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 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.

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. 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. In the first study, 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, there was an increased use of blocking behaviour by nurses after training as patients...