History Taking in Palliative Care:
skills, approach, and the personal interaction

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"Information is intellectual, whereas communion is spiritual; but information was the path that led to communion. Communion touches the person. Through information I can understand a case; only through communion shall I be able to understand a person."

Paul Tournier – The Meaning of Persons

Many of us are very familiar with the definition and the philosophy of palliative care. To highlight a few points in the WHO definition\(^2\) of palliative care, palliative care aims at relieving patient from pain and other distressing symptoms; palliative care integrates the psychological and spiritual aspects of patient care; and palliative care adopts a team approach to address the needs of patients and families. Looking at this statement, one might have a preliminary impression or assumption that these different aspects of care could be "divided" among the team, and when combined together, it becomes a "whole" and therefore integrating physical, psychological and spiritual care. Particularly for the physicians, it would be difficult for those who are trained in the traditional biomedical model to comprehend the role of physicians to go beyond physical to psychosocial, not to say the spiritual aspect. As patient presents his own spiritual issues, a physician may be unaware of it, may avoid it, or refer to someone else to take care of it. Should or could a physician address the spiritual need of patient? Yes, one should and one could. When a patient is facing his own dying, the spiritual dimension is an integral part of his illness experience. Moreover, the patient does not just present himself as he is now, but also with his past stories. Palliative care physician could address the spiritual issues of a patient in history taking, as patient tells us his life stories.

**History taking** is among the first things a medical student learns in the clinical years. Physicians are all so familiar with history taking that it becomes our default action as symptoms bring our patients to us. Information and facts are documented in a standard format, using medical terms that are universally adopted. Basically, the process is one of questioning and answering one. Upon completion of history and physical examination, a diagnosis or problem list is generated for management.

In palliative care, physicians are facing a different scenario. All patients already carried with them a diagnosis of incurable illness, and this is no longer a challenge as in many other non-terminally ill patients. Getting to know their symptoms is important but the symptom list is short of the total representation of the patient. In palliative care, we hope that we can get a history that is different from the traditional ones, one that illustrates their needs and concerns; and one that includes the reminiscence of patient's past life stories. From our clinical experience, patients are often candid instead of inarticulate in the interaction. So, what on the part of the palliative care physician that makes the difference in the history? Is it simply because of our empathy? Or is it because of our communication skills?

**Communication skills – only skills**

There is a call for improvement in communication skills of physicians as physicians were shown to have poor performance in communication, and failed to elicit about 50% of patient’s complaints, main concerns, or psychosocial problems.\(^3\) Good communication skill is essential. It serves as a vehicle so that our messages can be delivered in a more effective manner. It helps to overcome the barrier between people. Skills are something that can be taught and transferred, or even studied scientifically. However, it could be a myth if thinking that intense training in communication skills will make a difference. In two studies on communication of hospice nurses with patients, intensive training in communication skills for 10 weeks and 2 months respectively failed to elicit more concerns or the main concern of patients.\(^4,5\) In the first study \(^4\), the percentage of eliciting the greatest concern of patient actually dropped from 51.7% pre-training to 37.3% at 9 months post-training. In the second study \(^5\), there was an increased use of blocking behaviour by nurses after training as patients
disclosed more distress. The results suggest that communication skills, even if acquired, may not be diligently applied; and training in communication skills appears to have a ceiling effect. Evidences have also shown that relying on relatives for information cannot compensate for such deficiencies in communication with patients. Good communication skill is not therapeutic per se, rather, like the inactive base carrier of a tablet of medicine, it brings along the active ingredients to the patient. Nevertheless, as the basic preparation for the interaction, one should shift from stereotyped questioning to active listening; from asking leading questions to asking open questions; and from following a preset format to patient-led agenda.

**Approach: from biomedical to biopsychosocial**

While we possess the communication skills, we still need to move from a biomedical approach to a biopsychosocial approach to make a difference in history taking in terms of information collection. In the biomedical approach, we focus on arriving at a diagnosis of disease i.e. what is causing the symptoms? In the biopsychosocial approach, we focus on the symptoms and how are they affecting our patients, i.e. their impact on the patient; and the distress as experienced by the patient. In the biomedical approach, we focus on problem solving; but in the biopsychosocial approach, we focus on eliciting patient's own needs and concerns.

A symptom as experienced by the patient, has to be understood not just in terms of its severity and the underlying causes, but also in terms of their impact on patient's physical, psychological and social well being. The distress that the patient is experiencing, as presented in his own words, is affected by the disease characteristics, patient's demographics, and patient's individual characteristics. Disease characteristics refer to the disease trajectory, the treatment and comorbidities; demographics refer to patient's age, gender, marital status, race, culture, roles, education and socioeconomical status; whereas patient's individual characteristics refer to his health knowledge, value, past experience, and sense of cohesiveness.

The past stories of the patient, therefore, are crucial in understanding how and why the patient presents himself to us as he is now. Going through the past stories, we may ask the similar questions as in a typical history taking process, but the biopsychosocial approach will lead us to collect very different information. For example, occupational history means little as a health hazard, but reflects patient's struggles, fulfillment and roles; past health history tells us previous losses and patient's perception of illness; family history means more than hereditary illness, but can reveal the support, stresses, coping, and relationship problems; childhood is the history of how one is shaped; history of substance abuse is not the ground for mistrust, but for understanding the coping mechanisms and personality.

Apart from symptoms, we also need to elicit the needs and concerns of our patients, which may or may not be related to their symptoms. The concerns elicited should not be equated with the medical problems to be solved as in the biomedical model, or else, it is the natural tendency for one not to elicit them, so that they remain with patient, or put in the trash, so that they are not in the "problem list". Patient's concerns are personal, and can cover a wide scope. It can be related to symptom e.g. Will symptoms escalate before death? Will I become tolerant to drugs? Is pain inevitable? It can be related to medical uncertainty e.g. Is there a hope for cure? How long am I going to live? It can be related to the dying process e.g. Is it going to be painful? Is it a lingering death? It can be related to afterdeath issues e.g. Who is going to take care of my funeral? Who is going to take care of my spouse? It can be related to his own existence and meaning of life e.g. what is the meaning of life when I have to suffer like this? Many a time, we do not have perfect solutions or answers, but patient's concerns are not to be ignored.

**The person to person interaction**

With the communication skills and a biopsychosocial approach, we will obtain information on the symptoms and the distress of the patient, and his needs and concerns, in the background of his past life stories. Adopting good skills and a biopsychosocial approach suffices for us to write up the patient's history, but such information collection can remain as a scientific, logical and intellectual process - one without the personal interaction at the spiritual dimension. The exploration process should not end at information collection, which serves only to open the gateway for personal encounter at the spiritual dimension. As one moves from information to "one person interacting with another person", patient will be understood as a person.

What is a person then? In "The Meaning of Persons", Paul Tournier described the person and the personage of a human. A human exists as a person, but appears as the personage. The personage is the image appears to others, and is very much related to external factors, e.g. occupation, social status, roles, possessions, friendships, relatives etc. The personage can be invented by ourselves, or imposed on us by
other people or circumstances. Like many other images in the world, the personage can be deceptive, and in a highly modernised and technological era, it can be de-personalised and de-humanised. Nevertheless, the personage represents oneself when facing others. The person is the original creation, whereas the personage is the automatic routine; as Paul Tournier described them. As I shared and taught in my own Hospice Unit, I used to term the personage as the outer self and the person as the inner self for convenience, serving to give a pictorial sense of the personage and person.

With the diagnosis of incurable cancer, and as the disease progresses and the patient approaches death, the outer self can no longer remain what it used to be. It may be threatened, not sustainable, or to be cast away not just temporarily, but permanently. This is often the time when people have the urge or need to address their inner self or inner world, a world that may be left unexplored in the past, but to be unfolded as the coating of outer self melts away. For our patients, this may be a journey that they have never go in depth to, or a process too painful to be on their own. They need a safe environment, a personal touch with support and facilitation from us to move on. It is important to realise that we do not address the spiritual aspect of care out of our own desire to achieve the goal of "holistic", but to serve the genuine needs of our patients. For our advanced cancer patients, they expect us not to understand them as cases, but also expected to be understood as persons.

How can the physician appear as a person to the patient? A containing environment such as a palliative care ward, the role as a palliative care worker, a set of guidelines and common practices, even the skill itself, will not automatically help the physician to format a sense of person. All these may well give us our personage i.e. how we should behave and appear in front of our patients. If we are delivering our care with the personage, and not as a person, we are delivering an institutional form of interaction. If one observes that personal interaction is both rare and difficult, why is it so? Where are the hurdles? Fear of emotions of patients; remorse, shame and fear of being judged or not respected; the incompetence of facing the distress of dying are among some of them, and these hurdles will not be overcome by skill-based training. From the personage to the sense of a person, one has to go back to own self awareness, reflections, and personal growth. With self awareness, we are in touch with our own inner world. In the process, we become aware of our own inadequacies and weaknesses. We learn, we reflect, and we grow. It is only as this person, that we can support and facilitate another person, to be in touch with his own inner world. By this, the interaction is no longer "institutional", but with one person in touch with another person. (Fig. 1)

The "person to person" encounter should not be confused with psychotherapy, or regarded as a mystique. It is the fundamental of medicine, which is not just a human science, but also a healing art. Over-whelming emphasis on science diminishes the element of human, and physicians lost the sense of person. We should appreciate the goodness that advances in technology bring to our patients, it is also important that we have the interest to understand our patient as a person. It is only through this interaction that our relationship with our patients is therapeutic, and allows deeper encounters.

References

Fig 1: The institutional form vs the personal form of interaction