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Duty, Diagnosis & Documentation: The Clinical And Legal Importance Of Medical History Taking

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History taking remains one of the most critical components of clinical assessment, guiding the formulation of differential diagnoses, informing appropriate investigations and determining safe as well as effective treatment plans.

A thorough medical history can, in some cases, account for up to 70% of diagnoses, even before any physical examination or diagnostic testing. In addition to eliciting symptoms, good history taking uncovers relevant comorbidities, risk factors, allergies, family history, medication use and social determinants of health. It also plays a vital role in establishing rapport and trust between patient and practitioner - the foundation of good clinical care.

What Are The Types Of Duties In History Taking?

Several duties arise in the context of history taking, particularly from a medico-legal and professional practice perspective. These duties may not always be explicitly listed in clinical guidelines, but they are inferred from case law and ethical standards.

Though clinical in nature, these duties carry legal significance, particularly where failure to discharge them leads to harm. The duties can be broadly categorised as follows:

- duty to listen to the patient
- duty to inquire
- duty to clarify and elicit more information
- duty to recognise clinical patterns (i.e. differential diagnosis and red flags)
- duty to consider vulnerable populations
- duty to document the history accurately and contemporaneously
- duty to ensure patient understanding

Can A Doctor Rely On The History Provided By A Patient As Being True And Accurate?

The Court of Appeal in *Dr Premitha Damodaran v GTK (a child suing through her father and litigation representative, Taranjeet Singh a/l Bhagwan Singh) & Anor and another appeal* [2022] 3 MLJ 484 held that while a doctor has a legal duty to take a patient's medical and family history, this duty does not extend to requiring the doctor to explain to the patient the importance of providing accurate and truthful information. It is implied that the patient understands the need to be truthful when giving history, and there is no legal obligation on the doctor to reinforce this point.

In this case, the 1st defendant, a consultant obstetrician and gynaecologist, had discharged her duty by taking a comprehensive history including specific questions about the birth weight and delivery of the patient's previous child.

The patient provided detailed history including specific details about the birth weight down to decimal points. There was no indication that the history was vague or unreliable, nor was there any reason for the doctor to suspect inaccuracy or to conduct further inquiries. The issue arose only because the patient later disputed the accuracy of what had been recorded.

The Court of Appeal rejected the idea that the doctor had a further duty to verify the patient's history by contacting previous treating physicians or hospitals. Unless there is a clear reason to doubt the accuracy or completeness of the patient's history, a doctor is entitled to rely on the information provided.

Accordingly, the Court of Appeal found no breach of duty by the 1st defendant in relying on the history provided by the patient and affirmed that there is no general legal duty to verify a patient's history unless there is cause for concern.

What Happens When A Doctor Fails To Ask The Right Questions?

In *Chin Keow v Government Of Malaysia & Anor* [1967] 2 MLJ 45, the patient was presented with an ulcer on her right ankle and swollen glands in her thigh. After examination, the doctor gave an injection of procaine penicillin, from which the patient died within an hour.

The doctor breached his duty by failing to make appropriate inquiries before administering a penicillin injection, which was admitted to have caused the patient's death. Had he made proper enquiries, he would have discovered that the patient had previously experienced an adverse reaction to penicillin in 1958, leading to a documented warning on her outpatient card stating "Allergic to Penicillin."

Does The Standard Of Care Vary If The Doctor Is A Specialist?

This issue was considered in the case of *FB (Suing by her Mother and Litigation Friend, WAC) v Princess Alexandra Hospital NHS Trust* [2017] All ER (D) 92 (May).

FB, a child, suffered permanent brain damage due to pneumococcal meningitis. The claim focused on the alleged negligence of Dr R, a 25-year-old Senior House Officer (SHO), who attended to FB at the emergency ward and discharged her without taking an adequate history or conducting a proper examination. It was accepted that had FB been referred to the paediatric team, she would have received timely antibiotics and avoided injury.

At trial, the judge held there was no breach of duty, partly on the basis that a lower standard of care applied to a junior doctor.

The Court of Appeal disagreed and allowed the appeal. It clarified that doctors should be judged by the standard expected of the role they are performing, not their personal experience level. The court further emphasised that history-taking is context-specific, but the standard of care remains consistent. Dr R's failure to elicit the reason for FB's attendance in the early hours constituted a breach of duty. Her flawed approach to history-taking fell below the standard expected of a competent SHO. The Court of Appeal held:

> *"History taking was not a 'one-size-fits-all' task. Different skills were needed when taking history from different groups of patients, namely, children or the elderly. It was for the doctor in A&E to use appropriate techniques to elicit why a patient was there at any given time. The standard of care imposed on the history taker was the same, how it was discharged might well be different depending on the patient and the context.".*

Failure To Identify Red Flags In History Taking

In *Shaw v Stead* [2019] EWHC 520 (QB), a patient who sustained a lower back injury after being kicked by a pupil progressively developed symptoms over the following days including severe back and leg pain, numbness, urinary difficulties and eventually loss of mobility.

Despite multiple contacts with the general practitioner (GP), the red flag symptoms of cauda equina syndrome were not recognised. Notably, the patient arrived at the out-of-hours clinic in a wheelchair and reported urinary issues, and yet the GP's notes stated that there were "no red flags."

The patient was only referred to hospital the following day, where an MRI revealed a large disc prolapse at L3/4 and a diagnosis of incomplete cauda equina syndrome was made. Emergency surgery was subsequently performed.

The court held that the GP was negligent for failing to identify and act upon the red flag symptoms, which should have triggered immediate referral and the GP's history taking and/or examination fell below the required standard. It is standard practice to record key findings such as wheelchair use and the absence of such documentation led to the rest of the notes being viewed with caution.

This case emphasises the importance of recognising and documenting red flags in primary care, particularly in patients presenting with acute low back pain.

Commentary

History taking is not just a clinical skill, it is also a legal safeguard. A systematic, attentive, and well-documented approach protects both the patient's health and the practitioner's professional integrity.

As illustrated by the cases discussed, the significance of history taking extends well beyond clinical judgment; it is integral to fulfilling the legal and ethical obligations owed to patients. The applicable standard of care is defined not by a practitioner's seniority, but by the responsibilities inherent in the role being undertaken within the clinical context. Practitioners must therefore remain alert to red flag symptoms, adapt their history-taking approach to the needs of vulnerable patient groups and ensure comprehensive documentation.

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