



The house doctor at a private hospital was extracting a medical history—slowly, painfully, like pulling teeth—from an irritated bored woman who by the sound of it had been through it all before. “Have you had chest pain or anything like that?”

“No.” “Have you ever vomited blood or anything like that?” “No.” So he slugged on, one extraction at a time, then writing it all down in a jumble.

He could use some help, I thought from behind the curtain that separated his patient’s bed from mine. I felt sorry for the now figuratively toothless old lady; also for the house officer—busy, harassed, paged by everybody while trying to come to grips with all these patients, and now firing away all these blank cartridges in the dark. I reflected that all these lectures and seminars and medical school curricula revised for the nth time had really not done him much good. Apparently no one had ever taken the time to show him how to take a history, how to relax and get the patient to relax, how to refrain

from interrupting and asking pointless questions, how to “listen to the patient, for he is telling you the diagnosis.” Even the cross old lady might have liked to tell her story, given a chance.

Since that day I have made it a point to periodically inflict on small captive groups of unsuspecting medical students a 10 minute talk on how to elicit a meaningful history from patients perverse enough not to have attended medical school for the benefit of their house physicians. Listen to the patient, I say, don’t interrupt, but if there are questions you must ask—for only psychiatrists have the luxury to listen for ever—at least ask the right ones, especially with inarticulate patients who have short memories and wander from hospital to hospital, from doctor to doctor, or from clinic to clinic.

What indeed distinguishes the novice from the experienced physician, I proceed, is that the first asks about symptoms and the second about events that the patient can remember—hospital admissions, operations, visits to a doctor’s office. Experienced doctors analyse these events, asking what was done, what was said, when, why, by whom, what tests were done, what was prescribed, what colour were the pills, or, for instance, did the doctor shake his head in dismay each time he measured your blood pressure? At times it

Extracting the history

may require the skills of Sherlock Holmes to reconstruct from such circumstantial evidence a reasonably coherent picture of the evolution of a chronic illness. All this is elementary indeed, but it is surprising how many Dr Watsons never catch on.

Flawed history taking leads naturally to flawed history writing. It gives rise to exasperating case presentations devoid of chronology that are like reports from the local branch of the inquisition: Victim presents with swelling feet. Denies shortness of breath. Denies (?under torture) haemoptysis. Admits to having asthma (how long, oh how long?). Now also has abdominal pain. Blood gases normal, computed tomogram scan within normal limits. The abdomen is benign (doesn’t bite?) and the head is (tautologically) normocephalic.

Could this be merely a normal phase in the evolution from student to clinician, something to be expected? Or is it because our “role models” are fleeing the bedside to become corporate executives who must balance budgets and attract grant money? I wondered about this for a fleeting moment, while behind the curtain the indomitable house officer kept firing away at his victim: “Have you ever had dizziness, or ringing in the ears, or anything like that?”—GEORGE DUNEA, attending physician, Cook County Hospital, Chicago, USA