3 The Medical Interview

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The medical interview is the practicing physician's most versatile diagnostic and therapeutic tool. However, interviewing is also one of the most difficult clinical skills to master. The demands made on the physician are both intellectual and emotional. The analytical skills of diagnostic reasoning must be balanced with the interpersonal skills needed to establish rapport with the patient and facilitate communication.

Interviewing is often considered part of the "art" in contrast to the "science" of medicine. There are many reasons to dispute this distinction. Perhaps the most compelling is that labeling it an "art" removes interviewing from the realm of critical appraisal and suggests that there is something magical or mysterious about interviewing that cannot be described or taught. This chapter will demonstrate the validity of interviewing as a clinical science based on critical observation and analysis of the patient without diminishing its excitement as a clinical activity. It provides a guide to conducting initial interviews and making sense of what happens. It will outline the knowledge, attitudes, and skills that lead to effective interviewing. The discussion will focus on the problem-oriented diagnostic interview, but the health promotion interview and interviews during follow-up visits will also be mentioned.

Before reading this chapter, the student should keep in mind that interviewing is a practical skill that can only be learned through doing. No amount of reading can replace the experience of actually talking with patients, especially if the student's interviews can be observed and critiqued. As clinicians, we do in fact spend a great deal of our time talking with patients.

Nature and Goals of the Interview

Most clinicians rate the patient's medical history as having greater diagnostic value than either the physical examination or results of laboratory investigations (Rich, 1987). The clinical adage that about two-thirds of diagnoses can be made on the basis of the history alone has retained its validity despite the technological advances of the modern hospital. An accurate history also provides focus to the physical examination, making it more productive and time efficient. Clinical hypotheses generated during the interview provide the basis for a cost-effective utilization of the clinical laboratory and other diagnostic modalities.

The diagnostic utility of the interview is complemented by its therapeutic power. As the medium through which a positive relationship is established between the doctor and the patient, an empathic, patient-centered interview can bolster the patient's sense of self-esteem and lessen the feelings of helplessness that often accompany an episode of illness. The therapeutic alliance forged during the clinical encounter provides the foundation for ongoing patient care and education.

The student may wonder how the medical interview differs from other conversations and why special skills are required. It is the sense of direction that distinguishes the medical interview from the casual conversations of most social encounters. Fundamentally, the medical interview is a purposeful conversation undertaken with a set of goals and priorities clearly maintained in the physician's mind. Its direction reflects the respective needs of both participants—patient and physician. The patient enters the interview seeking relief from the discomforts and uncertainties of illness, while the physician actively conducts the interview in order to clarify the patient's problems and derive diagnostic and therapeutic plans for the patient's benefit. During the interview the patient's need to have his or her story heard and suffering understood is balanced by the physician's need to know and understand as much as possible about the patient and his or her problems (Engel, 1988). For most physicians, the most difficult aspect of interviewing patients is maintaining a balance between the patient's and the physician's agenda; between actively directing the encounter and facilitating the patient's spontaneous report of history. At its best, the interview becomes a dialogue between two people driven toward a common goal.

The Problem-Oriented and the Health Promotion Interviews

Medical interviews are of two basic types: the *problem-oriented* and the *health promotion* interviews (Levinson, 1987). The goals of the problem-oriented interview reflect the patient's request for help with specific problems. The health promotion interview establishes a data baseline concerning the patient's current and past health problems, assesses current health risk factors (e.g., smoking, diet, alcohol consumption, heritable diseases in the family), and can detect early evidence of disease (e.g., change in bowel habits, weight loss, chest discomfort) that the patient did not consider severe enough to warrant a problem-specific visit to the doctor. In reality, most medical encounters combine the problem-oriented and health promotion approaches. Issues of health promotion are important to all patients, and patients who come to the doctor for a "routine check-up" may have hidden concerns about specific symptoms. In fact, careful questioning about why and when a patient schedules a routine check-up often uncovers significant health concerns.

Diagnostic Functions: Process and Content

The medical interview provides two categories of information unavailable from any other source: *what* the patient says about the illness and *how* it is said. What the patient tells the physician provides the factual *content* of the medical history. The factual content is what the physician edits and records in the written record—the medical history. It should include a comprehensive, chronological report of the patient's illness with enough information, both positive and

negative, for accurate and inclusive diagnostic reasoning regarding possible etiologies of the patient's problem(s). The *process* of the interview is what actually happens between physician and patient during their encounter.

Observation of process, both verbal and nonverbal, provides important information about the patient as a person. Through the patient's behavior during the interview (e.g., facial expressions, posture, gestures) he or she communicates emotional concerns, reactions to illness, and style of relating to others. Sudden shifts of topic, avoidance of certain issues, and the flow of spontaneous associations may point to concerns that are not expressed directly. The physician's communication style and behavior during the interview is also a critical element of the interviewing process.

The distinction between content and process highlights the dual skills required in the medical interview—analytical and interpersonal. Although these skills can be discussed separately, they must be practiced together. The clarity and validity of information gathered during the interview (its content) may be critically determined by the quality of the relationship that develops between patient and physician (its process). A candid disclosure of patient concerns is most likely to come about in the context of a nonjudgmental interviewing style.

A final comment on process and content may be helpful to the beginning student. The content and organization of the written medical history is often confused with the process by which the clinician actually collects information during the interview. The written medical history is actually a journalistic endeavor in which the clinician edits and organizes the patient's spontaneous report into a formal, organized presentation. The final product in the medical chart may bear little resemblance to the work the clinician performs at the bedside. Patients rarely report their symptoms in an organized and logical fashion comparable to the descriptions of disease in medical texts. In fact, patients complain of illness or sickness rather than stating their problems in terms of the pathophysiologic categories of disease. Students who expect their patient's to present classic symptom complexes in an organized fashion experience considerable frustration and may become rapidly disillusioned with clinical medicine. The complaint that, "The patient was a poor historian," may reflect unrealistic expectations on the interviewer's part.

In clinical practice, the interview is a collaborative effort between physician and patient. Reiser (1980) states that, "The physician, no matter how skilled, cannot simply extract a history from his patient. The patient, no matter how articulate, cannot give a history in final form without help and guidance from the physician." To say that we "take a history" from the patient implies that the story of illness can be extracted from the patient like shaking a coin from a piggy bank. This erroneous conception of the medical interview leads to frustrated attempts at shaking out the history as if the patient was willfully keeping this valuable coin hidden.

Therapeutic Tasks: Establishing a Helping Relationship

The helping relationship is a cornerstone of medical care (Rogers, 1961). In the practice of medicine, the medical interview provides perhaps the most important avenue for establishing a helping relationship built on trust and commitment. This does not occur magically. The physician actively employs interviewing techniques to promote the relationship. Nonjudgmental interest in the patient's problems (active listening), empathy (communicating to the patient an accurate assessment of emotional state), and concern for the patient as a unique person are among the most important tools in the physician's interpersonal repertoire. These techniques not only strengthen the therapeutic bond, they improve the interview's diagnostic power by providing the patient with an attentive and receptive audience.

Many visits to the physician, excluding those for catastrophic illness, are motivated by a request for interpretation of symptoms that the patient finds confusing (Barsky, 1980). By helping the patient describe and sort out experiences, the physician can provide explanations and meaning to events and feelings that were formerly perplexing and threatening. The patient's sense of control can be reestablished in a realistic fashion, and feelings of helplessness and hopelessness can be addressed in the context of the helping relationship. Problems can be reframed and prioritized to help the patient develop his or her own solutions. Obviously, the goals of the medical interview have much in common with psychotherapy. Furthermore, patients who sense that their story is taken seriously may feel encouraged to become more active participants in their medical care. Patient compliance and cooperation with future diagnostic and therapeutic plans often hinge on the physician's skill in developing and negotiating a management plan that encourages patient involvement and initiative.

The method a physician uses to establish rapport differs with each interview. Each encounter is unique. One patient may respond best to a reassuring touch, one to a well-timed interpretation of emotional concerns, another to a moment of shared silence. Observation of the patient's responses serve as the physician's guide to which techniques to employ and provides feedback about when and how to change course. Patients demonstrate a remarkable variety of responses to the medical interview reflecting the range of human personality types and responses to illness. Anger, anxiety, denial, vagueness about detail, emotional embellishment, and unreasonable expectations or demands are but a few of the difficult but common challenges in the medical interview.

Conducting the Interview

The First Minutes—Greetings and Assuring Patient Comfort

During the first minutes of the interview the physician actively sets the stage for an effective interaction. Since the interview begins with a meeting between strangers—the physician and patient—clear introductions are important. They communicate the physician's respect for the patient as a unique individual. Feelings of anxiety are common during the initial moments of the encounter and may be particularly intense for the beginning student who is uncertain of his or her role. A simple statement is usually a good way to start.

> Hello Mrs. Parish, my name is John Simmons. I am a second year medical student here at the school. I will be interviewing you for about 30 minutes to learn what kinds of problems you are having and how they have affected you. Will this be O.K. with you?

This introduction establishes names, roles, purpose (including an interest in the patient's response to illness) and the time limits of the interview. Of course, it is important to knock before entering the patient's room to begin the interview. Unfortunately, this courtesy is often neglected during hospital rounds.

Assessing the patient's comfort is the next step. An IV or oxygen mask, facial expressions of distress, or an emesis basin at the bedside provide nonverbal clues to the alert clinician. Bringing a cup of water, raising the head of the bed, or helping the patient to the bathroom may be greatly appreciated. They also provide a natural opportunity for a caring touch. Questions such as "How are you feeling?" "Are you comfortable now?" "Do you feel well enough to talk now?" are helpful.

It is best to conduct the interview in a quiet and private environment. This may be impossible in a busy hospital. However, televisions can be turned off, doors closed, and curtains pulled. The bedrail should be lowered to remove this physical barrier to communication. If the patient feels well enough, it may be best to help him or her into a chair. The difference between interviewing a patient who is lying flat in bed and one who is sitting in a chair can be striking. This simple act can emphasize patient autonomy and active involvement in the interview.

If family members or other visitors are in the patient's room, the physician should introduce him- or herself to all those present and explain the purpose of the interview. If they are allowed to stay, the interviewer should inform the family that the patient must be given an opportunity to speak without excessive interruptions or editorial comments. If family do not comply, this problem must be addressed directly.

"Calibrating" the Interview

The first minutes give the observant physician valuable information about the patient's communication style and behavior, as well as providing a tentative list of problems. Some patients need considerable prompting to discuss their current problems, while others need limits set because of a rambling history. The patient's vocabulary and clarity of expression can be assessed early in the encounter. Emotional reactions such as anxiety, defensiveness, or hostility are often evident. All these elements are important in determining the patient's reliability as a historian. The first minutes give the interviewed time to "calibrate" his/her techniques to the individual patient (Engel). By recognizing the patient's emotions and responding to them in a supportive manner, the clinician can conduct an effective patient-centered interview. As examples, the interviewer will expect the confused patient to give a confused history; the emotionally reactive patient to embellish and exaggerate symptoms or reactions; and the depressed patient to be withdrawn and require considerable support.

Questioning, Listening, and Observing

With introductions completed and patient comfort assessed the physician must decide how to initiate further questioning. Some physicians like to ask about the patient's social and personal background, including residence, employment, and family. Although this technique works well with some patients, others find it distracting. They seem to expect a more direct inquiry about their health and current problems. Frequently used opening questions include, "What problems brought you to the hospital (or office) today?" or "What kind of problems have you been having recently?" or "What kind of problems would you like to share with me?" These open-ended, nondirective questions encourage the patient to report any and all problems. At this point in the interview it is important to let the patient talk spontaneously rather than restricting and directing the flow of information with multiple questions. Let the patient talk freely for the first few minutes before initiating a more detailed inquiry.

From Beckman's (1984) observations of internal medicine residents it appears that physicians all too frequently interrupt their patients in the first few seconds of the interview. Patients are prevented from expressing their major concerns. These unexpressed concerns may become part of a "hidden agenda" not because the patient is hiding them but because the physician hasn't given the patient a chance to talk. What the patient patient says first may not be the only or even the most important complaint.

Premature selection of a direction for detailed questioning (for example, a report of generalized fatigue) can confuse or distract the patient from reporting other, perhaps more significant problems (for example, chest pains and the fear of heart problems). Beginning with directive, closed questions early in the interview communicates that the patient should remain silent until asked a specific question. The patient may feel, for good reason, that his major complaint is being ignored. The physician, in turn, may feel frustrated as direct questions lead to dead ends. The physician's task is arduous because he/she must think of a new question after each patient response. In such situations, describing the patient as a "poor historian" obscures the fact that the major problem stems from the physician's premature selection of a line of inquiry before the full scope of the patient's concerns was defined and the physician's overuse of a closed question–answer interactional technique.

Facilitation Techniques

To obtain accurate, unbiased information, exert only as much control over the interview as is needed. The physician's task is to keep the patient talking about the illness in a productive fashion. Facilitation techniques are employed to encourage and guide the patient's spontaneous report. These include the use of posture, gesture, and words to indicate that the interviewer is interested in what the patient is saying. These techniques reassure the patient that he or she should go on speaking and provide time for the patient to think and respond. A shared silence often helps the flow of the interview if the interviewer maintains eye contact and an interested manner. It is not necessary to come up with a question each moment the patient falls silent. Silences often help the patient reexperience emotions and provide the time needed for reflection. Most interviewers can judge if a patient is actively thinking during the silence or needs help getting started again. Prompt the patient to continue with a spontaneous report by repeating the patient's last phrase in a questioning tone such as ". . . you felt short of breath?" Or, make an observational statement such as, "You stopped talking a few moments ago after telling me about

your weight loss . . . can you tell me what you are thinking about?" Occasional nods of the head, following the patient's response with "Yes?" or "and then?" or "huh, huh?" in a questioning tone may keep the patient talking.

The Patient's Chief Complaint

Before selecting the focus for questioning, ask, "Anything else?" or "Do you have any other problems?" If the list is extensive and obviously beyond the time limit available for the interview, ask, "Which of these problems concerns or bothers you the most?" or "Which of your problems did you hope I could help you with today?" The physician then ranks the problems in order of importance and listens for patterns that suggest disease processes. Some problems will be clearly related to the chief complaint. Others are unrelated or of only possible relevance.

It may become evident that the patient is most troubled by problems that the physician considers of lower priority or less urgent. For example, the patient may be most concerned about his finances, while the physician wants to learn more about the chest pain and palpitations. In general, the clinician should briefly communicate concern for the patient's major concerns even if they do not seem to be medically significant. For example,

> You have mentioned quite a few problems and we may not have time to clarify all of them now. I can see that you are very worried about your finances. Those concerns will need further attention . . . and we will work on them. What I would like to do now is find out more about your chest pain and the fainting spell that you mentioned.

The physician cannot assume that all of the patient's concerns will be raised early in the interview. Patients may talk about embarrassing or confidential problems when rapport and trust have been deepened. Not infrequently, the patient brings up important issues only at the end of the encounter by stating, "Oh, by the way doctor. . . ."

The History of Present Illness (H.P.I.) or Story of Illness

The clinician now explores as fully as possible the patient's major problems, following leads obtained during the discussion of the chief complaint. The history of the present illness (HPI) includes all of the patient's history, both recent and remote, that is pertinent to understanding the current illness. In completing the HPI, the physician will often collect pertinent information about the patient's past history (for example, a history of hypertension in a patient with stroke), the patient's family history (for example, a family history of breast cancer in a patient with a breast lump), and the social history (for example, domestic discord in a patient with insomnia and fatigue).

Each new piece of information is assessed for reliability, completeness, and relevance to the patient's problem. The physician should repeatedly scan the information already gathered looking for symptom complexes or diagnostic patterns. For example, the physician interviewing a 30-year-old woman with fever, back pain, and urinary frequency would immediately consider the possibility of a urinary tract infection. With increasing knowledge of clinical syndromes, the clinician's ability to form more complex diagnostic hypotheses improves. Each hypothesis is tested for validity with further specific questions such as, "Have you ever had a bladder or kidney infection? Any kidney stones? Are you sexually active?" Through this process, speculations are tested against objective reality and accurate hypotheses are generated.

TYPE OF QUESTIONS

Begin each line of inquiry with an open-ended question and proceed to more specific questions to fill in the gaps. Encourage the patient to provide primary data in his or her own words about the symptoms rather than provide diagnostic labels or "hearsay" from other doctors or family members (secondary or tertiary information). The patient may need coaching about what information the physician seeks. For example, the patient who complains of her "esophagitis" should be asked to describe her symptoms before the physician accepts this diagnostic label. Questions should be worded so that the patient has no difficulty understanding what is being asked. Avoid using technical terms and diagnostic labels. The interviewer's questions should indicate what type of information is requested, but not what answer is expected. The difference between asking, "Are you having any stomach problems?" and "You're not hurting in your stomach, are you?" is obvious, but it is easy to fall into the pattern of asking leading questions. Effective questions are usually simple. Avoid double-barreled questions, such as "Are you having any stomach pains or bladder problems?"

CHARACTERIZING THE PATIENT'S SYMPTOMS

Engel (1982) describes seven dimensions that characterize the bodily and emotional aspects of a symptom: its chronology, bodily location, quality, quantity, setting, any aggravating or alleviating factors, and associated manifestations. In general, the clinician should gather information clarifying all seven dimensions for each area of major concern. A directive statement may be needed to direct or coach the patient about what information is needed. "A detailed description of your symptoms will help *me* to help *you*. Let's start at the beginning."

CHRONOLOGY

A chronologic description provides the framework for characterizing the course of an illness. The interviewer should obtain a chronologic report by asking when the problem first started and facilitate a continuing flow of information with questions such as "And then what happened?. . . and then?. . . and after that?" Dating the onset of illness may be difficult for some patients, but a general estimate should be made. Questions such as, "When did you last feel really well?" or "How did you feel at Christmastime?" can help time the onset of illness. Ask specifically if the patient has ever had similar symptoms in the past.

Chronology also includes the duration of a symptomatic episode (for example, minutes for the chest pain of angina, days for the chest pain of rib fractures), its periodicity (for example, the on-and-off pain of an early small bowel obstruction versus the constant pain of peritonitis), and whether the symptom has gotten better or worse over time.

BODILY LOCATION AND RADIATION

The bodily location of pain or other discomfort should be defined as accurately as possible. The patient may be en-

couraged to indicate the location and radiation of pain using hand gestures, which also indicate how large an area is involved. Remember that the patient may have more than one pain and that multiple pains may indicate multiple disease processes. Ask the patient to characterize and differentiate each.

QUALITY

Most patients use analogies to describe the quality of a sensation. The pain of a myocardial infarction is often described as similar to a "vise" tightening around the chest or "someone standing on the chest." The patient's exact words are important, and a "tightness" should not be assumed to be a "pain." Try to use the patient's own vocabulary if possible. Some patients use highly descriptive or emotion-laden terms like, "It felt like someone was stabbing me with a knife." This provides important clues about the patient's emotional state and reactivity. Other patients need the interviewer's help to find descriptive language. Providing the patient with a choice of descriptions such as "Was the pain sharp or dull?" may be necessary, although the clinician should realize that limiting the patient's response to these two alternatives can bias the history.

QUANTITY

The intensity of pain can be estimated on a scale of 1 to 10 or compared to another pain the patient has experienced. The scalar method is particularly helpful in following the intensity of symptoms over time. Other examples of quantity include volume (for example, the quantity of sputum expectorated in a day), number (for example, the number of times the patient has lost consciousness), and the degree of impairment the patient suffers. Impairment or disability is best characterized in terms of the patient's usual daily activities, such as dyspnea with climbing stairs at home or chest pain while sweeping the floor. Some patients minimize while others amplify the quantity or intensity of their symptoms—important indicators of emotional responses and communication styles.

SETTING

The setting in which the symptoms occur is often critical in developing a clear description of an illness. "Where were you when you first felt ill?" "What were you doing?" "Who was with you?" are excellent questions to use early in the interview. Hypotheses regarding the etiology of symptoms frequently evolve from an understanding of the accompanying physical, social, or emotional events that surround an episode of illness.

AGGRAVATING AND ALLEVIATING FACTORS

Initial data about what makes a symptom worse and what makes it better flows from the patient's spontaneous account. Chest tightness brought on by exertion or shortness of breath at night relieved by sitting up points to specific pathologic processes, effort angina, and paroxysmal nocturnal dyspnea. A knowledge of clinical syndromes sharpens the physician's ear for clues and provides the basis for a directed line of inquiry. For example, the physician would ask the patient who reports the sudden onset of shortness of breath and chest pain four days after a fractured tibia if the pain was pleuritic—worsened with deep breath or cough—a symptom associated with pulmonary embolus. The clinician also collects data concerning what kinds of help the patient has sought for the symptom and types of treatments already tried, including prescribed and over-the-counter medications.

ASSOCIATED MANIFESTATIONS

Symptoms rarely occur singly. The clinician should listen for groups of related symptoms that provide diagnostic clues about pathologic processes and involved organs. The physician might ask, "When you had the joint pains, did you notice anything else?" If the patient's response is positive, he or she is asked to describe the associated symptoms through open-ended questions. Further clarification can be obtained later using more specific questions. Even if the patient reports no associated symptoms, the physician may decide to ask directed questions which help support or reject a given diagnostic possibility. When the patient complains of joint pains, the physician might ask, "Have you had any fevers? Night sweats? Rash? Sensitivity to the sun? Irritation in your eyes? Negative answers, often termed pertinent negatives, may be as important as positives in defining the nature and severity of the illness. They help "rule in" or "rule out" specific diagnoses.

OTHER PERTINENT ASPECTS OF A SYMPTOM

Several other dimensions should be pursued in a comprehensive interview, including the patient's emotional reactions to the illness and the patient's means of coping with discomfort and disability. The patient's reactions to events are often as important as the events themselves. In addition, the patient's thoughts and fantasies about what may have caused the illness are important in understanding why, when, and from whom the patient decided to seek care. The majority of illness episodes are treated outside the physician's office. In both the problem-oriented and the health promotion interviews it is interesting to ask why the patient decided to seek care now. Patients often have specific, perhaps unrealistic, fantasies about what the physician will or can do. The interviewer should try to identify these. The patient's explanatory model of illness, differing with each patient and with each cultural group, may significantly determine an individual's behavior during an illness and affect compliance with medical therapy. Negotiation may bring doctor and patient closer together (Kleinman et al., 1978).

SUMMARIZING THE HPI

The interviewer uses clinical discretion in determining when the history of present illness has been clearly defined. Summarizing the history is a useful way of concluding this section of the interview. "Before we go on, let's see if I understand your history. Last March you first noticed . . ." This summary gives the patient a chance to check the accuracy of the history and gives the physician a chance to review the history for gaps or lack of clarity.

When the HPI is completed, the physician will have collected a great deal of data about the remaining segments of the medical history: the past medical history, family history, social history/patient profile, and review of systems. Of course, new information may appear at any time. During the remainder of the interview, the physician directs the patient to fill in the blanks, completing the rest of the history.

Transitional Statements

Before proceeding with each new section, make a clear transitional statement. For example, "I think I've got a pretty

good idea of your major problems and how they have developed. Now I would like to ask you some questions about your past health." Transitional statements prepare the patient for what is coming next.

Past Medical History

A review of past medical problems and treatments not directly pertinent to the HPI completes the past medical history. A prior diagnosis of diabetes mellitus in a patient with a gangrenous toe belongs with the HPI, whereas a remote appendectomy does not. The past medical history defines a data base for future reference. Major elements of the past medical history include childhood and adult illnesses, operations, trauma, allergies and drug sensitivities (characterized in detail), immunizations, and health maintenance (for example, PPD status and whether or not the patient performs a breast self-examination, has routine pap smears or sigmoidoscopies).

Family History

Medical problems in family members should be reviewed with special attention to heritable disorders. Furthermore, the patient's reaction to an illness in the family may influence response to personal medical problems. A family history of hypertension and myocardial infarction would be included with the HPI of a patient with new-onset chest pain. Time limitations may preclude a detailed inquiry into the health of each family member. Use discretion if the family is very large, and, in elderly patients, remember that the major purpose of the family history is to assess risk factors for the patient's current and future health.

Social History/Patient Profile

The physician collects personal data about the patient to complete the patient profile. Much of this information will have emerged as the patient describes his story of the present illness but gaps are often apparent. During the social history portion of the interview, the physician can gather data about the patient's education, occupation, usual daily activities, functional status, relationships with friends and family, social supports and stresses, financial status/insurance coverage and habits such as use of cigarettes or alcohol that have known health consequences. Again, relevance to the patient's health and life adaptation guide the interviewer in deciding how much information to gather.

Review of Systems (R.O.S.)

Before concluding the interview, the physician should complete a symptom checklist to assure that all important areas of the patient's physical and psychologic health have been considered. Some clinicians prefer to complete the review of systems while examining the patient but this may be distracting for the beginning student. Begin the review of systems with an open-ended question such as "Are you having any other problems that we haven't discussed?" If the patient mentions a new problem, the symptoms can be further characterized. A transitional statement prepares the patient for the next line of questioning. "Before we move on to the physical examination, I would like to ask you a series of questions about specific health problems. Stop me if you are having one of these problems, and we will find out more about it." The interviewer should inquire about each system in an orderly fashion. Questions such as "Have you *ever* had headaches?" may have the unwanted effect of inspiring an overly complete patient response. Try providing direction and limits with the following. "I would like to ask you about your other recent health problems. Have you had any *severe* headaches *recently*?" The entire review of systems should take less than 5 minutes if the physician begins with an open-ended request for information before proceeding. Some patients have a "positive review of systems"—problems in every area. This may indicate emotional problems that cause the patient to amplify symptoms and use them to gain attention and emotional support.

Closing the Interview

Before closing the interview ask the patient if there is anything else he or she would like to discuss or if there are any questions. The clinician then proceeds with the physical examination. Interestingly, some patients become quite talkative during the examination. They seem reassured by the physician's touch and may feel more at ease than when sitting face to face during the interview. Examination of a specific body region or system may remind the patient of previously forgotten details of considerable diagnostic importance. The alert physician will take the stethoscope from his or her ears long enough to hear what the patient has to say.

Communication techniques are of critical importance as the physician reports the findings of the history and physical examination. Diagnostic and prognostic discussions are most effective if tailored to the patient's individual cognitive and communication style. Special emotional concerns discovered during the interview can guide a sensitive approach to sharing news and preparing for the future. The physician's knowledge of the patient as a person provides the foundation for patient education. In a very real sense the interview continues throughout the clinical encounter.

Diagnosing and Solving Problems in the Interview

Even the most skilled clinician may encounter problems interviewing patients. For the interview to get back on track, the clinician must recognize the problem and must find a solution. Interviewing problems can be roughly divided into three categories:

1. Problems with the patient (for example, intense emotional reactions, altered mental status, unrealistic fantasies about the doctor).
2. Problems with the interviewer (for example, an overly judgmental attitude, too directive an approach in questioning, failure to listen to the patient).
3. Problems with the physician–patient relationship (for example, a language barrier, failure to negotiate a shared goal for the encounter).

Given the complexities of the interviewing process, problems from more than one category are often found in one encounter.

The first step in solving problems is to recognize that the interview is not going well. Recognition is facilitated if the clinician assesses the interview in reference to its two major functions: data gathering and establishing a supportive therapeutic relationship. From the first minutes of the interview the clinician asks him/herself the following questions:

Have I established rapport with this patient?

Am I helping the patient provide an accurate, unbiased report of the illness?

Have I collected enough data to make accurate diagnostic hypotheses about the patient's problems?

The clinician also monitors his or her own reactions to the interview. Frustration, anger, or boredom may signal a troubled interview.

Once a problem is recognized, the interviewer uses clinical reasoning to establish the nature of the problem and what may have produced it. The effort to diagnose problems in the interview parallels the process of diagnosing the patient's presenting problems or chief complaint. Like all diagnostic processes, defining the problem is based on observations of what the patient says, and how the patient says it. The clinician must "step back" mentally to form hypotheses about what is going wrong in the communication process. For example, the interviewer may notice that the patient appears depressed and withdrawn, or perhaps confused. It may become evident that the interviewer feels negatively about the patient, disapproves of his or her behavior, or has been distracted by personal thoughts.

After the problem is recognized and hypotheses generated about its etiology, the clinician tries out solutions as the interview progresses. A more complete mental status examination may be needed with the confused patient along with a decision to interview the patient's family to check for reliability of the history. An interpreter may be needed if there is a language barrier. A less directive interview style may be required if the patient's problems have yet to be identified. A more limiting technique may be employed if the patient rambles. Clarifying and highly directed questions may be needed if the history is vague. Cultural differences may be detected and a shared approach negotiated. The physician's limitations may be defined if the patient makes unreasonable requests (Quill).

Emotional Responses: Reassurance and Empathy

Frequently, problems in the interview result from the patient's emotional reactions to illness and the medical encounter. Most patients experience considerable anxiety about their illness and about visiting the doctor. Other patients will have feelings of anger or helplessness. Responses vary with the severity of illness, past experiences, personality, current stresses and supports. The patient who appears reticent to talk may need emotional support. Active, nonjudgmental listening demonstrates the physician's interest and concern and encourages the patient to go on talking.

Reassurance may be provided as the interview proceeds in an attempt to reduce the patient's anxiety. Statements such as "Anyone would be upset if they didn't know what caused their pain" or "Waiting for biopsy results is pretty tough for most patients" may increase the patient's self-esteem and let him or her know that it is all right to share experiences with the physician. Avoid false reassurance—the unrealistic promise of a happy outcome.

To obtain accurate information about emotion-laden issues, the physician may need to "roll out the carpet," inviting the patient's honest answers. Patients often respond defensively to questions such as "How much do you drink?" minimizing the quantity to please the interviewer. Rephrasing the question in a less accusatory tone provides reassurance and an atmosphere of acceptance. "Some people under stress find that they drink more than they would like to. Have you ever experienced that?" During the sexual history, patient's often respond more candidly to the statement "Some patients with heart problems find that they have difficulties with sexual function. Has this been a problem for you?" rather than "How is your sex life?"

Empathy is closely related to reassurance. Empathic statements communicate the physician's recognition of the patient's feelings and provide feedback that the interviewer understands. Empathy begins with the interviewer identifying the patient's emotional state. The following statement communicates the physician's recognition and acceptance of the patient's feelings and encourages further exploration of what is going on: "You look sad when you talk about your son. Can you tell me more about him?" Pointing out the patient's emotion is a form of gentle confrontation. It focuses attention on an aspect of the patient's feelings that has been communicated through statements or behaviors. Since the physician may point out an emotion that the patient is unaware of or defensive about, appropriate timing is critical. The interviewer must be prepared for a hostile response or perhaps for denial. The nature of the response depends on the patient's personality and the depth of rapport that has been established.

Patients often cry during the course of a medical interview. The interviewer does not have to rush in to stop the tears. It is often best to let the storm pass, providing time for the emotional release that crying provides. The interview can then resume with gentle questioning. In general, it is good to avoid questions like "Why do you feel angry (or sad) about that?" Instead, try rephrasing the question to: "You seem angry about that. Can you tell me more about what has been going on?" or "Tell me what the tears are about."

Gentle confrontation may be needed to address communication problems between physician and patient. For example, if the patient seems reticent to talk about issues that seem important, this can be pointed out as follows. "You seem reluctant to talk with me about your problems. I wonder if you may be uncertain about whether or not you can trust me. . . . For me to be able to help you I need to know as much as possible about your problems. . . . How do you think we should proceed?" These statements identify the problem with a confrontation, suggest a possible cause for the problem (distrust), establish the physician's need to know more, and invite patient participation in deciding what course the interview will take. The principle of sharing problems in the interview with the patient is seldom practiced but frequently effective.

Time Limitations

Clinicians often feel rushed to complete the interview and move on to other activities. Time limitations are a reality in clinical medicine, and it may not be possible to complete data collection during a single encounter. In many settings

the physician has the opportunity to go back to the patient again and again to further clarify the history. Patients can be encouraged to reflect on their memories and clarify them as much as possible before the next visit.

Some patients seem unaware of the physician's time restraints. A patient's claim to a monopoly of the physician's efforts must be addressed. A dependent patient may express the wish to have more time with the doctor, especially during follow-up visits, by reporting worrisome symptoms (e.g., rectal bleeding, exertional chest pain, night sweats) at the end of the appointment. If recurrent, this behavior angers and frustrates most physicians and can jeopardize the physician–patient relationship. A gentle confrontation may be helpful in modifying this situation.

> In the last few visits you have told me about worrisome symptoms right at the end of your appointment. This is a real problem for us because it doesn't give us a chance to discuss these problems fully. I'd like you to decide what problems you would like me to hear about before coming to your next visit. I'll ask for the list at the beginning of the appointment. Given the length of your appointments we'll have to decide which problems we can cover and which will have to wait until later.

This statement establishes the physician's limits in a way that also encourages the patient's active participation in deciding how to utilize the scheduled time.

A Review of Common Problems

1. Confusing the traditional, rigid order of the written medical history with the actual process by which information emerges during the medical interview.
2. Relying too heavily on directed, closed questions. This style discourages the patient's associations and spontaneous report of symptoms.
3. Ignoring the patient's emotional responses and concerns during the interview process.
4. Narrowing the scope of inquiry too early in the interview.
5. Failure to clarify the seven dimensions of a symptom in the patient's own words.
6. Insisting that the interview must be accomplished in one session. (Experienced clinicians return to the patient again and again to clarify the history.)
7. Limiting the list of diagnostic hypotheses before adequate data has been collected.
8. Using questions that are leading, too complex, double barreled, or unclear.
9. Failure to follow basic courtesies in the interview: lack of clear introductions, ignoring the patient's comfort, and failure to establish an atmosphere of trust and confidentiality.
10. Failure to elicit the patient's own ideas about the cause of the problem and the patient's fantasies about what the doctor will do.
11. Note taking that interrupts the flow of the interview.

Conclusion

The selected references that follow elaborate and extend many of the concepts discussed here. The student should remember, however, that clinicians learn to conduct interviews by actually interviewing patients, and supervision can be a critical element in the educational process. Engel (1982) compared learning to interview patients with learning to play a musical instrument. Both tasks require practice and critical, yet supportive, assessment of how things are going. A review of audio or video recordings can help the student observe and understand the interviewing process. Nowhere in the practice of medicine is self awareness more important. The learning process extends over many years. The finest clinicians find new reasons for excitement and humility with each new patient encounter—with the challenge of each new interview. It is always good to hear a patient say, "I've finally found a doctor who really listens to my problems." Despite the technologic wizardry of the modern hospital, the most difficult diagnostic puzzles are often unraveled by a carefully conducted, patient-centered interview.

References

Barsky AJ. Hidden reasons some patients visit doctors. Ann Intern Med 1980; 93:490–93.

Beckman HB, Frankel RM. The effect of physician behavior on the collection of data. Ann Intern Med 1984; 101:693–96.

Bernstein L, Bernstein RS. Interviewing—a guide for health professionals. Norwalk, Conn.: Appleton-Century-Crofts, 1985.

Enelow AJ, Swisher SN. Interviewing and patient care. New York: Oxford University Press, 1972.

Engel GL. What if music students were taught to play their instruments as medical students are taught to interview? Pharos 1982; 45(4):12–13.

Engel GL, Morgan WL. Interviewing the patient. Philadelphia: WB Saunders, 1973.

Engel GL. How much longer must medicine's science be bound by a seventeenth century world view. In White KL: The Task of Medicine: Dialogue at Wickenburg. Menlo Park: The Henry J. Kaiser Family Foundation, 1988.

Kassirer JP, Gorry GA. Clinical problem solving: a behavioral analysis. Ann Intern Med 1978; 89:245–55.

Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med 1978; 88:251–58.

Levinson D. A guide to the clinical interview. Philadelphia: Saunders, 1987.

Lipkin M, Quill TE, Napodano RJ. The medical interview: a core curriculum for residencies in internal medicine. Ann Intern Med 1984; 100:277–84.

Nardone DA, Reuler JB, Girard DE. Teaching history-taking: where are we? Yale J Biol Med 1980; 53:233–50.

Platt FW, McMath JC. Clinical hypocompetence: the interview. Ann Intern Med 1979; 91:898–902.

Quill TE. Partnerships in patient care: A contractural approach. Ann Intern Med. 1983; 98:228–34.

Reiser DE, Schroder AK. Patient interviewing—the human dimension. Baltimore: Williams and Wilkins, 1980

Rich EC, Crowson TW, Harris IB. The diagnostic value of the medical history: Perceptions of internal medicine physicians. Arch Intern Med 1987; 147:1957–60.

Rogers C. Characteristics of a helping relationship. In Rogers C: On Becoming a Person. Boston: Houghton Mifflin. 1961.