Reviewer's report

**Title:** History-taking and empathetic communication - two sides of the same coin?

**Version:** 1  **Date:** 1 February 2013

**Reviewer:** Anne M Cushing

Reviewer's report:

Major Compulsory revisions before considering publication.

1. Is the question posed by the authors well defined? No

The question posed by the authors is ill defined. In particular the authors refer to History Taking Skills when in fact it becomes apparent that they mean history taking content - they measure the number of questions asked about content not skills - Introduction para 3.

They also imply that communication skills are only about empathy which is a very outdated concept of communication. Any reference to the literature (McWhinney and Silverman Kurtz - Calgary-Cambridge Guide) indicate that interviewing skills include listening, open to focussed questions summarising and clarifying to gain comprehensive information as well as rapport and empathy etc. Also where is the evidence that asking lots of questions leads to better clinical reasoning - students could be asking these in a scattergun approach with little understanding of pattern and clinical reasoning in their process.

Patients satisfaction and compliance (an old term) is also related to some structuring aspects of communication (orientation, facilitation and signposting) not just empathy as they state in Introduction para 2. (See Stewart et al.)

2. Methods. They don't discuss whether SPs were trained or if more than one SP was playing the same role. How the SPs interpreted their ratings.

What % of the information (123 items) is psychosocial and what % biomedical.

Were the students instructed to take a history to reach a differential diagnosis or to arrive at a diagnosis and management plan?

Often students are unclear about what types of information is expected because they aren't clear about the outcome expected.

3. Yes

4. Results

The authors do not report the correlation co-efficient. It is obviously small from figure 1 but then it doesn't appear to be negative either and this could be discussed. It is possible from this data to say that being empathic is not detrimental to asking relevant questions?
They provide average questions but not means and SDs which would be relevant.

5. Discussion & Conclusion
In the results para 2 they state patients gave 17.2% of aspect. The authors conclude that students asking on average 56% of the content questions is alarming but offer no discussion of this. Indeed if the patients 17.2% offered info is added then it looks like 17/18 pieces of info emerge from the average of 23 per patient case (73%). One might ask if this would be sufficient to reach differential diagnosis and management consideration and if not why not. Would a practitioner in everyday clinical practice ask 56%, much more than that or indeed less to work through clinical reasoning?

Why do the authors say that history taking (content presumably) and empathetic communication skills do not seem to be two sides of the same coin? What was their proposition that they are - ie the relationship between them?

There is little discussion about length of station or the fact that they didn't assess the students clinical reasoning or diagnostic ability - because they count questions ie bits of info rather than they way/ chronology/ reasoning apparent in sequential questioning they should be circumspect in discussion and conclusions.

Discussion
para 1 sentence 4 - this would appear obvious and sentence 5 is incomprehensible.

The last sentence introduces the concept of attitudes - what attitudes are the authors talking about as there is no assessment of attitudes in their study and again what are the history-taking skills of their participants that they refer to - other than knowledge of content and what question to ask.

Para 2 last sentence - what is meant by different objectives learning in communication skills training for male and female students. This suggests stereotyping as there will be a range in each gender group with a mean difference.

What was the range for male participants and for female participants.

Conclusions
'History taking' isn't the correct term here unless it is very specifically defined at the outset as being knowledge of what questions to ask. Otherwise it should be replaced with something like. 'Asking relevant questions to get important information for clinical reasoning'

7. The authors have referenced widely but missed some key references particularly in relation to claims they make that nothing is known about patient preference when it is. Introduction Para 3 (Elwyn G at al, Salmon P et al who have looked at what patients want in consultations).
8. The title is confusing - the authors don't explain their hypothesis/concept of 2 sides of the same coin and then draw a conclusion that this is disproved.

9. Some minor grammatical errors e.g. Introduction para 2 sentence 4. e.g. Results para 3 should be 'When data from all female standardised patients were combined ... and para 1 the 1st sentence.

In Summary
There are some interesting findings here and a lot of work has been done. I appreciate the opportunity to read and review the paper.

I would recommend major revisions to clarify the concepts and terminology, to incorporate a discussion of distinction between history taking skills (which are communication skills) and history taking as knowledge of what questions to ask. I would recommend the authors to be more discursive about the findings and whether the number of questions asked might or might not mean better diagnostic and clinical reasoning ability.

I would expect

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Needs some language corrections before being published

**Statistical review:** Yes, and I have assessed the statistics in my report.

**Declaration of competing interests:**

I declare that I have no competing interests