“Building” a History Rather Than “Taking” One
A Perspective on Information Sharing During the Medical Interview
Paul Haidet, MD, MPH; Debora A. Paterniti, PhD

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.

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.

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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. 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-
ter, shaping both interactants’ views of their roles, what to expect from each other, and how their relationship will function. 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. 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. 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. Such outcomes include faster symptom resolution and better biomedically relevant parameters, such as lower blood pressure and glycohemoglobin levels. Physician solicitation of patient perspectives also has a positive impact on patient trust, satisfaction, and adherence. In addition, the ability for patients to share their perspectives through narrative satisfies a basic human need for expression that may in itself have therapeutic value.

DEEMPHASIZING THE PATIENT’S NARRATIVE

Information sharing during the typical encounter tends to be one-sided in terms of perspective. 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. 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. 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 of the patient’s perspective, such curricula are often swamped by the sheer volume of use of the history-taking heuristic.

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. 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.

“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. 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. Others address information sharing during the medical interview directly by suggesting potential language and strategies that physicians might use to elicit patients’ narratives.

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 focuses through a biomedical lens that concentrates on “pertinent positives and negatives,”
Table 1. Example of 2 Approaches to Information Sharing

<table>
<thead>
<tr>
<th>History Taking</th>
<th>History Building</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr: Hello, I'm Dr Jones. How may I help you?</td>
<td>Dr: Hello, I'm Dr Smith. How may I help you?</td>
</tr>
<tr>
<td>Patient (Pt): Hello. I came in to see you because I've been having dizzy spells.</td>
<td>Pt: Hello. I came in to see you because I've been having dizzy spells.</td>
</tr>
<tr>
<td>Dr: Dizzy, eh? Can you tell me more?</td>
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</tr>
<tr>
<td>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...</td>
<td>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...</td>
</tr>
<tr>
<td>Dr (interrupting): Does your dizziness feel like you are going to pass out, or does it feel like the room spinning?</td>
<td>Pt: I never passed out before, so I'm not sure...</td>
</tr>
<tr>
<td>Pt: I never passed out before, so I'm not sure...</td>
<td>Dr: You take nitro, huh. What medical problems do you have?</td>
</tr>
<tr>
<td>Pt: I have high blood pressure and I had a heart attack 5 years ago.</td>
<td>Pt: I have high blood pressure and I had a heart attack 5 years ago.</td>
</tr>
<tr>
<td>Dr: Is the chest pain associated with the dizziness?</td>
<td>Pt: I don't know.</td>
</tr>
<tr>
<td>Pt: I don't know.</td>
<td>Dr: Does it ever feel as if your heart is beating fast during the dizzy spells?</td>
</tr>
<tr>
<td>Pt: Well, maybe, but I get really scared, you know?</td>
<td>Pt: I think it happened twice, it's hard to remember now, it happens so much more...</td>
</tr>
<tr>
<td>Pt: I think it happened twice, it's hard to remember now, it happens so much more...</td>
<td>Dr: Does it ever feel as if your heart is beating fast during the dizzy spells?</td>
</tr>
<tr>
<td>Pt: When did this start?</td>
<td>Pt: Well, maybe—I'm wondering what you mean when you say are dizzy.</td>
</tr>
<tr>
<td>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...</td>
<td>Pt: You know, it's—just, kind of—dizzy, you know?</td>
</tr>
<tr>
<td>Dr: When did this start?</td>
<td>Dr: Has this ever happened before?</td>
</tr>
<tr>
<td>Pt: It's happening 3, maybe 4 times a day.</td>
<td>Pt: No, that's why I came in to see you, it came out of the blue.</td>
</tr>
<tr>
<td>Dr: How long does it last?</td>
<td>Dr: Do you have any other symptoms that concern you?</td>
</tr>
<tr>
<td>Pt: About an hour.</td>
<td>Pt: No.</td>
</tr>
<tr>
<td>Dr: Does anything make it get better?</td>
<td>Pt: No.</td>
</tr>
<tr>
<td>Pt: No.</td>
<td>Dr: Has this ever happened before?</td>
</tr>
<tr>
<td>Dr: Do you have any blurred vision, double vision, or tunnel vision?</td>
<td>Pt: No.</td>
</tr>
<tr>
<td>Pt: No.</td>
<td>Dr: Do you have any numbness, tingling, or feel &quot;pins and needles&quot;?</td>
</tr>
<tr>
<td>Pt: No.</td>
<td>Pt: No.</td>
</tr>
<tr>
<td>Dr: What medications do you take besides the nitroglycerin?</td>
<td>Pt: Any numbness?</td>
</tr>
<tr>
<td>Pt: I take Plendil and Dyazide.</td>
<td>Pt: No, but sometimes my hand [points to left hand] feels like it is going to sleep.</td>
</tr>
<tr>
<td>Dr: OK, let me ask you a few more questions and then I'll do a physical examination.</td>
<td>Dr: Is that during the episodes of dizziness?</td>
</tr>
<tr>
<td>Pt: OK.</td>
<td>Pt: Sometimes.</td>
</tr>
</tbody>
</table>

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.
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 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. Focus, then, is usually achieved by asking the patient narrowly constructed yes/no questions. While this may 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. In the history-taking example in Table 1, Dr Smith 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), 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 this open-ended dialogue than at the end of the history-taking dialogue, in part because of Dr Smith’s refusal to impose 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 that was left unspoken is important. Dr Smith’s reflective practice of putting the story back into the words and making sense of the story is strengthened by retelling the story again, using the patient’s organization and language, and filling in important biomedical pieces.

**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 Smith 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. 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.
Use of Conversational Devices Other Than Questions

Physicians who build histories with their patients should use other conversational devices in addition to questions during information sharing. Such conversational devices include orientation statements, paraphrasing statements, reflections, and directives. Examples of these and other devices appear in Table 2. Such devices not only add variety to the conversation and deemphasize the interrogational nature of the medical interview, they can help elicit information when the physician gets stuck. In the history-building example in Table 1, Dr Smith switches from questions to a directive statement (“Tell me about the first time it happened”) in order to facilitate the patient’s more complete description of the dizziness sensation. Nonquestion conversational devices should be used in the same mindful manner as open- and close-ended questions.

We highlight silence as a particularly powerful conversational device. North American culture directs people to “fill in” gaps in conversations with sound or language.69 Pauses are often uncomfortable for both physician and patient alike. Physicians who can tolerate and strategically use such pauses will often collect additional information from their patients at key points by simply not speaking. Patients will often fill in such a pause by adding information related to what they were just speaking about.

A Biopsychosocial Focus

Although the skills we outlined above are necessary for efficient history building, their use alone will not validate the patient’s narrative if the physician does not recognize that there are pieces of information just as important to the patient as biomedical information is to the physician. While many commentators have praised the merits of the biopsychosocial model of care first described by Engel,65 studies of physicians in practice indicate that this is not a primary focus.1,16,17,19 For example, Levinson and colleagues66 recently demonstrated that physicians left patient-centered information unexplored 72% of the time. In the history-building example in Table 1, Dr Smith gives the patient space to express concerns about employment and then follows up those concerns both immediately (“This is causing you to miss work?”) and later on in the interview (“Do you have any other concerns about this besides your work?”). These behaviors contribute to Dr Smith’s understanding of the patient’s primary reason for seeking care, namely, a desire to continue his livelihood by returning to work. While this information may not necessarily alter Dr Smith’s diagnostic or treatment plan, it will allow a discussion of that plan in the context of getting the patient back to work. Such a discussion is more likely to succeed in gaining the patient’s trust and adherence, since the main issue from the patient’s point of view is acknowledged and addressed.24,25

The physicians who successfully build histories with their patients learn to cultivate a focus on psychosocial issues in parallel with a focus on biomedical issues. Physicians can make this focus possible by defining their roles more explicitly with patients. In the history-building example in Table 1, Dr Smith must be prepared to negotiate the role of the physician in the patient’s care. For example, the patient may want the physician to intervene with the employer while the biomedical workup proceeds. Even if Dr Smith is not willing to take such a role, Dr Smith should at least acknowledge the patient’s need. Depending on available resources and time, in a history-building paradigm, physicians need to do more than take the role of biomedical expert. Physicians must also elicit and negotiate the roles that patients might expect them to assume.

Future Directions

The theoretical framework of skills and attitudes we have outlined may provide a useful point of reference for future research and teaching on the information-sharing phase of the medical interview. Development of tools to measure these skills and attitudes will assist researchers by providing process-oriented measures of quality for information sharing. The skills and attitudes provide a concrete focus that can be the basis for the construction of educational goals and objectives for courses in medical interviewing. Ideally, teaching strategies that could be applied in real time during physicians’ everyday clinics would foster the learning of the skills required for history building without requiring large expenditures of time. For example, physicians might make audiotapes of their everyday consultations for later review and evaluation to encourage greater question-asking mindfulness.

In addition to the skills and attitudes we have outlined, new communicative outcome measures that take into account the patient’s perspective need to be developed. For example, we are currently developing a postconsultation survey that will measure the degree of agreement between physicians’ and pa-

Table 2. Some Conversational Devices Other Than Questions

<table>
<thead>
<tr>
<th>Device</th>
<th>Example</th>
</tr>
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<tbody>
<tr>
<td>Orientation statements</td>
<td>“Now I would like to talk about your other medical problems.”</td>
</tr>
<tr>
<td>Paraphrasing</td>
<td>“OK let me make sure I have this straight...”</td>
</tr>
<tr>
<td>Reflection</td>
<td>Patient: “I’m worried.” Physician: “You’re worried?”</td>
</tr>
<tr>
<td>Directive</td>
<td>“Tell me what happened next.”</td>
</tr>
<tr>
<td>Request for clarification</td>
<td>“Help me understand what the pain felt like at that point.”</td>
</tr>
<tr>
<td>Empathic statements</td>
<td>“That sounds like it must have been difficult.”</td>
</tr>
<tr>
<td>Time management</td>
<td>“We only have about 1 more minute to talk. Is there anything else I should know?”</td>
</tr>
<tr>
<td>Facilitating body language</td>
<td>Head nods, facial expressions, hand movements, etc.</td>
</tr>
<tr>
<td>Facilitating utterances</td>
<td>“Uh-huh,” “mm-hmm,” etc</td>
</tr>
</tbody>
</table>
patients' perspectives. 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: 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 anything? [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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**Corresponding author and reprints:** Paul Haidet, MD, MPH, Houston Veterans Affairs Medical Center, 2002 Holcombe Blvd (152), Houston, TX 77030 (e-mail: phaidet@bcm.tmc.edu).

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