a clinical sign and is an important part of the assessment.
- Tailor your approach to the specific challenge encountered.
- It is not uncommon for multiple challenges to be faced in the same encounter.
- It is often appropriate to temporarily abandon the normal approach to history taking while addressing these challenges.

The details are imprecise

Despite otherwise being very helpful and forthcoming some patients find it difficult to describe the characteristics or the timing of their symptoms and may say things like: 'It's just an odd feeling, not a pain as such' or 'It started a while ago'.

It is best to use open-ended questions and try to establish exactly what the patient means. If the patient states that it is hard to describe a symptom ask him/her: 'What would you liken it to?' If this approach is unsuccessful, try direct questioning but offer a reasonably extensive list of options. For example: 'Is the pain dull, sharp, aching, pressing, throbbing or burning?' Ensure that these options are in a random order and try not to give away which ones you would be most concerned about.

With regards to timing try to be as accurate as possible. Again, a practical solution to imprecise responses is to offer a range of times, like 'Weeks, months, or years'. For briefer episodes it is important to establish just how long the symptoms lasted. For example: 'What did you or the person with you do during this time?' or 'Let's sit here for 1 minute, I'll time it… Was it as long as that?'

Only diagnoses or jargon terms are provided

Rather than reporting their symptoms some patients will use medical jargon or indicate what their diagnosis is as determined by another doctor, friend, a Google search or a test that they have had done. The patient may elaborate on what investigations and treatments he/she has had or which doctors he/she has seen without any mention of symptoms. An approach in this situation is to frame the consultation early, for example:

> **'Can I just stop you there for a moment? We will come back to all the doctors that you have seen and the tests that you have had later. To really get to the bottom of what is going on here I need to understand the symptoms that you have experienced. Can you tell me a bit more about the symptoms that led you to see a doctor?'**

Sometimes the response of 'Isn't it all in the referral letter from my GP?' may be encountered. Explaining the rationale for wanting to hear the whole story first hand to avoid any misinterpretation can be helpful (Silverman et al, 2005). As an example:

> **'For me to help you I really need to understand the pattern of your symptoms and how they have affected you. This will help me to interpret the tests that you have had.'**

The conversation seems confused

It will sometimes become apparent while taking a history from a patient that the story is simply not making sense. The patient may be alert but unresponsive, have garbled, incomprehensible speech, or be able to converse in a superficially normal way, but there are inconsistencies.

Here it is often helpful to abandon the standard history-taking template and focus on major life events to establish where things begin to break down. For example: 'Where were you born?', 'Tell me about where you went to school.', 'What was your favourite subject?', 'Did you ever have a partner or have a family?', 'Have you ever worked?', 'What work have you done?', and 'Tell me about the last holiday you went on.' Another approach is to ask the patient how he/she feels, for example: 'Are you in pain?', 'Do you feel sick?' An essential step in this situation is to obtain a collateral history.

The conversation is emotional

It is not uncommon in clinical encounters to be faced with a patient who spontaneously bursts into tears or becomes anxious or even angry during the course of your conversation.

The most helpful technique in such settings is to acknowledge your patient's emotional state. Reflecting on the emotions displayed will de-escalate the situation and take the emotion out of the interaction. Having established rapport you can continue taking the history. Sometimes it may be helpful to take a break or even abandon the history-taking process. Reconvening at a later time point and seeking support from a family member or friend can be a useful strategy.

Conclusions

Good generic communication skills will avoid many challenging situations when taking a history. Despite this all clinicians will encounter patients who challenge their skills. With experience clinicians recognize and adapt to these challenges at an earlier stage in patient encounters, in an increasingly automated way. It is important to note that the nature of the challenge encountered can be of immense value in the diagnostic formulation and will influence subsequent management. This article has purposely not explored the interpretation of these clinical signs as this is context specific and would cover a large swathe of medicine. With experience, particular combinations of challenges can become pathognomonic (Ranjan et al, 2015).

Finally, it is important to realize that, as identified by Hippocrates over two millennia ago, the doctor also contributes to the encounter and can be the cause of the challenge. It is essential for all clinicians to reflect on their own behaviour and consider addressing factors such as fatigue or stress that may be impairing their performance. It is hoped that this article will provide a lens for clinicians to develop their skills in dealing with challenging encounters. **BJHM**

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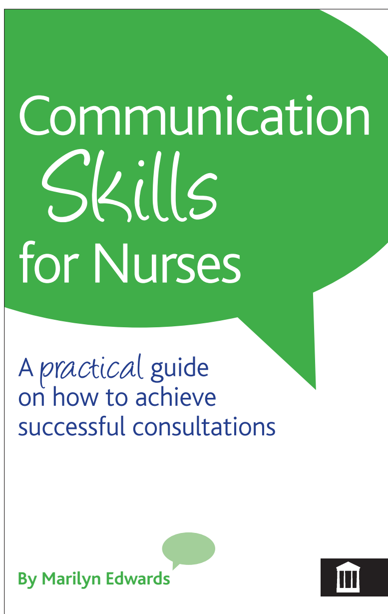
KEY POINTS

- Medical school teaching promotes good generic history-taking skills.
- Good generic history-taking skills circumvent many of the problems encountered while taking a history.
- Challenging doctor–patient interactions have implications for the patient, the doctor and the health system.
- Higher level communication approaches are required when good generic history-taking skills are struggling to elicit meaningful information.

Communication Skills for Nurses
A practical guide of how to achieve successful consultations



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A practical guide on how to achieve successful consultations

By Marilyn Edwards

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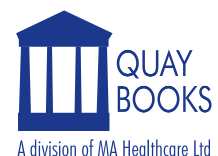

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