Why Your Doctor Should Take Your History: Not a Computer, Not an Assistant

245

By: W. Grant Thompson, M.D., F.R.C.P.C., F.A.C.G., Professor Emeritus, Faculty of Medicine, University of Ottawa, Ontario, Canada

International Foundation for Gastrointestinal Disorders (www.iffgd.org)

Reading time: 4 minutes

Some doctors and managers suggest that medical care would be more efficient if an assistant or even a computer took patients' histories. This would spare the doctor's time for "more important" activities, like writing prescriptions and doing medical procedures. I will argue that this is wrong. The physician's most important function is to interview and get to know his or her patient. Otherwise, he or she is ill-prepared to prescribe or treat.

History-taking is Crucial to the Doctor and Patient

History-taking is the first and primary interaction between doctor and patient. It should not be delegated. The first objective is to learn the facts surrounding the patient's complaints. This establishes not only a provisional diagnosis, but also other possible diagnoses. These permit the doctor to decide upon the necessary tests and plan appropriate treatment.

But the history-taking process involves much more. The doctor must introduce herself and establish a relationship while putting the patient at ease. She must show empathy, a desire to help, and sufficient authority to indicate that help is on the way. She must try to assess the patient's personality, mood, and how he is reacting to his symptoms. Is he upset, displaying features that may influence the tests and treatments she recommends?

Symptoms like pain and nausea are nuanced and many-faceted. They are not binary – not "yes" or "no" – like a computer input. A correct diagnosis might hinge upon many questions, like: "What brings the symptom on, what relieves it, how long does it last, how frequent is it, how long has it been occurring, are family members affected, how severe is it, and how does it affect daily living"?

Many factors influence the questions to be asked. Body language and the manner in which the patient describes the symptom may tell the doctor much about his emotional response to the symptom. The doctor's questions should be as open-ended as possible. In this way the patient is able to tell his story in his own way. She may need to prompt him from time to time. Directed questions can ascertain important features that he may have overlooked.

Meanwhile, the experienced doctor is busy constructing diagnostic hypotheses. She is testing them with new questions, and discarding or retaining them as new evidence emerges. At the same time she must consider the parts of the body most carefully to be examined, and what treatments may be necessary. Each possible serious disease is carefully ruled out, or if necessary noted for possible testing. Moreover, a doctor who is kind, patient, and empathetic has a therapeutic effect. She begins the healing process with this interview. The patient sees that help is at hand, that the problem is being addressed.

A diagnosis made in this manner is powerfully comforting, even if the news is not good. At least we know what the problem is – now let's see what can be done about it. Nowhere is this process more important than in a patient who has a functional gastrointestinal disorder. Symptom patterns that fit diagnostic criteria may suggest a disorder. They are no substitute for a careful clinical interview of an ill patient.

There is a positive relationship between a patient's satisfactory treatment and the length of the doctor's interview. Regrettably, busy family doctors often must accomplish all the objectives described above within a very brief period of time. Some specialists may rush the process to do a procedure. As a medical professor I learned how difficult it is to teach or accomplish the art of history-taking. As a patient now, I am reminded ever more frequently of its importance.

If the Doctor's so Busy, Why not Use a Computer?

Can a computer program digest a list of the patient's symptoms, process them, and print out a diagnosis? Consider the multiple tasks undertaken in a medical interview. What computer programmer could predict all the life circumstances that might influence the onset of abdominal pain? What central processor can deduce the meaning of a person's complaint and his often subtle responses to it? How can the physician holding a

computer print-out engage in a meaningful healing relationship, when she has not personally shown her interest in his health? The notion that symptoms are digits that can be quantified and processed by a computer is fanciful. Some may use a computer questionnaire to focus the interview. But the task is inadequately performed if the doctor does not then pose the relevant questions herself.

Then why not Use a Physician's Assistant?

History-taking is the most difficult and most important task a doctor must perform. Even a brain surgeon must understand the patient's suffering (through worried relatives if the patient is disabled) before she can properly attempt a cure. Few physicians would want to trust another person for vital information. But surely a nurse could treat a cold or a bout of diarrhea? Yes, and they must do so in remote areas where there are no doctors. Nevertheless, only a physician has undertaken the long training in order to understand, not only the art of interviewing, but also the vast sciences of anatomy, physiology, biochemistry, microbiology, and pathology that prompt relevant questions and underlie diagnostic hypotheses. Only those trained in therapeutics and evidence-based medicine can develop a comprehensive and safe treatment plan. For a family doctor this may take eight years, and for a specialist much longer. That is why doctors are expensive and managers look for cheaper alternatives. Even well-trained nurses do not receive such a comprehensive education. They cannot be expected to compensate through a brief training period.

There are no simple patient complaints. Each symptom means much to the patient and has many possible meanings to the doctor. Only the doctor can fully discern both the physical and psychological meanings of a symptom, and then only through a properly conducted interview.

Conclusion

One of the paradoxes of modern medical management is the popular notion that the most demanding yet vital history-taking functions of a doctor can be delegated to someone lesser trained. Yet straightforward, repetitive acts that can be taught in a short program such as sewing up cuts, and some diagnostic procedures seem solely the province of highly-specialized physicians. How can we accept that anybody but a practicing doctor should take a patient's history?

When you next visit your doctor, see how well he or she accomplishes the many tasks described above. Let's help our beleaguered physicians with a team of lesser-trained assistants by all means. But that time-honored and benevolent central interface with the doctor, the medical history, must not be denied. Through it the therapeutic doctor-patient relationship is established.

Suggested Reading

The future of primary care. *New Engl J Med* 2008; 359:2085-2092.

Thompson WG. *The placebo effect and health: combining science and compassionate care*. Amherst: Prometheus Books. 2005.

Thompson WG. The therapeutic relationship. In: *Understanding the irritable gut: the functional gastrointestinal disorders*. McLean: Degnon Associates. 2008.

About IFFGD

The International Foundation for Gastrointestinal Disorders (IFFGD) is a 501(c)(3) nonprofit education and research organization. We work to promote awareness, scientific advancement, and improved care for people affected by chronic digestive conditions. Our mission is to inform, assist, and support people affected by gastrointestinal disorders. Founded in 1991, we rely on donors to carry out our mission. Visit our website at: www.iffgd.org or www.aboutIBS.org.

IFFGD
537 Long Point Road, Suite 101
Mt Pleasant, SC 29464

About the Publication