Dr.Sahni's Homoeopathy Clinic & Research Center Pvt. Ltd

November 2005

Case Taking

Dr. Sahni BS
Dy.CMO, ONGC Hospital, Panvel, Navi Mumbai, INDIA

Introduction

The foremost step towards making a good prescription is a well taken case. Hahnemann writes "If the physician clearly perceive what is to be cured in disease, that is to say, in every individual case of disease (*knowledge of disease, indications*), if he clearly perceives what is curative in medicines, that is to say in each individuals medicine (*knowledge of medical powers*), and if he knows how to adapt, according to clearly defined principles, what is curative in medicines to what he has discovered to be undoubtedly morbid in the patient, so that the recovery must ensure—to adapt it, as well in respect to the suitability of the medicine most appropriate according to its mode of action to the case before him (*choice of the remedy, the medicine indicated*), as also in respect to the exact mode of preparation and quantity of it required (*proper dose*), and the proper period for repeating the dose;-if, finally, he knows the obstacles to recovery in each case and is aware how to remove them, so that the restoration may be permanent: then he understands how to treat judiciously & rationally, and he is a true practitioner of the healing art".....*Para –3 of Organon of Medicine*

Case taking is an art on which the success or failure depends. A proper case taking is essential for the success process of the study of the Repertory and repertorization. Further, the art of the physician in taking the case must so record it that we may glean from this record those elements that may be translated into the rubrics of the repertory.

However, it is impossible to secure from the patient a clear-cut picture of his difficulties, inspite of the best art the physician may exercise.

Talking to the patients and obtaining their health histories are usually the first and often the most important parts of the health case process.

Approach to the Patient

The physician should approach his patients with humility and gratitude, with confidence and pride in the responsibility which will be his for the remainder of his life. It is all a mater of communication between patient and physician. It is no exaggeration to say that even facial expression tone of voice and manner of movement can affect the ability to elicit the patient's story and to lead him back to health. For it is in such outward signs that we display those attitudes of mind - impatience, boredom, embarrassment, disbelief and reproach - which act as barrier to communication with others. In the presence of his patients, the physician must master his emotions, clear his mind of distracting thoughts and avoid all appearances of haste. His manner should be alert and attentive yet gentle and sympathetic. Without these qualities, he will neither obtain the facts needed for the diagnosis nor effectively convey the advice essential to the patient.

The Disease...

Disease is a departure from health and is manifested in an individual during life by *symptoms*. These Symptoms are as under:

- **Subjective Symptoms** are those symptoms that are recognizable only by the patient and present no external indications such as pain, itching or a feeling of chilliness etc. Philosophically Subjective reality that exists in the mind only!
- **Objective Symptoms** are those that can be detected by observer e.g. abdominal enlargement or dullness on percussion. Philosophically objective reality is that which can be demonstrated by means of tangible or outward signs, good deal of pain.

  The word symptom is used in two senses. Sometime it used in a general sense to indicate all the subjective & objective evidence of a disease; but more usually it is employed in a narrow sense, as synonymous with subjective symptoms. Objective symptoms are usually spoken of as ***signs***; and those objective symptoms, which are made out by physical examination, are known as ***physical signs***.

  Just as the value and significance of physical signs depend on the skill and experience of the physician who observes them, so the significance of subjective symptoms has to be weighed and considered in relation to the character and constitution of the patient who complains of them. Thus a certain symptom may appear trivial and unimportant to a patient of strong character not addicted to introspection, although serious disease may be present; whereas in women with a susceptible nervous system every subjective symptom, however slight, may cause great anxiety, exaggeration, and even real suffering. Sub-mammary pain, for instance, in the first might indicate aneurysm; in the second, hysteria.
- **General (or constitutional) symptoms** are those, which relate to the whole body, such as debility or pyrexia.

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Hahnemann writes (Para 71 Organon of Medicine) "As it is now no longer a matter of doubt that the diseases of mankind consist merely of groups of certain **symptoms** and of mankind and transformed into health by medicinal **substances** but only by such as are capable of artificially producing morbid symptoms (and such is the process in all genuine cures), hence the operation of curing is comprised in the following points":

- How the physician to ascertain **what is necessary to be known in order to cure the disease?** (Case Taking)
- How is he to gain knowledge of the instruments adapted for the cure of the natural disease, the pathogenetic powers of the medicines?
- What is the most suitable method of employing these artificial morbific agents (medicines) for the cure of natural disease?

In case taking, our objective is, ***first,*** to elicit all the data of the case; and, ***secondly***, by reasoning based on those data to arrive at its Diagnosis, Prognosis and Treatment. It will be found in actual practice that everything turns on the diagnosis; this is our first and principal object; the prognosis and treatment follow from this.

The investigation of a case consists of three parts:

- The Interrogation of the Patient
- The Physical Examination
- The further Investigation by Special Ancillary Methods (e.g., Radiology, Clinical Pathology), where necessary

Case Taking

A. Interrogation of the Patient: By interrogating the patient the objective is to obtain the following information:

- What is his/her chief or cardinal symptom?
- The facts concerning the present illness,
- The patient's previous history,
- The patient's personal history, and
- His/her family history

Throughout the interrogation of the patient it is well to follow **three general rules**:

1. *Avoid putting what barristers call "leading questions"* i.e., questions that suggest their own answer: e.g., "Have you had a pain in the back?" suggests an obvious answer to the patient. It might be put thus: " Have you had any pain, and if so, where?" The patient should be encouraged to tell his own story, without interruption. Moreover, the very words he uses should be recorded between inverted commas, and on no account should his words be translated into scientific terms. Some say that leading questions are permissible when the patient is very ignorant and stupid, but these are the very cases in which leading questions should be specially avoided. The only legitimate way of putting a leading question is in an alternative form—e.g., "Have you suffered from diarrhea or constipation?" Time, patience and tact are necessary to elicit the true facts of the case, without irrelevant detail. Our object is to learn what the patient feels and knows, not what he thinks of his disease; and our patience is often sorely tried by a long story of his own or his previous doctors' views on his case. Our record should be comprehensive, including all-important data, negative as well as positive, yet concise i.e., excluding irrelevant facts. Only experience and knowledge of medicine can teach us what is or is not relevant. The beginner should strive after completeness rather than conciseness.
2. *A chronological order* should always be adopted, both in eliciting and in recording the facts. Nothing is more wearisome than to wade through a mass of verbiage, which mixes up dates. Dates should be recorded always in the same terms. It is very common, for instance, to read in students' reports that "breathlessness began in the year 1952", "palpitation started when the patient was aged forty," " edema came on two years ago."
3. Always adopt a kindly and *sympathetic manner*. Not only is it our bounden duty to be considerate and patient with those who suffer, but by entering into the spirit of the patient's sufferings we can often get at more important facts, and a truer narration of them, than can one whose harsh or abrupt manner causes the patient to shrink up like an oyster into its shell. Put your questions in as simple and non-technical a form as possible, and be sure that the patient attaches the same meaning to the words as you do. Much will depend on the tact of the physician, and two very good rules may here be added—viz., Never enquire concerning a family history of a lethal illness such as cancer before a patient whose illness is likely to be of that nature; Never put questions bearing on venereal disease before the husband or wife of the patient.
    a. The *Chief or Cardinal Symptom*: The first question to ask a patient should always be the same "What do you complain of?" Special attention should be paid to the main symptom for which the patient seeks advice or is admitted to hospital, because it is this symptom, which guides most of our subsequent inquiries. It should always, as far as possible, be recorded in the patient's own words. The best way to avoid error is to verify your observations by repeating your examination.
    b. The *History of the Present Illness* must be/taken and recorded with care. Some patients come out at once with their story; others remain silent. The former must not be interrupted except to steer them away from irrelevancy. The latter should be gently encouraged rather than questioned. In other words, the patient's history should whenever possible be received, not taken.

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Most patients expect the doctor to make the first move. After a few words to put the patient at ease, he must find out why the patient has come. The conventional opening question "What do you complain of?" is not always suitable. Some patients have no real symptoms but feel obliged to mention a minor discomfort in answer to this question when in fact they have come with a problem rather than a pain. The more sympathetic question, "What can I do to help you?" sometimes brings a more revealing answer. However, more than one approach may have to be made before the appropriate response is obtained; a list of suggested alternative is given as under:

Whether the patient is presenting with a symptom or a problem, this should be recorded in the patient's own words, along with note of its duration. If the patient's own words consist of a diagnosis rather than a symptom, he must be asked to indicate this condition affects him. The symptoms and not the "diagnosis" are then recorded e.g. Chest pain: One wk, Cough: 2 moths etc.

Questionnaire

- What do you feel wrong with yourself?
- In what way do you feel ill?
- What can I do to help you?
- Tell me why you wanted to have homoeopathic treatment?

When the patient is finished his story and answered "No" to the question: "Have you any other symptom at all?", he may then be asked leading questions to ensure that no symptom has been forgotten.

Questionnaire

Onset (record for each symptom in chronological order)

- When did you (symptom) first start?
- Were you perfectly well before then?
- Have you ever had anything like this before?
- Did your (symptom) come suddenly one day or gradually or periodically?
- What were you doing when it came on? (if onset is sudden)

Development (record for each symptom in chronological order)

- What has happened to your (symptom) since then?
- Coming & going? (record frequency, duration & relationship if any to physiological or environmental factors)

Getting worse or better? (Record whether the change has been gradual; if not, then when it occurred and whether related to physiological or environmental factors.

Description (pain given here as an example)

- Show me where you feel pain?
- Does it move anywhere?
- What kind of pain is it? (aching, stabbing, throbbing, gripping etc)
- How bad is it? Does it make you stop what you are doing?

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- How often do you get it? (record whether continues or number of times per day, week, month or year)
- How long does it last?
- Does it come at any special time?
- Does anything brings it on or makes it worse?
- Does anything relive it? What do you do when it comes out?
- Do you feel anything else wrong at the same time?

It cannot too strongly be emphasized that in many diseases a full and accurate history of the illness may be the only method of arriving at a diagnosis, for physical signs may be absent or in abeyance (e.g., in angina pectoris). Taking an average, it is fair to compute that of the information on which a diagnosis is ultimately founded, at least 50 per cent comes from an accurate history, and rather less than 50 per cent, from the physical examination and subsequent special investigations. The history should then reveal

i. The mode of onset, whether sudden or gradual,

ii. What he patient was doing at the time, and whether he attributed the onset to any cause. In many cases it is necessary to enquire in to

iii. Whether the symptom is localized or widespread,

iv. Does it radiate to other areas; also

v. The duration of the symptom,

vi. Whether it ended suddenly or gradually,

vii. Its severity,

viii. Whether it has occurred since, and if so, how many times, and is it getting more or less severe,

ix. What intervals of freedom have occurred, when the patient has been entirely free of the symptom,

x. Have other symptoms occurred in association with this chief symptom, and if so, what are they,

xi. What does the patient do during the time of the symptom to relieve it,

xii. Has the patient found any measures of avail to ward off attacks, e.g., drugs, diet, etc. In many cases, e.g., in juvenile and unconscious persons, the history has to be elicited from near relatives or friends. It is useful also to know whether the patient has recently been, or is now, under medical care, not only because the symptoms may have been modified by treatment, but also because one of the most important ethical principles of the medical profession may be involved. In all these enquiries the above stated general rules given above apply.

c. The *Previous History* of the patient bears largely on the etiology, or causation, of his illness, and deals with any illnesses the patient may have had. Note in chronological order all ailments from which the patient has suffered prior to the present one, with the dates of their occurrence and their duration: e.g., contagious diseases of childhood; and especially previous operations or serious illnesses.

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If the illnesses have been at all obscure, it is desirable to add a few of the leading symptoms to prove the nature of the alleged attacks, and in such instances inverted commas should be freely used. For instance "rheumatism" is vague terms which may mean any disease attended by pains in the limbs, such as are due to alcoholism, syphilis, tabes dorsalis or neurasthenia. The subject of syphilis should always be approached with delicacy in the case of women. Indirect information may often be gained by enquiring for prolonged sore throat, followed by loss of hair, enlarged glands, skin rashes, etc. In married women, a series of stillbirths, or children born with eruptions or snuffles, may have the same significance.

Questionnaire

- Have you had any serious illness in the past?
- How did it affect you?
- Any operation or bad injuries?
- Any stillbirth, miscarriage or problem in pregnancy?
- Have you ever been to hospital?
- Have you missed time from work because of illness?
- Have you ever visited doctor before?
- Have you ever had (here list illness possibly relevant to present complaint)

d. The *Personal History* must be enquired into such as:

i. Present and previous occupations;

ii. Previous residence abroad;

iii. The home conditions;

iv. Habits as to alcohol and tobacco and whether alcohol (e.g., wine, beer or spirits) is taken between or with meals, because more harm is done by alcohol before meals (especially cocktails) than many times the same quantity taken with meals;

v. The appetite;

vi. The state of the digestion and the bowels;

vii. The weight, and whether this is constant, being gained or lost;

viii. The general state of the nervous system, e.g., depression, excitability, nervousness;

ix. The orientation of the patient to his (or her) work and to home life, and whether there are any special anxieties attached to these;

x. The amount and quality of sleep;

xi. In women, the previous state of the catamenia, and the number of pregnancies, miscarriages or stillbirths, should be noted.

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e. The *Family History* may, like the previous history, have a casual relationship to the patient's illness. The age and state of health if living, age and cause of death if dead, of near relations, should always be noted: i.e., father and mother, brothers and sisters, sons and daughters, also of husband or wife. Enquiry should also be made as to whether any members of the family (parents, grandparents, brothers, sisters, uncles, aunts or cousins) have suffered from tuberculosis, cancer, acute rheumatism, gout, nervous disease, asthma, heart disease, apoplexy, and especially those diseases to which the patient himself seems liable.

Questionnaire

- Are you married?
- Is your wife/husband well?
- Do you have children? (record age & sex)
- Have they ever been seriously ill (record details)
- Have you lost any children? (record age & cause of death)
- Do you have brothers & sisters (record age & sex)
- Have they ever been seriously ill? (record details)
- Have you lost any brothers or sisters? (record age & cause of death)
- Are both of your parents living? (if not, give age & cause of death)
- Have they ever been seriously ill? (record details)
- Do you know of any one in the family with symptoms like yours?
- Do you know of any disease affecting more than one member of your family?

f. *Social History*, question asked under this heading are designed to uncover anything in the patient's personal life, relevant to either the cause or management of his ill health. We need therefore, to know about his work, hobbies, habits, environment at home, visits abroad, domestic and marital life any potential source of mental illness.

Questionnaire

- Are you working?
- What exactly do you do? (record hours, physical activity, potential hazards, travel-ing)
- How long you have done this job?
- What jobs have you done before, starting when you left school? (record as above)
- What do you do in your spare time? (hobbies, sports etc.)
- Are your mealtime's regulars?
- When is your main meal?

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- Do you or did you smoke? (record duration, number of cigarettes/cigars/pies per day)
- Do you or did you take alcohol? (record type & amount)
- Do you or did you take drugs of any kind? (record type & amount)
- Have you been abroad? (record where & when)
- Tell me about your home? (rooms, stairs, toilet facilities, state of repair)
- Who is living in the same house?
- Have any been ill recently?
- Do you have animals at home?
- Have you had any recent worries or stresses?

B. Physical Examination:

1. Here, again, having learned by interrogation our patient's chief complaint, we should ask ourselves, is there any striking or predominant sign or appearance (Latin fades)? The importance of inspecting our patient cannot be overestimated. In these days of scientific instruments we are too apt of or get to use our faculties. By simply using our eyes many important data may be learned besides the color of the skin, the condition of the teeth and gums, the general nutrition, the attitude or decubitus, and the facial expression. For instance, the manner in which a patient answers questions is often the first clue to anxiety, and a peculiar mode of speech is one of the patho-gnomonic signs of general paralysis of the insane, disseminated sclerosis and other diseases. Moreover, with experience we can by this means form a conclusion as to the kind of patient we have to deal with. Again, never be in a hurry; only by taking time can we fully appreciate all the points presented to us. This habit of "observing" the patient is only developed by long practice; it will never be developed if the young physician allows himself to be infected by the hurry of modern times.
2. It is important always to commence examination with that ORGAN TO WHICH THE SYMPTOMS ARE MAINLY REFERABLE. Some teachers direct their pupils, to examine and report on the physiological systems always in the same order (first the heart, then the lungs, then the digestive system and so forth), whatever, may be the illness. But such a course has three objections:
    i. The student goes about his work in a mechanical fashion;
    ii. If the patient suffers from some serious disorder, such as peritonitis, he may be exhausted by a complete investigation of the chest and other parts during the acute illness; and
    iii. Often it is a waste of time to examine all the organs with equal thoroughness. The same educational advantages and experience can be obtained by the other method, and in that way we come to the most important facts first.
3. In all cases EVERY ORGAN IN THE BODY SHOULD BE CAREFULLY EXAMINED; for although we may find in one physiological system sufficient mischief to account for the patient's symptoms, the other organs may reveal changes, which considerably modify treatment, prognosis & even diagnosis. Whatever order is adapted; the student should not wander from organ to organ, but examine each physiological system thoroughly before proceeding to the next.

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It is best to get in to the habit of adopting some such order of physical examination as the following: *first*, note the general conditions; *second*, examine the organ chiefly affected; *third*, other organs in the following order: Thorax (heart and lungs), Abdomen (alimentary canal, liver, spleen and genitor-urinary system), Head and Limbs (nervous and motor systems).

The examination should always be carried out gently and without undue exposure. In serious cases, especially when the heart or lungs are involved, it is often well to postpone a thorough examination of some organs, so as not to risk harming the patient by exposing or fatiguing him. On the other hand, the young physician should never allow modesty to prevent his making a through decision. This rule is more necessary in sensitive patients, but a little firmness, tact, and a courteous demeanor will generally enable him to perform what is a duty both to his patient and to himself.

After completing the above schedule, we have to individualize remedies and patient. The concept of individualization as reflected in the totality of the symptoms furnishes the only sound basis for selection of remedy in Homoeopathy practice. Individualization is another name for a process of synthesis done after the analysis of an accurate and complete data recorded after observation and examination of the patient.

As individuality of each man is unique, his reactions to environment and other factors also vary from man to man. In homoeopathic language such a concept of a whole and an individual man that is ill, is expressed through *"totality of symptoms"* which is indicative of the deviation from the total state of health.

In Homoeopathy the entire examination of a patient is conducted with a view to discovering not only the general or common features of the case by which it is classified diagnostically and pathologically, but also the special and particular symptoms which differentiate the case from others of the same general class. It recognizes the fact that no two cases or patients, even with the same disease are exactly alike. In actual practice the "differences" are very often the deciding factor in the choice of the remedy.

Homeopathically each symptom of the patient's sickness has to be modified by the following factors before going for Repertorisation / Simlimum:

- Laterality or sides
- Time-hour
- Modifications-conditions, circumstances
- Extension
- Location
- Character or kind of sensation

In Organon para 83-104, Hahnemann provides the complete instructions for "Case taking".

ACCORDING TO THE MASTERS, MOST HOMOEOPATHIC DOCTORS MAKE THE THREE MISTAKES IN CASE TAKING

- Interruption
- Yes or No answers
- Confirming the remedy you want (Pet remedy)

Hahnemann writes ".....he then makes a note of what he himself observes in the patient and ascertains how much of that peculiar to the patient in his healthy state" (para 90 of Organon).

Case Taking

How to Diagnose?

It is always important that how the data elicited may be utilized in order to arrive at Diagnosis. An attempt is made to find a single diagnosis which will account for most or all the facts of the case. If some facts do not fit the pattern appropriate to diagnosis, their accuracy must be checked and the original diagnosis reviewed before two or more separate diagnosis are postulated. A complete diagnosis would describe the patient's illness in terms of the site (Anatomy: *where?*), nature (Patho-physiology: *what?*) and cause (Etiology: *why?*) of the disease process. In most instances, however, the physician has to satisfied with a differential diagnosis which admits to more that a single possible answer to one or more of these questions. The alternative diagnosis should be listed in order of probability and reasons given in support of the one which is preferred.

When considering the differential diagnosis, priority must always be given to the problems for which the patient sort medical advise.

C. Special Investigations:

Having arrived at a tentative diagnosis, it is always advisable to confirm (where ever applicable) this by the use of X-rays, pathological tests, and other special methods of investigations. These should only be used in confirmation of a clinical diagnosis and ***should never replace the interrogation and physical examination of the patient in the search for a diagnosis***.

References

- Organon of Medicine 6th Edition
- Savill's System of Clinical Medicine
- Chamberlain's Symptoms and Signs in Clinical Medicine