When collateral is “the” lateral

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The essence of the science of clinical examination is the art of history taking [1], more so in geriatric patients. In geriatric patients, the geriatric assessment is a multi-dimensional screening tool [2]. It serves to detect overlooked areas of importance in elderly patient management. It is also used to detect the presence of geriatric syndromes and non-medical issues of relevance [3]. The process of assessment is based on assumption that there is no delirium, dementia or cognitive dysfunction [4]. The art of history taking in this situation in view of memory problems and cognition is fraught with danger which might lead to treatment hazards and even medicolegal issues. This key component is rarely a feature of medical literature, academic curricula and do not have clear cut guidelines [5].

The presentation of older people to the emergency room is complicated by the presence of dementia and delirium. Low tech often overlooked or down looked upon the informant/collateral history is the key to the diagnosis and further management. This history is usually collected from friends, relatives, health workers and is about problems experienced with memory, cognition as well as functional ability [6].

Available data say that collateral history taking is usually taken by 3% of physicians, and usually, there is no formal training or curricula for study [7].

The co-element of diagnosis of dementia and delirium is collateral/informant history; in spite of which almost no critical thoughts have been directed towards it [8]. In the context of technology of imaging and bio-marker-driven diagnosis of dementia, is wholly based on clinical diagnosis which is entirely dependent on collateral history.

There exists no guidelines, pathway or consensus opinion in performing this important aspect of assessment. Key textbooks, both generalist or specialist, do not exist on this aspect. Audit done on dementia patients in UK showed that only in odd 30% informant history was recorded and available [9].

Assessment of a confused patient is common in both offices based and also in hospital practice. It often goes unrecognized and is poorly managed. Early diagnosis and proper assessment including collateral history taking will improve outcomes. An ideal collateral history should be taken if possible, with the consent of the patient. Patients with memory problems should first be interviewed alone “not only in terms of their own dignity and establishing the doctor patient relationship but also in terms of recognizing the asymmetry of communication and the power of triadic doctor–patient–care–giver relationship”. The rule should be.

Suspect	Patient history, appearance, changes in behavior
Confirm	Collateral history from family
Exclude	Depression, neurological/psychiatric disease medication
Measure	Psychometric testing

Ethically there is a challenge for the physician to preserve the essentials of dyadic relationship within the triadic dynamics. Advance dementia patients preserve emotional and relational sensitiveness which can respond to an attenuated physicians’ empathetic engagement; preserving the primacy of hopes and wishes of a demented patient is the challenge in the face of an erudite care giver with greater articulatory.

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With the ageing population, new complexities arising, it calls for a general reorientation of medical education to deliver knowledge, attitude and skills to take a collateral history cannot be left to hazardous and haphazard methodology, but requires incorporation as a core element of training and post-graduation education for all healthcare personnel engaged in care of elderly patients. It is time to re-write the geriatric curricula including “comprehensive geriatric assessments”, by proxy in elderly patients through collateral history taking. Collateral history taking can also be done by general physician and/or family physician, in turn they also are a source for collateral history taking. Definition and guidelines need to be drawn up with clarity.

Lateral thinking now requires collateral history taking.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

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