

The Beginning of the Interview: Patient-Centered Interviewing

The doctor may also learn more about the illness from the way the patient tells the story than from the story itself. (1861–1954)

James B. Herrick, MD

This chapter describes a user-friendly step-by-step method for the beginning of the medical interview that has been effective in many hands for more than 25 years.^{1–9} Your first task is to master the 5 steps and 21 substeps shown in Table 3-1. We urge you to learn these thoroughly, to the point that they become reflexive—this is easily accomplished by studying and then practicing them. Even though this may seem like a lot to learn, just as you learn the intricacies of cardiac physiology, this is your major task in mastering the medical interview. Using these steps and substeps will make you a more scientific and more humanistic physician—and your patients will benefit (see Appendix B for a detailed humanistic and scientific rationale for being patient-centered). To assist you, we also have developed a video that demonstrates the same skills described here: www.accessmedicine.com/SmithsPCI (see Preface). (See AccessMedicine video titled “How to Interrupt”: www.accessmedicine.com/SmithsPCI.)

When first learning these steps, use them in the order presented, primarily as a learning tool. As you become more skilled, you can vary the steps and substeps to experiment as well as to adapt to specific occasions and needs. You may find that some substeps can be omitted and, in other instances, you may want to change the ordering as you follow the patient’s lead.¹⁰ The steps and substeps are simply a pathway to lead you through the interview; use them flexibly to individualize and enhance your own style and the patient’s individuality.

■ TABLE 3-1. 5-Step Beginning of the Interview

5-Step Patient-Centered Interviewing

Step 1: Set the stage for the interview (30–60 s)

1. Welcome/greet the patient
2. Use the patient's name
3. Introduce yourself and identify specific role
4. Ensure patient readiness and privacy
5. Address barriers to communication (sit down)
6. Ensure comfort and put the patient at ease

Step 2: Elicit chief concern and set agenda (1–2 min)

7. **Indicate time available** (e.g., “We've got about 20 minutes together today ...”)
8. **Forecast what you would like to have happen during the interview** (e.g., “... and I see that we need to review the blood tests you had done yesterday, ...”)
9. **Obtain a list of all issues patient wants to discuss;** specific symptoms, requests, expectations, understanding (e.g., “... but before we do that, let's make a list of the things you wanted to discuss today.” “Is there something else?” “What else?”)
10. **Summarize and finalize the agenda;** negotiate specifics if too many agenda items (e.g., “You mentioned 8 things you were hoping to cover. In the time we have together today, I don't think we can address them all. Can you tell me which one or two are most troublesome for you; we'll do a good job with those and I'll see you back soon to work on some of the others.”)

Step 3: Begin the interview with nonfocusing skills that help the patient to express her/himself (30–60 s)

11. **Start with open-ended question/statement** (“Tell me all about your headache.”)
12. **Use nonfocusing open-ended skills** (attentive listening): silence, continuers, nonverbal encouragement
13. **Obtain additional data from nonverbal sources:** nonverbal cues, physical characteristics, autonomic changes, accoutrements, environment, and self

Step 4: Use focusing skills to learn 3 things: symptom story, personal context, and emotional context (3–10 min)

14. **Obtain a further description of the symptom**
 - Description of symptoms, using focusing open-ended skills such as:
Echoes (repeat the patient's words, e.g., “excruciating pain?”)
Requests (“That sounds important; can you say more about it?”)
Summaries (“First you had a fever, then 2 days later your knee began to hurt, and yesterday you began to limp.”)
15. **Elicit/develop personal context**
 - Broader personal/psychosocial context of symptoms, patient beliefs/attributions, again using focusing open-ended skills.
16. **Elicit/develop emotional context**
 - Use emotion-seeking skills.
Direct: “How are you doing with this?” “How does this make you feel?” “How has this affected you, emotionally?”
Indirect: **Impact** (e.g., “How has this affected your day-to-day life?” “What has your knee pain been like for your family?”); **Beliefs** about the problem (e.g., “What do you think might be causing your knee pain?”); **Intuit how the patient might be feeling** (e.g., “I think I might be frustrated if that happened to me,” “I can imagine that this might be worrying for you.”); **Triggers** (e.g., “What made you decide to come in now for your ...?” “What else is going on in your life?”)
17. **Respond to feelings and emotions with empathy skills**
 - Respond with words that empathically address the emotion (**NURS**):
Name: “You say being disabled by this knee pain makes you angry.”
Understand: “I can see how you could feel this way.”
Respect: “This has been a difficult time for you.” “You show a lot of courage.”
Support: “I want to help you get to the bottom of this and see what we can do.”
18. **Expand the story to new chapters**
 - Continue eliciting further personal and emotional context, address feelings/emotion with NURS.

Step 5: Transition to middle of the interview (clinician-centered phase) (30–60 s)

19. Brief summary.
20. Check accuracy.
21. Indicate that both content and style of inquiry will change if the patient is ready (“I'd like to switch gears now and ask you some questions to better understand what might be going on.”). Continue with middle of interview.

The five steps in the beginning of the interview establish the clinician-patient relationship and encourage the patient to express what is most important to him/her. Throughout this book, an ongoing interview with “Ms. Joanne Jones” illustrates each step; this and other examples are derived from real patients and situations; we changed all names and identifying information to protect the confidentiality of our patients.

Let’s first talk about the preparatory skills of setting the stage (Step 1) and determining the agenda (including the chief concern) for the interview (Step 2). These steps prepare both you and the patient for the patient-centered interviewing skills you will use in Steps 3 and 4, where the data-gathering and relationship-building skills you learned in Chapter 2 are incorporated.

■ STEP 1: SETTING THE STAGE FOR THE INTERVIEW

Setting the stage for the interview begins before entering the patient’s room. It is helpful to prepare for the interview, much as an athlete or musician might prepare for a performance.¹¹ Begin by reviewing the patient’s record, getting a sense of the patient’s problem list, medications, allergies, and reading notes from recent visits/hospitalizations. However, do not allow this information to bias you before you meet the patient—every clinician-patient encounter is unique and medical records may contain inaccuracies.

Determine your agenda for the encounter; for example, you may want to update the patient’s immunizations or follow-up on chronic conditions. As you will learn, the patient will also have an agenda that may differ from yours.

We recommend taking a “mindful moment” before entering the patient’s room to mentally prepare yourself to be fully present to whomever is behind the door. Some clinicians take a breath in and “breathe out” the last patient, making the intention to be open to the next patient. Others use hand sanitizer or soap and water as an ablution to “wash away” the last encounter and ready themselves for next. Mindful practice has been demonstrated to reduce clinician burnout and improve empathy.^{12,13} (See DocCom Module 2.)

The skills in Step 1 are simple, but often overlooked^{14–16} courtesies that ensure a patient-centered atmosphere. Table 3-2 lists these substeps in their usual order of use at the first meeting with a patient; appropriate adjustments are made when the patient is already known to the clinician. These skills establish or reaffirm participants’ identities, put both the clinician and the patient at ease, and ensure that the setting is appropriate for the interview. These preparatory steps *should take no more than 30 to 60 seconds.*

■ TABLE 3-2. Step 1: Setting the Stage (30–60 s)

1. Welcome/greet the patient
2. Use the patient's name
3. Introduce yourself and identify specific role
4. Ensure patient readiness and privacy
5. Address barriers to communication (sit down)
6. Ensure comfort and put the patient at ease

Welcome/Greet the Patient

As noted above, maintain patient safety and hygiene by washing your hands before entering the patient's room.

When people become patients and enter our healthcare system, they experience many “micro-aggressions”—such as being partially clothed or being barged in on while using the commode—that can negatively affect their experience of care. Knocking and then waiting for permission to enter is a “micro-courtesy” that can help to re-empower the patient and restore dignity.

Greetings set the stage for relationships and their absence can make the relationship difficult to salvage. The clinician who enters the patient's room and says, “So what seems to be the problem here?” is missing an opportunity to use the relationship as therapy.

In day-to-day life, we often greet others by saying, “How are you?” or “How are you doing?”. We suggest not using these words in healthcare settings. Why? When a clinician, simply trying to greet a patient, asks, “How are you?”, many patients begin to talk about their ailment. Others will say (or think), “If I was well I sure wouldn't be here!”. We recommend using different greetings with patients, such as, “It's nice to meet you” or “Nice to see you again!” This keeps the interview from jumping ahead to Step 2 before you are ready.

A handshake is an important part of greetings in many cultures. Because of cultural taboos about touch, a male clinician should generally wait for a female patient to begin to extend her hand first, before reaching out to shake it. Women clinicians should also be sensitive to nonverbal cues and cultural norms that indicate that the patient may not be open to a handshake.¹⁴ For example, among some Muslims and orthodox Jews shaking hands in a cross-gender situation is viewed as culturally inappropriate. When it is not possible to shake hands, for example with very ill patients, a friendly pat on the hand or arm is equally beneficial to the relationship. You can develop some important initial nonverbal impressions about the patient from the handshake; for example, a hearty handshake suggesting a confident person,

a cold sweaty palm suggesting anxiety, and the feeble handshake of someone very ill. Healthcare professionals have mixed feelings whether to ban, change, or allow handshaking due to hygiene risk.^{17–19} We suggest you make your own informed decision on handshaking as a greeting. Remember that the patient is also reading your nonverbal cues, so personal awareness is crucial.^{14,20–22} Smiling; having a friendly, personable, polite, and respectful demeanor; being attentive and calm; making eye contact; and making the patient feel like a priority will enhance the relationship with the patient. Alternatively, fidgeting, frequently glancing at your watch or mobile device, avoiding eye contact, or looking distracted may be interpreted negatively by the patient.²³

Use the Patient's Name

Patients are divided on how they want to be addressed.^{14,24–26} Some patients want their first name to be used when they are greeted; but others prefer either their last name or both their first and last names. We recommend that you use formal terms of address, Mr., Miss., Mrs., or Ms., and the patient's first and last name in your initial greeting. It is easier to go from more formal to less formal terms of address than the reverse. If the patient has an unusual name, you may need to ask how to pronounce it. It is sometimes useful as a way of creating a welcoming atmosphere to ask if a non-English name, for example, Rakesh, Ming, Ganady, Kwesi, has a translation into English and what it means.

Some patients reject or do not conform to the male–female gender binary. To avoid misperceiving the gender identity or expression of gender nonconforming patients, you can ask, “Out of respect for my patients’ right to self-identify, I ask all patients what gender pronoun they’d prefer I use for them. What pronoun would you like me to use for you?”²⁷

Introduce Yourself and Identify Your Specific Role

When introducing yourself, be sure to match identity terms to avoid suggesting an unequal relationship.²⁴ As with patients, initially use your full name—“Hi Mr. James Brown, I’m Dr. Jane Smith.” You should not say, for example, “Hi George, I’m Dr. Smith” or “Welcome Mr. Brown, I’m Betty.” Occasionally at the beginning but more often after some time, a relationship on first-name basis may develop. After you introduce yourself, mention your official role, for example, “resident physician,” “medical student,” “PA student,” or “nursing student.” Medical students can use the term “student doctor” or “student physician” after they pass USMLE Step 1.²⁸ However, it is not appropriate to

use a professional label like “doctor,” “nurse,” “nurse practitioner,” or “physician assistant” until you have been certified to do so.

It is common for new learners, particularly preclinical students, to feel uncomfortable in their first patient interviews. You may feel like an imposter, that you are intruding or being voyeuristic, or that you are not playing a meaningful role in the patient’s care. Remember that every clinician learned to interview through the generosity of patients. Patients often are quite happy to help a young clinician learn if you politely ask, express thanks, and understand why some patients may feel too ill to participate in this way. As a clinical trainee however, you are an important and legitimate member of the medical team, so you should not apologize or otherwise devalue yourself (“I’m just a student, thanks for letting me talk to you.”). The annals of medicine are replete with stories of new learners’ contributions to care, as they are with stories of patients deferring to trainees’ opinions; for example, when the resident or attending physician makes a recommendation directly to the patient, the patient may say, “I’ll have to ask Ms. Burns [the trainee] first.” To respect patient autonomy, your supervisor/attending physician should ensure that the patient has no reservations about being interviewed or cared for by a trainee.²⁸

When visitors are in the room, ask the patient to introduce them and their relationship to the patient; this allows the patient to control the flow of information. Greet each person by name as above. Ask the patient if visitors or family members should remain in the room during the interview. You might ask, “I’m going to be asking you a lot of questions; some of them are very personal. Should we ask your brother to wait in the family room while we talk or would prefer that he stay?” If the patient elects to have the visitor(s) stay, you may need to ask sensitive questions at another time when you can be alone with the patient. This is particularly important if intimate partner violence is suspected (see Chapter 5).

Substeps 1, 2, and 3 of Step 1 can be combined in a single statement like “Mr. George Brown? Hello, I’m Larry Burns. I’m the medical (or nurse practitioner, PA) student on the team that will be looking after you.”

Ensure Patient Readiness and Privacy

Clinicians often assume that patients are always ready to speak with them but, especially in hospital settings and with very ill patients, it is important to determine if the patient is ready for the interview. Sometimes it is necessary to postpone the interview; for example, until after the patient has eaten dinner or relatives have departed; or until the vomiting from recent chemotherapy has abated. Severe pain, severe nausea, need for a medication, and a soiled bed,

for example, are physical problems that must be addressed before an interview is appropriate. It is also important to monitor the patient's circumstances for nonphysical, potentially interfering problems; for example, a patient may have lost his car keys in the waiting room, just received a disturbing telephone call, or be worried that the baby sitter will have to leave before she gets home. With all patients, it is important to determine if there are pressing needs that might require a brief delay in the interview; for example, to use the bathroom, get a drink of water. These courtesies not only help the patient directly but enhance patients' acceptance of you as a caring professional. Once ready, some actions that will improve the patient's readiness and privacy are shutting the door, pulling a curtain around the hospital bed, or respectfully excusing extra visitors from the room.

Address Barriers to Communication

You may have to ask permission to turn off a noisy air conditioner or TV set, or make efforts requiring more insight such as recognizing that the patient hears best out of one ear or needs to be able to directly see the clinician's mouth in order to speech-read. If there is any question, ask the patient whether s/he can hear you well. Strategies for addressing specific communication problems are outlined in Chapter 7.

Patients experience that you have spent more time with them if you sit, so do so whenever possible, asking permission to do so in the hospital setting.²⁹ Communication is optimal if you and the patient are at the same eye level.³⁰ If you are both sitting, orienting the chairs at approximately a 90-degree angle is optimal for communication (see DocCom Module 14³¹). Attention to the nonverbal aspects of communication is important and is covered in more detail in Chapter 8, section "Nonverbal Dimensions of the Relationship." And remember, at the end of the encounter, it is just as important to turn the TV you asked permission to turn off, back on!

Exam-room computing may be one of the biggest barriers to the clinician-patient relationship.^{32,33} If you plan to use a computer during the interview, be sure that it is placed so that you both can see the screen. Explain to the patient that you will be taking some notes or entering information into the computer and ask whether this is okay.³⁴ Write or enter information in the medical chart or computer only intermittently, and not until the patient has finished speaking. When writing or entering information, pause frequently and make eye contact with the patient. We suggest that you focus on the patient and not the computer during the beginning, patient-centered part of the interview and use the computer as a communication tool.^{35,36} See Chapter 10 for more details.

Ensure Comfort and Put the Patient at Ease

Determine if anything at the immediate time is interfering with the patient's comfort. Ask, "Is that a comfortable chair for you?", "Is the light bothering your eyes?", "Are you comfortable there?", or "Can I raise the head of the bed for you?" Continue to monitor the patient's comfort as the interview proceeds. Your task is to put the patient at ease, as much as you can. Attention to these potential barriers fosters the patient's subsequent full attention and also shows your caring and concern.

When clinically appropriate, a little social conversation—"small talk before big talk"—can help put the patient at ease before discussing intimate issues related to bodily or psychological concerns.³⁷ This brief social conversation should have a patient focus such as, "I hope you got your car parked OK with all the construction going on around here." With an inpatient, you can ask about get well cards or flowers in the room, or the food; whatever is appropriate to the patient's situation can be briefly discussed. This allows the patient to get more comfortable with you and shows your humanity.

■ STEP 2: OBTAINING THE AGENDA (CHIEF CONCERN AND OTHER ACTIVE PROBLEMS)

In Step 2, you will focus on the patient and setting the agenda for the interview. This fosters the patient-centered interaction to follow (Steps 3 and 4) because it orients and empowers the patient and ensures that concerns are properly prioritized and addressed. Some clinicians unwittingly preclude agenda setting by saying "What brings you in today?". Patients often interpret this as an invitation to tell the story of the first concern on their list, rather than generating a list of concerns. This often leads clinicians to miss important information and fail to meet patients' expectations.³⁸⁻⁴² Setting an agenda usually takes little time, improves efficiency, empowers patients,⁴³ and yields more information. However, it is not necessarily easy and serious pitfalls can arise if it is conducted improperly.^{14,15,44,45} The following four substeps, summarized in Table 3-3, usually are performed in the order given. *It generally takes no more than 1 to 2 minutes.*

Indicate Time Available

Setting limits is difficult for many clinicians, so do not be surprised if this substep feels uncomfortable at first. Begin by indicating how much time is available for the interaction. This orients patients by letting them know the visit length and helps patients gauge what and how much to say.⁴⁶ One common pitfall is to use the word "only" as in, "We only have 20 minutes today" which has a negative

■ TABLE 3-3. Step 2: Chief Concern/Agenda Setting (1–2 min)

1. Indicate time available
2. Forecast what you would like to have happen during the interview
3. Obtain list of all issues patient wants to discuss; e.g., specific symptoms, concerns, requests, expectations, understanding
4. Summarize and finalize the agenda; negotiate specifics if too many agenda items

connotation. Rather say, “Good, we’ve got about 20 minutes together today.” In the inpatient setting, where visits are not usually on a schedule, it may be easier to use phrases such as “few,” “short,” “medium,” or “long,” for example, “I’d like to take a few minutes of your time to....” Of course, in any setting there will be occasional times when you must extend the visit beyond what was scheduled or you had planned, for example, if a patient has gotten bad news or where you may be concerned about a patient’s physical or emotional safety.

Forecast What You Would Like to Have Happen During the Interview

Tell the patient what you need to do during the interview to make sure the patient is properly cared for. For example, with a new patient, you may need to ask many routine questions or perform a physical examination; with a returning patient, you may need to discuss the results of a recent diagnostic test.

Obtain a List of All Issues the Patient Wants to Discuss

Most importantly, you must obtain a list of all issues your patient wants to discuss to ensure that the most important concerns are addressed during the encounter and to minimize the chance of an important concern being raised at the end of the conversation when time has run out.^{42,46} This substep is usually combined with the first two substeps in one sentence, for example, “Good, we’ve got about 40 minutes together today; I need to ask you a lot of questions and do an examination but let’s start by making a list of all the things you want to discuss.” Notice the use of the words “we” and “together” that help to establish a partnership with the patient.

You may need to help the patient enumerate all problems. Possible patient agenda items include, but are not limited to symptoms, requests (prescription for a sleeping pill), expectations (get a note for work), and understanding about the purpose of the interaction (perform an exercise stress test).

Obtaining a complete list may require some persistence.^{40,42,44,45,47} Often, the patient will try to give details of the first problem. When that happens, you must respectfully interrupt and refocus the patient on setting the agenda. The art of interrupting can be learned as any other communication skill.^{48–51} (See AccessMedicine video titled “How to Interrupt.”) Holding up fingers prominently as you count concerns helps to communicate that a list is being sought, not details of each symptom or concern. For example, while holding up one finger to signify the first problem given, you might say “Sorry to interrupt, that’s important and we’ll get back to the leg pain in a moment, but first I need to know if there are additional problems you’d like to talk about. I want to be certain we get a list of all your concerns.” You may have to do this several times, asking questions like, “Is there something else?”,⁵² “What else?”,⁴⁷ “How did you hope I could help?”, “What would a good result from this visit today look like?”, or “Was there something else you were worried about?”.⁵³ In the outpatient setting it is unusual for patients to have just one concern;^{42,54} one study found that diabetic patients had on average three concerns they wanted to share with their clinician, the third one mentioned being the most important from their perspective. Importantly, 70% of these patients never got to share their most important concern.⁵⁵

Only if the patient raises a highly charged emotional issue while setting the agenda should you postpone agenda-setting and encourage further discussion at that point (e.g., if the patient is acutely distraught about a recent death in the family or a recent diagnosis of cancer in himself). In most situations, however, you can set the agenda and briefly delay addressing the emotional issue. Careful agenda-setting prevents patients’ common complaint that they did not get to talk about all their concerns, as well as the common clinician complaint that the patient voiced his/her most serious concern at the end of the appointment.⁴⁶

Summarize and Finalize the Agenda

This substep allows you to prioritize the list and, if it is too long for the time available, to empower the patient to decide what will be addressed and what will be deferred to the next visit: “You mentioned eight concerns you wanted to cover. I don’t think we’ll have time to address them all in the time we have together today. Can you tell me which one or two are most troublesome to you today? We’ll focus on those together and I’ll see you back soon to work on the others.” Of course, if one of the items is medically concerning (e.g., blood in the stool, substernal chest pain suggesting heart disease), you need to address it even if not chosen by the patient.

Note how mentioning the time available at the beginning of Step 2 allows you to refer to it without it being off-putting to the patient. You and the patient are aligned against the allotted time, instead of you and the time being aligned against the patient.

Usually, however, because different symptoms may be related to a common cause it is possible to cover all the patient's concerns, in which case these are simply summarized. This also is a good point to determine, if not already known, which concern is most important to the patient, for example, "Which one would you like to start with?". This identifies the chief concern ("chief concern" is preferred over "chief complaint" because "complaint" has a pejorative connotation. In response to hearing the word "complaint," patients have said, "I'm not complaining, it hurts!").

We now begin to follow Ms. Joanne Jones through her initial visit by providing a continuous transcript for each step; some areas are shortened as noted for space considerations.

Vignette of Ms. Joanne Jones

Step 1

Clinician: (Knocks)

Patient: Come in.

Clinician: (Enters examining room). Ms. Joanne Jones? Welcome to the clinic. I'm Michael White, the medical student who will be working with you along with Dr. Black. (Patient extends her hand and clinician shakes it.) [Clinician uses his and her full names, welcomes the patient, and identifies his role in her care.]

Clinician: I'll be getting much of the information about you and will be in close contact with you about our findings and your subsequent care.

Patient: I wasn't sure who I was going to see. This is my first time here.

Clinician: If it's OK with you, I'll close this door so we can hear each other better and have some privacy. [The clinician now ensures readiness for the interview and establishes as much privacy as possible.]

Patient: Sure, that's fine.

Clinician: Anything I can help with before we get started?

Patient: Well, they didn't give my registration card back to me. I don't want to lose it.

Clinician: We'll give that back when we're finished today. They always keep them. Is there something else?

Patient: No.

Clinician: (Sits down) Would you like to sit in that chair? It's more comfortable than the examining table. [The clinician addressed this barrier to communication, established equal eye level, ensured comfort, and put the patient at ease.]

Patient: Sure. Thanks. (She moves.)

Clinician: Well, I'm glad to see you made it despite the snow. I thought spring was here last week.

Patient: I guess not. My kids have been home the last 2 days. I'm ready to get them back to school! I'm getting spoiled with them both in school. [Patient places the topic "kids" and her feelings about the kids being home "on the table" for discussion.]

Clinician: People have had all kinds of trouble getting in here for their appointments since the snow. It's no fun.

Patient: You're telling me. I don't even ski! [The stage is set, a light conversation ensued, and the patient is joking.]

Step 2

Clinician: (laughs) Well, we've got about 40 minutes together today and I know I've got a lot of questions to ask you and that we need to do a physical exam. Before we get started, though, I'd like to get a list of the things you wanted to address today. You know, so we're sure everything gets covered. [Clinician gives his agenda in one statement. Doing this first models the more difficult task to follow: obtaining the patient's agenda.]

Patient: It's these headaches. They start behind my eye and then I get sick to my stomach so I can't even work. My boss is really getting upset with me. He thinks that I don't have anything wrong with me and says he's going to report me. Well, he's not really my boss, but rather is ... [Clinician artfully and respectfully interrupts. She places "boss" on the table for discussion.]

Clinician: That sounds difficult and important. Before we get into the details, though, I'd like to find out if there are some other problems you'd like to look at today, so we can be certain to cover everything you want to. We'll get back to the headache and your boss after that. Your headache and your boss—that's two things (holding up two fingers). Is there something else you wanted to address today?

Patient: Well, I wanted to find out about this cold that doesn't seem to go away. I've been coughing for 3 weeks.

Clinician: (Holding up three fingers now): OK, cough; what other concerns do you have?

Patient: Well, I did want to find out if I need any medicine for my colitis. That's doing ok now but I've had real trouble in the past. It started bothering me back in 2010 and I've had trouble off and on. I used to take cortisone and ... (clinician interrupts); [Notice that the clinician has now interrupted the patient twice in order to complete the list of concerns. This is necessary, done respectfully, to complete the agenda in a timely way.]

Clinician: (Holding up five fingers): So, there are two more problems we can look into, the colitis and the medications. We'll get back to all these soon; they're all important. To make sure we get all your questions covered, though, is there something else?

Patient: No. The headache is the main thing.

Clinician: So, we want to cover the headaches and the problem they cause at work, cough, colitis, and the medications for the colitis. Is that right? [It is here that the patient and clinician would negotiate what to cover at this visit if the clinician determined that the patient had raised too many issues to cover on this day.]

Patient: That's about it.

Clinician: And do I understand correctly that the headache is the worst problem? [Ms. Jones' headache is her most bothersome concern, what we earlier defined as the chief concern.]

Patient: Yes.

■ OPENING THE HISTORY OF PRESENT ILLNESS (STEP 3)

Having set the stage (Step 1) and obtained the agenda (Step 2), we now use the patient-centered skills learned in Chapter 2 to begin to elicit the history of the present illness (HPI). As reviewed in Chapter 1, the HPI is the most important component of the interview because it reflects the patient's current problem in its psychosocial and biomedical totality. The HPI begins at the beginning of the interview (patient-centered part) and continues into the middle of the interview (clinician-centered part), where relevant details are clarified using clinician-centered interviewing skills.

Step 3, summarized in Table 3-4, consists of asking one open-ended question (or making one open-ended request) and then allowing the patient to talk. It establishes an easy flow of talk from the patient, conveys that the clinician is attentively listening, and gives a feel for "what the patient is like." Ordinarily, *Step 3 lasts no more than 30 to 60 seconds* as the clinician listens attentively, using the following substeps.

■ TABLE 3-4. Step 3: Opening the HPI (30–60 s)

1. Open-ended beginning question/statement
2. “Nonfocusing” open-ended skills (attentive listening): silence, continuers, nonverbal encouragement
3. Obtain additional data from nonverbal sources: nonverbal cues, physical characteristics, autonomic changes, accoutrements, environment, and self

Start with Open-Ended Beginning Question/Statement

When first learning the medical interview, some new learners are so worried about what they should say next that they don’t hear what the patient is saying! Step 3 gives you the opportunity to take a deep breath, relax, and listen to the patient. It starts with an open-ended beginning question or statement, for example, “So headaches are the big problem, tell me more.” Avoid saying, “Tell me a little bit about the headache,” because you do not want to hear a little bit about the symptom, you want to encourage a detailed, chronological narrative. Sometimes, especially with reticent or disorganized patients, it is helpful to be clear about your desire: “Tell me all about the headache, starting at the beginning and bringing me up to now.” Sometimes an open-ended beginning question is not necessary; having completed the agenda, especially if there are only one or a few related items, many patients continue spontaneously.

Use “Nonfocusing” Open-Ended Skills (Attentive Listening)

Following the open-ended beginning question, allow the patient to talk freely for 30 to 60 seconds or so to get the gist of his/her primary concern. Encourage a continued free flow of information using the nonfocusing open-ended skills described in Chapter 2. Silence, nonverbal gestures (eye contact, leaning forward, hand gestures), and continuers (e.g., uh-huh, mmm, go on) encourage the patient to continue speaking. Listen carefully to the patient’s opening statement for clues to the patient’s story. Using these nonfocusing open-ended skills encourages the patient to put information “on the table,” typically details about the patient’s symptom story and its personal and emotional context.

Some clinicians are reluctant to use nonfocusing skills in the beginning of the interview because of fears that patients will talk incessantly, and that nothing will get accomplished. Research shows that when patients are given all the time they need to complete their initial statement, in nearly 80% of the cases it lasts 2 minutes or less; in the few instances where it went longer, physicians agreed that the patients were giving important information.⁵⁶

Although uncommon, patients sometimes do not talk freely. If this occurs, and 4 seconds or so of silence does not lead the patient to resume talking, you

can use focusing open-ended skills (echoing, request, summary) to promote a free flow of information. If focusing open-ended skills are not effective, you can also ask closed-ended questions about the patient's problem to get a dialogue going. This may be necessary in very shy patients, especially adolescents.

Obtain Additional Data from Nonverbal Sources

Although you are verbally quiet during the brief Step 3, you should be very mentally active, noticing the information the patient is putting "on the table" and thinking about what it means. Observe the patient for nonverbal cues (reviewed in Chapter 7), for example, depressed facial expression, arms folded across the chest, toes tapping nervously that may indicate psychological conditions or a style of relating to the clinician. Observe also for clues in the following areas that will give additional physical information about the patient^{57,58}: (1) physical characteristics: general health, skin and hair color, odor, deformities, habitus (e.g., emaciated and disheveled, "uremic" breath, jaundice, amputated leg, kyphoscoliosis); (2) autonomic changes: heart rate, skin color, pupil size, skin moisture, skin temperature (e.g., rapid pulsation of the carotid artery observed in the neck, handshake reveals cold and moist palms, pupils constricted but then dilate when relaxed, sweating at outset of interview); (3) accoutrements or accessories: clothing, jewelry, eyeglasses, makeup (e.g., expensive suit and jewelry, thick eyeglasses, tattoos and body piercings, no makeup or poorly applied makeup); (4) environment: in the hospital setting, items such as greeting cards, flowers, photographs (e.g., several paintings by a grandchild, photograph of spouse, or their absence); (5) self: becoming aware of your own emotions and reactions to patients in real time is an important clinical skill.^{4,21,59} We cover this important topic in detail in Chapter 9 (also see DocCom Module 2).

Continuation of Ms. Jones Visit

Patient: Yes.

Clinician: So, tell me all about the headache. [An open-ended beginning statement that is linked to the chief concern.]

Patient: It's not bad at the moment, I guess.

Clinician: (sits forward slightly) Uh Huh.

Patient: Things weren't so good last week, though, when I made the appointment.

Clinician: Mmmm.

Patient: That's when my boss really got on me. Well, he's kind of uptight anyway, but he was saying how I was upsetting the whole office operation because I was off so much. And someone had to cover for me. I'm the lead attorney.

■ **TABLE 3-5. Step 4: Continuing the Patient-Centered HPI (3–10 min)**

1. Use focusing open-ended skills to obtain further description of physical or other symptom (symptom)
2. Use focusing open-ended skills to elicit/develop personal context of symptom (personal context)
3. Use emotion-seeking skills to elicit/develop emotional context of symptom and/or its personal context (emotional context)
4. Use empathy skills to address the emotion(s) expressed by naming, understanding, respecting, and supporting (NURS)
5. Use sequences of focusing open-ended skills → emotion-seeking skills → empathy skills to expand the story to new chapters (expand story)

from 3 to 10 minutes, depending on the clinical setting and the information the patient presents.

In addition to attentive listening, use focusing open-ended skills to help the patient continue his/her unique story of the present illness. In this step, you are picking things up “from the table” in order to learn more about them. First, direct the patient to talk more about the *symptom* (usually physical, but can also be cognitive, emotional, or other); second, the *personal* context of the symptom; and, third, the *emotional* context, that is, the patient’s emotional reactions to the symptom and/or the personal context. This flow mirrors the way that patients often describe their concern to their clinician.

Use the focusing open-ended skills, emotion-seeking skills, and empathy skills outlined in Chapter 2 to identify the story theme(s); rarely, use closed-ended skills for clarification. You will usually be much more active and verbally participatory in Step 4, compared with Step 3; often figuratively on the edge of your seat during the give-and-take interaction between you and the patient as you help the patient build the history.⁶⁰ You may initially find this step to be the most difficult of the entire interview. To help in understanding it, we have broken Step 4 down into five substeps, now considered in their usual sequence. These substeps produce the overarching story themes: symptom, personal, and emotional.

Obtain a Further Description of the Symptom

In a medical setting, patients typically present with symptoms mixed with their personal and emotional context. Because most patients expect it in a medical setting, we recommend an initial focus on physical symptoms while learning these skills; later, you can experiment with a different ordering. Use focusing open-ended skills (echoing, open-ended requests, summarizing) to help the patient to further describe the symptom(s) in his or her own words. This usually helps uncover the personal context in which the symptom(s) occurred. Let’s pick up Ms. Jones’ interview again.

Continuation of Ms. Jones Visit

Patient: All I want to do is go home and go to bed. [Four seconds of silence]

Clinician: Say more about the headaches. [Since silence—a nonfocusing skill—was ineffective, the learner tries an open-ended request, one of the focusing open-ended skills, to learn more about the headaches.]

Patient: Well, I never had any trouble until I got here. [Comment about personal context of her symptom and how long it has been present.]

Clinician: How long's that been? [Appropriate closed-ended question for clarification]

Patient: Only 4 months. The headache started about 3 months ago.

Clinician: Tell me more. [Keeps the focus on the headache]

Patient: Well, they just throb and throb and it seems like every time I see my boss any more I get one of these headaches. I sometimes just get a little nauseated and can't concentrate because of the pain. [We learn much more of the description of the symptom and, also, that her boss seems to precipitate the symptom.]

Clinician: Nauseated? [echoes a word he wants to learn more about]

Patient: Yeah, queasy like I might throw up, but I never have.

Clinician: What more can you tell me about the headaches or nausea? [Continuing to use open-ended questions to elicit more details of her symptom(s)]

Patient: That's all I can think of. [The patient's response suggests that open-ended skills are unlikely to result in a further description of the symptom. Some patients will begin to repeat themselves in describing their symptom(s). Either of these behaviors indicates that it is time to develop the personal context. We have a good description of the symptom, know when it began, have heard some associated symptoms, and know (from Step 3) that it occurs in the setting of her boss. In less than a minute, the clinician has learned how the personal context and symptom interact by facilitating (encouraging) the patient's spontaneous narration.]

Notice that at the outset of Step 4 the clinician used focusing open-ended skills to learn the patient's description and chronology of symptoms and learned some of the classic descriptive terms (throbbing headache and nausea but no vomiting), continuing in this way until the patient demonstrated she had no more details to offer. The clinician needs more diagnostic data about possible underlying disease (e.g., any head injury, fever, vision changes, prior investigation), but these details are not "on the table" and asking those specific questions here would run the risk of not exploring the patient's personal and emotion context, which are so important for diagnosis and patient satisfaction. The clinician should resist the urge to use clinician-centered skills at this point ("Did you ever have a head injury?" or "How does the headache affect your vision?" or pursuing other diagnostic data with closed-ended questions), and instead explore the personal and emotional context of the patient's story—those topics that the patient has placed on the table. The clinician will be asking closed-ended questions soon in the middle of the interview to answer these appropriate but premature questions.

While the new learner may not be aware of this, the symptom data given by Ms. Jones are quite suggestive of migraine headaches; that is, they are throbbing, unilateral, periodic, and associated with nausea. When given the chance, patients almost always provide information about their symptom that is highly diagnostic. Indeed, it is the great diagnostic yield of the beginning of the interview that led Sir William Osler to say, “Listen to the patient, he (sic) is telling you the diagnosis.”⁶¹ We also know that, occasionally, information diagnostic of a disease arises here that does *not* arise in later clinician-centered interviewing.⁶² On the other hand, even when symptom data are not diagnostic, you will obtain a good overview of the problem, one that does not need repeating after your transition to the middle of the interview.

If there are only psychological concerns (no physical symptoms presented), the psychological symptoms are treated in the same way as for physical symptoms; for example, if Ms. Jones was complaining of anxiety or feeling blue and down instead of having headaches, the clinician would elicit the description of these psychological symptoms, using open-ended skills. (See AccessMedicine video for an example of a mental health interview, titled “Patient with a Mental Health Disorder”: www.accessmedicine.com/SmithsPCI.)

Develop the Psychological and Social Context of the Symptom (Personal Context)

Your next task is to learn about the patient and his/her illness in its broader psychosocial/personal context. This information relates less to symptoms and may be of less value for diagnosing disease, but is important for understanding the patient’s illness. In general, the longer the interview, the less the personal data relate to symptoms, and the more they reflect the patient’s general life situation. Nonetheless, important diagnostic data about actual diseases can still arise, for example, stress-related disorders, occupational, or drug/alcohol problems. This information will directly influence treatment and prevention recommendations. Continue to rely upon focusing open-ended skills, redirecting the patient to personal statements “on the table” that seem most important to understanding his/her personal context—in this instance, Ms. Jones’ stressful job situation.

Continuation of Ms. Jones Visit

Clinician: You mentioned your boss. [Invites patient to talk about how her boss relates to the headache]

Patient: Well, I have no trouble at all when he’s not there. He was gone for 2 weeks and I didn’t have any. But he’s there a lot, although I don’t have to be around him all the time. [The relationship

of Ms. Jones' headaches and her boss are becoming clear and we hear some considerations for treatment; perhaps avoiding her boss. Such information often does not arise during isolated clinician-centered interviewing.]

Clinician: Not around him? [Echoing, a focusing open-ended skill, maintains the focus on the relationship of boss to symptoms.]

Patient: I'm on the road a lot. No trouble then either, I guess ... except once when he called me.

Clinician: Tell me more about him. [Encourages discussion of an important personal issue rather than keeping the focus on symptoms such as headache or nausea, because of the patient's prior indication that further description of the symptom would be unlikely without the use of clinician-centered interviewing skills; the clinician also could have focused on the job itself and accomplished the same goal of obtaining more personal data. Rather than an open-ended request, the clinician also could have focused the patient by echoing ("he called you") or summarizing the personal aspects; that is, any of the focusing open-ended skills could be used. They all lead to the same theme.]

Patient: Well, he's been there a long time and I've replaced him in every way there is, except he is still in charge, at least in his title. He yells at everybody. Nobody likes him and he doesn't do much. That's why they got me in there, the Board, so something would get done. These headaches have all come since I got this job—right here. They throb behind my eye and ... [Note the corroboration of earlier data: the job is linked to the headaches but Ms. Jones is now giving additional personal information about her situation that helps the clinician better understand this connection. Note too that she is repeating herself in describing her symptom, again indicating that patient-centered inquiry about the symptom is unlikely to be of high yield.]

Clinician: Wait a second, I'm not following you. You say he's in charge but you are the lead attorney? [Clinician interrupts respectfully, and then summarizes personal issues to refocus on the job because the patient is getting away from personal data and going back to symptoms already discussed; also, the clinician knows he will address symptom details just a few minutes from this point, during the middle of the interview.]

Patient: Yeah, they are phasing him out but he's still there in the meantime. Who knows how long it'll take. I hope I last. [She is further expanding the story to personal issues less directly related

to symptoms, allowing the clinician to begin to appreciate the nuances and depth of how her job and headaches interact.]

Clinician: Hope you last? [Echoing will maintain the focus in this personal/psychosocial area. Note how focusing open-ended skills are used repeatedly to focus the patient, and that they can be applied to the patient's immediately preceding utterances, or they can interrupt them to focus on utterances previously mentioned—but they never introduce new data to the conversation. The clinician develops a free flow of information from the patient, focusing the patient where intuition suggests the most key information resides, typically emotional information.]

Patient: I'm not sure how much of this I can take. They said there wouldn't be any problem with him and that he would be helpful. Actually, I kind of liked him at first but then all ...

Clinician: They said? Who are they? [Clinician interrupts to focus on a bit of information mentioned just before and redirects her to that with echoing; if the clinician wanted her to simply proceed, using nonfocusing skills or an open-ended request would have sufficed, such as "Go on."]

Patient: The Board, they run the company. It's not real big, but it's a good chance for someone like me to get experience in the corporate world. [A new layer of data that is not directly related to her headache but provides a deeper understanding of its context]

Clinician: Sounds like the Board told you one thing; that you liked him at first, but then he changed, and you're left with a problem? [Clinician summarizes what is becoming a free flow of personal data. This is abbreviated for space reasons, but the clinician ordinarily would further develop this with more focusing open-ended inquiry.]

Although no disease explanation is found for 20% to 75% of physical symptoms,⁶³ patients often have several personal concerns around their symptoms. In one study,⁶⁴ 67% of patients worried about serious illness, 72% expected medications, 67% wanted testing, 53% expected referral, and 62% indicated interference with routine activities. While 47% of patients who, like Ms. Jones, described stress and about 20% recognized depression and anxiety, only 1% considered their problem to be psychiatric in nature. In that study clinicians viewed the symptoms as being far less serious than patients did; and, not surprisingly, unaddressed concerns accounted for most of the patient dissatisfaction. Other patients may have disbelief/distrust of the medical system,⁶⁵ grief and other losses, concerns about becoming independent (young people) or

dependent (older or seriously ill people), issues concerning retirement, family or job problems, and administrative issues (needing an insurance form filled out). It is these personal concerns, the personal context of your patient's symptoms, that you want to understand. In general, whether the symptom is physical or psychological, you can easily establish a personal focus as you inquire into the broader personal context of the patient's illness.

To maintain the personal focus, avoid directing the patient back to previously discussed symptoms. You will focus on them when moving to the clinician-centered interview in a few minutes. At this point in the interview, you want to expand your understanding of the patient as a person.

Patients will occasionally share their stories without much facilitation. Usually, however, they give small bits of personal information, one at a time, as though testing the water to see if you are interested, comfortable, and willing to follow them into what is often a deeply personal story. Because of this step-by-step unfolding of the account, you must use focusing open-ended skills repeatedly to draw out the underlying narrative thread.

Early on, direct the patient to whatever bits of personal data appear to be of most interest to the patient and you. Once you identify the narrative thread of the patient's story and its apparent meaning, stay with it. If the patient gets away from this theme, respectfully interrupt with focusing open-ended skills and refocus the patient on the main story thread. Such refocusing is often needed because patients wander back to previously discussed symptoms (or other diagnostic or therapeutic data).

After no more than a few minutes, you will get a good sense of the broader personal context—and have further enhanced the clinician-patient relationship by addressing features of central importance to the patient's life. If emotions are “placed on the table” during these early stages, address them as discussed later.

It is here that the initial integration of symptoms and personal factors occurs, the first view of the patient's mind–body connection, with further integration to occur when you address feelings and emotions.

Uncommonly, patients may volunteer only physical symptom details in response to your patient-centered inquiry. In this case, we recommend that you “prime the pump” for personal data by using the indirect emotion-seeking skills described in Chapter 2 (*impact, belief, intuiting how the patient might be feeling, and triggers*). For example, if a patient offers no personal context of the physical symptom, you might ask, “How's that affecting your day-to-day life?”, “How's that affecting your spouse?”, “What do you think is causing the problem?”, “Many patients with these sorts of symptoms are worried,” or “What made you decide to come in now for your (symptom)?” See also Chapter 7, section entitled “The Stoic/Unemotional Patient.”

Develop an Emotional Focus (Emotional Context)

Just as you sought to understand the personal context of the symptoms, you now seek to understand the emotion associated with the personal and symptom information. This further deepens the story and makes apparent the three-way interaction among symptom, personal, and emotional dimensions. The full mind–body link and the biopsychosocial description become clear as you include the patient’s emotional response to the illness. In developing an emotional focus, always monitor the patient’s readiness to engage by observing how he or she is responding to the process so far and for any untoward responses to inquiry about emotion; for example, changing the subject after the clinician inquires about emotion. As you develop experience with the interview you will notice that many patients will offer the personal and emotional contexts of their story as a natural progression of describing the symptom. This will help you recall that it is often not just the symptom that motivates a person to seek healthcare and become a patient, but also how the symptom interacts with the personal and emotional contexts of the person’s life. Patients often seek healthcare because they are concerned. If the patient does not spontaneously put the emotional context “on the table,” you will need to develop an emotional focus.

To establish an emotional focus, you will need to change the style of inquiry. Emotion-seeking skills, both direct and indirect, temporarily supplant focusing open-ended skills. Start to explore the emotional domain with direct inquiry about how the patient feels about the personal situation so far described (“How is this for you?”, “How does that make you feel, emotionally?”).⁶⁶ If the patient is uncomfortable or simply reticent, you may need to make several efforts before emotion can be expressed. Indirect inquiry about impact, beliefs and triggers, and intuiting how the patient might be feeling also may be necessary and are used when direct inquiry does not reveal emotional content (see Chapter 2).

Once you identify an emotion, ask for clarification using open-ended skills to get a good understanding of the emotion and what produced it so that you can then respond empathically.

As noted earlier, emotion-seeking skills are not needed if the patient is already showing or expressing emotions, as many will do spontaneously following open-ended inquiry alone.

Continuation of Ms. Jones Visit

Clinician: Sounds like the Board told you one thing; that you liked him at first, but then he changed, and you’re left with a problem?

Patient: Yeah, sounds kind of bad, huh?

Clinician: How do you feel about that? [Direct emotion-seeking]

Patient: Oh, I don't know. The headache is what bothers me.

Clinician: But how do you feel, you know, emotionally? [She did not give any emotion the first time and clinician uses direct emotion-seeking inquiry again. It is okay to encourage emotional expression, as long as the patient does not protest or try to change the subject.]

Patient: Oh, nothing really bothers me that much. We were taught to turn the other cheek.

Clinician: You know, I think I would be upset if I were put in a bind like this. [Changes strategy and tries intuiting how the patient might be feeling.]

Patient: Well, yeah, I guess I am too, now that you mention it.

Clinician: What is the feeling? [She has acknowledged emotion (upset) but the clinician wants to get an accurate description, returning to a direct emotion-seeking question about feeling.]

Patient: Well, I just want to throw something at him. He makes me so mad! I didn't do anything against him. I work really hard there and things are going much better since I've been there. It's when I get mad that the headaches come. The nausea is even worse and then sometimes I get these spots in my eyes and ... [A more precise direct link to headaches, now not just to her job situation but more specifically to being angry. Note the value of encouraging emotion: she is now expressing it.]

Clinician: So you get mad when he gets on you? [Interspersing open-ended skills is appropriate as the clinician summarizes to continue this focus.]

Address Feelings and Emotions with Empathy Skills

When the patient names a feeling or expresses emotion, either spontaneously during open-ended inquiry or after you use emotion-seeking skills, and once you have clarified with open-ended skills why this patient has this feeling or emotion, use the empathy skills outlined in Chapter 2: Naming, Understanding, Respecting, and Supporting, recalled by the mnemonic NURS.

To address an emotion or feeling, convey to the patient that you have recognized it by naming it, that you understand it, that you respect the patient's situation, and that you are available to help in any way possible. These skills typically are used multiple times during the course of an interview. It may take you considerable time to work through strong emotional reactions. Using these skills once is seldom enough.

You can use all four empathy skills together as a set, in the order given; we recommend this when first learning them. Once they are learned, however, in addition to using all four at once, you can use one or two skills at a time to avoid their repeated use as a quartet from striking the patient as peculiar or scripted.

Empathy skills are used only after you have heard enough to adequately understand the patient's feelings and emotions. For example, when a patient expresses sadness over loss of a spouse, it is not appropriate to immediately say you understand the patient's sadness. You must first listen to enough of the story in an open-ended manner to be able to legitimately make these empathic statements. Stating that you "understand" before the patient describes the feeling conveys an attempt to blindly follow communication scripts rather than real understanding. Patients may then respond, "How can you understand what I'm going through!" Allow and encourage the patient to describe the feeling in some depth; then your statement of "understanding" the feeling will be authentic. Words such as "see," "appreciate," and "imagine" can also be used to express understanding, for example, "I can see why you'd be sad," "Given what you've told me, I can appreciate why you are sad," "I can only imagine how sad this makes you."

On the other hand, with reticent patients you may have to use empathy skills with much less emotional information than is desirable. For instance, in a very reticent patient who has lost a job and will only acknowledge being "slightly upset," you can still use the NURS skills effectively.

Some new learners resist emotion-seeking and empathy skills, usually because of unfamiliarity. They worry that these skills will seem forced and false. It may be helpful to recall the compelling scientific rationale for using them (see Appendix B). It may indeed feel awkward and contrived at first for some but, as self-consciousness is overcome, confidence is gained, and benefit to the patient is observed, most clinicians become converts,⁶⁶ recognizing that they feel progressively more comfortable themselves, that their responses become quite genuine, and that patients respond favorably to this emotional connection, sometimes even saying, "You know, I'm feeling better already."

Continuation of Ms. Jones Visit

Clinician: So, you get mad when he gets on you?

Patient: Yeah, he really gets me mad. I just get so furious I could scream sometimes (clenches fist and strikes table firmly).

Clinician: You get furious. It sure makes sense. It seems like you've done so much there to help, and all you get is grief from him. I appreciate the way you're able to talk about it. Maybe you and I can

talk more later about how you might handle that. [The clinician *names* the feeling using her exact word—furious, expresses *understanding* briefly, and spends more time expressing *respect* for her: acknowledging she had been through a lot, that she was successful at work, and praising her for talking about her emotions. Finally, the clinician *supports* the patient by offering to work with her on managing her anger.]

Patient: That would probably help. Just talking about it gets me upset and gives me a headache, right now. [This further demonstrates the association between headaches and emotional upset, now occurring as a result of anger-laden material during the interview.]

Clinician: I can imagine. You've put up with a lot. [Naming "mad" or "furious" again is unnecessary because it's obvious, but the clinician again indicates *understanding* and makes a *respecting* statement.]

Patient: You know, I think I'm even madder at that damn Board. They didn't tell me any of this and said everything would be OK. Who needs all this? [As a result of addressing her emotions, the patient is now presenting new personal data and its associated emotional material; that is, the story deepens as the narrative thread further unfolds.]

Clinician: That's a tough situation. [Clinician again *respects*, using just one of the NURS quartet.]

The rich description of symptom(s), personal context, and emotional context obtained in the first four substeps of Step 4 provides the first chapter of the patient's story. Subsequent chapters are developed by expanding the story as shown in Fig. 3-1 and described in substep 5 below. As you will learn next, subsequent chapters of the patient's story do not usually return to symptoms, but concern just the evolving personal and emotional aspects of the story—the narrative thread.

Expand the Story to New Chapters

Let us review the sequence of skills outlined so far in Step 4: focusing open-ended skills followed by emotion-seeking skills and then empathy skills. This typically produces a beginning, but still incomplete, story. To develop the story further requires the repetitive, cyclic use of this sequence of patient-centered interviewing skills. Each cycle produces a deeper level of the story, another chapter. Personal information and its associated emotion(s) evolve in parallel—neither is more important than the other. This deepening of

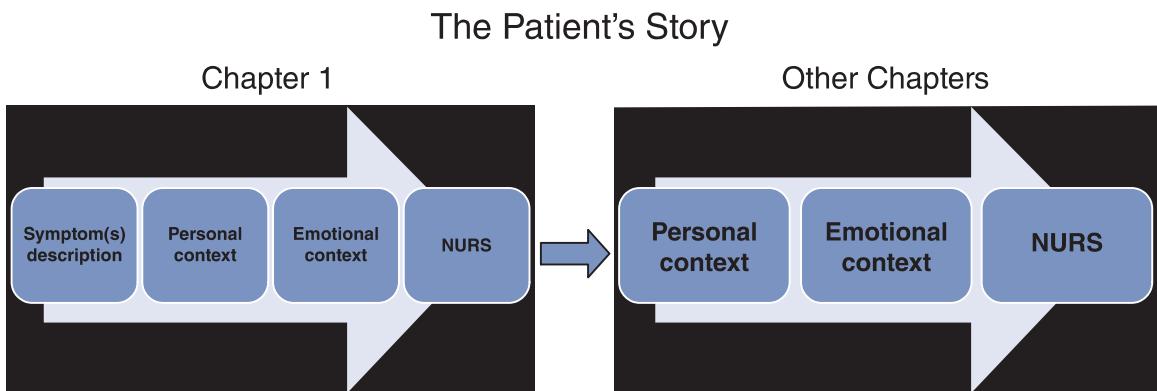


FIGURE 3-1. The patient's story.

the narrative thread occurs because empathy skills stimulate the patient to place new personal information “on the table,” offering you an opening to inquire about them and develop the story further. Then, you can return to emotion-seeking and empathy skills to develop the emotional dimension of the new data. Do this until you are satisfied with the depth of the story. The self-reinforcing effect of patients’ psychological statements and emotions is key to obtaining the full personal and emotional story. This does not mean that you should focus on just the personal or just the emotional aspect. Both are developed nearly simultaneously in a progressive unfolding of the narrative theme. Returning to a symptom focus is generally not recommended, rather, remaining in the personal, emotion realm will help you better develop the narrative thread.

The story will develop spontaneously as you repeatedly cycle through focusing open-ended, emotion-seeking, and empathy skills. As the patient becomes comfortable in expressing emotion, fewer of the emotion-seeking skills are needed and empathy and focusing open-ended skills alternate, taking the patient quickly to progressively deeper levels of his/her story.

You will find that in developing the story, you will have ideas (hypotheses) about what it implies. Paradoxically and distinct from the middle of the interview (clinician-centered part), you should not directly ask about your hypotheses until they have first been mentioned by the patient—only what is placed “on the table” for discussion by the patient can be commented on during this portion of the interview. This is a principle drawn from nondirective psychotherapy in which the meaning of an event or experience for the patient becomes apparent over time and without interpretations from the clinician.⁶⁷ For example, if you thought a patient’s story about disliking a woman who

"looks like my wife" meant that the patient disliked his wife, you should not ask directly ("Don't you like your wife?") because it would insert new data (*dislike* of wife) into the conversation. Rather, get the patient to continue talking about what he put on the table by saying, for example, "Tell me more about your wife." The hypothesis-testing process is analogous to dancing or playing jazz.¹⁰ While the patient leads the dance or musical performance, once the patient has led to a specific place, the clinician can maintain a focus on that spot.

Continuation of Ms. Jones Visit

Clinician: That's a tough situation.

Patient: You know the head of the Board even told me my boss is a good guy who was looking forward to me coming so he could retire!

Clinician: The head of the Board? [The clinician shifts away from empathy to focusing open-ended inquiry with echoing to get what appears to be new information about the situation. This will start a new cycle of active open-ended, emotion-seeking, and empathy skills.]

Patient: She's the one who recruited me here. I could have gone to a couple other places but came here because she convinced me it was such a good chance for me.

Clinician: Sounds like you didn't get a full picture of this place. [Focusing open-ended summary, still trying to learn more new information]

Patient: Yeah, it's not really fair.

Patient: How's that for you? [Now back to emotion with a direct emotion-seeking inquiry]

Patient: Well I must sound kind of stupid, and I feel kind of sheepish; but mostly just mad.

Clinician: It makes sense to me, but I don't understand why you feel sheepish. You did everything that you could. [Back to empathy skills with *understand* and *respect* statements. Notice how open-ended and relationship-building skills are interwoven to generate both emotional and nonemotional data. Notice also that one can indicate lack of understanding and ask for clarification.]

Patient: Yeah, I guess, but I still feel kind of dumb.

Clinician: Dumb? [Echoing; an obvious story is already present but the clinician is exploring further by again moving away from emotion.]

Patient: That's what my mother used to say, that I was smart but dumb. You know what I mean?

Clinician: Smart with books but not so much with people? [A combination of a summary and an educated guess]

Patient: Yeah, maybe she's right.

Clinician: How'd that feel, when she'd say that? [Back to emotion with direct emotion-seeking]

Patient: I felt mad! Seems like a pattern, huh? And I used to get headaches as a kid too when she'd get on me. I'd forgotten that. [Additional supportive data about the association of headaches and anger]

Clinician: So that made you mad, too. I'm impressed at how you're able to talk about it and put this together. [Clinician uses a *name* and a *respect* statement. Depending on the time available, the clinician could have further addressed another obvious clue, the patient's mother, perhaps with an open-ended request such as "Tell me more about your mother." Note in this vignette that another cycle of focusing open-ended, emotion-seeking, and empathy skills has been used to further develop the story.]

Patient: Well, I appreciate your saying that. Actually, it feels kind of good talking. [A positive response to this interaction and an indication of a good clinician–patient relationship.]

Clinician: Say more about that. [An open-ended request]

Patient: Well, I just haven't talked much about it. My husband doesn't want to talk about it.

Clinician: He doesn't want to talk about it? [Echoing]

Patient: No. I think he feels bad because he thought this was the best place for me to come.

Clinician: Well, I'm glad it's been helpful here. You've really been open. [A *support* statement followed by a *respect* statement. An obvious new area for further discussion has been introduced, the patient's husband, and this could be pursued further if time allowed. The patient also has referred positively to their present interaction. Simply acknowledging it, as the clinician did is appropriate.]

Patient: Thanks. My headache's better now. It does help.

The first three chapters of Ms. Jones' story are illustrated in Fig. 3-2.

Given the importance of the clinician–patient relationship, it is important to check how the interaction is going if the patient does not raise it. You can inquire directly, such as "So how are we doing here so far?" If you have been patient-centered, the response usually will be positive and you simply

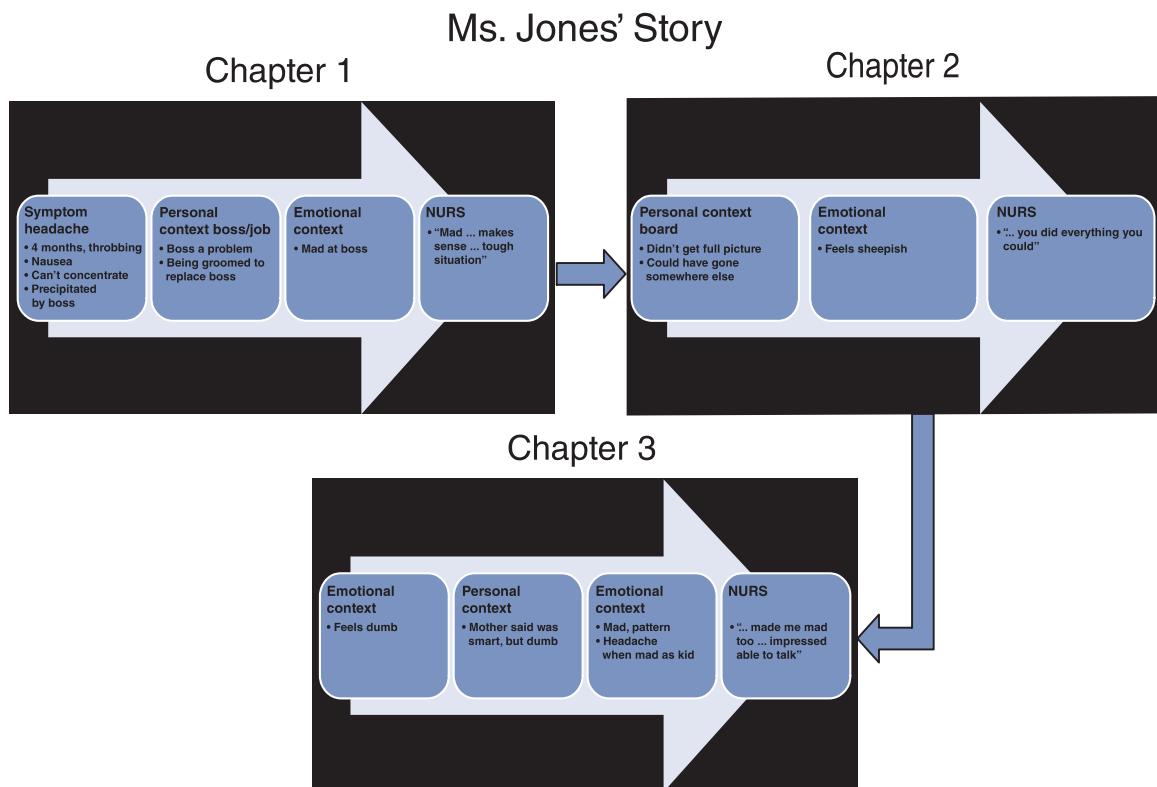


FIGURE 3-2. Ms. Jones' story.

acknowledge this; for example, “Good, it seemed like things were going OK to me, but I wanted to check.” When the patient mentions the clinician–patient relationship, as Ms. Jones did, this provides the answer about the relationship and you can simply acknowledge it. Of course, if the patient raises problems with the interaction, for example, getting tired, address these.

If an urgent personal problem exists, easily determined in 5 to 15 minutes, the patient may require additional time, even immediate action. For example, if you discover a patient is a victim of intimate partner violence, you may have to take additional time to ensure his/her immediate safety. In the absence of an urgent problem, the usual situation, prepare to transition into the middle portion of the interview when you have an understanding—not of the entire story, but of the most salient, immediate aspects of the patient's story; that is, the first few chapters. Certainly, there is more to Ms. Jones' story but, given time constraints and lack of urgency, these areas can be explored another

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■ TABLE 3-6. Step 5: Transition to the Middle of the Interview (30–60 s)

1. Brief summary
2. Check accuracy
3. Indicate that both content and style of inquiry will change if the patient is ready. Continue with middle of interview.

Clinician: If it's OK then, I'd like to shift gears and ask you some specific questions about your headaches and colitis, as well as a lot of questions to get to know you better as a person. [The clinician is checking if it is satisfactory to change the subject and indicating what is going to occur.]

Patient: Sure, that's what I came in for.

(Ms. Jones' visit continues in Chapter 5)

■ BEYOND BASIC INTERVIEWING

We have already begun to develop a clear understanding of the patient's story and the psychological, social, and emotional meaning it has for him/her. It is at this point that you can clarify your understanding of the story and begin developing preliminary hypotheses about what might be causing the problem(s) and what opportunities there might be to remedy them. Focusing open-ended skills, emotion-seeking skills, and empathy skills are essential for eliciting the required data, but there are many more skills in the experienced clinician's toolbox. Prejudices, time pressures, and preoccupation with other issues, for example, can interfere with hearing the patient's story. Take care of pressing personal or professional issues beforehand, relax, clear other issues from your mind, and focus on the patient. As noted above, it is often useful to breathe deeply or simply close your eyes and become aware of your state of mind and what you would most like to accomplish with this patient for a few seconds before entering the clinic or hospital room. This will help you listen at multiple levels,^{11,70,71} a skill that will improve over time as the basics described in this text become reflexive.

Attention to multiple levels means going beyond the obvious content and emotion presented by the patient to consider how the patient says something, what is left unsaid, and what is implied. This requires attention to subtleties of grammar, syntax, verb tense, changes of subject, tone of voice, nonverbal cues, incongruity in verbal and emotional content, and understanding metaphors.^{72,73} These areas are addressed using the same basic skills; for example, "What do you mean when you say, 'my daughter's father'?"; "I've noticed you often say, 'You can't win for losing.'"

■ SUMMARY

The beginning of the medical interview consists of two preparatory steps during which we set the stage (Step 1) and the agenda (Step 2); followed by an open-ended beginning of the HPI (step 3), continuation of the HPI (Step 4),

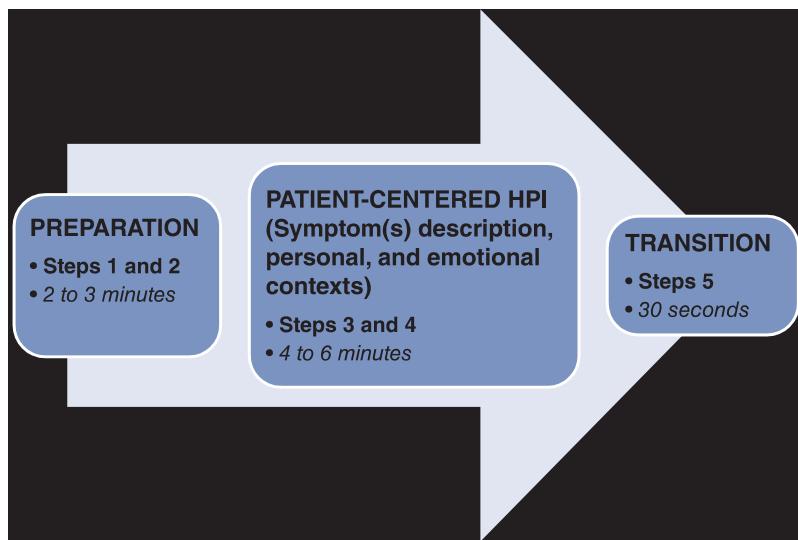


FIGURE 3-3. Summary of the beginning of the interview.

and transition to the middle of the interview (Step 5). The transition (Step 5) prepares the patient for the more direct clinician-centered style of the middle of the interview. In Steps 3 and 4, you use the following patient-centered skills to “build the patient’s history”⁶⁰: nonfocusing and focusing open-ended inquiry, rare closed-ended questions, emotion-seeking and empathy skills. The cyclic, integrated use of these patient-centered skills occurs in Step 4. These tools allow you to begin to understand the richness and complexity of the human condition.

Figure 3-3 summarizes the major events in the beginning of the medical interview. Usually, preparing the patient takes 1 to 3 minutes, eliciting the beginning of HPI (symptoms with personal and emotional contexts) takes 4 to 12 minutes, and making the transition takes 30 seconds. Using patient-centered interviewing skills primarily and delaying clinician-centered skills for 6 to 15 minutes will lead to the remarkable benefits described in Appendix B, for example, improved patient satisfaction, decreased risk of malpractice law suits, and improved health outcomes. After this investment, you will find the rest of the interview to be fairly easy and routine. The data you generate will be easily understood and usually describe the primary symptoms and their personal context. The mind–body connection will be established; data that will lead to a biopsychosocial story will begin to emerge; and, most important, the patient will feel listened to, understood, and cared for.

SKILLS EXERCISES

(Likely spread over several sessions)

1. Practice Steps 1 and 2 together in role play until you can do them without looking at the book to recall all the substeps. Work on simple opening statements for each step, including several substeps in one sentence or so. See the vignette of Ms. Jones and the demonstration video.
2. When question #1 is mastered, practice Steps 1 to 5 together in role play, covering all 21 substeps. Conduct the entire patient-centered interview in 10 to 15 minutes, spending about 1 minute each in Steps 1 to 3 and 5—with 5 to 10 minutes in Step 4.
3. After you can complete all steps and substeps in role play, conduct the same exercise with a real or a simulated patient.
 - A. Problems to watch out for:
 - a. Hurrying into the interview rather than engaging in some small talk to let the patient get comfortable with you.
 - b. Inefficient agenda-setting, omitting repeated “what else” statements until you know all items the patient wants to discuss.
 - c. Excessive time spent in Step 3 which is just a 30 to 60 second step where

- you simply listen attentively—after an initial open-ended question—the next comment you make that isn’t a continuer starts Step 4.
- d. Not touching the key bases in Step 4: symptoms, personal concerns, emotions
 - e. Too little emotion-seeking
 - f. Not enough NURS
 - g. Not adequately signaling the transition
- B. With time and practice, you will notice the following markers of success:
- a. Smooth, seamless flow of data
 - b. Understand mind–body links
 - c. Ability to focus wherever you wish
 - d. Ability to effectively and respectfully interrupt
 - e. Control of the interview
 - f. Skilled critiquing ability of your own and others’ interviews
 - g. Efficient interview. Once facile with the 5 steps and 21 substeps, you will be able to conduct the patient-centered process in 6 to 15 minutes. With further mastery, you will be able to be equally effective in 3 to 6 minutes.

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Symptom-Defining Skills

*I keep six honest serving-men
(They taught me all I knew);
Their names are What and Why and When
And How and Where and Who.*

Rudyard Kipling,
The Elephant's Child. In: *Just So Stories*.¹

In the beginning of the interview, you greeted the patient (Step 1) and set the agenda for the visit (Step 2). You then obtained the first portion of the history of present illness (HPI) by eliciting the patient's unique description of his/her chief concern and its personal and emotional contexts (Steps 3 and 4); you responded to the patient's emotions with empathy. In Step 5, you informed the patient of the transition to the middle of the interview.

The data you collected in the beginning of the interview, while essential, are rarely complete. In the middle of the interview, you will gather more detailed information on the patient's HPI and other active problems (OAP). You will also ask about other symptoms, the patient's life and medical history to help you make a diagnosis, identify medical issues other than the chief concern, assess for disease risk, and come to know the patient better. This additional information falls under the headings of past medical history (PMH), social history (SH), family history (FH), and review of systems (ROS). We will cover each of these in detail in Chapter 5.

In the middle of the interview, you will be more directive, guiding the topics discussed by using the *clinician-centered* interviewing skills as contrasted with the *patient-centered* interviewing skills you used in the beginning of the interview. Clinician-centered skills, such as “coning-down”—following

open-ended questions with closed-ended ones (see Chapter 2)—help you to clarify and explore details of the patient's symptoms to test hypotheses and make a diagnosis, as well as to efficiently gather the large amount of data required. Even though you will often be asking lists of clinician-centered questions, it is important to remain alert to the patient's emotional state and any verbal or nonverbal cues of emotion, and respond with emotion-seeking and empathy skills (NURS) as needed.

Your first goal in the middle of the interview is to develop as complete and precise a characterization as possible of the patient's symptom story. To do this, you will use symptom-defining skills. Just as you learned facilitating skills before conducting the beginning of the interview, symptom-defining skills will help you perform the middle of the interview.

But first, what is a *symptom*? Generally speaking, a symptom is an indicator of the existence of something else. In medicine, we take it to mean the subjective evidence of the patient's underlying problem. In this way, it differs from a *sign*, which is the objective evidence of a disease or disorder. The patient tells the clinician about a symptom (chest pain, shortness of breath), while the clinician observes a sign on physical examination (tender ribs, heart murmur). You will learn about signs in physical diagnosis courses and on clinical rotations. But, before you can learn all you can about the patient's symptom, you need to ask: *Is the patient describing a symptom?*

■ THE REVIEW OF SYSTEMS LISTS THE SYMPTOMS OF MOST DISEASES

We introduce the ROS (Table 4-1) here because it lists and organizes most known symptoms related to underlying diseases. Symptoms are important because they are the language you will use to convert a patient's concerns to a diagnosis. Table 4-1 lists symptoms according to the body system they are usually associated with, although many occur in more than one system. The ROS listing is not exhaustive. Beginning clinicians should not worry if they don't understand what diagnosis a given symptom points to. You can make a diagnosis only after you have obtained and synthesized enough data about the patient. Medical terminology for some symptoms is noted in parentheses. Remember, though, that you need to remain bilingual, using technical terms with your colleagues and plain lay language with your patients.

Beginning clinicians should learn all 19 categories of the ROS and know a few symptoms in each. All clinicians are advised to memorize all symptoms in each category, a necessary prerequisite for effective clinician-centered interviewing.²

■ TABLE 4-1. Review of Systems^a

General Usual state of health Fever Chills Night sweats Appetite Weight change Weakness Fatigue Pain	Ears Hearing loss Use of hearing aid Discharge Pain Ringing (tinnitus)
Skin Sores/skin ulcers Rashes Itching (pruritus) Hives Easy bruising Change in size or color of moles Lumps Loss of pigment Change in hair pattern Change in nails	Nose Nosebleeds (epistaxis) Discharge Loss of smell (anosmia)
	Mouth and throat Bleeding gums Sore throat Painful swallowing (odynophagia) Difficulty swallowing (dysphagia) Hoarseness Tongue burning (glossodynia) Tooth pain
	Neck Lumps Goiter Stiffness
Hematopoietic Enlarged lymph nodes (lymphadenopathy) Urge to eat dirt (pica) or ice Abnormal bleeding or excessive bruising Frequent or unusual infections	Breasts Lumps Milky discharge (galactorrhea) Bleeding from the nipple Pain
Head Dizziness Headaches Fainting or loss of consciousness Head injuries	Cardiac and pulmonary Cough Shortness of breath (dyspnea) Shortness of breath with activity (exertional dyspnea) Shortness of breath when lying down and need to sit to breathe (orthopnea) Awaking at night with shortness of breath (paroxysmal nocturnal dyspnea) Sputum production Coughing blood (hemoptysis) Wheezing Chest pain Pounding or fluttering sensation in the chest (palpitations)
Eyes Use of glasses Change in vision Double vision (diplopia) Pain Redness Discharge History of glaucoma Cataracts Dryness	<i>continued</i>

■ TABLE 4-1. Review of Systems^a (continued)

Cardiac and pulmonary (continued) Shortness of breath on exertion Swelling of feet or other regions (edema)	Blood in urine (gross hematuria) Pain or burning on urination (dysuria) Particulate matter in urine (urinary gravel)
Vascular Pain in legs, calves, thighs, hips, or buttocks when walking (claudication) Leg swelling Blood clots (thrombophlebitis) Leg ulcers	Female genital Lesions/discharge/itching Age at menarche Interval between menses Duration of menses Amount of flow Last menses Painful menses (dysmenorrhea) Absence of menses (amenorrhea) Irregular, heavy menses (menometrorrhagia) Bleeding between periods Pregnancies Abortions/miscarriages Libido Painful intercourse (dyspareunia) Orgasm function Age at menopause Menopausal symptoms Postmenopausal bleeding
Gastrointestinal Loss of appetite Weight change Nausea Vomiting (emesis) Vomiting blood (hematemesis) Difficulty swallowing (dysphagia) Painful swallowing (odynophagia) Heartburn (dyspepsia) Abdominal pain Difficult or infrequent bowel movements (constipation) Loose, frequent bowel movements (diarrhea) Passing mucus Change in stool color/caliber Black, tarry stools (melena) Rectal bleeding (hematochezia) Hemorrhoids Rectal pain (proctalgia) Rectal discharge Rectal itching (pruritus ani) Yellow discoloration of sclerae and skin (jaundice) Dark urine—the color of tea or cola drink Excessive upper (belching or eructation) or lower (flatus) bowel gas Lump in groin or scrotum	Male genital Lesions/discharge Erectile function Orgasm function Bloody ejaculation (hematospermia) Testis swelling/pain Libido Hernia
Urinary Frequent urination (polyuria) Awakening at night to urinate (nocturia) Infrequent urination Abrupt urge to urinate (urinary urgency) Difficulty starting stream (urinary hesitancy) Loss of control of urination (incontinence)	Neuropsychiatric (See headings Head, Eyes, Ears, Nose, Mouth, and Throat for cranial nerves) (See heading Musculoskeletal for motor function) Fainting Paralysis Tingling (paresthesia) Decreased sensation (hypesthesia) Absent sensation (anesthesia) Tremors Loss of memory

continued

■ TABLE 4-1. Review of Systems^a (continued)

Neuropsychiatric (continued)	Endocrine
Depression	Excessive thirst
Mania	Frequent urination
Apathy or loss of interest	Numbness or tingling of hands/feet
Loss of enjoyment of life (anhedonia)	Weight gain or loss
Suicidal thoughts	Episodes of confusion, sweating, light-headedness (hypoglycemic reaction)
Sleep	Blurred vision
Anxiety/nervousness	Date of last eye exam
Speech disorders	Swelling in neck
Dizziness or vertigo	Weight gain or loss
Poor balance (ataxia)	Palpitations or racing heart
Inability to get to sleep or stay asleep (insomnia)	Tremulousness
Excessive sleep (hypersomnolence), nightmares	Hair loss (alopecia)
Symptoms without an explanation (somatization)	Dry skin
Bizarre or unrealistic thoughts (intrusive thoughts)	Heat or cold intolerance
Bizarre or unrealistic perceptions (hallucinations)	Loss of skin pigment (vitiligo)
Seizures	Constipation or diarrhea
Musculoskeletal	
Weakness	
Muscle pain (myalgia)	
Stiffness	

^aMany of these symptoms can be caused by diseases in several systems (including other than where listed). Medical terms (used in oral and written presentations) are in parentheses.

■ DISTINGUISHING CLOSELY RELATED MATERIAL (SECONDARY DATA) FROM SYMPTOMS (PRIMARY DATA)

Sometimes, instead of describing a symptom such as, “My head aches” or “My big toe is hurting,” a patient will say, “I have a migraine,” or “I think it’s the gout.” While the patient may well be correct, s/he is describing a disease in each case, not a symptom. Symptoms are the patient’s area of expertise and no verification is necessary. This is primary data.³ Secondary data are any data apart from a patient’s direct experiences. They are less reliable and more in need of verification. Non-symptom information obtained from the patient (such as a disease or disorder, treatment, procedure, medication, cause of the problem, or a laboratory test result) are secondary data that differ from the patient’s actual symptoms. While these secondary data are less important,³ they often guide the clinician to areas requiring verification and additional information. We discuss how to incorporate secondary data into the interview in Chapter 5.

■ TABLE 4-2. Some Common Concerns Needing Conversion to Symptoms in the Review of Systems

- | | |
|---|---|
| <ul style="list-style-type: none">• Blahs• Dragged-out• Bad blood• I've got a "bunch"• Really weird• Funny smelling urine• Wrung-out• Midlife crisis• Menopause• Old age | <ul style="list-style-type: none">• Terrible two's• A rod in my head• Wigged-out• Sun troubles• Chronic fatigue syndrome• Heart murmur• Indigestion• The flu• Dizzy• Allergies |
|---|---|

■ TRANSLATING CONCERNs INTO SPECIFIC MEDICAL SYMPTOMS

Patients often speak in nonmedical terms (Table 4-2) that you must convert to medically meaningful symptom terms. When the patient tells you that s/he has the “blahs,” a “wrung-out feeling,” or “bad blood,” what does s/he mean and how is the information to be used medically? If you couldn’t clarify it in the beginning of the interview using patient-centered facilitating skills, you need to use symptom-defining skills in the middle of the interview: start with a brief open-ended question (focused on the patient’s term) and follow-up with enough closed-ended questions to adequately understand:

Clinician: Say more about what you mean by the blahs. [A focused, open-ended request]

Patient: Well, you know, the nausea all the time and no appetite. [Nausea and no appetite are medically meaningful symptoms (see GI System in ROS).]

Clinician: Any vomiting? [Closed-ended question drawn from the GI System in ROS]

Patient: No.

Clinician: How's your weight been? [The clinician would continue to better define what the patient calls the blahs but has already identified at least two commonly understood medical symptoms in the ROS.]

Likewise, certain medical terms are ambiguous or are used by patients in an unconventional way. For example, “dizzy” usually means vertigo, a sensation

of whirling, as though one had just gotten off a merry-go-round or had too much alcohol to drink. But, some clinicians and many lay people use the term dizziness to mean a faint or light-headed feeling unattended by vertigo. This distinction is important because one approaches the patient with vertigo differently from the patient who is light-headed:

Clinician: Tell me what you mean by dizzy. [Focused, open-ended request; this could also be phrased as a question such as, “What do you mean by dizzy?”]

Patient: I get wobbly on my feet. [Still not very specific]

Clinician: Do you get a sensation of whirling about, like you’d just stepped off a merry-go-round? [Closed-ended question to get necessary details]

Patient: Yeah, that’s it. I feel like I’m going around the room.

Clinician: Do you feel light-headed, like you might faint or have to put your head down between your knees to get relief? [Closed-ended inquiry to determine if “dizzy” means light-headedness to the patient.]

Patient: No, that makes it worse to put my head down. [The interviewer has identified the medical symptom vertigo as the meaning of the complaint of dizziness, although many more questions remain about associated symptoms and other details of the problem.]

Other examples include “diarrhea,” which means frequent liquid stools, but which lay people often use to mean frequent stools, regardless of consistency; and “constipation,” which traditionally has been defined as fewer than three stools per week. Patients have a broader definition for this term, using it to also describe having to strain at stool or a sense of incomplete evacuation. In fact, the medical definition of constipation was broadened to include patients’ usage of the word.⁴

■ CHARACTERIZING SYMPTOMS

Once the symptom is clear, you want to learn as much about its characteristics as possible. To fully understand a symptom, you need to know its descriptors or “cardinal features”: Onset and chronology, Position, Precipitating factors, Quality, Quantification, Radiation, Related symptoms, Setting, and Transforming factors (aggravating/alleviating). Some use the mnemonic OPPQQRST to recall these (Table 4-3). These descriptors incorporate the “classic seven” attributes of symptoms.⁵

■ TABLE 4-3. The Descriptors of Symptoms—OPPQQRRST

1. **O**nset and chronology (“When does [did] it begin?” “How long does it last?” “How often does it happen?”)
 - a. Time of onset of symptom and intervals between recurrences
 - b. Duration of symptom
 - c. Periodicity and frequency of symptom
 - d. Time course of symptom
 - i. Short term
 - ii. Long term
2. **P**osition (“Where is it located?”)
 - a. Precise location
 - b. Deep or superficial
 - c. Localized or diffuse
3. **P**recipitating factors (“What brings it on?” “What were you doing when it started?”)
4. **Q**uality (“What is it like?”)
 - a. Usual descriptors
 - b. Unusual descriptors
5. **Q**uantification (“How bad is it?” For pain, “On a scale of 1 to 10, with 1 being no pain and 10 being the worst pain you can imagine, like surgery without anesthesia, what number would you give your pain?”)
 - a. Rate of onset
 - b. Intensity or severity
 - c. Impairment or disability
 - d. Numeric description
 - i. Number of events
 - ii. Size
 - iii. Volume
6. **R**adiation (“Does it travel anywhere?”)
7. **R**elated symptoms (“Have you noticed anything else that occurs with it?”)
8. **S**etting (circumstances that contribute to or precipitate the symptom)
 - a. Environmental factors
 - b. Social factors
 - c. Activity
 - d. Emotions
9. **T**ransforming factors (“What makes it better?” “What makes it worse?”)
 - a. Aggravating factors
 - b. Relieving factors

Onset and Chronology—Course of Individual Symptoms Over Time

Understanding the precise sequence of symptoms and other events is key to making a correct diagnosis and should be asked about first. Here we focus on the chronology and timing of individual symptoms and discuss how to integrate these data into the overall chronology of all symptoms and other data in Chapter 5.

Time of Symptom Onset and Intervals Between Its Occurrences

The time of onset of the symptom and the time intervals between occurrences of the symptom are diagnostically significant; for example, the onset of a cough 6 months earlier that recurs at intervals of 1 to 2 days suggests a chronic pulmonary problem such as cancer or tuberculosis, while the onset of a cough 2 days ago that is continuous suggests an acute process such as bronchitis or pneumonia. Recalling Ms. Jones' clinic visit from Chapter 3, migraine headaches characteristically have specific times of onset and pain-free intervals of days to weeks, whereas a brain tumor or tension headaches usually cause daily and non-remitting pain.

Rate of Onset

Whether the symptom began gradually or suddenly has diagnostic significance; the latter suggests an acute but not necessarily more important disease process. You might hear a patient with polymyositis say, "the weakness just gradually developed in my shoulders and thighs over a couple months" or a patient with pulmonary embolus or heart failure might say "the shortness of breath had been kind of gradual over that day but the chest pain and coughing blood came all of a sudden."

Focused open-ended inquiry often suffices, although patients sometimes benefit from being given examples:

Clinician: How did this begin?

Patient: What do you mean?

Clinician: You know, slow or all of a sudden.

Patient: Gradual, a little bit at a time.

Duration of Symptom

The duration of a symptom also is of diagnostic importance. Precise understanding is essential; is the duration a few seconds, 5 minutes, 2 hours, 10 days, 3 years? To illustrate, typical substernal crushing chest pain of coronary disease lasting only 5 to 10 minutes suggests angina pectoris without myocardial infarction (heart attack) while a similar pain lasting an hour or so is more consistent with myocardial infarction. Similarly, migraine headaches typically last from 1 to 12 hours in contrast to the more constant headaches of a brain tumor or tension headaches.

Periodicity and Frequency of the Symptom

The pattern of symptoms can be diagnostically important. To illustrate, the fever and chills of malaria occur at distinctive and sometimes diagnostic frequencies. Body cycles also can affect symptoms; for example, premenstrual

syndrome happens around menses and nocturnal myoclonus occurs during non-rapid eye movement sleep. External influences can also have a cyclic impact; regular stressful events such as work or the anniversary of a loss can exacerbate migraine or depression, and allergic rhinitis and asthma can have a seasonal association.

Time Course of the Symptom

You will want to learn the course of the symptom over an individual episode and its pattern of occurrence over a longer period. For instance, pain stemming from obstruction of a hollow organ progressively increases and then subsides, often to complete relief, only to be followed at varying intervals by recurrence of the same pattern. This course is often described as crampy or colicky and is seen, for example, in biliary colic, ureteral colic, and labor. A migraine headache, on the other hand, typically pursues a slow but progressive buildup of a constant throbbing pain.

The overall course of a symptom is equally important, as we will describe more extensively in Chapter 5. A patient with headaches of 20 years duration that are unchanged will seldom have a brain tumor while a progressively worsening headache over several weeks or months is more suggestive of a tumor or other intracranial disease process.

You will usually obtain much of the chronology of a symptom in Step 4, using open-ended patient-centered skills. If more detail is needed, you will pursue it with mostly closed-ended questions as shown here:

Clinician: When did the burning in the stomach begin?

Patient: About a year ago. [Onset]

Clinician: Do you have pain every day?

Patient: No, sometimes it will be gone for weeks at a time. [Intervals between symptom occurrences]

Clinician: And how long do they last each time?

Patient: Quite a while.

Clinician: How long is that? I need to understand your pain in detail.

Patient: Oh, I don't know. Maybe a couple hours.

Clinician: What's the shortest they might last and the longest?

Patient: Well, some of them are gone in just a few minutes. But most are about an hour I guess.

Clinician: What's the longest?

Patient: The worst one I ever had lasted from supper until just before bedtime, about 4 hours. [Longest and shortest duration of symptom]

Clinician: What seems to determine that?

- Patient:** I don't know, but it's always worse in the Spring, and it's not there on weekends when I'm not working. [Frequency and periodicity]
- Clinician:** What happens to the pain over the course of each episode?
- Patient:** It just gradually comes on and then gets a little worse. [Short-term course of symptom]
- Clinician:** Overall, how is the pain doing?
- Patient:** It seems worse to me.
- Clinician:** How's that?
- Patient:** Well, it's not more pain, but it's more often. It used to be just once every day or so but now it's four or five times a day. [Overall course of symptom]

Position of the Symptom and Its Radiation

Determine the precise locations of symptoms when possible. Both the location and area of radiation of the symptom can have diagnostic significance. For example, generalized chest pain without radiation is nonspecific, but chest pain located in the substernal area that radiates into the neck, jaw, and left arm is suggestive of angina pectoris. Similarly, low back pain radiating into the left buttock and posterior thigh and down into the lateral aspect of the calf and over the dorsum of the foot into the great toe is highly suggestive of L5-S1 nerve root impingement from a herniated lumbar disc. If the patient does not do so automatically, ask him/her to point to the area of discomfort.

Ask whether the pain is deep or on the surface, specific in location or more diffuse. For example, a patient with headache who locates his pain over the course of the left temporal artery and describes the pain as "on the surface" may be suffering from temporal arteritis, rather than tension headache or migraines.

To locate the symptom and its radiation, begin with a focused, open-ended request or question such as, "Can you describe or point to the location for me?" If the patient does not provide a precise description, use closed-ended inquiry to get sufficient specificity:

Clinician: So, as part of the blahs you've got this stomach pain. Can you describe its location for me? [A focused open-ended request, phrased as a question, to be followed by several closed-ended questions.]

Patient: It's in my stomach.

Clinician: Where exactly is it? Point at it, if you can [Always be as specific as possible.]

Patient: (points to upper mid-abdomen, the epigastrium)

Clinician: How big an area? Can you draw a circle around it?

Patient: (draws an outline) This big.

Clinician: Does it move anywhere else, like your back or chest? [Giving examples is helpful as long as the answer is not suggested.]

Patient: No.

Clinician: Is it deep down, or does it feel more like it's right on the surface?

Patient: Down inside.

Quality of the Symptom

You can often achieve additional diagnostic specificity from knowing what the symptom feels like. A patient with burning chest pain may have gastroesophageal reflux, whereas tearing chest pain might be a symptom of a dissecting thoracic aortic aneurysm. Here are some other descriptors and the diagnoses that are frequently associated with them: burning (gastritis or peptic ulcer when substernal or epigastric), crushing (acute coronary syndrome when substernal), throbbing (migraine when in head, or localized infection anywhere), burning, electrical, shooting, or numb (neuropathic pain), or cramping (disorder of a hollow organ such as the ureter, intestine, or uterus).

Unusual descriptions can signify psychological problems or stress, and can sometimes be understood metaphorically.⁶ For example, psychotic people have said such things as “it feels like my intestines have grown shut” or “it feels like they left a surgical instrument in there.” Similarly, comments like “it’s pushing up through my soul and tearing my heart out” are extraordinary and suggest the presence of some associated psychological issues.

Learn the quality of the symptom by starting with a focused, open-ended request such as, “Tell me what the pain is like.” Use closed-ended inquiry as necessary to pin down details:

Clinician: What does it feel like? [A focused open-ended request, again phrased as a question]

Patient: Pretty bad.

Clinician: Well, how would you describe it: aching, sharp, dull? [It is appropriate, if necessary, to give examples, as long as several options are given without emphasizing any of them, so as not to influence the patient.]

Patient: Kind of burning, like hot or on fire.

Quantify the Symptom

You will gain further precision and specificity for disease diagnosis by quantifying the symptom in the following ways.

Severity

You can obtain a measure of intensity or severity by asking for comparisons to prior experiences (toothache, delivering a baby) or getting a rating on a 1 to 10 scale where 1 is no pain and a 10 rating is the worst pain ever. In general, the more severe the symptom, the more serious the problem; however, a patient who animatedly describes his pain as a 10 while seeming at ease may have a psychological problem, be opiate-seeking, or have learned that he needs to amplify his symptom in order to get adequate pain relief. Less intense pain does not signify an unimportant problem. Angina pectoris reflects serious disease but the pain is not always severe. In addition, certain pains are characteristically more severe than others, for example, testicular injury, renal calculus, and labor pains.

You can begin open-endedly with a question like, “Give me an idea how bad it was,” but closed-ended questions usually are necessary to get the needed details:

Clinician: Tell me how severe it is.

Patient: Well, it wasn’t too bad.

Clinician: On a 1 to 10 scale, where 10 is the worst ever, like surgery without anesthesia, how would you rate it?

Patient: Not so bad, really. I guess a 3.

Clinician: How is it compared to a toothache?

Patient: Not that bad.

Impairment or Disability Resulting from the Symptom

Another measure of severity is how the symptom has affected the patient on a daily basis. For example, a minor episode of hoarseness could be a severe hardship for an opera singer or public speaker while it might be of less consequence to a writer or night watchman.

You should have learned this from the patient while eliciting the personal context of the problem in the beginning of the interview, but if you did not, you can begin here with a focused, open-ended question such as, “What effect is this having on your day-to-day life?” Use closed-ended questions for detail. Asking about what the patient is no longer able to do helps clarify the situation; for example, “Since the chest pain started, what have you had to give up?” Comparing the patient’s daily activities before and after the symptom further clarifies this. Many of these data will often have been obtained in the beginning of the interview and, if so, they are not repeated:

Clinician: How’s this affecting what you do?

Patient: Well, it’s caused a lot of problems.

Clinician: Is it keeping you off work or anything? [A closed-ended question to get accurate details. The interviewer could also have tried an open-ended request such as, "Tell me about the problems."]

Patient: No, nothing like that really. I haven't missed a day of work. I'm just getting tired of it and snapping at the wife at home. She's getting sick of it.

Obtain Numerical Data Where Possible

You can usually identify or closely estimate the total number of occurrences of the symptom; for example, there have been about 20 such episodes of chest pain in the last week after no more than one weekly during the preceding year. It also can be necessary to precisely quantify symptoms in other ways when applicable: "It swells to the size of a softball at times but then goes back down to like a golf ball" (inguinal hernia); "Only passed about a glassful of urine all day" (renal failure, urinary obstruction, dehydration). You will find that patients seldom respond with precise numbers, preferring "quite a bit" or "not too much" to precise quantities. It is your job to find out details without alienating the patient.

You will obtain these data almost entirely by closed-ended inquiry. You will often have to follow-up on answers that are not precise enough; for example, upon being asked how many times a pain occurs, the patient answers "A lot" to which the clinician might respond, "Can you be more specific, you know, how many times in a day or week?"

Clinician: How many times a day do you have the pain?

Patient: A lot

Clinician: Can you be more specific, you know, how many times in a day?

Patient: Oh, three or four or five

Clinician: What's the most you've had?

Patient: Seven or eight times

Clinician: And the least?

Patient: One or even none sometimes

Related Symptoms

As you learn more clinical medicine, you will find that it is uncommon to have only one symptom with an underlying disease. Rather, there often are several specific symptoms and, in addition, there may be secondary symptoms reflecting the general impact of the disease; for instance, in a patient with pneumonia, cough and chest pain are likely specific symptoms from the pneumonia while fatigue and irritability are nonspecific symptoms due to the general effect of the pneumonia on the body. Related symptoms (also called associated symptoms) are important because different combinations

have diagnostic importance; for example, in a patient with weight loss, a good appetite often suggests diabetes mellitus or hyperthyroidism while a poor appetite might suggest infection, depression, or cancer.

Ask about associated symptoms by beginning in an open-ended manner, such as “Tell me any other symptoms that go along with this.” Closed-ended questions usually are required, however, as you ask about the presence or absence of symptoms that might be expected in association with the main symptom:

Clinician: Tell me any other symptoms that go with this burning pain.

Patient: Well, a little diarrhea when it's bad. [The clinician would fully develop this new symptom and its descriptors, just as was done for the epigastric burning pain.]

Clinician: Any other symptoms with it?

Patient: Not really.

Clinician: Any nausea? [After the patient gives no additional symptoms, the clinician uses his/her knowledge of common associations to make further specific inquiry, as expanded upon in Chapter 5.]

Setting

Here you move away from understanding the symptom itself to considering external influences on the symptom that can have diagnostic significance. Patients will usually describe the setting while describing their symptoms in the beginning of the interview, or when you ask about the onset and chronology of the symptom in the middle of the interview. If this does not happen, you can elicit the setting with questions such as, “Where were you?” or “Who else was present?” or “What exactly were you doing when you first noticed it?” or “Where was this?”

As always, begin with an open-ended question like, “Can you tell me the background of the symptom, you know, what you were doing at the time and who was there?” If this does not suffice, closed-ended inquiry can help:

Clinician: Can you give me some of the background for the pain, like who's around and where you are when it happens?

Patient: Almost always at work—there's been a lot of stress lately.

Clinician: Not at home?

Patient: Never. Isn't that funny?

Clinician: Who's around at work?

Patient: Well, it's just since I transferred to the parts department. [If you had not elicited this information while drawing out the personal context of the patient's symptom in the beginning of the interview, you would further develop it here.]

Precipitating and Transforming Factors

Additional external influences on the symptom that can have diagnostic significance include what brings the symptom on, what aggravates it once present, and what relieves it. For example, aspirin, alcohol, tobacco, spicy foods, and caffeine all are known to precipitate and aggravate gastritis or gastroesophageal reflux disease, while relief is typically obtained by drinking milk, eating bland food, and using antacids. Similarly, angina is brought on and aggravated by exertion, mental or emotional stress, or cold air blowing in the face, while it is relieved, usually in less than 10 minutes, by rest and the use of nitroglycerin.

Begin open-endedly, but most of this information is obtained through closed-ended questioning, the specific content of which reflects your knowledge of individual diseases:

Clinician: Tell me about anything that seems to aggravate or bring these pains on.

Patient: Well, coffee does sometimes.

Clinician: What about aspirin, does that cause it? [The clinician would continue closed-endedly to ask about what s/he knows can cause epigastric burning: other medications, tea, alcohol, tobacco, spicy foods.]

Clinician: (continuing after completing the preceding inquiry) Have you noticed anything that helps, you know that relieves it?

Patient: Eating almost anything, especially milk.

Clinician: What about antacids?

Patient: Yeah, they help a lot.

Often the patient is unable to describe transforming factors but can say what s/he does (or avoids) during the symptoms, for example, walk about, lie down, and quit eating.

Like a good journalist you want to understand *all* aspects of the patient's story. Reporters use the memory aid "What? Why? When? How? Why? Who?" Combining this aid with the descriptors of a symptom will ensure that you obtain the full story. Also note that the answers to some of these questions are usually offered by the patient during the beginning of the interview, as occurred in the vignette of Ms. Jones. If so, there is no need to repeat them here.

■ SUMMARY

Use open- and closed-ended skills to establish a medical understanding of the individual symptom and then to refine it using the seven descriptors to enhance its diagnostic specificity. Remember, individual symptoms are

SKILLS EXERCISES

1. Each member of the group reads about a specific disease in a standard textbook⁷ with pain as a major symptom; for example, low back pain in sciatica, headache in migraine, flank pain in renal colic, chest pain in angina pectoris, abdominal pain in intestinal obstruction, and headache in temporal arteritis.
2. This member then acts as the “patient” in a role-play and portrays the pain problem s/he just read about to another group member who elicits the descriptors of pain.
3. Elicit the symptoms and their descriptors from a real or simulated patient.

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The Middle of the Interview: Clinician-Centered Interviewing

Give each patient enough of your time. Sit down; listen; ask thoughtful questions; examine carefully. ... Be appropriately critical of what you read or hear. ... Follow the example set by William Osler: "Do the kind thing and do it first."

Paul Beeson, MD

This chapter describes the steps involved in conducting the middle of the interview using clinician-centered interviewing skills. This part of the interview includes the latter part of the history of the present illness (HPI) and other active problems (OAP), continuing directly from the patient-centered HPI, and the past medical history (PMH), social history (SH), family history (FH), and review of systems (ROS).

Recall our progress to this point. During the beginning of the interview you used patient-centered interviewing skills to begin eliciting the HPI (Steps 1–5): you set the stage; obtained the chief concern and agenda; drew out the symptom story, personal context, and emotional context; responded with empathy, and made a transition to the middle of the interview, the point where we now find ourselves. There are five additional steps (Steps 6–10) in the middle of the interview, as shown in Fig. 5-1. To illustrate each step, we will continue to follow Ms. Jones.

■ **COMPLETE A CHRONOLOGICAL DESCRIPTION OF THE PATIENT'S CHIEF CONCERN AND OTHER ACTIVE PROBLEMS—STEP 6**

Step 6 (Table 5-1) is the most important and most challenging part of the middle of the interview. By the end of this step, you often will be able to make a disease diagnosis or, if not, you can greatly narrow the range of possible disease

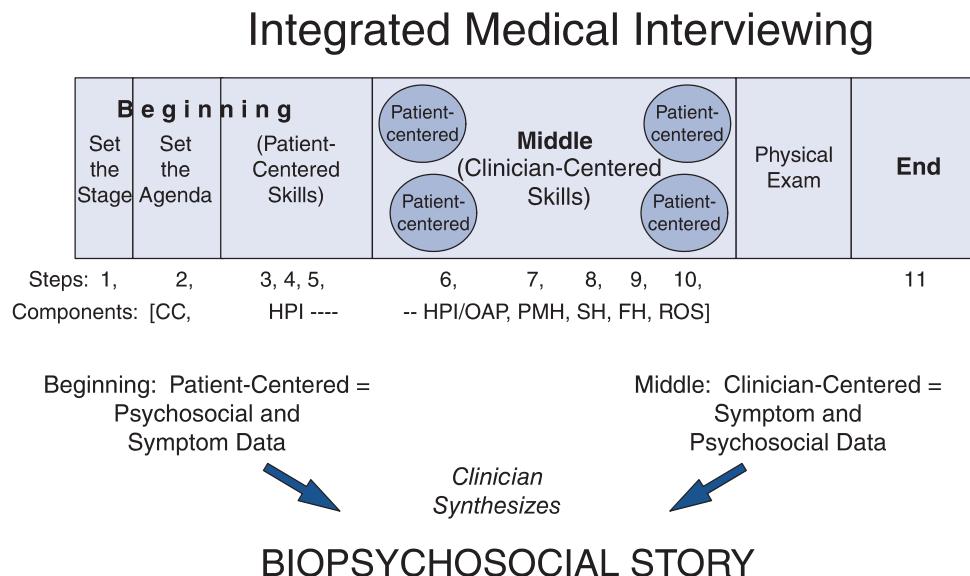


FIGURE 5-1. The integrated medical interview.

explanations for the symptom(s). This will guide your physical examination and the subsequent laboratory evaluation, if any. The companion video titled “Clinician-Centered Interviewing: An Evidence-Based Approach,” available on the McGraw-Hill website (www.accessmedicine.com/SmithsPCI) demonstrates what we will now describe. Module 8 in DocCom provides additional information about developing and clarifying the patient’s HPI.¹

In almost all instances, you will have obtained a satisfactory overview of the HPI during Steps 2 to 4 but sometimes the patient’s description of the personal or emotional context of the symptom was urgent enough that you will not have gotten a good symptom description in Step 4. If this is the case, you can begin Step 6 by obtaining an overview of the major symptoms, when they began, and the most pressing current issue, using both open- and closed-ended skills.

Otherwise, as presented in Chapter 4, begin by converting each of the patient’s concerns to a standard symptom and further clarify it according to the descriptors (OPPQQRST: onset and chronology, position, precipitating factors, quality, quantification, radiation, related symptoms, setting, and transforming factors [aggravating/alleviating]). You will also need to know what other symptoms occurred before, during, or after the symptom under discussion.

■ TABLE 5-1. Continuing the HPI/OAP

Step 6—Complete a Chronological Description of the Patient’s Chief Concern and Other Active Problems

1. Obtaining and describing data without interpreting it
 - A. Expand the description of symptoms already introduced by the patient
 - B. Describe symptoms not yet introduced in the already identified body system (and general health symptoms)
2. Interpreting data while obtaining it: Testing hypotheses about the possible diseases causing symptoms^a
 - C. Describe relevant symptoms outside the body system involved in the HPI
 - D. Inquire about the presence or absence of relevant non-symptom data (secondary data) not yet introduced by the patient
3. Understand the patient’s perspective
 - Impact (meaning) of illness on self/others
 - Health beliefs
 - Triggers for seeking care

^aOnly clinical-level students are expected to be proficient with this style of inquiry.

As you talk with patients, you may begin to have ideas about what is causing the patient’s problems, and how the symptoms may be affecting physical functioning or activities of daily life. These ideas are known as “hypotheses” and the process of asking questions that make them more or less likely is called hypothesis testing. When you first learn how to interview patients, you may not have sufficient medical knowledge to test hypotheses, but you can still conduct an effective interview. Focus on first collecting as much data as you need to comprehensively describe the patient’s problem(s). Beginners often need to postpone hypothesis testing to a second interview after they have had time to read about the problems that have been described.²⁻⁴ As you become experienced and learn more about specific diseases and conditions, you will become faster, more efficient, and more accurate at gathering data and will learn to recognize patterns in the patient’s story that suggest certain diagnoses.⁵ Chest pain, for example, has well over 20 possible disease causes, such as, angina pectoris, myocardial infarction, pericarditis, esophagitis, pneumonia, pleurisy, pulmonary embolus, costochondritis, and rib fracture. Each diagnosis has unique symptom and other diagnostic features and, often, different related symptom patterns. In the meantime, just ask the questions that will help you to comprehensively describe the patient’s symptoms.

As a beginning clinician, you can still test hypotheses during the interview but comprehensive questioning gives you data from which you can generate

better and more hypotheses.² Comprehensively question only in relevant areas, do not ask the same questions of every patient, and do not simply elicit all known symptoms from the entire ROS.² As you acquire clinical experience and your knowledge base grows, you will use more hypothesis testing and comprehensive questioning will be less necessary. Nevertheless, even seasoned clinicians use comprehensive questioning in challenging cases when hypothesis testing is ineffective.²

Beginning clinicians can generate a surprisingly relevant data base with the comprehensive questioning approach. We will explore this in more depth next and then briefly consider how the more advanced clinician integrates the hypothesis-testing approach.

Obtaining and Describing Data Without Interpreting It—For Beginning Clinicians

Both beginning and advanced clinicians should begin Step 6 with: A—expand the description of symptoms already introduced by the patient, and B— inquire about symptoms located in the same body system that have not yet introduced.

A: Expand the Description of Symptoms Already Introduced by the Patient

Begin with the patient's most important problem and identify all symptoms and secondary data starting from the onset of the concern. (Recall from Chapter 4 that secondary data are any non-symptom information, such as, tests the patient has had or medications s/he has taken.) Group the concerns by common times of occurrence, translate each into a symptom, and then refine each symptom using the “OPPQQRRST” descriptors (see Chapter 4). Make use of repeated queries for temporal connections such as, “Then what?”, “What happened after that?”, or “And then?” The patient sometimes will not introduce secondary data and so you must ask about prior treatment, procedures, diagnoses, and other secondary information (see Step 6D, below). Alternatively, the patient may present a host of secondary data from which you must sift out the symptoms. For example, a patient might say, “This chest pain and shortness of breath occurred before my heart catheterization but after they found my cholesterol and blood sugar were high; that was when I was in the hospital last October for coughing up blood.” Here, the clinician must recognize the primary data (chest pain, shortness of breath, and hemoptysis) and not confuse them with the secondary data (heart catheterization, elevated cholesterol and blood sugar, hospitalization).

Seek to understand the temporal (time) course of all data, using calendar dates and exact times when possible, and always for recent or acute problems. More remote problems often can be marked by weeks, months, or even years.

As you will see in the next vignette, the clinician uses closed-ended questions to elicit most information and offers periodic supportive remarks, maintaining a patient-centered atmosphere of warmth and understanding.

Continuation of Ms. Jones Visit (From Chapter 3, p. 64)

Clinician: If it's OK then, I'd like to shift gears and ask you some different types of questions about your headaches and colitis. I'll be asking a lot more questions about specifics.

Patient: Sure, that's what I came in for.

Clinician: I know the headache is the biggest problem now (chief concern). [The clinician will now elicit the descriptors of the symptom, recognizing that some were heard in Steps 3 and 4. If, however, the clinician somehow had not yet heard about the headache and other physical problems (because the patient expressed a pressing personal concern in the beginning of the interview), he would first obtain a detailed description in the patient's own words.]

Patient: Yeah, it sure is.

Clinician: When exactly did it begin? [The interviewer wants to reaffirm the time frame of the headaches and uses a closed-ended question.]

Patient: Oh, just a few weeks after I got here. That's about 4 months ago now, so the headaches have been about 3 months. [Time of onset]

Clinician: How long does each headache last, the shortest and the longest they might last?

Patient: At least a couple hours. When they get bad, they'll last up to 12 hours or so. [Further characterizing the onset and chronology by identifying the duration]

Clinician: What happens to the symptom when it's there?

Patient: Well, it's not so bad at first but it just keeps getting worse and then the nausea comes. [Time course of symptom]

Clinician: How many do you have in a week or a month?

Patient: I can have 2 to 3 a week when they're bad. You know, every 2 to 3 days. [Symptom periodicity and frequency]

Clinician: How long have they been that often?

Patient: Since things got bad in the last month, especially the last couple of weeks. Before that they were only once or twice a week. [Total number can be calculated if important]

Clinician: You said the headache was in the right temple; can you point to it for me? [Having gotten a good story of the *onset and chronology*,

the interviewer shifts to understanding the *position (location)*, referring to the patient's description of the headache location in the beginning of the interview.]

Patient: (puts hand over much of right side of head) It's all over here, sometimes larger than others. [Sounds more diffuse than specifically in one location]

Clinician: Is it always in the same spot? [The clinician asks a closed-ended question, focusing away from the personal dimension and on the symptom itself, now getting the precise *position*.]

Patient: Yes.

Clinician: Does it move any place else? [Another of what will be many closed-ended questions as the clinician asks about *radiation*, another descriptor of the symptom. Note that the clinician is introducing new topics and is also leading the conversation, appropriate for the middle of the interview.]

Patient: No, it stays right there. [No radiation]

Clinician: Does it feel like it's inside your head or outside on the surface; you know, does it hurt to comb your hair or touch it?

Patient: No, it doesn't hurt to touch it. It's down inside I think. [A deep rather than superficial pain]

Clinician: Could you give me a description of what it feels like; such as aching, burning, or however you'd describe it. [It's appropriate to give examples, if necessary, but provide more than one, with no particular emphasis, so as not to influence the patient.]

Patient: Oh, it's more throbbing or pounding, like you feel each pulse beat. [*Quality* of the pain identified, and the patient offers no bizarre description]

Clinician: How do they begin, gradually or all of a sudden?

Patient: Oh, pretty much out of the blue. [*Onset* is sudden]

Clinician: Now I want to get an idea of how severe these headaches are. On a scale of 1 to 10, with 1 being no pain and 10 being the worst pain you can imagine, like labor pains, what number would you give these headaches?

Patient: Well, they're sometimes worse than having a baby! I'd give them a 10, especially when they get bad. And I've missed work a few days but not very often. [*Quantifying* the intensity and noting some disability]

Clinician: They sound pretty bad. You've really had a lot of trouble with this! [A respect statement. Empathetic comments and behaviors are used during the middle of the interview.]

Patient: You're telling me!

Clinician: Do you know of anything that brings them on? [The clinician asks about *precipitating factors*. He is not inquiring about the *setting* because he already knows that from the beginning of the interview.]

Patient: Well, just what I've told you, getting upset. Once or twice it seemed like having some wine did it but I was stressed then too. [Perhaps another precipitant]

Clinician: Anything that worsens them once they've begun?

Patient: No, they're bad enough already! Well, bright lights sure do, now that I think about it. [A *transforming (aggravating) factor* identified]

Clinician: They sure have been bad. What seems to help them once they occur?

Patient: Just lying down in a dark room, and an ice bag on my head. Well, the narcotic shot they gave me in the emergency room took it away too. [Another *transforming (relieving) factor* elicited. Also, *secondary data*, the narcotic and the emergency room visit, are introduced by the patient.]

Clinician: What about the nausea? When did it start? [With a full description of the headache symptom, the clinician is moving now to better define a *related symptom*, staying with primary data for the moment. Notice that a non-pain symptom has fewer appropriate descriptors; for example, one usually does not try to identify location or radiation of nausea.]

Patient: I've had it for about 2 months now, just when the headaches are bad.

Clinician: Help me understand better what the nausea is like. [A focused open-ended request]

Patient: Like I'm sick to my stomach and could vomit if it got worse. [Quality of nausea]

Clinician: And how does it begin? [A closed-ended question, as many of the subsequent inquiries will be]

Patient: Oh, it just kind of gradually comes on after the pain has been there awhile. [Gradual Onset]

Clinician: How bad is it, how severe?

Patient: It's minor compared to the pain. It's never really been the problem the pain is. [Not very severe or disabling]

Clinician: How often does the nausea occur?

Patient: Just when the pain gets bad. I've probably had it each time with the headache in the last month; that's when the pain has been worse. [Number of episodes identified]

Clinician: You said this began about a month after the pain, so that means the nausea has been there about 2 months? [Ms. Jones has previously indicated the time of *Onset*]

Patient: Yeah, but it's been worse in the last month.

Clinician: How long does the nausea last once it begins?

Patient: Oh, about a couple hours, when the headache finally goes away. [Duration of nausea and *Transforming (relieving)* factor]

Clinician: Anything else that relieves it?

Patient: Not that I know. I tried some antacid but it made me worse. [Other *Transforming (aggravating and relieving)* factors explored. Secondary data also introduced (antacid).]

Clinician: And what's the time between each episode?

Patient: Same as the headaches, you know, every couple of days. [Intervals identified. Chronology of symptom and setting also can be inferred from what Ms. Jones has said already since the nausea is linked to headaches.]

Clinician: Ever throw up with them?

Patient: Just once. That's when I went to emergency. [*Related symptom*]

Clinician: How much did you vomit?

Patient: Oh, just enough to soak a hankie. [The clinician has obtained pertinent descriptions of the nausea and now has discovered another symptom, vomiting, which would now be similarly explored. It can take considerable time to obtain appropriate details of each symptom for complicated patients.]

Clinician/ [Not recounted here, the clinician and patient now develop

Patient: details of the patient's vomiting and cough. As you gain experience, you will recognize that the *headache, nausea, and vomiting go together*. This allows you to develop the symptoms simultaneously and avoid repetition.]

Clinician: It sounds like you went to the emergency room once when it was bad. What's been the time course of the headaches and nausea; you know, better, worse, or about the same?

Patient: They are getting worse. They last longer and are more often in the last 2 weeks. [The overall course of the primary data is learned.]

Clinician: Have you seen anyone for them? [A good description of symptoms and their course to the present has been obtained, and the clinician is beginning to move away from symptoms to associated *secondary data*.]

Patient: Nobody, except the emergency room a week ago. I thought the aspirin would help.

Clinician: Have you taken anything else?

Patient: Nothing except that one shot; a narcotic of some sort I think.

Clinician: Did they do any tests on you in the emergency room?

Patient: Yeah, they did a blood count and a urine test.

Clinician: Any scans or any X-rays of your head? [Recent inquiry is aimed at understanding pertinent *secondary data*. Notice the repeated use of closed-ended questions to obtain a more precise description of the symptoms.]

Patient: No.

B: Inquire about Symptoms Located in the Same Body System(s) Not Yet Introduced (and General Health Symptoms)

Until this point, the clinician has addressed symptoms (and related secondary data) volunteered by the patient but there often are other symptoms (“related symptoms” from Chapter 4) that have not been mentioned, which either by their presence or absence are pertinent to making a diagnosis; the absence of a symptom can be just as diagnostically important as its presence. The clinician thus needs to develop a more complete profile of the patient’s problem(s).

You can often assume that symptoms in the same system are related to the same underlying disease process. You know what the patient’s major concerns are and can therefore identify the body system likely involved if disease is present. At this point, ask the questions from the ROS under the involved system heading; for example, a patient with urinary hesitancy and increased urinary frequency usually (but not always) has a disease in the urinary system and so you would use closed-ended questions to inquire about the symptoms under that heading in the ROS (dysuria, nocturia, urgency, hematuria, particulate matter in the urine, and so on until you comprehensively questioned about all possible symptoms under the urinary system heading of the ROS). At times, however, a symptom can suggest more than one system as a source of disease; for example, shoulder pain can indicate disease in the musculoskeletal system (rotator cuff injury), gastrointestinal system (cholecystitis), or the cardiopulmonary system (angina). In this case, you would inquire about all possible musculoskeletal, cardiopulmonary, and gastrointestinal symptoms (joint swelling, hemoptysis, orthopnea, vomiting, diarrhea, and so on).

Questioning in this way often uncovers symptoms the patient may have forgotten or not thought important, and can at times provide crucial diagnostic information; for example, in the preceding patient with urinary concerns, discovering the periodic presence of particulate matter in the urine in association with bloody urine suggests renal calculi. Frequently, however, the patient will deny most symptoms on the list, this is also diagnostically important; for example, the absence of gross hematuria in this patient would weigh against renal calculi as well as some bladder or renal diseases.

Inquiring about symptoms under the General heading of the ROS fills out the symptom profile. In most patients, ask about appetite, weight, general feeling of well-being, pain, and fever, regardless of the system their symptoms reside in. Many diseases, especially more serious ones, exhibit one or more of these general symptoms. In our vignette, the clinician relies predominantly on closed-ended questions, and continues to intersperse supportive remarks.

Continuation of Ms. Jones Visit

Clinician: Any other symptoms you might have had? [A focused, open-ended request, phrased as a question.]

Patient: Well, nothing that I think of.

Clinician: Ever had problems with dizziness or lightheadedness? [Because the patient's major symptom, headaches, is a neuropsychiatric system symptom, the clinician is beginning to closed-endedly inquire about other possible neurological symptoms in the neuropsychiatric system as well as relevant neurological symptoms listed primarily in head, neck, eyes, ears, nose, and throat.]

Patient: Not now. I used to get carsick as a kid and did a couple times then.

Clinician: Ever had a fainting spell?

Patient: No.

Clinician: Stiff neck?

Patient: No.

Clinician: Any problems with your vision?

Patient: No. I don't even use glasses.

Clinician: Any double vision?

Patient: No.

Clinician: Difficulty hearing?

Patient: No.

Clinician: Ringing in your ears?

Patient: No.

Clinician: Any change in your sense of taste or smell?

Patient: No.

Clinician: Any face pain?

Patient: No. [The clinician would continue exploring all remaining symptoms in the above systems of the ROS: facial paralysis; difficulty swallowing or with speech; difficulty elevating the shoulders; muscle weakness or movement difficulty; extremity numbness, tingling, decreased sensation, or paralysis; the shakes or tremor; difficulty with balance or walking; and seizures.]

Clinician: Besides the nausea and vomiting once, have you had any other problems in your stomach or digestion? [A focused, open-ended question starts a new area of inquiry. The clinician will now obtain a complete profile of the patient's other major symptom, nausea.]

Patient: There haven't been any.

Clinician: [Even though the patient indicates none was present, the clinician would now use closed-ended questions to go through the symptoms in the gastrointestinal system not already addressed: appetite, weight, heartburn, abdominal pain, vomiting blood (hematemesis), bloody or black stools, constipation or diarrhea, dark urine or jaundice, and rectal pain or excessive gas. The clinician then shifts to general symptoms.]

Clinician: You've told me a lot already about this, but how've you been feeling in general? [A focused open-ended question introduces a new area of inquiry, her general health. Information about appetite and weight will already have been obtained during the above inquiry about gastrointestinal symptoms.]

Patient: Great, except all these things.

Clinician: You've sure been through a lot. Any problem with fevers? Chills? Night sweats? Change in appetite? [The clinician continues to make empathetic comments and asks some closed-ended questions about general health.]

Patient: No. [Therefore, there is no problem with general health symptoms of fever, chills, appetite, or weight. Not included here, the clinician completes the general health questions from the ROS.]

With experience, you will base the extent of this ROS upon clinical acumen, and it almost always can be considerably shortened; for example, an experienced clinician might be seriously considering a diagnosis of migraine and inquire only about "Have you ever had a stroke? Head injury? Recent fevers?" For beginning clinicians, however, systematically going through all the possibilities is the best way to learn them.

Interpreting Data while Obtaining It: Testing Hypotheses about the Possible Disease Meaning of Symptoms—For More Advanced Clinicians

From the gathering/describing technique described above, you now have a complete profile and chronology of symptoms. But, you have not interpreted or grouped them in a way that points to specific diseases that could cause them. Just recounting symptoms usually does not identify a disease. Nor have you

accounted for potentially significant symptoms in other systems. Inquiring about all symptoms outside the involved system is not feasible, would take too long, is intellectually unsound, and is boring.²

After completing parts A and B of Step 6, more advanced clinicians should therefore add two additional parts: C—ask about relevant symptoms outside the body system involved in the HPI, and D—inquire about the presence or absence of relevant non-symptom data (secondary data) not yet introduced by the patient, before concluding with the third part, understand the patient's perspective.

C: Ask about Relevant Symptoms Outside the Body System Involved in the HPI

Ask about symptoms outside the involved body system if they are pertinent to a diagnosis you are considering. For example, in a patient with advanced rheumatoid arthritis who is feeling fatigued, asking about gastrointestinal bleeding symptoms (“any black stools?”), while outside the musculoskeletal system, is still warranted if you suspect that gastrointestinal bleeding due to nonsteroidal anti-inflammatory drug (NSAID) therapy is causing the fatigue. In patients with more than one problem, you will need to inquire in multiple systems during the HPI.

D: Inquire about the Presence or Absence of Relevant Non-Symptom Data (Secondary Data) Not Yet Introduced by the Patient

It is important to know about any medications taken to relieve the symptom, diagnoses given for the symptom in the past, prior treatments, and clinician visits or hospital stays for the symptom. This is especially true for complementary and alternative medicine treatments. Research shows that patients, as a rule, will not volunteer information about complementary and alternative treatments, therefore you must ask specifically and concretely about their use and do so in a nonjudgmental way.⁶ Also, asking relevant questions about possible etiological explanations for the diagnoses being entertained may help narrow the differential diagnosis. For example, if pulmonary embolism is a concern, ask about recent long car rides or air travel; if lung cancer is a hypothesis, ask about cigarette smoking.

How do you test hypotheses during the interview? Based on unique symptom(s) characteristics and secondary data suggesting one diagnosis over the others, and based on knowledge of what diseases are most common, you rank-order disease possibilities in your mind starting from the opening moments of the interview.^{2,5,7} Then, as noted earlier, seek additional diagnostic data (primary and secondary) to support the current best choice, almost always via extensive closed-ended questioning. If complete data have already been obtained descriptively, the new data will be largely outside the

involved system. If not supported, another disease hypothesis becomes the best choice (“next best choice”) to explain the symptom(s) and you will similarly explore it. By following this process of testing multiple, ever-changing best hypotheses, you will eventually arrive at the best diagnostic possibility, the “current best hypothesis”—which is the best fit of our patient’s primary data (and secondary, if available) with a known disease.

It is common to start with one disease hypothesis (angina) and, based on symptom descriptors and associated symptoms, end with a quite different one (esophagitis). For example, because of substernal chest pain radiating into the arms, the clinician’s first hypothesis was angina. But, s/he knew esophagitis also was a possible cause of chest pain radiating to the arms and asked about descriptors and other symptoms associated with this diagnosis and they were present (precipitation of pain by coffee or recumbence, relief by belching and antacids, poor appetite) and other descriptors expected with angina were not present (no relationship of pain to exertion, no dyspnea, or diaphoresis). When a hypothesis is well supported, it greatly enhances the probability that the corresponding diagnosis is present. A diagnosis can often be inferred from the history alone (e.g., angina) but sometimes additional data from the physical examination (e.g., elevated jugular venous pressure for a diagnosis of congestive heart failure) or the laboratory (e.g., low hemoglobin for a diagnosis of anemia) are needed before you can establish a diagnosis.²

The more knowledge and experience you gain the more facile and efficient you will become in formulating the diagnosis and knowing the proper questions to ask in real time rather than in a subsequent interview. Nevertheless, virtually all beginning clinicians will find themselves fully synthesizing the diagnosis only after completing the interview, reading about the problem, talking again with the patient to clarify issues they overlooked, and discussing the problem with faculty and more senior team members. Although this vast topic of clinical diagnosis⁸ is outside the scope of this text, and you will study this material extensively during your clinical years of training, the process of clinical problem solving is illustrated in Table 5-2. The table shows how clinicians test hypotheses while obtaining the HPI.

Continuation of Ms. Jones Visit

Clinician: Ever had problems with swelling or pains in your joints? [The clinician has the hypothesis that vasculitis might be causing headache and knows that this diagnosis is sometimes associated with arthritis. He is thus using closed-ended questions to inquire about specific primary data outside the system involved to support this hypothesis.]

Patient: No.

■ TABLE 5-2. An Example of Clinical Problem Solving

Clinicians proceed, much as Sherlock Holmes,² by first obtaining a few bits of presenting data (e.g., non-radiating chest pain, fever, acute shortness of breath, and a swollen left leg in a 70-year-old man) with which to generate the current best hypothesis (e.g., pulmonary embolus) and then ask specific questions (e.g., whether the patient has had hemoptysis) that would further support or detract from this hypothesis.^{2,7,5} In this example, the clinician asks about hemoptysis, previously unmentioned by the patient, because her or his first hypothesis was pulmonary embolus and this symptom is pertinent to its diagnosis. Let us say that hemoptysis was not present but the clinician pursued the hypothesis further by inquiring if the leg swelling was recent or if there had been any long trips or immobility of the leg recently, common findings of some diagnostic value in pulmonary embolism. We'll suppose that symptoms began following a 12-hour car ride just 3 days ago and the clinician became more confident of pulmonary embolus as a possible diagnosis.

Even though the diagnosis may be likely, the clinician tests alternative hypotheses—other diseases likely to be causing this patient's chest pain. For example, the advanced clinician also would consider questions supporting myocardial infarction (substernal location of pain, crushing or squeezing pain, diaphoresis), pneumonia (productive cough, chills), rib fracture (injury), pericarditis (pain relieved by sitting up and leaning forward, and aggravated by lying supine), lung cancer (weight loss, cigarette, or asbestos exposure), and a host of other possibilities as long as they reflected reasonable possible causes of the patient's chest pain and other symptoms. Notice that none of these symptoms had been mentioned previously by the patient, that the clinician introduced them with close-ended questions, that if left to a simple comprehensive questioning/descriptive approach and subsequent routine inquiry many would have been completely dissociated from the HPI (a history of chest trauma is usually asked about in the PMH and cigarette use is asked about in the SH), and that some may never have arisen without such hypothesis-driven inquiry (relief of pain by sitting up is not a routine question).

The clinician in this case would of course proceed to obtain a complete history and physical examination and appropriate laboratory and imaging data to clarify her or his hypotheses and, hopefully, establish a diagnosis.

Clinician: Ever had any dancing or bright, shimmering lights in your vision for a few minutes before the headache starts? [The clinician has learned that this symptom (scintillating scotomata) is of diagnostic value in migraine and is properly inquiring specifically about it to build support for the hypothesis of migraine headaches.]

Patient: No.

Clinician: Because these could be what we call vascular headaches, you know, like migraines, I want to ask you some specifics about that. Do you use birth control pills or other hormones? [The clinician is beginning to formulate diagnostic hypotheses about what has caused the headaches. He suspects migraine from the clinical story and his knowledge of headaches. Accordingly, it is appropriate to obtain additional supporting diagnostic data and, hence, the question about birth control pills, as these can

cause migraine headaches in some women. In addition, because head injuries also can cause headaches, the clinician will ask about that as an alternative hypothesis. Indeed, any possible causes that have been entertained could be further addressed in this way; for example, if the clinician were suspicious of meningitis from the story, perhaps because of intermittent fever and stiff neck, additional questions to support or refute that hypothesis would be in order: any rashes, sick contacts, or other exposure, and whatever else the clinician considered important in supporting a diagnosis of meningitis.]

Patient: Yeah, I've been on them for the last 6 years. [The clinician would pursue the type, doses, and experience with this later in the PMH.]

Clinician: Any family history of migraine? [Because this clinician knows that a positive family history supports the hypothesis of migraine, he includes these questions here rather than in the family history.]

Patient: One of my aunts had what they called sick headaches when she was young but they all cleared up when she got a lot older.

Clinician: By the way, have you ever had any head injuries? [The clinician is testing another non-migraine hypothesis for the headache.]

Patient: No.

Clinician: Have you ever been unconscious for any reason?

Patient: No.

Clinician: Any neck injuries or problems there? [Neck problems also can cause headaches and the clinician is exploring this hypothesis.]

Patient: Nope.

Understand the Patient's Perspective

By this point, you have elicited a detailed description of the patient's symptom(s), performed a targeted ROS and, if you are an intermediate or advanced clinician, sought symptoms in relevant body systems and obtained pertinent non-symptom (secondary) data. Nevertheless, the patient's history of present illness is not complete until you have a good understanding of the patient's perspective on his/her illness. This is key to making an accurate diagnosis and being of the most help to the patient. Much of this information may have been elicited during Steps 3 and 4, particularly if you used indirect emotion-seeking skills in Step 4. The patient may also have related some of this data while answering your questions thus far in Step 6. Ask about each of the remaining areas now.

Impact (Meaning) of Illness on Self/Others

Ask, "How is this symptom affecting your life/work?", "How has it impacted your family/spouse/coworkers?" [How an illness affects the patient and his or her family is important psychosocial information and it can have practical implications, for example, need for home services.]

Health Beliefs (See Also DocCom Module 9⁹)

Ask about the patient's "explanatory model" of illness, "What do you believe is causing your (symptom)?" because it is critical to understanding how the symptom is affecting the patient and what is important to her or him¹⁰; it can also give you an opportunity to correct misconceptions and address fears with an empathic response. It is useful to normalize this question by saying something like, "Many patients already have ideas about what's causing their problems so I ask this question of everyone. It really helps me help them." Occasionally, in eliciting a patient's belief or attribution s/he will say, "You're the clinician, you tell me!" Don't get flustered by this response. Calmly explain, "I find that it helps to share each of our perspectives so that we can come up with the best treatment plan for you." If the patient persists in saying that you're the clinician and it's your job, you can switch to a more clinician-centered interviewing style, having learned about a strong patient preference at the same time.

Triggers for Seeking Care

Another indirect emotion-seeking skill which, if not asked about in Step 4, should be elicited here is to understand the reason(s) why the patient came at this time: "What made you decide to see me today for this (symptom)?" This often provides a window on the patient's personal life, important relationships, and health beliefs (e.g., a coworker with similar symptoms is recently told of a serious diagnosis, or a worried spouse insists that the patient seek care). Asking, "What else is going on in your life?" can uncover interpersonal crises or other sources of distress that can cause or amplify symptoms.¹¹

In the case of Ms. Jones, we learned in Steps 3 and 4 that her headache is related to her work and a bit about the impact on her relationship with her husband. The clinician now asks several questions to learn more about her perspective:

Continuation of Ms. Jones Visit

Clinician: You mentioned that troubles with your boss might be causing your headaches. How has all this affected you and your family's lives? [Open-ended inquiry about the impact of the headaches on her and others' lives. This question could have been asked in

Step 4 (Chapter 3) as a way to “prime the pump” for personal context and as an indirect emotion-seeking skill if the patient had not spontaneously mentioned the personal context of her symptom story. Clinician-centered skills allow the clinician to take the lead like this to obtain necessary details about personal data.]

Patient: It's been very disruptive. We were always quite happy and enjoyed things together. Even our love life has suffered.

Clinician: Say more about that.

Patient: For the past 3 months I just haven't been in the mood much. We used to make love a few times a week, now it seems like once every few weeks, and now the kids seem to get on my nerves all the time too. Things need to get settled down. The job; not just the headaches. I'm not sure I'll stay in this job if things don't change.

Clinician: It's been a difficult time. I do think we can help with the headaches, but I don't know about your boss. [Interspersing a patient-centered intervention, here with naming and supporting statements, continues to be important. The clinician could pursue her sexual issues here, but there is also the opportunity to do so during the social history.]

Patient: He's supposed to retire in 6 months. If the headache comes around, I can make it that long.

Clinician: I know you think the headaches are from your boss, but any other ideas about why you might be getting them? [The clinician is leading and shifting away from her boss and probing for any other beliefs about why she is ill.]

Patient: Well, I'm not really sure. At first, I thought it was just because of my boss but they have lasted a long time now, are more frequent and are getting worse.

Clinician: Go on.

Patient: I know it sounds silly but the past couple of days I've been worried that I might have a brain tumor or something.

Clinician: I can appreciate why that thought would worry you. Thanks for sharing your concern. It really helps to know about it. We still have a lot of data to gather before coming to any conclusion but nothing you've told me so far makes me concerned about a brain tumor. I will keep your concern in mind and keep you as informed and up to date as possible. [The clinician offers respect and support.]

Patient: It's a relief to know and it somehow feels less scary.

Clinician: Good. Any other thoughts about what might be causing the headaches?

Patient: Only punishment! I was raised with that always there. [Depending on the amount of time available, the clinician could use patient-centered interviewing skills and explore this, allowing Ms. Jones' ideas to lead. On the other hand, it is not current and she is exhibiting no distress so that it also can comfortably be left until another time as the clinician does here. If it seemed relevant, the clinician could pursue any triggers for making the appointment now, but he seems to have gotten a good idea of her perspective on this illness.]

Clinician: That's an important piece of information that I'll want to come back to later or the next time I see you. Right now, I need to ask you some other questions about your colitis, cough, and your past health issues, if you feel finished talking about the headache. Anything else we need to cover, before we go on? [It continues to be important to note transitions, check if the patient is finished, and see if she has anything further to add to the topic at hand.]

Patient: That's fine. You've covered everything, I think. [This evaluation shows how a novice clinician first obtains data in the involved system to help develop hypotheses, then tests the hypotheses with selective questions designed to support or refute them, and wraps up with understanding her perspective. Not shown here because of space constraints, the clinician now learns about the patient's other active problems (OAP): her recent cough and her colitis. The write-up in Appendix D presents this information.]

Procedural Issues

When the patient presents more than one concern, you will need to evaluate each one in much the same way. For example, Ms. Jones also had colitis and a recent cough. These now could be systematically explored. If these are not currently active health problems, though, they can be explored instead as part of the PMH (Step 7), in less depth. And when not contributing to current problems, as in Ms. Jones' situation, they are included in the PMH portion of the written report. When they are contributing to the patient's current problems, they are included as OAP at the end of the HPI.

This is a lot to assimilate, and it will require much practice before you feel competent and confident interacting with patients. Review the demonstration

■ TABLE 5-3. To Minimize Bias from Closed-Ended Questioning

1. Listen actively—When the patient responds, listen to what she or he says and how she or he says it, rather than thinking about what question to ask next.
2. Proceed from general to specific—Start with an open-ended question in each major area and then “cone down” with closed-ended questions. (“Other than this chest pain, how is your health? Do you have any medical problems?”, “How about high blood pressure?”, “High cholesterol?”, etc.)
3. Pursue details—for example, dosage of medications, how often they are meant to be taken, how often the patient actually takes them, barriers to taking them, side effects.
4. Use single questions—Avoid “Have you ever had headaches, fainting, loss of vision, blurred vision, poor memory, or a stroke?” Rather ask, “Have you ever had headaches?”
5. Orient the patient with transitional statements between sections—for example, “Now I’d like to shift and ask you some questions about your family’s health, because some diseases can run in families.”
6. Avoid negatively worded questions: “You’re not coughing up blood?”
7. Don’t suggest a response by the way the question is framed—Avoid “Do you feel the pain in your left arm when you get it in your chest?” or “You don’t smoke, do you?”
8. Give equal weight to alternative answers—Ask “It sounds like there is some pain when you exert yourself, but what about when you’re not exerting?”
9. Don’t interpret data while collecting it—Avoid “Must be hemorrhoids. Ever had any nausea or vomiting?”
10. Give balanced attention to all aspects—Advise, “We’ve talked a lot about your constipation, but not much yet about the chest pain.”
11. Don’t confuse the patient with rapid shifts or technical language/jargon—Avoid “Did they do an ERCP or another endoscopy?” “Were any lesions found?”, or “Have you had an MI before?”
12. Encourage questions.
13. Check patient’s understanding.
14. Summarize—at the end of section or end of interview.

information into the conversation where necessary. This is especially helpful in testing hypotheses; for example, in a patient with a chronic cough, it is perfectly appropriate to introduce these thoughts if the patient hasn't mentioned them: "Are you a cigarette smoker?", "Have you lost weight?", or "Have you ever been tested for TB?"

The HPI/OAP concludes when you have addressed all the patient's presenting symptoms. At this point you will, after some experience, understand the problem and have the best possible disease explanation in mind, if not the actual diagnosis. This will determine what corroborating data to look for on the physical exam and in the laboratory evaluation. You will also more fully recognize the close interaction of symptoms and secondary data with the personal data obtained in the beginning of the interview.

At this time, you will make a statement about changing the conversation to some topics "we haven't yet talked about, such as your past health issues," as the clinician did with Ms. Jones earlier, inquiring if she thought her story has been completely discussed, summarizing, and asking if there was anything further to add.

Addressing a Predominantly Psychological Problem

In patients with psychiatric diseases or other serious psychological problems, the personal contextual data you obtained during the beginning of the interview usually are not sufficient for complete evaluation. Steps 1 to 5 are just the beginning. In Step 6, you pin down details about the psychological problem, just as you would with a physical symptom. Elicit the patient's symptoms and test hypotheses about the underlying diagnosis by selectively testing different diagnostic possibilities. For example, a patient's depression may have become apparent during Steps 1 to 5, but it now is your task to explore its possible disease causes, potential complications, and treatment options. Using open-ended inquiry and "coning-down" to closed-ended questions you differentiate, for example, major depression, bipolar disorder, schizophrenia, medication side-effects, and medical diseases as causes of depression. You will gain much more experience with the medical interview questions needed to diagnose both medical and psychiatric diseases during your clinical clerkships, but we use depression as an example here, because depressed mood can be a normal emotion or a symptom of a psychiatric disorder. One psychiatric diagnosis called major depressive disorder is prevalent, so we screen for it by asking two questions¹²:

Over the last 2 weeks, how often have you been bothered by:

1. Having little interest or pleasure in doing things?
2. Feeling down, depressed, or hopeless?

If the patient answers, “more than half the days” or “nearly every day” to one or both questions, the sensitivity to rule in the diagnosis of depression is 83% and the specificity is 90%. In this case you would follow-up with seven more questions to confirm the diagnosis. The patient needs to answer “more than half the days” or “nearly every day” to a total of at least five of the nine questions (the two screening questions and the seven follow-up questions) to meet diagnostic criteria for major depressive disorder.¹³ These questions are:

Over the last 2 weeks, how often have you been bothered by:

3. Trouble falling or staying asleep, or sleeping too much?
4. Feeling tired or having little energy?
5. Poor appetite or overeating?
6. Feeling bad about yourself—or that you are a failure or let your family down?
7. Trouble concentrating on things, such as reading the newspaper or watching television?
8. Moving or speaking so slowly that other people could have noticed, or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?
9. Thoughts that you would be better off dead, or of hurting yourself in some way?

Many medical patients are like Ms. Jones and have no apparent overriding psychological problem or diagnosis. That may surprise you after everything we have heard about Ms. Jones’ job stresses and interpersonal conflicts. While it is important for you to understand your patients at this level, life stresses such as these are not necessarily symptoms of a psychiatric disease. Indeed, these types of problems occur in everyone’s personal lives and are not outside the realm of normal. Simply feeling heard and understood by a caring person is often enough to help. Indeed, some patients express, “I feel better just having come to see you!” You will gather additional personal details for patients like Ms. Jones in the SH (Step 8).

General Comments about the Remainder of the Interview

You now have completed the most important part of the middle of the interview. Step 6 is where you will spend most of your time. *The remaining steps (Steps 7–10) are very straightforward*, consisting of lists of questions on various topics you ask one by one. *In many practice settings, patients complete a questionnaire beforehand* and the clinician uses it to efficiently guide this part of the interview. While continuing to be on the lookout for clues to hypotheses, most hypothesis testing should have been completed.

You will note that the questions are extensive and to completely ask and answer all of them could literally take several hours! We present all of this

material in order to provide you with an idea of the magnitude of potentially important information about the patient and what may be necessary to understand her/him fully. Note that the experienced clinician rarely obtains all of this information, certainly not at one sitting; pertinent but nonurgent information often is obtained over many visits. *Information in Steps 7 to 10 is gathered selectively according to the individual patient's needs.* As you proceed through these steps, consider which might be more important in, for example, older patients, women, men, children, crisis situations, and high-risk patients. As a beginning clinician, you should initially obtain complete information in all areas as a way of learning the categories and beginning to appreciate the rich diversity of your patients. When you have learned and memorized all the categories you should become more selective also.

While much of the information in Steps 7 to 10 is quite routine, continue to watch your patient's response, particularly fatigue and impatience with a long process. Periodically ask how the patient is responding to the interview itself. It can be tiring and you may need to ask if the patient needs a break or if it would be appropriate to continue at a later time. At the other extreme, while these may appear to be very standard questions, they often strike an emotional chord in patients and you may need to return to patient-centered inquiry, particularly empathy skills (NURS); for example, when asking a spouse's age, the patient becomes sad because of a recent divorce. It is also essential in this more routine part of the history to maintain the respectful, patient-centered atmosphere you have previously established and not become hurried. Finally, normalize the situation by *telling patients that the questions you are asking are indeed customary and asked of all patients*; for example, a patient might get insulted when asked about drug use or sexual practices if you do not explain the reason for asking.

■ PAST MEDICAL HISTORY (STEP 7)

In the past medical history (PMH), you elicit information about significant past medical events unrelated to HPI/OAP. Events occurring in the past that are related to the HPI/OAP, however, are elicited as part of the HPI/OAP. For instance, in a patient presenting with chest pain, the prior history of myocardial infarction usually is obtained in the HPI rather than the PMH; it would also be reported there in the written and oral presentation of the history and physical (H and P). Similarly, because of the close association of diabetes and coronary artery disease, if this patient also were a diabetic of 20-years duration, this fact would be elicited and recorded in the HPI. On the other hand, if the same patient presented with diverticulitis or hip fracture, the cardiovascular history would be obtained and presented in the PMH as long as it was

■ TABLE 5-4. Past Medical History (Step 7)

- Inquire about general state of health and past illnesses
 - Childhood: measles, mumps, rubella, chicken pox, scarlet fever, and rheumatic fever
 - Adult: hypertension, heart attack, stroke, heart murmur, other heart disease, diabetes, tuberculosis, sexually transmitted infections, cancer, major treatments in the past (blood transfusions, steroid treatments, anticoagulation), and visits to healthcare providers during the last year
- Inquire about past injuries, accidents, psychological problems, unexplained problems, procedures, tests, psychotherapy
- Elicit past hospitalizations (medical, surgical, obstetric, rehabilitation, and psychiatric)
- Review the patient's immunization history
 - Childhood: measles, mumps, rubella, polio, hepatitis B, tetanus/pertussis/diphtheria, human papilloma virus, influenza, meningococcal, varicella, *Haemophilus influenzae* type B, rotavirus
 - Adult: diphtheria/tetanus/pertussis boosters, hepatitis A, hepatitis B, influenza, pneumococcal pneumonia, herpes zoster
- Inquire about status of age-appropriate preventive screening
- Obtain the female patient's women's health history
 - Age of menarche, cycle length, length of menstrual flow, number of tampons/pads used per day
 - Number of pregnancies, complications; number of live births, spontaneous vaginal deliveries/cesarean section; number of spontaneous and therapeutic abortions
 - Age of menopause
- List current medications, including dose and route
 - Ask specifically about inhalers, over-the-counter medicines, alternative remedies, oral contraceptives, vitamins, laxatives
- Review allergies
 - Environmental, medications, foods
 - Ensure that medication "allergies" are not actually expected side effects or nonallergic adverse reactions

understanding of diagnoses or interpretations of treatments. Follow the already described procedure: convert concerns to symptoms from the ROS and refine them with the symptom descriptors, and then organize relevant primary data (symptoms) and secondary data (doctor visits, hospitalizations, tests) into chronologic sequence.

For PMH problems with little significance to present health (appendectomy or tonsillectomy many years ago), little detail is needed other than getting the patient's version of diagnosis, complications, and statement that there have been no subsequent problems. *Indeed, time constraints and patients' comfort discourage acquiring unnecessary data*, such as the details of an uncomplicated appendectomy 30 years earlier.

As listed in Table 5-4, identify significant past problems by inquiring in the following areas.

Screen for Major Diseases

Screen for problems that might not yet have been identified. Begin with childhood illnesses by asking "Tell me about any illness you had as a child." Then inquire about specific childhood illnesses (e.g., measles, mumps, German measles, chickenpox). Continue with adult illnesses by asking, "Other than (chief concern), how is your health? What significant illnesses have you had?", followed by specific inquiry about common adult illnesses (hypertension, heart attack, stroke, heart murmur, other heart disease, diabetes, tuberculosis, sexually transmitted infections, cancer), blood transfusions, and visits to healthcare providers during the last year. Similarly, ask about prior treatment, such as cortisone, insulin, blood transfusions, and anticoagulants, that suggests serious problems.

Other Medical, Surgical, or Psychological Problems

Inquire about injuries, accidents, visits to the emergency room, illnesses requiring several visits, unexplained problems, procedures, tests, psychological problems, and psychotherapy.

Hospitalizations

Hospitalizations may identify the most serious problems patients have experienced: surgical, medical, psychiatric, obstetric, rehabilitation, and any other type. The more recent and the more serious a hospitalization, the more data are required, sometimes more extensive than the HPI; for example, in a patient who is admitted with a hip fracture as the primary problem but who had a history of three heart attacks, you would need to elicit extensive details

of all primary and secondary cardiovascular data in order to assess the safety of planned hip surgery. Hospitalizations usually are presented in chronological order.

Immunizations

Ask about childhood (measles, mumps, rubella, polio, *Haemophilus influenzae* type b, hepatitis B, tetanus/pertussis/diphtheria, HPV, varicella, meningococcal, rotavirus) and adult (diphtheria booster, tetanus boosters, measles/mumps/rubella boosters, hepatitis A, hepatitis B, influenza, pneumococcal, herpes zoster, meningococcal) immunizations. The most recent Centers for Disease Control and Prevention vaccination recommendations can be found at <https://www.cdc.gov/vaccines/schedules/index.html>.

Screening

There are a number of recommended health-screening procedures (varying by age, circumstance, and gender) that you will want to ensure are up to date. These might include screening for tuberculosis, hyperlipidemia, hypertension, cervical cancer, breast cancer, colon cancer, etc. Screening recommendations change as new knowledge is discovered. You can find the latest US Preventive Services Task Force health screening recommendations applicable to your patient at <http://www.ahrq.gov/clinic/pocketgd.htm>.

Women's Health History

Essential information to obtain from women and girls about menses is age at onset (“How old were you when you had your first period?”), cycle length (“How often do you get your period?”), duration (“How long does your period last?”), discomfort or pain with menses, number of pads or tampons daily, and age at menopause. Use of contraceptives, including birth control pills or other hormonal preparations also is sometimes elicited here (“Do you or your partner[s] use birth control? What type? How often?”). The sexual history, sexually transmitted infection history, and intimate partner violence questions found in the SH can be asked here in the PMH if you prefer.

The obstetric history includes number of pregnancies (“Have you ever been pregnant?” “How many times?”), deliveries of living children and their outcome, other deliveries and reason for adverse outcome, any complications of pregnancy, spontaneous abortions (“Have you had any miscarriages?”), and induced abortions. You can elicit breast-feeding history and problems here. The women’s health history often is elicited and reported as part of the HPI when genitourinary problems are the focus. Many women’s health questions are also

found in the ROS because some clinicians ask about women's health history there instead of in the PMH or SH. You will learn from your teachers which section you are expected to record and report the women's health history in.

Medications and Other Treatments

List all prescribed and other medications with dose, duration of use, reason for use, and any adverse reactions. Also obtain a listing of medications used during the last year but which are not presently being taken. Specific inquiry about agents sometimes not considered to be medications is necessary as well: inhalers, eye drops, laxatives, tonics, hormones, birth control pills, patches, and vitamins. Inquire about agents obtained over-the-counter, from alternative healers, or from other sources such as a friend. In order to identify all the patient's medicines, you may need to contact the pharmacy or ask the patient to bring in the actual medications so that they can be definitively identified, particularly when all the patient knows is that "I'm taking a brown pill for my circulation." Sometimes it helps to consult an online resource such as Pillbox from the National Library of Medicine (<http://pillbox.nlm.nih.gov/>), which allows for rapid identification of pills based on color, shape, and size.

Ask about non-pharmacologic forms of treatment, whether administered by self or others, including physical therapy, massage, biofeedback, relaxation techniques, yoga, acupuncture, psychotherapy of any type (e.g., individual, group), diet, and exercise. Specifically inquire about complementary and alternative treatment (e.g., homeopathy, herbal medicine, chiropractic) since these often are not mentioned out of embarrassment or fear of disapproval by the clinician.¹⁴

Allergies and Drug Reactions

If not already ascertained, ask about asthma, hay fever, hives, and atopic eczema because they are common allergic disorders and these patients also may be more sensitive to certain medications (e.g., aspirin in asthmatics).

Drug reactions can be allergic/immunological (rash due to penicillin) or non-immunological (candida vaginitis due to an antibiotic). Patients seldom make this distinction but you must because true allergic reactions usually preclude subsequent use of the medication while alterations in dosage and frequency can sometimes allow continued use following a nonallergic drug reaction. List all allergic or other drug reactions, dose and duration of use of the agent, specific symptoms (e.g., hives, anaphylaxis, rash) and secondary data (e.g., desensitization, skin tests, cortisone), recurrence, history of reexposure, and final outcome.

We now pick up again with Ms. Jones.

Continuation of Ms. Jones Visit

Clinician: Other than the headaches and colitis, how is your health? [A good way to start the PMH with an open-ended question.]

Patient: Fine.

Clinician: I'm going to ask you about some specific diseases now and just tell me if you've ever had them. By the way, these are routine questions; I'm not asking because I suspect something. [Instructions and a normalizing statement]

Clinician/ Rheumatic fever (no), scarlet fever (no), diabetes (no), TB (no),
Patient: cancer (no), stroke (no), heart attack (no), or any other diseases (no). [The clinician begins the PMH by screening for major diseases. In a series of questions like this is, ask each one individually and give the patient sufficient time for an answer; the patient should not feel pressured nor should a string of questions be asked at once. It is important throughout to be sensitive to the patient's response to all inquiry and to respond to questions. In particular, it almost always helps to reassure the patient that items being inquired about are routine and that you have not noticed something to make her or him suspicious.]

Clinician/ Besides the cortisone for your colitis, I'm going to ask you a
Patient: lot more specifics now about major treatments you might ever have had: blood transfusions (no), insulin (no), or anticoagulants (no). [This is an additional way of screening for any major problems not yet mentioned.]

Clinician: Any visits to your doctor during the last year or so for anything we haven't covered?

Patient: Well, I did have a bladder infection once and got some medicine for it.

Clinician: How was it diagnosed? [The clinician is not taking her word for the diagnosis (secondary data) and wants to know more.]

Patient: Oh, my doctor did a urine test and gave me an antibiotic. With the medicine it was gone in about 2 days, but I took the medicine for a week.

Clinician: Any tests done, like X-rays or cultures of the urine?

Patient: No.

Clinician: Ever had this before?

Patient: Nope, it didn't amount to much. [The clinician has established the chronology of what sounds like an uncomplicated lower urinary tract infection. This is a very simple and straightforward problem, but the clinician would evaluate each PMH

problem that might be significant to the patient's present health in a similar fashion.]

Clinician: Any other problems you've seen your doctor or anyone else for?

Patient: No.

Clinician: Tell me about any hospitalizations you've had, you know, other than that time for the colitis. [Although not recounted in the HPI/OAP or PMH, for space considerations, the clinician already has addressed Ms. Jones' cough and colitis; the results of this inquiry are given in the write-up of the history in Appendix D.]

Patient: I had my tonsils out as a kid.

Clinician: Any other hospitalizations? [The clinician might have asked about any complications or subsequent problems.]

Patient: Well, I did break my arm once in high school and they had to set it.

Clinician: How's that been since? Any problem? [It would be important to know how it was broken.]

Patient: No, it's just fine. I play tennis and have no trouble.

Clinician/ Other hospitalizations (no), injuries (no), accidents (no),

Patient: or sickness (no)? [These questions are asked and answered individually.]

Clinician: Didn't you mention having kids?

Patient: Oh, yeah. I forgot! They're six and eight. But I had no trouble delivering [This sounds uncomplicated at this point, and the clinician will get the details of the menstrual and obstetric history at the end of the PMH although it could just as easily be done now.]

Clinician: OK. If there's nothing else, I'd like to shift and find out about any medications you take, and some other things. [A good open-ended and orienting start into this new area. Because of space constraints, we'll simply summarize the clinician's findings about Ms. Jones: Except for the birth control pill and aspirin with the headaches (detailed doses and other data obtained), she is taking no medications or other treatments from either prescribed or other sources. Her history of prednisone use is reviewed. She has no allergic diseases and there is no history of adverse reactions to any drugs or other substances. She had her "baby shots" years ago and had a tetanus shot 2 years ago when she punctured her hand with a nail. Her women's health history reveals that she has Pap smears every 3 years and performs breast

self-examination about a week after each menstrual period. She has not had any sexually transmitted infections such as gonorrhea, syphilis, HIV, chlamydia, abnormal Pap smears (caused by human papilloma virus—HPV), genital warts, or hepatitis. The remainder of her women's health history is recounted in the write-up in Appendix D.]

SOCIAL HISTORY (STEP 8)

Also called the psychosocial history, the psychosocial ROS, or the patient profile, the social history (SH) is where you learn about the patient's behaviors and other personal factors that may impact disease risk, severity, and outcome; it also helps you to get to know the patient better. The routine information obtained here compliments, and should not be confused with, the rich psychosocial data that you obtain in Steps 3 and 4. As with other parts of the history, you may uncover aspects of the SH during different parts of the encounter. Regardless of where in the history you obtain the data, when you do an oral or written case presentation, you will place those parts of the SH not involved in diagnosing the chief concern under the heading social history, to help organize the information.

Start with a transition statement ("Now I'd like to ask you some questions about your life and things you do to stay healthy") and initiate each major SH area in Table 5-5 with a focused open-ended request or question ("Can you tell me about your work?"), then follow-up with enough closed-ended questions to get the necessary details. Because the SH addresses many sensitive areas, be especially careful to be patient, courteous, nonjudgmental, and understanding as a way of ensuring continuation of the patient-centered atmosphere. Patients often are reassured when you state that the questions are routine and asked of everyone. Address tension-laden areas delicately with considerable use of open-ended and empathy skills; *you may need to use patient-centered interviewing skills if significant issues or emotions develop, or if a previously reticent patient begins to open up.* It is not uncommon to go back and forth between patient-centered and clinician-centered skills many times. The interviewing strategy for obtaining very sensitive information, such as sexual or drug use history, is expanded upon in Chapter 7.

The list of potential topics of inquiry in the SH is extensive and may not seem relevant to the reason the patient is seeking healthcare. However, understanding these aspects of the patient's life can aid you in diagnosing the chief concern, helping the patient recuperate after hospital discharge, and keeping the patient healthy by addressing harmful behaviors. As you gain experience, you will learn which questions are most important to ask for a particular

■ TABLE 5-5. Social History (Step 8)^a

Occupation	Exposures
Workplace	Pets
Level of responsibility	Travel
Daily routine and schedule	Illness at home, in the workplace
Health hazards	Sexually transmitted infections
Occupational exposures	Substance use
Work stress	Caffeine
Financial stress	Tobacco
Satisfaction	Forms Pack-years
Health promotion	Alcohol
Diet	Type and amount consumed at 1 time/daily/weekly “CAGE” questions
Physical activity/exercise history	Drugs
Functional status	“Recreational” or “street” drugs Illicit use of prescription drugs
Dressing	Personal
Bathing	Living arrangement (with whom, how are things at home?)
Feeding	Personal relationships and support systems (Who do you count on? How have people responded to your illness?)
Transferring	Sexuality
Walking	Orientation
Shopping	Difficulty
Using the toilet	Intimate partner violence/abuse
Using the telephone	Life stress
Cooking	Mood
Cleaning	Spirituality/religion
Driving	Faith Importance Community Address
Taking medication	Health literacy
Managing finance	Hobbies, recreation
Cognitive function	Important life experiences
Extent of interference with normal life	Upbringing and family relationships Schooling Major losses/adversity
Safety	Military service
Seat belt use	Financial situation Aging
Safety helmet use	Retirement Life satisfaction
Smoke detectors in home	End-of-life planning Cultural/ethnic background
Toxins at work and home	Legal issues
Safe gun storage	Living will or advance directives Power of attorney
Health screening	Emergency contact
Cervical cancer	
Breast cancer	
Prostate cancer	
Colon cancer	
Lipids	
Hypertension	
Diabetes	
HIV	
Sexually transmitted infections	
Tuberculosis	
Glaucoma	
Dental	
Self-examination	

^aItems in bold should be asked about in most new patient encounters: they have high yield for risk factor modification, assist in building the doctor–patient relationship, and/or are important to patients but rarely brought up by them. Ask about other items as time allows and as indicated by the patient’s symptom(s).

patient encounter. The bold items in Table 5-5 should be addressed in most encounters; these topics will identify targets for risk factor modification and assist in building the clinician–patient relationship. These issues, although rarely brought up by patients, should be discussed openly and in a nonjudgmental fashion to both garner trust and obtain accurate information. You may need to obtain this type of information over multiple encounters with the patient.

Ask about the unbolded items in Table 5-5 if time allows or when directed by the patient’s illness. For example, you would ask about travel and pets if the patient presented with acute fever.

We recommend that you begin with less sensitive topics first, generally following the order listed in Table 5-5. Make a transition statement between topics and assure the patient that you ask these questions of all your patients.

Recommended questions for some important topics are listed in the following sections, followed by the rationale [in brackets].

Occupation

Ask, “Do you work outside the home? Tell me about your work. How long have you done this work? What other jobs have you had? Have you ever been exposed to fumes, dust, radiation, or loud noise at work? Do you think your work or environment is affecting your symptoms now?” If so, ask, “Do your symptoms improve away from work?” and “Are others at work having similar symptoms? Tell me about stress at work.” If the patient does not work outside the home, ask what a typical day is like.

[A patient’s occupation can affect health through toxic exposures, injuries, and stress.¹⁵ For example, auto body workers can develop asthma, woodworkers have an increased incidence of nasopharyngeal carcinomas, and clinicians can be exposed to tuberculosis, HIV, and viral hepatitis.]

Health Promotion

Diet (See Also DocCom Module 25¹⁶)

Ask for a 24-hour dietary recall, “Tell me what you’ve eaten in the past 24 hours, starting with just before you came here and working backward.” Avoid asking, “Tell me about your diet,” because for some patients a “diet” is something one goes on to lose weight. A 24-hour dietary recall (assuming the day is typical) gives you a more accurate understanding of actual dietary practices than asking about what the patient eats on an average day.

Screen for bulimia by asking, “Are you satisfied with your eating habits?” If the patient answers no, then follow-up with, “Do you ever eat in secret?”¹⁷

Depending on the clinical scenario, you may need to explore some additional areas:

- Sodium: Reducing sodium can decrease blood pressure as much as starting a medication, and it can relieve heart failure symptoms, so ask about salt use in patients with hypertension and congestive heart failure. Does the patient add salt during cooking and/or at the table? Ask about hidden sodium, found in prepared foods such as cold cuts, bacon, ham, canned soups and vegetables, and in restaurant meals.
- Fat: Dietary animal and hydrogenated fat intake can significantly affect heart disease risk. Inquire about intake of dairy products, eggs, red meat, and organ meats.
- Caffeine: Can cause nervousness, tremor, palpitations, eyelid twitching, and insomnia. Ask about intake of caffeinated beverages (e.g., coffee, tea, cola, Mountain Dew, energy drinks) and caffeine pills (e.g., No-Doz).
- Fiber: Low-fiber diet can lead to constipation, hemorrhoids, and diverticulosis.
- Dairy products: For patients who might have lactose intolerance.
- Wheat: For patients who might have celiac disease.

[Understanding your patient's dietary choices and relationship to food is important because of the increasing incidence of obesity and eating disorders. Diet also plays an important role in many common diseases such as hypertension, diabetes, and hyperlipidemia. Symptoms can also be caused by foods, such as diarrhea and bloating in patients with lactose intolerance after consuming dairy products, and in patients with celiac disease who eat wheat. Malnutrition can exist even if the patient is obese.]

Exercise (See Also DocCom Module 25¹⁶)

Ask, "Tell me what you do for physical activity or exercise."

[A sedentary lifestyle contributes to many illnesses including obesity, type 2 diabetes, and heart disease. The US Department of Health and Human Services in its 2008 Physical Activity Guidelines for Americans (www.health.gov/paguidelines) recommends that adults get at least 2½ hours per week of moderate intensity, or 1 hour and 15 minutes a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity. It also recommends that adults should do muscle-strengthening activities that are moderate or high intensity and involve all major muscle groups on 2 or more days a week. Understanding the details of a patient's exercise and physical activity can allow you to counsel the patient appropriately.]

Safety

Say, "Now I want to ask you about some personal safety issues. Do you wear seat belts? How often? Do you use a bicycle helmet? How often? Do you ride a motorcycle? (If so) Do you wear a helmet? How often? Do you have smoke detectors in your home? How often do you change the batteries? Can children get at medications or toxic substances like cleaning products? Is there a gun in your home? (If so) How is it stored?"

[Asking patients about their day-to-day safety practices provides an opportunity for counseling that may be lifesaving.^{18,19} For example, in recent years about 60% of the approximately 30,000 annual fatal motor vehicle accidents have been due to failure to use seat belts. The National Highway Traffic Safety Administration estimates that seat belt use saves about 13,000 lives a year. Accidents are the leading cause of death of young adults. If a clinician can convince a healthy young patient to use a seat belt, it is possible to have more impact on that patient's lifespan than any other medical intervention. It may be advantageous to reinforce the fact that seat belt use saves thousands of lives every year. Bicycle helmets reduce the risk of head injury by 85%; motorcycle helmet use reduces the risk of fatal head injury by 27%.¹⁹ Ensuring that firearms in the home are safely handled and stored may reduce the risk of homicide or suicide: homicide risk has an odds ratio of 2.7, and suicide risk has an odds ratio of 4.8 in households with handguns compared to households without a handgun.^{18,20-23} Smoke detectors reduce the risk of death from residential fires by 80%.^{18]}]

Substance Use (See Also DocCom Modules 24,²⁴ 29,²⁵ and 30²⁶)

Ask about tobacco use, including forms of tobacco (e.g., pipe, snuff, chewing tobacco) and number of pack-years for cigarette use (packs smoked per day multiplied by number of years of smoking, e.g., smoked 2 packages of cigarettes daily for 8 years = 16 pack-years).

Determine whether the patient consumes alcohol and whether it may be a health problem. Ask "Do you drink alcohol, including beer, wine, and hard liquor? How much alcohol do you drink? Has alcohol ever been a problem in your life? When was your last drink?" A response of "less than 24 hours ago" to this last question has a positive predictive value of 68% and a negative predictive value of 98% for alcohol abuse.²⁷ Then, you can follow-up with the "CAGE" questions^{28,29}:

"Have you ever:

- felt the need to Cut down on your drinking?
- felt Annoyed by criticism of your drinking?
- had Guilty feelings about your drinking?
- taken a morning Eye opener?"

An affirmative answer to two or more has a sensitivity and specificity of >90% for alcohol dependence.²⁷

Determine whether the patient uses or abuses either “street” drugs or prescription drugs, and quantify the amount. Also determine if the patient shares drug equipment, such as needles and straws. Prescription drug abuse is now the most common form of drug abuse.³⁰⁻³³

Patients often minimize their use of drugs or alcohol, in an attempt to delude themselves rather than hide the truth from you. Maintain a respectful and nonjudgmental approach in order to win the patient’s trust. You might ask if the patient has had problems from using addicting substances (divorce, job loss, delirium tremens with alcohol withdrawal, emphysema from cigarettes), attempted to quit or decrease the habit; whether s/he was successful in stopping before and if not, why not; and if s/he is interested in getting help to quit. As well, ask about problems with the legal system, and with other substance abuse problems in the patient’s life. Finally, particularly with drug and alcohol abuse, be alert for psychiatric issues that commonly co-exist with these problems, such as anxiety and depression. You will often find that, when alcohol or drug abuse exists, it often relates to the major problem the patient has and almost always has a significant impact on the patient’s health. In such cases, you will present this information in the HPI, even if you obtain it as part of the SH. Examples include a patient who presents with chest pain suggesting angina and also a history suggesting alcoholism, or a patient who presents with progressive shortness of breath who also has a 40 pack-year smoking history.

Personal

Living Arrangement and Personal Relationships

A good way to inquire about home life is to ask, “How are things at home? Does anyone else live at home with you? Tell me about him or her”, “Tell me about your support systems in your life. Who do you count on?”

[Most beginning clinicians are uncomfortable inquiring about patients’ personal lives. It can feel intrusive or voyeuristic to ask intimate questions about a stranger’s private life. This is understandable. It is helpful to keep in mind some of the reasons you are asking these questions. As a clinician, you are interested in public health issues such as the spread of communicable diseases; you are also interested in patient safety, including falls and intimate partner violence; risky behaviors such as unprotected sex; inherited and inheritable genetic diseases; etc.

As a beginning clinician, you may not feel that you can do anything helpful with the information you have gotten. Once you are on clinical rotations, you will be a key member of the team caring for the patient and the history you obtain may be the most important and complete one the patient will undergo.

For example, knowing a patient's personal relationships allows the team to know who to contact and when it is time to discharge the patient, the team will know the potential support systems (or lack thereof)—this may mean the difference between sending the patient home, arranging for visiting nurse, or sending the patient to a rehabilitation center. Regardless of your clinical level, be honest with patients that you are learning about medical interviewing; most patients will be very willing to help you learn by answering all your questions. In fact, your encounter with the patient may be the high point of the patient's otherwise boring day.]

Sexuality (See Also DocCom Module 18³⁴)

A transition statement such as, "In order to provide healthcare that is right for you, it is helpful for me to understand your lifestyle" may provide a comfortable segue into asking about sexuality.³⁵ Also, stating that "these are questions I ask all of my adult patients" may be helpful. After the transition, the following questions can then be asked:

- "Is there someone special in your life? Are you and this person having sex?"
- "Are there any other sexual relationships that I should know about?"
- "Do you have sex with men, women, or both?"
- "Do you have sex with people who might be at risk for having sexually transmitted diseases or HIV (intravenous drug users, cocaine users, prostitutes, unknown partners or gay or bisexual men)?"
- (For persons having sex with men) "Are you using condoms to prevent disease? What percent of the time?"
- (For women) "Do you have a need to discuss birth control?, Have you ever had a Pap smear? When was your last one? What were the results? Have you ever had an abnormal Pap smear? Have you ever had a biopsy or other procedure on your cervix because of an abnormal Pap smear?"
- "Have you ever had gonorrhea? Syphilis? HIV? Chlamydia? Herpes? HPV? Genital warts? Hepatitis?"
- "Do you have any other questions or concerns about sex? I'm happy to discuss any concerns you have."

To detect sexual problems, ask:

- "Have you noticed any recent changes or problems with your sexual functioning?"
- Men: "Do you have any problems having or maintaining an erection? Any trouble having an orgasm?"
- Women: "Do you have pain during intercourse? Any problems with lubrication or becoming aroused? Do you have difficulty having an orgasm?"
- "Has your illness affected your sexual functioning?"

[Do not make assumptions about a patient's sexual orientation or practices and do not assume that orientation determines practices. For example, some men who have sex with men do not consider themselves to be gay or bisexual. Avoid questions such as "Are you married or single?" or (to a woman), "Do you have a boyfriend?" Gender-neutral language (e.g., "partner") communicates to gay, lesbian, bisexual, and transgender patients that it is safe for them to be themselves with you.³⁶ Seek to understand both a patient's sexual orientation and the sexual activities s/he engages in. This will allow you to screen appropriately for sexually transmitted infections, give relevant health education, and provide personalized healthcare. For example, gay and lesbian patients receive less preventive care than heterosexual patients, primarily because of dissatisfaction with the clinician–patient relationship.³⁷ Also, gay and lesbian teens are six times more likely to attempt or commit suicide than the national average.³⁸ A trusting relationship with the clinician may help establish safety and uncover and respond to extreme distress and suicidal thoughts.

It can be helpful to explore issues of gender identity with a screening question, such as, "Because so many people are impacted by gender issues, I have begun to ask everyone if they have any concerns about their gender. Anything you say about gender issues will be kept confidential. If this topic isn't relevant to you, tell me and I'll move on."³⁹

As with the rest of the medical interview, tailor questions to the particular encounter. For example, it would not be appropriate to take a detailed sexual history from a person in acute congestive heart failure in a crowded emergency department. Once the patient is stabilized and in a more private setting, you could return to these questions as indicated.]

Intimate Partner Violence/Abuse (See Also DocCom Module 28⁴⁰)

One in three women and one in four men have been physically abused by an intimate partner; one in five women and one in seven men have been *severely* physically abused by an intimate partner.⁴¹ Although it may feel uncomfortable, you must learn to sensitively inquire about intimate partner violence, since patients are unlikely to broach this important issue themselves.⁴² One suggested approach⁴³ is "Have you ever been hit, slapped, kicked, or otherwise physically hurt by someone?", "Has anyone ever forced you to have sexual activities?" If the patient answers yes to either question, learn more about the situation, using open-ended questions. You can then follow-up with the "SAFE" questions⁴⁴:

- Stress/Safety: "What stress do you experience in your relationships? Do you feel safe in your relationships/marriage? Should I be concerned for your safety?"

- Afraid/Abused: “Are there situations in your relationships where you have felt *afraid*?” “Has your partner ever threatened or *abused* you or your children?” “Have you been physically hurt or threatened by your partner?” “Are you in a relationship like that now?” “Has your partner forced you to engage in sexual activity that you did not want?” “People in relationships/marriages often fight; what happens when you and your partner disagree?”
- Friends/Family: “Are your friends, parents, or siblings aware that you have been hurt?” “Do you think you could tell them, and do you think they would be able to give you support?” (Assess the degree of social isolation.)
- Emergency plan: “Do you have a safe place to go and the resources you (and your children) need in an *emergency*?” “If you are in danger now, would you like help in locating a shelter?” “Would you like to talk with a social worker/counselor/me to develop an emergency plan?”

Stress

Stress is ubiquitous in life. Unmanaged, it can negatively affect mental and physical health through chronic activation of the hypothalamic–pituitary–adrenal axis and suppression of the immune system.⁴⁵ If not disclosed earlier in the interview, ask, “Can you tell me about the kinds of stress you’re under?”, “Have you had any recent changes or losses at home? At work?”

Mood (See Also DocCom Module 27⁴⁶)

You might get clues to a mood disorder in the beginning of the interview and you could choose to pursue your hypothesis while you are completing the HPI in Step 7. Alternatively, you can inquire about the patient’s mood here, or as part of the ROS (Step 10). Begin by asking, “How has your mood been?” or “How are your spirits?” To screen for depression, the most common mood disorder, ask, “Over the past 2 weeks, have you been bothered by little interest or pleasure in doing things? Feeling down, depressed, and hopeless?” If the patient answers yes to either question, there are more in-depth questionnaires such as the PHQ-9 to confirm the diagnosis and its severity.¹³

Spirituality/Religion (See Also DocCom Module 19⁴⁷)

One suggested mnemonic for asking about spiritual and religious beliefs is FICA⁴⁸:

Faith and belief: “Do you consider yourself to be a spiritual or religious person?” “What is your faith or belief?” “What gives your life meaning?”

Importance and influence: “What importance does faith have in your life?” “Have your beliefs influenced the way you take care of yourself and your illness?” “What role do your beliefs play in regaining your health or coping with illness?”

Community: "Are you a part of a spiritual or religious community?" "Does the community support you? If so, how?" "Is there a group of people you really love or who are important to you?"

Address in care: "Would you like me to address these issues in your health-care?"

[Spirituality and religious beliefs are important to many patients, especially in times of illness. Beliefs can be a source of comfort and support. Some studies show an association between spiritual beliefs and improved health.^{49,50} Religious belief can also result in poorer health outcomes through avoidance of care.⁵¹ Additionally, belief that illness is a punishment from God can lead to increased mortality.⁵² Depending on the severity of the illness and time available, seek to understand what is ultimately meaningful for patients, how this relates to their suffering, what their belief and faith are, who and what they love, their meditation or prayer practices, their orientation to giving and forgiving, and the patient's actual worship practices; that is, the integration of mind, body, and spirit.⁵³

While most patients welcome their clinicians knowing about their religious beliefs, the number is highest in cases of serious illness and lowest for routine office visits, so, as always, be sensitive to patient preferences.]⁵⁴

Health Literacy (See Also DocCom Module 9⁹)

Health literacy is defined as the capacity of a person to obtain, process, and understand health information to make decisions regarding illness prevention or treatment.⁵⁵ Ask the screening question "How confident are you filling out forms by yourself?" to identify patients with low health literacy.⁵⁶

[Examples of behaviors where health literacy is required include reading the instructions on a medication bottle, understanding an appointment slip, filling out health forms, participating in an informed decision discussion before an operation, managing a chronic health condition, and enrolling in a health insurance plan. Patients with low health literacy have worse health outcomes and incur higher costs than patients with adequate health literacy. Low health literacy is more prevalent among older people, those with less educational attainment, those with limited English proficiency, those in minority groups, and the medically underserved. It is estimated that one-third of patients in the United States have low health literacy. Patients may try to hide their low literacy by avoiding reading ("I forgot my glasses."); they may have few questions and may not be able to explain how to take their medications.]

Other Issues

Ask about the following areas as time permits and as indicated by the clinical situation.

Advance Directives (See Also DocCom Module 32⁵⁷)

With patients who are severely ill, disabled, or elderly, inquire about advance directives (e.g., “do not attempt resuscitation” wishes, living will, use of a ventilator to sustain life), power of attorney, and whom to contact in the event of serious health problems. An advance directive makes the patient’s end-of-life wishes known in the event of incapacitation. Experts in bioethics recommend advance directives, but they are not being used nearly often enough, leaving patients biased toward choosing cardiopulmonary resuscitation when they don’t understand its ramifications. Research data show that addressing advance directives improves elderly patients’ satisfaction,⁵⁸ which can be enhanced by using patient-centered skills when necessary.⁵⁹

Functional Status (See Also DocCom Module 23⁶⁰)

Especially in the elderly and those with disabling problems, it is important to know what their functional status is; for example, how well they can dress and bathe themselves, use the toilet, transfer from bed to chair, walk, shop, cook, clean, drive, take medications, and keep track of their bank account. Indeed, the American College of Physicians has asked that patient histories be standardized to include routine functional status and well-being assessments.⁶¹ In addition, make an assessment of how much a disability interferes with the patient’s life and wishes; for example, one may no longer be able to climb stairs but this does not interfere with what the patient wants to do or, alternatively, the same disability results in great hardship by preventing the patient from attending baseball games.

Continuation of Ms. Jones Visit

Clinician: Let me ask you now some other questions about your life and what you do to stay healthy. [A good transition into the SH.]

Patient: Seems like I’ve told you everything.

Clinician: I need to get a few more details so that I can be of best help to you. First, though, how are you doing with all this questioning? [Always attending primarily to the patient’s needs, the clinician takes time to inquire about the process of the interview itself.]

Patient: No problem. I like how thorough you are. [She is doing well and makes a positive comment about the clinician, indicating that a good relationship exists.]

Clinician: Thanks. I imagine it can feel like pressure to get so many questions coming at you. I appreciate your patience. Now, I do need to get some more information. How old are you? [The clinician is beginning to get some basic demographic data. Age is sometimes asked much earlier for basic orientation.]

Patient: 38 and just had a birthday.

Clinician: Well, happy birthday! And your family has been here for how long? [The clinician is not clear how long she has actually been in the city.]

Patient: About 4 months.

[Because of space constraints, we will again simply summarize the findings about Ms. Jones, some of which required return to a patient-centered process of inquiry. We know about her work but also learn that she worries about being “workaholic.” The clinician explores more about her work stress and support, since it seems to be a very important contributor to her symptoms.]

Clinician: If it's ok to change topics a bit, I'd like to ask you something else (she nods approval). You mentioned your husband earlier. Anybody else around that you can talk with?

Patient: There's another new person at work with the same problem and we commiserate all the time. He's taking over in another area but has the same boss. We get along great and seem to help each other. And, a couple other guys there know what's going on and have been very helpful—and had some good advice: stay away from him. [As with the rest of this dialogue, nothing urgent is arising so the clinician, recalling the need to be timely, simply obtains the information and doesn't pursue these issues in any depth.]

Clinician: It's great that you have some trusted colleagues at work. Is it possible to avoid your boss? [An empathic respect statement, followed by a closed-ended question addressing a very practical personal issue that has therapeutic implications, once again showing how inextricable is the link of disease and the personal dimension.]

Patient: Actually, it is. I have to do a lot of traveling and can schedule it around him and things are much better then. I figured it out and I can miss him for at least half the time in the next 6 months! [If it weren't possible to avoid him and treat the headaches, the clinician and Ms. Jones would have a bigger problem on their hands. In that event, this could be further addressed now or, more likely, at a subsequent visit that might be set up specifically for developing a strategy.]

Clinician: You've sure had a lot of stress. Are financial issues a problem, you know like medical insurance or anything? [Changing the subject to another important potential problem that must be raised by closed-ended means.]

Patient: No! That was one of the benefits here. They cover everything with their insurance plan. I only pay a few dollars for everything, even medicines.

Clinician: Let me now ask you how your mood has been.

Patient: Other than feeling stressed about my boss, I guess it's fine.

Clinician/ Have you been feeling down over the past 2 months? (no).

Patient: Depressed? (no). Hopeless? (no).

Clinician: Have you been bothered by a loss of interest or pleasure in doing things?

Patient: No. Painting is my true love. It really helps get my mind off of things, especially these days. I would like to do it every day, come rain or shine, but work has been so busy lately I've only been getting to it on weekends. [Current outside interests or hobbies rule out anhedonia, a frequent symptom of depression.]

Clinician: That must be hard for you; I get a sense of how important your painting is to you for stress management.

Patient: It sure is. I think I need to fit it back into my life.

Clinician: Sounds like a good idea. [The clinician would generally postpone helping the patient strategize how to put regular painting back into her life until the end of the interview, see Chapter 6.] [Summarizing the remainder of the social history, she eats a low-fat/salt diet and exercises three times weekly in a 45-minute aerobics class, maintaining her weight around 120 pounds. She wants to do more about relaxing but isn't sure what to do. She is trying to be a good model for her "lax husband" and always uses her seat belt. Except for an occasional cup of coffee and glass of wine, she has never used addicting substances. She and her husband socialize frequently and she views him as her main source of emotional support. Her husband has had some erectile dysfunction; she has no reason to suspect her husband has other sexual partners. She thinks her decreased libido "will take care of itself" when her job problems are resolved. She's not interested in talking any further about it at this point. She has no sexual partners outside of her marriage and had two other sexual partners prior to marriage. There's no history of sexually transmitted infection or intimate partner violence (or other types of abuse now or in the past), and she and her husband are heterosexual. She feels that, if not for her work stress, her mood would be fine and she does not endorse symptoms of depression or anxiety. She acknowledges the role of stress in her symptoms.]

Her church attendance has decreased since moving here due to her busy schedule, but she still prays regularly and finds it a comfort. The clinician learns that Ms. Jones has no functional limitations, has done nothing about an advance directive but thinks it's a good idea. Ms. Jones' situation is admittedly very straightforward, and she is a bright, resourceful patient. The circumstances and details, however, don't always fall together so easily and this inquiry can take much longer. Because of space constraints, we won't recount the remainder of the SH but, rather, indicate that the clinician inquired about each remaining item in Table 5-5 that had not already been covered. This information can be found in the written report of Ms. Jones in Appendix D.]

■ FAMILY HISTORY (STEP 9)

The family history (FH) is another rich source for completing the personal database, as well as for understanding familial health risks, both genetic⁶² and environmental. The FH can provide information about contagious (pinworms, tuberculosis, varicella), toxic (carbon monoxide, lead), familial (breast cancer, coronary artery disease, alcoholism, depression), and heritable (hemophilia, sickle cell anemia) diseases. Also ask if anyone in the family has similar physical problems to the patient's, or if anyone at home has been ill lately with similar concerns.

With families, the complexities of multiple interpersonal interactions come to the forefront.⁶³ You most want to know who is who, who is available to the patient and in what way. In general, obtain information for at least two generations preceding the patient, as well as for any subsequent generations, and include parents, siblings, and children for each generation. Although not significant for genetic disorders, this includes spouses, adoptees, and other significant members of the family outside the bloodline, because shared environmental factors may contribute to illness, and these relationships can have importance for the patient's health that transcend genetics.

Once again, use open-to-closed coning inquiry to obtain the information in Table 5-6. After announcing the transition and explaining your rationale ("Now I'd like to ask about the health of your family members, because sometimes diseases can run in families"), begin with a screening open-ended question ("Tell me about any illnesses or other problems that run in your family"). Then ask open-ended questions about the age and health of the patient's immediate family as well as the causes of death and ages of first-degree relatives

■ TABLE 5-6. Family History (Step 9)

1. General inquiry
2. Inquire about age and health (or cause of death) of grandparents, parents, siblings, and children
3. Ask specifically about family history of
 - Diabetes
 - Tuberculosis
 - Cancer
 - Hypertension
 - Stroke
 - Heart disease
 - Hyperlipidemia or high cholesterol
 - Bleeding problems
 - Anemias
 - Kidney disease
 - Asthma
 - Tobacco use
 - Drug use
 - Alcoholism
 - Weight problems
 - Mental illness
 - Depression
 - Suicide
 - Schizophrenia
 - Multiple somatic concerns
 - Symptoms similar to those the patient is experiencing
4. Develop a genogram
 - a. Two generations preceding the patient and all subsequently; involves parents, siblings, children, and significant members outside the bloodline for each generation
 - b. Age, sex, mental and physical health, and current status are noted for each; note age at death and cause
 - c. Note interactions among family members for psychological and physical/disease problems
5. Psychological
 - a. Dominant members and style (e.g., love, anger, alcoholism)
 - b. Major interaction patterns (e.g., competition, abuse, open, distant, caring, manipulation, codependent)
 - c. Family gestalt (e.g., happy, successful, losers)
6. Physical/disease
 - a. Patterns of disease (e.g., dominant, recessive, sex linked, no pattern)
 - b. Patterns of physical symptoms without disease (e.g., bowel trouble, uncoordinated, headaches)
 - c. Inquire about others with similar symptoms (e.g., infection, toxic, anxiety, anniversary reaction)

("How is your father's health?" "Your mother's health?", etc.). Patients with recent losses may exhibit emotion, which you should address with "NURS." Then list specific diseases, for example, tuberculosis, diabetes, colon cancer, breast cancer, prostate cancer, heart disease, bleeding problems, kidney failure or dialysis, alcoholism, drug and tobacco use, weight problems, asthma, and mental illness (depression, schizophrenia, multiple somatic concerns, suicide, violence) ("Thinking now about all of your relatives, does anyone have diabetes? Tuberculosis?", etc.). In the case of genetic diseases, determine if the affected family member is a blood relative; obviously this doesn't apply for infectious or environmental diseases.

Some clinicians construct a genogram to organize these data.^{63–65} Genograms can identify conditions that might be amenable to genetic testing, and help identify dysfunctional family patterns and high medical utilization. As demonstrated by Ms. Jones' genogram in Appendix D, this graphic form depicts myriad features in the family. Ages, gender, state of mental and physical health, and current status are obtained for each; when deceased, the age and cause of death are noted. Depending upon time, data can profitably be extended to include education, work, psychological style, and a host of other features for each member.

Given time and need, learn also about dominant and nondominant family members, and their specific styles, for example, controlling, passive, caring. In addition to individual psychological profiles, the interactions among family members (e.g., direct, indirect, conflicted, close) are equally important. You can also ascertain the gestalt of the family and its unique persona, for example, the patient came from a happy family or a fighting family.

Many patients link diseases in the family and their disorder ("my father had a heart attack and I've got a murmur" likely refers to different problems). Finally, especially following the death of a relative, patients worry about being at increased risk because of familial connections. To illustrate, a healthy 21-year-old woman presents with chest pain and worries about having a heart attack 10 days after her grandfather died suddenly of a myocardial infarction. Most of these symptoms relate to the patient's understandable grief and worry. While not the intent of the FH, if emotional material arises you must be supportive and address it; for example, in discussing the dates of death of her grandfather, the patient becomes sad and tearful. As before, patient-centered interviewing skills may be called upon.

With the large amount of potential data, the FH focuses on family data relevant to current problems. Beginning clinicians, however, again are urged to obtain all FH data during initial interviews in order to learn the categories themselves and the richness and variability of the FH in different people. Busy clinicians often must acquire these data over many visits, often aided by questionnaires that patients can complete beforehand.

Continuation of Ms. Jones Visit

Clinician: Well, that's a lot of information. You've sure had a lot going on (referring to the SH). We've still got a little more information to gather and need to switch now to your family because some illnesses can run in families. [The clinician continues to weave a patient-centered, respectful atmosphere into orienting comments to Ms. Jones, and is making yet another transition, now into the FH.]

Patient: That's fine.

Clinician: Are there any medical problems in your family, you know illnesses or any problems? [Focused, open-ended beginning]

Patient: Nothing really. You made me think earlier about that one aunt who had some kind of headaches.

Clinician: Besides headaches, is there anything running in the family. [The clinician makes sure Ms. Jones knows that any familial problem is being inquired about.]

Patient: Well, my grandmother had diabetes; is that what you mean?

Clinician/ Yeah, that's it. Any other diabetes in the family (no)? Tell me

Patient: if anyone in the family has any of these diseases when I mention it: tuberculosis (no), cancer (no), high blood pressure (no), stroke (no), kidney failure (no), bleeding problems (no), heart attacks (no), alcoholism (no), high cholesterol (no), tobacco use (no), drug use (no), or mental problems (no) [This helps the patient understand what is being requested; the clinician screens for a number of diseases of possible familial origin, each asked individually.]

Clinician: I need now to get some information on your immediate family, and then we'll go to your parents' and grandparents' families. Can you start by giving me the ages of your kids and your husband? [The clinician has begun getting a listing of each family member of this and the preceding two generations. This will include their ages, sex, mental and physical health, and age and year of death, as applicable. We will not recount the interview here because of space constraints but Ms. Jones' genogram is presented in Appendix D. Note the interactions among many members.]

Clinician: Well, we're just about done. Before we go on, though, how are you doing?

Patient: A little weary but I'm fine.

Clinician: I know this is a lot of questions to be asking. You've been very helpful. Anything I can do for you before we go on? [Once again, the clinician uses patient-centered skills and attends to the patient's needs.]

■ REVIEW OF SYSTEMS (STEP 10)

The review of systems (ROS) is less important than other parts of the history^{66,67}; we already have discussed the ROS in Chapter 4 as a resource that lists most symptoms; Table 4–1 has a detailed list. Indeed, by this point, the interviewer ordinarily knows everything of significance. *The ROS is not used for obtaining pertinent HPI/OAP, SH, or PMH data, rather, it serves only as a final screening tool.* Recall that the HPI and OAP are elicited after repeated inquiries of “What other concerns do you have?” and “Is there something else?” during agenda-setting (Step 2)—which means that little if any new, important, or active information should arise here. Nonetheless, relevant data are sometimes acquired; you must then fit them into the appropriate section (HPI/OAP, SH, or PMH) during the write-up or oral presentation.

The ROS concerns primary and secondary data from systems not yet considered. Here you return to the ROS and inquire about still unaddressed symptoms and any secondary data, including specific diseases such as psoriasis or cataracts.

Some patients may attempt to list each cold and upper respiratory illness they have had over the last 20 years when you are asking about nasal symptoms. Rather than obtaining details, you want to know only if the problem has caused any disability, represents a significant issue, or has not completely cleared. Refocusing patients helps, with comments such as “I don’t need all the details, but I do want to know if there have been any major problems.” Do not probe for, or encourage, symptoms except in pediatrics (see Chapter 7). Most frustrating is the patient who answers positively to most questions, exhibiting a “positive system review.” If this persists following clarification, it suggests still unrecognized diseases or, more likely, a psychological disorder such as somatization in which patients present with multiple physical concerns that have no disease explanation. This represents the patient’s expression of psychological distress through physical symptoms.

The ROS proceeds almost entirely by rapidly paced, brief closed-ended questioning after an initial, orienting question such as “I need to ask you now about any other important or current problems or symptoms you might have had, so we don’t miss something. Say yes only if the symptom has been significant problem.” For example, if the gastrointestinal system had not yet been addressed, the interviewer might begin open-endedly with “Any trouble with your digestion or bowels?” and then inquire “Have you ever had trouble with your appetite” (No); “Weight loss?” (No); “Weight gain?” (No); “Difficulty swallowing?” (No); “Nausea?” (No); and so on until all of this system has been explored. Questions of course are asked and answered individually. *When the more advanced clinician has memorized all symptoms on the ROS list, s/he is urged to obtain the ROS when performing the physical examination—as*

a time-saving device. For example, while examining the nose, ask questions about nasal symptoms, while examining the eyes, ask questions about eye symptoms, and so on. Always remain attentive to the patient's responses and needs, and tell her or him that questions are "routine" and that you have not noticed something to make you suspicious.

When the ROS is concluded, summarize briefly, ask if the patient has any questions, and indicate that the physical examination will follow. Continue a patient-centered atmosphere of courtesy, respect, and support throughout the encounter.

Continuation of Ms. Jones Visit

Clinician: I need to ask you now about some symptoms we haven't yet talked about, you know, to be sure we haven't missed something so far. Just let me know if you've had significant issues with any of the areas I mentioned. [An effective open-ended introduction to the ROS]

Patient: Fine, but I don't think there's much more.

Clinician: We haven't talked yet about any skin problems; any problems there? [An open-ended introduction to the integument system]

Patient: I thought I had some infection in my elbow once in 2000, but it turned out I'd used too strong a soap. It's cleared long ago.

Clinician/ Any problems since (no) or other skin problems like sores (no),

Patient: itching (no), rashes (no), changes in moles (no), abnormal hair growth (no), or nail problems (no)? [The clinician is getting an idea of how significant this is to Ms. Jones' current health and then completes the ROS for the integument-related system.]

Clinician: [The clinician would now proceed to other systems not yet addressed and inquire about all possible symptoms in each, as outlined in Table 4-1 of Chapter 4; for example, hematopoietic, endocrine, breasts, genital. At its conclusion, he would conclude the middle of the interview as noted next.]

Clinician: Well, you've done a nice job telling me a lot about the problems with headaches and your boss, and about the colitis. I think I have a very good picture of what's going on. Is there anything else you'd like to add? [A brief summary, understanding, support for her performance, and a patient-centered invitation for any final words.]

Patient: No, I don't think so.

Clinician: In that case, we'll move on to the physical examination. I'll step out now so you can get completely undressed. Please put this gown on with the opening in the back, have a seat on the exam table and drape this sheet over your legs. I'll be back in a few

SKILLS EXERCISES

(Likely spread over several sessions)

Note: All the following exercises are preceded by 3 to 5 minutes of patient-centered interviewing using Steps 1 to 5 with a smooth transition into Step 6. This emphasizes the integration of patient-centered and clinician-centered skills, which are not used in isolation from each other.

1. Conduct Step 6 in role play multiple times, taking from 5 to 15 minutes. Initially, use very straightforward disease problems, much as with Ms. Jones, over 5 minutes or so. As you become comfortable with developing the chronological description of symptoms (Step 6), the role play “patient” can begin to have more complicated problems, such as angina pectoris of 3 years duration but worsening over 3 weeks in conjunction with cigarette

smoking and a family history of high cholesterol. See the vignette of Ms. Jones and the video demonstration for examples.

2. When comfortable in role play, begin doing the same exercise with real or simulated patients.
3. Try to do some hypothesis-testing with each exercise. When doing role plays, have the “patient” tell you in advance what problem they will depict so you can read up on it beforehand and, therefore, have some hypotheses and relevant questions in mind to ask about.
4. Each learner performs a complete history on a family member or fellow learner. Ask all questions in each substep of Steps 6 to 10. It is recommended that you use the book or a checklist as a reminder of the many questions.

SUMMARY

Begin the clinician-centered HPI/OAP by converting the patient's concerns to symptoms from the ROS and then refining them with the symptom descriptors. Then organize primary and secondary data into chronological sequence, progressively learning to test disease hypotheses as you proceed. Use the PMH to elicit important but not current problems. The SH and FH complete the personal and, to a lesser extent, the primary and secondary data base. Finish by screening for still undetected primary and secondary data using the ROS. (This order—with minor variation—is used by clinicians throughout the world to present [in writing and verbally] the patient's history. Obtaining it in the same order will help you organize your presentations.)

By the repeated coning-down process of brief open-ended screening followed by closed-ended acquisition of necessary details, you will better understand previous personal and symptom data from the beginning of the interview and, in addition, acquire other essential parts of the data base to complete the interview. Although not now as prominent, intermittently use patient-centered interviewing skills by making supportive comments and inquiring about how the patient is doing with the process of the interview, more extensively using these skills when the patient becomes emotional or presents important, new personal data, in order to draw out the story, seek out the emotion, and respond empathically (NURS).

This completes the middle of the interview. You can now make a complete biopsychosocial description of the patient using integrated patient-centered and clinician-centered interviewing skills. By fully appreciating the patient's disease problems and the personal/emotional illness context in which they occur, you are using a scientific approach, which will benefit the patient. After obtaining further information from the physical examination, you will be ready to end the interview, as we will discuss in the next chapter.

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Step 11: The End of the Interview

The doctor of the future will give no medicine but will instruct his patient in the care of the human frame, in diet and in the cause and prevention of disease.

Thomas Edison, 1902

In the beginning and middle of the interview you gathered information from the patient and established a relationship with him/her. At some point in the interaction, usually after an appropriate physical exam and/or review of laboratory data, you need to share your impressions and engage in a conversation about the next steps of diagnosis and/or treatment. You may be tempted to educate and/or motivate patients earlier in the interview, but this vital activity is usually best done after data gathering is completed. A successful end of the interview leads to better health outcomes, because patients are more likely to understand and agree with plans and carry them out. Patients take the pills we prescribe, go for x-rays and tests, and keep their appointments. We do not do it for them. Therefore, the end of the interview is a key element in successful health outcomes.^{1–6} See also DocCom Modules 10 to 12.^{7–9}

The structure of the end of the interview depends on the needs of the patient. Consider these patients during a single clinic morning. The *first patient*, new to your care and similar to Ms. Jones, requires information on your findings from the history and physical examination, answers to questions, and diagnostic and treatment plans for the future. The *second* is a patient making a follow-up visit to discuss the results of a recent test. Unfortunately, you have discovered a life-threatening disease and you need to deliver bad news to this patient. In this case, you devote a large part of the interaction, following the interview and physical examination, to delivering the bad news and making subsequent plans. The *third* patient asks for no information but you want to discuss a topic that the patient does not ask about—the patient's

■ TABLE 6-1. End of the Interview—General Guide

1. Share information
 - a. Orient patient to the end of the interview and ask for permission to begin discussion
 - b. Frame the discussion (diagnosis, treatment, prognosis) according to the patient's perspective—ideally already elicited
 - c. Iteratively provide information using “ART loops”
 - d. Use plain language
2. Assess understanding
 - a. Ask patient to teach-back, using ART
 - b. Provide written plans/instructions
3. Invite the patient to participate in shared decision making
4. Close the visit
 - a. Clarify next steps, as necessary
 - i. What you will do
 - ii. What the patient will do
 - iii. What the time of the next communication will be
 - b. Encourage questions
 - c. Acknowledge and support

Speak as plainly as possible, avoid jargon, and give information in small chunks. Answer patient's questions, elicit and/or address patient's emotional reactions throughout the encounter.

use of tobacco. You devote the end of this interview to motivating the patient to consider quitting smoking.

The end of the interview thus involves issues stemming from either the beginning or middle of the current interview, or from a previous interview; and requires effective skills in delivering information, motivating, and sharing decisions with patients.^{10,11} The end of the interview guide that follows, outlined in Table 6-1, provides a pathway for ending most clinical interviews. Sections entitled “End of the Interview—Giving Difficult News” and “End of the Interview—Motivating Patients for Behavioral Change” describe steps for those tasks.

■ END OF THE INTERVIEW—A GENERAL GUIDE

Share Information

Orient the Patient to the End of the Interview and Ask for Permission to Begin Discussion

This can be done with a simple statement, such as, “We have about 5 minutes left; I'd like to share my thoughts about what may be causing your symptoms and then discuss where to go from here. Is that all right with you? Seeking permission before sharing information increases the patient's receptivity to it.”⁶

Frame the Discussion (*Diagnosis, Treatment, Prognosis*) According to the Patient's Perspective—Ideally Already Elicited

Sharing information with patients can be a difficult task as they often do not understand the information provided and forget up to 40% of it.¹² Equally problematic, most clinicians underestimate their patients' desire for information, especially when the patients are shy, reticent, or inarticulate. As a result, they spend very little time explaining their findings to patients.^{4,5,13–15}

Seeking permission before sharing information increases the patient's receptivity⁶: "Would it be OK if I shared my thoughts about what's causing your symptoms?" Sharing information effectively does not mean you have to turn the patient into a "mini expert" on the topic under discussion.¹⁰ Rather, provide enough information until the patient has a conceptual understanding or "gets it."¹⁰

By this time, you should have an understanding of your patient's perspective regarding the chief concern, for example, fear that a headache could be due to a brain tumor. It can be helpful to incorporate this perspective in your discussion. Depending on their expectations, health beliefs, previous experiences, or general disposition, some patients can perceive as "bad news" diagnostic data that you consider routine.^{16,17} One way to mitigate this is to deliver good prognostic information before you declare the diagnosis,¹⁸ for example, "After reviewing all the information I feel confident that we have an excellent chance of controlling your headaches. I believe you have migraine headaches, not a brain tumor, as you feared."

Clinicians have a tendency at this point to provide a "data download," which can overwhelm patients, even those with high health literacy. Derived from the motivational interviewing literature, the Academy of Communication and Healthcare has developed some better, systematic ways for providing information at the end of the interview.¹⁹ After sharing the diagnosis and before presenting details or plans, use the mnemonic ART to *Ask, Respond, and Teach*.

Ask the patient what he/she knows about the diagnosis in order to establish the patient's baseline knowledge and help you tailor your message for maximum benefit, for example, "Have you heard of migraine headaches? What do you know about them?" See also DocCom Module 10.⁷

Once you have heard the patient's answer, *Respond*, with empathy if needed, for example, "Sounds like you know a lot about this!" or, "Wow, your cousin really had a difficult time with her headaches. I can imagine that could be concerning for you"—that is, use your NURS skills.

Having a sense for the patient's *a priori* knowledge, *Tell* him/her what s/he needs to know to correct misunderstandings or fill in knowledge gaps. While giving information, speak as plainly as you can, avoiding medical jargon, for

example, saying “pain killer” instead of “analgesic” and “cancer” instead of “carcinoma.” Use clear, short statements with simple words about just one bit of data at a time. Encourage and answer questions until the patient understands the information.

Present each major piece of data about diagnosis, therapy, or prognosis with ART. These “ART loops” can turn the “data download” monologue into a dialogue, encouraging the patient’s questions and helping to ensure that the patient understands the information.

Use the steps outlined in the section entitled “End of the Interview—Giving Bad News” and Table 6-2 in the cases where you anticipate strong negative reactions to the news you are about to deliver.

Assess Understanding

Use ART to ask the patient to “teach-back” information,²⁰ for example, *Ask*, “Just to be sure we are on the same page, can you tell me what you understand so far?” or, “When you get home your spouse is going to ask, ‘What did the doctor say?’ What will you tell him?” *Respond* to the patient, for example, “You really recalled the details!” and *Tell* what is needed to correct any misunderstanding or repeat the most important messages if the patient does not mention them. “Closing the loop” in this way enhances patient understanding and adherence.²⁰ Remember to assess and address the patient’s emotional reaction(s) to the information given.

Invite the Patient to Participate in Shared Decision Making

Clinicians are increasingly expected to involve patients in decisions about their care.¹⁰ For example, the 2010 Affordable Care Act includes provisions that foster shared decision making in clinical practice. A clinician may order the right tests and prescribe the best treatments, but these will do no good if a patient is not able or willing to follow the clinician’s recommendations. Many patients are not aware that they can or should participate in decision making; so, explicitly invite patients to participate¹¹ by saying, for example, “I’d like us to make this decision together,” or “I want to make sure whatever we decide works for you; so, I want you to be sure to let me know your preferences and concerns about where to go from here.”

Some clinical decisions, such as whether or not to order a routine blood test, only require a clear statement of what you would like to do and why, for example, “I think we should check your iron level to see how much blood you have lost. Does that seem reasonable to you?” Typically, these basic decisions have clear, singular outcomes. ART can be used for other decisions, like starting a new medication, which have moderately uncertain outcomes but are

■ TABLE 6-2. Giving Difficult News

- | | |
|---|--|
| 1. Prepare yourself to give difficult news | 5. Use relationship-building skills to express empathy |
| a. Prepare emotionally | a. Monitor/address patient's emotional reaction throughout interaction |
| b. Confirm the medical facts | b. Use emotion-seeking and empathy skills (NURS) |
| c. Prepare your delivery (consider patient personality, health literacy) | c. Recognize that your presence alone can be therapeutic |
| d. Arrange proper place and adequate time | d. Convey hope while avoiding false reassurances |
| e. Determine who the patient would like to be present | e. Reassure patient of your support; that you will not abandon |
| 2. Establish what the patient (and family) already knows | f. Explore beliefs about implications of the news |
| a. Set the stage if not already done | 6. Iteratively explain and negotiate next steps |
| b. Ensure a safe, comfortable, private setting | a. Provide details as requested by the patient |
| c. Ensure patient's readiness to hear the news | b. Develop a plan for the future |
| d. Set the agenda | i. May include further testing, treatment, consultations |
| e. Address/negotiate another time for patient's unrelated concerns | ii. Schedule next follow-up telephone and/or in patient contact(s) |
| f. Assess patient's ability to comprehend the news | c. Assess/address patient safety/suicidality |
| 3. Determine how much the patient wants to know | d. Ensure support system is available, including spiritual resources. If necessary, help patient to access support |
| a. Recognize, support various patient preferences | e. Ask patient to summarize main points and next steps |
| i. Decline voluntarily to receive information | f. Correct misunderstandings. |
| ii. Designate someone to communicate on her or his behalf | g. Provide (written or taped) summary of discussion |
| b. People handle information differently | |
| i. Race, ethnicity, culture, religion, socioeconomic status, age, and developmental level | |
| 4. Deliver the news | |
| a. Start with a warning shot | |
| b. Give the news, then stop | |
| Be comfortable with silence; do not rush patient | |
| c. Give information in small chunks (categories) with appropriate transitions | |
| d. Speak as plainly as possible | |
| e. Allow patient to determine pace and flow | |
| f. Encourage/answer questions directly | |

Based on information in Buckman R. *How to Break Bad News: A Guide for Health Care Professionals*. Baltimore, MD: Johns Hopkins University Press; 1992:65–97.

not controversial. These decisions usually require discussion of alternatives with their pros and cons; for example, “We need to control your blood pressure better. We could increase the dose of your water pill or add a medication called a beta blocker. The higher dose of the water pill might make you urinate a lot but the beta blocker might make you fatigued. Are you clear about the pros and cons of these choices? What would you like to do?”¹¹

Decisions that are controversial require explanation of the associated uncertainties; again, ART can be a helpful structure.

Clinician: Ask “We should talk about your desire for a prostate-specific antigen (PSA) test. What do you know about the test?”

Patient: “It catches prostate cancer early and I’m worried about prostate cancer.”

Clinician: *Respond and Teach* “Many men are worried about prostate cancer; thanks for letting me know. Yes, the test can detect early cancers, but it can also be abnormal if you have large prostate with no cancer. Unfortunately, finding prostate cancer early is unlikely to help you live any longer, and we do know that there can be serious side effects from testing and treatment such as not being able to get an erection and leaking of urine. However, different men have different preferences, so I would like to hear your views. What questions do you have about the test?”¹¹ Regardless of the complexity of the clinical decision, be sure patient understands pertinent information and decisions by asking him/her to “teach [them] back.”²⁰

Decisions that require patients to significantly change their behaviors often require more active engagement from the clinician than just explaining and inviting patient participation. The section entitled “End of the Interview—Motivating Patients for Behavioral Change” describes a method that has been effective for motivating behavioral change in some of the most challenging patient encounters in clinical practice.^{21–23} See also DocCom Module 31.²⁴

Close the Visit

In the final moments of the encounter, ensure that the patient is clear about the next steps, has a final chance to ask questions, and that you part ways with warmth and courtesy.

Clarify Next Steps, as Necessary

Summarize the conversation and be prepared to provide a handout if necessary; be sure the patient can read and understand the written information. “We have decided that you will take one pill every morning and every evening until the bottle is empty, that will be 7 days. We also agreed that you would come back in … Here is a handout of the exercises we talked about … Do you have any problem reading it?” If necessary, have patient “teach-back”¹⁹ the discussion one last time.

A three-step process can ensure clarity: state what you will do, what the patient should do, and when the next communication will be. “I will step out to call the radiologist. When you are dressed, please go to the receptionist to pick up the instruction sheet and schedule your next appointment. I will call you as soon as the x-ray results are back.”

Encourage Questions

Give the patient a chance to ask remaining questions. It can be tempting, at the end of the encounter, to subtly discourage questions, by saying, “Do you understand?” or “Do you have any questions?” Instead be more encouraging by asking, “What questions do you have?”

Acknowledge and Support the Patient before Saying Goodbye

Warm partings, like warm greetings, lead to strong and trusting relationships. “It’s been a pleasure to be involved in your care,” “It was good to see you again,” “Please call if you think of any other questions before our next visit,” “Take care of yourself and say hello to your spouse for me.”

Conclusion of Ms. Jones Visit

Clinician: We have about 5 minutes left. If it's okay, I'd like us to talk about where to go from here. [Clinician orients patient to end of interview and asks for permission to begin discussion.]

Patient: Please go ahead.

Clinician: Well, based on your history and physical examination, I'm pretty confident that I know what is going on.

Patient: Oh good.

Clinician: I know that these headaches really were interfering with your work and that you'd become worried that they could be due to a brain tumor [incorporating the patient's perspective]. After talking with you and examining you, the good news is that I don't believe you have a life-threatening disease like a tumor or stroke. I think you have migraine headaches. Tension headache is also possible, but less likely. Do you know anything about migraines? [notice how clinician begins with good news before sharing the diagnosis. Before explaining further, the clinician tries to establish patient's prior knowledge (Ask in ART)]

Patient: Not much, but one of my coworkers mentioned it when I was telling her about my headaches. Boy I'm glad to hear that I don't have stroke or a tumor.

Clinician: I can certainly understand that. I'm glad to be able to address that concern. [Here, the clinician *Responds* to the patient and expresses empathy with an understanding and support statement.]

Patient: Me too.

Clinician: Okay, let's talk about what causes migraines; and then we can talk about what to do about it. The exact cause isn't known, but there is probably a problem with how blood vessels on your

brain react to stress and other factors. Sometimes what you eat, changes in weather, or hormones in your body can “trigger” a migraine. We will have to figure out what your other triggers are, but it certainly sounds like stress is one of them. [Clinician first indicates the topics to be discussed, and then *Teaches*, using plain language.]

Patient: [Nodding] How can we find out if I have any other triggers?

Clinician: The best way is to keep a diary of your headaches. I can give you a handout: every time you get a headache, you will write down what you ate or drank, events prior to the headache, things like that. Bring the diary to your next appointment and you and I can look to see if we can figure out what brings on the headaches. Do you think you can do that? [Clinician follows the patient's guide in iterative discussion by answering patient's questions and responding to emotions and feelings.]

Patient: I can certainly try.

Clinician: Okay, once we figure out what your triggers are, we can talk about how to avoid them. In the meantime, I have some suggestions about what to do to help the headaches. Is it okay if I talk about them now?

Patient: Yes, please, that's what I need.

Clinician: First let me say that I want to make sure we decide what's best for you; so, please let me know if you have any preferences or concerns about anything we discuss.

Patient: Okay.

Clinician: Sometimes just managing stress and knowing that you do not have a life-threatening disease can really help the headaches; so, it is reasonable to just wait and see, but I'd like to prescribe a medication that can help with the headaches if they become too frequent or unbearable.

Patient: Oh, that would be great. I'd definitely like to avoid taking pills if possible, but I like the idea of having something on hand in case I need it.

Clinician: Okay. You don't have to remember all this, because it will be written out on the pill bottle, but for the pills to work best, you will need to take one at the first sign of a headache. If the headache is not significantly improved, take another one after 2 hours.

Patient: I'm glad it will all be written down.

Clinician: Absolutely. In fact, I can send prescriptions electronically to the pharmacy right now so that they will be ready when you

get there. Which pharmacy would you like me to send it to?
(Clinician sends prescription electronically to pharmacy after explaining dosage and instructions to patient.)

Patient: Thank you.

Clinician: So, if you go home and your husband asks you what we talked about, what will you tell him? [Clinician is closing loop by inviting patient to “teach-back.”]

Patient: I have migraine headaches. They are caused by a problem with the blood vessels in my brain, but stress can make it worse ... I have to figure out what else can bring them on by keeping a diary of my headaches, activities, and what I eat. In the meantime, if my headaches become unbearable, you want me to take this medicine whenever I get a headache; but you don't want me to take more than two pills for any one headache. Is that right?

Clinician: Perfect. Now, it is important for us to see each other again in about a month to see how you are doing and go over your diary. Will you be able to come for a follow-up appointment in about a month?

Patient: Yes, that will be all right.

Clinician: Before you leave I'll give you a sheet that summarizes everything that we have talked about. It explains what a migraine is and some of the things that trigger it. It also has a headache diary for you to keep and gives some suggestions about how to relax when you are in the middle of a stressful situation. I'd like you to read it when you get home and we can talk some more about it at your next appointment.

Patient: Okay. What about my colitis?

Clinician: Thanks for bringing that up. I'd like you to sign this form to allow us to get your records from Dr. Jergens. In the meantime, our referral clerk will call you next week, after we get approval by your insurance company, to schedule an appointment with the specialist.

Patient: Okay, thank you.

Clinician: What other questions can I answer before we finish?

Patient: What are the side effects of the medicine I will be taking?

Clinician: Excellent question. A rare but significant side effect is chest pain, and you should call right away if you experience this. It is also possible to have an allergic reaction to it. This side effect is also pretty rare, but you can call me if you have any problems with it, and we can try something else.

Patient: Okay that sounds good.

Clinician: What other question I can answer for you?

Patient: No. You've explained everything very well.

Clinician: Wonderful. Just to make sure we are on the same page, can you tell me what we have agreed to do from here? [The clinician uses ART to ask the patient to "teach-back" periodically and at the end of the conversation to enhance patient recall of important information.]

Patient: Well, I'll pick up my prescription from the pharmacy and take it at the first sign of a headache. I will keep a diary and bring it to the next appointment in about a month so that we can figure out what I can do to prevent these headaches. I'll read this handout on stress management for some ideas on how to better deal with my stress. Is that right?

Clinician: Yes, very good. The only other thing is that our referral clerk will call you next week to schedule an appointment with the specialist for your colitis. [The clinician *responds* to what the patient said before *teaching* to correct misconceptions or to reinforce information.]

Patient: Oh yeah, that's right.

Clinician: Okay, I will go out and get the headache information sheet and Please bring this paperwork to the receptionist so that she can schedule your appointment and give you a token for the parking lot. I look forward to seeing you in a month. [The clinician closes the visit by stating what the clinician will do now, what the patient should do now, and when the next communication will be.]

Patient: Okay, I'll do that. Thank you very much.

Clinician: Thank you. Have a wonderful day.

Patient: You too.

END OF THE INTERVIEW—GIVING DIFFICULT NEWS

As noted above, some patients may react negatively to routine information about their health, and you may inadvertently find yourself in the middle of a "bad news" situation.^{25–27} Certain situations, such as sharing a new diagnosis of cancer, will negatively affect most patients. While we do not expect or recommend that students share difficult news with patients on their own without a more senior clinician being present for support, anyone who has mastered the skills already discussed in this book can learn to effectively deliver this news by following the steps outlined in Table 6-2.²⁵ See also DocCom Module 33.²⁸

Prepare to Give the Difficult News

First prepare yourself to be fully present with the patient. Consider how you feel about the news you are about to deliver. Clinicians who fail to attend to their own responses often are ineffective in delivering such news.²⁹ Unrecognized emotions like guilt, sorrow, identification, or fear can cause you to falsely reassure a patient, ignore her or his emotions, or avoid giving the news altogether.^{30,31}

Next, determine who needs to be informed of the difficult news. In rare cases, giving this news might be medically or psychologically dangerous, for example, if the news would increase the risk of a depressed patient committing suicide. Nevertheless, we advise against long delays in giving difficult news. Sometimes families ask that information be withheld from the patient, often to “protect” them; sometimes cultural issues are involved (e.g., in some Asian cultures, family members make health decisions with or without the patient, and the patient sometimes defers all information and decisions to the family). The clinician may accommodate a brief delay, for example, to bring a close relative home, but a postponement should not be prolonged unless the patient declines to receive the information. Patients have the right to information about themselves and they can also decline to receive it (see Step 3). Determine who else, if anyone, needs to be informed and if this person should be at the initial meeting. When the patient is young or of limited competence, a responsible person must be present. Similarly, a psychologically fragile patient or one in denial needs a responsible and supportive person present. Indeed, many benefit from the presence of a supportive person. On the other hand, if the patient does not want anyone present, accept this initially.

Review all relevant laboratory and other diagnostic tests prior to the meeting to make sure you have accurate data and that you fully understand them. Most patients will ask questions about further testing, therapeutic choices, and/or prognosis.³² Be prepared with the answers to these questions as well as questions about logistics such as which consultants to see and where/when to obtain testing. Most patients remember very little after being given bad news, so be prepared to keep answers short, simple, and tailored to patients’ needs. Before the difficult discussion, determine the important points you plan to make; you can even rehearse the key statements aloud. Incorporate information about the patient’s personality style, spiritual life, beliefs, and support system in your preparation. Be prepared to offer the patient some written information that summarizes the major points of the conversation. This will help the patient later remember the information and follow your recommendations.

Be sure to arrange a proper place and time to ensure privacy and allow enough uninterrupted time to deliver the news, address the patient’s emotions, and answer questions. A private office or room often suffices. Avoid

discussions in hallways, coffee shops, or any other place where privacy and comfort are unlikely. When bad news can be anticipated, negotiate in advance who should be present at the follow-up meeting. If advance arrangements have not been made, you can personally make them; but avoid giving bad news on the phone; say instead, “Some of your lab tests are back. They’re too complicated to talk about on the phone so, I’d like you and your wife to come in later today, to discuss them.” This sort of “message framing” sounds innocuous but may still worry the patient, so try to arrange the meeting as soon as possible and provide sufficient time.

Establish What the Patient Already Knows

Use patient-centered skills to uncover and address immediate concerns and eliminate potential barriers to communication. As with every patient-centered encounter, first set the stage by properly greeting the patient and companions and making sure the patient is ready for the conversation.

Next, set the agenda for the encounter. Indicate how much time is available and your need to discuss the health problem, and invite the patient to give his/her agenda items; for example, “We have about 20 minutes together. I want to discuss the results of your tests. Before that, though, I’d like to know whether there is something else you wanted to talk about.” Setting the agenda allows you to learn about whatever else might be going on in the patient’s life at the time that might be more important and/or more stressful than the news you are about to deliver.³³ If the patient brings up an item that is not easily addressed during the allotted time, negotiate a deferral. As you set the agenda, inquire about the patient’s expectations and specific needs for the interaction; for example, “What do you understand about your illness?” “How would you describe what is going on with your health right now?” “What did other doctors tell you about your condition or any procedures that you might have had?” “When you first developed your symptom, what did you think it might be?” Try to engage the patient in a conversation about what s/he understands about his/her condition. Determine if absent family members that the patient relies on can be brought in; reschedule if needed.

Look especially for emotions; you may discover, for example, that the patient fears anticipated bad news or has exaggerated anxiety about its implications. Alternatively, you may learn that the patient has some misinformation that needs to be corrected.

Determine How Much the Patient Wants to Know

Having established what the patient already knows about his/her condition, it is important to determine how and if the patient wants to learn about any

bad news. Many clinicians misinterpret the biomedical ethical principle of autonomy as meaning that every patient must know all relevant information about their condition, that is, become a “mini expert.”¹⁰ Autonomy means that patients can decide how much, if any, information they want to hear. Patients have various preferences regarding the amount of information they want/need, and this step, while it seems counterintuitive, allows you to determine and respect those preferences. One patient may want all the details, while another may decline to receive information, designating someone else to make decisions on his/her behalf. You can begin this discussion by asking, for example, “If this condition turns out to be serious, do you want to know?” or “Would you like to know the full details of your condition? If not, is there somebody else you want me to talk to?” or “Some people like detailed information, some people only want ‘broad brush strokes,’ and some people don’t want to know what is happening with them, but would rather their families be told. What do you prefer?”

The steps of this pathway up until now are best completed before diagnostic tests are ordered, but often in the hospital setting this is not possible and you will need to perform these steps while keeping the knowledge of the difficult news to yourself. This can be emotionally challenging, especially for clinicians early in their training. We urge you to seek out support from more experienced clinicians. It is often helpful to watch an expert share such news with a patient first, and then get support and coaching when you do so.

Deliver the Difficult News (See Also Section Entitled “Share Information”)

Based on what you learned from the prior steps, you are now able to share the news in a way that the patient prefers. It is important to prepare patients to receive difficult news, as sudden delivery may heighten the shock and prevent the patient from processing the information.³⁴ Preface by indicating that a problem exists; for example, “I’m afraid I have some difficult news for you,” “This is more serious than we thought,” “I’m afraid the news is not good.” This “warning shot” allows the patient to brace him-/herself for what is to come and lessens the shock of the news. Proceed by sharing the news, “The growth turned out to be cancer.” As always, use plain language, avoiding euphemisms and jargon, and then stop to allow the news to sink in.

Giving difficult news is often anxiety-provoking for the beginning clinical student. Many clinicians in high-anxiety situations find that silence adds to their distress and they respond by talking, in the case of difficult news by launching into a “data download” and listing treatment options and citing survival statistics. We urge you to resist the temptation and put yourself in the

patient's shoes at the moment they have been given what may be life-altering news. You and your patients will benefit from the use of engaged silence, what some label being a "non-anxious presence." Patients' responses vary widely, but they will usually give you adequate verbal and nonverbal clues as to what to do next.³⁵

Use Relationship-Building Skills to Express Empathy

While relationship-building skills are always important in interactions with patients, they are especially important in the setting of delivering difficult news. After hearing this news, many patients express emotions either verbally or nonverbally. Respond with empathy often using NURS. If emotion is not forthcoming, ask for it with emotion-seeking skills and then respond to it using NURS. As the interaction evolves, reinforce the patient's other supports, strengths, and prior abilities in dealing with adversity. Assess the impact of the news on the patient's life and the lives of others. Reassure patients that they will not be abandoned, a common and weighty fear. Silence and a quiet presence are powerful. Your own genuine emotions are appropriate and often consoling. Alleviation of suffering can be most successful when you abandon efforts to reassure and recognize there may be nothing to do but be available and provide support. You will be most effective if you can establish and develop this relationship over many encounters, as might occur in a primary care setting.

When giving the news, avoid false reassurance but still convey hope (hope for the best; prepare for the worst). For example, in sharing a new diagnosis of cancer with a patient, you might say, "I know it looks bad but treatment is working better all the time, and there's still some chance for a cure." Sometimes, though, you and your empathy provide the only immediate hope. Your presence and support (both verbally and nonverbally such as placing your arm around the patient's shoulder or holding the patient's hand) are often the first link in eventually restoring meaning and hope to the patient, "I will be here with you and for you."

Iteratively Explain and Negotiate Next Steps (See Also Sections Entitled "Share Information" and "Close the Visit")

After attending to the patient's emotions and allowing the initial shock to pass, the patient will often have questions. Indeed, difficult news interactions usually involve multiple topics (such as the patient has cancer; s/he blames him-/herself for the diagnosis; the patient needs further testing but is worried about how to pay for it; the best treatment is surgery, but the patient is afraid of surgery because sister had a complicated post-op course).¹⁶ Give only one

bit of the most important information at a time and make clear transitions between topics.

Remember to speak as simply and plainly as possible. Many patients do not understand common medical terms like “mass” or know the location of organs. Diagrams and pictures can be very helpful tools in explaining problems and diagnoses to patients. Try to avoid words like “positive,” “negative,” and “progressing” that inappropriately alarm or reassure patients because they have different connotations in nonmedical settings.

Follow the patient’s lead in deciding how far and how fast to proceed, accepting questions and listening for emotions. Patients will usually ask for more information. Give clear answers and explanations, and clarify any misperceptions or overreactions; for example, “Yes, surgery will be needed but they usually remove just the lump and not the entire breast anymore.” Gauge how well the patient is handling the information and try not to overwhelm him/her. Keep it short and simple. Most patients remember very little after being given bad news. You will find that it is often more efficient and effective to discuss details (e.g., of referrals and treatments) in a subsequent visit. Additional meetings are often necessary to allow sufficient assimilation of all information.

When the patient is ready, develop a plan for the future. Next steps may include further testing, referral, and/or treatment. Ensure that the patient has satisfactory support. This includes medical and psychological professionals as well as family, friends, church, support groups, and others. With some patients, you may need to assist in obtaining support, either because there is little of it or the patient is too overwhelmed or defeated to seek it out.

It is important to determine if the patient is suicidal. This can only be done through direct inquiry; for example, “This is a lot to throw at you and I know you’re quite down. Do thoughts of hurting yourself arise, you know, taking your life?” If you detect suicidal intent, hear more about it and ask for immediate outside help. DocCom Module 27³⁶ has more information on communicating with depressed patients.

In emotion-laden situations many people do not assimilate information well and can develop an erroneous understanding, often one that is dramatically better or worse than the actual situation. For example, a patient might erroneously expect to get better from a diagnostic test. Just asking the patient whether s/he understands what you have talked about may not uncover gaps in understanding. Instead, use ART to get a “teach-back,”²⁰ described in section entitled “Assess Understanding.” Have the patient state his/her understanding of the main points and the next steps; correct misunderstandings and reinforce key points. Even if a patient provides an accurate summary, s/he may later not recall important information and/or instructions. To offset

this, it can help to audio or video record the interaction and give the recording to the patient, or provide written material as you normally would for the end of the interview.^{37,38}

Arrange a specific follow-up visit in the very near future both to provide support and to monitor the patient for any further psychological impact of the news. Follow-up can be in person or via telephone. In the inpatient setting, you can ask if the patient would like a visit from the chaplain; you can get a sitter for the patient who is suicidal or visit the distressed patient again later that day. Psychological or medical interventions may be necessary. Prescribing specific tasks helps the overwhelmed patient; for example, listing who and how to tell the news, writing down questions, and talking to others with similar problems.

■ END OF THE INTERVIEW—MOTIVATING PATIENTS FOR BEHAVIORAL CHANGE

In addition to giving information, clinicians often have to ask patients to adopt or change behaviors in order to improve their health. This can lead to a conflicted end of the interview and jeopardize the clinician–patient relationship. Shared decision making in the clinical encounter is a prerequisite for successful behavioral change.³⁹ The transtheoretical model of change shows that behavioral modification depends on the readiness of the patient to change.² Patients in early stages of preparation need the most help in arriving at the decision to change. The clinician helps raise the issue to full awareness, encourages insight, helps patients set realistic goals that are consistent with their values, and negotiates specific plans with the patient. The skills that are outlined in sections entitled “Share Information” and “Invite the Patient to Participate in Shared Decision Making” are necessary, although not always sufficient, for motivating patients to change. The patient who has already made the decision to adopt a behavior requires support to make and maintain the change. These principles have been used to help patients adopt healthy diet and exercise programs (see DocCom Modules 16 and 25^{40,41}) and quit smoking (see DocCom Module 24⁴²), drinking (see DocCom Module 29⁴³), and abusing drugs (see DocCom Module 30⁴⁴).

We present here an evidence-based model of motivating patients that has its foundation in the patient-centered skills you learned in Chapters 2 and 3^{3,21,45} and in the principles of motivational interviewing.^{19,46,47} For the patient who is not ready to commit to change, work to maintain the relationship and keep the door open for later educational activities. You can assume that you are working with emotionally charged material. Use relationship-building skills throughout, particularly at points of resistance. You will need

■ TABLE 6-3. End of Interview—Motivating Patients

1. Education
 - a. Determine knowledge base, the patient's specific situation, and readiness for change
 - b. Clearly inform about adverse potential of health habit needing change
 - c. Make brief, explicit recommendation for change
 - d. Highlight patient's capacity for change
 - e. Emphasize that help is available
 - f. Indicate that past failures do not bode poorly
 - g. Check understanding and desire for change
2. Commitment
 - a. Declare need for commitment
 - b. Assess patient's readiness to commit
 - c. Reaffirm commitment
 - d. Manage decisions against advice
 - e. Reinforce victories great and small
 - f. NURS liberally
3. Goals
 - a. Set realistic long-term goals
 - b. Set short-term goals to operationalize long-term goals
 - c. Should be specific, behaviorally defined, limited
4. Negotiation
 - a. Medical interventions
 - b. Behavioral change
 - c. Consultations and referrals
 - d. Follow-up

a sound clinical base to effectively educate the patient. Because the specific approach to each adverse health habit is unique and varied, we have presented a general guide only. As you learn clinical medicine, you can easily fit specific clinical information into the template outlined in Table 6-3 (1). (See also DocCom Module 31.)²⁴ Use the mnemonic *ECGN* to help you remember the following steps.

Educate the Patient

Use ART loops to explain the issue and options (including doing nothing) to the patient. Assess the patient's knowledge base and readiness to change; for example, "What do you know about the health impact of cigarette smoking? Where are you in thinking about quitting?" In order for a person to change a behavior, the pros for the change must outweigh the cons.³⁹ Help the patient arrive at a realistic and meaningful understanding of the risks and benefits of the different options.

Make a clear statement of your recommendation for the desirable behavior; for example, "Your smoking is putting you at considerable risk. I'd like to see you quit." Use your knowledge of the patient's personality type (see Chapter 8 section entitled "Dimensions of the Patient that Affect the Relationship—The Patient's Personality Style") to maximize impact and to enhance the relationship. For example, cite statistics to a patient with obsessive-compulsive personality trait, for example, "research shows that smoking increases your risk of lung cancer by 10-fold, even more for cardiovascular disease; it reduces your life expectancy by 6 to 7 years. If you quit smoking now, your health will improve immediately; if you continue to be smoke-free for a year, your risk for heart attacks and strokes will be almost as though you'd never smoked; the same is true for emphysema after 2 years and cancer after 10 years"; emphasize cosmetic benefits to a patient with histrionic personality trait, "... if you quit smoking your skin will be brighter, your teeth will look much whiter, and your breath will be fresher ... I will work hard with you to prevent weight gain." Similarly, appealing to a patient with a self-defeating style that continued smoking could prevent his/her ongoing care of an ailing family member may be compelling. Emphasize interests that the habit could interfere with such as seeing grandchildren grow up, and the patient's capabilities for change, for example, "You've really done a lot at your church and are known as a doer. You could add this to your list of achievements, set a good example for many, and gain the benefit of saving a lot of money." Gauging from the patient's personality style and response to suggested interventions, you may need to be by turns a cheerleader, politician, diplomat, and/or confidant.

Use the skills outlined in sections entitled "Share Information" and "Invite the Patient to Participate in Shared Decision Making" to foster shared decision making as you educate the patient. If you use undue pressure without attending to the patient's needs and preferences, s/he is likely to resist. Keep a hopeful and positive tone; for example, "There are smokers' support groups and medications that are helpful. We've had some great results." To further encourage the patient, you can say that having failed before at changing a bad habit bodes well for future success because most successful patients have had many unsuccessful previous attempts.

Obtain a Commitment

Behavior change requires commitment from both the patient and the clinician. Signal your own commitment, for example, "I'll be working with you weekly on this if you decide to go ahead ..." and explicitly ask for commitment from the patient, "Quitting is not easy and it will require effort from both of us—are you ready to start working on this?" Trying to obtain a commitment

may be the most awkward part of the interaction; tension can lead you to be vague, indirect, or provide a loophole for escape. To someone who appears to be on the fence about changing, you might begin to obtain commitment by saying, “Are you really committed to walking … On a scale of 1–10 (Where 1 is not at all and 10 is total commitment) where would you put yourself? Why did you choose that number and not a lower one? What would it take to help you get closer to 10?”

If the patient does commit to change, support the plan and reaffirm your availability and that of other help. Praise and reinforce the decision to make a change; for example, “I’m impressed that you’re willing to work on such a big change. I know it will be hard work but I know you can do it.” Failure to do an agreed upon task is common and predictable. Patients may consent to a task because it is socially acceptable but fail to follow through because of unexpressed ambivalence that results in weak commitment. They may have difficulty disclosing the ambivalence or be unaware of it until after the visit. Maintain an empathic stance and express curiosity, for example, “We were both optimistic that you would set a quit date by the end of last month. Tell me what prevented you from doing so.” Focusing on a patient’s positive qualities when progress is fleeting or absent can be difficult, but it is essential to helping the patient to eventually succeed.

Shared decision making allows and accommodates the option that the patient may choose not to follow your advice or recommendations. Nonjudgmentally inquire about the patient’s refusal, being careful that the patient does not feel pressured or criticized, and clarify any possible misunderstandings. You can ask, “What would it take for you to change your mind?”⁴⁸ Our cigarette smoker, for example, might answer with, “Well, a heart attack or cancer, I guess.” The answer itself sometimes helps the patient realize how really dangerous the habit is and encourages behavior change.

Let the patient know that you accept and respect his/her decision. Defuse differences or tension that might interfere with subsequent care. Reassure the patient that you will neither pressure nor abandon him/her—but that you will continue to gently explore the patient’s readiness to change. One empathic technique is to express understanding of a dilemma; for example, “I can see you are caught in a bind. On the one hand, you’re tired of these chest colds and want to stop smoking. On the other hand, you enjoy smoking and find it releases stress at work. So you want both to quit and not to. That’s a real predicament!”

Help Patient Set Realistic Goals

A key component of effective behavior change is goal setting. Many chronic diseases like diabetes, cardiovascular disease, and medically unexplained

symptoms (MUS) are not curable; patients who suffer with them need to establish realistic long-term goals to keep functioning or improve functioning after setbacks. Healthy people may want to prevent disease and maintain their well-being. Dialogue about goal-setting may include statements like, "What are some of the things you would be doing if you weren't feeling so badly?" Long-term goals are realized by achieving specific, measurable short-term goals. Ask the patient, "What two or three things could you commit to doing over the next 1 to 2 weeks?" If a patient indicates that she or he would like to start exercising, ask him/her, "What exactly do you plan to do ... How many times a week will you walk ... for how long?" Review these short-term goals during subsequent visits and revise them together as needed, for example, "You thought that stretching every morning would be possible for you. What got in the way?" Write down all long- and short-term goals to help keep both you and the patient accountable.

Negotiate a Specific Plan

After goals have been set and commitment is made, you need to negotiate specific plans with the patient and understand the details of the behavior to be changed so that an effective plan can be agreed upon. In our example of the patient who smokes cigarette, you want the details of when the patient smokes, the most important times for smoking (e.g., while drinking coffee), what stresses prompt smoking (e.g., work), who else in the patient's environment smokes (e.g., best friend), and what situations might make the patient resume smoking once stopped (e.g., "having a beer with the boys"). Strategies for change must address these issues and, at the same time, be compatible with the patient's daily life.

As usual, involve the patient actively in identifying problem areas and the solutions. For example, if a cigarette smoker identifies drinking beer with his friends as a situation that leads to smoking, you can ask the patient to identify ways to either avoid or manage this potential trigger. Similarly, if a patient says that s/he wants to light up every time s/he drinks coffee, you might ask the patient what else s/he could drink or do instead of having coffee. Only the patient can find those solutions that are unique to his/her life circumstance.

With some habits, use a "step at a time" approach; for example, in initiating a low-cholesterol diet, negotiate decisions about which foods to reduce (e.g., red meats), the amount of reduction (e.g., one serving daily instead of three), and the meal from which they are reduced (e.g., breakfast). Only if the cholesterol level does not fall would further negotiation be required (e.g., further reduce red meat intake to twice weekly, and omit butter).

When applicable, negotiate medical interventions as well. For example, you may use medications for elevated cholesterol only after dietary measures

KNOWLEDGE EXERCISES

1. At what point in the interaction does patient education usually occur?
During which visit?
2. List several circumstances where providing routine data is involved; list several circumstances where you might need to give bad news; list several circumstances where you may want to not only inform the patient but also motivate them to action.
3. In which patient education category will an extra focus upon the clinician–patient relationship be most important? In addition to using NURS, what other factor(s) enhance the relationship in motivating the patient to change?

SKILLS EXERCISES

1. In role play, inform a patient of the necessary details of his/her program for several medications taken at different times of day; for example, an antibiotic, decongestant, vaporizer, and oxygen for a patient with mild (“walking”) pneumonia.
2. In role play, give a patient bad news; for example, that they have AIDS, an abnormal mammogram, an abnormal amniocentesis, an elevated blood sugar, or a cancerous-appearing lump in a chest x-ray.
3. In role play, inform and motivate a patient to stop or change a deleterious habit; for example, to stop smoking cigarettes, to change to a low-fat diet, to begin a program of progressively increasing exercise.
4. When facile in role play, conduct all exercises with real or simulated patients.

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Adapting the Interview to Different Situations and Other Practical Issues

The interview vignette with Ms. Jones that we have presented thus far in this textbook is just one example of how the patient-centered interaction between a clinician and a patient can unfold. If you have viewed the AccessMedicine companion videos or the DocCom modules, you know that the patient-centered interview can be adapted to different clinical settings and all patient encounters. In this chapter, we will provide you with more instruction and details on working with patients and situations that differ from the routine medical visit and present challenges. We will discuss how you can adjust the interview to different clinical situations. Perhaps you worry about interviewing a patient who cannot seem to stop talking, or one who it feels hard to pull information from. The skills required in these situations are used primarily in the beginning of the interview (Steps 1–5). This chapter focuses only on how you can tailor the process of the interview in various medical encounters with a variety of patients and does not consider the content that needs to be addressed in specific clinical situations. Clinical textbooks will help you obtain the details that must be incorporated into many of the encounters discussed here.¹

To aid you, we have developed several companion videos available at AccessMedicine (www.accessmedicine.com/SmithsPCI). Rather than have experts demonstrate the clinician's role, we have used resident trainees to make the videos more realistic and applicable for readers who are themselves new to interviewing. The demonstrations show what is possible after training.

■ BALANCING PATIENT-CENTERED AND CLINICIAN-CENTERED INTERVIEWING SKILLS

There is no fixed rule on how to distribute the time you have for an interview between the beginning of the interview, the middle, and the end. Based on the

patient's needs, you will determine the initial balance during Steps 1 to 5. You might average 10% of your time in the beginning of the interview for most patients, but this allocation of time can vary from 2% for, say, a patient who needs a medication refill and has no personal issues to more than 50% with, for example, a patient with severe marital problems. The balance will depend on the severity and urgency of the patient's personal issues. It may also be necessary to return repeatedly to using patient-centered interviewing skills even late in the interview.

In the beginning of the interview, the main block of controllable time lies in Step 4, continuing the HPI. Steps 1 to 3 and Step 5 usually take little time and are similar from patient to patient. Consider the following examples where we first describe patient-centered medical encounters in a variety of clinical situations and then with patients who possess various styles and characteristics.

■ ADDRESSING VARIOUS MEDICAL ENCOUNTERS AND CHALLENGES

New Inpatient or Outpatient without Urgent or Complex Personal Problems

First consider a typical new patient, like Ms. Jones, who comes to the clinician without urgent medical concerns (where immediate action is required) or complex personal problems. Physical symptom complaints often predominate and we usually devote about 10% of our time to the initial patient-centered process of the interview. This will be your experience with most new patients in a medical setting, whether inpatient or outpatient. Such patients, like Ms. Jones, have definite personal issues, yet they are not urgent or overwhelming; for example, a patient with known cancer is admitted to the hospital for chemotherapy but is more worried about his wife being home alone with the flu; an outpatient presents with a weight loss of 5 pounds and is somewhat concerned about possible cancer and wants "to be sure." The companion AccessMedicine video "New Inpatient Interview" demonstrates a typical first patient encounter in the hospital setting. In this setting, the same five steps are used. The AccessMedicine video, "Evidence-based Interviewing: Patient-Centered Interviewing" is much longer and depicts the entire patient-centered interview with extensive labeling; it involves a new outpatient and is conducted by an expert.

New Patient with Urgent or Complex Personal/Behavioral Health Problems

Some new inpatients and outpatients present with more urgent and complex personal problems; for example, acute marital discord led to sleeplessness,

depression, headaches, and diarrhea for an outpatient who requested a “checkup”; or a recent unexpected business setback immediately preceded the admission to the hospital of a now very angry man with chest pain; or a patient admitted for pneumonia who is overwhelmed and crying after being informed that his HIV test came back positive. In these instances, you will give more time to exploring personal and emotional issues by increasing time in Step 4 and, very likely, you also will spend time during the middle of the interview (especially in Steps 6 and 7) to better understand details of what could be a serious psychological problem (see Chapter 5). The companion AccessMedicine video, “Patient with a Mental Health Disorder” depicts Ms. Johnson, who comes to see her physician with vague complaints of fatigue. After development of the personal and emotional stories and through the use of NURS, her clinician learns that Ms. Johnson suffers from depression.

Follow-up Inpatient or Outpatient without Urgent or Complex Personal Problems

Just as with new patients, most follow-up (return visit) patients do not have urgent or complex personal problems but these encounters differ because they are much briefer. Consider a 5- to 15-minute follow-up visit, either in- or outpatient, for predominantly physical concerns. You progress through Steps 1 to 4 but Step 4 will be rather brief, since the patient offers no pressing personal issues or emotional burdens. You will then make a transition (Step 5) to the middle of the interview (Step 6) where you will fill in the HPI of the patient’s physical symptoms; for example, any worsening or new symptoms after treating the patient’s strep throat 1 week ago or any change from the preceding day in this inpatient’s chest pain. In both instances, you must listen for new personal contextual information (“want to get back to work,” “want to go home”) and respond empathically, yet most personal data already will be known and the patient’s symptoms will be your primary focus. The personal issues of follow-up patients frequently concern treatment and disposition; these are often addressed in the end of the interview, as we saw in Chapter 6. The companion AccessMedicine video “Follow-up Inpatient Interview” with Ms. Jones (a different Ms. Jones than the one we have gotten to know throughout this book) demonstrates using the five steps for a follow-up visit as does the vignette with a clinical student and Mr. Gomez below.

Vignette of Mr. Gomez

(Ward rounds by a clinical student on a patient with primarily physical symptoms on his second day of hospitalization with no more than 15 minutes available.)

- Student:** (Observes patient for comfort, helps with pillow, and sits down)
Hi Mr. Gomez, it's Nancy Brown. I'd like to examine you this morning (pointing to stethoscope), but before I do that, let's get a list of the concerns you want to talk about. [The student sets the stage by attending to the patient's comfort, gives her own agenda (stethoscope), and asks about the patient's agenda so that both Step 1 and Step 2 are addressed in no more than a few seconds.)
- Patient:** Nothing new.
- Student:** How are you doing with the pain? [An open-ended question to start Step 3]
- Patient:** The pain is better. Can I leave now? [The patient gives both symptom and personal data]
- Student:** Leave?
- Patient:** Yeah, to go to my job. Remember, we talked about it?
- Student:** We did talk about that, anything new?
- Patient:** No, but they still need me at work, and my wife's in a fix being alone at home with the kids.
- Student:** Well, I sure understand you're concerned about your job and that's a tough situation for your wife to be in, but there's a little more. Our (gesturing to the patient and herself) biggest concern now is to be certain you are OK and don't have an appendicitis and we aren't sure yet. [Note that, in a brief visit, the student addresses the personal issue to start Step 4, but does not reexplore what she already knows except to ascertain no change. The student also incorporates *naming, understanding, respect, and support* into her response. The response was supportive both verbally and nonverbally, involving the patient by pointing and using the terms "our" and "we."]
- Patient:** You still think tomorrow?
- Student:** Well, if the blood count and CT scan turn out OK and the pain clears up, it's possible. But we just don't know for certain yet. Our focus now is your health and getting you back to your job in good shape. Sounds difficult for you, though. [The student continues addressing personal issues in Step 4 by staying focused on the question raised by the patient and again makes a supportive statement about wanting most to help the patient, and a respect statement about how difficult this situation is.]
- Patient:** Yeah, thanks [The patient seems satisfied.]
- Student:** Let me shift now and ask you to tell me more about the pain. [This is Step 5, the transition, and a beginning of Step 6 of the middle of the interview still using open-ended requests. Note

that the student effectively conducted the patient-centered process in about 1 minute and now will address the patient's symptom in Step 6.]

Patient: Well, the pain yesterday was more around the belly button but now it's down here on the right (right lower quadrant). It hurts to push on it but isn't bad otherwise.

Student: Have you had bowel movement yet? ... [The student will spend the next several minutes determining symptom descriptors, if symptoms are changed from yesterday, and search out and define any new symptoms. She will then examine the patient, review the laboratory data, and make further plans, in conjunction with the resident and supervising physician. Steps 7 to 10 of the clinician-centered process will be unnecessary because the student obtained these data when the patient was admitted to the hospital the previous day. The student also will inform the patient that she will be back when the results of the lab tests and computed tomography (CT) scan are available. Note again how closely the patient's personal issues revolve around the symptom.]

This vignette demonstrates that a predominantly clinician-centered follow-up interaction also can address personal issues.

Follow-up Patient with Urgent or Complex Personal Problems

You may have a follow-up patient with urgent or complex personal issues, often but not always with no physical complaints. You will quickly determine this during Steps 1 to 4, and then take more time in Step 4 to better develop the personal issues, uncover emotion, and respond with NURS, resulting in a predominantly patient-centered interview. Even with no physical concern expressed by the patient, you will still make a transition to the middle of the interview and use clinician-centered skills to, for example, ask more about symptoms of depression (see Chapter 5, section entitled "Addressing a Predominantly Psychological Problem" and the companion AccessMedicine video with Ms. Johnson titled "Patient with a Mental Health Disorder"), and/or briefly inquire about the patient's physical health; for example, "Any more problems with the heartburn? The constipation?", that is, always integrating the personal and symptom data.

Vignette of Ms. Wong

(An outpatient previously seen for other problems now presents with a predominantly personal problem in a 15-minute appointment slot.)

Clinician: Hi, Ms. Wong. I haven't seen you for a while. Are you comfortable sitting there? (She nods.) Anything you need before we get started? [Step 1]

Patient: No, unless you can fix my son. He's getting a divorce. And that means the grandchildren will have to leave town. And then ... [The patient is introducing tension-laden personal material already.]

Clinician: That sounds very important. I want to hear more about it in a moment, but before we get started, I want to be sure to get a list of what you would like to talk about today, so I can be sure to address all your concerns, OK? [The clinician determines that it is appropriate, as is usually the case, to interrupt briefly and respectfully to get the agenda (Step 2).]

Patient: Well, I came because of my back. It's a little worse, and you did all those tests a year ago that were OK. I think it's the stress with my son.

Clinician: OK, the back and the stress. Is there something else? [The clinician is being certain that the entire agenda is elicited.]

Patient: No, that's enough!

Clinician: OK. So, tell me more about this stress. Sounds like a tough time for you [When the patient has already begun with strongly felt personal data, it is appropriate to return directly to the material raised to start Step 3.]

Patient: Well, my son has been married for nearly 15 years and everything always seemed OK. I think they thought so, too. And now this. My daughter-in-law is furious at him.

Clinician: (Silence) [The clinician is in the nonfocusing Step 3 and simply letting the patient lead.]

Patient: He's always been a bit of a ladies' man and, well, that's caused problems before, too.

Clinician: This sounds like it's been a tough time for you. How're you doing with all this? [Beginning to grasp the problem and recalling the need to be timely, the clinician introduces Step 4 by changing the focus to her emotions. While following the steps in sequence, one does not always need to address all substeps such as, in this example, addressing physical symptoms before proceeding to emotion. The details of the son's problem are less important also and can be developed later if necessary.]

Patient: (Starting to cry) I'm mad at him for being so stupid. And I can't stand having to be away from the grandkids. She'll get them and they'll move back to her home. (More crying)

[This story would now be developed by using, active open-ended, emotion-seeking, and empathy skills over and over in a cyclic way. Using these skills allowed Ms. Wong to admit that she'd been feeling depressed and had stopped going to her card games; she expressed worry because this is how she felt following her husband's death. We will now pick it back up to show the transition to the middle of the interview.]

Clinician: You've sure been through a lot and I'm glad you've told me about it. Do you feel OK to change gears now so I can ask a few more questions about your back? [The clinician is in Step 5 and checking to see if the patient is finished talking about this difficult problem.]

Patient: Sure, and thanks again for listening. I feel better.

Clinician: [In Step 4, the patient related that she had lost interest in a previously enjoyable activity—her card games (anhedonia) and felt depressed. She offered positive answers for depression, without having been specifically asked the depression screening questions (see Chapter 5, the section entitled “Addressing a Predominantly Psychological Problem” and the companion AccessMedicine video titled “Patient with a Mental Health Disorder”). Now, in the middle of the interview, the clinician will ask more questions to complete the diagnostic criteria for depression.] I wanted to ask about your sleep. How's that going?

Patient: Not very good.

Clinician: Tell me about it.

Patient: I just stare at the ceiling and worry! [In addition to sleep disturbances, the clinician will learn that Ms. Wong has other symptoms of depression: a poor appetite, low energy, and difficulty concentrating, further supporting the diagnosis of major depression, an urgent problem that will require treatment. The clinician then ascertains, continuing to use predominantly closed-ended inquiry, that Ms. Wong is not suicidal. We now pick up the conversation where the clinician is addressing the back pain that brought the patient in.]

Clinician: Well, that's sure been a hard time for you. Could you now say more about the backache? [One still addresses physical symptoms—however insignificant they may seem or however much the patient downplays them. Note again how closely the symptoms and personal problems often are related.]

Patient: It's the same place. And it never did go down the leg after that one time 4 years ago. I don't think it's anything ... [During the

next few minutes the clinician reviews the symptom descriptors and then examines her. When the patient has dressed, the clinician will make recommendations about the depression and the back pain.]

When a patient relates personal issues that cannot be “fixed,” it is easy to feel overwhelmed and unhelpful, but remember that communication is therapeutic. The key to successfully managing the encounter is to recognize the power of simply connecting with the patient through careful listening (which begins in Step 3), drawing out the emotional context of the personal issue, and responding empathically, using NURS (Step 4). Most often patients merely want to express their problems and receive empathic witnessing, rather than being told what to do to fix the problem. Of course, as in this case when a diagnosis such as depression is made, specific treatments can be offered such as antidepressant medications, psychotherapy, counseling, and other mental health treatments. Some mental health treatments share the quality of professional and patient emotional connection seen with patient-centered interviewing, yet they are different, more complex treatments with different processes and outcomes, and do not substitute for one another.

Disease-Prevention Visit

Patients often come without a focused, specific problem to address, yet they might want preventive screenings, frequently referred to as an “annual physical.” In this case, you will proceed in the same stepwise fashion that has been outlined. In Step 2, the patient may often want to discuss several issues, for example, flu shot, exercise program, diet, mammogram, and Pap smear. Because the patient has no particular concern and may have many agenda items, it is essential to keep asking, “What else?” or “What other concerns do you have?” until all the concerns have been elicited.²⁻⁴ It is often fruitful to ask why the patient has come in at this particular time. You might learn that some health problems have occurred in a family member or friends, or that the patient has noted some alteration in body function and wants to be sure there is nothing wrong such as cancer, high cholesterol, or diabetes. Upon eliciting this story in an open-ended manner, use the emotion-seeking skills to explore the attendant worry and anxiety. Then, you can use *naming, understanding, respecting, and supporting* (NURS), offer especially a respect statement praising the patient for coming in and working to achieve maximum health status. On the other hand, many patients simply come in for routine visits without a specific reason. In that instance, the beginning of the interview may be no

more than 1 to 2 minutes of largely agenda-setting and praising the patient for coming in. In all disease-prevention visits, much time is spent in the middle and end of the interview, using clinician-centered skills in the middle to pin down details of the patient's health-related activities; for example (a) present exercise pattern, how many minutes, how vigorous, or any related injuries; and (b) specific daily diet, understanding of caloric and fat content, interest in making major changes, and prior attempts to diet. Chapter 6 addressed how to educate and motivate patients to change harmful behaviors such as smoking. In addition, even though the patient may not have it as an agenda item, you will want to determine his/her interest in pursuing routine age-appropriate health-prevention recommendations, such as colon cancer screening, immunizations, and mammograms. During such visits, address all pertinent (to the patient's age, gender, and status) aspects of social history (Chapter 5): ethical-social-spiritual practices, functional status, health-promoting and health-maintenance activities, and health hazards.

Of course, there is a spectrum of patients between the urgent and less urgent personal categories, and there is no way to predict how many physical symptoms will be present in either category.⁵ In the difficult situation where both personal and symptom data are plentiful, urgent, and complex, careful agenda-setting (Step 2) will define what seems most important to both you and to the patient. Even so, some issues may have to be deferred to a later appointment.

Acute, Life-Threatening Medical Illness Visit

During an acute, possibly life-threatening illness visit as seen in the AccessMedicine companion video titled "Acutely Ill Patient" the clinician remains patient-centered as she addresses Mr. Green's medical issues, concerns, and fears. Patient-centered communication includes the use of touch and reassurance—no need to use all five steps during these visits. Patients require immediate medical/physical attention as they receive empathic words regarding their physical state and the state of loved ones. As seen in Mr. Green's emergency room encounter, the physician introduces herself, clarifies her role, orients the patient, provides education regarding injuries and subsequent plan, attends to comfort, and asks about his immediate emotional needs. Generally, emergency patients require care that respects, honors, and addresses patients' and families' needs, wishes, preferences, and participation in decision making. Patient-centered communication geared toward care, comfort, information and education, privacy and expectation management facilitates the patients' understanding and capacity to aid in their recovery.⁶

■ ADDRESSING COMMON PATIENT COMMUNICATION STYLES AND CHALLENGES

Even after you learn how to distribute time between the beginning, middle, and end of the interview, there are still patient communication styles and clinical situations that influence interviewing and affect how time will be spent. Patients interact with clinicians in diverse ways—some assertive, some passive, some informed, some less so, and some with communication challenges. For example, as can be seen in AccessMedicine video titled “How to Interrupt” and the section below “The Art of Interrupting,” a loquacious patient can require more time, more interruption, and less encouragement to talk than a reticent patient telling the same story. Closing the encounter can feel awkward until the art of interrupting and skillfully controlling the encounter becomes learned through deliberate practice and learned techniques. Different interactional styles are influenced by many factors, including age, gender, education level, personality style (see Chapter 8, section entitled “Dimensions of the Patient that Affect the Relationship—the Patient’s Personality Style”), and cultural upbringing (see section below entitled “Cultural Competence”). We now consider some of these unique considerations, noting that most decisions about the available time are made during Steps 1 to 5.

The Less Talkative, Reticent, Embarrassed, or Fearful Patient

It is important to get reticent patients talking, about anything, whatever it takes. Typically, the agenda items (Step 2) are limited and focused on physical symptoms, and there is little response on the patient’s part to initial open-ended inquiry (Step 3). The nonfocusing open-ended skills (silence, continuers, nonverbal encouragement) often are ineffective and, in Step 4, you must rely on the focusing open-ended skills (echoing, requests, summary) and emotion-seeking skills (direct, indirect). Among the latter, self-disclosure may be particularly effective; for example, “I once had back pain and was very frustrated, how about you?” Even though the patient may express no emotion, you can direct empathy skills toward what you do know about the patient, for example, “It sounds like some difficult problems you’ve had; you were right to come in so we can help (naming, respecting, supporting).” Or “I bet you have feelings about that tough situation.” The reticent patient will often share additional information in response.

To get the conversation going, you might need to be very explicit about what you are asking for. For example, to begin Step 3 you might normally say, “It sounds like the back pain is the most important thing for you today—tell me about it.” If the patient responds, “It hurts,” you will need to provide more detailed instructions: “Please tell me all about your back pain, from the time

it started until today, in as much detail as you can remember. This will help me to help you.” This cueing will often get a reticent patient started. The key is to not give up on your open-ended skills too quickly. Rather, rely on more actively using the focusing open-ended skills than you might in another interview. Often patients need time and experience to learn that you are interested in the symptom story. If you try all the open-ended skills repeatedly and you still cannot get much of a symptom story from the patient, then, in Step 4 ask about the patient’s symptoms using closed-ended questions, such as, “Where exactly is the back pain located?”, “Does it go down your leg?”, “Any leg weakness?” Remember though to elicit the personal context of the symptom, looking for any thread of personal data to facilitate; for example, if the patient says, “I can’t walk the dog anymore,” focus on it to get some personal conversation going and attempt to elicit the emotional context in order to respond empathically. Specifically, ask about, for example, the kind of dog and age of the dog, rather than medical symptoms.

Ordinarily, reticent patients will talk and satisfactory stories can be elicited, albeit briefer and less complete than with other patients. Symptom data are easier to obtain during the middle of the interview because you have more control of the conversation, and sometimes reticent patients offer personal data during the middle or end of the interview, seemingly warmed-up by what has preceded. For example, while giving the family history (FH) or deciding on starting an exercise program, the patient begins to talk about personal issues. Of course, you would then alter your style to become patient-centered and further develop this personal information.

Thus far, we have assumed that the personal information obtained during the beginning of the interview is the most important personal information. Indeed, that is almost always so, but such data aren’t always complete, especially around topics where patients feel embarrassed or fear others will perceive them to be abnormal; common examples include sexual practices, substance use, suicidal intent, and intimate partner violence.

Proceeding through Steps 1 to 5, you may first suspect a hidden problem, such as a story of severe depression, which causes you to wonder about suicidal intent or a story of frequent fractures, which raises the question of falls due to alcoholism or elder abuse. In fact, sometimes awareness does not become apparent until later (e.g., you observe unusual bruises during the physical exam leading you to consider intimate partner violence).

Clinician-centered interviewing skills allow you to obtain the necessary information, usually early in the middle of the interview (Step 6) although sometimes later, for example, in the past medical history (PMH) or social history (SH). Begin with a transition statement (“I want to focus now on your use of alcohol”) and follow-up with progressively more closed-ended inquiry

until all significant information is obtained. Following this format orients the patient to the interview and what is asked of him/her. The social history section of Chapter 5 (Step 8) shows the key data you should elicit about areas such as intimate partner violence or substance abuse.

Perform this inquiry sensitively, nonjudgmentally, and respectfully. Tell the patient how important this information is for you to be able to help, and reassure confidentiality. Often, the patient has some strong feelings that you must elicit with emotion-seeking skills and address using empathy skills.

We recommend using clinician-centered interviewing skills in this way whenever pertinent personal information is not obtained in the beginning of the interview. For example, if the patient does not seem to be following your treatment recommendations, you might start the middle of the interview open-endedly with a question or statement such as, "Let's talk about how you're taking each of your medicines each day," and follow-up with more narrowly focused inquiry until clarity is achieved; for example, "Let's count how many pills you have left in the container to be sure you're taking them like I think you are." Thus, clinician-centered skills that are predominantly closed-ended often are required to supplement the personal database.

Clinicians usually find it difficult to address issues that patients are avoiding and have strong feelings about. It is normal to experience fear, concern, abhorrence, or voyeuristic curiosity. If you are personally aware, you can keep these responses from interfering with your patient interaction, as we discuss in more detail in Chapter 8.

The Overly-Talkative Patient

Loquacious patients make clinicians feel overwhelmed. It is important to establish a personal and emotional focus efficiently, while redirecting the patient if conversation is either too detailed or too tangential. Talkative patients may begin without you saying anything. Developing the agenda (Step 2) typically is difficult. Nevertheless, you must develop a list of concerns, often by respectfully interrupting and refocusing frequently. Further, in Step 3 you might not even need an open-ended beginning question or statement because the patient is already giving much information. Indeed, silence alone often suffices as the patient talks on. After no more than 1 minute with a new patient (sooner with follow-up patients), you will need to get actively involved, lest you become a nonparticipant.

Some patients feel the need to recount every detail of their symptoms and concerns. This sort of over-inclusive talk can interfere with your getting personal and emotional data. You must respectfully and tactfully interrupt, refocus, and redirect, sometimes repeatedly. Summarizing what has been

said up to that point can assist a patient to move on. (“Excuse me. So, you were hurrying, slipped, and fell on the ice, and still had to go to work where you were uncomfortable sitting all day, right? Tell me more about...”) Other patients discuss issues that do not relate to themselves directly, for example, other people’s care, politics. Still others focus on remote past events with no apparent relevance to their present situation. In all instances, you will need to actively refocus the patient (Step 4) to the here and now (“The President’s health policy affects us all; can you tell me how it applies to you personally?”) and, in particular, their emotional reactions, using the emotion-seeking skills (“Those are important details, but how did that affect you, emotionally?”). Also, you can use NURS to redirect the patient; for example, “That’s been a long spell for you. I can sure understand how upsetting it might be. Thanks for giving me that background. Let’s move on now to what happened yesterday.” On the other hand, if patients are talking about themselves in the present and giving emotional data, you will want to stay with and facilitate this focus. Once such a focus is established, your task is to complete Step 4 in a timely manner. A firm, clear transition statement effectively changes focus to the middle of the interview; for example, after summarizing and using NURS, “We need to change gears now so I can ask you some questions to learn more about your constipation if that’s OK.”

Talkative patients produce plentiful personal data and you may easily obtain a long story. Because of time constraints, avoid a prolonged return to personal information if the patient reintroduces it later in the middle of the interview. The most important data usually will already have arisen. Nonetheless, if the patient expresses emotion, you must address it. Briefly listening and using empathy skills usually will suffice.

Talkative patients can seem “easy” to the student inclined to passivity and “irritating” to one who likes to take control—either way your task is to remain patient-centered as you gather relevant information. Awareness of your own personality characteristics will maximize effectiveness. In Chapter 8, we discuss further strategies for addressing your personal responses and for managing these patients.

Let’s take a moment to discuss the art of interrupting in greater detail.

The Art of Interrupting

Even though you may have been warned, “never interrupt,” interrupting is a key patient-centered skill if it refocuses the patient on *something they already have mentioned*.⁷ But, during the patient-centered portion of the interaction, you should not interrupt to change the subject raised by the patient to something not yet mentioned by him/her. As described in Chapter 2, in the patient-centered portion of the interview, the clinician only talks about

what the patient has “put on the table” for discussion—and does not bring up new topics. For example, if a patient mentions chest pain but not dyspnea (shortness of breath) or mentions his own worry but not his wife’s, it would be inappropriate to interrupt to ask, “is there any shortness of breath?” or “is your wife worried?”. On the other hand, it is very patient-centered to interrupt to focus (more accurately, refocus) on *something already mentioned* by the patient. In the example above, it is perfectly appropriate to interrupt your patient who has perhaps meandered away from describing the symptom story, the personal context, or the emotional context to say, “you’re getting ahead of me, sorry to interrupt but I’d like to get back the chest pain you mentioned,” or “excuse me, that’s important, but let’s first get back to what you mean when you say you are worried.” These are patient-centered interruptions because they simply refocus the patient on something already mentioned, typically something the interviewer believes needs further elucidation. As depicted on the AccessMedicine video “How to Interrupt” interrupting may be necessary, especially with the talkative patient, during agenda-setting, during the body of the interview when the patient gets away from something the interviewer thinks is important (often emotional material), or at the end of the interview when the interviewer needs to interrupt a talkative patient in order to end the encounter.

The sequential model (five steps) of patient-centered interviewing outlined in this text organizes the medical appointment to give the patient time and encouragement to discuss concerns as well as providing respect and understanding in an efficient manner. Patients want to be heard and you can learn ways to listen and still guide the conversation.^{8–10} Here are examples of appropriate interruptions that successfully refocus the patient in a respectful way.

- *Agenda-setting*—“Just a minute, could we go back to our list of concerns today? I want to make sure I get them all down so we cover everything you want to talk about”; “Excuse me, we’ll get back to that, but I want to make sure we get a list of all of your concerns today.”
- *During Step 4 and other times*—“Can I ask you about something you said a minute ago? It sounded important;” “We’ll get back to your medications, but you mentioned being angry, can you first say more about that.” Going back to a previously stated topic or word helps the patient to join you in the conversation, and not feel interrupted.
- *Ending the interview*—“I’m saddened to hear that your daughter’s babysitting job (patient raised a new topic) has been hard for you (respecting). Before we end our visit today (telegraphing the interaction is about to end), could you tell me which pharmacy to send your prescriptions to?”

(changing the topic). “I know, you mentioned that earlier (concern about what an x-ray technician said) and I can understand your concern, I’ll check on it for you. So, it’s time for us to stop today, I’ll see you for your next appointment in a month.”

Patients “feel interrupted” when the clinician changes topics, does not recognize that an interruption took place, or gives only a perfunctory response to a concern and then moves ahead. This is foremost with inappropriate, clinician-centered interrupting during agenda-setting. Research demonstrated that clinicians interrupt patients an average of 18 seconds after asking the patient what concerns they had, meaning that the clinician took the lead away from the patient before they got their first sentence out. Beckman and Frankel⁸ also found that when cut off early, patients often later raised the concerns—at the end of the visit. This means now needing to address the problem that should have arisen during agenda-setting, one that now must be addressed after the interview should be over.

The Stoic/Unemotional Patient

We now focus on a difficult and fortunately less common problem: when the patient seems unable to discuss the personal context of the symptoms or the emotions connected with them and persists in describing symptoms and reciting secondary data, such as results of tests s/he has had. This patient differs from “The Less Talkative, Reticent, Embarrassed or Fearful Patient” discussed above in that, the patient is not able to focus on and describe emotions—they lack words to describe feelings/emotions.

In these cases, open-ended skills may not be enough to encourage the patient to share the personal and emotional context of the situation, and you may have to actively direct the patient with emotion-seeking skills. The symptoms may be prominent, and these patients may be secretly fearful. Uncovering and empathically addressing the emotion can be therapeutic. First, summarize the symptom information and then follow immediately with emotion-seeking skills. Direct emotion-seeking (e.g., “How does that make you feel?”) is often ineffective, and indirect emotion-seeking must be used. Asking about impact (“How does this affect your life?”) can be particularly effective in getting a focus on the personal context. Then you can ask about emotion directly. Respectful interrupting often facilitates the transition as well. As with the reticent patient, the personal stories often are more truncated and less complex.

These patients can be frustrating because the interview is difficult and because they are hard to get to know personally. Simply recognizing this frustration will help you provide them the best care they will allow you to.

Vignette of Mr. Swenson

Patient: (In Steps 3 and 4, the patient has given limited descriptions of arm pain, headache, loose stools, and nausea from medication, but without expression of concern, emotion, or anything more personal. The patient also mentions a negative CT scan and Dr. Johnson's diagnosis of arteritis) [The clinician knows that s/he is going to have to work harder than usual to draw out the broader personal context of these symptoms.]

Clinician: (first summarizes the physical problems and immediately follows with this entry) Boy, you've sure had a lot of things going on. How does that make you feel, you know, emotionally? [Clinician makes a respect statement followed by a direct emotion-seeking question.]

Patient: I don't know. This pain keeps going right over here. And I've also been coughing. That started last ... (clinician interrupts) [Patient is staying with symptoms and not responding with hoped-for information about the personal impact of the symptoms; clinician interrupts quickly to try again to establish a more personal focus, otherwise the symptom focus will continue.]

Clinician: I'm sorry to interrupt, but what I'm asking about are other things, like what you think is going on. Why's all this happening? [Indirect emotion-seeking probing patient's beliefs is tried instead of repeating the direct inquiry about feelings]

Patient: Dr. Johnson says it's arteritis. It's a blood vessel disease ... (clinician interrupts) [Clinician continues to look for personal clues but none yet—will keep trying]

Clinician: But why you, why do you think you got it? [Probes for beliefs; most patients usually have some opinion about this, which will lead to personal data.]

Patient: I don't know. [The patient isn't saying much; clinician needs to use other indirect inquiry or return to direct inquiry about feelings.]

Clinician: With so much going on, how's it affected your life? [This may be a more productive indirect emotion-seeking inquiry because it forces some personal data; the patient can hardly say he doesn't know.]

Patient: Not much. I retired and wasn't doing anything anyway, until all this stuff came. That pain is right in ... (clinician interrupts) [At last, some personal data is "on the table"; the interviewer will now actively focus on this.]

Clinician: Tell me more about that, retiring and not doing much. [Combined open-ended summary and request; now that personal data have appeared, focusing open-ended skills will be used repeatedly to maintain the focus and develop the personal story, as already described. Earlier, rather than indirect inquiry about beliefs and personal impact, the clinician could also have used triggers, self-disclosure, or asked about the impact of illness on others' lives; if the patient lapses back into symptom data, these would be used now.]

Patient: Well, since I retired I don't have a regular schedule. I just sort of sit around all day watching TV—not sure what to do. Then I stay up late thinking that I will sleep in but my internal clock wakes me up at the usual 6:00 am that I am used to, but now I have nowhere to go and nothing to do. [This personal data gives clues to the adjustment difficulties the patient has encountered since retiring—biopsychosocial data. Use NURS to both demonstrate empathy and elicit more information to rule out depressive disorder vs. adjustment disorder vs. alexithymia.]

In many of the common interviewing challenges, learners can become frustrated and disappointed, either because the patient is reticent or because the patient's story lacks personal and emotional information. Learners sometimes lament they "didn't get much." Nevertheless, the patient still feels understood and a good clinician–patient relationship develops. *The amount of personal information obtained, especially emotional, is not a marker of a successful interview. Rather than measuring a good interview by getting the patient to cry or express anger, we look for successful use of the patient-centered steps, and ultimately a good clinician–patient relationship.*

■ ADDRESSING COMMON CHALLENGING COMMUNICATION SITUATIONS

Developing a patient-centered focus requires special attention when communication problems exist. A clinician may focus so much on how to communicate with a deaf, blind, or dysarthric patient that s/he can be distracted from a patient-centered approach. In these cases, it helps to pay special attention to the relationship. Nonverbal communication like touching, a well-timed smile or friendly gesture, or an accepting demeanor can be especially effective. The following section presents additional measures that can enhance data-gathering and the relationship, often focusing on setting the stage for a successful interview and attending to comfort (Step 1).

Patients Who Are Deaf or Hard of Hearing

Most common in older patients, hearing loss can cause great difficulty, and is associated with higher than normal mortality due to lower health status¹¹ and is a barrier to mental healthcare.¹² A person who is hard of hearing can still get linguistically useful information from speech, whereas a person who is deaf cannot. Certain skills can help improve communication with the patient who is hard of hearing.¹³ Ask the patient how you can best communicate, with an attitude of mutual decision making. Minimize background noise as much as you can. Sit so that your face is well lit. Be sure that the patient is looking at you before you speak. If the patient has a hearing aid, encourage the patient to use it. Use repetition, then rephrasing if the patient does not understand you. Check-in with the patient from time to time, "Am I doing a good job communicating with you? How might I be more effective?" Summarize periodically to be certain that you and the patient are getting the information right. Portable speech amplifiers, available at some clinical sites, can help you interview a patient who is hard of hearing.

People who become deaf later in life and orally educated deaf people may communicate orally by speech reading. However, physicians often overestimate the amount of words that can be lip-read (only 30%).¹⁴ The same guidelines for communicating with patients who are hard of hearing apply. Additionally, be sure that your mouth is not covered while speaking. Because the patient has learned to speech-read normally speaking people, do not slow down, shout, or over articulate your speech. Speak at a moderate rate, pitch, and volume; pause at the end of sentences; use complete sentences; and inform patients of changes in topics being discussed. Because the speech of a deaf person who communicates orally may be difficult to understand, you may need to ask the patient to repeat, rephrase, or write to ensure that you understand.

Interviewing a deaf patient who communicates with sign language requires a sign language interpreter. Use the preceding guidelines for communicating with limited English proficiency (LEP) patients and orally communicating deaf patients, with a few modifications.¹⁴ The patient and interpreter will determine the best seating arrangement, usually with the interpreter sitting next to and a bit behind the clinician. The interpreter will interpret simultaneously, in contrast to the sequential interpretation of an interpreter for LEP patients. Writing notes is not a substitute with deaf patients who do not orally communicate because American Sign Language (ASL) is its own language, with a different vocabulary and grammar than English; many deaf people who are deaf from birth or an early age may not learn English fluently.

Deaf people, particularly those who use ASL, comprise a cultural group that has its own norms and values. You are not expected to be an expert in the details of every cultural group that you encounter; instead, expressing

respectful curiosity will allow you to better understand how your patient self-identifies and how to successfully interact with him/her. You might learn that “hearing impaired” is felt to be offensive because of the term “impaired”; that people who are involved in the Deaf community and share their culture (especially the use of ASL) prefer the term “Deaf”; that lower case “deaf” refers to the audiological condition; that the term “hard of hearing” is used for others who may or may not be part the Deaf community and may have some residual hearing (i.e., individuals that have some hearing loss or those that have had oral schooling or may not know ASL). Such understanding can help to create rewarding bonds between clinician and patient, regardless of cultural differences.

Patients Who Are Blind

Persons who are blind, while communicating verbally in normal ways, use auditory cues to understand others’ mood, style, friendliness, and other features rather than depending on sight clues. Therefore, it is helpful to check-in with their perceptions; for example, you might ask, “I believe I am understanding, so far, yet I want to check with you how I’m coming across and how our interaction is going.” Barriers often include communication, including difficulty interacting with physicians and other medical staff, physical barriers in the office, and information barriers such as receiving written material in inaccessible formats.¹⁵

It is useful to inquire if the blind patient has special ways of proceeding, if s/he needs assistance, if s/he has any requests relating to her/his blindness, and not to offer unwanted help, yet this does not replace medical staff education to ensure patient-centered experience. Patients with low vision or blindness may use assistance, such as service dogs, canes, and others assisting them. Allowing the patient to take the lead and know that you are available and open to his/her needs demonstrates respect for self-sufficiency. Introduce yourself and professionals in the room, and orient the patient to furniture and doors along with your movement during the history and physical examination. Your speech quality, intensity, and pace should remain normal and not be “adjusted” for the patient who is blind, although patient education materials may offer a challenge (e.g., need for Braille or large print labels, voice-recorded instructions, etc.).¹⁵

Patients Who Are Cognitively Impaired

Persons who are cognitively impaired have challenges processing auditory or visual information. Therefore, the information they give you may be less reliable and meaningful, especially when the cognitive loss is severe.

Cognitive dysfunction is a vast topic you will learn about during clinical rotations in medicine, pediatrics, surgery, psychiatry, and neurology. Such dysfunction is common, can be acute or chronic, and may have many causes, such as congenital, head injury, dementia, brain tumor, alcohol withdrawal, drug abuse, meningitis, medications, anemia, uremia, sepsis, hypoxia, poisoning, and postoperative state. In addition, psychiatric disorders of mood, altered thinking, and abnormal mental experiences can have cognitive changes as part of their presentation, for example, schizophrenia and depression.¹⁶

Until now, we have assumed that the patient was a reliable authority for primary and secondary data. Cognitively impaired patients can vary considerably in symptom reporting with each telling and the chronology is typically unreliable. Similarly, emotions and other personal issues often are quite variable and nonreproducible. In these cases, you need to *obtain external corroboration*, often from family, caregivers, and others, while still attending to the patient's needs and the relationship. Use patient-centered interviewing skills with the family member, including empathy for the challenges caregivers often face.

Begin the interview in the usual way. With severe cognitive dysfunction, you will easily recognize the problem during Steps 1 and 2: the patient may not know where he is, that he is in a medical setting, or who is with him. He may make little sense and his story may be inconsistent. There may be additional psychiatric symptoms such as hallucinations if the cognitive changes are part of a psychiatric problem.

Mildly affected patients who remain aware that they are losing their cognitive capacities often compensate by keeping detailed notes of events and appointments to assist their failing memory, and carefully guard against showing evidence of cognitive dysfunction. Nevertheless, such loss of thinking capacity can be suspected during Steps 1 to 5 by vagaries, inconsistencies, an undue focus on familiar areas, and deft circumventing of areas where memory has failed. The patient may use humor to mask confusion and failing memory. Unlike in the case of severe cognitive impairment, you usually need to perform a systematic mental status evaluation to be certain.

The formal mental status evaluation (MSE) is summarized in Table 7-1. The MSE and the screening Mini-Cog¹⁷ MSE are presented in Appendix E. Perform the MSE as part of the middle of the interview, starting as usual with a general open-ended statement and the pinning down details using closed-ended inquiry; for example, "Tell me about your memory" (No problems), "Good, I need to ask you some specific questions so we can get the details"; then ask specific questions in the Mini-Cog or the formal MSE, shown in Appendix E. A score of less than 3 or 4 on the Mini-Cog should prompt a formal MSE (Appendix E and summarized in Table 7-1).

■ TABLE 7-1. Formal Mental Status Evaluation (See Appendix E for Details)

1. Appearance: age, physical stigmata, dress, depression, general health, cleanliness, neatness
2. Attitude: cooperative, angry, guarded, suspicious, attentive, seductive, playful, obsequious
3. Activity: increased (hyperactivity, agitation), decreased, catatonic, abnormal movements (tics, tremors), visual-motor integrity
4. Mood (sustained objective emotional feeling): sad, happy, anxious, angry, depressed, detached, irritable
5. Affect (transitory, immediate emotional expression): full, flat, blunted, inappropriate, anhedonic, labile
6. Speech: normal, slowed, reduced, increased, pressured, mute, dysarthria, punning, rhyming
7. Language: bizarre, distracting, colorful, word salad, circumstantial, tangential, loosening of associations, neologisms
8. Thought content: logical, incoherent, derailment, poverty of content, obsessive, delusional, paranoid
9. Perceptions: illusions, hallucinations (visual, auditory, olfactory, tactile), depersonalization, derealization
10. Judgment and insight: realistic, unrealistic, la belle indifference
11. Neuropsychiatric evaluation
 - a. Level of consciousness: comatose, stuporous, drowsy, alert, hyper-alert
 - b. Attention and concentration: repeating digits, serial 7's, spelling backwards, immediate memory
 - c. Language function: fluency, comprehension, naming, repetition, reading, writing
 - d. Memory: recent (orientation to time, place, and person; recall three unrelated objects); remote (past events); amnesia (retrograde, anterograde)
 - e. Other higher functions: abstraction (proverbs), calculation, intelligence

Data from Andreasen NC, Black DW. *Introductory Textbook of Psychiatry*. Washington, DC: American Psychiatric Press, Inc.; 1991:37–40.

We suggest that you complete the full MSE in all new patient evaluations during your early clinical rotations as a way of learning the content and becoming familiar with how cognitively intact and impaired patients respond. Written reports of the patient should include comments on the MSE in conjunction with the physical examination of the neurological system. Although mostly obtained during an earlier phase of your interaction, the MSE is part of the “physical examination” of the brain and its functional integrity. Interpreting the MSE requires knowledge of the various psychiatric, neurologic, and medical conditions that cause abnormalities of mental status. These details can be found in standard clinical textbooks.^{16,18}

■ PEDIATRIC PATIENTS (SEE ALSO DOCCOM MODULES 21¹⁹ AND 22²⁰)

Integrating patient-centered and clinician-centered interviewing skills applies with children and adolescents as well as adults.²¹ You still want to establish a trusting, therapeutic relationship and obtain adequate personal and symptom data, but with an emphasis on growth, development, and family interactions.^{22,23} The younger the child, the more age-related communication issues are involved: decreased ability to communicate, shorter attention span, less cognitive development, and increased dependency on parents.

For pediatric and some adolescent patients, Steps 1 to 5 are modified. Children often lack the psychological maturity to participate fully in the beginning of the interview, and you may need to rely more on clinician-centered interviewing skills.²⁴ Nevertheless, always elicit their concerns and involve them in treatment discussions and decisions.²¹ Children become increasingly autonomous as they grow older and patient-centered interviewing skills will become more effective; however, even as young children they have a right to express their perspective of their bodies and healthcare needs.²⁵ Patient-centered interviewing skills should be used in interacting with the parent, with a focus on the child's problems, but also empathizing with the impact of the child's illness on the parent.

Attend to the various steps of the interview, modifying your approach for the age and initiative of the pediatric patient. In Step 1, age-appropriate opportunities and facilities can be made available; toys, games, and small chairs can improve interactions with younger children while teens frequently do not want to sit with children or in childlike circumstances.^{22,23} Older children and adolescents can often provide their own agenda in Step 2 but parents usually formulate the issues for younger children.

The age of the child determines how Steps 3 and 4 are best carried out. Involve the parent more when the patient is a younger child. Even then, address the child first in an open-ended style and keep the child the focus of the inquiry.^{21,23} Directly interview children who can speak, irrespective of age, but keep in mind their unfamiliarity with many medical and other words.²⁵ The younger the patient, the more concrete, simple, and brief your questions should be. Always try an open-ended approach; it can be productive even in the very young. In fact, clinicians often underestimate how much information they can get from little children—"Mommy says Daddy needs to get a better job." Nevertheless, it frequently helps to initiate conversation by giving age-appropriate "menus" of topics to choose from such as inquiring about recent birthdays, school, siblings, friends, athletic events, social events, and the like in an open-ended manner.²² Get the child to talk about whatever interests

him/her. In addition, you will want to see how the child interacts with the parent and others, perhaps observing the child in the waiting room.²³ Try to interact with the child, even if briefly, without the parent present. Observe the child's behavior as well as his/her communication.

In Step 6 (completion of HPI) obtain information from child, parent, or both as already described in Chapter 5. Step 7 (PMH) and Step 8 (SH) are specialized in pediatric interviews. Because growth and development are critical, the younger the child the more detail is required about the mother's pregnancy and delivery, and the child's birth and infancy, and subsequent developmental landmarks (e.g., feeding, growth, walking, talking, toilet training, progress in school, social development). Immunization status, usual childhood illnesses, hospitalizations, poisonings, accidents, and injuries merit special attention. The SH contains information about the pertinent social aspects of the family (e.g., father's job) as well as the patient (e.g., less fighting at school and improved reading). Inquire about salient family interactions as well (e.g., ignoring a new brother, parents getting along better since mother got a new job). It might also be helpful to speak with a child's teacher to best understand the SH, especially if the child is having problems. Ensure that parents store toxic substances and medications out of reach, check that hot water temperature is no more than 125°F to prevent scalding, and use protective devices like car seats, seat belts, and bicycle helmets.²⁶ As the child ages, the interview more closely resembles that of the adult PMH and SH.

Step 9 (FH) also has a unique emphasis in the pediatric interview. The FH and genogram include the health histories of grandparents, parents, and siblings. Because genetic disorders and precursors of adult diseases frequently begin in childhood, it is important to obtain a careful genetic pedigree. The mother's health is especially important. Inquire about menses, contraception, marriages, pregnancies, and outcomes, subsequent progress of children, and plans for more pregnancies. Ascertain her feelings about her pregnancy with the patient, and learn about her physical and psychological health. Her own rearing (punishment practices, abuse) and expectations of what being and raising a child are like are germane. Assess preparedness for motherhood and look for areas where an intervention or support may be helpful; for example, she may need support to build her confidence as a mother. Similarly, inadequate father involvement is associated with poorer child health outcomes and higher infant mortality.²⁷ All parents, whether living in the child's home or not, need to be included in the child's healthcare.²⁸ With many dual-income homes, employment and the parenting relationship are important health considerations. Whether or not both parents live in the child's home, most want to be included and not marginalized.

Step 10 (review of systems [ROS]) is more important with children than adults.²² Because children have much shorter histories and because it can be more difficult to obtain pertinent symptoms during the HPI, make detailed inquiry in all systems prior to the physical examination and pay more attention to transient or “minor” complaints; for example, increased urinary frequency off and on can signify severe disease, such as a congenital genitourinary malformation.

Adolescence can be a physically and psychologically tumultuous period. Some adolescents will be perfectly comfortable with the patient-centered approach you would use with an adult, while others can be made uncomfortable and anxious by it and prefer a more structured approach, that is, transitioning to the middle of the interview sooner than you would with an adult. Prominent issues and themes that can emerge include dependency on parents, being forced to come to the clinician, conflict with parents and others, confidentiality, desire to see an “adult clinician,” obliviousness of health risks, hypochondriasis, mood changes, confusion about sexual orientation, and rebelliousness.²² It may be more important to provide support and comfort rather than obtaining open-ended information, particularly at the beginning of the relationship. Seeing the adolescent alone for at least part of the visit is often more effective and can lead to a better relationship. Being aware of various ages of consent and under which conditions parental consent/involvement necessitates a conversation with the adolescent. For instance, in some states a pregnant teenage girl can give consent for her child, but not for herself. It is important that you provide patient-centered care with the legal guidelines in mind.

■ **ELDERLY PATIENTS (SEE ALSO DOCCOM MODULE 23²⁹)**

As with pediatric patients, geriatric patients have unique issues,³⁰ particularly difficult to address because older patients often have been overlooked in research.³¹ Research provides critical information. For example, older age is a strong predictor of long-term benzodiazepine use, which predisposes older patients to falling.³² Older patients often have multiple medical problems combined with greater functional, social, psychological, and economic impairments. To understand and integrate this multiplicity of biopsychosocial problems, you will often seek the help of other professionals such as nurses, social workers, and therapists.

Setting the stage and ensuring comfort in Step 1 requires special attention. Consider your patient's comfort and pride (dentures available, hearing aids in and on, full dress), their ease of hearing and seeing, and show proper respect (use the patient's surname). During the interview, the patient may tire if the

pace is too fast and s/he does not have time to formulate responses. Your rate of speech will likely be faster than the patient is accustomed to—mindfulness of this factor can help you slow down. Check with the patient frequently to see how you are doing. In addition, the presence of friends and relatives may make the patient more comfortable and also provide information; confidentiality issues of course must be clarified.

The longer one lives, the longer one's medical history typically is. Agenda-setting in Step 2 can be difficult if there are many problems. The time available, the number of concerns, and the patient's fatigue may necessitate that you defer less pressing problems to a later visit; obtaining a full history may sometimes take two or three visits. Completion of a pre-visit history questionnaire form (and sometimes other forms assessing functional status, mental status, and psychosocial status) can be useful adjuncts that provide necessary information without overly taxing the patient.³⁰

Steps 3 and 4 usually are conducted as already described. The following can sometimes greatly facilitate the interaction: touching the patient sensitively and caringly, showing interest and patience, and addressing the older patient's priority concerns.³⁰ It can sometimes be difficult to get older patients to talk spontaneously, rather than responding to questions. It may be hard to move them from symptoms to talking about personal or emotional concerns. Nevertheless, most respond to and benefit from a patient-centered approach if you gently persist.

Some older patients tend to recite long stories about the past, posing difficulty for the interviewer. Patients often tell "old war stories" to communicate to the clinician that they were, and therefore still are, people of value and dignity.³⁰ To shift the conversation to current concerns, you must first acknowledge what the patient is trying to tell you. For example, to a patient relating his successes with a job in 1949, you might say, "That's quite an accomplishment; you sure did a lot. Thanks for telling me. We'll get back to that if we can, but let me shift gears because I am very interested in how things are going for you now."

The history of present illness/other active problems (HPI/OAP) will be longer in most elderly patients because they usually have more than one problem, their multiple problems interact, and many problems are chronic with long histories. Focus primarily on currently active problems. Falls, painful feet, incontinence, sexual dysfunction, waning memory, depression, insomnia, and decreased hearing and vision are common. Similarly, functional difficulties are increasingly common as people age: dressing, bathing, feeding, using the toilet, transferring, using a telephone, shopping, cooking, cleaning, driving, taking medications, and managing finances. Multiple losses (of function, spouses, siblings, and friends) and loneliness are prominent. There also may

be more concerns about death and disability as well as about living circumstances and remaining independent.

The past medical history (PMH—Step 7) also is apt to be extensive. Once again, focus on problems relevant to the patient's health. The social history (SH—Step 8) elicits the patient's social situation and her/his support structure. As patients age, they may lose capacity in what was previously routine, such as bathing and cooking. It is essential to learn specifically what their support structure is and how it is affecting their health (e.g., senior citizens' center, church groups, meals on wheels).

Ask if the home has been assessed for fall hazards, such as throw rugs and uneven floors. This assessment can be done during a house call or by the local visiting nurse agency.

Many elderly patients have active sexual interests and are willing and interested to talk about them.³³ They also have high rates of alcohol abuse.³⁴ Health maintenance activities are especially important but frequently ignored; it is particularly important to make a nutritional assessment for caloric excesses and deficiencies. Make sure the patient has the opportunity to discuss advance directives and end-of-life issues.

The family history (FH—Step 9) can become quite complex, and it is essential that only information that is still important to the patient's health is obtained; for example, a family history of elevated blood pressure or diabetes in an 80-year-old is of little value, but who is available to help the patient is a critical question. Similarly, the ROS (Step 10) is focused only on issues salient to the patient's health.

When More than One Person Is Present

Although the family interview³⁵ is beyond the scope of this text (see DocCom Module 20), there are other situations where the clinician involves more than one person in the interview (e.g., it is estimated that the mean rate of family accompaniment to routine older adult physician visits was about 46%).³⁶ The interviewer might decide (with the patient's consent) to consult a patient's relative or friend hoping to obtain unique information (e.g., a father giving information about his child, what happened while the patient was unconscious, information the patient has forgotten or denied). A properly conducted interview involving a relative or other third person provides information otherwise unavailable, including how the patient interacts in this relationship, for example, domineeringly, passively, distantly, angrily, or lovingly; many hours of interviewing the individual patient would be needed to provide as much "hard data" about the patient's interactional style. Perhaps the patient relates a story of great independence and achievement only to behave in a very dependent way when his/her spouse arrives. Or a person who appeared

very sensitive and considerate during the interview becomes hostile and sharp with a family member.

During Step 1, it is useful to first introduce yourself to the patient and then ask the patient who the other parties are and their relationship to the patient; then determine if both the patient and the other parties want the other parties present. Sit closest to the patient, asking others to move as needed. Next, ensure the other parties that you value their input, that you would like to begin by interviewing the patient, and that you will ask them for their information afterward. Conduct the patient interview as usual. Monitor how the third party is doing, how s/he interacts with the patient, and what effect s/he has on your learning about the patient. Weigh whether more or less information is being obtained because of the third party's presence. Although older patients are known to contribute less information when accompanied to a visit, family members often contribute missing information.³⁴ Problems can arise if the third party interrupts or nonproductively lengthens the interaction. Often, this possibility has led clinicians mistakenly to reflexively dismiss all third parties rather than productively structure the dialog placing limits on third-party input when necessary. If they are interfering, which is unusual, it is best to focus on them, obtain the information they might have, and then respectfully excuse and thank them. On the other hand, relatives and friends typically remain quiet. Involve them for points requiring clarification or at the end of the interview to see how they view the problem and how they are responding emotionally (e.g., a spouse may see the patient as at great risk for cancer while the patient denies this or ask practical questions the patient did not raise or may be far more upset than the patient). You can do this by asking if they have anything they would like to add, how they are doing with the patient's problem.

Ensuring privacy while discussing sensitive issues and during physical examination are other reasons for excusing some third parties. You should always try to have some time alone with the adult patient, especially if the patient is a woman and the accompanying person is a man. Some partners in abusive relationships can be very controlling, answering for the patient, and not wanting the patient to be alone with the clinician. Also, in some cultures, the man traditionally is more controlling. Regardless of the reason, you cannot tell whether there is abuse or not unless you have the chance to ask the patient in private. The transition to the physical examination is often a good time to say, "I must ask you to wait outside now while I do the physical examination. I will invite you back in when we are through." A patient's partner may feel more comfortable leaving if a female staffer is present as a chaperone, often required policy in clinics and hospitals. Once the partner has left, you can explore issues such as intimate partner violence and sensitive information such as sexual practices and illegal drug use.

The pressure of a group, often with an acutely ill or dying patient, is another complex and challenging interaction. If it is possible to conduct an interview with the patient, the earlier guidelines pertain. The less responsive the patient, the more important are the relatives, and the more important to identify who knows the most about the patient. Once you have attended to the patient's needs, consider your obligation to the relatives who also need to feel heard and understood. Listen to their concerns and emotions, use empathy skills, answer questions, and help find solutions. We often forget that spouses and significant others are impacted as much or more than patients themselves. Indeed, they sometimes require more empathic/NURS support than the patient.

Involving third parties usually takes little time and produces information that otherwise would not be available (on average 5 minutes³⁶). Nevertheless, the additional time required, the need to incorporate data from new sources, and having to focus on the needs of third parties do increase the demands on the clinician. Understanding your own feelings (e.g., frustration, loss of control, aggravating an already inefficient approach, strict time orientation) can help you avoid adverse, often reflexive responses such as impatience, dismissing third parties, or avoiding relatives.

Working with an Interpreter

Limited English proficient (LEP) patients report more problems and less satisfaction with their healthcare.^{37,38} Poor clinician–patient communication is often to blame, including the fact that clinicians often are less patient-centered when interacting with LEP patients.³⁸ LEP patients prefer a clinician who is fluent in the same language, especially for complicated or long-term care. However, it is possible to have an effective, satisfying, and therapeutic clinician–LEP patient relationship by using interpreters. Indeed, Title VI of the Civil Rights Act of 1964 requires providers who participate in Medicaid, Medicare, or any other federally funded program to provide oral language assistance. Professional interpreters in healthcare are held to high standards of accuracy, confidentiality, impartiality, respect, cultural awareness, role boundaries, and professionalism established by the National Council on Interpreting in Health Care (NCIHC).³⁹ If in-person medical interpreters are not available, video or telephone interpreters are usually accessible, even at remote sites,⁴⁰ and are much preferable to ad hoc interpretation by a family member or untrained staffer. If you must use a family member as an interpreter, realize that confidentiality will be an issue that may limit the patient's willingness to answer questions. All ad hoc interpreters should be advised of the requirements of their task, for example, "I'm going to speak to your mother and she to me. I need you to translate exactly what I say and exactly what she says back."

■ TABLE 7-2. Guidelines on Using Interpreters

- Recognize that, by definition, the visit will take (at least) twice as long
- Use trained interpreters whenever possible
- Ask for exact translation
- Place interpreter out of the sight-line
- Speak directly to the patient and watch her or him when interpreter is speaking
- Write down key points, instructions, and ask interpreter to transcribe for patient
- Check for comprehension by asking patient to summarize

I know you'll be tempted to add or subtract information because of what you know already but, for now, I need a precise translation only. Can you do that for me? When we are done I will be sure to ask your thoughts and answer your questions." Table 7-2 summarizes guidelines for using interpreters.

The interpreter should sit slightly behind and next to the patient, so you speak to the patient one sentence at a time, making good eye contact with the patient. Conduct the interview as you normally would; avoiding jargon, technical terms, abstractions, highly idiomatic speech, complicated sentences, sentence fragments, and changing your ideas in the middle of a sentence. Multiple questions at one time can be confusing for both the interpreter and the patient. Speak in shorter, simpler sentences so that the interpreter can communicate accurately. A professional interpreter can give you information on the patient's nonverbal reactions, their understanding, cultural interpretation, and tips on how to make the interview flow smoothly. Even with such an effort, the experience can be less fluid for patient and clinician alike. Indeed, it is helpful to acknowledge this; for example, "It may be harder for us to get to know each other, but I want you to know I'm going to work on it." Recognize that, since everything is said twice, the interview will take at least twice as long as a language concordant one. Allow for adequate time. Interviewing through an interpreter will take twice the usual time since every utterance will need to be repeated. Note that professional interpreters translate every word spoken in the examination room, even if you are speaking to the medical assistant or a colleague.³⁹ When possible, have bilingual family members complete the patient's medical history in writing on standard intake forms.

Cultural Competence (See Also DocCom Module 15⁴¹)

You may think that cultural competence is important only when working with patients who speak a different language or who come from a different country, but every interaction between clinicians and patients is an intercultural encounter.³⁷ Even if you and your patient have similar backgrounds, the

patient is from the culture of patient and you are from the culture of clinician. How does your patient want to be treated? The golden rule ("Do unto others as you would have them do unto you") is unlikely to give you an answer. The "platinum rule" is more helpful: "Do unto others as they would have you do unto them." Cultural competence requires cultural humility—the willingness to learn from patients how they would like you to interact with them.³⁷

While the patient-centered interviewing skills discussed in this book can be useful in any medical encounter, additional knowledge, skills, and attitudes can benefit clinicians who care for patients from different cultures. Culture can be defined as, "Ideas, beliefs, values and assumptions about life, created by people and transmitted across generations, that are widely shared among a group of people and guide behavior."⁴²

The first step in improving interactions with others is to understand your own culture. One's own values are cultural blind spots until understood.⁴³ For example, many clinicians value punctuality and, as "time people," they may get irritated with "event people," for whom what is happening now is more important than artificial time constraints. Another example is the value placed by dominant American culture on individuality and self-actualization. Clinicians can become frustrated when caring for a patient from one of the many cultures that value reliance on family overreliance on self, because our dominant biomedical ethical principle, autonomy, may not be dominant for the patient.

After understanding your own culture and culture-bound values better, we urge you to learn about the cultures frequently encountered in your hospital or clinic, specifically the members' values, beliefs about health and illness, and folk illnesses.⁴⁴ In addition to asking local cultural representatives, you can access resources with cultural information.^{45–47} A danger of relying solely on lists of cultural values and beliefs is generalizing them to all members of a cultural group. Cultures can consist of subgroups (e.g., Latinos include Puerto Ricans, Mexicans, Dominicans, Cubans, and others) with widely different beliefs. Cultural beliefs are also, in part, affected by socioeconomic status, education, level of acculturation, and English language proficiency.

Respectful curiosity and sensitive inquiry can help determine a patient's culturally mediated health beliefs. Kleinman⁴⁸ recommends specific questions (Table 7-3). This knowledge can be critical to negotiating a treatment plan that the patient will adhere to. In follow-up visits, specifically inquire about medication side effects, concerns, and the patient's belief about medication effectiveness. For example, in some cultures the shape or color of pills is believed to indicate their potency. Failing to understand this belief can lead to poor adherence and outcomes.

Health disparities exist among different races, ethnicities, gender identities, and sexual orientations and those with limited English proficiency.

■ TABLE 7-3. Determining Patients' Explanatory Model

- What do you call this problem?
- What do you believe is the cause of this problem?
- What course do you expect it to take? How serious is it?
- What do you think this problem does inside your body?
- How does it affect your body and your mind?
- What do you most fear about this condition?
- What do you most fear about the treatment?

Based on information in Kleinman A. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York, NY: Basic Books; 1988.

“Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual’s ability to achieve good health.”^{49,50} Because all of us operate on various assumptions within our careers and personal lives, you may want to learn more about your own implicit assumptions by taking an Implicit Assumption test at <http://projectimplicit.net/index.html>.⁴⁹

■ UNIQUE ISSUES FOR THE NEW LEARNER

How Much Time Does the Interview Take?

Learners in the first clinical year (e.g., third year of medical school) are usually required to obtain complete histories from new patients, often inpatients. Beginning clinical learners can ignore the need for efficiency. As experience accumulates, efficiency follows. Initially, the beginning of the encounter (Steps 1–5) takes at least 15 minutes; the middle of the interview (Steps 6–10) can take up to 30 minutes; physical examination will take another 30 minutes or more at the outset; learners must carefully attend to the patient’s comfort and sometimes may have to return at a later time to complete the evaluation if the patient tires. The learner then reads, discusses, synthesizes data, obtains data from other sources, plans and analyzes diagnostic interventions, participates in treatment decisions—and may again interview the patient to focus the differential diagnosis.

By graduation or certification, you should be able to conduct a full interview in less than 60 minutes and by completion of residency and with experience, in 20 minutes or so. New patients typically receive 40- to 60-minute appointments in residents’ and advanced students’ clinics. Follow-up visits with both inpatients (ward rounds) and outpatients (clinic visits) typically involve patients you know and should range from 10 to 30 minutes.

Taking Notes

During the beginning of the interview (Steps 1–5), you can unobtrusively jot down a few pertinent words or dates. This helps when the patient is giving the chronology of his/her chief concern. Nevertheless, avoid any excessive break in eye contact, so as not to disrupt the flow of information. You will be surprised how much of the patient's story you can remember, because you heard it as a story.

During the middle of the interview, the patients tends to respond with isolated facts, rather than a narrative, and so most physicians take notes, sometimes quite extensive, but still keep the primary focus on the patient. In Chapter 10 we discuss how to use electronic health records during the encounter.

Recording of Interviews

You may have been introduced to using and critiquing audio or video recording during initial instruction in patient-centered interviewing skills (Steps 1–5). Because the interview is a core skill, it is important to continue recording interviews on your own, much as musicians or athletes hone their most important skills daily. Self-critique and input from your peers or supervisors lead to continuing improvement.

Inexpensive audio recorders or your cell phone can be used with minimal inconvenience and great benefit. Inform patients that recording is confidential and that it will be erased when its use is completed; you should of course inform patients if others will be listening to the recording and who they are. In getting permission to record, you benefit from patients' usual willingness to help; for example, "Before we get started talking, I'd like to ask your help. I'm interested in improving my communication skills and would like to record our interaction. I (and my instructor—or my group) will listen to it afterward to see how I could have communicated better. Nobody else will hear it. Then we'll erase it. Your medical care will not be affected whether you agree to the interview or not. This is purely for my training. If during the interview, you change your mind I will erase the recording immediately." Patients rarely refuse. Recording Steps 1 to 5 is especially important—to critique your patient-centered interviewing skills and transition into the middle of the interview.

Clinical Conduct

Many of our students and residents have debated which behaviors and attitudes are appropriate in the clinical encounter and, in many discussions, generated the guidelines presented here. These suggestions are not intended to be comprehensive, however.

There is consensus that the *behaviors listed in Table 7-4 are the most important.*

■ TABLE 7-5. Harmful Clinician Behaviors

- Drinking any beverage or eating
- Chewing gum or a toothpick
- Swearing
- Behaving seductively or making sexual remarks or jokes
- Poor personal hygiene
- Uncomfortable joking or teasing
- Expressing personal opinions about others
- Going beyond appropriate self-disclosure to discuss one's own problems
- Making judgments that imply good or bad about the patient or others

Our students and residents believe the *behaviors listed in Table 7-5 are seldom if ever appropriate when with the patient.*

Our discussions with learners addressed other difficult issues. While certainly wanting to avoid seductive behavior, what is the role of touching the patient outside the physical examination? The students and residents generally agreed that this was appropriate but only if it felt comfortable to the student or resident, was motivated out of genuine personal concern, and would appear professional. Although hugging or putting one's arm around a well-known patient can be appropriate and professional, they preferred more limited touching, for example, a pat on the back or arm.

What sort of conversation should one conduct during the physical examination, especially during the more tension-laden portions, for example, pelvic, breast, genital, or rectal examination? All agreed that calm, confident discussion of what one is doing and why is appropriate, while attending to the patient's experience and comfort. Inquiry about symptoms and problems in the areas being examined also defuses tension. The clinician can explain self-examination and other preventive techniques, for example, during breast examination, instructing a woman in self-examination.

■ **EFFECTIVE CLINICIAN–PATIENT RELATIONSHIP AS TREATMENT**

As noted already, this book is not intended to outline specific treatments for medical conditions. Nevertheless, it merits comment that you now have two powerful therapeutic tools at your command. *Expressing empathy (NURS) and being present with the patient in times of difficulty, whether physical or psychological, are highly therapeutic in and of themselves.* In this way, the clinician is the medicine. These skills are key determinants of the clinician–patient relationship.⁵¹

Clinicians may believe that they have nothing to offer patients who are beyond hope medically and/or surgically (e.g., terminal cancer) or who have no disease explanation for their physical symptoms (medically unexplained symptoms), but we know that being with patients in a supportive way and using empathy (NURS) are highly effective, from a humanistic and scientific perspective. Even for the many patients whose diseases respond to biomedical treatments, there is good evidence that the relationship contributes significantly to their health outcomes and satisfaction. We invite you to read an in-depth explanation of this effect in Appendix B. We have come full circle: these are the benefits that accrue from being patient centered—and you now know how to achieve them!

■ **SUMMARY**

In the clinic or at the bedside, the advanced clinician makes key practical decisions during Steps 1 to 5. These decisions fine tune the interview as required for a particular patient: for patients who are reticent, talkative, focused on biomedical material, or in for a routine exam; when the personal context is not offered in the beginning of the interview; when more than one person is present; for patients with communication problems (hard of hearing, deaf, blind, cognitively impaired); and for pediatric and geriatric patients. Interviewing issues unique to the clinical student include taking sufficient

SKILLS EXERCISES

1. To get the feel for short patient-centered interactions, practice (in role play) using all five steps in 2 to 3 minutes. Touch all five steps but don't worry about each substep, except in Step 4 be sure to always start with eliciting the symptom story, switch to the personal context, and end up with the emotional context and NURS.
2. When you are comfortable with question #1, try omitting some of the substeps; for example:
 - a. Ignore physical symptoms in an emotion-laden situation; ignore personal data in same situation; in each case proceed directly to NURS and rely upon that as your sole patient-centered activity;
 - b. In a low-key emotional situation but with many serious medical problems, use just NURS even though the patient has little or no emotion.
3. When you have mastered questions #2 and #3 in role play, do the same with real or simulated patients.
4. Perform an in-depth patient-centered interview, lasting 15 to 20 minutes, with a patient who has significant personal issues. The key here is in Step 4 where you keep using the cycle of skills to develop chapter after chapter of the patient's story.
5. In role play or with patients, practice Steps 1 to 5 in the following circumstances: reticent patient, talkative patient, deaf patient, using an interpreter, blind patient, pediatric patient, geriatric patient, patient with a terminal disease, with a relative present, with a demented patient.

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