

blank answers, or answer spaces with lines (—) or circles (o) or checks (✓) through them do not indicate whether the answer is “no” or “none,” whether the patient can’t remember, or simply that the question was overlooked. During malpractice litigation and hospital inspections (e.g., by JCAH) medical records are of increasing use to evaluate self-imposed standards. Unanswered questions may suggest that a physician or technologist was not meeting the department’s self-imposed standard for history evaluation. Therefore, if a question is important enough to be on a form, it should be answered to the best of the ability of the person taking the history.

Another important aspect of form completion is the actual art of asking the patient questions. Since some patients may be embarrassed or insulted by questions regarding cigarette smoking or alcohol use, it often helps to precede the questions with a statement that these are routine questions asked of all patients and that the answers will better enable the nuclear medicine physician to interpret their test results.

Appropriately phrasing a question avoids ambiguous answers and saves time, both essential to professional practice standards. Have you ever tried to obtain a history from a patient and asked “What brought you to the hospital today?” If you have asked that question then you have probably been told “I came by car.” As silly as this sounds, asking a question that results in meaningless information only wastes time which can be significant when dealing with large numbers of patients. Another question asked of patients is “Why are you having this test?” The answer may be “. . . because my doctor ordered it.” A better way to ask this question might be “What problem do you have that made your doctor order this test?”

In order to intelligently discuss the content of the form, the reason for having historical information must be understood. It is not uncommon for a referring physician to say that he wants the test interpreted without history for a non-biased interpretation. This approach ignores the major role of the nuclear physician as a consultant. In order to be a consultant, the nuclear medicine physician should maximize the value of scan information and advise the referring physician. The nuclear physician often utilizes a probability scheme for test significance. The clinical probability of a diagnosis must be compared with the test probability of a diagnosis with a resulting final probability of a diagnosis. The clinical probability is often based on historical information, examination findings, or abnormal laboratory results. An example of how the probability algorithm can be used for determining the presence of pulmonary emboli in a patient is one such example. When clinical suspicion that a patient has had pulmonary emboli is low in the opinion of the referring physician and the lung scan is highly suspicious, an angiogram may be appropriate to resolve the discrepancy. Conversely, if the clinical suspicion and scan suspicion of pulmonary emboli are both high or both low, additional pulmonary angiography may not be necessary. The nu-

clear physician is often asked to advise the referring physician as to the necessity of pulmonary angiography after the above probability algorithm has been considered.

The next area for consideration regarding history content relates to differentiation between diagnosis(es) responsible for the patient’s hospital admission and the diagnosis(es) or problem(s) to be evaluated by the scan. For example, if a patient whose admitting diagnosis is congestive heart failure due to hypertension is found to have prostate cancer, it is not necessary for the bone scan history to discuss congestive heart failure or hypertension, but the report must note the suspected or proven prostate cancer.

Laboratory values often influence the probability of a diagnosis and should be included on a pre-prepared history form when appropriate. An equivocal bone scan abnormality might be considered more significant if the patient has an elevated bone alkaline phosphatase level. Similarly, a better thyroid scan interpretation might be rendered if results of thyroid function studies and thyroid antibody levels are made available.

Saving previous histories serves to provide valuable historical information at the time of the next scan. Repeat histories add nothing, however, if they are stamped “see old history.” If a woman with breast carcinoma has periodic bone scans, the most important new information relates to the time interval since the previous scan. The question is not, “Has the patient had chemotherapy or radiation?” but, “Has the patient had chemotherapy or radiation since the previous scan?, Has the patient developed pain since the previous scan? and, Has something changed for the better or worse since the previous scan?”

Conscientious nuclear physicians will want to continue obtaining supplementary histories and performing appropriate examinations. Physicians have the responsibility of continuing appropriate patient contact and avoiding the inappropriate delegation of total “history taking” to technologists.

Technologists need to perform history taking to the best of their ability, keeping in mind the importance of historical information and using the historical information for selecting non-routine image views. The technologist’s other responsibilities should not suffer because of time committed to obtaining histories.

During the three years in which technologists have acquired preliminary patient history information on prepared history forms in our department, technologists have become professionally as well as technically more sophisticated and thorough. Nuclear physicians have continued appropriate patient contact, and patients seem pleased and reassured by the additional interest afforded them by the technologists concerning their medical problems.

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