2 History taking

> A smart mother makes often a better diagnosis than a poor doctor.
>
> August Bier (1861–1949)

LISTENING TO MOTHERS

The most important attribute of any good doctor is to be a good listener. Listen carefully to mothers and note what they say. History is the vital cornerstone of paediatric problem solving. More important information is often gathered from a good history than from physical examination and laboratory investigation.

The first important ground rule in history taking is: *mother is right until proved otherwise*. Mothers are, by and large, excellent observers of their offspring and make good interpreters of their problems when sick. Even the most

ill-educated mother will often surprise you by her intuition. She may not know what's wrong but she certainly knows something is wrong. If a mother says, 'I think my baby can't hear properly', the onus is on the doctor to corroborate or negate that statement.

In our view no one can replace the mother in providing an accurate and thorough description of the child and his complaints. Fathers will vary in their expertise, but often lack the information, insight and instinct that a good mother can provide. While the principle that mother is usually right prevails, the corollary must be that fathers can be off cue and off course. However, the modern day domesticated father is improving. Other caretakers – guardians, aunts, housemothers – will vary widely in their knowledge of the child. We have been impressed by the inhibitory nature of some grandparents' presence at initial interviews and history taking.

At the outset it is important to try to establish a good rapport with the mother. Allow her to understand that you are more concerned with what she has to say than what Dr X has suggested. Make sure you understand her idiom and her concerns, A useful opening question is: 'What do you yourself think really is the cause of his trouble?' or 'Do you have any views as to what is wrong with him?'

These questions may lead you in the right direction. Alternatively, they may be important to negate following examination and investigation. Get into the habit of quoting verbatim from mother. Mothers frequently make statements whose importance, if not noted and recorded during history taking, may be subsequently lost. We both have the experience of saying to ourselves: 'If only I had listened to that mother; she was trying to tell me what was wrong'.

Students can unquestioningly accept a mother's complaints about her child without asking her to define her terms. Terms such as 'diarrhoea' or 'vomiting' require defi-

nition. Does diarrhoea mean frequent stools, semi-formed stools, offensive stools? Do you (or mother) know the normal frequency of stool passage? Is it reasonable to expect a teenaged single parent to know children? What does the term 'hyperactivity' mean to you – are not all children active to varying degrees?

Listen to mother talking

- What are her worries?
- What does she think?
- Quote verbatim
- Understand her idiom
- Ask her to define her terms (What do you mean by . . . ?).

You need to establish that you are both talking about the same thing, be it croup, anorexia or breath-holding. You

Fig. 2.1 Listen attentively to mother.

need also to learn her local idiom or slang (for example the penis may be referred to as the 'private parts', 'willy' or 'johnny'). In our hospital the residents have come to learn that when mothers say that the baby is 'lobbing and lying', they mean something serious is wrong. Australian mothers may state that the infant is 'crook'.

One needs to know the questions which produce the desired answers. A good opening ploy is, 'Tell me about your baby', and then simply let the mother talk. As you gain experience you will learn the important pointers and know when to interject succinct questions without interrupting her flow.

The student must of course take thorough notes interspersed with pithy quotations or spicy titbits. In time you'll learn how to cut corners, how to proceed down diagnostic avenues and how to recognize important cues. Learn through history taking (receiving) to be a good listener – to parents primarily, but also to your better teachers as they elicit clinical histories.

A poorly taken and recorded history

Cough × 3 days
Off feeds × 2 days
Wheeze × 1 day
Temperature × 1 day
Vomit × 2.

Many current charts contain such anecdotal and unexplored facts. While the basic details are stated there is inadequate inquisition and description. The diagnosis may then be recorded as 'chest infection', symptomatic of historical haziness and clinical laziness.

Always ask the parents to relate the sequence of events leading to the present complaints. A suitable start might be

'When was he last well? Which came first, the cough or the wheeze? In what way has he changed?' In eliciting the history of a convulsion, details of the time, place, surroundings, stimuli, etc. are of vital importance.

You will need also to obtain a general knowledge of the child. What sort of fellow is he? Is he active? Has he much energy? Is he outgoing, sociable? How does he sleep? Is school progress satisfactory? Is he developing normally? Whose side of the family does he resemble?

Let mothers talk

- Tell me about your baby
- What sort of fellow is he?
- When was he last well?
- Tell me what happened.

Patients also appreciate a doctor who gives them individual attention and whose time is devoted to them (even though he may be in a hurry). Listen and you will hear. Time spent on history taking will be well repaid. Try to ensure that your written notes reflect adequately the time taken and interest shown. Some mothers do 'beat about the bush' dragging in all sorts of irrelevancies. With experience you will learn how to conduct and interrupt such garrulous gabblers.

Any of your standard texts and tutors will cite examples of how to fully explore a symptom, such as cough or pain.

When does it occur?
How long has he had it?
Can you describe it?
What brings it on?
Does anything relieve it?
How long does it last?
What is its pattern and periodicity?

Are there any associated symptoms?
What does he do when he has it?
What have you done about it?

This will necessarily be followed by a careful and thorough exploration of the relevant system, and then by a systems review. With time and experience, systems reviews tend to abbreviate and to become more precise. There is nothing special or different in paediatrics about the necessity of obtaining an adequate past history, family history and social history. Awareness of the child's place in the family, relationship with parents, siblings and peers is crucial in obtaining a broad view of the child. So many of today's illnesses have social and behavioural overtones that the importance of the holistic view cannot be overemphasized.

A knowledge of the family's socioeconomic status, present financial situation, housing and employment is vital. Are the parents married, separated, cohabiting? Is the mother single? In some cases of handicap or metabolic disorder it will be prudent to enquire cautiously about consanguinity.

CUE WORDS

Computers accept key words; students ought to look out for *cue words* when taking histories. By cue words we mean simple statements, hidden in histories, which may be diagnostically alerting. Let us cite a few examples.

1. *Cue*: 'She does not like bread or biscuits.'
   Think: Could this be gluten enteropathy?
2. *Cue*: 'He just loves salt; he even licks it from things.'
   Question: Has he a salt losing state?
3. *Cue*: 'He's hungry after he vomits.'
   Answer: This is suggestive of mechanical vomiting, whether due to pyloric stenosis or gastro-oesophageal reflux.

4. *Cue*: 'He's always drinking, he'll drink anything, he'll even drink from toilet bowls.'
   Response: This sounds like true polydipsia.
5. *Cue*: 'I don't know where all the food goes.'
   Comment: When referred to a relatively inactive infant this statement may suggest a malabsorptive state, for example cystic fibrosis.

Mothers may, of course, unintentionally deceive. A common complaint is: 'I can't get him to eat anything.' And there in front of you sits a solemn, pudgy infant sucking on a bottle containing a mélange of milk, rusks, and maybe tea. In a similar vein, the seemingly contradictory statements, 'But he eats nothing doctor' followed rapidly by 'He never stops going' are frequently encountered. They usually reflect the overactive (and perhaps under-disciplined) toddler who is 'addicted to the bottle' and is consuming excessive carbohydrate by day and night.

A SAMPLE HISTORY

To obtain the right answers any detective must know how to ask (and frame) the right questions. This simple maxim applies to any system; nowhere is it more pertinent than in taking a history of a fit or convulsion. In any convulsion one needs to know as much as possible, about the child, his environment and the surrounding circumstances.

However, by way of example of a thorough history we have chosen the questioning of a mother whose child is wetting the bed (enuretic). This common complaint, source of much maternal irksomeness but often a dearth of medical interest, exemplifies the value of detailed and diligent history taking.

What age is he?
Where does he come in the family?
When did the bed wetting commence?

How frequently does he wet?
Does he wet by day?
How long can he retain his urine by day?
Does he have a good stream?
Has he had any kidney infections?
When was he dry by day?
Was dryness achieved easily or with difficulty?
Has he his own bed?
Does he awake when he wets?
Does he waken more than once per night?
Is he in nappies at night?
Who changes the sheets?
Have you inside toilets?
What have you done about wetting?
Does he want to be dry?
Has he had any dry nights?
What was his best dry period?
Is he dry when away?
Have you lifted him?
Have you restricted his fluids?
Have you reprimanded or punished him?
How does he get on at home and in school?
Have medication or alarms been tried?
Did any of his siblings wet at night?
Were either of you (his parents) wet when children?
How does the wetting affect him?
How does the wetting bother you?

This may seem like a ream of questions but with experience they can trip off the tongue promptly and build-up a picture of the child and his problem. Bed wetting is one of those complaints for which it can be useful to see the child and mother both together and separately.

Similar interrogation in depth can be constructed for a whole variety of symptoms from fits to fainting to

feeding difficulties. There is simply no substitution for a thorough history, properly phrased and fully recorded, in diagnosing childhood disorders. Try writing one for asthma, abdominal pain or anaemia. Think of a suitable programme of questions one might feed into a computer and have the parents perform themselves while awaiting consultation.

Did you know that it has been estimated that about 70% of paediatric diagnoses are based mainly on *history*?

Summary 1

Eight-year-old boy. Recurrent chest infections particularly in winter. Nocturnal cough. Persistent runny nose. Past history of eczema. No physical findings today.

Impression: Asthma.

Summary 2

Two-year-old girl. Six-month history of diarrhoea. Stools are messy, loose and contain undigested food. Three to five bowel motions per day. Good energy, appetite. Normal height and weight for age. Well nourished. No findings.

Impression: Toddler diarrhoea ('peas and carrots syndrome').

Summary 3

Seven-year-old primary school girl. One-year history of staring, vacant episodes noted by parents and teacher. Eyes flicker. Child stops momentarily. Child not bothered by events. Carries on as if nothing has happened. Episodes occur two to three times per week. Occasionally two to three times per day. Normal intelligence, no past history, no physical findings.

Impression: Primary generalized epilepsy (absence seizures).

The above examples show that a good history with the pertinent points abstracted is the best pointer to diagnosis in paediatrics.

Help strategy

H = **H**istory
E = **E**xamination
L = **L**ogical deduction
P = **P**lan of management

Feeding history

Feeding is such an intrinsic part of infancy, and feeding problems so common, that a good history on feeding pattern and content is crucial. Too many doctors when presented with a feeding problem change the milk. The problem does not usually lie in the milk but in management of feeding and in the mother–infant relationship (harmonious or otherwise?). A detailed feeding history is vital if one is going to be able to discuss diet with today's allergy-conscious mothers.

Was the baby bottle or breast fed? If *breast fed*, what was the duration of exclusive breast feeding? Was this a satisfying experience for mother and baby? How often did she feed? Was he content? Were there any problems? How did he sleep, feed and gain? Did she feed on demand or to some sort of schedule? Was she complementing the breast milk with anything else?

If *bottle fed*, was he fed on formula or unmodified cow's milk? Which formula did he receive? How was it prepared? What volume did he take each feed and how long did he take over it? Frequency of feeds? Total daily intake? Any additives (iron or vitamins) given with milk? Duration of exclusive milk feeding?

Weaning

At what age were solids first introduced? Which solids? How were they administered – by spoon or in bottle? At what age were gluten-containing foods first given? Had he any preferences? When could he manage lumpy food?

Any known food allergies? Why do you think he is allergic to that substance? Does he suck well? Does he swallow well? What stops him feeding? Is it, for example, satiety, sleepiness or breathlessness? Were there weaning problems? How did you two get on? Did the father assist with bottle feeding? Do you feed him every time he cries? Do you give him drinks of water?

If all these questions fail to sort out the problem, one may have to resort to the request 'Show me how you do it please'.

Students can with benefit spend time doing nursing duties – changing, washing, holding and above all feeding babies. Learn by doing.

In conclusion, good history taking is the hallmark of the good student of paediatrics. In all histories it is imperative to get to the root of the problem. It may be worth repeating, now that you have established rapport with the parent, the following questions:

- Remind me again, why did you bring your child along?
- Just what are you worried about?
- What do you think is wrong with him?

A **full paediatric history** will enquire along the following general lines:

pregnancy
delivery

perinatal events
feeding practice
developmental progress
immunizations
infectious diseases
accidents and injuries
hospital admissions and operations
allergies
minor illnesses
medications
serial heights and weight, if known
school progress
travel.

During the taking of the history, preferably in relaxed surroundings, the opportunity should arise to observe how the child separates from the parent, how creatively and independently he plays, and occasionally how expressively he draws.

The whole history and nothing but the whole history

The full facts
The precise sequence of complaints
Changes noted since onset of illness

Insofar as students are concerned, the ten commandments of *record keeping* are:

Thou shalt write legibly
Thou shalt note the date and the time
Thou shalt record thorough histories and examinations
Thou shalt avoid abbreviations
Thou shalt write a succinct summary
Thou shalt list the important problems

Thou shalt make a diagnosis or, if not possible,
Thou shalt assemble a differential diagnosis
Thou shalt sign thy name and status
Thou shalt not alter entries.

LET THE CHILDREN SPEAK

While we repeatedly emphasize the value and importance of a mother's history of her child's complaints, don't forget the child. He may be very anxious to tell you his story and may have a useful contribution to make. Often times, especially if he's verbally precocious and outgoing, or if he has a chronic condition and much experience of hospital, he may express himself remarkably lucidly. Children need to be heard and be seen to be noticed. They have a viewpoint which they are frequently eager to express. Children over 5 years should be asked to give their account of events with parental corroboration of certain points. One brief example.

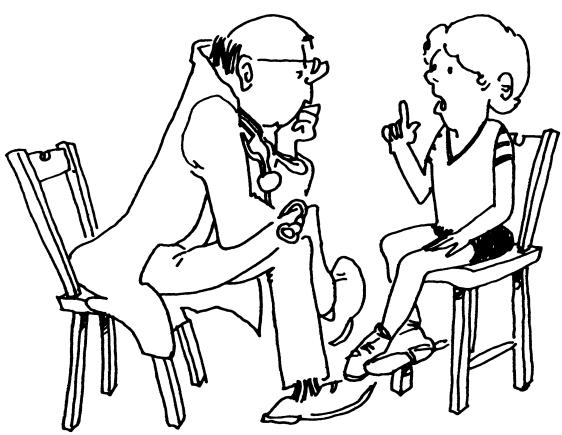

Fig. 2.2 Let the children speak!

Fig. 2.3 An anxious mother with ill baby.

We recently saw a bright 10-year-old boy with a proven duodenal ulcer. He described his pain as being 'like a laser beam going through my stomach'. Brilliant!

If he's reticent, shy or mute don't push him. He may talk later. Allowing him to draw himself, his family, their home may be revealing to those with psychological insight. Use of a tape recorder, or even a video (if your Department of Child Health is well equipped) can be useful, particularly in exploring behavioural or conduct problems.

Make sure you know the child's pet name as well as his given name. Laurence may be called 'Larry', Robert 'Bobby' and Catherine 'Katie'. In addition, the child recorded as Patrick Joseph, may in fact be called 'Junior'.

TALKING TO PARENTS

Parental anxiety is difficult to assess and can vary in degree from mild concern to severe emotional upset, sometimes culminating in aggressive behaviour. Being comfortable in discussions with parents comes from experience and observation of the approach used by more senior colleagues. Although there is no single correct approach one must adapt to the great variation in paediatric conditions, from neonatal anomalies, through children with disabilities, to the otherwise healthy child with an acute illness. Preferably both parents should be present, with the exclusion of other relatives unless parents insist.

In many cases both doctor and parents are strangers to each other. The initial approach will be a mutual assessment. A quick appraisal of the age of the parents, their education and social status may be helpful to the physician. It is important to show respect for the parents and, where possible, to avoid interruption during the discussion. Always use the child's name and be fully briefed in relation to age, previous history and if necessary sibling history. If appropriate, the child should be present and language and communication should reflect respect for the child concerned.

It is important to be as factual as can be whatever the circumstances, at the same time explaining the limitations of professional knowledge. When asked about statistical or percentage chances of recovery be careful to point out that each child is an individual. It is also pertinent in present times to have a witness from either medical or nursing staff present and to make a detailed note in the patient's chart.

Good listening is contributory to learning, good communication is the key to cooperative caring.

Parents of ill children broadly seek four degrees of information

1. What is it? What is wrong?
2. What caused it? How did it happen?
3. What will be the outcome?
4. Will it happen again?

Clearly the answers to the above questions will considerably depend on whether the child's disorder is an acute one (e.g. meningitis) or whether it is an inherited abnormality (e.g. cleft palate). It is evident that one has difficulty responding to questions 2, 3 and 4 if one cannot answer question 1. Students should be reticent about discussing causes and consequences with parents until they possess the appropriate acumen and authority. Finally, don't forget the unvoiced (fifth) question:

Is it leukaemia, or cancer, or some lethal familial trait?

Could we, at the risk of sounding old fashioned and conservative, remind students to dress presentably. In your final years you are dealing with people as a trainee doctor rather than a science student. Many studies have shown that

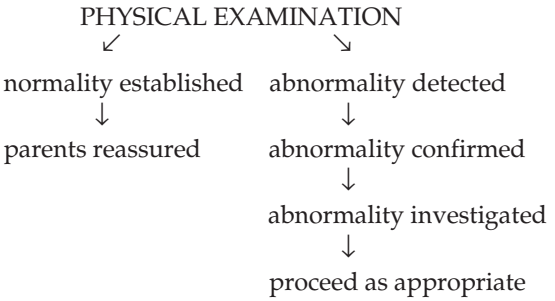

Fig. 2.4 Algorithm for action in consulting.

parents interact reluctantly with shabby, unshaven, scruffy students.

An initial office consultation perhaps should be the easiest to deal with. However, interpreting the history given – which may vary from one parent to another – can take time.

At some point you should ask the direct question, 'Is there some serious condition that you are worried or have read about?' The answer, in many cases, will get to the root of the problem, from where one can embark on physical assessment, appropriate investigations and possibly early management. (It is advisable to avoid meeting with relatives other than the parents, as in such circumstances the history may become more confusing.) In this day and age one must be prepared for extensive knowledge of some conditions

Fig. 2.5 In this day and age extensive knowledge can be acquired from the internet.

acquired by parents from the internet, but remember that interpretation of such information is where the problem may lie.

BREAKING BAD NEWS TO PARENTS

As an undergraduate student, *don't*. You lack the authority, experience and acquired empathy. You can, however, learn the necessary attributes through communication skills exercises (videoed and later discussed), or better by sitting in on real scenarios in the hospital. Telling the parents that their newborn baby has Down's syndrome, or that their toddler has serious meningitis, or that the infant they rushed in for resuscitation has in fact died is always difficult, draining and demanding. The impact of bad news can be lessened if done quietly, sensitively and responsively.

- Speak slowly and simply
- Avoid medical terms
- Be as clear and concise as you can
- Don't try to transmit too much information
- Ask for questions
- Always have a nurse present
- Express your sympathy.

Never, never give bad news over the telephone. Give the news in private, appropriate surroundings. Allow parents time to express their shock, grief, guilt, anger, or whatever emotion.

Key paediatric points

Listen to mothers and note their concerns

Preverbal children's ability to communicate is limited. Learn to appreciate 'body language' and acquire some skills in observation (see p. 79)

Certain illnesses have predilections for certain ages:

bronchiolitis	<1 year
laryngotracheobronchitis	<3 years
transient synovitis	<5 years
slipped upper femoral epiphysis	~10 years.

As parents prepare to leave a discussion, always conclude by asking whether there are any points not clearly understood, or whether there are any further questions which they may have forgotten to ask.