SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

Date: 08/12/2017

From
Dr. Aravind. C
Professor and Head,
Department of General Medicine
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research
Chennai

To
The Dean,
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research
Chennai

Sub: Permission to conduct value-added course; Importance of history taking in diagnosis

Respected Madam,

With reference to the subject mentioned above, the department proposes to conduct a value added course titled: "Importance of history taking in diagnosis" on 05/01/2018. We solicit your kind permission for the same.

Kind Regards

Dr. Aravind. C.

FOR THE USE OF DEAN'S OFFICE

Names of Committee members for evaluating the course:

The Dean, Dr. JayaLakshmi

The HOD: Dr. Aravind. C

The Expert: Dr. Chellapandian

The committee has discussed about the course and is approved.

Dean | Subject Expert | HOD

OFFICE OF THE DEAN

Sri Lakshmi Narayana Institute of Medical Sciences

OSUDU, AGARAM VILLAGE, VILLIANUR COMMUNE, KUDAPAIKKAM POST,
PUDUCHERRY - 605 502.
[Recognised by Medical Council of India, Ministry of Health letter No. U-12012/248/2005-ME (P-II) dt. 11/07/2011]
[Affiliated to Bharath University, Chennai - TN]

Circular

13/12/2017

Sub: Organising Value-added Course IMPORTANCE OF HISTORY TAKING IN DIAGNOSIS reg

With reference to the above mentioned subject, it is to bring to your notice that Sri Lakshmi Narayana Institute of Medical Sciences, **Bharath Institute of Higher Education and Research**, is organising a Value added course, titled, "Importance of history taking in diagnosis" between January 2018 and April 2018. The course content is enclosed below.

The hard copy of the application should be sent to the institution by registered/ speed post only so as to reach on or before 02/01/2018. Applications received after the mentioned date shall not be entertained under any circumstances.

Dean

Encl: Copy of Course content

COURSE PROPOSAL

Course Title: Importance of history taking in diagnosis

Course Objective: To create an awareness among students of the 2nd year M.B.B.S about the importance of history taking in diagnosis

Course Outcome: The Students acquired knowledge on the importance of history taking in clinical diagnosis

Course Audience: A batch of 15 students belonging to the 2nd year of M.B.B.S

Course Coordinator: Dr. Aravind. C

Course Faculties with Qualification and Designation:

1. Dr. Chellapandian

   Professor

   Department of General Medicine

   SLIMS

2. Dr. Muthukumarasamy. B

   Professor

   Department of General Medicine

   SLIMS

Course Curriculum/Topics with schedule

Sl No	Date	Topic	Time	Hours	Name of the faculty
1.	05/01/2018	What is history taking?	5 pm to 8 pm	3 hours	Dr. Chellapandian
2.	12/01/2018	The age old tradition of collecting ailment related information	4: 20 pm to 6: 30 pm	2 hours	Dr. Chellapandian
3.	19/01/2018	Winning trust and building rapport	5 pm to 8 pm	3 hours	Dr. Muthukumarasamy. B
4	26/01/2018	How history taking aids in diagnosis the most	5 pm to 7 pm	2 hours	Dr. Muthukumarasamy. B
5	09/02/2018	The current investigation oriented medical practice – A boon or a bane?	5 pm to 7 pm	2 hours	Dr. Chellapandian
6.	16/02/2018	How to gather	4: 30 pm to 6: 30	2 hours	Dr. Chellapandian

		certain personal history	pm		
7.	23/02/2018	Converting the patient's symptoms to analog at a diagnosis	5 pm to 7 pm	2 hours	Dr. Chellapandian
8.	02/03/2018	How to approach an anxious, apprehensive patient	5 pm to 7 pm	2 hours	Dr. Muthukumarasamy. B
9.	16/03/2018	How to disintegrate a convoluted history	4 pm to 6 pm	2 hours	Dr. Muthukumarasamy. B
10.	23/03/2018	The ever-changing diagnostic tools	4 pm to 7 pm	3 hours	Dr. Chellapandian
11.	30/03/2018	How the new diagnostic tools assist history taking	4 pm to 6 pm	2 hours	Dr. Aravind. C
12.	06/04/2018	Informing the probable diagnosis to an anxious patient	4 pm to 7 pm	3 hours	Dr. Chellapandian
13.	13/04/2018	SUMMARY – History taking the lost art!	4 pm to 6 pm	2 hours	Dr. Aravind. C
			Total Hours	30	

REFERENCE BOOKS:

1. **HARRISON'S PRINCIPLES OF INTERNAL MEDICINE: 18TH EDITION**
2. **HUTCHINSON'S CLINICAL METHODS**

VALUE ADDED COURSE

1. Name of the programme and code

   Importance of history taking in diagnosis: IM08

2. Duration & period

   30 hrs. between January 2018 – April 2018

3. Information Brochure and course content of value-added courses

   Enclosed as Annexure – I

4. List of students enrolled

   Enclosed as Annexure – II

5. Assessment procedures:

   Short notes – Enclosed as Annexure – III

6. Certificate model

   Enclosed as Annexure – IV

7. No. of times offered during the same year

   1: January 2018 – April 2018

8. Year of dissemination

   2018

9. Summary report of each program year wise:

VALUE ADDED COURSE: January 2018 – April 2018

Sl. No.	Course code	Course name	Resource persons	Target Students	Strength and year
1	IM08	Importance of history taking in diagnosis	Dr. Chellapandian Dr. Muthukumarasamy. R	2nd year MBBS	15 (January 2018 - April 2018)

10. Course feedback

    Enclosed as Annexure V

RESOURCE PERSON – Dr. Chellapandian

COORDINATOR – Dr. Aravind. C

ANNEXURE - I

PARTICIPANT HANDBOOK

IMPORTANCE OF HISTORY TAKING IN CLINICAL DIAGNOSIS

HISTORY TAKING – THE LOST ART!!!

COURSE DETAILS

PARTICULARS	DESCRIPTION
Course title	IMPORTANCE OF HISTORY TAKING IN DIAGNOSIS
Course code	IM08
Objective	1. What is history taking? 2. The age old tradition of collecting ailment related information 3. Winning trust and building rapport 4. How history taking aids in diagnosis the most 5 The current investigation oriented medical practice – A boon or a bane? 6. How to gather certain personal history 7. Converting the patient's symptoms to arriving at a diagnosis 8. How to approach an anxious, apprehensive patient 9. How to disintegrate a convoluted history 10. The ever-changing diagnostic tools 11. How the new diagnostic tools assist history taking 12. Informing the probable diagnosis to an anxious patient 13. SUMMARY – History taking the lost art!
Key competencies	On successful completion of the course, the students will have a better knowledge about the importance of history taking in arriving at a clinical diagnosis
Target students	Second year MBBS
Duration	30 hours; between January 2018 and April 2018
Assessment procedure	Short notes

IMPORTANCE OF HISTORY TAKING IN DIAGNOSIS

"With the rapid extension of laboratory tests of greater accuracy, there is a tendency for some clinicians and hence for some students in reaching a diagnosis to rely more on laboratory reports and less on the history of the illness, the examination and behavior of the patient, and clinical judgment. While in many cases laboratory findings are invaluable for reaching correct conclusions, the student should never be allowed to forget that it takes a man, not a machine, to understand a man."

The important contribution of the history and physical in making a correct medical diagnosis has been known for centuries. Rufus of Ephesus in approximately 100 AD wrote, "It is important to ask questions of patients because with the help of these questions one will know more exactly some of the things that concern the disease and one will treat the disease better." Although the history and physical continues to be the most important tool that enables the competent physician to make a correct diagnosis, these skills are being undermined by technology that many physicians mistakenly believe to be the new gold standard

In 1938, William Mayo said, "Sometimes I wonder whether today we take sufficient care to make a thorough physical examination before our patient starts off on a round of laboratories, which have become so necessary that oftentimes we do not fully appreciate the value of our five senses in estimating the condition of the patient." In most medical schools, students are taught the art of physical diagnosis early in their preclinical years without a thorough understanding of their application to clinical medicine. These students are then placed under the tutelage of residents and junior attendings who often are not skilled practitioners of the art of physical diagnosis and who, themselves, rely heavily on technology to make a diagnosis. Morning report, which is a prime educational venue for physicians-in-training, has become a contest to see which resident can develop the longest list of differential diagnoses instead of the single most likely diagnosis.

This often leads to "shotgun" testing to rule out or in all possibilities. It is, therefore, no wonder that the cost of medical care is skyrocketing as every patient is scanned and tested to absurdity.

HISTORY TAKING – THE LOST ART

In 1946, Allen in his monograph, Medical Education and the Changing Order, wrote: "With the rapid extension of laboratory tests of greater accuracy, there is a tendency for some clinicians and hence for some students in reaching a diagnosis to rely more on laboratory reports and less on the history of the illness, the examination and behavior of the patient and clinical judgment. While in many cases laboratory findings are invaluable for reaching correct conclusions, the student should never be allowed to forget that it takes a man, not a machine, to understand a man." Although it is often said that much of the reliance on

testing results from the fear of malpractice, there is no evidence that excess testing diminishes the number of diagnostic errors. The major problem seems to be that the science of medicine is replacing the art of medicine. Preclinical students are usually taught the physical examination in a lecture hall. They practice on each other and mostly find a normal examination. Even when they are taken to the bedside, the teaching of clinical skills is often done by trainees or junior faculty, who themselves do not possess the necessary expertise. The students are then tested with an objective structured clinical examination during which they go through the motions of demonstrating an examination that has little content. During the 3rd and 4th years, medical students rotate on the wards where their clinical skills are supposed to be reinforced by their residents. The most common notation that we find documented in the cardiovascular examination is often "regular rate and rhythm without murmurs or gallops," despite the presence of numerous abnormal findings. The mnemonic, LGFD (looks good from door), has been jokingly used by more senior clinicians to describe the examinations of their younger colleagues. Although many medical schools now offer courses in advanced physical diagnosis, these are usually as electives. How many students participate in these courses and how effective is the learning, is unclear.

WHERE ARE WE FALLING SHORT?

Less than 50% of medical students report that attending physicians observed them performing some aspect of a physical examination, and less than 20% report they are observed interviewing a patient. Even when faculty members do observe a student's performance, many do not identify the errors made by those students during their examinations. Schwartz et al have shown that the physical examination skills of medical students at the end of the 3rd

year declined compared with the 2nd year students. At the end of the 4th year, before joining a residency program, students are required to pass a clinical skills examination. Again, they are asked to demonstrate the motions of an ideal examination on standardized (normal) patients. Whether they can actually identify an abnormality is not tested. That, unfortunately, is all the skill needed to be an internal medicine resident who is then supposed to teach 3rd and 4th year medical students.

Multiple studies have shown that residents across specialties lack the skills required to identify or recognize common abnormalities on a physical examination. Wu et al demonstrated that self- confidence in the ability perform certain examination skills (fundoscopic examination, identifying a thyroid nodule, interpreting a diastolic murmur) remained low throughout the continuum of training from student to faculty. More concerning was these authors found that residents perceived the physical examination to be of less utility than did the medical students.

There is no doubt or question regarding the need of appropriate laboratory and radiological testing or the fact that the physical examination may often be misleading and therefore cannot diagnose every condition. However, that does not limit the value or importance of a well-performed history and physical. Even in these modern times dominated by technological innovations, most diagnoses are still made by the history and physical.

An automated analysis of the complicated clinicopathological conference (CPC) cases presented in the New England Journal of Medicine showed that correct diagnosis could be made in 64% of the cases using only the findings from the history and physical.

The problem is as obvious as the solution. Residents need a formal curriculum for teaching the physical examination. It is not as easy as it sounds. It will mean policy changes from accrediting and certifying bodies and it will require programs to develop a standardized curriculum. In response to the realization that training programs have been deficient in insuring that graduating residents have achieved clinical competence, the Accreditation Council for Graduate Medical Education (ACGME) has dramatically changed the accreditation system.

Accredited programs must be directly observed to demonstrate that they have achieved appropriate milestones in their physical examination training. Yet, to be successful, we have to be certain that those who are doing the observing not only have the time to do this but have

the necessary training. Some academic centers have faculty development programs directed at rejuvenating clinical skills in interested faculty. Unfortunately, such centers are in the minority.

FACULTY DEVELOPMENT

Faculty development in the area of physical diagnosis skills and teaching techniques will need to go hand in hand with increased direct training and supervision of trainees. Programs will need to identify proficient teachers and clinicians and adjust schedules to allow increased direct supervision in an already busy program. It may even mean hiring more faculty and providing incentives for those who teach this curriculum, all of which are major challenges in this era of declining resources.

TECHNOLOGY vs. TECHNIQUE

By the end of World War II, x-rays, which formerly entailed several minutes of exposure time, could be performed in a matter of seconds and, for the first time, arterial blood gas measurement was possible.

As attractive as these technologies seemed in the 1940s, the advancements of medical technology since then are even more alluring. Yet, technology seems to be replacing basic medical skills rather than complementing them. In "Introduction to Clinical Medicine: A Time for Consensus and Integration," Omori and colleagues discuss concerns over history-taking and physical examination instruction, particularly during the first 2 years of medical school. A national collaboration on the integration of clinical skills education through medical school curriculum will be necessary.

Although this is a critical initial step, beyond the poor acquisition of basic clinical skills is the documented decline of some rudimentary skills after the second year of medical school. Why should history-taking and physical examination skills erest when they remain esoteric concepts and plateau or decrease when they should be used in actual practice of medicine? Regardless of the formal educational curriculum, the skills should improve if they are used to guide patient care decisions.

Contrary to the paramount importance often ascribed to technology, numerous studies have demonstrated that technology has not necessarily improved the quality of patient care. Successive cohorts of autopsies over the last century have consistently demonstrated similar

rates of misdiagnosis despite the use of advanced diagnostic procedures. For example, unknown malignancies were diagnosed in 36.5% of autopsies in 1923, compared with 41% in 1972 and 44% in 1998. In another study of 167 patients who died during a stay in the intensive care unit, autopsies uncovered a major diagnostic error in 8.7% of patients despite extensive diagnostic testing. In fact, the use of imaging was noted to contribute to misdiagnosis. Physicians missed the diagnosis of endocarditis in 9 patients despite ordering echocardiograms in the week before each of their deaths. By contrast, 3 patients diagnosed with endocarditis by echocardiogram subsequently had their diagnoses refuted during autopsy. In another autopsy study, the authors determined that ultrasound and computed tomography scanning provided misleading information for 7% of patients, whereas history and physical examinations rarely misled physicians (1% for history and 2% for physical examination).

More recently, the Medicare program evaluated the use of imaging services nationwide and found a threefold variation in the number of examinations obtained across the United States. Despite substantial differences in the use of imaging studies, no demonstrable changes in quality or patient outcomes were noted.

Although recent technological advances offer numerous tools to aid in diagnosis, their use should be guided by thorough history and physical examinations. Studies have consistently demonstrated that history-taking and physical examinations are the most important factors in arriving at a correct diagnosis, whereas lab tests and imaging studies play only minor roles. The aforementioned study of autopsy results concluded that history-taking and physical examinations provided conclusive information for determining the main diagnosis in 73% and 62% of patients, respectively. By comparison, imaging techniques provided conclusive information for diagnoses of 35% of patients and standard lab tests for 22% of patients. In fact, inaccurate, incomplete, or misinterpreted patient histories are among the leading causes for diagnostic errors. Physicians acknowledge the poor discrimination of individual history and physical examination findings but often neglect to consider the true sensitivity and specificity of imaging and other tests. Using technology becomes a "gold standard" for diagnosis instead of an adjunct to clinical judgment.

THE STATE OF CLINICAL SKILLS

Inconsistencies between laboratory findings and clinical data go undetected simply because too many physicians are insufficiently disciplined in the proper use of clinical skills and in the analysis of clinical data. Too often, palpably illogical laboratory findings are accepted without question

Despite the importance of history-taking and physical examination, clinical skills education has decreased since the 1960s, with deficiencies beginning in medical school and continuing through residency and into practice. With the erosion of thorough history-taking and physical examinations, clinical reasoning (the ability to develop the gestalt impression) has also decreased. Although essential to determining the correct diagnosis, appropriate history-taking and physical examination are futile without the ability to interpret gathered information. History-taking is frequently limited by close-ended questions that fail to gather specific details critical to clinical decision-making. For example, instead of determining the severity, context, alleviating factors, exacerbating factors, and chronology of dyspnea, its presence becomes a yes or no response.

Beyond the clear decline in skills, medical students who demonstrate proper technical ability have serious deficiencies in clinical reasoning before they enter residency training. In a study comparing student scores on an objective structured clinical examination (OSCE), which requires a complete organ system examination and a clinical performance examination (CPX), which requires a focused physical based on the patient's history, a large discrepancy was noted among student scores. Students who excelled in the technical examination (OSCE) performed inconsistently when deciding on the appropriate physical examination elements during the patient scenario (CPX).

In fact, the two scores showed no correlation on individual cases. Apparently, being able to perform a physical examination correctly during an OSCE (the standard used by most medical schools) does not translate into appropriate use of these skills in patient care.

CLINICAL SKILLS IN TEACHING HOSPITAL

A glimpse of clinical education during medical school and residency illuminates several reasons for the overall decline in clinical decision-making skills. Before the Feddock Clinical Skills 1970s, internal medicine rounds with the attending physician were considered the platform for demonstrating history-taking, physical examinations, and clinical decision-making. Attending physicians demonstrated clinical skills, refined a physician-in-training's

techniques, and corrected errors or misinterpretations. By 1978, the rate of performing bedside examinations during teaching time had decreased to 16%, and many physicians estimate that number has decreased even further. Today, physicians-in-training rarely see attending physicians demonstrate history-taking and physical examination techniques and apply their findings to clinical decision-making. Rounds at many hospitals have shifted from bedside interactions with patients focused on the patient's history and physical examination to conference room learning focused on the patient's latest laboratory and imaging results. A recent national survey of medical students inquired about the quality of teaching during the inpatient component of their internal medicine clerkships. One third of students reported that their attendings rarely or never saw new patients with the team, not including the number who saw but did not examine the patients with the team.

Not only are senior physicians failing to demonstrate clinical skills, but physicians-in-training are rarely observed taking histories or performing physical examinations, or offered feedback on their clinical skills. Less than 50% of medical students reported that the attending physician observed them performing some aspect of a physical examination, and less than 20% reported they were observed interviewing a patient. Even when faculty members do observe a student's performance, many do not identify the errors made by those students during their examinations. Observation and feedback are essential because physicians-in-training commit a high number of errors in routine history-taking and physical examinations. These errors have significant consequences: in one study, an attending physician's physical examination ultimately changed the diagnosis or disease management for one-quarter of the patients admitted to an internal medicine service, providing proof that any feedback on clinical skills is beneficial.

In another study of the accuracy of resident presentations, resident physical examination skills directly correlated to the amount of time attending physicians spent with them at the bedside examining patients.18 However, physical examination skills did not correlate with classic measures of medical knowledge, such as resident in-training examination scores or prior medical school class rank, indicating those measurements do not automatically translate to clinical skills.

Despite its decline, both medical educators and physicians-in-training still consider bedside teaching one of the most valuable learning tools. Although many lament the changes in medical education focus, medical schools overall have done little to improve the way clinical

skills are taught. Since the 1980s, innovations in medical education have attempted to refocus the activities of medical schools and teaching hospitals back on education. New modalities, such as standardized patients, simulators, and computer technology, have been included to improve the teaching of clinical skills. However, these recent instructional methods have one common factor – they require less faculty involvement.

In a recent case study, faculty members at one medical school consistently made curricular decisions that would best preserve faculty research time, resulting in a persistent decrease over the last half-century in student-faculty contact. Identifying faculty who will take the time to teach medical students is now one of the most substantial difficulties faced by course directors. Although many of the new teaching technologies offer outstanding, nonintimidating platforms for students to refine their skills, they cannot replace patient interactions supervised by faculty.

SUMMARY:

Current movements to improve clinical skills education are essential and long overdue. Acknowledging that the provision of high quality medical care requires strong clinical skills and clinical reasoning, the Association of American Medical Colleges established the Task Force on the Clinical Skill Education of Medical Students

Several recommendations from this task force emphasize the importance of clinical skills. First, the task force acknowledged that clinical skills education is a longitudinal process that must be taught throughout medical school, residency training, and postgraduate work. Clinical skills are often ignored after the second year of medical school, even though they should be continuously reinforced and advanced to include more sophisticated techniques.

Second, the task force emphasized that faculty members must take the primary role in teaching clinical skills. The development of clinical skills requires close mentorship with someone who can not only teach the specified skills, but also assess andprovide feedback to the student.

Third, the task force recommended that the evaluation of clinical skills must be patient-centered. Simulators and computerized technology are useful adjuncts to teaching clinical skills, but to deliver high-quality patient care, students mustlearn with actual patients.

Emphasizing clinical skills is as significant as acknowledging the impact of the hidden curriculum perpetuated in many clinical arenas. Students and residents will value what their faculty mentors value and their observations of faculty-patient interactions demonstrate what skills are truly important to succeed as a physician. Rushed rounds with attending physicians exaggerate the importance of ancillary testing at the expense of clinical skills. With a greater reliance on laboratory studies and imaging, the details of history and physical examinations become inconsequential and no longer change the diagnostic approach. Physician educators must not only dedicate themselves to teaching clinical skills, but also emulating those skills in everyday work. They must integrate new technology into clinical education without diverting attention from patients. Expectations for physicians-in-training should include a progressive improvement in clinical skills, guided by faculty feedback to correct and advance those skills.

Although clinical faculty members play an essential role in promoting the development of necessary clinical skills in physicians-in-training, they must have sufficient support from medical school or teaching hospital leadership, as well as individual departments. Even motivated teaching faculty find numerous barriers within the administration of the medical school or teaching hospital. Medical education, particularly basic clinical skills education, is a low priority, especially in comparison to the income-generating endeavors of research and clinical work. In general, faculty are given little time to dedicate to teaching duties, so they either risk salary cuts or they teach "on their own time" after completing their clinical or research activities.

In addition, teaching activities often do not contribute significantly to promotion and tenure decisions. Many medical school promotion and tenure committees have difficulty accepting the expanded definition of scholarship that rewards certain teaching activities. Ultimately, medical schools and teaching hospitals must install value in teaching basic clinical skills by providing physicians the time and the compensation for these activities.

Teaching clinical skills is time-intensive and requires dedicated faculty who are able to demonstrate, teach, and provide feedback. Current faculty members may lack the clinical expertise to be successful, adding to the difficulty in finding strong physician models proficient in teaching clinical skills. Most current medical school or teaching hospital faculty completed their education during a time of diminished emphasis on clinical skills, so they

may lack confidence in their own skills. Teaching is not an intuitive endeavor for all physicians, and faculty are limited in their ability to assess clinical skills and provide quality feedback to physicians-in-training. Faculty development is necessary to improve the current clinical skills of medical school faculty and provide proper instruction on the teaching and evaluation of clinical skills.

Although history taking and physical examination skills are often considered rudimentary, they serve as the foundation for all clinical decision-making and their significance should not be disregarded or forgotten.

Modern technology has improved physician understanding of ailments and created new tools to use in diagnostic paradigms, but the technology is not infallible. Indiscriminate use of new technology will not improve health care but will only contribute to spiraling health care costs. The enhancement of clinical skills curricula must be accompanied by focusing clinical training back on patients and away from computerized data.

In the words of Sir William Osler, "it is a safe rule to have no teaching without a patient for a text, and the best teaching is that taught by the patient himself."

Annexure II

Bharath Institute of Higher Education and Research

Sri Lakshmi Narayana Institute of Medical Sciences

Participant list with signatures

Value added course: **Importance of History taking in clinical diagnosis (dated 05/01/2018)**

Sl.No	Reg.No	Name of the candidate	Signature
1.	U15MB272	CIBIBALAA. D	
2	U15MB273	DEEPIKA DIVYA KUMARI .B	
3	U15MB274	DEEPIKA PRIYADHARSHINI. B	
4	U15MB275	DEVANAND .M	
5	U15MB276	DEVANATHAN .R	
6	U15MB277	DHANA PRIYA .P	
7	U15MB278	DHANALAKSHMI. M	
8.	U15MB279	DHANUSH .R	
9.	U15MB280	DHANUSH KODALI	
10.	U15MB281	DIVYA KUMARI .P	
11.	U15MB282	DIVYA .S	
12.	U15MB283	DIVYA DHARSHINI .N	
13.	U15MB284	EVANGELINE PRETTY .G	
14.	U15MB285	EZHILARASI. R	
15.	U15MB286	FATHIMA BANU. A	

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

Annexure - III

IMPORTANCE OF HISTORY TAKING IN CLINICAL DIAGNOSIS

SHORT NOTES

Course Code: FM08

WRITE SHORT NOTES ON THE FOLLOWING:

1. How to obtain history from an anxious, apprehensive patient
2. Importance of personal and family history
3. Important communication techniques to establish rapport and earn trust from a patient
4. How technology is overshadowing technique in medical practice

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

Annexure - I(c)

IMPORTANCE OF HISTORY TAKING IN CLINICAL DIAGNOSIS

SHORT NOTES

Course Code: IM08

WRITE SHORT NOTES ON THE FOLLOWING:

- How to obtain history from an anxious, apprehensive patient
- Importance of personal and family history
- Important communication techniques to establish rapport and earn trust from a patient
- How technology is overshadowing technique in medical practice

1. To obtain history from an xious patient we have to first ask the patient to the calm down the patient down

2. personal and family history up- personal history will let us know the habits & how they gather of the patient

any known addiction like Alcohol can cause reactions and faith loss

smoking can cause COPD.

family history will let us know about the genetically acquired diseases like DM; HTN; BA.

3. listening to the patient carefully and gaining their trust.

showing the patient that we are concerned about their problem

4. technology is overshadowing medical practice because patients are searching on internet and taking self treatment because everything is available on the internet

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

Annexure - II

IMPORTANCE OF HISTORY TAKING IN CLINICAL DIAGNOSIS

SHORT NOTES

Course Code: IM08

WRITE SHORT NOTES ON THE FOLLOWING:

1. How to obtain history from an anxious, apprehensive patient
2. Importance of personal and family history
3. Important communication techniques to establish rapport and earn trust from a patient
4. How technology is overshadowing technique in medical practice

1) By identifying the reason for their anxiety & to start a session that will help them to be more comfortable. Educating the patient about their illness / procedures. Being calm while collecting the history. Being kind. Look professionally.

2) Personal history: ingestion of substances which is chief cause of various other problems. Family history can also give a clue on clarity ... illness. ... CAD

3) Practicing compassion & empathy, using kind & pleasant words. By being calm & collected makes the patient be ...

4) Technology has reduced the practical & manual approach to the patient in diagnosing a disease. For example palpating method to find a diagnosis has been shifted to doing a USG abdomen.

2.

Sri Lakshmi Narayana Institute of Medical Sciences

CERTIFICATE OF MERIT

This is to certify that DHIVYA KUMARI .P has actively participated in the Value Added Course on "Importance of history taking in diagnosis" between January 2018- April 2018, organized by Sri Lakshmi Narayana Institute of Medical Sciences. Pondicherry- 605 502, India.

Dr. Chellapandian
RESOURCE PERSON

Dr. Aravind. C
COORDINATOR

ANNEXURE - 7

Sri Lakshmi Narayana Institute of Medical Sciences

CERTIFICATE OF MERIT

This is to certify that DHANA PRIYA .P has actively participated in the Value Added Course on "Importance of history taking in diagnosis" between January 2018 -April 2018, organized by Sri Lakshmi Narayana Institute of Medical Sciences. Pondicherry- 605 502. India.

Dr. Chellapandian
RESOURCE PERSON

Dr. Aravind. C
COORDINATOR

ANNEXURE – V

Student Feedback Form

Course Name: **Importance of history taking in clinical diagnosis**

Subject Code: **IM08**

Name of Student: _____ Roll No.: _____

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear				✓	
2	Course contents met with your expectations				✓	
3	Lecture sequence was well planned				✓	
4	Lectures were clear and easy to understand			✓		
5	Teaching aids were effective				✓	
6	Instructors encourage interaction and were helpful				✓	
7	The level of the course				✓	
8	Overall rating of the course				✓	
		1	2	3	4	5

* ***Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory***

Suggestions if any:

Signature

Date: [illegible]

Student Feedback Form

Course Name: **Importance of history taking in clinical diagnosis**

Subject Code: **IM08**

Name of Student: _____ Roll No.: _____

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear					✓
2	Course contents met with your expectation					✓
3	Lecturer sequence was well planned					✓
4	Lectures were clear and easy to understand				✓	
5	Teaching aids were effective				✓	
6	Instructor encourage interaction and were helpful					✓
7	The level of the course					✓
8	Overall rating of the course	1	2	3	4	5

* ***Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory***

Suggestions if any:

Signature

Date

Date: 16/04/2018

From
Dr. Aravind. C
Department of Internal Medicine
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research.
Chennai.

Through Proper Channel

To
The Dean.
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research.
Chennai.

Sub: Completion of value-added course: Importance of history taking in diagnosis

Respected Sir,

With reference to the subject mentioned above, the department has conducted the value added course titled: **"Importance of history taking in diagnosis"** on 13/04/2018. We solicit your kind action to send certificates for the participants. Also, I am attaching the photographs captured during the conduct of the course.

Kind Regards,
Dr. Aravind. C

Encl: Photographs