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Story of the Patient's Illness (SPI): A Useful Educational Tool for Teaching History Taking?

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Many educators have expressed concern that the emphasis on acquiring technology-centered diagnostic skills is overshadowing the development of 'healing skills" such as the ability to hear patients and understand their "stories". They forecast a growing disconnect between medical students, increasingly focused on technology-based diagnoses and patients beleaguered by disease, bewildering treatments and insurance bureaucracy. From my experience in reviewing histories received from young practitioners, such concerns are compelling. Histories, as currently recorded, often add little to my or other's understanding of patients as individuals. In part, this is due to the increasing reliance on lab tests and radiological techniques that reduce the need to glean pivotal diagnostic information from patients themselves. But this may also reflect changes in how medical students view histories, their role in diagnosis and patient care.

It is worth remembering that the history, particularly the history of the present illness (HPI), is the only document in a patient's records that can give a glimpse into who a patient is and the milieu they live in. Yet as currently applied, it usually becomes merely a chronology of symptoms, signs, lab values and check-off list on marital status and substance use. In its current structure, there is no section for vital, treatment- modifying information such as: 1) the patient's self-image, i.e., leader, follower, stoic, etc.; 2) priorities, i.e., cure at any cost or palliative care; and 3) view of disease, i.e., "I didn't quit smoking and this is my punishment". So how will we teach students to "hear" their patients and empathize with those who often live in "foreign" socioeconomic and cultural places?

Recently there has been interest in applying literary techniques to improve history taking and empathy with patients. Charon suggests that writing a narrative account of a patient's condition may enhance our understanding of and empathy for patients. This approach has been particularly useful in managing difficult patients or avoiding "burn out" amongst physicians such as oncologists.[1] Nonetheless, the prospect of writing an unstructured narrative is intimidating to some students and residents, years removed from writing classes (if they took any). Moreover, with the popularity of CDs and "movies on demand", students may be more familiar with movies than great novels.

Substituting a "Screenplay/Story of the Patient's Illness" (SPI) for the History of the Present Illness (HPI) may represent a practical solution. To many, constructing an SPI may be intimidating. Yet creating this portion of the medical record may be less difficult than perceived if students are provided with a basic story outline to follow. As Vogler points out, most novels and screenplays, from The Wizard of OZ to Star Wars, follow a set structure.[2] Teaching this structure to students should facilitate construction of an insightful patient story. With use, the visualization of a patients "story" might naturally include at least most of the elements listed below facilitating empathy and interactions with patients. I simplify it as:

1. The Hero's (Patient's) Ordinary life
2. The Hero's (Patient's) Call to Arms
3. Denial and Reluctance to Accept the Call
4. Crisis
5. Hero (Patient) Takes Up Arms Guided by Mentor (s)
6. Battle
7. Transformation
8. Adjustment to a New Life

This structure can accommodate considerable information that may improve the diagnostic evaluation, treatment of and empathy for patients. In brief, considering the patient's "Ordinary Life" may provide an appreciation of the patient as an individual and afford insight into the socioeconomic milieu they live, and will be treated in. It will also provide understanding of the environment discharged patients return to.

Pinpointing the true "Call to Arms" may reveal an earlier onset of symptoms than that listed in a standard HPI format. Noting the "Denial" phase should help students maintain sensitivity to the emotional trauma inherent to facing catastrophic or unexpected diseases. It can also identify personality traits that may become

obstacles to effective treatment.

Identifying the actual symptoms and signs of the "Crisis" prompting medical consultation is critical to any form of "History". But, in this context, such facts may better illustrate the natural history and life-altering effects of various diseases.

The "Hero Takes Up Arms, Guided by Mentors" section provides a glimpse into a patient's view of the disease, coping skills and who is counseling them. In many cases, the mentor will be more than one physician, nurse, spouse, family member or clergyman. As in screenplays, mentors may be complex with "good" or "detrimental" motivations that facilitate or hinder patient treatment. Actively acknowledging this should help students understand complex patients and obstacles to treatment.

The "Transformation" of patients during or after ongoing battle with disease, seems less often discussed at rounds. Yet considering this may be particularly important in helping patients adjust to a new life, irrevocably changed by disease. Because many patients cannot be cured, but could be aided or "healed" by counseling, this point in the story may be particularly useful in helping students appreciate their role, not as "technodocs", but as "healers".

Why should this tool work? Because construction of a SPI, within a limited space and word count, forces the author to create a comprehensible, coherent story in which the "pieces of the puzzle" fit reasonably well. "Character" (patient) motivation and actions must be explained or at least considered to a degree rarely seen in the assembly of a standard History and Physical. As Verghese points out, in constructing a patient's story, "God is in the details"[3]. Sorting the details, deciding which are important to a brief SPI, creates an intellectual exercise that benefits not only the storyteller but those who hear, discuss or challenge him.

A recent muscle biopsy case referred to me illustrates this. The office note I requested stated:

> "HPI: This 38 year old has a 3-4 week history of muscle pain and tenderness primarily in both legs but also arms. He has no history of trauma or recent illness. Questionable cramps with exertion. No myoglobinuria. His CPK is 440.
> PMHx: No diabetes, connective tissue disease or muscular disorder.
> Medications: None.
> Social: No EtOH, drugs. Married with one son."

Despite the mildly elevated CPK, the quadriceps muscle was histologically normal and had no evidence of a glycogen or lipid storage disease. Because healthy African-American males often have CPK values that are twice the standard normal range, I called the primary care physician for more history. His SPI was this:

> SPI: It had been almost 15 years since John had finished college on a basketball scholarship. Like many, it was his ticket out of the inner city. He knew the quest for superb conditioning and basketball glory had kept him from temptations of the streets. He'd even spurned smoking and drinking. But now his son, twelve, was facing worse temptations - drugs, gangs, infected girls. So John increased their basketball, one-on-one, Saturday and Sunday nights. If they played more, they'd talk more. As long as he won, his son would respect him, and listen. But the son was now determined to prove himself. As "the series" progressed, John left the games exhausted. His muscle hurt for days. At first he thought little of it. At thirty-eight he was still healthy, with unremarkable annual physicals. But sedentary friends began to question his slowed gait, chronic soreness. So he reluctantly went to the clinic.

The SPI, along with various analyses, confirmed my suspicion that this a normal variant influenced by unappreciated patient characteristics.

Some might worry that "story" connotes fiction and using a "Story of the Patient Illness" will encourage imprecise use of patient information. Clearly, the teaching of this tool must be accompanied by admonitions against embellishment. Nonetheless, most practitioners of any specialty would admit that the medical dramas experienced by some patients and physicians rival any plot of film or fiction. Thus, teachers could emphasize that the details from a patient's life are dramatic enough. Whether this exercise is called the "SPI", "Narrative of the Patient's Illness" (NPI), or something else seems less important than the lesson itself.

This concept could be introduced during courses on physical diagnosis and revisited throughout the medical school curriculum. Substituting an accepted SPI for HPI might also serve as a constant reminder that the practice of medicine remains a humanitarian endeavor centered

on appreciating patients as complex individuals rather than complex diseases.

In the past several decades, advances in diagnostics and therapeutics have transformed medicine and how we practice it. Many would say that these advances and the changing economics of health care and medical education combine to depersonalize the practice of medicine. In this time of change, the format for the History should be re-evaluated. Substituting SPI for the standard Patient History, particularly in the context of medical student/ resident education, may be one small change that fosters the sacred therapeutic alliance between patients and the physician/healers whom they entrust with their care.

References

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