Clinical assessment still matters

Editorial

Clinical assessment of a client (could somebody tell me why client is politically correct and patient is not?) may seem to be almost of the past. History-taking is solved for us by the huge number of assessment lists there are now in existence. One simply has to feed information into the computer and out will come the answer. My own good colleague O'Brien and his co-authors in their recent (and extremely useful) summary on measuring behaviour in developmental disabilities,[1] list 14 schedules for diagnosing autistic spectrum disorders, no fewer than 30 for assessing psychiatric disorders including ADHD, and 22 for looking for problem behaviours not necessarily psychiatric. These will allow us to pick up things like Rett syndrome, Lesch-Nyhan, and the other behavioural phenotypes. The scales allow for detection, diagnosis, and assessment. Equally when we come on to examine the child, we have numerous tools now to help us; in this issue of DMCN, for example, there are two. Observation and contact may no longer play a part in medicine. The client will answer the questions, the machines will measure the pathology, and the diagnosis and treatment will be sorted out electronically.

Hang on a bit there. Do these things always work? And don't they exclude the essence of assessment, namely that the techniques should be flexible and responsive to the individual account and situation? The widespread availability of these questionnaires, not only to us but via the internet to our clients, may lead to quite comic confrontations. A recent example was a carer who came in explaining that her doctor had sent her up for a further assessment to confirm that the child needed methylphenidate. She said "Look at his Connors questionnaire." I did and was astonished by its 'proof' that the young man sitting quietly on a chair beside me had indeed ADHD. It was necessary to go beyond the questionnaire to discover the lad's grossly disturbed family patterning that led on occasion to behaviour which would result in a positive finding on the Connors; equally problematic with the autistic child when you're suddenly informed that he doesn't quite make DSM-IV criteria. Perhaps that is the moment to move on to the clinical examination. Here, one problem – particularly acute when one works in less favoured parts of the world – is the time that the new clinical assessments may take. Gait lab analysis takes time to set up: appointments, equipment, staff to be trained, expensive equipment to be bought. Meanwhile the family, with the child's walking pattern deteriorating, may reasonably want something to be done more quickly.

It is dangerous, you might say, taking short cuts but no more dangerous than the situation for the young clinician who told me when we were in a school that he could not assess fine motor movements because no one-inch bricks were available. What of children who refuse to carry out the procedures that you require of them? In my view this all comes back to the need for a flexible, directed approach to assessing each individual child, both in the historical and the physical assessment of the person; this may be derived from standardized assessments but clinically requires a varied approach.

Prechtl, an ethologist by training, takes us back to direct clinical observation. He develops our understanding of the motor patterns of the normal and the abnormal young child.[2] The movements require visual observation and interpretation. Visual function in the child with a visual disability has to be observed and often detected from what the person does in his visual behaviour rather than what a standardized test doesn't reveal. The orthopaedic surgeon feels the subluxation, although helped by the X-rays.

It is perhaps in the field of behavioural assessments that one is clearest that the checklist has only begun the analysis of the neuropsychiatric disorder with which the child is presenting. Anyone who has worked within the autistic spectrum disorders has been struck not by their uniformity but by their variability. Undoubtedly, it is only when we come to a more rigorous observation of the behaviours that we will begin to understand them. The whole field of behavioural phenotypes, which has opened up in recent years, relates to careful observations of behaviour. The hand-wringing, the laughter of the child with Rett syndrome, the eating behaviours we see in so many disorders – all need individual observation and careful description before they make a straightforward question on a scale.

Researchers are still keen for clinical observation and I am amused to find geneticists, with the genome unrolled behind them asking, almost desperately, for clear descriptions of the behavioural phenotype so that they can begin the attempt to link phenotype to genotype. All perhaps a little bit reassuring that the clinician is still going to be in work and indeed I do enjoy meeting medical students as they wander around the hospital still with their stethoscopes strung round their necks. I am trying to analyze the many different types of motor disorder in cerebral palsy. I'm sure that some methods of measurement and quantification will help me, but at the same time I need to hone up those clinical skills.

Martin C O Bax

References

1. O'Brien G, Pearson J, Berney T, Barnard L. (2001) Measuring behaviour in developmental disability: a review of existing schedules. *Developmental Medicine & Child Neurology* **43:** (Suppl. 87).
2. Prechtl HFR. (2001) General movement assessment as a method of developmental neurology: new paradigms and their consequences. *Developmental Medicine & Child Neurology* **43:** 836–42.