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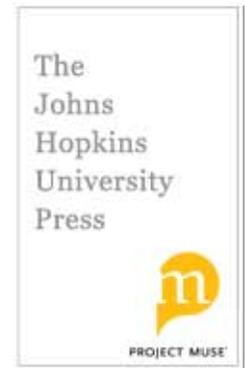
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The History of the Patient History since 1850

JONATHAN GILLIS

SUMMARY: For the ordinary doctor the taking of a medical patient history is and has been one of the fundamental procedures. This article looks at instructions on the taking of a history in medical texts, to delineate what happened to the position of the patient history in clinical assessment with the increased emphasis on physical examination that began around the middle of the nineteenth century. The analysis reveals that the taking of a history remained important, with a consistent approach from 1850 to the end of the twentieth century. The patient history became incorporated into the physician's examination as another set of observations and signs, thus producing two histories: a superficial, chaotic story presented by the patient, and a deep, "true" history revealed by the skill of the physician. Within pediatrics, the primacy of the physical examination appears to have been asserted well before the introduction of history-taking.

KEYWORDS: patient history, clinical encounter, clinical assessment, medical history-taking

When a person is sick and medical treatment is sought, a clinical encounter is initiated and a physician will take a medical history either directly from the person or from a third party (parent, partner, relative, friend, or witness). The physician will combine this history with a physical examination to form the clinical assessment. For the ordinary doctor, this is and has been one of the routine and fundamental medical procedures. The historical study of the taking of a medical history is therefore likely to be particularly revealing of changing issues at the level of everyday medical practice.

How, then, to obtain a historical glimpse of the clinical encounter? One method is to use patient records to "reconstruct workaday activity at the bedside."¹ John Harley Warner has commented that the reconstruction

1. John Warner, "The Uses of Patient Records by Historians—Patterns, Possibilities and Perplexities," *Health & Hist.*, 1999, 1: 101–11, on p. 101.

of clinical activities from medical records brings out the “disparity that often exists between normative statements and actual practices. What textbooks and journal articles said clinicians should do is not a reliable index of what they actually did.”² While this assertion cannot be disputed, it should be remembered that hospital patient records are themselves only a secondary source of what was actually said and done; and that from the recorder’s, usually the physician’s, perspective. They are the records of the observer—what the observer thought he saw, perhaps even what he wanted to see and hoped to do.³ Another method is instead to acknowledge and accept the gap between the “actual practices” and “normative statements,” but to use the fact that some physicians wrote down and spoke of the way in which they wished to represent the clinical process—that they wrote in journal articles and textbooks for colleagues and students how they thought the clinical encounter should be conducted. This then is another, although unusual, sense of “medicine from below,”⁴ not from the “sufferer’s,” but from the working doctor’s perspective: the analysis of what physicians perceived as the main elements of the business of medical practice.⁵

In this article I use the view from this particular angle to reexamine the historical construction of the evolution of the clinical assessment and the relation within it between the patient history and physical examination. I look at medical descriptions and instructions on the taking of a medical history from a patient, not to discover what “actually” happened, but rather to understand how medical writers wanted the clinical encounter to be conducted and what they identified as the normative principles of practice to be passed on to medical students and other physicians. The texts analyzed were published from 1850 to 1998 in either the United Kingdom or the United States (with a few from Australia), although many appeared in and featured contributors from both countries. They demonstrate a comparable approach to the clinical encounter, despite some local differences in professional development and organization. I also briefly look at history-taking in the setting of pediatrics as a particular

2. *Ibid.*, pp. 102–3.

3. For discussion of the problems of using patient records as evidence of clinical reality, see Steven Noll, “Patient Records as Historical Stories: The Case of Caswell Training School,” *Bull. Hist. Med.*, 1994, 68: 411–28; Guenter Risse and John Harley Warner, “Reconstructing Clinical Activities: Patient Records in Medical History,” *Soc. Hist. Med.*, 1992, 5: 183–205.

4. See Roy Porter, “The Patient’s View: Doing Medical History from Below,” *Theory & Soc.*, 1985, 14: 175–98.

5. “It takes two to make a medical encounter—the sick person as well as the doctor; and for this reason, one might contend that medical history ought centrally to be about the two-way encounters between doctors and patients” (*ibid.*, p. 175).

window into history-taking because of its reliance on a third party to provide that history.⁶

Previous writings on the medical history have emphasized its central role in pre-nineteenth-century clinical assessment, and the way this changed with the advent of hospital medicine and medical control of the clinical process.⁷ History-taking and prescribing have been described as the main functions of medical practitioners at the end of the eighteenth century: “The important thing then was what the patient thought about it: the important thing became later what the doctor found.”⁸ Stanley Reiser has traced the history of the clinical assessment through different phases: the first dominated by the taking of the patient history; the second, by physical examination; and the third, by technology.⁹ The invention of the stethoscope by Laennec in 1816 (accepted in the United States and the United Kingdom by about 1850) introduced a new model of physical signs that, with autopsy information, could be correlated with disease states; this model “largely replaced the [previous] model constructed from the patient’s subjective impressions and the physician’s own visual observations of the patient.”¹⁰

6. I have employed a similar method to look at history-taking in the setting of pediatrics, but in that case to map out how parents were perceived and represented by physicians rather than, as in this article, the changing balance between physical examination and history-taking: Jonathan Gillis, “Taking a Medical History in Childhood Illness: Representations of Parents in Pediatric Texts since 1850,” *Bull. Hist. Med.*, 2005, 79: 393–429.

7. See Lester King, *Medical Thinking: A Historical Preface* (Princeton: Princeton University Press, 1982). Edward Shorter, “The History of the Doctor-Patient Relationship,” in *Companion Encyclopedia of the History of Medicine*, ed. W. F. Bynum and Roy Porter (London: Routledge, 1993), pp. 783–99, describes the “traditional consultation,” prior to the nineteenth century, where there was history-taking with little examination and observation (pp. 783–84). See also Malcolm Nicolson, “The Art of Diagnosis: Medicine and the Five Senses,” *ibid.*, pp. 801–25; W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994), pp. 33–42; Bynum, “Health, Disease and Medical Care,” in *The Ferment of Knowledge: Studies in the Historiography of Eighteenth-Century Science*, ed. G. Rousseau and R. Porter (Cambridge: Cambridge University Press, 1980), pp. 211–54. For other analyses emphasizing power and marketplace, see Mary Fissell, “The Disappearance of the Patient’s Narrative and the Invention of Hospital Medicine,” in *British Medicine in an Age of Reform*, ed. Roger French and Andrew Weir (London: Routledge, 1991), pp. 92–109; Michel Foucault, *The Birth of the Clinic*, trans. A. Smith (1963; New York: Vintage, 1975); Nicholas Jewson, “The Disappearance of the Sick-Man from Medical Cosmology, 1770–1870,” *Sociology*, 1976, 10: 225–44.

8. Charles Newman, *The Evolution of Medical Education in the Nineteenth Century* (London: Oxford University Press, 1957), pp. 30–31.

9. Stanley Reiser, “Technology and the Use of the Senses in Twentieth-Century Medicine,” in *Medicine and the Five Senses*, ed. W. F. Bynum and Roy Porter (Cambridge: Cambridge University Press, 1993), pp. 262–73.

10. Stanley Reiser, *Medicine and the Reign of Technology* (Cambridge: Cambridge University Press, 1978), pp. 43–44. See also Russell Maulitz, *Morbid Appearances: The Anatomy of Pathology in the Early Nineteenth Century* (Cambridge: Cambridge University Press, 1987).

The second half of the nineteenth century saw the continuing development of physical examination and of technological advances such as thermometry and the ophthalmoscope, laryngoscope, and X-ray machine, which allowed the physician to see into the body. The development of the use of laboratory testing of patient specimens and of physiological signals, such as ECG, further aided diagnosis. History-taking continued to be part of the clinical assessment, but it appeared not to yield such useful data as those obtained by other modalities. According to Reiser, in the first half of the twentieth century “young physicians increasingly tended to neglect history-taking”¹¹—but this attitude changed after the 1940s, with the influence of psychoanalysis converting history-taking into an interview.¹²

The increasing emphasis on physical examination was associated with an increase in the complexity of the diagnostic process, moving from classification systems such as that of William Cullen, which used symptoms as the defining nosological criteria, to one in which diseases were defined by pathological criteria as distinct entities.¹³ The structure of the clinical assessment became more defined around the 1860s with a general medical distinction between physical “objective signs,” as elicited and detected by the doctor, and “subjective symptoms” narrated by the patient.¹⁴ It was within this evolving structure that medical texts gave instructions on how to take a medical history.

The purpose of this article is to delineate what happened to the patient history in instructions on clinical assessment in medical texts from about 1850. As we shall see, my analysis reveals that there was a generally consistent approach in the texts over the 150-year period. Within this overall constancy, there was an increasing acknowledgment of patient need and expectation, and the inclusion of observations of the way the patient told the history as data. Patient history remained important and became

11. Reiser, *Medicine and the Reign of Technology* (n. 10), p. 170.

12. John Stoeckle and Andrew Billings, in “A History of History Taking: The Medical Interview,” *J. Gen. Internal Med.*, 1987, 2: 119–27, reviewed old medical records and again emphasized the influence of psychiatry after about 1940.

13. William Cullen, *Nosology, or a Systematic Arrangement of Diseases* (Edinburgh: Creech, 1800). See also Joel Wilbush, “Clinical Information—Signs, Semeions and Symptoms: Discussion Paper,” *J. Roy. Soc. Med.*, 1984, 77: 766–73.

14. In Richard Hoblyn, *A Dictionary of Terms Used in Medicine*, 8th ed. (London: Whittaker, 1858), there was no entry under either “sign” or “history”; on p. 594, “Symptom” was defined as “a sign or mark by which a disease is characterized.” The ninth edition of 1868 introduced a new comparison: “Symptom. . . . objective, when they can be seen or otherwise detected by the physician; and subjective, when they can be known only through the statements of the patient” (Richard Hoblyn, *A Dictionary of Terms Used in Medicine*, 9th ed. [London: Whittaker, 1868], p. 646).

incorporated into physician examination as another set of elicited signs and medical observations, thus producing two histories: a superficial, chaotic story presented by the patient or parent and another deep, “true” history revealed by the skill of the physician. The theory and practice of this skill changed, but there was little change in the status of the patient history, which was consistently a creation of the clinical encounter rather than an account of a patient’s story.

The Role of the Patient History in General Medical Writings

1850–1900

Medical texts often originated as lectures to medical students, and these generally included a guide to the process of clinical assessment. History-taking was a constant topic in medical education because it was concerned with the daily practice of medicine and dealt with both what doctors should expect from their practice and what services the patients expected of a doctor. Texts in the second half of the nineteenth century suggested that, despite the increasing prominence of physical examination, taking a medical history remained important to both patients and physicians. Typical of this emphasis was the 1873 student guide by the British physician Samuel Fenwick, physician and lecturer at the London Hospital, in which he explained that history was both necessary for diagnosis and difficult to obtain. Fenwick’s guide was an important student textbook, passing through nine editions in thirty-three years. Successive medical students were warned of the inchoate nature of the patient narrative:

Physical signs cannot be exclusively relied upon for the formation of a diagnosis: the symptoms and history of the case must be also taken into consideration. It is generally difficult for the young student to guide the patient’s account in such a way as to derive the necessary information from the details. Most persons ramble in describing their symptoms, and many insist on giving their own or other persons’ opinions as to the nature of their disease, instead of confining themselves to the narration of facts.¹⁵

15. Samuel Fenwick, *The Student’s Guide to Medical Diagnosis*, 3rd ed. (London: Churchill, 1873), pp. 2–3. There was no change in the ninth edition in 1903 (written with W. Soltau Fenwick); the first edition had been published in 1869. “This book, in editions brought out over a period of some thirty years, became the vade-mecum for successive generations of students during their introduction to clinical medicine. At a time when physical methods of diagnosis were proving so rewarding he warned against the danger of underestimating the patient’s symptoms” (D. D. Gibbs, “Samuel Fenwick, M.D., F.R.C.P. (1821–1902): Physician and Gastroenterologist,” *Brit. Med. J.*, 1970, 3: 339–42, on p. 340).

This passage illustrates the core message that was to be repeated in one form or another over the second half of the nineteenth century: history was important despite the availability of physical examination, but skill was required in order to obtain it accurately.

Within the patient narrative there were “facts” to be discovered, which would be revealed only if the physician took control of the history; therefore, for physicians, the taking of a patient history could not be a passive experience. This dynamic nature of the clinical encounter was brought out in Thomas Laycock’s 1856 lectures. Laycock was appointed professor of medicine in Edinburgh in 1855, and for him a patient’s gratification in being allowed to tell his or her story provided the attentive physician an opportunity both to establish facts and to observe the patient:

Patients in general, if mentally competent, have a great anxiety to detail their ailments from the beginning. All you need do is to listen attentively to the story, only asking a question now and then, when the statement is doubtful or imperfect, or required to clear up a deduction already made. . . . These questions should be as few as possible, and therefore pointedly direct. Nothing gratifies patients so much as attentive listening; if they become wearisome and prolix, they can readily be stopped by asking them to shew the tongue; this step being followed by appropriate questions. While the patient is speaking, you need not be idle. You can now study more minutely and carefully the various external characteristics.¹⁶

In this description the physician is placed in paternalistic command, like a tolerant parent who sat back, observing the patient and tricking him, as one would with a child, by asking him to put out his tongue for inspection.

Patients and physicians were coming to the clinical encounter with different expectations and needs. Such a dynamic made it a struggle for the doctor to gain access to important clinical information. The important emphasis was on the physician’s experience, skill, and knowledge to unravel the patient history. To get the full sense and flavor of the approach advocated, it is useful to quote at length a passage from the 1883 student text written by the Scottish physician and president of the Royal Medical Society of Edinburgh, J. Graham Brown:

The more serious symptoms are often lightly touched upon, the more trivial exaggerated, and the whole jumbled together without logical sequence or the slightest attempt at orderly arrangement. This story, trying as it is to the physician, and all the more trying the more his own mind is duly trained, he ought to

16. Thomas Laycock, *Lectures on the Principles and Methods of Medical Observation and Research* (Edinburgh: Black, 1856), pp. 81–82. The first lecture emphasized the “professional skill and tact” necessary for bedside clinical medicine.

listen to; for this the patient expects, and perhaps has a right to expect. During the tedious narration it may give him patience to bear in mind two considerations: first, that from it he must obtain the right end of the clue which is to guide him in the difficult task of ascertaining the nature, extent, and seat of the disease; and second, that by this often most prolix narrative, taken along with his attitude, manner, and expression, the patient, absorbed in his own sufferings, is giving his physician, if he is careful and observant, the best opportunity of becoming acquainted with the *ego* with whom he has to deal.¹⁷

Technique and patience were the paths to understanding the facts of the disease. The physician had to observe the patient and be “a student of human nature, and [be] able to arrive almost intuitively at some knowledge of the mental characteristics and peculiarities of his patient. . . . [He] must unravel for himself this tangled web.”¹⁸

The noted English physician Sir Robert Hutchison summarized this view of the history-taking process in his 1898 *Clinical Methods*. Hutchison was a physician at the London Hospital, and his book was the standard text for junior doctors who were studying for the physician specialist examination.¹⁹ There was no doubt as to the “value of accurate and systematic case-taking,”²⁰ the purpose of which was quite straightforward: “The object of the interrogation of the patient is to elicit information regarding his present illness and the state of his previous health and that of his family.”²¹ It was important to be patient, and “two good rules should be remembered, first to avoid leading questions; and, secondly, never to ask the same question twice,” because the taking of the history was an opportunity for the patient to judge the physician: “It is important to avoid asking the same question twice, because to do so looks careless, and conveys to the patient the impression of taking but a languid interest in his case.”²²

17. J. Graham Brown, *Medical Diagnosis: A Manual of Clinical Methods*, 2nd ed. (Edinburgh: Bell and Bradfute, 1883), p. 1 (italics in original). The book had reached five editions by 1906.

18. *Ibid.*, p. 2.

19. “[Hutchison’s] famous *Clinical Methods* reached the 15th edition in 1968 and is still known as the bible of the Membership examination” (Donald Hunter, “Centenary of the Birth of Robert Hutchison,” *Brit. Med. J.*, 1971, 4: 222–23, on p. 223); “On one occasion returning from a holiday he spoke a few words to the patient and turning to his students said: ‘Gentlemen, in considering the patient’s history you must always sort the wheat from the chaff’” (*ibid.*).

20. Robert Hutchison and Harry Rainy, *Clinical Methods* (London: Cassell, 1898), p. 1.

21. *Ibid.*, p. 2.

22. *Ibid.*, pp. 2–3. This customer focus was emphasized in the 1902 second edition, with a footnote added on p. 3: “It is a mistake to ask ‘What is the matter?’ as this lays one open to the retort that that is what the patient came to find out” (Robert Hutchison and Harry Rainy, *Clinical Methods*, 2nd ed. [London: Cassell, 1902]).

It is of interest to note the changes in this section over multiple editions. There was no change in the tenth edition of 1935, but in the twelfth edition of 1949 there was an extended description of different patient histories and the importance of physician experience and technique, including a sensitivity to the patient's feelings. Such sensitivity was to aid the effectiveness of history-taking: "To sort out what is relevant in a history and to do it well is an art which comes only by experience. . . . The experienced doctor shows great skill in the choice and wording of his leading questions."²³ The 1968 fifteenth edition further emphasized patient needs by claiming that eliciting an accurate history required an understanding of patient behavior and expectations.²⁴

1900–1950

The emphasis by 1900 was thus on the need for the physician's expertise, technique, and patience in the face of the flawed patient history. Over the next fifty years such putative medical skill came to include the need to understand patient character and behavior. Understanding patients when their history was so faulty was not easy, and was best reconfigured by using the giving of a history by a patient as an opportunity for another set of observations by the physician. This produced two histories: the patient story, and the physician history—derived both from a teasing out of "facts" and from examination of the history telling.

For the New York physician Glentworth Butler writing in 1903 in his textbook for students and practitioners, medical history was "more or less necessary, in some [cases] absolutely essential. . . . It is in obtaining a history that the largest draughts are made upon the tact and experience of the physician."²⁵ Patients were difficult people: they could be too talkative, or not talkative enough; they could suffer from "dense ignorance," or "false modesty or shame"; there could be "exaggeration of symptoms,"

23. Robert Hutchison and Donald Hunter, *Clinical Methods*, 12th ed. (London: Cassell, 1949), pp. 2–3.

24. "Some seem quite unable to give any precise account of what they feel . . . due to stupidity or to the effects of disease on their mental faculties. Some, however, fail to understand the need for accurate information, and feel that if only they can impress the doctor with the urgency of their distress (which in such cases often turns out to be emotional in nature) he will be able as if by magic to relieve them of it. It is important to recognize the reason for the evasiveness of such patients and not to allow oneself to become annoyed with them" (Donald Hunter and R. R. Bomford, *Hutchison's Clinical Methods*, 15th ed. [London: Baillière, Tindall & Cassell, 1968], pp. 1–2).

25. Glentworth Butler, *The Diagnostics of Internal Medicine* (New York: Appleton, 1903), p. 22. This text reached three editions by 1909, and a fourth in 1922.

or “a stoic pride in making light of pain.”²⁶ “Leading questions are to be avoided, especially with impossible or ignorant patients.”²⁷ In the view of authors such as the London physician Thomas Savill in 1903, such difficulties should be used to gain a general understanding of the patient’s behavior and nature, so that “just as the value and significance of physical signs depend on the skill and experience of the physician who observes them, so the significance of subjective symptoms has to be weighed and considered in relation to the character and constitution of the patient who complains of them.”²⁸

The patient history had to be judged, therefore, in the context of the patient’s character. There were such things as “true facts,” but patients could be relied on only for feelings and not for ideas. The physician must use techniques, usually forensic and legal, to get the “true facts” from an unreliable witness. There were three general rules:

(1) *Avoid putting what barristers call “leading questions,”* i.e., questions which suggest their own answer. (2) *A chronological order.* (3) Always adopt a kindly and *sympathetic manner.* . . . Time, patience, and tact are necessary to elicit the true facts of the case without irrelevant detail. Our object is to learn what the patient *feels* and knows, not what he *thinks* of his disease. . . . Much will depend on the tact of the physician.²⁹

This advice came from Savill’s 1903 text *A System of Clinical Medicine*, which was particularly praised for its grounding in practical bedside experience.³⁰ Students and practitioners seeking to understand the clinical

26. *Ibid.*, p 22.

27. *Ibid.*

28. Thomas Savill, *A System of Clinical Medicine* (London: Churchill, 1903), pp. 1–2. “Character” included gender overtones: “Thus a certain symptom may appear trivial and unimportant to a man of strong character not addicted to introspection, although serious disease may be present; whereas in a delicate woman with a susceptible nervous system every subjective symptom, however slight, may be to her a cause of great anxiety or exaggeration, and even real suffering. Sub-mammary pain, for instance, in the first might indicate aneurysm; in the second, hysteria” (*ibid.*, p. 2). There was no change in these passages over twelve editions (the twelfth, edited by E. C. Warner, appeared in 1944), except the changing of the word “man” to “patient.”

29. *Ibid.*, pp. 3–4 (italics in original).

30. Savill was a physician at the West-end Hospital for Diseases of the Nervous System and the St. John’s Hospital for Skin Diseases in London. His obituary mentioned “*a System of Clinical Medicine*, founded largely on his experiences while working at Paddington Infirmary. It has reached a second edition, and is markedly original both in arrangement and matter. It is entitled in any respects to be regarded as of much value . . . it is an attempt to write on disease from the standpoint from which it is considered at the bedside” (*Brit. Med. J.*, 1910, 1: 238).

encounter were introduced here to a distinction between the patient's story and the physician's history. The patient's story was affected by character, wrong ideas, reliance on other doctors, and irrelevant detail, and it often served to obstruct the physician's access to relevant facts. The physician's history, on the other hand, was about extracting the true facts by good history-taking technique, tact, and sympathy. Instruction on history-taking therefore conveyed a pejorative message for the student and practitioner about frightened, confused, and uninformed patients.

The American physician John Musser, professor of clinical medicine at the University of Pennsylvania 1898–1912, agreed with Savill that one way of dealing with the difficulties of the patient history was to use the time to make important observations of the patient: “While much time is lost in listening to a prolix account of sufferings, the student will do well at first to bear with the patient, for it gives him the opportunity to study character, observe the patient's mental and emotional characteristics, and expression of the countenance.”³¹ Taking the history was about the physician's objective examination of the patient without the patient's knowing that the examination was taking place. The patient was to be watched and observed for clinical information, and so the data revealed by history-taking were now included as clinical signs, rather than the symptoms that the patient thought were being carefully listened to. The history itself had to be judged for reliability and credibility, while the perceived character of the patient would affect the physician's interpretation of that history: “The subjective symptoms . . . can be simulated and are therefore sometimes fallacious.”³² The patient was a witness to his own disease and as such his reliability must be assessed and judged. The physician needed to be both detective and judge and to use his knowledge of human nature to come to a verdict:

Notwithstanding the fallacy of subjective symptoms in that they may be feigned or mimicked, they are valuable evidences in the hands of the scientific inquirer. If the patient is a good witness, their value is much enhanced. He must be intelligent and truthful. His testimony is of value if he can array in logical order the sequence of symptomatic events which culminated in the condition for which he seeks relief. If he can clearly narrate the events in his past life, or in the lives of his ancestors, that appertain to physiological aberrations, his story is an aid to the searcher for truth.³³

31. John Musser, *A Practical Treatise on Medical Diagnosis*, 5th ed. (Philadelphia: Lea, 1904), pp. 51–52.

32. *Ibid.*, p. 55.

33. *Ibid.*, pp. 56–57.

In this search for truth, the taking of a history was not just a simple clinical encounter about a simple illness event; rather, it was about patient and physician character. The value of the patient history could be brought to fruition only by the physician's expertise, which included the physician's guarding against his own "personal bias."³⁴ The process was essentially about obtaining "a true account of the patient's sufferings" rather than "a correct history of his disease," and "adroitness, combined with tact and good judgement" were the essential techniques in securing this.³⁵ For John Musser, therefore, the taking of the history was ultimately actually a test of the character of the physician, the "searcher for truth," "capable of discerning the truth and discarding the false."³⁶

The experience, expertise, and sophistication of technique required of physicians were emphasized by other writers of the time. The Swiss physician Herman Sahli, for example, felt that "before attempting any objective examination, merely by skilfully directing his questions, in this way can an experienced physician obtain a fair idea of the disease. . . . There are even cases in which the history affords the only clue to diagnosis. A ripe experience is requisite in order properly to utilize the history in making a diagnosis."³⁷ The patient's story was of value only in the hands of an experienced, expert physician who could analyze it in much the same way as he did the objective signs of physical examination. Patients were not "mentally constituted as to communicate to the physician simply and directly the medically important facts of their ailment. . . . Most patients relate a mass of unimportant matter and say nothing about the essentials"—so the patient history could be rescued only by "skilfully planned questions . . . [to] prevent the patient or his relatives from irrelevancy."³⁸ At the same time, the patient should not be allowed to realize that the physician did not value his narrative: "A patient should never feel that he is being guided, nor that his physician does not enter with interest and sympathy into all the minute details of his trouble."³⁹ Physicians had to

34. *Ibid.*, p. 57.

35. *Ibid.*

36. *Ibid.*, p. 56. It is of interest that in 1911 Musser refused the "didactic chair of medicine as his greatest ambition ever lay in clinical lines, and a large consulting practice left no time for the pressing duties of the chair" (Howard Kelly and Walter Burrage, *Dictionary of American Medical Biography* [Boston: Milford House, 1928], p. 894).

37. Herman Sahli, *A Treatise on Diagnostic Methods of Examination*, 4th ed. (Philadelphia: Saunders, 1905), pp. 17–18. Sahli was well known for a number of inventions measuring blood flow and pressure.

38. *Ibid.*, p. 18.

39. *Ibid.*

be careful to show appreciation for what the patient perceived as his own needs, and indeed such appreciation could also help reveal other useful information. The patient history, however, often needed translation, especially when the patient used medical terms:

The patient's statement that he has had a chill is not sufficient; we must inquire more particularly as to the nature of the chill. Often enough patients betray their mistake by using the word chill in the plural. Similar errors may arise from the statements patients make in regard to many other symptoms or long-standing diseases. The names they give to their former illnesses are especially apt to be incorrect and often occasion serious errors, for many are diagnoses made by the laity and many others are incorrect.⁴⁰

Students and practitioners reading or listening to such ideas about history-taking were given a strongly ambivalent message about patients. They were warned that they might be confronted with "stupid and prattling patients," but that this experience was not to be dismissed, since "even this is a relative gain, for at least we discover how little we can trust them, and draw no false conclusions."⁴¹ On the other hand, the student or physician had to remain aware that these same patients were his public, the source of his custom, and that the taking of a history was essentially the physician's shop-front:

In general, good history-taking requires much diplomacy, tact and knowledge of people and of medicine. A physician should never allow a patient to feel that he is in a hurry. The public considers that the physician has time for everything and everybody. Sit quietly, even if you are sitting upon hot coals; and wait for a favorable moment to interrupt, in a diplomatic way, the flow of talk.⁴²

Such an ambivalent message could be reconfigured by identifying different elements in the patient history. Lewellys Barker, professor at Johns Hopkins Hospital in 1916, divided the history into important feelings and useless ideas and opinions:

In recording these, it is important to distinguish between the actual feelings and sensations of the patient, and the interpretation or explanations he gives of them. A layman's diagnosis, while often interesting, is not what is most helpful to the physician. When a patient is asked how he suffers, he replies most often with a "diagnosis" . . . While the physician will, for the moment, patiently listen to such a statement, he should at once ask the patient why he thinks he has the trouble he mentions, and will put down as the complaint of

40. *Ibid.*, p. 19.

41. *Ibid.*, p. 20.

42. *Ibid.*

the patient, not the latter's diagnosis, but (1) any objective changes the sick person has noted himself and (2) the subjective symptoms upon which the layman's diagnosis is based.⁴³

Barker was physician-in-chief at the Johns Hopkins Hospital in 1905–14 and succeeded William Osler as professor of medicine. As such he had a major influence in training future physicians, and was also instrumental in the organization of clinical research throughout American hospitals and in “creating the scientific base of modern medical practice.”⁴⁴ His conception of history-taking, as fundamentally about the physician's examination and observation rather than the patient's ideas, was completely consonant with his emphasis on the formal establishment of laboratories and clinical research.

Another way of making sense of the ambivalent message about patients and their history was to employ the legal analogy, as had Thomas Savill in 1903. Physicians were urged to adopt legal techniques with the patient, who was often a difficult witness to his own illness. Charles Greene, professor of medicine at the University of Minnesota in 1909–15, stressed, for example, that the physician essentially relied on “Hearsay Evidence”:

In the patient we may encounter garrulity, stupidity, concealment, deceit or hypochondriacal exaggeration. If he is comatose or possesses no common language, we are left dependent upon the testimony of outsiders. In any event we must exercise sound judgement, keen discrimination and facility in cross-examination or we cannot weigh properly the fallible, yet extremely valuable subjective data.⁴⁵

Such legal analogies, and the idea that the patient's story should be separated into useful feelings and useless opinions, were constructed because history appeared to be important to the clinical assessment despite major difficulties in the content and telling of that history. Writers therefore continued to emphasize that history was necessary but required special techniques. For the British authors Thomas Horder and A. E. Gow,

43. Lewellys Barker, *The Clinical Diagnosis of Internal Diseases* (New York: Appleton, 1916), p. 8.

44. Barker “took the important step of organizing research divisions within the Department to provide opportunities for investigation into the nature of various disease processes. . . . *the institution of laboratories for this specific purpose* started a movement which not only greatly influenced the character of university clinics but started a chain reaction in the evolution of clinical investigation that was to play a major role in creating the scientific base of modern medical practice” (italics in original) (A. McGehee Harvey, “Creators of Clinical Medicine's Scientific Base: Franklin Paine Mall, Lewellys Franklin Barker, and Rufus Cole,” *Johns Hopkins Med. J.*, 1975, 136: 168–77, on p. 169).

45. Charles Greene, *Medical Diagnosis* (Philadelphia: Blakiston, 1917), p. 11.

writing in 1928, history was “all important” and “[took] the observer a long way towards a correct diagnosis.”⁴⁶ There were rules for the taking of a successful history: do not accept a patient’s self-diagnosis or terminology, or “alleged diagnosis of a previous disease.”⁴⁷ Similarly, the American physicians Richard Cabot (famous for introducing the regular patient case series in the *New England Journal of Medicine*) and F. Adams wrote in 1938: “The history is the key to diagnosis. . . . *More errors in diagnosis are traceable to lack of acumen in eliciting or interpreting symptoms than have ever been caused by a failure to hear a murmur, feel a mass, or take an electrocardiogram.*”⁴⁸ The secrets to the obtaining of a satisfactory history were

tact and diplomacy, a manner which conveys understanding and sympathy, the ability to quickly appraise personality, and adopt the approach which will put the patient at ease. If these qualities are lacking or there is any show of haste, intolerance, or irritability, the patient will be so frightened or antagonistic that his statements may be hurried, confused, or inexact.⁴⁹

There were guides for different approaches to “the timid or inarticulate individual,” “the garrulous patient,” and “the evasive or not wholly dependable patient”; “laymen” terms were inexact and had to be questioned, and “careful judgement must be used in evaluating statements which are the patient’s own deductions or interpretations.”⁵⁰ Leading questions had to be avoided.

1940–2000

These themes of the importance of the history, the difficulties it presented, the skills required of the physician, and the need to put the patient at ease continued to recur over the latter half of the twentieth century. On the importance of the history, for example, the American physician Cyril MacBryde of the Washington School of Medicine wrote in 1944:

46. Thomas Horder and A. E. Gow, *The Essentials of Medical Diagnosis* (London: Cassell, 1928), p. 1. Both men were physicians at St. Bartholomew’s Hospital, London, and had numerous royal appointments; Sir Thomas Horder was president of the Medical Society of London.

47. *Ibid.*, p. 5.

48. Richard Cabot and F. Adams, *Physical Diagnosis* (London: Baillière, Tindall & Cox, 1938), p. 2 (italics in original).

49. *Ibid.*, p. 4.

50. *Ibid.* See Andrew T. Dodds, “Richard Cabot: Medical Reformer During the Progressive Era (1890–1920),” *Ann. Internal Med.*, 1993, 119: 417–22; Christopher Crenner, “Diagnosis and Authority in the Early Twentieth-Century Medical Practice of Richard C. Cabot,” *Bull. Hist. Med.*, 2002, 76: 30–55.

It is widely recognized by experienced clinicians that a skilfully taken history, with a careful analysis of the chief complaints and of the course of the illness, will more frequently than not indicate the probable diagnosis, even before a physical diagnosis is done or any laboratory tests are performed. A master diagnostician I know says: "Let me take the history, and I will accept any good interne's word on the physical findings." In other words, even today the accomplished physician learns more in the majority of cases from what his patient says and the way he says it, than he can learn from any other avenue of inquiry.⁵¹

On the same theme, the Australian E. H. Stokes wrote in 1953:

Without any doubt the history is the most important single factor in arriving at a diagnosis. . . . errors most frequently arise in internal medicine because the clinician does not know what questions should be asked. The art of history-taking requires knowledge of disease and long experience of sick people, and can be acquired only by hard work.⁵²

The "art of history-taking" was pivotal because of its role in the initiation of the clinical encounter. The physician required both diagnostic and social skills to make the patient feel comfortable in these early stages of their meeting. As the American physician Roscoe Pullen of Tulane University wrote in his 1944 textbook, "Bearing in mind that the symptoms of disease are the chief factors prompting an individual to seek professional advice, the student and clinician alike will appreciate that elicitation and interpretation of the patient's complaints are of paramount importance."⁵³ For Pullen, history-taking was indeed an "art" that required an immense skill and a "profound understanding of human frailties."⁵⁴ This was the doctor as an exalted being—wise, intelligent, experienced, and talented, "privileged to observe his patient during the narration of the present illness and to evaluate the patient's emotional and mental constitution—a consideration of far reaching clinical significance—as well as the physical status."⁵⁵ Similarly for E. H. Stokes, although there was to be seen in patients a great "variation in descriptive powers," the physician could observe the way in which the history was told in order to conclude "what manner of man the patient is."⁵⁶

51. Cyril MacBryde, ed., *The Analysis and Interpretation of Symptoms* (Philadelphia: Lippincott, 1944), pp. 1–2.

52. E. H. Stokes, *Clinical Investigation* (Sydney: Angus and Robertson, 1953), p. 7.

53. Roscoe Pullen, ed., *Medical Diagnosis* (Philadelphia: Saunders, 1944), p. 1. Pullen published widely in the 1950s on the subject of medical education.

54. *Ibid.*, p. 2.

55. *Ibid.*

56. Stokes, *Clinical Investigation* (n. 52), p. 3.

The physician's quest to understand the patient was intimately tied to the importance of developing a relationship with the patient for their mutual benefit, but skill was necessary to guide the patient to this relationship. As a widely used 1992 Australian textbook outlined:

History taking requires a lot of practice and depends very much on the doctor/patient relationship. . . . unless a rapport is established between these two people the history taking is likely to be unrewarding. There is no doubt that one's treatment of a patient begins the moment one reaches the bedside. The patient's first impressions of a doctor's professional manner will have a lasting effect.⁵⁷

In these descriptions there were still the images of patients emphasizing "irrelevant facts" and physicians needing to "keep a garrulous patient on the track," but the emphasis was now on sympathy and understanding and the techniques used to achieve "rapport": "Introduce yourself to the patient and shake his or her hand. It is important to establish rapport."⁵⁸ Such techniques were aimed just as much at achieving a satisfied customer as achieving a complete history. The physician had to comprehend the patient's viewpoint: "Not uncommonly, a patient has many complaints. An attempt must be made to decide which led the patient to present. It must be remembered that the patient's and the doctor's idea of what constitutes a serious complaint may differ."⁵⁹

That such themes in instructions in history-taking were representative of standard ideas imparted to students and colleagues in the latter half of the twentieth century is confirmed by tracing them through editions of the standard American student text, *Harrison's Principles of Internal Medicine*. In the 1958 third edition, all the elements previously highlighted are illustrated: the history may "hold the key to the solution of a medical problem," but "we are dealing with subjective manifestations filtered through the consciousness of individuals who vary in their capacity to observe and describe . . . whose accounts are coloured, consciously or unconsciously, by fears and misconceptions"; physicians can become impatient and

57. Nicholas Talley and Simon O'Connor, *Clinical Examination*, 2nd ed. (Sydney: MacLennan and Petty, 1992), p. 1.

58. *Ibid.*, pp. 2–3; the passage continues, "Asking the patient 'what brought you here today?' can be unwise as it often promoted the reply 'an ambulance' or 'a car'. This little joke wears thin after some years in clinical practice." The theme of the patient's attempt at a joke is especially constant: see Hutchison and Rainy, *Clinical Methods* (n. 20), p. 3. The observation that patients make jokes at the doctor's expense has implications both for the customer role of the patient and for the need for patients to have some input into the medical process.

59. Talley and O'Connor, *Clinical Examination* (n. 57), p. 3.

must steer between “credulity” and “rigid scepticism”; “skill, knowledge and experience” are needed by the physician; “an interested sympathetic interview constitutes the foundation for a successful patient-physician relationship.”⁶⁰ The eighth edition of 1977 repeated these sentiments, but added that taking the history could be used to observe the patient: “in listening to this recitation, one discovers not only something about the disease, but also something about the patient.”⁶¹ The 1998 fourteenth edition was unchanged but included a paragraph to the effect that an “effort should be made to place the patient at ease” and that the patient should “receive expressions of interest, encouragement and empathy from the physician.”⁶²



In summary, there appears to have been a remarkable constancy in approach to history-taking in nonpediatric medical texts from 1850. In all the texts quoted, spanning the years 1856 to 1998, the patient story was described as important, but at the same time flawed—full of exaggeration, verbosity, and irrelevancy. It could be tedious and rambling, and, from early in the twentieth century, there were frequent comments that patients tended to use medical terms incorrectly and to make their own incorrect diagnoses. Physicians and students were instructed to separate patients’ feelings and subjective sensations from patients’ erroneous ideas and opinions. The patient history was never to be valued for its intellectual content and, with its incorrect words and ideas, was to be distinguished from the ultimate physician history, which would be an organization of true facts. This true history had to be untangled and distilled by the physician in the history-taking process. History-taking was therefore a skill that required training, instruction, and expertise. With these skills, which some authors saw as possessed only by individuals with great talent and character, the physician could give the patient history a utility and value.

During the twentieth century, in addition to this general approach, three new elements of history-taking were increasingly emphasized, although they had been alluded to in previous years: (1) A recognition of patient need and expectation: since the clinical encounter was initiated

60. T. R. Harrison, R. D. Adams, I. L. Bennett, et al., eds., *Principles of Internal Medicine*, 3rd ed. (New York: McGraw-Hill, 1958), pp. 3–4.

61. George Thorn, Raymond Adams, Eugene Braunwald, et al., eds., *Harrison’s Principles of Internal Medicine*, 8th ed. (New York: McGraw-Hill, 1977), pp. 3–4.

62. Anthony Fauci, Eugene Braunwald, Kurt Isselbacher, et al., eds., *Harrison’s Principles of Internal Medicine*, 14th ed. (New York: McGraw-Hill, 1998), p. 2.

by the patient, the patient needed to gain some gratification and satisfaction from the process,⁶³ which would also make it easier for the physician to elicit information. Throughout this period, texts emphasized that physicians needed to demonstrate tact, patience, and diplomacy. Later in the century this came to mean that the history-taking process had a major function in establishing a future doctor-patient relationship, and as such it could have a therapeutic function. (2) A forensic approach using investigative and legal terminology was employed, so that the history was framed as evidence from a witness who might or might not be reliable, trustworthy, or intelligent. This way of interpreting the history appears to have been used less after about 1920, but traces remained in later years. (3) The way the patient *told* the history was to be observed, and used as data on the patient and his character, to be incorporated into the physical examination. Ultimately, therefore, all elements of the clinical assessment could come under a structure of medical expertise and organization.

The Pattern of History-Taking Instructions in Pediatric Texts

It is of interest to briefly see how stable this analysis is in the face of other types of clinical encounter. Pediatric practice, for example, provides a different angle from which to view history-taking because of two distinct features—namely, the absence of a direct patient history, and the consequent reliance on a history from a third party.⁶⁴ Although the approach taken to third-party parental history mirrored that described above in adult medical practice, of particular relevance here are the difficulties in the practice of pediatrics articulated by nineteenth- and early twentieth-century practitioners. It has been generally stated that prior to that time the medical profession resisted seeing and treating sick children, and this

63. This point was very clearly put by John Ryle, physician at Guy's Hospital in London, in an article in the *Lancet* in 1931: "In the earlier part of our clinical training it is usual to stress the importance of physical signs, and long hours are properly devoted to perfection in the arts of palpation, percussion, and auscultation. Nevertheless I am persuaded that with the growth of experience pride of place is often given to symptoms—that is to say, to the purely subjective phenomena of disease. Without symptoms patients would not come to us at all. . . . As the years go by, however, we begin to understand and be grateful for symptoms" (John Ryle, "The Study of Symptoms," *Lancet*, 1931, 1: 737–41, on p. 737).

64. I have written in depth about the role of parental history in the childhood medical encounter and its implications for the history of pediatrics in Gillis, "Taking a Medical History" (n. 6). I have used some of the same primary quotations here, but in order to draw out a different theme.

has been ascribed to the impossibility of taking a direct patient history.⁶⁵ As Michael Underwood explained in the preface to the fourth edition of his *Treatise on the Diseases of Children* of 1799:

A very principal cause of the above-mentioned neglect has arisen from an ancient idea, for a long time too generally entertained, that, as medical people can have but an imperfect knowledge of the complaints of infants, from the inability of children to give any account of them, it is safer to trust the management of them to old women and nurses.⁶⁶

Underwood himself compared the dilemma to having to treat adult “idiots and lunatics.”⁶⁷

The early medical response to this absence was the idea that the physician’s examination was the only real path to diagnosis in childhood disease. The lack of access to subjective symptoms meant that diagnosis had to be based, according to David Francis Condie in 1847, on “the attentive observation of the physician, compared with those of the parents or nurse”⁶⁸; for Job Smith in 1881, it “must evidently be made from the objective symptoms.”⁶⁹ Luther Emmett Holt’s influential 1897 textbook, *The Diseases of Infancy and Childhood*, made “objective signs” essential to pediatric practice: “What is really peculiar to children belongs especially to the first three years of life, before speech has developed. During this

65. George Armstrong wrote in 1771 that “I know there are some of the physical tribe who are not fond of practising among infants” because “they are not capable of telling their ailments; and therefore, say some, it is working in the dark” (G. Armstrong, *An Essay on the Diseases Most Fatal to Infants*, 2nd ed. (1771), pp. 4, 5, 7; quoted in Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine* (Cambridge: Cambridge University Press, 1994), p. 280. See also Thomas Cone, *History of American Pediatrics* (Boston: Little, Brown, 1979), p. 69; F. H. Garrison and A. F. Abt, *Abt-Garrison History of Pediatrics* (Philadelphia: Saunders, 1965), p. 1.

66. Michael Underwood, *A Treatise on the Diseases of Children*, 4th ed. (London: Mathews, 1799), p. xi.

67. *Ibid.*, p. xii. Underwood, an English physician, has been called “the last ‘man mid-wife’” (Garrison-Abt, *History* [n. 65], p. 78).

68. D. Condie, *A Practical Treatise on the Diseases of Children*, 2nd ed. (Philadelphia: Lea and Blanchard, 1847), p. 107. This text went through six editions between 1844 and 1868: “It was the most widely accepted textbook on children’s diseases in the United States until it was superseded by Job Lewis Smith’s in 1869 and Meigs’ and Pepper’s in 1870” (Cone, *History* [n. 65], p. 81).

69. Job Smith, *Treatise on the Diseases of Infancy and Childhood*, 5th ed. (Philadelphia: Lea, 1881), p. 89. This textbook “passed through eight editions (1869–96), was translated into Spanish, and is still esteemed as a solid, reliable work” (Garrison and Abt, *History* [n. 65], p. 105).

period the chief and almost the sole reliance of the physician must be upon the objective signs of the disease."⁷⁰

The answer for the average doctor was to make an effort to improve his skill in physical examination. Accordingly, in an article on "Essentials in Pediatric Diagnosis" in *Minnesota Medicine* in 1918, a Dr. Goldie Zimmerman wrote:

The average doctor in general practice pays little attention to pediatrics. He says it takes too much time; and then, too, the infants and young patients cannot explain their symptoms. So much the better, for it is not from subjective symptoms alone that we are ever to make a diagnosis. In working with children we find that our patients have no imagination. We learn more from the objective symptoms than the subjective.⁷¹

Another author, writing in the same year, agreed that "we must arrive at our diagnosis almost entirely by such observation and routine physical examination in each case."⁷² Thus physical examination by the physician was identified as the essential element in the pediatric clinical encounter.⁷³

The idea that physical examination was the only real path to diagnosis in childhood disease was a response to the absence of direct first-person history. This sole reliance on physical signs was quite different from most adult practice where a history could be taken from the patient. In their analysis of the physical signs, however, writers frequently revealed a need for the presence of that first-person history. The general clinical medical paradigm required it, and, as if to fit pediatric practice into this paradigm, physicians began to write about identifying a language and voice in the actual physical signs.⁷⁴

70. Luther Emmett Holt, *The Diseases of Infancy and Childhood* (New York: Appleton, 1897), pp. 31–32. This standard text passed through nine editions by 1926. Holt had major influence on the early definition of pediatric practice. See Jonathan Gillis, "Bad Habits and Pernicious Results: Thumb Sucking and the Discipline of Late-Nineteenth-Century Paediatrics," *Med. Hist.*, 1996, 40: 55–73; B. S. Veeder, *Pediatric Profiles* (St. Louis: Mosby, 1957), pp. 33–60.

71. Goldie Zimmerman, "Essentials in Pediatric Diagnosis," *Minnesota Med.*, 1918, 1: 298–302, on p. 298.

72. C. K. Johnson, "Symptomatology in the Child," *Vermont Med.*, 1918, 3: 83–86, on p. 83.

73. This was reinforced by analogy to veterinary practice. See, e.g., James Goodhart, *Diseases of Children* (London: Churchill, 1885), p. 2: "Yet there is not so very much difference between the student who has to investigate the diseases of children, and one who has to deal with those of the lower animals. In both cases the diagnosis will chiefly rest upon the doctor's personal observation and examination; in both it is intelligible speech that is wanting." Goodhart was physician to the Evelina Hospital for Children in London from 1875 to 1889.

74. "His physical signs and symptoms are true and dependable. . . . To the experienced physician it largely replaces, even reconstructs, the history. The nature of the cry of an infant,

There was, however, a growing acknowledgment that some history from a third party was necessary and valuable, if only because the parent, usually the mother, had access to observations not available to the physician. Progressive editions of Luther Emmett Holt's *Diseases of Infancy and Childhood*, for example, gradually bring the history into more prominence in the clinical assessment. The first edition of 1897 summarized the relative values of physical examination and parental history:

the chief and almost the sole reliance of the physician must be upon the objective signs of the disease. . . . In the examination of a sick infant quite a different method is to be followed from that pursued in adults. Much information is to be gained from a history carefully taken from an intelligent mother or nurse, and much more from a close observation of the child, whether asleep or awake, quiet or screaming. . . . never trust to the statements of the mother or nurse with regard to the character of the faecal discharges or the urine.⁷⁵

The third edition of 1907 gave more details about the history:

The history.—In view of the fact that but little information can be had from the patient, none at all in most cases, it is important to obtain from the mother or nurse as full and complete information as possible. A good history carefully obtained from an intelligent mother or nurse, puts the physician in possession of a fund of information about the patient which is of the greatest value, not only in arriving at a diagnosis in the illness for which he is consulted, but is exceedingly helpful in the future management of the child. He may thus know the individual peculiarities and special pathological tendencies. The laity attach great importance, and justly so, to advice from the physician who “knows the child’s constitution.”⁷⁶

Although the parental history came to be interrogated in similar ways to the history given by adult patients, the early differences in the development of the pediatric clinical assessment indicate a difference from the usually described evolution of an encounter that relied on the patient history to one in which physical examination became emphasized. The salient feature here is the recognition that in pediatric practice there was never a subjective patient narrative available to the physician. Instead,

the wince that establishes tenderness or a fleeting pain, the posture, the stare, the expression of the face, the wrinkled forehead, the presence or absence of the smile in the infant, the purple gums of scurvy, all tell a true story, often far more instructive than the story of the mother” (Joseph Brennemann, “Examination of the Child,” in *Brennemann’s Practice of Pediatrics*, ed. Irvine McQuarrie [Hagerstown: Prior, 1947], pp. 1–3).

75. Holt, *Diseases of Infancy and Childhood* (n. 70), pp. 31–32.

76. Luther Emmett Holt, *The Diseases of Infancy and Childhood*, 3rd ed. (New York: Appleton, 1907), p. 32.

the physician's physical examination and observation was the original and primary method of assessment, coming before the incorporation of history, albeit a third-party parental history.

Conclusion

There are two major conclusions to be drawn from the analysis presented here:

First, the clinical encounter is a space where patients and doctors have always met and interacted, and historically doctors have often written down their views on such encounters. Physicians' instructions to their colleagues and students on how to conduct the clinical encounter, although without revealing what actually happened, can give a significant insight into what they thought *should* happen, and into their vision for the daily practice of medicine.

Second, the patient history continued to be important to the clinician throughout the nineteenth and twentieth centuries. That patient history, however, was never simply equivalent to the patient's story, and was always subject to the physician's skepticism, interpretation, and skill. In pediatric texts the absence of direct patient narrative led, at first, to nonengagement with sick children, and then to an emphasis on physical signs as observed by the physician: there was a reversal of the path from patient history to physical examination, with examination preceding history in the evolution of the clinical encounter. In both adult and pediatric practice, the patient history came to be more or less identified as another set of observations and signs to be elicited by the physician, which were then to be filtered and reconstructed by the physician and incorporated into the overall "objective" medical examination.

There are thus two patient histories: a superficial, overt, story presented by the patient or parent, and a deep, covert, and "true" history revealed by the technique and artistry of the physician. The patient history has therefore been consistently a construct and production of the clinical encounter, rather than a simple expression of the patient's narrative.



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