COMMENTARY

The informant history: a neglected aspect of clinical education and practice

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For millennia, the relationship between physician and patient has been essentially dyadic, emphasizing privacy and confidentiality. With the progressive ageing of our populations, and attendant increase in the age-related syndromes of dementia and delirium, a new diagnostic imperative shapes the interactions between the doctor and the patient, that of including an informant history as routine in those with cognitive impairment.

Although an informant history is a core element of the diagnosis of dementia and delirium, it is striking how little scientific scrutiny has been directed towards it. This is particularly so in the context of the enormous body of research on neuroimaging and putative biomarkers in dementia, all of which are based on a clinical diagnosis which in turn relies on an informant history. Guidance on performing this important aspect of assessment is also absent from key textbooks on clinical assessment, generalist and specialist textbooks, and an audit of dementia care in the UK reported that only one-third of those classified as dementia had an informant history recorded, despite guidelines highlighting the critical need for informant history.

If a memory problem is suspected in any clinical setting, either through a formal cognitive screening tool or clinical observation, an informant history is integral to the confirmation of cognitive impairment in the patient. At the heart of the diagnosis of dementia is the confirmation of a loss of social or occupational function due to the acquired cognitive deficits, a judgement that can only realistically arise from an informant history. A satisfactory informant history is therefore a prerequisite in differentiating between mild cognitive impairment and dementia through clarification of whether or not there is a loss of function which can be ascribed to cognitive deficits.

The informant history may also be useful in determining the possible aetiology of dementia. For example, the linkage of significant memory or functional loss by informant history to events such as a major operation or stroke may point to a contributory diagnosis of perioperative cognitive impairment or vascular dementia, while an insidious, gradual cognitive decline is more suggestive of Alzheimer’s disease.

Delineation of the onset, course and pattern of deterioration is also required to separate dementia from delirium. One screening tool for delirium, the Confusion Assessment Method-Intensive Care Unit, has an inbuilt requirement for an informant history to identify an acute change of mental status.

An ideal informant history will be taken with the consent of the patient. Patients with memory problems should be interviewed on their own in the first instance, not only in terms of their own dignity and establishing the doctor–patient relationship but also in terms of recognizing the asymmetries of communication and power within a triadic doctor–patient–caregiver relationship. Once the history and formal cognitive assessment have been carried out, it should be explained to the patient that the diagnostic workup of a memory problem requires an informant history. The patient should be asked which family member or friend they would prefer to involve, and the informant told that consent was obtained from the patient prior to talking to them.

In the clinic setting, the default position should be that the informant history is performed with the patient present. From experience most patients prefer to be present, and their response during the taking of the informant history can be informative in itself. Occasionally, particularly in the face of a severe anosognosia whereby the patient would be exceptionally upset by hearing an informant history with which he/she cannot identify, clinician discretion should prevail. In an emergency or acute setting, it may be necessary to take the informant history by telephone if a relative/caregiver is not present in the clinical area.

The informant history should in the first instance seek to confirm the presence of a memory problem, and if present, to characterize its onset as well as the rate and nature of progression. It should then establish the functional abilities of the
detecting milder cognitive deficits. These tools should be seen as a reliable alternative but may be less sensitive than the AD8 for in-person administration compared with in-person. The IQCODE is brief, and has equal reliability when administered over the phone compared with in-person. The IQCODE is better for detecting cognitive impairment than a direct AD8 from the patient with the informant history. Functional decline may have occurred so gradually that both patient and family may have adapted to it over time, to such an extent that there may not be awareness that any functional loss is present. More complex tasks such as paying bills or cooking may have been delegated to either a spouse or close relative over time.

Additionally, medical comorbidities such as osteoarthritis and cardiac disease can also contribute to functional decline in later life. When taking an informant history, it is important to separate functional loss due to medical illness or deconditioning from that caused by cognitive deficits, and at times this can be challenging, sometimes requiring input from a senior clinician. Clinical staff may also harbour ageist attitudes, and consider impaired function as ‘normal for age’: there should be no diagnostic tolerance for decline in higher levels of function in older people.

A welcome recent innovation has been the development of screening tools such as the AD8 and the Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE), which can provide a structured, validated framework to assist with the informant history. The informant AD8 is better for detecting cognitive impairment than a direct AD8 from the patient with a sensitivity of 85% and a specificity of 86% in mild to severe dementia. It is brief, and has equal reliability when administered over the phone compared with in-person. The IQCODE is a reliable alternative but may be less sensitive than the AD8 for detecting milder cognitive deficits. These tools should be seen as an adjunct to the informant history rather than replacing it.

Although cognitive impairment is most commonly encountered with older people in clinical practice, an appropriately structured informant history is also critical to the clinical assessment of patients at all ages with a range of acute or subacute encephalopathies, such as those due to encephalitides and infections.

From an ethical perspective, the key challenge for physicians is the preservation of the essentials of the dyadic relationship within a triadic dynamic. Even with advanced dementia, patients preserve relational and emotional sensibilities, which can respond to sympathetic engagement by the attuned physician, and it is important to preserve a primacy for the wishes and hopes of the person with dementia to the greatest extent possible in the face of the greater articulacy of the caregiver.

As a part of the general reorientation of medical education towards the new complexities arising from population aging, the teaching of the knowledge, attitude and skills necessary to take an informant history can no longer be left to hazard but need to be incorporated as a core element of the training and postgraduate education of all physicians engaged in the care of adults.

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References