The house doctor at a private hospital was extracting a medical history—slowly, painfully, like pulling teeth—from an irritated bored woman who by the sound of it had been through it all before. “Have you had chest pain or anything like that?”

“No.” “Have you ever vomited blood or anything like that?” “No.” So he slugged on, one extraction at a time, then writing it all down in a jumble.

He could use some help, I thought from behind the curtain that separated his patient’s bed from mine. I felt sorry for the now figuratively toothless old lady; also for the house officer—busy, harassed, paged by everybody while trying to come to grips with all these patients, and now firing away all these blank cartridges in the dark. I reflected that all these lectures and seminars and medical school curricula revised for the nth time had really not done him much good. Apparently no one had ever taken the time to show him how to take a history, how to relax and get the patient to relax, how to refrain

from interrupting and asking pointless questions, how to “listen to the patient, for he is telling you the diagnosis.” Even the cross old lady might have liked to tell her story, given a chance.

Since that day I have made it a point to periodically inflict on small captive groups of unsuspecting medical students a 10 minute talk on how to elicit a meaningful history from patients perverse enough not to have attended medical school for the benefit of their house physicians. Listen to the patient, I say, don’t interrupt, but if there are questions you must ask—for only psychiatrists have the luxury to listen for ever—at least ask the right ones, especially with inarticulate patients who have short memories and wander from hospital to hospital, from doctor to doctor, or from clinic to clinic.

What indeed distinguishes the novice from the experienced physician, I proceed, is that the first asks about symptoms and the second about events that the patient can remember—hospital admissions, operations, visits to a doctor’s office. Experienced doctors analyse these events, asking what was done, what was said, when, why, by whom, what tests were done, what was prescribed, what colour were the pills, or, for instance, did the doctor shake his head in dismay each time he measured your blood pressure? At times it

Extracting the history

may require the skills of Sherlock Holmes to reconstruct from such circumstantial evidence a reasonably coherent picture of the evolution of a chronic illness. All this is elementary indeed, but it is surprising how many Dr Watsons never catch on.

Flawed history taking leads naturally to flawed history writing. It gives rise to exasperating case presentations devoid of chronology that are like reports from the local branch of the inquisition: Victim presents with swelling feet. Denies shortness of breath. Denies (?under torture) haemoptysis. Admits to having asthma (how long, oh how long?). Now also has abdominal pain. Blood gases normal, computed tomogram scan within normal limits. The abdomen is benign (doesn’t bite?) and the head is (tautologically) normocephalic.

Could this be merely a normal phase in the evolution from student to clinician, something to be expected? Or is it because our “role models” are fleeing the bedside to become corporate executives who must balance budgets and attract grant money? I wondered about this for a fleeting moment, while behind the curtain the indomitable house officer kept firing away at his victim: “Have you ever had dizziness, or ringing in the ears, or anything like that?”—GEORGE DUNEA, attending physician, Cook County Hospital, Chicago, USA

Gene genies

The American social psychologist Kurt Lewin found that the best way to change attitudes was to get people to argue out opinions contrary to the ones they actually held. I had forgotten this dusty old finding until recently, when I agreed to propose an anti-genetics research motion in a debate in Cambridge. Knowing nothing about modern genetics did not seem to disqualify me—in fact there was no one else daft enough to propose such a silly motion. After all, does not genetic research hold the key to the successful treatment of mortal illnesses? Is not the mapping of the human genome one of the century’s great scientific challenges, on a par with splitting the atom or unravelling the structure of DNA?

But, as Lewin would have predicted, as I prepared for the debate, I found myself turning from a reluctant protagonist of the motion to one for whom the sanguine reassurances of genetic researchers began to ring hollow. For instance, I found Reith lecturer Professor Steve Jones writing: “Germ-line therapy is too close to Frankenstein for most geneticists. There are no plans to use it on humans themselves.”

I had come across the horror stories, of course: like the pigs which had had cow genes implanted into them, such that they went

lame with arthritis at an early age, developing bulging eyeballs and heart problems; they slithered about in their filth because they could not stand up. Or in Oxford, where researchers added the gene responsible for scorpion venom to caterpillar viruses, which then produced a toxin that kills the caterpillar. Could viruses infect other creatures, creating unanticipated problems? Do we want to eat genetically engineered plant or caterpillar viruses with our fresh salad? The public alarm about irradiated food seems laughable in contrast with the possible effects of genetic manipulations of our food sources.

But what I found most chilling about Professor Jones’s reassurances were the words “most geneticists.” The fear of genetically manipulated changes being propagated through the species in perpetuity cannot be assuaged by the reassurance that random mutations occur naturally anyway, and that the people doing this are all nice, well intentioned scientists who can make sure that nasty things don’t happen. Try selling that line to the neighbours of earthquake-prone Armenia, whose desperate government will reopen later this year a fabulously dangerous nuclear power station recently closed down for safety reasons.

Modern genetics offers many of the dilemmas of nuclear power—and more. The risks

may be containable in a stable industrial democracy, but wait until governments start to get desperate, ruthless, or both. Even now, the ability to sex fetuses by genetic methods is resulting in large scale aborting of female fetuses in parts of Asia, but this is small beer compared with the abuses that genetic engineering could lead to.

I lost the debate—massively. My opponent was kind enough to disclose, however, that most of the audience were geneticists, and over a pleasant postdebate drink I began to hope that someone might invite me to propose a pro-genetics motion soon so that I could engineer my attitudes back to their original stance. But then one young researcher casually mentioned a former supervisor in North America who was a leading researcher in the field: “He told me that he was really worried because it was all getting out of control,” she said, quietly. Maybe I won’t bother with that other debate.—IAN ROBERTSON, neuropsychologist, Cambridge