

Interviewing and the Health History

The health history interview is a conversation with a purpose. As you learn to elicit the patient's history, you will draw on many of the interpersonal skills that you use every day, but with unique and important differences. Unlike social conversation, in which you can freely express your own needs and interests and are responsible only for yourself, the primary goal of the clinician–patient interview is to improve the well-being of the patient. At its most basic level, the purpose of conversation with a patient is threefold: to establish a trusting and supportive relationship, to gather information, and to offer information.^{1–3}

Relating effectively with patients is among the most valued skills of clinical care. As a beginning clinician, you will focus your energies on gathering information. At the same time, by using techniques that promote trust and convey respect, you will allow the patient's story to unfold in its most full and detailed form. Establishing a supportive interaction helps the patient feel more at ease when sharing information and itself becomes the foundation for therapeutic clinician–patient relationships.⁴ Because illness can make patients feel discouraged and isolated, “A feeling of connectedness with the doctor, of being deeply heard and understood, reduces this feeling of isolation and despair. This feeling is the very heart of healing.”⁵

This chapter introduces you to the essentials of interviewing. It emphasizes the approach to gathering the health history, but covers all the fundamental habits that you will continually use and refine in your conversations with patients. You will learn the guiding principles for skilled interviewing and how to forge trusting patient relationships. You will read about preparing for the interview, the sequence of the interviewing process, important interviewing techniques, and strategies for addressing various challenges that may arise in patient encounters. To help you navigate this journey, look over the Interviewing Milestones, on the next page, that mark the complex tasks of a skilled interview.

As a clinician facilitating the patient's story, you will come to generate a series of hypotheses about the nature of the patient's concerns. You will then test these various hypotheses by asking for more detailed information. You will also explore the patient's feelings and beliefs about his or her problem. Eventually, as your clinical experience grows, you will respond with your



Interviewing Milestones

Getting Ready: The Approach to the Interview

Taking time for self-reflection. Reviewing the chart. Reviewing your clinical behavior and appearance. Adjusting the environment. Taking notes.

Learning About the Patient: The Sequence of the Interview

Greeting the patient and establishing rapport. Inviting the patient's story. Setting the agenda for the interview. Expanding and clarifying the patient's story. Creating a shared understanding of the patient's concerns. Negotiating a plan. Following up and closing the interview.

Building the Relationship: The Techniques of Skilled Interviewing

Active listening. Guided questioning. Nonverbal communication. Empathic responses. Validation. Reassurance. Partnering. Summarization. Transitions. Empowering the patient.

Adapting Your Interview to Specific Situations

The silent patient. The confusing patient. The patient with impaired capacity. The talkative patient. The angry or disruptive patient. Interviewing across a language barrier. The patient with low literacy. The deaf or hard-of-hearing patient. The blind patient. The patient with limited intelligence. The patient seeking personal advice.

Sensitive Topics that Call for Special Skills

The sexual history. Mental health. Alcohol and drug use. Family violence. Death and dying.

Societal Aspects of Interviewing

Achieving cultural competence. Sexuality in the clinician–patient relationship. Ethical considerations.



understanding of the patient’s concerns. Even if you discover that little can be done, encouraging the patient to discuss the *experience of illness* is itself therapeutic, as shown by the words below from a patient with long-standing and severe arthritis:

The patient had never talked about what the symptoms meant to her. She had never said: “This means that I can’t go to the bathroom by myself, put my clothes on, even get out of bed without calling for help.”

When we finished the physical examination I said something like: “Rheumatoid arthritis really has not been nice to you.” She burst into tears, and her daughter did also, and I sat there, very close to losing it myself.

She said: “You know, no one has ever talked about it as a personal thing before. No one’s ever talked to me as if this were a thing that mattered, a personal event.”

That was the significant thing about the encounter. I didn’t really have much else to offer. . . . But something really significant had happened between us, something that she valued and would carry away with her.⁶

As you can see from this story, the *process* of interviewing patients requires a highly refined sensitivity to the patient’s feelings and behavioral cues and is much more than just asking a series of questions. This process differs significantly from the *format* for the health history presented in Chapter 1 (p. 5). Both are fundamental to your work with patients but serve different purposes:

- The *health history format* is a structured framework for organizing patient information in *written or verbal form* for other health care providers; it focuses the clinician’s attention on specific kinds of information that must be obtained from the patient.
- The *interviewing process* that actually generates these pieces of information is much more fluid and demands effective communication and relational skills. It requires not only knowledge of the data that you need to obtain but also the ability to elicit accurate information and the interpersonal skills that allow you to respond to the patient’s feelings and concerns.

Underlying the new interviewing skills that you will learn is a mindset that allows you to collaborate with the patient and build a healing relationship.

Different Kinds of Health Histories. As you learned in Chapter 1, the kinds of information you seek varies according to several factors. The scope and degree of detail depend on the patient’s needs and concerns, the clinician’s goals for the encounter, and the clinical setting (e.g., inpatient or outpatient, amount of time available, primary care or subspecialty).

- For new patients, regardless of setting, you will do a *comprehensive health history* described for adults in Chapter 1.

- For other patients who seek care for specific complaints (e.g., cough, painful urination), a more limited interview tailored to that specific problem may be indicated, sometimes known as a *problem-oriented history*.

In a primary care setting, clinicians frequently choose to address issues of health promotion, such as tobacco cessation or reduction of high-risk sexual behaviors. A subspecialist may do an in-depth history to evaluate one problem that incorporates a wide range of areas of inquiry. Knowing the content and relevance of all the components of a comprehensive health history enables you to select the kinds of information most helpful for meeting both clinician and patient goals. Be assured that you will fully gain the knowledge of what types of information to pursue, and when to pursue them, as you deepen your clinical experience.

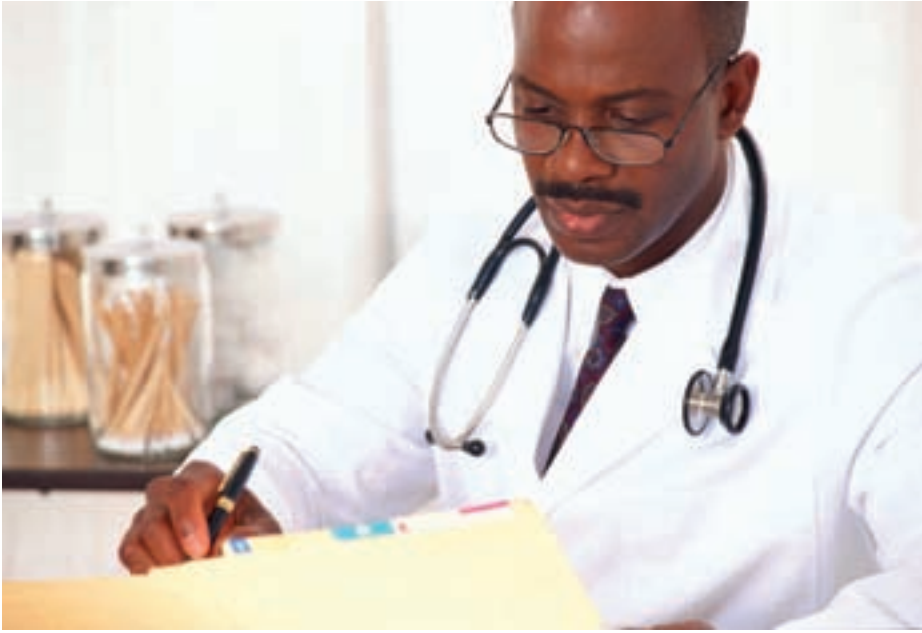


GETTING READY: THE APPROACH TO THE INTERVIEW

Interviewing patients requires planning. You are undoubtedly eager to begin your relationship with the patient, but first consider several steps that are crucial to success: taking time for self-reflection, reviewing the chart, setting goals for the interview, reviewing your behavior and appearance, adjusting the environment, and being ready to take brief notes.

Taking Time for Self-Reflection. As clinicians, we encounter a wide variety of individuals, each one unique. Establishing relationships with people from a broad spectrum of age, social class, race, ethnicity, and states of *health or illness* is an uncommon opportunity and privilege. Being consistently respectful and open to individual differences is one of the clinician's challenges. Because we bring our own values, assumptions, and biases to every encounter, we must look inward to clarify how our own expectations and reactions may affect what we hear and how we behave. *Self-reflection is a continual part of professional development in clinical work. It brings a deepening personal awareness to our work with patients, which is one of the most rewarding aspects of patient care.*

Reviewing the Chart. Before seeing the patient, review the medical record or chart. Doing so helps you gather information and plan what areas you need to explore with the patient. Look closely at identifying data such as age, gender, address, and health insurance, and peruse the problem list, the medication list, and details such as the documentation of allergies. The chart often provides valuable information about past diagnoses and treatments, but do not let the chart prevent you from developing new approaches or ideas. Remember that information in the chart comes from different observers and that standardized forms reflect different institutional norms. Moreover, the chart is not designed to capture the essence of the unique individual you are about to meet. Data may be incomplete, or even disagree with what you learn from the patient—understanding such discrepancies may prove helpful to the patient's care.



Setting Goals for the Interview. Before you begin talking with the patient, it is important to clarify your goals for the interview. As a student, your goal may be to obtain a complete health history so that you can submit a write-up to your teacher. As a clinician, your goals range from completing forms needed by health care institutions to following up on health care issues to testing hypotheses generated by your review of the chart. *A clinician must balance these provider-centered goals with patient-centered goals.* There can be tension between the needs of the provider, the institution, and the patient and family. Part of the clinician's task is to consider these multiple agendas. By taking a few minutes to think through your goals ahead of time, you will find it easier to strike a healthy balance among the various purposes of the interview to come.

Reviewing Your Clinical Behavior and Appearance. Just as you carefully observe the patient throughout the interview, the patient will be watching you. Consciously or not, you send messages through both your words and your behavior. Be sensitive to those messages and manage them as well as you can. Posture, gestures, eye contact, and tone of voice all convey the extent of your interest, attention, acceptance, and understanding. The skilled interviewer seems calm and unhurried, even when time is limited. Reactions that betray disapproval, embarrassment, impatience, or boredom block communication, as do any behaviors that condescend, stereotype, criticize, or belittle the patient. Although these types of negative feelings are at times unavoidable, as a health care professional, you must take pains not to express them. Guard against these feelings not only when talking to patients but also when discussing patients with your colleagues.

Your personal appearance also affects your clinical relationships. Patients find cleanliness, neatness, conservative dress, and a name tag reassuring. Remem-

ber to keep *the patient's perspective* in mind if you want to build the patient's trust.

Adjusting the Environment. Try to make the interview setting as private and comfortable as possible. Although you may have to talk with the patient under difficult circumstances, such as in a two-bed room or the corridor of a busy emergency department, a proper environment improves communication. If there are privacy curtains, ask permission to pull them shut. Suggest moving to an empty room instead of talking in a waiting area. *As the clinician, it is part of your job to make adjustments to the location and seating that make the patient and you more comfortable.* These efforts are always worth the time.

Taking Notes. As a novice, you will need to write down much of what you learn during the interview. Even though experienced clinicians recall much of the interview without taking notes, no one can remember all the details of a comprehensive history. Jot down short phrases, specific dates, or words rather than trying to put them into a final format, but do not let note-taking or written forms distract you from the patient. Maintain good eye contact, and whenever the patient is talking about sensitive or disturbing material, put down your pen. Most patients are accustomed to note-taking, but for those who find it uncomfortable, explore their concerns and explain your need to make an accurate record.

LEARNING ABOUT THE PATIENT: THE SEQUENCE OF THE INTERVIEW

Once you have devoted time and thought to preparing for the interview, you are fully ready to listen to the patient, elicit the patient's concerns, and learn about the patient's health. In general, an interview moves through several stages. *Throughout this sequence you, as the clinician, must always be attuned to the patient's feelings, help the patient express them, respond to their content, and validate their significance.* A typical sequence follows.

The Sequence of the Interview

- Greeting the patient and establishing rapport
- Inviting the patient's story
- Establishing the agenda for the interview
- Expanding and clarifying the patient's story
- Generating and testing diagnostic hypotheses
- Creating a shared understanding of the problem
- Negotiating a plan (includes further evaluation, treatment, and patient education)
- Planning for follow-up and closing the interview

As a student, you will concentrate primarily on gathering the patient's story and creating a shared understanding of the problem. As you become a practicing clinician, reaching agreement on a plan for further evaluation and treat-

ment becomes more important. Whether the interview is comprehensive or focused, you should move through this sequence with close attention to the patient's feelings and affect, always working on strengthening the relationship.

Greeting the Patient and Establishing Rapport. The initial moments of your encounter with the patient lay the foundation for your ongoing relationship. How you greet the patient and other visitors in the room, provide for the patient's comfort, and arrange the physical setting all shape the patient's first impressions.

As you begin, *greet the patient* by name and introduce yourself, giving your own name. If possible, shake hands with the patient. If this is the first contact, explain your role, including your status as a student and how you will be involved in the patient's care. Repeat this part of the introduction on subsequent meetings until you are confident that the patient knows who you are: "Good Morning, Mr. Peters. I am Susannah Martinez, a third-year medical student. You may remember me. I was here yesterday talking with you about your heart problems. I am part of the medical team taking care of you."

Using a formal title to address the patient (e.g., Mr. O'Neil, Ms. Washington) is always best.^{7,8} Except with children or adolescents, avoid first names unless you have specific permission from the patient or family. Addressing an unfamiliar adult as "granny" or "dear" can depersonalize and demean. If you are unsure how to pronounce the patient's name, don't be afraid to ask. You can say: "I am afraid of mispronouncing your name. Could you say it for me?" Then repeat it to make sure that you heard it correctly.



When visitors are in the room, be sure to acknowledge and greet each one in turn, inquiring about each person's name and relationship to the patient. Whenever visitors are present, *you are obligated to maintain the patient's confidentiality*. Let the patient decide if visitors or family members should remain in the room, and ask for the patient's permission before conducting the interview in front of them. For example, "I am comfortable with having your sister stay for the interview, Mrs. Jones, but I want to make sure that this is also what you want" or "Would you prefer if I spoke to you alone or with your sister present?"

Always be attuned to the patient's comfort. In the office or clinic, help the patient find a suitable place for coats and belongings. In the hospital, after greeting the patient, ask how the patient is feeling and if you are coming at a convenient time. Arranging the bed to make the patient more comfortable or allowing a few minutes for the patient to say goodbye to visitors or finish using the bedpan demonstrates your awareness of the patient's needs. In any setting, look for signs of discomfort, such as shifting position or facial expressions showing pain or anxiety. You must attend to pain or anxiety first, both to encourage the patient's trust and to allow enough ease for the interview to proceed.

Consider the best way to *arrange the room* and how far you should be from the patient. Remember that cultural background and individual taste influence preferences about interpersonal space. Choose a distance that facilitates conversation and allows good eye contact. You should probably be within several feet, close enough to be intimate but not intrusive. Pull up a chair and, if possible, sit at eye level with the patient. Move any physical barriers, like desks or bedside tables, out of the way. In an outpatient setting, sitting on a rolling stool, for example, allows you to change distances in response to patient cues. Avoid arrangements that connote disrespect or inequality of power, such as interviewing a woman already positioned for a pelvic examination. Such arrangements are unacceptable. Lighting also makes a difference. If you sit between a patient and a bright light or window, although your view might be good, the patient may have to squint uncomfortably to see you, making the interaction more like an interrogation than a supportive interview.

As you begin the interview, give the patient your undivided attention. Spend enough time on small talk to put the patient at ease, and avoid looking down to take notes or reading the chart.

Inviting the Patient's Story. Now that you have established rapport, you are ready to pursue the patient's reason for seeking health care, designated the *chief complaint*. Begin with *open-ended questions* that allow full freedom of response: "What concerns bring you here today?" or "How can I help you?" Helpful open-ended questions are "Was there a specific health concern that prompted you to schedule this appointment?" and "What made you decide to come in to see us today?" Note that these questions encourage the patient to express any possible concerns and do not restrict the patient to a minimally informative "yes" or "no" answer. Sometimes patients do not have a specific complaint or problem—they may want only a blood pressure check

or a routine examination. Others may say they just want a physical examination but feel uncomfortable bringing up an underlying concern. In all these situations, *it is still important to start with the patient's story.*⁹

Train yourself to *follow the patient's leads*. Good interviewing technique includes using verbal and nonverbal cues that prompt patients to recount their stories spontaneously. If you intervene too early or ask specific questions prematurely, you risk trampling on the very information you are seeking. You should listen actively and make use of *continuers* (see p. 38), especially at the outset. These include nodding your head and phrases such as “uh huh,” “go on,” or “I see.” Using additional guided questioning (see p. 36) helps you avoid missing any of the patient's concerns.

Listen to the patient's answer *without interrupting*. Studies show that clinicians interrupt patients during office visits after only 18 seconds!¹⁰ If patients are allowed to tell their stories, most will finish within 2 minutes. After you have given the patient the opportunity to respond fully, inquire again or even several times, “What else?” “Tell me more,” or “Any further concerns?” You may need to lead patients back several times to elicit additional concerns or issues they may want to tell you about.

Establishing an Agenda. The clinician often approaches the interview with specific goals in mind. The patient also has specific questions and concerns. It is important to identify all these issues at the beginning of the encounter. This allows you to use the time available most effectively and ensures that you hear all the patient's issues. As a student, you often have enough time to cover the breadth of both your concerns and those of the patient in one visit. For a clinician, however, time is almost always constrained. As a clinician, you may need to focus the interview by asking the patient which problem is most pressing. For example, “You have told me about several different problems that are important for us to discuss. I also wanted to review your blood pressure medication. We need to decide which problems to address today. Can you tell me which one you are most concerned about?” Once you have agreed on a manageable list, let the patient know that the other problems are also important and will be addressed during a future visit—this reinforces the patient's confidence in your ongoing collaboration. Then proceed with questions such as, “Tell me more about that first problem that you mentioned.”

Expanding and Clarifying the Patient's Story. You then guide the patient into elaborating areas of the health history that seem most significant. As a clinician, each symptom has attributes that you must clarify, including context, associations, and chronology. For pain and many other symptoms, understanding these essential characteristics, summarized below as the seven key attributes of a symptom, is critical.

Always pursue the seven attributes. Two mnemonics may help: **OLD CARTS** (**O**nset, **L**ocation, **D**uration, **C**haracter, **A**ggravating/**A**lleviating Factors, **R**adiation, and **T**iming) and **OPQRST** (**O**nset, **P**alliating/**P**rovoking Factors, **Q**uality, **R**adiation, **S**ite, and **T**iming).

THE SEVEN ATTRIBUTES OF A SYMPTOM

1. **Location.** Where is it? Does it radiate?
2. **Quality.** What is it like?
3. **Quantity or severity.** How bad is it? (For pain, ask for a rating on a scale of 1 to 10.)
4. **Timing.** When did (does) it start? How long does it last? How often does it come?
5. **Setting in which it occurs.** Include environmental factors, personal activities, emotional reactions, or other circumstances that may have contributed to the illness.
6. **Remitting or exacerbating factors.** Is there anything that makes it better or worse?
7. **Associated manifestations.** Have you noticed anything else that accompanies it?

As you explore these attributes, be sure that you *use language that is understandable and appropriate* to the patient. Although you might ask a trained health professional about dyspnea, the customary term for patients is “shortness of breath.” It is easy to slip into using medical language, but beware. Technical language confuses the patient and often blocks communication. Whenever possible, *use the patient’s words*, making sure you clarify their meaning.

It is important to establish *the sequence and time course* of each of the patient’s symptoms if you are to arrive at accurate assessments. You can encourage a chronologic account by asking such questions as “What then?” or “What happened next?” or “Please start at the beginning, or the last time you felt well, and go step by step.” To fill in specific details, guide the patient’s story by using different types of questions and the techniques of skilled interviewing described on pp. 35–41. You will need to use some focused questions to elicit specific information that the patient has not already offered (see p. 37). *In general, an interview moves back and forth from open-ended questions to increasingly focused questions and then on to another open-ended question.*

Generating and Testing Diagnostic Hypotheses. Eventually, as you gain experience listening to patient concerns, you will develop the skills of “clinical reasoning.” You will *generate and test diagnostic hypotheses* about what disease process might be present. Identifying the various attributes of the patient’s symptoms and pursuing specific details are fundamental to recognizing patterns of disease and to generating the differential diagnosis. As you learn more about diagnostic patterns and epidemiology, knowing what data you are listening for and asking about specific details become more automatic. For additional data that contribute to your analysis, use items from relevant sections of the review of systems. (In your oral presentations and written record, add the information gathered from your responses to review of systems questions to the latter paragraphs of the History of Present Illness—this information now constitutes “pertinent positives” and “pertinent negatives”—see Chapter 1, p. 7).

Appropriate questions about symptoms are also suggested in each of the chapters on the regional physical examinations. This is one way that you build evidence for and against various diagnostic possibilities. This kind of clinical thinking is illustrated by the tables on symptoms found in the regional examination chapters and further discussed in Chapter 3, Clinical Reasoning, Assessment, and Plan. The challenge is to not let this kind of inquiry dominate the interview and displace learning about the patient's perspective, conveying concern for the patient's well-being and building the relationship.⁵

Creating a Shared Understanding of the Problem. Recent literature makes it clear that delivering effective health care requires exploring the deeper meanings patients attach to their symptoms. Although the “seven attributes of a symptom” add important details to the patient's history, the **disease/illness distinction model** helps you understand the full range of what every good interview needs to cover.¹¹ This model acknowledges the very different yet complementary perspectives of the clinician and the patient. *Disease* is the explanation that the *clinician* brings to the symptoms. It is the way that the clinician organizes what he or she learns from the patient that leads to a clinical diagnosis. *Illness* can be defined as how the *patient* experiences symptoms. Many factors may shape this experience, including prior personal or family health, the effect of symptoms on everyday life, individual outlook and style of coping, and expectations about medical care. The melding of these perspectives forms the basis for planning evaluation and treatment. *The clinical interview needs to take into account both of these views of reality.*

Even a chief complaint as straightforward as sore throat can illustrate these divergent views. The patient may be most concerned about pain and difficulty swallowing, missing time from work, or a cousin who was hospitalized with tonsillitis. The clinician, however, may focus on specific points in the history that differentiate streptococcal pharyngitis from other etiologies, or on a questionable history of allergy to penicillin. To understand the patient's expectations, the clinician needs to go beyond just the attributes of a symptom. Learning about the patient's perception of illness means asking patient-centered questions in the six domains listed below. This information is crucial to patient satisfaction, effective health care, and patient follow-through.^{12,13}

EXPLORING THE PATIENT'S PERSPECTIVE

- The patient's thoughts about the nature and the cause of the problem
- The patient's feelings, especially fears, about the problem
- The patient's expectations of the clinician and health care
- The effect of the problem on the patient's life
- Prior personal or family experiences that are similar
- Therapeutic approaches the patient has already tried

The clinician should explore the patient's thoughts about the cause of the problem by saying, for example, “Why do you think you have this stom-

achache?” To uncover the patient’s feelings you might ask, “What concerns you most about the pain?” A patient may worry that the pain is a symptom of serious disease and want reassurance. Alternatively, the patient may be less concerned about the cause of the pain and just want relief. You need to find out what the patient expects from you, the clinician, or from health care in general . . . “I am glad that the pain is almost gone, how specifically can I help you now?” Even if the stomach pain is almost gone, the patient may need a work excuse to take to an employer.

It may be helpful to ask the patient about prior experiences, what has been tried so far, and any related changes in daily activities.

Clinician: “Has anything like this happened to you or your family before?”

Patient: “I was worried that I might have appendicitis. My Uncle Charlie died of a ruptured appendix.”

Explore what the patient has done so far to take care of the problem. Most patients will have tried over-the-counter medications, traditional remedies, or advice from friends or family.

Ask how the illness has affected the patient’s lifestyle and level of activity. This question is especially important for patients with chronic illness. “What can’t you do now that you could do before? How has your backache (shortness of breath, etc.) affected your ability to work? . . . Your life at home? . . . Your social activities? . . . Your role as a parent? . . . Your function in intimate relationships? . . . The way you feel about yourself as a person?”

Negotiating a Plan. Learning about the disease and conceptualizing the illness give you and the patient the opportunity to create a complete and congruent picture of the problem. This multifaceted picture then forms the basis for planning further evaluation (e.g., physical examination, laboratory tests, consultations) and negotiating a treatment plan. It also plays an important role in building rapport with your patient. More specific techniques for negotiating a plan can be found in Chapter 3. Advanced skills, such as steps for motivating change and the therapeutic use of the clinician–patient relationship, are beyond the scope of this book.

Planning for Follow-Up and Closing. You may find that ending the interview is difficult. Patients often have many questions, and if you have done your job well, they are engaged and affirmed as they talk with you. Let the patient know that the end of the interview is approaching to allow time for the patient to ask any final questions. Make sure the patient understands the mutual plans you have developed. For example, before gathering your papers or standing to leave the room, you can say, “We need to stop now. Do you have any questions about what we’ve covered?” As you close, reviewing future evaluation, treatments, and follow-up is helpful. “So, you will take the medicine as we discussed, get the blood test before you leave today, and make a follow-up appointment for 4 weeks. Do you have any questions about this?” Address any related concerns or questions that the patient raises.

The patient should have a chance to ask any final questions; however, the last few minutes are not the time to bring up new topics. If that happens (and the concern is not life-threatening), simply assure the patient of your interest and make plans to address the problem at a future time. “That knee pain sounds concerning. Why don’t you make an appointment for next week so we can discuss it?” Reconfirming your continued commitment to improving the patient’s health is always appreciated.

BUILDING A THERAPEUTIC RELATIONSHIP: THE TECHNIQUES OF SKILLED INTERVIEWING

Building the Relationship. You probably had many reasons to become a health care professional, but one of them was undoubtedly the desire to serve others. To succeed in fulfilling this laudable goal, you must sustain this motivation throughout your rigorous training and transform this goal into a set of behavioral approaches to your patients.

The paradigm that embeds your relationship with the patient into the therapeutic process itself now has many names and models, including the biopsychosocial model and patient-centered care, among others.^{5,12,14,15} Comparing these various models reveals common elements that include interest in the patient as a whole person, an empowering approach to the patient role, and involvement of the clinician’s self on an emotional and reflective level.¹⁶ There is now robust literature demonstrating that an approach to patient care anchored in these principles is not only more satisfying for the patient and the clinician but also more effective in achieving good health care outcomes.¹⁷

This section describes the skills that form the basic tools of interviewing. Some of these habits are purely techniques that you can readily put into practice. Some are constructs that will inform your interviewing behaviors. You will employ these interviewing skills to achieve the tasks described earlier in the Sequence of the Interview (see p. 28) more effectively. You need to practice using these tools and find ways to be observed or recorded so that you can receive feedback on your progress. A number of these fundamental skills are listed below and then described in more detail. Pick one or two of them to incorporate into your next patient interview. Then refer back to this chapter to build your repertoire of skills.

The Techniques of Skilled Interviewing

- Active listening
- Guided questioning
- Nonverbal communication
- Empathic responses
- Validation
- Reassurance
- Partnering
- Summarization
- Transitions
- Empowering the patient

Active Listening. Underlying all the various techniques is the habit of *active listening*. Active listening is the process of really attending to what the patient is communicating, being aware of the patient's emotional state, and using verbal and nonverbal skills to encourage the speaker to continue and expand. This takes practice. It is easy to drift into thinking about your next question or the differential diagnosis when you and the patient are best served by your concentration on listening.



Guided Questioning: Options for Expanding and Clarifying the Patient's Story. There are several ways you can ask for more information from the patient without interfering with the flow of the patient's story. Your goal is to facilitate the patient's fullest communication. Learning the following specific techniques will allow you to guide patients' disclosures, while minimizing the risk for distorting their ideas or missing significant details. This is how you avoid asking a series of specific questions, which takes more time and makes the patient feel more passive.

Guided Questioning: Options for Expanding and Clarifying the Patient's Story

- Moving from open-ended to focused questions
- Using questioning that elicits a graded response
- Asking a series of questions, one at a time
- Offering multiple choices for answers
- Clarifying what the patient means
- Offering continuers
- Using echoing

Moving from Open-Ended to Focused Questions. Your questioning should proceed from general to specific. Start with a truly open-ended question that does not inadvertently include an answer. A possible sequence might be:

“Tell me about your chest pain.” (Pause)

“What else?” (Pause)

“Where did you feel it?” (Pause) “Show me.”

“Anywhere else?” (Pause) “Did it travel anywhere?” (Pause) “To which arm?”

You should avoid *leading questions* that call for a “yes” or “no” answer. If a patient answers yes to a question such as “Is your pain pressure like . . .?”, you run the risk of turning your words into the patient’s words. A better phrasing is “Please describe your pain.”

Questioning that Elicits a Graded Response. If necessary, ask questions that require a *graded response* rather than a single answer. “How many steps can you climb before you get short of breath?” is better than “Do you get short of breath climbing stairs?”

Asking a Series of Questions, One at a Time. Be sure to *ask one question at a time*. “Any tuberculosis, pleurisy, asthma, bronchitis, pneumonia?” may lead to a negative answer out of sheer confusion. Try “Do you have any of the following problems?” Be sure to pause and establish eye contact as you list each problem.

Offering Multiple Choices for Answers. Sometimes patients seem quite unable to describe their symptoms without help. To minimize bias, *offer multiple-choice answers*: “Which of the following words best describes your pain: aching, sharp, pressing, burning, shooting, or something else?” Almost any specific question can provide at least two possible answers. “Do you bring up any phlegm with your cough, or is it dry?”

Clarifying What the Patient Means. At times, patients use words that are ambiguous or have unclear associations. To understand their meaning, you need to *request clarification*, as in “Tell me exactly what you meant

by ‘the flu’ ” or “You said you were behaving just like your mother. What did you mean?”

Continuers. Without specifying content, you can use posture, gestures, or words to encourage the patient to say more. Pausing with a nod of the head or remaining silent, yet attentive and relaxed, is a *cue for the patient to continue*. Leaning forward, making eye contact, and using phrases like “Mm-hmm,” or “Go on,” or “I’m listening” all maintain the flow of the patient’s story.

Echoing. A simple repetition of the patient’s last words, or *echoing*, encourages the patient to express both factual details and feelings, as in the following example:

Patient: “The pain got worse and began to spread.” (Pause)

Response: “Spread?” (Pause)

Patient: “Yes, it went to my shoulder and down my left arm to the fingers. It was so bad that I thought I was going to die.” (Pause)

Response: “Going to die?”

Patient: “Yes, it was just like the pain my father had when he had his heart attack, and I was afraid the same thing was happening to me.”

This reflective technique has helped to reveal not only the location and severity of the pain but also its meaning to the patient. It did not bias the story or interrupt the patient’s train of thought.

Nonverbal Communication. Communication that does not involve speech occurs continuously and provides important clues to feelings and emotions. Becoming more sensitive to nonverbal messages allows you to both “read the patient” more effectively and send messages of your own. Pay close attention to eye contact, facial expression, posture, head position and movement such as shaking or nodding, interpersonal distance, and placement of the arms or legs—crossed, neutral, or open. Be aware that nonverbal language is culturally bound.

Just as mirroring your position can signify the patient’s increasing sense of connectedness, matching your position to the patient’s can signify increased rapport. You can also mirror the patient’s *paralanguage*, or qualities of speech, such as pacing, tone, and volume, to increase rapport. Moving closer or physical contact like placing your hand on the patient’s arm can convey empathy or help the patient gain control of difficult feelings. Bringing nonverbal communication to the conscious level is the first step to using this crucial form of patient interaction.

Empathic Responses. Conveying empathy greatly strengthens patient rapport. As patients talk with you they may express—with or without words—feelings they may or may not have consciously acknowledged.

These feelings are crucial to understanding their illnesses and to establishing a trusting relationship. *To empathize with your patient, you must first identify the patient's feelings.* This requires a willingness and even interest on your part in hearing about and eliciting emotional content. At first, this may seem unfamiliar or uncomfortable. When you sense important but unexpressed feelings from the patient's face, voice, words, or behavior, inquire about them rather than assuming that you know how the patient feels. You may simply ask, "How did you feel about that?" Unless you let patients know that you are interested in feelings as well as facts, you may miss important insights.

Once you have identified the feelings, respond with understanding and acceptance. Responses may be as simple as "I understand," "That sounds upsetting," or "You seem sad." Empathy may also be nonverbal—for example, offering a tissue to a crying patient or gently placing your hand on the patient's arm to show understanding. When you give an empathic response, be sure that you are responding correctly to what the patient is feeling. If your response acknowledges how upset a patient must have been at the death of a parent, when in fact the death relieved the patient of a long-standing financial and emotional burden, you have misunderstood the situation. Instead of making assumptions, you can ask directly about the patient's emotional response. "I am sorry about the death of your father. What has that been like for you?"

Validation. Another important way to make a patient feel accepted is to legitimize or validate his or her emotional experience. A patient who has been in a car accident but has no physical injury may still be experiencing significant distress. Stating something like, "Being in that accident must have been very scary. Car accidents are always unsettling because they remind us of our vulnerability and mortality. That could explain why you still feel upset," reassures the patient. It helps the patient feel that such emotions are legitimate and understandable.

Reassurance. When you are talking with patients who are anxious or upset, it is tempting to reassure them. You may find yourself saying, "Don't worry. Everything is going to be all right." Although this may be appropriate in nonprofessional relationships, in your role as a clinician, such comments are usually counterproductive. You may fall into reassuring the patient about the wrong thing. Moreover, premature reassurance may block further disclosures, especially if the patient feels that exposing anxiety is a weakness. Such admissions require encouragement, not a cover-up.

The first step to effective reassurance is simply identifying and acknowledging the patient's feelings. This promotes a feeling of connection. The actual reassurance comes much later after you have completed the interview, the physical examination, and perhaps some laboratory studies. At that point, you can interpret for the patient what you think is happening and deal openly with expressed concerns. The reassurance comes from conveying information in a competent manner, making the patient feel confident that problems have been fully understood and will be addressed.

Partnering. When building your relationships with patients, one of the most useful steps is to make explicit your desire to work with them in an ongoing way. When you discuss a diagnosis or express uncertainty about how to explain their symptoms, it is reassuring to state that regardless of what happens with their disease, as their provider, you are committed to a continuing partnership. Even in your role as student, especially in a hospital setting, this support can make a big difference.

Summarization. Giving a capsule summary of the patient's story during the course of the interview can serve several different functions. It indicates to the patient that you have been listening carefully. It can also identify what you know and what you don't know. "Now, let me make sure that I have the full story. You said you've had a cough for 3 days, that it's especially bad at night, and that you have started to bring up yellow phlegm. You have not had a fever or felt short of breath, but you do feel congested with difficulty breathing through your nose." Following with an attentive pause or stating "Anything else?" lets the patient add other information and confirms that you have heard the story correctly.

You can use summarization at different points in the interview to structure the visit, especially at times of transition (see below). This technique also allows you, the clinician, to organize your clinical reasoning and to convey your thinking to the patient, which makes the relationship more collaborative. *It is also a useful technique for learners to use when they draw a blank on what to ask the patient next.*

Transitions. Patients have many reasons to feel vulnerable during a health care visit. To put them more at ease, tell them when you are changing directions during the interview. This gives patients a greater sense of control. As you move from one part of the history to another and on to the physical examination, orient the patient with brief transitional phrases like "Now I'd like to ask some questions about your past health." Make clear what the patient should expect or do next. "Before we move on to reviewing all your medications, was there anything else about past health problems?" "Now I would like to examine you. I will step out for a few minutes. Please get completely undressed and put on this gown." Specifying that the gown should open in the back may earn the patient's gratitude and save you some time.

Empowering the Patient. The clinician–patient relationship is inherently unequal. Your sense of inexperience as a student will predictably and appropriately transition over time to a sense of confidence in your knowledge and skills and power in your role as clinician. But patients have many reasons to feel vulnerable. They may be in pain or worried about a symptom. They may be overwhelmed with the health care system or just unfamiliar with the process that you will come to take for granted. Differences of gender, ethnicity, race, or class may also create power differentials. However, ultimately, patients must be empowered to take care of themselves. They must make lifestyle changes or take the medications you recommend. They must feel confident in their ability to follow through on your advice. Listed next

ADAPTING YOUR INTERVIEW TO SPECIFIC SITUATIONS

are principles that will help you to share power with your patients. Although many of them have been discussed in other parts of this chapter, the need to empower patients is so fundamental that it is worth summarizing them here. Keep them in mind.

EMPOWERING THE PATIENT: PRINCIPLES OF SHARING POWER

- Inquire about the patient's perspective.
- Express interest in the person, not just the problem.
- Follow the patient's lead.
- Elicit emotional content.
- Share information with the patient (e.g., transitions).
- Make clinical reasoning transparent to the patient.
- Reveal the limits of your knowledge.

ADAPTING YOUR INTERVIEW TO SPECIFIC SITUATIONS

Interviewing patients may precipitate several behaviors and situations that seem perplexing or even vexing. Your ability to handle these situations will evolve throughout your career. *Always remember the importance of listening to the patient and clarifying the patient's concerns.*

The Silent Patient. Novice interviewers are often uncomfortable with periods of silence and feel obligated to keep the conversation going. Silence has many meanings and many purposes. Patients frequently fall silent for short periods to collect thoughts, remember details, or decide whether you can be trusted with certain information. The period of silence usually feels much longer to the clinician than it does to the patient. The clinician should appear attentive and give brief encouragement to continue when appropriate. During periods of silence, watch the patient closely for nonverbal cues, such as difficulty controlling emotions.

Patients with depression or dementia may lose their usual spontaneity of expression, give short answers to questions, and then fall silent. If you have already tried guiding them through recent events or a typical day, try shifting your inquiry to the symptoms of depression or begin an exploratory mental status examination (see Chapter 16, pp. 573–593).

At times, silence may be the patient's response to how you are asking questions. Are you asking too many short-answer questions in rapid succession? Have you offended the patient in any way by signs of disapproval or criticism? Have you failed to recognize an overwhelming symptom such as pain, nausea, or dyspnea? If so, you may need to ask the patient directly, "You seem very quiet. Have I done something to upset you?"

The Confusing Patient. Some patients present a confusing array of *multiple symptoms*. They seem to have every symptom that you ask about, or

“a positive review of systems.” With these patients, focus on the meaning or function of the symptom, emphasizing the patient’s perspective (see p. 32), and guide the interview into a psychosocial assessment. There is little profit to exploring each symptom in detail. Although the patient may have several illnesses, a somatization disorder may be in play.

At other times, you may feel baffled, frustrated, and confused because you cannot make sense out of the patient’s story. The history is vague and difficult to understand, ideas are poorly connected, and language is hard to follow. Even though you word your questions carefully, you cannot seem to get clear answers. The patient’s manner of relating to you may also seem peculiar, distant, aloof, or inappropriate. Symptoms may be described in bizarre terms: “My fingernails feel too heavy” or “My stomach knots up like a snake.” Perhaps there is a mental status change like psychosis or delirium, a mental illness such as schizophrenia, or a neurologic disorder (see Chapter 17). Consider delirium in acutely ill or intoxicated patients and dementia in the elderly. Such patients give histories that are inconsistent and cannot provide a clear chronology about what has happened. Some may even confabulate to fill in the gaps in their memories.

When you suspect a psychiatric or neurologic disorder, do not spend too much time gathering a detailed history. You will only tire and frustrate both the patient and yourself. Shift to the mental status examination, focusing on level of consciousness, orientation, memory, and capacity to understand. You can work in the initial questions smoothly by asking, “When was your last appointment at the clinic? Let’s see . . . that was about how long ago?” “Your address now is . . . ? . . . and your phone number?” You can check these responses against the chart or seek permission to speak with family members or friends and then obtain their perspectives.

The Patient With Altered Capacity. Some patients cannot provide their own histories because of delirium from illness, dementia, or other health or mental health conditions. Others are unable to relate certain parts of the history, such as events related to a febrile illness or a seizure. Under these circumstances, you need to determine whether the patient has “*decision-making capacity*,” or the ability to understand information related to health, to make medical choices based on reason and a consistent set of values, and to declare preferences about treatments. The term *capacity* is preferable to the term “*competence*,” which is a legal term. You do not need to consult psychiatry to assess capacity unless mental illness impairs decision making. For many patients with psychiatric conditions or even cognitive impairments, their ability to make decisions remains intact.

For patients with capacity, obtain their consent before talking about their health with others. Even if patients can communicate only with facial expressions or gestures, you must maintain confidentiality and elicit their input. Assure patients that any shared history will be kept confidential, and clarify what you can discuss with others. Your knowledge about the patient can be quite comprehensive, yet others may offer surprising and important information. A spouse, for example, may report significant family strains, depressive symp-

toms, or drinking habits that the patient has denied. Consider dividing the interview into two segments—one with the patient and the other with both the patient and a second informant. Each interview has its own value. Information from other sources often gives you helpful ideas for planning the patient's care, but remains confidential. Also learn the tenets of the *Health Insurance Portability and Accountability Act (HIPAA)* passed by Congress in 1996, which sets strict standards for disclosure for both institutions and providers when sharing patient information. These can be found at <http://www.cms.hhs.gov/hipaa/>.

For patients with impaired capacity, you will often need to find a *surrogate informant or decision maker* to assist with the history. Check whether the patient has a *durable power of attorney for health care* or a *health care proxy*. If not, in many cases, a spouse or family member who can represent the patient's wishes can fill this role.

Apply the basic principles of interviewing to your conversations with patients' relatives or friends. Find a private place to talk. Introduce yourself, state your purpose, inquire how they are feeling under the circumstances, and recognize and acknowledge their concerns. As you listen to their versions of the history, assess the quality of their relationship with the patient because it may color their credibility. Establish how they know the patient. For example, when a child is brought in for health care, the accompanying adult may not be the primary or even frequent caregiver, just the most available ride. Always seek the best-informed source. Occasionally, a relative or friend insists on being with the patient during your evaluation. Try to find out why, and assess the patient's wishes.

The Talkative Patient. The garrulous rambling patient may be just as difficult as the silent or confused patient. Faced with limited time and the need to “get the whole story,” you may grow impatient, even exasperated. Although this problem has no perfect solution, several techniques are helpful. Give the patient free rein for the first 5 or 10 minutes, listening closely to the conversation. Perhaps the patient simply needs a good listener and is expressing pent-up concerns. Maybe the patient's style is to tell stories. Does the patient seem obsessively detailed? Is the patient unduly anxious or apprehensive? Is there a flight of ideas or disorganized thought process that suggests a thought disorder? What about confabulation?

Try to focus on what seems most important to the patient. Show your interest by asking questions in those areas. Interrupt only if necessary, but be courteous. Learn how to be directive and to set limits when needed. Remember that part of your task is structuring the interview to gain important information about the patient's health. A brief summary may help you change the subject yet validate any concerns (see p. 40). “Let me make sure that I understand. You have described many concerns. In particular I heard about two different kinds of pain, one on your left side that goes into your groin and is fairly new, and one in your upper abdomen after you eat that you have had for months. Let's focus just on the side pain first. Can you tell me what it feels like?”

Finally, do not show your impatience. If time runs out, explain the need for a second meeting. Setting a time limit for the next appointment may be helpful. “I know we have much more to talk about. Can you come again next week? We will have a full hour then.”

The Crying Patient. Crying signals strong emotions, ranging from sadness to anger or frustration. If the patient is on the verge of tears, pausing, gentle probing, or responding with empathy gives the patient permission to cry. Usually crying is therapeutic, as is your quiet acceptance of the patient’s distress or pain. Offer a tissue and wait for the patient to recover. Make a supportive remark like “I am glad that you got that out.” Most patients will soon compose themselves and resume their story. Aside from an acute grief or loss, it is unusual for crying to escalate and become uncontrollable.

Crying makes many people uncomfortable. If this is true for you, you will need to learn how to accept displays of emotion so that as a clinician you can support patients at these significant times.

The Angry or Disruptive Patient. Many patients have reasons to be angry: they are ill, they have suffered a loss, they lack their accustomed control over their own lives, and they feel relatively powerless in the health care system. They may direct this anger toward you. It is possible that this hostility toward you is justified . . . were you late for your appointment, inconsiderate, insensitive, or angry yourself? If so, acknowledge the fact and try to make amends. More often, however, patients displace their anger onto the clinician as a reflection of their frustration or pain.

Accept angry feelings from patients. Allow them to express such emotions without getting angry in return. Avoid joining such patients in their hostility toward another provider, the clinic, or the hospital, even when privately you may feel sympathetic. You can validate their feelings without agreeing with their reasons. “I understand that you felt very frustrated by the long wait and answering the same questions over and over. Our complex health care system can seem very unsupportive when you are not feeling well.” After the patient has calmed down, help find steps that will avert such situations in the future. Rational solutions to emotional problems are not always possible, however, and people need time to express and work through their angry feelings.

Some angry patients become overtly disruptive. Few people can disturb the clinic or emergency department more quickly than patients who are angry, belligerent, or out of control. Before approaching such patients, alert the security staff—as a clinician, maintaining a safe environment is one of your responsibilities. Stay calm, appear accepting, and avoid being confrontational in return. Keep your posture relaxed and nonthreatening and your hands loosely open. At first do not try to make disruptive patients lower their voices or stop if they are haranguing you or the staff. Listen carefully. Try to understand what they are saying. Once you have established rapport, gently suggest moving to a different location that is more private (and will cause less disruption).

The Interview Across a Language Barrier. Nothing will convince you more of the importance of the history than having to do without one.

If your patient speaks a different language, make every effort to find an interpreter. A few broken words and gestures are no substitute for the full story. The ideal interpreter is a neutral person who is familiar with both languages and cultures. Recruiting family members or friends to serve as interpreters can be hazardous—confidentiality may be violated, meanings may be distorted, and transmitted information may be incomplete. Untrained interpreters may try to speed up the interview by telescoping lengthy replies into a few words, losing much of what may be significant detail.

As you begin working with the interpreter, establish rapport and review what information would be most useful. Explain that you need the interpreter to translate everything, not to condense or summarize. *Make your questions clear, short, and simple.* You can also help the interpreter by outlining your goals for each segment of the history. After going over your plans, arrange the room so that you have easy eye contact and nonverbal communication with the patient. Then speak directly to the patient . . . “How long have you been sick?” rather than “How long has the patient been sick?” Having the interpreter close by the patient keeps you from moving your head back and forth as though you were watching a tennis match.

When available, bilingual written questionnaires are invaluable, especially for the review of systems. First, however, be sure that patients can read in their language; otherwise, ask for help from the interpreter. In some clinical settings, there are speakerphone translators; use them if there are no better options.

GUIDELINES FOR WORKING WITH AN INTERPRETER

- Choose a trained interpreter in preference to a hospital worker, volunteer, or family member.
- Use the interpreter as a resource for cultural information.
- Orient the interpreter to the components you plan to cover in the interview; include reminders to translate everything the patient says.
- Arrange the room so that you and the patient have eye contact and can read each other’s nonverbal cues. Seat the interpreter next to the patient.
- Allow the interpreter and the patient to establish rapport.
- Address the patient directly. Reinforce your questions with nonverbal behaviors.
- Keep sentences *short* and *simple*. Focus on the most important concepts to communicate.
- Verify mutual understanding by asking the patient to repeat back what he or she has heard.
- Be patient. The interview will take more time and may provide less information.

The Patient With Low Literacy. Before giving written instructions, assess the patient’s ability to read. Literacy levels are highly variable, and marginal reading skills are more prevalent than commonly believed. Explore the many reasons people do not read: language barriers, learning disorders, poor vision, or lack of education. Some people may try to hide their inabil-

ity to read. Asking about educational level may be helpful, but can be misleading. “I understand that this may be difficult to discuss, but do you have any trouble with reading?” Ask the patient to read whatever instructions you have written. (This will also address any difficulty with your handwriting.) One rapid screen is to hand the patient a written text upside down—most patients who read will turn the page around immediately. Literacy skills may be the reason the patient has not followed through on taking medications or adhered to recommended treatments. Respond sensitively, and remember that illiteracy and lack of intelligence are not synonymous.

The Patient With Impaired Hearing. Communicating with the deaf presents many of the same challenges as communicating with patients who speak a different language. Even people with partial hearing may define themselves as deaf, a distinct cultural group. Find out the patient’s preferred method of communicating. Patients may use American Sign Language, a unique language with its own syntax, or various other combinations of signs and speech. Thus, communication is often truly cross-cultural. Ask when hearing loss occurred relative to the development of speech and other language skills. Query about the kinds of schools the patient has attended. These questions help you determine whether the patient identifies with the Deaf culture or the Hearing culture. Written questionnaires are also useful. If the patient prefers sign language, find an interpreter and use the principles identified earlier. Time-consuming handwritten questions and answers may be the only solution, although literacy skills may also be an issue.

Hearing deficits vary. If the patient has a hearing aid, find out if the patient is using it. Make sure it is working. For patients with unilateral hearing loss, sit on the hearing side. A person who is *hard of hearing* may not be aware of the problem, a situation you will have to tactfully address. Eliminate background noise such as television or hallway conversation as much as possible. For patients who have partial hearing or can read lips, face them directly, in good light. Patients should wear their glasses to better pick up visual cues that help them understand you.

Speak at a normal volume and rate and do not let your voice trail off at the ends of sentences. Avoid covering your mouth or looking down at papers while speaking. Remember that even the best lip readers comprehend only a percentage of what is said, so having patients repeat what you have said is important. When closing, write out any oral instructions.

The Patient With Impaired Vision. When meeting with a blind patient, shake hands to establish contact and explain who you are and why you are there. If the room is unfamiliar, orient the patient to the surroundings and report if anyone else is present. It still may be helpful to adjust the light. Encourage visually impaired patients to wear glasses whenever possible. Remember to use words because postures and gestures are unseen.

The Patient With Limited Intelligence. Patients of moderately limited intelligence can usually give adequate histories. In fact, you may even

be able to omit their disability from their evaluations. If you suspect problems, however, pay special attention to the patient's schooling and ability to function independently. How far have such patients gone in school? If they didn't finish, why not? What kinds of courses have they taken? How did they do? Have they had any testing done? Are they living alone? Do they need assistance with activities such as transportation or shopping? The sexual history is equally important and often overlooked. Find out if the patient is sexually active and provide information that may be needed about pregnancy or sexually transmitted diseases.

If you are unsure about the patient's level of intelligence, make a smooth transition to the mental status examination and assess simple calculations, vocabulary, memory, and abstract thinking (see Chapter 16, *The Nervous System: Mental Status and Behavior*).

For patients with severe mental retardation, you will have to turn to the family or caregivers to elicit the history. Identify the person who accompanies the patient, but always show interest in the patient first. Establish rapport, make eye contact, and engage in simple conversation. As with children, avoid "talking down" or using affectations of speech or condescending behavior. The patient, family members, caretakers, or friends will notice and appreciate your respect.

The Patient With Personal Problems. Patients may ask you for advice about personal problems that fall outside the range of your clinical expertise. Should the patient quit a stressful job, for example, or move out of state? Instead of responding, explore the different approaches the patient has considered and related pros and cons, whom else they have discussed the problem with, and what supports are available for different choices. Letting the patient talk through the problem with you is usually much more valuable and therapeutic than any answer you could give.

SENSITIVE TOPICS THAT CALL FOR SPECIFIC APPROACHES

Clinicians talk with patients about various subjects that are emotionally charged or sensitive. These discussions can be particularly difficult for inexperienced clinicians or during evaluations of patients you do not know well. Even seasoned clinicians have some discomfort with certain topics: abuse of alcohol or drugs, sexual practices, death and dying, financial concerns, racial and ethnic experiences, family interactions, domestic violence, psychiatric illnesses, physical deformities, bowel function, and others. These areas are difficult to explore in part because of societal taboos. We all know, for example, that talking about bowel habits is not "polite table talk." Many of these topics evoke strong cultural, societal, and personal values. Mental illness, drug use, and same-sex practices are three obvious examples of issues that can touch on our biases and pose barriers during the interview. This section explores challenges to the clinician in these and other important and sometimes sensitive areas, including domestic violence and the dying patient.

Several basic principles can help guide your response to sensitive topics:

GUIDELINES FOR BROACHING SENSITIVE TOPICS

- *The single most important rule is to be nonjudgmental.* The clinician's role is to learn about the patient and help the patient achieve better health. Disapproval of behaviors or elements in the health history will only interfere with this goal.
- *Explain why you need to know certain information.* This makes patients less apprehensive. For example, say to patients, "Because sexual practices put people at risk for certain diseases, I ask all of my patients the following questions."
- Find opening questions for sensitive topics and learn the specific kinds of data needed for your assessments.
- Finally, consciously acknowledge whatever discomfort you are feeling. Denying your discomfort may lead you to avoid the topic altogether.

Look into other strategies for becoming more comfortable with sensitive areas. Examples include general reading about these topics in medical and lay literature; talking to selected colleagues and teachers openly about your concerns; taking special courses that help you explore your own feelings and reactions; and ultimately, reflecting on your own life experience. Take advantage of all these resources. Whenever possible, listen to experienced clinicians, then practice similar discussions with your own patients. The range of topics that you can explore with comfort will widen progressively.

The Sexual History. Asking questions about sexual behavior can be life-saving. Sexual behaviors determine risks for pregnancy, sexually transmitted diseases (STDs), and AIDS—good interviewing helps prevent or reduce these risks. Sexual practices may be directly related to the patient's symptoms and integral to both diagnosis and treatment. Many patients have questions or concerns about sexuality that they would discuss more freely if you ask about sexual health. Finally, sexual dysfunction may result from use of medication or from misinformation that, if recognized, can be readily addressed.

You can introduce questions about sexual behavior at multiple points in an interview. If the chief complaint involves genitourinary symptoms, include questions about sexual health as part of "expanding and clarifying" the patient's story. For women, you can ask these questions as part of the Obstetric/Gynecologic section of the Past Medical History. You can bring them into discussions about Health Maintenance, along with diet, exercise, and screening tests, or as part of the lifestyle issues or important relationships covered in the Personal and Social History. Or, in a comprehensive history, you can ask about sexual practices during the Review of Systems. Do not forget this area of inquiry just because the patient is elderly or has a disability or chronic illness.

An orienting sentence or two is often helpful. "To assess your risk for various diseases, I need to ask you some questions about your sexual health and prac-

tices” or “I routinely ask all patients about their sexual function.” For more specific complaints you might state, “To figure out why you have this discharge and what we should do about it, I need to ask some questions about your sexual activity.” Try to be “matter-of-fact” in your style; the patient will be likely to follow your lead. You should *use specific language*. Refer to genitalia with explicit words such as penis or vagina and avoid phrases like “private parts.” Choose words that the patient understands or explain what you mean. “By intercourse, I mean when a man inserts his penis into a woman’s vagina.”

In general, ask about both specific sexual behaviors and satisfaction with sexual function. Specific questions are included in Chapters 11, Male Genitalia and Hernias (pp. 413–415), and Chapter 12, Female Genitalia (pp. 432–435). Here are examples of questions that help guide patients to reveal their concerns in these discussions:

- “When was the last time you had intimate physical contact with someone?” Did that contact include sexual intercourse?” Using the term “sexually active” can be ambiguous. Patients have been known to reply, “No, I just lie there.”
- “Do you have sex with men, women, or both?” Individuals may have sex with persons of the same gender, yet not consider themselves gay, lesbian, or bisexual. Some gay and lesbian patients have had sex with the opposite gender. Your questions should always be about the behaviors.
- “How many sexual partners have you had in the last 6 months? In the last 5 years? In your lifetime?” Again, these questions give the patient an easy opportunity to acknowledge multiple partners. Ask also about routine use of condoms. “Do you *always* use condoms?”
- It is important to ask all patients, “Do you have any concerns about HIV infection or AIDS?” even if no explicit risk factors are evident.

Note that these questions make no assumptions about marital status, sexual preference, or attitudes toward pregnancy or contraception. Listen to each of the patient’s responses, and ask additional questions as indicated. To get information about sexual behaviors, you will need to ask more specific and focused questions than in other parts of the interview.

The Mental Health History. Cultural constructs of mental and physical illness vary widely, causing marked differences in acceptance and attitudes. Think how easy it is for patients to talk about diabetes and taking insulin compared with discussing schizophrenia and using psychotropic medications. Ask open-ended questions initially. “Have you ever had any problem with emotional or mental illnesses?” Then move to more specific questions such as “Have you ever visited a counselor or psychotherapist?” “Have you ever been prescribed medication for emotional issues?” “Have you or has anyone in your family ever been hospitalized for an emotional or mental health problem?”

For patients with depression or thought disorders such as schizophrenia, a careful history of their illness is in order. Depression is common worldwide

but still remains underdiagnosed and undertreated. Be sensitive to reports of mood changes or symptoms such as fatigue, unusual tearfulness, appetite or weight changes, insomnia, and vague somatic complaints. Two opening screening questions are: “Over the past 2 weeks, have you felt down, depressed, or hopeless?” and “Over the past 2 weeks, have you felt little interest or pleasure in doing things?”¹⁸ If the patient seems depressed, also ask about thoughts of suicide . . . “Have you ever thought about hurting yourself or ending your life?” As with chest pain, you must evaluate severity—both depression and angina are potentially lethal. For further approaches, turn to Chapter 16, *The Nervous System: Mental Status and Behavior*.

Many patients with schizophrenia or other psychotic disorders can function in the community and tell you about their diagnoses, symptoms, hospitalizations, and current medications. You should investigate their symptoms and assess any effects on mood or daily activities.

Alcohol and Illicit Drugs. Many clinicians hesitate to ask patients about use of alcohol and drugs, whether prescribed or illegal. Misuse of alcohol or drugs often directly contributes to symptoms and the need for care and treatment. Despite the high lifetime prevalence of substance abuse disorders—more than 13% for alcohol and 4% for illegal drugs in the United States—they remain underdiagnosed.¹⁹

Avoid letting personal feelings interfere with your role as a clinician. It is your job to gather data, assess the effects on the patient’s health, and plan a therapeutic response. Clinicians should routinely ask about current and past use of alcohol or drugs, patterns of use, and family history. Make sure to include adolescents and older adults in your questioning.

Alcohol. Questions about alcohol and other drugs follow naturally after questions about caffeine and cigarettes. “What do you like to drink?” or “Tell me about your use of alcohol” are good opening questions that avoid the easy yes or no response. Remember to assess what the patient considers alcohol—some patients do not use this term for wine or beer. To detect problem drinking, use several well-validated short screening tools that do not take much time. Two additional questions: “Have you ever had a drinking problem?” and “When was your last drink?” along with a drink within 24 hours are suspicious for problem drinking.²⁰ The most widely used screening questions are the **CAGE** questions about **C**utting down, **A**nnoyance if criticized, **G**uilty feelings, and **E**ye-openers.

THE CAGE QUESTIONNAIRE

Have you ever felt the need to **Cut down** on drinking?
Have you ever felt **Annoyed** by criticism of your drinking?
Have you ever felt **Guilty** about drinking?
Have you ever taken a drink first thing in the morning (**Eye-opener**) to steady your nerves or get rid of a hangover?

Adapted from Mayfield D, McCleod G, Hall P. The CAGE questionnaire: validation of a new alcoholism screening instrument. *Am J Psychiatry* 131:1121–1123, 1974.

Two or more affirmative answers to the CAGE Questionnaire suggest alcohol misuse and have a sensitivity that ranges from 43% to 94% and specificity that ranges from 70% to 96%.^{21,22} If you detect misuse, you need to ask about blackouts (loss of memory about events during drinking), seizures, accidents or injuries while drinking, job problems, conflict in personal relationships, or legal problems. Also ask specifically about drinking while driving or operating machinery.

Illicit Drugs. As with alcohol, your questions about drugs should generally become more focused if you are to get accurate answers that help you distinguish use from misuse. A good opening question is, “Have you ever used any drugs other than those required for medical reasons?”²³ From there, you can ask specifically about either patterns of use (last use, how often, substances used, amount) or inquire about modes of consumption. “Have you ever injected a drug?” “Have you ever smoked or inhaled a drug?” “Have you ever taken a pill for nonmedical reasons?” As fashions in drugs of abuse change it is important to stay up to date about the most current hazards and risks from overdose.

Another approach is to adapt the CAGE questions to screening for substance abuse by adding “or drugs” to each question. Once you identify substance abuse, continue with further questions like “Are you always able to control your use of drugs?” “Have you had any bad reactions?” “What happened . . . Any drug-related accidents, injuries, or arrests? Job or family problems?” . . . “Have you ever tried to quit? Tell me about it.”

Family Violence. Because of the high prevalence of physical, sexual, and emotional abuse, many authorities recommend the routine screening of all female patients for domestic violence. Other patients at increased risk are children and the elderly.²⁴ As with other sensitive topics, start this part of the interview with general “normalizing” questions: “Because abuse is common in many women’s lives, I’ve begun to ask about it routinely.” “Are there times in your relationships that you feel unsafe or afraid?” “Many women tell me that someone at home is hurting them in some way. Is this true for you?” “Within the last year, have you been hit, kicked, punched, or otherwise hurt by someone you know? If so, by whom?” As with other segments of the history, use a pattern that goes from general to specific, less difficult to more difficult.

Physical abuse—often not mentioned by either victim or perpetrator—should be considered in the following settings:

CLUES TO POSSIBLE PHYSICAL ABUSE

- If injuries are unexplained, seem inconsistent with the patient’s story, are concealed by the patient, or cause embarrassment
- If the patient has delayed getting treatment for trauma
- If there is a past history of repeated injuries or “accidents”
- If the patient or person close to the patient has a history of alcohol or drug abuse
- If the partner tries to dominate the interview, will not leave the room, or seems unusually anxious or solicitous

When you suspect abuse, it is important to spend part of the encounter alone with the patient. You can use the transition to the physical examination as an excuse to ask the other person to leave the room. If the patient is also resistant, you should not force the situation, potentially placing the victim in jeopardy. Be attuned to diagnoses that have a higher association with abuse, such as pregnancy and somatization disorder.

Child abuse is unfortunately also common. Asking parents about their approach to discipline is a routine part of well-child care (see Chapter 18: Assessing Children: Infancy Through Adolescence). You can also ask parents how they cope with a baby who will not stop crying or a child who misbehaves: “Most parents get very upset when their baby cries (or their child has been naughty). How do you feel when your baby cries?” “What do you do when your baby won’t stop crying?” “Do you have any fears that you might hurt your child?” Find out how other caretakers or companions handle these situations as well.

Death and the Dying Patient. There is a growing and important emphasis in health care education on improving clinician training related to death and dying. Many clinicians avoid talking about death because of their own discomforts and anxieties. Work through your own feelings with the help of reading and discussion. Basic concepts of care are appropriate even for beginning students because you will come into contact with patients of all ages near the end of their lives. (For a discussion of end-of-life decision making, grief and bereavement, and advance directives, turn to Chapter 20, The Older Adult, p. 854.)

Kubler-Ross has described five stages in a person’s response to loss or the anticipatory grief of impending death: denial and isolation, anger, bargaining, depression or sadness, and acceptance.²⁵ These stages may occur sequentially or overlap in any order or combination. At each stage, follow the same approach. Be sensitive to the patient’s feelings about dying; watch for cues that the patient is open to talking about them. Make openings for patients to ask questions: “I wonder if you have any concerns about the procedure? . . . your illness? . . . what it will be like when you go home?” Explore these concerns and provide whatever information the patient requests. Avoid unwarranted reassurance. If you explore and accept patients’ feelings, answer their questions, and demonstrate your commitment to staying with them throughout their illness, reassurance will grow where it really matters—within the patients themselves.

Dying patients rarely want to talk about their illnesses at each encounter, nor do they wish to confide in everyone they meet. Give them opportunities to talk, and listen receptively, but if they stay at a social level, respect their preferences. Remember that illness—even a terminal one—is only one small part of the total person. A smile, a touch, an inquiry about a family member, a comment on the day’s events, or even some gentle humor affirms and sus-

tains the unique individual you are caring for. Communicating effectively means getting to know the whole patient; that is part of the helping process.

Understanding the patient's wishes about treatment at the end of life is an important clinician responsibility. Failing to establish communication about end-of-life decisions is widely viewed as a flaw in clinical care. Even if discussions of death and dying are difficult for you, you must learn to ask specific questions. The condition of the patient and the health care setting often determine what needs to be discussed. For patients who are acutely ill and in the hospital, discussions about what the patient wants to have done in the event of a cardiac or respiratory arrest are usually mandatory. Asking about *Do Not Resuscitate (DNR) status* is often difficult when you have no previous relationship with the patient or lack knowledge of the patient's values and life experience. Find out about the patient's frame of reference because the media gives many patients an unrealistic view of the effectiveness of resuscitation. "What experiences have you had with the death of a close friend or relative?" "What do you know about cardiopulmonary resuscitation (CPR)?" Educate patients about the likely success of CPR, especially if they are chronically ill or advanced in age. Assure them that relieving pain and taking care of their other spiritual and physical needs will be a priority.

In general, it is important to encourage any adult, but especially the elderly or chronically ill, to establish a *health proxy*, who can act as the patient's health decision maker (see p. 52). This part of the interview can be a "values history" that identifies what is important to the patient and makes life worth living, and the point when living would no longer be worthwhile. Ask how patients spend their time every day, what brings them joy, and what they look forward to. Make sure to clarify the meaning of statements like, "You said that you don't want to be a burden to your family. What exactly do you mean by that?" Explore the patient's religious or spiritual frame of reference so that you and the patient can make the most appropriate decisions about health care.



SOCIETAL ASPECTS OF INTERVIEWING

Achieving Cultural Competence. Communicating effectively with patients from every background has always been an important professional skill. Nevertheless, disparities in health care resulting from factors such as class, education, ethnicity, and race have fueled renewed efforts to raise the standards of cultural competence among clinicians.²⁶

Working well with diverse patients is a career-long process built on genuine interest in learning about others, appreciation of the value of diverse cultures, and the practice of reflecting on how your own perspectives are equally shaped by culture. The following examples illustrate how cultural differences and unconscious bias can unwittingly lead to poor communication and influence the quality of patient care.

CULTURAL COMPETENCE: SCENARIO 1

A 28-year-old taxi driver from Ghana who had recently moved to the United States complained to a friend about U.S. medical care. He had gone to the clinic because of fever and fatigue. He described being weighed, having his temperature taken, and having a cloth wrapped tightly, to the point of pain, around his arm. The clinician, a 36-year-old woman from Washington, D.C., had asked the patient many questions, examined him, and wanted to take blood, which the patient had refused. The patient's final comment was ". . . and she didn't even give me chloroquine!"—his primary reason for seeking care. The man from Ghana was expecting few questions, no examination, and treatment for malaria, which is what fever usually means in Ghana.

In this example, cross-cultural miscommunication is understandable and so less threatening to explore. Unconscious bias leading to miscommunication, however, occurs in many clinical interactions. Consider the scenario below that is closer to daily practice.

CULTURAL COMPETENCE: SCENARIO 2

A 16-year-old high school student came to the local teen health center because of painful menstrual cramps that were interfering with concentrating at school. She was dressed in a tight top and short skirt and had multiple piercings, including in her eyebrow. The 30-year-old male clinician asked the following questions: "Are you passing all of your classes? What kind of job do you want after high school? What kind of birth control do you want?" The teenager felt pressured into accepting birth control pills, even though she had clearly stated that she had never had intercourse and planned to postpone it until she got married. She was an honor student and planning to go to college, but the clinician did not elicit these goals. The clinician glossed over her cramps by saying, "Oh, you can just take some ibuprofen. Cramps usually get better as you get older." The patient will not take the birth control pills that were prescribed, nor will she seek health care soon again. She experienced the encounter as an interrogation, so failed to gain trust in her clinician. In addition, the questions made assumptions about her life and did not treat her health concern with respect. Even though the provider pursued the important psychosocial domains, she received ineffective health care because of conflicting cultural values and unreflected clinician bias.

In both of these cases, the failure stems from mistaken assumptions or biases. In the first case, the clinician did not consider the many variables affecting patient beliefs about health and expectations for care. In the second case, the clinician allowed stereotypes to dictate the agenda instead of listening to the patient and respecting her as an individual. Each of us has our own cultural background and our own biases. These do not simply fade away as we become clinicians.

As you provide care for an ever-expanding and diverse group of patients, you must recognize how culture shapes not just the patient's beliefs, but your own. *Culture* is the system of shared ideas, rules, and meanings that influences how we view the world, experience it emotionally, and behave in relation to other people. It can be understood as the “lens” through which we perceive and make sense out of the world we inhabit. The meaning of culture is much broader than the term “ethnicity.” Cultural influences are not limited to minority groups; they are relevant to everyone. They reflect factors like geography, age, religion, gender, sexual orientation, ethnicity, race, and socioeconomic status.

Although learning about specific cultural groups is important, avoid allowing this knowledge to turn into stereotyping rather than understanding. For example, you may have learned that Hispanic patients convey their pain in a more dramatic fashion. However, it is still important for you to evaluate each patient with pain as an individual, not decreasing the amount of analgesic you would typically use, but being aware of your reactions to the patient's style. Work on an appropriate and informed clinical approach to all patients by becoming aware of your own values and biases, developing communication skills that transcend cultural differences, and building therapeutic partnerships based on respect for each patient's life experience. This type of framework, described in the section below, will allow you to approach each patient as unique and distinct.

THE THREE DIMENSIONS OF CULTURAL COMPETENCE

- *Self-awareness.* Learn about your own biases . . . we all have them.
- *Respectful communication.* Work to eliminate assumptions about what is “normal.” Learn directly from your patients—they are the experts on their culture and illness.
- *Collaborative partnerships.* Build your patient relationships on respect and mutually acceptable plans.

Self-Awareness. Start by exploring your own cultural identity. How do you describe yourself in terms of ethnicity, class, region or country of origin, religion, and political affiliation? Don't forget the characteristics that we often take for granted—gender, life roles, sexual orientation, physical ability, and race—especially if we are in majority groups. What aspects of your family of origin do you identify with, and how are you different from your family of origin? How do these identities influence your beliefs and behaviors?

A more challenging task in learning about ourselves is to bring our own values and biases to a conscious level. *Values* are the standards we use to measure our own and others' beliefs and behaviors. These may appear to be absolutes. *Biases* are the attitudes or feelings that we attach to perceived differences. Being attuned to difference is normal; in fact, in the distant past, detecting differences may have preserved life. Intuitively knowing members of one's own group is a survival skill that we may have outgrown as a society but that is still actively at work.

Feeling guilty about our biases makes it hard to recognize and acknowledge them. Start with less threatening constructs, like the way an individual relates to time, a culturally determined phenomenon. Are you always on time—a positive value in the dominant Western culture? Or do you tend to run a little late? How do you feel about people whose habits are opposite to yours? Next time you attend a meeting or class, notice who is early, on time, or late. Is it predictable? Think about the role of physical appearance. Do you consider yourself thin, mid-size, or heavy? How do you feel about your weight? What does prevailing U.S. culture teach us to value in physique? How do you feel about people who have different weights?

Respectful Communication. Given the complexity of culture, no one can possibly know the health beliefs and practices of every culture and sub-culture. Let your patients be the experts on their own unique cultural perspectives. Even if patients have trouble describing their values or beliefs in the abstract, they should be able to respond to specific questions. Find out about the patient's cultural background. Use some of the same questions discussed earlier in the section, *Creating a Shared Understanding of the Problem* (see p. 33). Maintain an open, respectful, and inquiring attitude. "What did you hope to get from this visit?" If you have established rapport and trust, patients will be willing to teach you. Be aware of questions that contain assumptions. And always be ready to acknowledge your areas of ignorance or bias. "I know very little about Ghana. What would have happened at a clinic there if you had these concerns?" Or, with the second patient and with much more difficulty, "I mistakenly made assumptions about you that are not right. I apologize. Would you be willing to tell me more about yourself and your future goals?"

Learning about specific cultures is valuable because it broadens what you, as a clinician, identify as areas you need to explore. Do some reading about the life experiences of individuals in ethnic or racial groups that live in your area. Go to movies that are filmed in different countries or explicitly present the perspective of different cultures. Learn about the concerns of different consumer groups with visible health agendas. Get to know healers of different disciplines and learn about their practices. Most importantly, be open to learning from your patients. Do not assume that what you have learned about a cultural group applies to the individual before you.

Collaborative Partnerships. Through continual work on self-awareness and seeing through the "lens" of others, the clinician lays the foundation for the collaborative relationship that best supports the patient's health. Communication based on trust, respect, and a willingness to re-examine assumptions allows patients to express aspects of their concerns that may run counter to the dominant culture. These concerns may be associated with strong feelings such as anger or shame. You, the clinician, must be willing to listen to and validate these feelings, and not let your own feelings prevent you from exploring painful areas. You must also be willing to reexamine your beliefs about what is the "right approach" to clinical care in a given situation. Make every effort to be flexible and creative in your plans and respectful of patients' knowledge about their own best interests. By consciously distinguishing what is truly important to the patient's health from what is just the standard advice, you and your patients can construct the unique approach to their health care that is in concert with their beliefs and effective clinical

care. Remember that if the patient stops listening, fails to follow your advice, or does not return, your health care has not been successful.

Sexuality in the Clinician–Patient Relationship. Clinicians of both genders occasionally find themselves physically attracted to their patients. Similarly, patients may make sexual overtures or exhibit flirtatious behavior toward clinicians. The emotional and physical intimacy of the clinician–patient relationship may lend itself to these sexual feelings.

If you become aware of such feelings in yourself, accept them as a normal human response, and bring them to conscious level so they will not affect your behavior. Denying these feelings makes it more likely for you to act inappropriately. *Any* sexual contact or romantic relationship with patients is *unethical*; keep your relationship with the patient within professional bounds, and seek help if you need it.

Sometimes clinicians meet patients who are frankly seductive or make sexual advances. You may be tempted to ignore this behavior because you are not sure that it really happened, or you are just hoping it will go away. Calmly but firmly, make it clear that your relationship is professional, not personal. If unwelcome overtures continue, leave the room and find a chaperone to continue the interview. You should also reflect on your image. Has your clothing or demeanor been unconsciously seductive? Have you been overly warm with the patient? Although it is your responsibility to avoid contributing to these problems, usually you are not at fault. Often these problems reflect the patient’s discomfort with feeling less powerful.



ETHICS AND PROFESSIONALISM

You may wonder why an introductory chapter on interviewing contains a section on clinical ethics. The potential power of clinician–patient communication calls for guidance beyond our innate sense of morality. *Ethics* are a set of principles crafted through reflection and discussion to define right and wrong. *Medical ethics*, which guide our professional behavior, are neither static nor simple, but several principles have guided clinicians throughout the ages. Although in most situations your gut sense of right and wrong will be all that you need, even as students, you will face decisions that call for the application of ethical principles.

Some of the traditional and still fundamental maxims embedded in the healing professions are listed below.

BUILDING BLOCKS OF PROFESSIONAL ETHICS IN PATIENT CARE

- **Nonmaleficence or *primum non nocere*** is commonly stated as, “First, do no harm.” In the context of an interview, giving information that is incorrect or not really related to the patient’s problem can do harm. Avoiding relevant topics or creating barriers to open communication can also do harm.

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BUILDING BLOCKS OF PROFESSIONAL ETHICS IN PATIENT CARE (Continued)

- **Beneficence** is the dictum that the clinician needs to “do good” for the patient. As clinicians, your actions need to be motivated by what is in the patient’s best interest.
- **Autonomy** reminds us that patients have the right to determine what is in their own best interest. This principle has become increasingly important over time and is consistent with collaborative rather than paternalistic clinician–patient relationships.
- **Confidentiality** can be one of the most challenging principles. As a clinician, you are obligated not to repeat what you learn from or know about a patient. This privacy is fundamental to our professional relationships with patients. In the daily flurry of activity in a hospital, it is all too easy to let something slip. You must be on your guard.

As students, you are exposed to some of the ethical challenges that you will confront later as practicing clinicians. However, there are dilemmas unique to students that you will face from the time that you begin taking care of patients. The following vignettes capture some of the most common experiences. They raise a variety of ethical and practical issues that are overlapping.

ETHICS AND PROFESSIONALISM: SCENARIO 1

You are a third-year medical student on your first clinical rotation in the hospital. It is late in the evening when you are finally assigned to the patient you are to “work up” and present the next day at preceptor rounds. You go to the patient’s room and find the patient exhausted from the day’s events and clearly ready to settle down for the night. You know that your intern and attending physician have already done their evaluations. Do you proceed with a history and physical that is likely to take 1 to 2 hours? Is this process only for your education? Do you ask permission before you start? What do you include?

Here you are confronted with the tension between *the need to learn by doing* and *doing no harm to patients*. There is a utilitarian ethical principle that reminds us that if clinicians-in-training do not learn, there will be no future caregivers. Yet the dictums to do no harm and prioritize what is in the patient’s best interests are clearly in conflict with that future need. As a student, this dilemma will arise often.

Obtaining *informed consent* is the means to address this ethical dilemma. Making sure the patient realizes that you are in training and new at patient evaluation is always important. It is impressive how often patients willingly let students be involved in their care. It is an opportunity for patients to give back to their caregivers. Even when clinical activities appear to be purely for educational purposes, there may be a benefit to the patient. Multiple care-

givers provide multiple perspectives, and the experience of being heard can be therapeutic.

ETHICS AND PROFESSIONALISM: SCENARIO 2

It is after 10 PM, and you and your resident are on the way to complete the required advance directives form with a frail, elderly patient who was admitted earlier that day with bilateral pneumonia. The form, which includes a discussion of Do Not Resuscitate orders, must be completed before the team can sign out and leave for the day. Just then, your resident is paged to an emergency and asks you to go ahead and meet with the patient to complete the form; the resident will cosign it later. You had a lecture on advance directives and end-of-life discussions in your first year of school but have never seen a clinician discuss this with a patient. You have not yet met the patient, nor have you had a chance to really look at the form. What should you do? Do you inform the resident that you have never done this before nor even seen it done? Do you need to inform the patient that this is totally new for you? Who should decide whether you are competent to do this independently?

In this situation, you are being asked to take responsibility for clinical care that exceeds your level of comfort and maybe your competence. This can happen in a number of situations, such as being asked to evaluate a clinical situation without proper back-up or to draw blood or start an IV before you have done one under supervision. For the patient above, you may have many of the following thoughts: “the patient needs to have this completed before going to sleep and so will benefit”; “the risk to the patient from discussing advance directives is minimal”; “you are pretty good with elderly patients and think that you might be able to do this”; “what if the patient actually arrests that night and you are responsible for what happens”; and finally, “if you bother the resident now he or she will be angry and that may affect your evaluation.” There is educational value to the learner in being pushed to the limits of his or her knowledge to solve problems and to gain confidence in functioning independently. But what is the right thing to do in this situation?

The principles listed above only partially help you sort this out because only part of your quandary relates to your relationship with the patient. Much of the tension in this scenario has to do with the dynamics of a health care team and your role on that team. You are there to help with the work of the team, but you are primarily there to learn. Current formulations of medical ethics address those issues and others. One such formulation is the Tavistock Principles.²⁷ These principles construct a framework for analyzing health care situations that extends beyond our direct care of individual patients to complicated choices about the interactions of health care teams and the distribution of resources for the well-being of society. A broadly representative group that initially met in Tavistock Square in London in 1998 has continued to elaborate an evolving document of ethical principles for guiding health care behavior for both individuals and institutions across the health care spectrum. A current iteration of the Tavistock Principles follows.

THE TAVISTOCK PRINCIPLES

Rights: People have a right to health and health care.

Balance: Care of the individual patient is central, but the health of populations is also our concern.

Comprehensiveness: In addition to treating illness, we have an obligation to ease suffering, minimize disability, prevent disease, and promote health.

Cooperation: Health care succeeds only if we cooperate with those we serve, each other, and those in other sectors.

Improvement: Improving health care is a serious and continuing responsibility.

Safety: Do no harm.

Openness: Being open, honest, and trustworthy is vital in health care.

In the second scenario, think about the Tavistock Principles of *openness and cooperation*, in addition to the balance between *do no harm* and *beneficence*. You need to work with your team in a way that is honest and reliable to do the best for the patient. You can also see that there are no clear or easy answers in such situations. What responses are available to you to address these and other quandaries?

You need to reflect on your beliefs and assess your level of comfort with a given situation. Sometimes there may be alternative solutions. For example, in Scenario 1, the patient may really be willing to have the history and physical examination done at that late hour, or perhaps you can renegotiate the time for the next morning. In Scenario 2, you might find another person who is more qualified to complete the form or to supervise when you do it. Alternatively, you may choose to go ahead and complete the form, alerting the patient to your inexperience and obtaining the patient's consent. You will need to choose which situations warrant voicing your concerns, even at the risk of a bad evaluation.

Seek coaching on how to express your reservations in a way that ensures that they will be heard. As a clinical student, you will need settings for discussing these immediately relevant ethical dilemmas with other students and with more senior trainees and faculty. Small groups that are structured to address these kinds of issues are particularly useful in providing validation and support. Take advantage of such opportunities whenever possible.

ETHICS AND PROFESSIONALISM: SCENARIO 3

You are the student on the clinical team that has been taking care of Ms. Robbins, a 64-year-old woman admitted for an evaluation of weight loss and weakness. During the hospitalization, she had a biopsy of a mass in her chest in addition to many other tests. You have gotten to know her well, spending a lot of time with her to answer questions, explain procedures, and learn about her and her family. You have discussed her fears about what

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ETHICS AND PROFESSIONALISM: SCENARIO 3 (Continued)

“they” will find and know that she likes to know everything possible about her health and medical care. You have even heard her express frustrations with her attending physician at not always being given the “straight story.” It is late Friday afternoon, but you promised Ms. Robbins that you would come by one more time before the weekend and let her know if the results of the biopsy were back yet. Just before you go to her room, the resident tells you that the pathology is back from her biopsy and shows metastatic cancer, but the attending physician does not want the team to say anything until he comes in on Monday.

What are you going to do? You feel that it is wrong to avoid the situation by not going to her room. You also believe that the patient’s preference and anxiety are best served by finding out then and not waiting for 3 days. You do not want to go against the attending physician’s clear instructions, however, both because you respect the fact that it is his patient and because that feels dishonest.

In this situation, telling the patient about her biopsy results is dictated by several ethical principles: the patient’s best interests, autonomy, and your integrity. The other part of the ethical dilemma concerns communicating your plan to the attending. Sometimes the most challenging part of such dilemmas tests your will to follow through with the right course of action. Although it may appear to be a lose-lose situation, a respectful and honest discussion with the attending, respectfully articulating what is in the patient’s best interest, will usually be heard. Enlist the support of your resident or other helpful attendings if that is possible. Learning how to navigate difficult discussions will be a useful professional skill.

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