Talking to patients: is it really an art or do we take the history for granted?

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We continue our series in which Consultant Interventionist Dr Michael Norell takes a sideways look at life in the cath lab… and beyond. In this column, he considers communication with the patient.

Two recent, but completely separate instances, prompted me to produce the paragraphs below. The first was National Institute for Health and Clinical Excellence (NICE) guidance covering the management of patients with recent onset chest pain. As a cardiologist with more years of experience than I would wish to count, this will, of course, prove to be most helpful in the interpretation of the symptom complex with which our patients present.

The second, and probably more pertinent, was a tutorial I was delivering (sic) to a small group of medical students about the clerking of cardiac patients. It dawned on me that the ease with which we chat to patients and come to a fairly accurate idea of their possible pathology, is a technique that has been honed over many years. To the student it looks blasé and completely effortless, but we are, almost unconsciously, using time-honoured skills as we watch and listen to what our patients tell us.

Establishing the story

So true is the aphorism that we heard at medical school: "Listen to the patient and he will tell you the diagnosis". And how important is that? If you do not have an idea of what the problem is after hearing the story, you are highly unlikely to get it at all; it is 90% of the solution.

It is not a checklist or a series of closed questions. It is about letting the story unfold while being prompted, encouraged and kept on course by occasional comments, a nod, or even silence on our part. As the journey veers into what might appear to be an irrelevant area, we gently bring the focus back onto the matter in hand. Eventually, we fill the last remaining gaps with more specific enquiries, but all the time we are processing the data we have thus far acquired in order to direct our next line of questioning. It is indeed a fascinating process.

The secret is to be interested. By wanting, genuinely, to hear an account of events and their effect on the individual, our concern allows questions to be meaningful and their answers to be more valuable.

I recall a lecture years ago on this subject and the words, "Just suppose this was happening to you; what would *you* want to know?"

We keep our mouth shut but our eyes open; we take note of the look on the face, the spreading of hands over the chest or the single finger positioned under the left breast. And the ears are doing more than just listening. They prick up when medical terminology is employed by a patient because of two critical reasons. First, we cannot assume that the patient's understanding of asthma, palpitation or migraine, is necessarily in keeping with our own medical knowledge of those disorders.

Second, and just as importantly, the use of such technical words is a vital physical sign; it indicates that there is a medical, nursing, ambulance, hospital manager or some other associated healthcare interest 'in the family' – if not actually sitting there right in front of you. Now, *that* is useful to know.

Enough is enough

There comes a time in the consultation when the amount of information received has reached capacity. No more facts or further comment will add to our ability to reach a diagnosis, and, indeed, such an excess may well begin to have a negative effect. For the sake of time management, let alone our own sanity, we need to recognise that 'enough is enough' and to then bring the interview to a polite and sensitive conclusion. Hint: that moment may well be prompted by the phrase, "I don't know if this will be helpful doctor, but…" (believe me; it won't). Equally, the sentence, "Come to think of it, my chest pain is actually there now" provides a similar signal.

The manner in which increasingly sensitive biomarkers of myocardial damage have been allowed to pervade our practice is a more than telling example of how important it is to *always* start with the history. If we try to shortcut the process by relying on upfront knowledge of the troponin assay, resting electrocardiogram (ECG) or any other investigation result, our interpretation of the story will not only be tainted; in some cases it may be totally invalid.

Detective work

Is there a good story of cardiac pain? If so, when and how did it start, and at what time were the

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symptoms at their worst? As the great detective Sherlock Holmes said in *A Scandal in Bohemia* courtesy of Sir Arthur Conan Doyle in 1891, "It is a capital mistake to theorise before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts".

Extracting an account of events and coming to a view about any pathology is all very well but we also need to be able to present our findings in a manner that can be easily assimilated by our colleagues. That is why the traditional sequence of 'presenting complaint' and its 'history' are so useful. The latter can be further annotated by direct questions and relevant past history such that, by that stage, the final diagnosis should be emerging.

I remember when I was a registrar, on a Monday morning ward round in the distant past, a junior doctor began summarising the events pertaining to the weekend admission of a patient with an exceedingly long and complex cardiac background. It became clear that she had presented in a parlous state. After 10 minutes, during which time I struggled to keep up with the chain of increasingly serious complications together with the many entries into her fifth volume of case notes, it finally emerged that she had succumbed the previous night.

In my most sensitive way, I suggested to the senior house officer that in future, and in order to save unnecessary mental gymnastics on my part, he might indicate such a terminal outcome at the beginning of his discourse, rather than at the end.

The notion that we start to work on the diagnosis as the data streams in, was apparent at the professorial grand teaching round at my medical school. A hapless student would present the case and members of the equally hapless audience would be singled out and quizzed by the great inquisitor himself. On one occasion, no sooner had the young and spotty Herbert stumbled out "Mr X is a 76-year-old man who presented to the casualty department with…" , than he was brought to an abrupt halt. The crusty old teacher, peering over his half-moon glasses then turned to the amassed throng with the question, "So what is going through our minds as to the diagnostic possibilities here?"

And of course he was spot on. Our cerebral computer should have already started whirring, even with that apparent paucity of information. Clearly an ectopic pregnancy, measles and alopecia could be safely excluded, as could appendicitis (probably), diphtheria and fibroids. And so the process of exclusion continues as more data arrive; "When you have eliminated the impossible, whatever remains, however improbable, must be the truth". No prizes for guessing the origins of that quote: quite right; the Great Detective himself. And should we be surprised? Medicine is just as much about deductive reasoning as is the investigation of the theft of six identical busts of Napoleon Bonaparte.

It's still an art

We must strive to remind our junior colleagues and students that the art of medicine is still essential no matter how much technology we amass to help us. It all begins with the history and you ignore that at your (and more probably, the patient's) peril.

As a footnote, and germane to the matter of presenting, I always encourage students to add colour and interest to the case with a phrase like "Mr AB is a 68-year-old, retired taxidermist". I pause and look at a sea of blank faces. A somewhat gawky lad, no doubt renowned as the year's swat, raises his hand when the obvious question follows; "Someone who stuffs animals", he answers proudly. I eye him cautiously and address the remainder of the group: "Nearly right: the more correct answer is someone who stuffs *dead* animals"