

Communication Skill 2

Logical Approach to History Taking

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*"From inability to let down alone,
from too much zeal for the new and contempt for what is old,
from putting knowledge before wisdom, science before art and cleverness before common senses,
from treating patients as cases,
and from making the cure of the disease more grievous than the endurance of the same,
Good Lord deliver us."
Michael Swash, The Royal London Hospital*

History taking is an art, the objective beyond which are many, the most obvious one is to direct your self to the probable involved system and you may able to formalize differential diagnoses or at least listing the genuine problems. Moreover, it is one of the essential quantified steps that increasingly confer better management.

How to take a proper history is well presented in the books of clinical methods, Nevertheless, certain areas need more emphasis and simplification for the benefit of the junior medical staff, I will give some elaboration for two important questions:

- What is the practical logical approach?
- How to have a concise summary for the clinical settings?

What is the practical logical approach?

put your self in the situation of the patient and his relatives As the initial aims of any first consultation are diagnosis and the nature of the patients perception of the problem, it is always worthwhile taking into consideration the following points:

1. Put your self in the situation of the patient and his relatives

Never forget that as a treating doctor, there is a professional obligations around you created by the expectations placed upon you by your patient and his or her relatives, one way to reconcile these expectation and to make friendly gain is to put your self in the situation of the patient and his relatives, also remind your self with your experience when

you were a co-patient -if any- consider how you wish to be cared.

I would like to remind you with old story of wisdom which says that two friends were travelling, then when of them fell from a stone in an open area, the time he said aahh a mysterious sound said aahh also, he lost his temper started furiously cursing the man behind that sound, he astounded when his friend calm him down and started to respond in a polite way, the man behind the sound did the same, he got the message. It is nothing but his ECHO.

2. Preserve patient dignity

Do not take history in public, if ever possible to avoid that. Treat the patient with respect; don't ignore the social part that accompanies his illness.

3. Make your question clear, mixing between the open and the closed type

When you dialogue the patient, give the patient the chance to tell his story if you felt that he straying his way help him by :

- o Asking closed questions yes, no type.
- o Many patients, for instance are not able to state clearly the onset of their disease, in such situation it is better to ask him directly **When the patient was last well?**

4. Always show your patient openness and trust worthiness

How to have a concise summary for the clinical settings?

The medical record is an important part of patient care, yet it is sometimes very difficult to use when looking into the hospital records admission sheet, files or charts which are always overflowing with information. So, this carries its importance from:

- o Good general practice is related to good keeping of clinical informative records.
- o The value of your notes on a patient is greatly enhanced if they can be communicated in a concise precise comprehensive way to serve: aiding memory, good guide for others who may replace you handling the case and to help your senior in providing and giving suitable assistance.

Practical points for a short summary

Summarizing a history in a clinical rounds and when presenting a case or calling your senior, try to make your summary in a conceptual, coherent and narrative way, not necessarily as given by the patient, it should contain the following points;

1. Relevant demographic data

Age, sex and any other relevant data that can explain or support your differential or list of the patient problems. No need to mention the name.

2. Risk factors

Any risk factors or chronic illnesses that blamed for the new or acute presentation should be mentioned first.

3. Presenting complaint

To structure this portion of the note, you comment on **O**nset, **L**ocation, **D**uration, **C**haracter (sharp, dull, severe mild, etc), **A**lleviating / **A**ggravating factors, **R**adiation, **T**emporal pattern (every morning, all day, etc). **S**ymptoms associated.

You can memorize your self by using the mnemonic: **OLD CHARTS** (written in bold capital).

4. Positive history and relevant negative ones

Mention the positive information as well as the negative ones which sound relevant in including or excluding problems. This is to done through out the other part of the history, i.e. function systemic enquiries, past history, family history, treatment history, social history ± gynaecological history.

5. List of the problems or the differential diagnoses

Finish your summary by listing the problem or putting differential diagnoses ,each of which can give account for all patient symptoms. Although this is axiomatic but still more have a disease process which either doesn't explain all the symptoms, yet please revert to this after exhausting your mind, thinking of one unifying diagnosis.

To be followed in the next version, I will talk about the four components of a SOAP approach, highlighting other parts of writing clinical letters and case reports, including management notes, also I promise to attach some practical vivid examples in sha Allah.

For further reading:

Douglas et al, Sect 1, Macleod's Clinical Examination 12E, 2010.

Michael Swash, Ch 1 Hutchison's Clinical Methods, 22E, 2007.

Fauci et al, Ch 1 Harrison's Principles of Internal Medicine, 17th Edition, 2008.