# Assessing the physical health of psychiatric patients

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**Aims and method** Most medical diagnoses are made from the physical history alone. In the psychiatric literature, physical assessment usually focuses on examination rather than history. We aimed to ascertain the relative importance that trainee psychiatrists attach to the physical history and examination, and to investigate their actual method of physical assessment. The relative weight that trainees attach to physical history and examination was assessed with a postal questionnaire. Their actual practice was evaluated by reviewing a selection of case notes from patients under their care.

**Results** Trainees weighted the physical examination as more important than the history in theoretical terms ($P$=0.02). They also indicated that they attached more importance to examination in their own practice ($P$=0.03). On review of the case notes, 34 (71%) of in-patients had been physically examined, but only one (2%) had evidence of a physical history.

**Clinical implications** It appears that many psychiatric trainees do not adhere to the basic medical principle of taking a physical history on which to base a physical examination. 'Blind' examinations are unlikely to yield medical diagnoses. These findings have implications for our patients' health and psychiatric training.

The assessment of physical health has endured an uneasy relationship with psychiatric practice. Routine physical examination is usually held to be a mandatory part of psychiatric admission and forms an integral part of the Membership examination of the Royal College of Psychiatrists. Several authors have demonstrated that examination is often neglected, inaccurate or poorly recorded. It is estimated that half of American psychiatrists never perform a physical examination (Krummel & Kathol, 1987). Low rates of physical examination have been demonstrated in the UK by Hughes (1991). More recently, Mitchell *et al* (1998), in a study of Scottish consultant psychiatrists, highlighted a discrepancy between opinion towards and practice of physical examination. When physical examination is performed on psychiatric patients, recording has been shown to be "uniformly poor" (Rigby & Oswald, 1987). They went on to show significant pathology, mostly neurological, that had been missed in these patients. The need for systematic physical assessment of psychiatric patients is indicated by repeated demonstration of the increased physical morbidity among this group (e.g. Koran *et al*, 1989; Kendrick, 1996).

The literature on this subject concentrates on physical examination as the key tool for assessing physical health. Indeed several psychiatric textbooks do the same, making no mention of taking a physical history. In many psychiatric units, proformas exist for the physical examination, detracting from the importance of a physical history. Most medical diagnoses are made from the history rather than examination. In a cardiology clinic, Hampton *et al* (1975) showed that the medical diagnosis could be made from the history alone in 83% of patients, compared to a figure of 9% for the examination. In a more general medical setting, Sandler (1979) showed that the history determined diagnosis in 56% of all referrals made, with only 17% of all diagnoses being deduced from examination alone. The conclusion was that much greater emphasis should be placed on the diagnostic capacity of the history.

This study was undertaken to determine whether trainees' attitudes and behaviour reflect the bias towards examination rather than history taking.

## The study

The cross-sectional survey comprised two parts: a survey of trainees' attitudes and measurement of corresponding behaviour.

### *Trainees' perception of the relative importance of the physical history and examination within the psychiatric assessment*

Questionnaires were distributed to all 50 senior house officer and registrar grade psychiatrists on the Royal Free training rotation. These consisted of 10 questions, mostly requiring responses on 10 cm visual analogue scales (VAS). Four questions concerning the importance of the physical history and examination were disguised among other decoy questions, to prevent respondents



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Table 1. Trainees' responses to attitude questionnaire; visual analogue scale 0–100 (0=never; 100=always)

| | Median | Interquartile range | Range |
|---|---|---|---|
| How often should psychiatrists be involved in the physical care of their patients? | 70 | 51–88 | 20–100 |
| How often should physical exam be performed in theory? | 98 | 93–100 | 42–100 |
| How often is a physical exam performed in reality? | 73 | 47–85 | 0–100 |
| How often should a screen for physical symptoms be performed in theory? | 97 | 70–100 | 6–100 |
| How often is a screen for physical symptoms performed in reality? | 51 | 18–82 | 2–100 |

from guessing the objectives of the study, thus reducing the social desirability set. The subject matter of the decoy questions included morale, career aims and biochemical investigations.

The VAS allowed respondents to indicate how frequently different components of the psychiatric assessment should be included in theory and how often they are included in reality. For instance, when asked how often they felt the physical examination should be performed in theory, a mark at one extreme, labelled 'always' would indicate 100% of the time. The other extreme was labelled 'never'. The VAS leaves the respondent free to indicate an attitude anywhere between these two extremes. Responses to questions about history and examination were measured in millimetres and compared for each respondent. Differences in the relative value trainees attach to the physical history and physical examination were assessed by Wilcoxon's test.

### *Assessing the method of physical assessment employed by trainees*

A cross-sectional survey of in-patients' case notes was undertaken contemporaneously with the distribution of the attitude questionnaire. The notes of every fifth consecutive admission were selected; none were missing. The source was each of the general adult psychiatric wards to which trainees admit patients. Patients who had been admitted by locum doctors were excluded, since locums did not receive the attitude questionnaire. Basic demographic data and primary diagnosis were recorded from the case notes. The presence of a physical examination was recorded, as was any indication that this exam was based on a physical history.

## Findings

Forty questionnaires (80%) were returned. Since the questionnaire was returned anonymously, no differences between respondents and non-respondents could be ascertained. Responses to key questions in the study are displayed in Table 1. The relative importance attached to history and examination are given in Table 2.

Table 2. Responses of trainees (using visual analogue scale) to assess perceived importance of physical history and physical examination in theory and practice

| Relative importance of components of physical assessment | Number of trainees | |
|---|---|---|
| | In theory | In practice |
| History > examination | 9 (23%) | 12 (30%) |
| Examination > history | 17 (42%) | 26 (65%) |
| History=examination | 14 (35%) | 2 (5%) |
| Significance level of bias towards examination | $P$=0.02[1] | $P$=0.03[1] |

1. Wilcoxon matched-pairs signed-ranks test.

### *Case note survey results*

Forty-eight sets of case notes were reviewed. Twenty-three (48%) were male, with an average age of 40 years (range 17–69). Ethnic origin as recorded in the case notes showed 35 (73%) to be Caucasian, 11 (23%) African–Caribbean and 2 (4%) 'other'. Primary diagnosis recorded in the notes was schizophrenia 29 (60%), unipolar depression 12 (25%), bipolar affective disorder 5 (10%) and eating disorder 2 (4.1%).

A physical examination had been recorded in 34 patients (71%). Twelve of these 34 had no examination of the nervous system. Only one (2%) set of notes included any indication that any inquiry into physical symptoms had occurred. For those who did not have a physical examination, no reason (such as 'patient refused') was recorded in the case notes. There was no association between lack of physical examination and any of the other recorded variables (i.e. race, age, gender or diagnosis of the patient).

## Comment

Our findings concur with previous studies (Hughes, 1991; O'Hare, 1995) that a significant



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number of in-patients do not have a physical examination. Given that almost no patients had an assessment of physical symptoms either, there is a risk of under-diagnosing physical illness and somatic manifestations of psychiatric illness.

Psychiatric trainees felt that the physical examination was significantly more important than taking a physical history. They weighed the examination as more important both in theory and their own practice. This attitude was reflected in the case note survey of trainees' practice. In almost no case notes was there evidence of inquiry into physical symptoms preceding physical examination. There are two possible reasons for these findings. It may be that trainees do usually inquire into physical symptoms before examining a patient, but fail to record this in the medical notes. This interpretation is not borne out by their estimation of their own practices as elicited in the attitude questionnaire; respondents favoured examination over history. On the other hand trainees may not routinely take a physical history. This may be a result of the over-emphasis placed on the examination in the psychiatric literature and training, which detracts from a usual principle of medicine, in taking a history first.

We believe the omission of the physical history is a significant finding. Physical symptoms are important for several reasons in psychiatric patients. Symptoms may allow diagnosis of underlying physical problems that are coincidental with, or causal to, psychological symptoms. They may represent somatic components of psychological disease or side-effects of psychotropic medication.

There is good evidence that the history is the most potent tool in the diagnosis of physical problems. When carried out in isolation, examination alone gives a low yield of diagnoses. For some psychiatric patients, a symptom review may reveal no indication for a full physical examination. For others, their symptom presentation may indicate the necessity for a more detailed examination of one or more systems than would otherwise be the case. There is little reason to subject all psychiatric patients to a full physical examination without evidence that this is required from the history. On occasions, subjecting a reluctant patient to an unnecessary physical examination may compromise the therapeutic alliance.

The membership examination stresses that candidates should physically assess their patients, but that this will rarely involve the patient needing to undress. This empirical approach could be incorporated into psychiatric teaching and practice. We feel an assessment of physical symptoms should precede physical examination on all occasions. The findings of this inquiry will then inform the clinician if any systems deserve closer examination.

Within psychiatry, the physical examination has been adopted uncritically as the gold standard of physical assessment. Indeed it is often regarded as a medico-legal necessity. We feel that a more pertinent question is whether an assessment of physical symptoms has been performed followed by judicious, targeted examination.

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