SPECIAL ARTICLE

"Building" a History Rather Than "Taking" One

A Perspective on Information Sharing During the Medical Interview

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Patients and physicians enter the medical encounter with unique perspectives on the illness experience. These perspectives influence the way that information is shared during the initial phase of the interview. Previous research has demonstrated that patients who are able to fully share their perspective often achieve better outcomes. However, studies of patient-physician communication have shown that the patient's perspective is often lost. Researchers and educators have responded with calls for practitioners to adopt a "narrative-based medicine" approach to the medical interview. In this article, we review the literature on narrative-based medicine with an emphasis on information sharing during the medical interview. We suggest a framework of skills and attitudes that can act as a foundation for future work in educating practitioners and researching the medical interview. *Arch Intern Med. 2003;163:1134-1140*

The following narratives represent the same events told from the perspectives of a patient and physician.

I am 50 years old. I don't usually go to doctors, because doctors are for people who are really sick, you know? It all began when I got this cough. It's not a bad cough—it's not like I'm coughing up blood or anything. It's probably just a cold or a bronchitis or something. Still, though, I keep thinking about Sam. He was my best friend; we used to work together at the docks. It's been 5 years now since Sam passed—lung cancer got him. You know, I worry about this cough because it's just like the one that Sam had when they did that CAT scan and found the cancer. I know I should have quit smoking long ago; now I'm gonna pay the price. Maybe I should have a CAT scan. You know, I've been putting it off, but I'm going to go to the doctor, because I might be really sick, and they might be able to do something—they say on those TV shows that doctors can cure cancer if they find it early enough.

Mr X is a 50-year-old male with a chief complaint of cough. His cough began 3 weeks ago; at that time it was productive of yellow sputum and was associated with nasal congestion and low-grade fever. The associated symptoms lasted approximately 1 week and then resolved. Since that time, the cough has been nonproductive, occasionally wakes him up from sleep, and is paroxysmal. He denies hemoptysis, dyspnea, wheezing, fevers, rigors, night sweats, paroxysmal nocturnal dyspnea, orthopnea, or chest pain. He has no known tuberculosis exposure. He has had no other unusual exposures. His past medical history is unremarkable; he takes no medications except for occasional aspirin; he has no allergies; his family history is significant only for hypertension and diabetes; social history is significant for 1 pack per day of nicotine for 30 years and 2 beers per day. Review of systems is otherwise negative.

For editorial comment see page 1131

Such perspectives form the background through which each member views the medical encounter, and they influence how information is expressed during the initial minutes of the interview. By these accounts, the patient's and physician's perspectives are set apart by the language they use to present their accounts, language by which the physician separates out subjective aspects of the patient's account from biomedical facts in the clinical presentation.

Whether and how patients and physicians share information has been the focus of a large amount of scrutiny by researchers, theorists, and educators.[1-6] "Information sharing," or that point in the medical interview when patients and physicians share information about the health issue at hand, represents a critical juncture. It sets the tone for the entire encoun-

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ter, shaping both interactants' views of their roles, what to expect from each other, and how their relationship will function.[7] In this article, we focus on information sharing during the medical interview. We examine the forces that shape patterns of interaction between patients and physicians during information sharing and review calls by multiple authors for a "narrative-based medicine" that incorporates the perspective of the patient. Lastly, we illuminate core skills and attitudes required of physicians to competently and efficiently incorporate patients' narratives into information sharing; we propose these skills as a foundation for teaching programs, quality assessment, and future research.

WHY IS THE PATIENT'S PERSPECTIVE IMPORTANT?

The patient's perspective is a critical mediator of illness behaviors that impact health outcomes.[8,9] Social science researchers argue that high-quality care requires the expression of patient and physician perspectives during the interview, along with negotiation toward a shared perspective.[10-15] Greater expression of patient perspectives through active participation in the medical encounter favorably impacts a variety of outcomes, presumably through better adherence to recommended treatment regimens.[16-21] Such outcomes include faster symptom resolution and better biomedical parameters, such as lower blood pressure and glycohemoglobin levels.[22-24] Physician solicitation of patient perspectives also has a positive impact on patient trust, satisfaction, and adherence.[25-31] In addition, the ability for patients to share their perspectives through narrative satisfies a basic human need for expression[32,33] that may in itself have therapeutic value.[34,35]

DEEMPHASIZING THE PATIENT'S NARRATIVE

Information sharing during the typical encounter tends to be one-sided in terms of perspective.[1,36-39] Most physicians are familiar with the concept of "taking a history," the terminology often applied to information sharing during the medical interview. "Taking a history" implies the use of a specific heuristic to guide the topics of conversation. This heuristic is organized along a disease-oriented paradigm; it directs physician and patient to specific topics that include positive and negative symptoms of biomedical significance, time course and severity of these symptoms, exacerbating and remitting factors, and various other adjunct histories (such as past medical, family, and social histories). In these adjunct histories, the history-taking heuristic also channels conversation toward mostly topics of biomedical significance.[40] Taught early in the course of medical education as part of history and physical examination courses, the heuristic is reinforced through use in framing medical case histories for a variety of formal and informal venues that range from grand rounds to discussions during everyday practice.[41] The heuristic is also reinforced by forces outside of the daily clinic; for example, third-party payers have adopted the history-taking heuristic by requiring physicians to document biomedical information under its major sections in order to be reimbursed. While many medical schools have begun to incorporate curricula aimed at the soliciting the patient's perspective,[42-45] such curricula are often swamped by the sheer volume of use of the history-taking heuristic.[41]

We need to make an important distinction between conversations that occur between patient and physician during information sharing and conversations that occur between physicians, either directly or through the medical chart. The history-taking heuristic facilitates biomedical communication among physicians by organizing data into a common language. The goal of this organizational strategy is to help physicians produce narratives that lead medical audiences to short lists of possible diagnoses. Yet, problems arise when the heuristic is used as the sole framework for information sharing. Under constraints such as time pressure, there is tension between the relative importance of physicians' and patients' perspectives.[46,47] We assert that both perspectives are important and need to be dually emphasized as such. The physician's perspective may exclude crucial patient-oriented data necessary to achieve therapeutic effectiveness. The patient's perspective may miss critical biomedical facts needed for accurate diagnosis. Physicians need a method of fostering efficient sharing of critical biomedical *and* patient-specific information necessary for *both* biomedical management of disease and therapeutic healing of illness.[13]

"BUILDING" A HISTORY RATHER THAN "TAKING" IT

A method for fostering efficient sharing of critical biomedical *and* patient-specific information exists. Its characteristics have been described by several authors who have called for a "narrative-based approach" to the medical interview.[48-52] Some commentators advise that narratives from the patient's perspective need to be expressed in the medical chart and during case presentations in order to incorporate the patient's perspective into the medical lexicon.[53] Others address information sharing during the medical interview directly by suggesting potential language and strategies that physicians might use to elicit patients' narratives.[5,54-58]

The essence of a narrative-based approach to information sharing involves the physician simultaneously attending to *two* narratives—one from the biomedical perspective and one from the patient's perspective. For example, the physician and patient whose narratives were told at the beginning of this article might communicate and act differently if each heard and understood the other's point of view. In an effort to better illustrate a narrative-based approach, we present in **Table 1** parallel dialogues, one using the history-taking heuristic and one using a narrative (what we will define below as a "history-building") approach.

A key difference between Drs Jones and Smith in Table 1 is their approach in developing the illness narrative. While both physicians are focused on the problem at hand (dizziness), Dr Jones' focus is through a biomedical lens that concentrates on "pertinent positives and negatives,"

Table 1. Example of 2 Approaches to Information Sharing

History Taking	History Building
Dr: Hello, I'm Dr Jones. How may I help you?	Dr: Hello, I'm Dr Smith. How may I help you?
Patient (Pt): Hello. I came in to see you because I've been having dizzy spells.	Pt: Hello. I came in to see you because I've been having dizzy spells.
Dr: Dizzy, eh? Can you tell me more?	Dr: Dizzy, eh? Can you tell me more?
Pt: Well, I get these spells where everything gets dizzy and then I worry that I am going to fall down. It's really causing problems because I can't go to work and . . .	Pt: Well, I get these spells where everything gets dizzy and then I worry that I am going to fall down. It's really causing problems because I can't go to work and I'm a stock manager in a warehouse and I'm worried that I'll get fired if I miss too much work.
Dr [interrupting]: Does your dizziness feel like you are going to pass out, or does it feel like the room spinning?	Dr: This is causing you to miss work?
Pt: I never passed out before, so I'm not sure . . .	Pt: Yes. It started off about a month ago and it was happening only once or twice a week, you know? [Dr nods.] And then, it started happening more often, you know—now it happens a couple times a day and I have to do climbing at work onto shelves and stuff—I'm worried that I'll fall off a shelf and break my neck, so I've had to stay home for the past week. Can you do something about this?
Dr: [interrupting] You said you felt like you were going to fall down, did you feel like you were losing consciousness?	Dr: Well, maybe—I'm wondering what you mean when you say you are dizzy.
Pt: I don't know, maybe.	Pt: You know, it's—just, kind of—dizzy, you know?
Dr: Do you have any chest pain with this?	Dr: What does this "dizziness sensation" feel like?
Pt: Well, I sometimes get chest pain and take a nitro[glycerine], then it goes away.	Pt: I don't know, it's hard to describe.
Dr: You take nitro, huh. What medical problems do you have?	Dr: Tell me some about the first time it happened.
Pt: I have high blood pressure and I had a heart attack 5 years ago.	Pt: I was at home in the garage, and I was working on a chair that I'm refinishing, and I looked up because there was a siren in the street, you know, and I felt like I was going to fall over. I had to grab on to the tool bench to keep from falling down.
Dr: Is the chest pain associated with the dizziness?	Dr: What did it feel like right then?
Pt: I don't think so.	Pt: It felt like I was going to fall to one side, you know? Like the whole world was out of balance.
Dr: Does it ever feel as if your heart is beating fast during the dizzy spells?	Dr: Is that the way it feels every time?
Pt: Well, maybe, but I get really scared, you know?	Pt: Yeh, except that time it went away and I didn't think of it again, until it started happening 2, 3 times a day, then I got worried.
Dr: When did this start?	Dr: OK let me make sure I have this straight—You have been having these episodes where you suddenly feel off balance, I think you said "as if the world is off balance," and they last—did you say how long they last?
Pt: About a month ago. I didn't pay much attention to it at first, but then it happened more and I began to get scared . . .	Pt: They usually last about a hour, then they go away on their own, you know.
Dr [interrupting]: How many times did it happen the first week?	Dr: OK they last about an hour, and then they go away on their own and it's really got you worried because you're worried you'll get injured at work if you fall down. Have I got it straight?
Pt: I think it happened twice, it's hard to remember now, it happens so much more.	Pt: Yeah, that's it.
Dr: How much does it happen now?	Dr: Do you have any other concerns about this besides your work?
Pt: It's happening 3, maybe 4 times a day.	Pt: No, I just want it to get better, you know.
Dr: How long does it last?	Dr: Let me ask a few specific questions.
Pt: About an hour.	Pt: OK.
Dr: Does anything make it get better?	Dr: Are you seeing double? [Pt: No.] Is your vision blurred? [Pt: No.] Any numbness?
Pt: No.	Pt: No, but sometimes my hand [points to left hand] feels like it is going to sleep.
Dr: So, it just gets better on its own?	Dr: Is that during the episodes of dizziness?
Pt: Yes.	Pt: Sometimes.
Dr: Does anything make it worse or more common?	Dr: Do you have any other symptoms that concern you?
Pt: No.	Pt: You know, I had a heart attack 5 years ago, and I sometimes get chest pain, but I take a nitro and it goes away . . .
Dr: Has this ever happened before?	Dr [interrupting]: How do you think the chest pain relates to your dizziness?
Pt: No, that's why I came in to see you, it came out of the blue.	Pt: Oh, I don't think it's related, because I've been having this chest pain for years and it hasn't changed at all.
Dr: Do you have any blurred vision, double vision, or tunnel vision?	Dr: OK, well let me have you get undressed, and we'll do a physical examination. I'd also like to ask you a few questions while I'm examining you about your other medical problems, your medications, and stuff.
Pt: No.	Pt: OK.
Dr: Do you have any numbness, tingling, or feel "pins and needles"?	
Pt: No.	
Dr: What medications do you take besides the nitroglycerin?	
Pt: I take Plendil and Dyazide.	
Dr: OK, let me ask you a few more questions and then I'll do a physical examination.	
Pt: OK.	

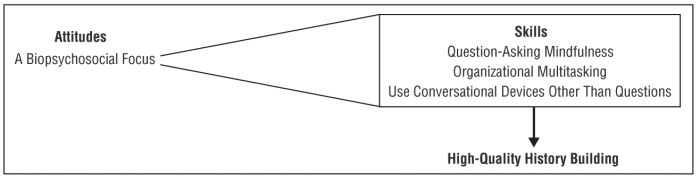
while Dr Smith's approach facilitates the story being told from the patient's perspective. In Dr Smith's approach, the biomedical "pertinent" information is still mentioned, but now there is also information about the patient's fears and concerns, and the information is told according to the patient's organization, rather than the doctor's. Thus, rather than "taking" the biomedical history *from* the patient, Dr Smith engages in a mutual activity *with* the patient in which the two work together to "build" the complete and contextualized history that includes both the biomedical and the patient-defined points of view. This "history-building" approach therefore provides important insights into the patient's perspective that may influence critical treatment and planning decisions, and does so efficiently without requiring large expenditures of time.

A FRAMEWORK FOR TEACHING AND RESEARCH ON HISTORY BUILDING

In the **Figure**, we propose a set of key skills and attitudes that may influence the quality of a physician's history-building approach. In this scheme, there are 3 communicative skills that physicians might use to facilitate cooperative history building and the patient's telling of his or her illness narrative: (1) question-asking mindfulness, (2) organizational multitasking, and (3) use of conversational devices other than questions. This skill set is mediated by a biopsychosocial focus that fosters the physician's openness to hearing the patient's perspective as well as the biomedical narrative. We assert that these skills and attitudes are learnable, and that they contribute to a physician's ability to facilitate the patient's telling of their narrative without adding undue length to information sharing during the medical interview. We focus on the physician, since the physician has traditionally directed the course of information flow (and in most cases still does). Below, we discuss these key skills and attitudes in detail and make suggestions for future teaching and research efforts on the information-sharing phase.

Question-Asking Mindfulness

In a recent essay, Epstein[59] characterized "mindful practice" as the ability of the physician to observe not only the patient during the medical interview, but himself/herself as well. This ability to observe one's self and make instantaneous adjustments in one's words and actions applies directly to question asking during the development of the patient's narrative. Physicians are taught to start with open-ended questions and gradually increase the focus, or "close-endedness" of questions until they have the specific information they need. However, in practice, physicians often redirect the patient to specific biomedical information early in the interview.[36,37] Focus, then, is usually achieved by asking the patient narrowly constructed yes/no questions. While this may



Key attitudes and skills in history building.

be a conscious decision, we suspect that most physicians have developed an implicit pattern of jumping directly to the "pertinent positives and negatives" such that they lose sight of the significance of the patient's narrative and, therefore, the sorts of questions that might elicit it.[60-63] In the history-taking example in Table 1, Dr Jones asks nothing but narrowly focused questions from the point of the first interruption onward.

History building requires the physician to make conscious decisions about the phrasing of questions during the course of dialogue. Questions that are focused, but still open-ended enough to give space for the patient to discuss the narrative from his or her point of view include, but are not limited to, the wh- questions (what, where, when, how, why, who).[55] Conscious decisions about how to phrase questions to be more or less focused are informed by the quality and content of the information the physician receives. In the history-building example, Dr Smith doggedly refuses to put words in the patient's mouth as the patient attempts to define the sensation of dizziness. Instead, Dr Smith uses a combination of focusing open-ended questions and statements aimed at getting the patient to expound on what is meant by "dizziness." Dr Smith finally receives a history consistent with the patient's complaint of imbalance by soliciting the patient's narrative about the first occurrence of the symptoms. Both the clinical picture of difficulty with balance and the content of the patient's lived experience of illness are clearer at the end of the history-building dialogue than at the end of the history-taking dialogue, in part because of Dr Smith's refusal to reduce the interview to a series of yes/no questions.

Organizational Multitasking

History building requires the physician to listen to a narrative that is organized around the context of the patient's life world while simultaneously mentally organizing the biomedical pieces of information within the diagnostic framework of the history-taking heuristic. Dr Jones does not do this in the history-taking example in Table 1; rather, the conversation is directed through an orderly progression of pertinent positives and negatives—onset, course, aggravating and remitting factors, and other pieces of biomedical history. The patient quickly learns—after 2 interruptions—that very short biomedically oriented answers are preferred and thus begins to leave out details when responding to Dr Jones' further questions. In the history-building example, Dr Smith organizes the story from 2 points of view—through the eyes of the patient and through the eyes of medicine.[2] Dr Smith uses caution in facilitating *the patient's* telling of the story, rather than imposing a set of close-ended options that require the patient to make a choice (eg, "Does your dizziness feel like you were going to pass out, or does it feel like the room spinning?"). Dr Smith paraphrases the patient's story ("OK, let me make sure I have this straight ..."), and, in so doing, realizes that information about the time course of the symptoms is missing. Dr Smith, therefore, fills in this important biomedical information while confirming the story from the patient's perspective ("and they last—did you say how long they last?"). Dr Smith's mental organization of the story, both the patient's perspective and the biomedical perspective, is strengthened by retelling the story using the patient's organization and language, and filling in important missing biomedical pieces.

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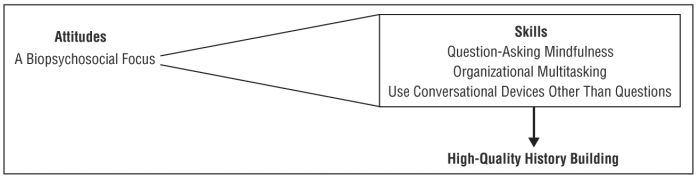

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tients' perspectives.[67] Such outcomes may be an important mediating factor in determining longer-range outcomes such as trust, satisfaction, and adherence.

CONCLUSIONS

Despite repeated calls for more inclusion of patients' perspectives in the medical encounter, research shows that information sharing continues to be mostly physician centered. By drawing on existing theory and describing key skills and attitudes, we hope to provide a foundation for future work in fostering a "history-building" approach that includes and confirms the illness narrative from the patient's perspective.

Doctor: Hi, I'm Dr Doe; how may I help you?
Patient: Doc, I got this cough.
Doctor: Hmm, cough ... can you tell me more?
Patient: Well, first it started as a cold, and then the cold went away but the cough stayed. It bothers me because I can't get to sleep.
Doctor: It's keeping you awake?
Patient: Yep. I get these spells where I cough so hard I think I'm going to throw up.
Doctor: That sounds pretty bad.
Patient: Yeah, it is—can you do anything about it?
Doctor: I have a couple of thoughts, but first, I was wondering what you were thinking was causing this cough...
Patient: I don't know—you're the doctor.
Doctor: Well, are you concerned about anything in particular?
Patient: I was kind of worried about—no that's stupid.
[Doctor is silent.]
Patient: It's just that I'm worried that I might have lung cancer or something.
Doctor: You look pretty worried—have you had experience with lung cancer?
Patient: My best friend had it and died 5 years ago. I'm kind of worried because I'm a smoker and this cough is just like his when they found his cancer. Do you think I should have a CAT scan or something?
Doctor: Well, I'm not sure just yet. How were you thinking a CAT scan might help?
Patient: Well I heard on TV that lung cancer can be cured if they find it early. They found Sam's cancer with a CAT scan, although he waited a long time before he went to see a doctor.
Doctor: I can see how this must be very scary.
Patient: Yeah it is.
Doctor: Let me recap here—you were feeling fine, then you got a cold, and after the cold went away you were left with this nagging cough that comes in spells that are really bad—did you say whether you were coughing up any thing? [Patient: No, I'm not now.] OK, so you're not coughing up anything now. And it's got you worried because you're thinking about smoking and your friend Sam who had similar symptoms that turned out to be lung cancer, and you're wondering whether you should have some sort of test to look for lung cancer so that you can catch it early if you have it.
Patient: Yeah, that's it.
Doctor: Let me ask a couple of specific questions here...

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