Editorial

Pearls

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I vividly remember the course in medical school where we learned how to "take" a medical history. It was held on Wednesday afternoons and taught by faculty who did not even pretend to be clinicians. ("I'm not a real doctor but I play one every Wednesday afternoon.")

Our textbook, softcover and robin's-egg blue, was full of suggestions for putting the patient at ease and collecting the requisite information that constituted a proper history. ("Empathy is shown by sitting forward and stroking the chin.") In an appendix at the end of the book was a 5-page list of symptoms that comprised the definitive "Review of Systems." Many students in my class memorized this list to prepare themselves for the problem solving ahead. I found the whole thing rather stupid: "Yes, sir, I know that you are having terrible chest pain, but I need to know if you have weakness of your urinary stream." I never could imagine Sir William Osler memorizing lists of symptoms in an appendix at the end of a robin's-egg blue paperback book.

The truth is that we do not "take" a history. We "make" a history. And we make it from what we hear, observe, intuit, and learn over time. A history is not made until the physician and the patient agree on both the nature of the problem and its cause. Diagnosis without patient concurrence is fiction.

A busy family physician is obligated to ask all of the right questions, to get the right diagnosis, to convince the patient that this is the diagnosis, and then to initiate definitive therapy, all in about 20 minutes. The amazing thing is how often it can be done! The reason for success is not the patient interviewing course taught in medical school. Instead, it is the collection of "pearls" learned with experience that make highly efficient problem solving possible. Here are a few of my favorites:

- "Everyone misses a few doses. How many have you missed in the last month?" Whether it is antihypertensive therapy or birth control pills, compliance is a major cause for treatment failure. This question raises noncompliance in a nonthreatening way that results in honest answers.
- "Who else is at home with you?" This question provides a great deal of information about the patient's home environment and who shares it. For many people, this is easier to talk about than responding to a question about "family" (eg, "Who is in your family?"). Family data invariably follow. ("It's just you and the two children? What happened to your wife?")
- "What do you think is causing this?" Often a patient seeks medical care not because of the symptom itself, but rather because of what he worries it might be. After all, the costochondritis could be an MI, the headache could be a stroke, and the abdominal pain may mean cancer. If you do not directly address the patient's concern, he will think that you are not very bright and that you have missed a serious illness. To convince him that it is costochondritis, you must first convince him that it is not an MI. The more reluctant a patient is to speculate on the cause of the symptom, the more likely he is to be worried about a bad disease. Such patients will say, "I don't know what it is. You're the doctor, you tell me." These patients will often reveal their concern by answering the follow-up question: "What is the worst disease that might cause this symptom?"
- "If I asked you to start climbing stairs, how far could you go?" This is a wonderful screening question for fitness in the elderly. I have often been suprised that individuals who walk without difficulty in the office can climb fewer than one flight of stairs. I usually

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follow this up with: "What would be the reason that you would have to stop?" Answers include "tired legs," "shortness of breath," and "chest tightness."

- "Show me with one finger where it hurts." There are typically three types of responses. For many diseases, the patient has no trouble putting a single finger on one spot and does this repeatedly with precision (eg, peptic ulcer disease). In other diseases, the patient refuses to identify a single spot (eg, angina). Finally, some patients identify multiple, specific painful areas. If these places are not highly reproducible, think somatiform disorder.
- "Can you tell me whether your dizziness is more like the room spinning, or like you are going to pass out, or something else?" The first of these describes vertiginous disease (eg, Meniere's disease), the second indicates near-syncope (eg, orthostatic hypotension or arrhythmias), and the final one is most characteristic of chronic disorders best described as the "weak and dizzies."
- "When was the last time you felt well?" This is a wonderful question for a patient who you think may be depressed. Most depressed patients will say that it has been years since they felt well. If they answer, "I felt fine until two weeks ago," think organic disease. Sometimes you will be suprised by the specificity of the answer. One of my older female patients told me, "I haven't felt good since last June." It was only on prolonged questioning that she realized that last June was when her husband had retired. Another medical mystery solved.
- "Which ear do you want me to look into first?" This is a guaranteed method to avoid fighting with children to accomplish otoscopy.
- "I know this problem is not caused by your nerves, but let's pretend for a minute that stress could be part of the problem. What are the most stressful things in your life at this moment?" The usual answers relate to work, family, and financial issues. Often there is a suprisingly long, detailed, and sad story. "Well, with all of that going on, if you're not stressed out or depressed, you should be!"
- "Have you found yourself doing silly things like getting in the car and then forgetting where you wanted to go?" Cognitive dysfunction is a suprisingly common symptom in run-of-the-mill depression and one that no patient spontaneously volunteers. Asking this unexpected question will convince patients that you know what you are doing, and this will make your diagnosis of depression more believable.
- "When you sit in a chair, do you find that you push your lower back into the chair to become more comfortable?" On more than one occasion, I have been misled by a patient who presented with knee, leg, hip, or groin pain that was, in fact, referred from the lumbar spine. People with disc disease unconsciously wiggle themselves into the back of the chair, to provide better lumbar support.
- "Does your spouse say you snore?" Sleep apnea is as common as diabetes but often overlooked. An obese patient with edema, heart failure, fatigue, or hypertension should be asked about snoring and daytime hypersomnia. The answers to this question are often amusing: "I snore so loudly that one time when we were camping, the park ranger came over to our tent because he thought there was a bear inside!"
- "Do you smoke?" "Yes." "What are your plans?" This is a very positive yet nonthreatening way to establish smoking cessation as an issue for patients who smoke. Most will answer, "I need to quit," which opens the door for further discussion.

I must admit that I have jealously hoarded these pearls until now. They have made it possible for me to make diagnoses that others have missed, and this has been great fun. I am sharing them with you, but hope that you will keep them a secret. I do not want to open some medical student book on patient history taking and find them in an appendix.

What pearls are you hoarding? Are you willing to share them with *The Journal*'s readers? Send them to: The Journal of Family Practice, 519 Pleasant Home Road Suite A-3, Augusta, GA 30907–3500.

Pearls from Geriatrics, or A Long Line at the Bathroom

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At a recent family medicine geriatric conference, the case of Alvin French was presented. Mr French was a 74-year-old man who lived alone in a senior high-rise apartment complex near the medical center. He had been admitted to University Hospital for exacerbation of congestive heart failure, his third admission for this problem that year. The resident physician who admitted Mr French attributed his acute deterioration to noncompliance with the prescribed medication regimen. Mr French acknowledged that he had stopped taking his furosemide and digoxin several weeks earlier. His refusal to consistently follow physicians' orders was clearly frustrating and upsetting to the resident.

Resident: "Mr French, why don't you take your medicine regularly?"
Mr French: "Because it makes my kidneys act too much."
Resident: "Do you realize that when you don't take the medicine, you get sick like you are now and could even die?"
Mr French: "Yes."
Resident: "Do you understand what the medicine is supposed to do for you?"
Mr French: "I think so."
Resident: "Can you afford to buy it?"
Mr French: "I have a card."
Resident: "Do you just forget sometimes?"
Mr French: "No, I don't forget."
Resident: "Do you like being in the hospital?"
Mr French: "No."

As frustration mounted, an unasked question hung in the air: "Do you understand that when you don't follow our advice to take your medicines regularly, you waste a lot of people's time, energy, and money?"

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Geriatricians regularly ask questions that have not traditionally been part of the routine medical history-taking taught during medical school and residency. Some of the most important of these questions relate to the patient's ability to function, ie, the ability to do the things that make life worthwhile. A common question a geriatrician might ask would be, **"What is a typical day like for you?"** This is a comfortable way to begin the *functional assessment.*

When asked to describe a typical day, Mr French replied that he got up around 6:30 AM, took a shower, and ate breakfast in his apartment. Then he went downstairs to participate in the activities associated with the senior center that operated on the first floor of his apartment building. He ate lunch in the dining room, hung around for another hour or so, and as people began to disperse, he went back up to his apartment to watch television or take a nap. He generally fixed his own supper and watched television again until he went to bed at around 10 PM.

When asked at what time during the day he took his medicines, Mr French replied that he had been told to take his furosemide and digoxin in the morning and his captopril in the morning, afternoon, and at bedtime. At this point, Mr French stated that he believed the furosemide and digoxin made him urinate too often. When asked how this affected his activities (his ability to function as he wished to), he explained that there was only one men's bathroom on the first floor of his building, and in the mornings, there was often a line to get into it. He admitted that when he had to urinate, he had to either go promptly or risk incontinence. Because he attributed the urinary frequency and urgency to his medicines and was afraid of an embarrassing incontinence episode, he decided that he had to choose between taking the medications and attending the morning activities. Often, he chose the activities.

A second standard geriatric question helped to clarify Mr French's functional goals: **"What would you like to be able to do that you can't do now?"**

Mr French replied that he would like to be able to walk a block and a half to the corner drugstore to visit

with the proprietor and some old friends who regularly gather there. He had been unable to do this because of shortness of breath and angina pectoris.

A discussion of congestive heart failure, its symptoms, and the measures available to control it followed. The physician suggested that if Mr French kept his condition under better control, and when necessary, used a sublingual dose of isosorbide dinitrate before excursions, he might very well be able to get to the drugstore and back. Together, the physician and patient decided that by switching his diuretic to bumetanide (hoping for a shorter duration of action), and having Mr French take both the digoxin and bumetanide in the early afternoon, he would be in his own apartment during the time of their maximum effect and would not have to wait in line for a bathroom. No attempt was made to convince him that the digoxin probably had little to do with his urinary frequency or urgency. There was a discussion of the high-sodium foods he should try to avoid. Mr French expressed confidence that he could stick to the agreed-upon regimen.

Mr French's story is not only an example of good geriatric care, it illustrates the fundamental principles of family practice. Health care ought to be person-centered. This requires the physician to understand something about the patient beyond his problem list. To be maximally helpful to the youngster with brittle asthma who is having difficulty coping with his disease, the adolescent with diabetes, the young mother struggling with obesity, the middle-aged man with heart disease, the physician must, among other things, inquire about daily activities as well as functional goals and limitations. Patients want physicians to ask about how their health affects their ability to perform everyday activities, but according to a recent population survey,[1] this occurs only 20% to 30% of the time.

The method of interviewing illustrated by the case of Mr French has particular relevance to geriatrics, a field in which long problem lists are the norm and full recovery is often impossible, but it has implications for physicians seeing patients of all ages. Health is important primarily because it allows us to do the things that—for us—make life worthwhile. The treatment of medical conditions is relevant when it can be expected to improve the quality of life for an individual. Therefore, questions that provide information about current and desired level of function, such as the two used in this case, should be a standard part of the evaluation of all patients.

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Reference

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