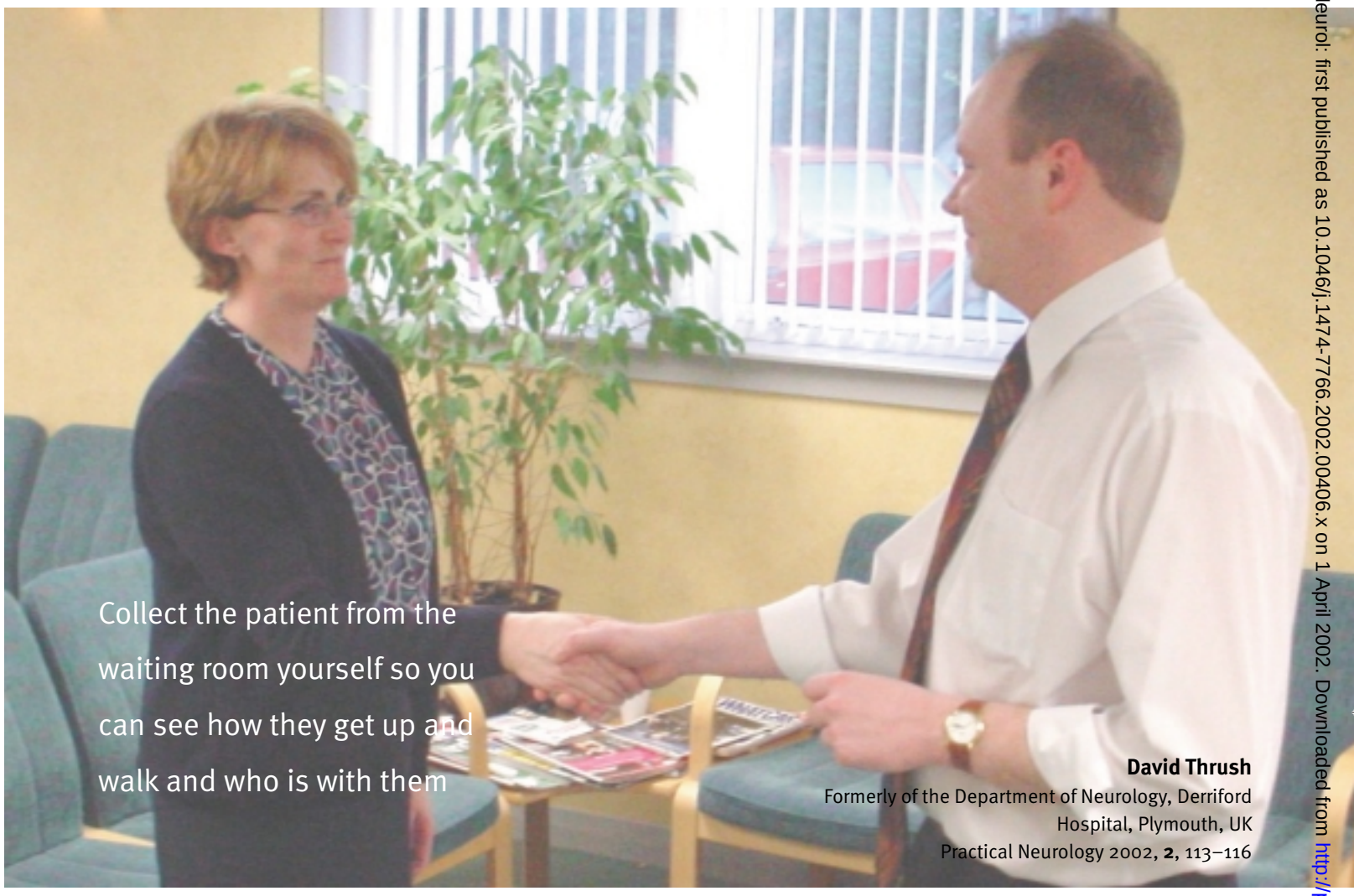

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Take a good history

Dear Lord,

So far today I am doing alright, I have not shouted at the nurses, been grumpy with my patients, lost my temper with management, been impatient with my secretary or gossiped with my colleagues. However, I am getting out of bed in a few minutes and I will need a lot more help after that.

Amen

When I was a medical student in the 1960s it was drummed into me that the diagnosis was made from the history, examination and special investigations, but the most important was the history. Despite the explosion of advances during the past 20 years, this is still true today, at least in clinical neurology, and yet histories are becoming increasingly shorter and they are frequently inadequate and incomplete.

We enter medicine for many different reasons but I suspect the two most frequently given are a love of meeting people and a desire to help them, but unfortunately because of the pressures we are under, particularly the junior staff, that joy and satisfaction appear to be disappearing and

medicine is becoming more mechanical. Protocols and guidelines proliferate at an alarming rate and the emphasis has switched from the history to multiple screening tests and scans. It is now difficult to be seen in the outpatient clinic or as in-patient without having thyroid function tests, B12, folate and auto-immune and clotting screens included in the routine bloods! Only the VDRL appears to have escaped from the screening profile, though even this lingers in a few centres of excellence. Such an undisciplined approach not only wastes time, money and resources but also an abnormal result may lead the inexperienced doctor on a wild goose chase.

Medicine remains an art as well as a science. It is not simply about making a diagnosis, it is about helping and caring for that unique patient with his or her neurological problems. Patients do not want doctors who are computer literate and competent in business studies (though computer literacy is now essential for all neurologists for keeping up to date and for their personal practice). They want a doctor with clinical experience and common sense, a doctor who is committed to doing their best for the patient, a doctor who is caring and who will understand the patients' problems and who will listen, advise and support both the patients and their families.

History taking is usually your first contact with the patient, it sets the scene and establishes the foundation for your future relationship with the patient and their family. It is a time when you begin to build trust, confidence and authority, so first impressions are important. Samuel Johnson wrote that a successful doctor needs three things: a top hat to give him authority, a paunch to give him dignity and piles to give him an anxious expression. I would recommend neither the paunch nor the piles but in my opinion the dress sense of doctors has sadly declined. We have the privilege of meeting patients of all ages and from all walks of life, they are coming to see a professional and we should look the part. Only the talented professor can get away with eccentric clothes.

Taking a good history requires time, skill, concentration, experience, tact, diplomacy and patience. It is vital for diagnosis, for communication with other doctors, for teaching and research and, regrettably in these days, on occasions for medico-legal purposes. After taking the history, you should have decided whether the patient has a neurological problem, if they do, where the lesion is and have some idea of what is causing it. The neurological examination will confirm the site of the lesion and rarely reveals anything unexpected. It should, however, always be thorough and this is particularly important in patients who do not have a neurological problem as it demonstrates that you care and that you have taken their symptoms seriously – in simple terms it is part of the treatment. On occasions it is also important to carry out a general examination: you will look for clubbing, cervical lymphadenopathy and examine the chest and abdomen if metastatic disease is suspected, and you should listen to the heart and for cervical bruits in patients with transient ischaemic attacks.

Nothing is more precious than time but a good history takes time. Listening is hard work and good doctors listen not only with their ears but also with their eyes and with understanding. It is a time when you are evaluating not only the presenting complaints but also the patient's intelligence, mood, attitude, behaviour, personality and speech.

Prior to seeing the patient in the outpatient clinic, I glance at the referral letter so I know what the major problem is and I then collect the patient from the waiting area. This gives me the opportunity of introducing myself, seeing how they get up and walk and who is with them. If a relative or friend comes with them they are always welcomed, as I am sure the patient finds them supportive and is therefore more able to relax. If the patient does come in alone, I ask if they would like the relative to come in too, but it is important to remember that not every patient wishes to have their relative with them, indeed they may be part of the problem, so ask out of earshot of the relative to avoid embarrassment. Do ask who the accompanying person is, I once made the cardinal error of calling the person his mother when it was his wife!

The clinic is your home ground but to the patient it is foreign territory. To you and me it is another clinic but to them it is one of the most important days of their life. Most patients will be anxious and apprehensive and some even frightened. It is therefore essential that you are relaxed and that you put the patient at ease. A few minutes discussing the patient's journey, the difficulties of parking in the hospital, the weather, their job or even the logo on their sweater will often pay significant dividends and is never time wasted. I call some patients by their

first names, as I think this helps to put them at ease, but others I will call by their surname or even 'sir'. It all depends on who they are and how anxious they appear. The aim is to demonstrate they are important, that you are a caring doctor and have all the time in the world to listen to their problems.

History taking should not be stereotyped. It will vary and depend on the patient's age, intelligence and their presenting complaints as detailed in the referral letter. After asking their age, occupation and handedness, I often ask what was the very first thing they noticed to be wrong and then work from there, but at other times I will tell them that I have received a very helpful letter from their general practitioner but that I would like them to tell me why they have come to see me. Please don't bury your head in the notes and write continuously. Look at the patient when they are talking and ask the patient to describe each symptom in detail, interrupting only to clarify times and to amplify certain aspects of the history. Few patients can recall their symptoms in a chronological manner, sometimes the history is full of irrelevancies and reminiscences, and at other times the patient will talk about the diagnosis given by their GP or a well-meaning relative or family friend, and you will then have to bring them back on track with tact and diplomacy.

As medical students, we were frequently taught to record the patient's words verbatim but often this is unhelpful for diagnosis and for communication to colleagues unless you are sure of the precise meaning that the patient attaches to the words he or she uses. Does 'numbness' mean impaired sensation, weakness or neither? Does 'dizziness' mean vertigo, light-headedness or unsteadiness? Does 'blackout' mean loss of vision, loss of consciousness or just a fall?

Inevitably, you will have to ask some leading questions but they should be relevant to the presenting complaint, e.g. in an elderly patient with headache, you will ask about scalp tenderness and symptoms suggestive of jaw claudication and in a patient who complains of heaviness of the legs and a tendency to drag their feet after walking a hundred metres, you will ask about sensory symptoms, sphincter disturbance, spinal pain and possible symptoms in the upper limbs.

Many of us were taught to take histories in a compartmentalised way – history of presenting complaints, review of systems, past medical history, family history and social history. But there is a danger of this becoming too mechanical and making the history somewhat fragmented. Ask questions that are appropriate to the patient's complaints, for example if a patient presents with transient ischaemic attacks, ask about possible symptoms of ischaemic heart disease, intermittent claudication, smoking and a family history of vascular disease, and put that all in the paragraph with the presenting complaint and not toward the end of the history. Similarly, if a patient has symptoms suggestive of a peripheral neuropathy, having decided what type of neuropathy the patient has – mononeuropathy, mononeuritis multiplex, plexopathy or polyneuropathy, whether it is acute, subacute, or chronic, whether it is motor, sensory or mixed, and whether there is autonomic involvement – you can then ask further questions to see if you can determine the cause. For example, in a patient with sensory neuropathy, you can ask about symptoms suggestive of diabetes, explore possible B12 deficiency by asking about intestinal problems and previous gastric surgery, whether there is a family history of any auto-immune disorders, symptoms that might suggest the possibility of underlying malignancy, their recent past and present medication, and sometimes it may be necessary to enquire sensitively into their sexual habits or recent trips abroad.

Frequently in the outpatient clinic, patients do not have a neurological problem and their symptoms result from psychological or social problems. Such patients should not be belittled, treated with indifference and dismissed as functional. They and their referring doctors require help, just as much as the patient with multiple sclerosis or Parkinson's disease. Tease out their problems with care. Are they anxious? If so, why? Are they depressed? Is there a reason? Are their complaints a manifestation of an hysterical illness, are they attention seeking or hypochondriacal, could they be malingering or do they have a personality disorder? Exploring their personal life, marriage, occupation and possible emotional difficulties requires skill and tact and if you have decided early on that the patient is going to require psychiatric help, then detailed questioning may be best left to the psychiatrist because some patients may have great difficulty in talking about intimate details on more than one occasion. If they do open up with you, it is vital that you listen and

this may take considerable time, as you cannot ask them to stop – that would be most unfair on the patient.

By the time you have evaluated the presenting complaints, you should have information on the time of onset and description of the major symptoms, their frequency and duration, whether they have progressed or improved. And do not forget to ask what effect the symptoms have had on their life, for example have they had to give up work or their hobbies, can they still drive, can they get to the shops, the local pub, the church, the library and are they independent for the activities of daily living? If they have had to give up work, I also ask about their financial allowances.

If the patient's complaint suggests an inherited disorder, then it is always important to construct a family tree and, depending on the referral letter, this may be undertaken at the start of the history taking.

Notes should always be taken about the patient's general health, recent past and current medication, past medical history, family history and social history asking if appropriate about recreational drugs. At the end of history taking, while the patient is getting undressed, I re-read the referral letter thoroughly as the patient's history may not be complete or they may have withheld information. I also take the opportunity of talking to any relative and this is particularly important in patients with blackouts, dementia or long standing symptoms. I also use this time to look through their hospital notes because this frequently reveals information that has been forgotten or withheld.

The history should be recorded clearly, logically and in a well-organized manner, so other doctors can pick up the notes and immediately understand the patient's problems. Beware of closing your ears to history that does not fit into the diagnosis you wish to make, or of manipulating the history into an accepted diagnosis. Never criticise the referring doctor, lecture the patient or allow the consultation to develop into a confrontation. Remember it is not what you ask but how you ask it that often provides you with more information. Do not hesitate, if necessary, to continue taking the history during the examination when the patient may be more relaxed, perhaps clarifying a particular aspect of the history, or asking more delicate questions out of earshot of any relative.

Steve Redgrave and Tiger Woods achieved their success from hard work on the river and on the practice fairway, not from multiple discussions, reading and watching other oarsmen or golfers on film or television

I cannot emphasise enough the importance of taking a good clinical history, it remains an art, reading about how to do it and watching yourself on video may be helpful and instructive, but the skill can only be acquired through experience, i.e. doing it repeatedly and regularly evaluating your efforts. Steve Redgrave and Tiger Woods achieved their success from hard work on the river and on the practice fairway, not from multiple discussions, reading and watching other oarsmen or golfers on film or television.

Taking a history to find out what is wrong with the patient should be detective work at its best, don't let it become a mechanical drudgery but make it come alive and don't be afraid to introduce humour. It should on most occasions be enjoyable, satisfying, at times fun, and at all times, at the back of your mind, should be four questions, is there a neurological problem? where is the lesion? what is causing it? how can I help? It is, however, never easy; frequently we have to work in inadequate rooms with meagre support, often with tendon hammers that look as if they have come out of Christmas crackers, and under pressure, and it does not help when your first patient is vague, garrulous or partially deaf. Nonetheless, it should be one of the most enjoyable aspects of clinical neurology and, for it to remain so, you must resist the temptation to squeeze yet more patients into the clinic. Beware the neurologist who boasts that they can see 12 new patients and six follow-ups in one clinic, they may be a good diagnostician but they will be of little help to most patients who come to see them.