History Taking in Clinical Medicine - A Forgotten Art?

Dear Editor,

History taking in the approach to treatment of illness and disease is devolving into a lost art. This is so because of paucity of time and large number of patients that visit most hospitals. The medical problems facing ex-servicemen are peculiar to their age group and are influenced by their post retirement occupations. Medical officers who are the point of first contact for most of the patients visiting hospitals need to elicit detailed occupational histories, especially for ex-servicemen. Employment of these retired personnel in certain high risk occupations predisposes them for certain diseases.

A 75 year old Ex-Serviceman visited a military hospital for obtaining treatment for cough and fever in May 2002. He was referred to the medical OPD with a cursory history and a provisional diagnosis of lower respiratory tract infection. Subsequent detailed history by the treating physician, revealed the patient to be an old case of Pulmonary Koch's having received treatment for a year in 1985. Detailed occupational history revealed that the patient had served in World War II in the Sahara Desert. After release from the Army in 1960, he had worked for nearly thirty years in a stone crushing unit, whereafter he had ceased work in 1990 due to incapacitation. The initial history at the point of referral had merely indicated that he was not employed currently, with a detailed occupational history being taken only subsequently by the authors.

After clinical examination, an initial diagnosis was made of bilateral extensive pulmonary Koch's superimposed on a pneumoconiosis. This was confirmed subsequently on radiographic examination of the chest. The patient was treated with anti tubercular treatment (ATT) and subsequently discharged after a month, to continue treatment on a domiciliary basis, with regular review by the physician. His age and physical condition precluded further work related exposure.

Clinical methods is the term used to describe a properly organized approach to the patient and to his disease. The aim of history taking is to elicit an accurate account of the symptoms that represent the clinical problem and to set this against the background of the patient's life. With experience, doctors prefer to obtain details of a patient's social, occupational, past medical and family history, before discussing the presenting complaint, since this provides a context within which the presenting illness can be viewed. The occupational history is almost always invaluable. If there is any suspicion that the patient's symptoms are occupational in origin a thorough occupational history needs to be obtained [1].

A history of exposure to free silica is important for the diagnosis of silicosis. A detailed work history is necessary with appropriate attention to occupations held in the past, since the latency period for characteristic X-ray abnormalities is often decades [2]. In India, silicosis was diagnosed as soon as systematic examination of miners were initiated in the 1950s. In the Bihar region, 34% of those

examined were found to have advanced silicosis [2]. The major occupational exposures include mining, stone cutting, abrasive process based industries like stone crushing and cement manufacturing [3]. In India, where the reporting system is unreliable, and the sector is mostly unorganized, data cannot be estimated and can only be surmised to be very high, given the general lack of concern to maintenance of health and implementation of preventive measures especially among the workforce. Hence the suspicion of tuberculosis must always be entertained wherever there is an occupational etiology suspected in chest symptoms.

Information about risk factors for lung disease should be explicitly explored to assure a complete basis of historic data. The smoking history should include the number of years of smoking, the intensity and the interval since smoking cessation, if applicable. The patient may have been exposed to other inhaled agents associated with lung diseases, either occupationally or avocational. This indicates the importance of detailed occupational and personal histories [4].

It is hence recommended that all Medical Officers who attend to patients in the peripheries of the medical echelons, obtain relevant and appropriate detailed occupational histories, especially from Ex-Servicemen, covering the entire period after retirement till date of reporting for treatment. The art of history taking thus needs to be revived and encouraged, with a view to improving diagnostic efficiency and institution of provisional treatment of patients and subsequently appropriate referral. A case can also be made for establishing of special OPDs for new patients with follow up patients being reviewed separately to allow for more devoted doctor patient interaction. The specialist referral proforma also would need to be reviewed to allow for a more comprehensive initial history taking at the peripheral level.

References

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