Patient-Centered Interviewing

An Evidence-Based Method

Second Edition

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Patient-centered interviewing leads to effective communication and a healthy provider–patient relationship. This groundbreaking book provides, for the first time, a step-by-step method for patient-centered interviewing. The technique advocated in *Patient-Centered Interviewing: An Evidence-Based Method* has been extensively used, and its 5-step method is easily learned and well received. Upon completion of training, most students and clinicians can conduct the initial patient-centered process in approximately 5 minutes.

Research data supporting the 5-step method has been published in the *Annals of Internal Medicine*, *Academic Medicine*, and *The Journal of General Internal Medicine*. *Patient-Centered Interviewing* presents the only interviewing method that has been directly tested by research. The striking results demonstrated by a randomized controlled trial indicate that the 5-step method can truly be called "evidence-based."

Patient-Centered Interviewing integrates patient-centered interviewing with traditional doctor-centered interviewing, which the student or clinician also uses to learn about the equally important disease aspects of patients. In addition, the book addresses clinical communication issues, including patient education (e.g., helping patients to stop cigarette smoking). It also describes how to write up patients' evaluations for their medical record and how to present them orally to preceptors. The book is designed for use during clinical years, as well as for preclinical interviewing courses.

Incorporating all aspects of interviewing, *Patient-Centered Interviewing* covers the following topics:

- **Basic interviewing skills**
- **Facilitating skills**
- **The patient-centered process**
- **Symptom-defining skills**
- **The doctor-centered process**
- **Practical issues**
- **The doctor–patient relationship**
- **Presenting the patient's story**
- **Patient education**

Finally, the book concludes with appendices that contain a research report published in the *Annals of Internal Medicine*, examples of common patient emotions, a method for evaluating a patient's mental status, and a write-up of the patient's evaluation for the vignette presented throughout the text.

A unique hands-on guide, *Patient-Centered Interviewing* is the essential reference for mastering effective patient communication and providing the best patient care possible.

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3 Patient-Centered Interviewing

Because patient-centered interviewing has often seemed confusing, my colleagues and I developed a user-friendly and complete method. The evidence-based method that I will present has been effective in both our and many others' hands during the last 10 years, as our research confirms (1–5). **The most difficult learning occurs at the outset when one learns the five steps and 21 substeps.** I urge the reader to **learn these thoroughly to the point that they become reflexive,** which is easily accomplished by first studying them and then using them in practice. Just as you, as a student, learned the intricacies of the Krebs cycle and cardiac physiology, learning these steps is your major task in mastering the most important clinical skill you must have. Once you know and can use the steps and substeps, you will have no problem. Using these steps and substeps will make you a more scientific and more humanistic physician, and your patients will benefit (see the Rationale section of Chapter 1). To assist you, a videotape that demonstrates the same skills described here has also been developed (6) (see Preface).

I recommend that, when first learning these skills, you use them in the order outlined, primarily as a way to learn them. As you become more comfortable with the interview, I recommend varying the steps and substeps to experiment, as well as to adapt to specific occasions and needs. Not infrequently, some substeps can be omitted; and, in other instances, you may want to change the order in which you use them. The steps and substeps are simply signposts and guidelines to lead you through the interview; using them flexibly enhances the individuality of both you and your patient.

This chapter describes and demonstrates the 5-step method. The method describes, step by step, exactly what to do. The five steps in the patient-centered process enhance the patient's lead and ability to express what is most important to her or him. As part of text material, an ongoing interview with "Mrs. Jones"

is introduced to demonstrate each step; this and other examples used are derived from real people and situations but are masked to protect confidentiality.

To begin, I first address some patient-centered skills that have not yet been introduced: setting the stage for the interview (Step 1) and determining the agenda (includes the chief complaint) for the interview (Step 2). These steps are not, strictly speaking, patient-centered because they may insert new information into the interaction, but they do serve a patient-centered purpose as they are preparatory or staging areas for the true patient-centered process that occurs in Steps 3 and 4, which are where the facilitating skills learned in Chapter 2 are incorporated.

Setting the Stage for the Interview (Step 1)

Step 1 skills are sometimes overlooked courtesies that ensure a patient-centered atmosphere. Table 3.1 lists these substeps in their usual order of use at the first meeting with a patient; appropriate adjustments are made when the interviewer already knows the patient. These rapport-building skills enhance the relationship, establish or reaffirm participants' identities, and set the stage for the patient-centered process in Steps 3 and 4; they *should take no more than 1 to 2 minutes* (7–9).

TABLE 3.1. SETTING THE STAGE FOR THE INTERVIEW (STEP 1)

1. Welcome the patient.
2. Use the patient's name.
3. Introduce yourself and identify your specific role.
4. Ensure patient readiness and privacy.
5. Remove barriers to communication.
6. Ensure comfort and put patient at ease.

Welcome the Patient

The patient must feel valued and welcome. Simple statements, such as "Welcome to the clinic," or, in a hospital setting, "Sorry to see you're sick but I am glad you came to see us," suffice. This sets the proper tone for a patient-centered interaction. The clinician or student should always try to shake

hands with the patient, although sometimes this is not possible with very ill patients; in this scenario, a friendly pat on the hand or arm is equally beneficial to the relationship. He or she can develop some important initial nonverbal impressions about the patient from the handshake (e.g., the hearty handshake of a confident person, the cold sweaty palm of an anxious person, and the feeble handshake of someone who is very ill).

Use the Patient's Name

This can be done efficiently by combining one courtesy with another, such as "You're Mrs. Garcia aren't you? Welcome to the clinic." The interviewer should use the patient's last name unless the patient volunteers the use of another name. If the patient has a difficult name, he or she may need to ask how to pronounce it.

Introduce Self and Identify Specific Role

Although first names are permissible, the interviewer usually begins by using her or his last name and also by noting her or his official role with the patient. Introductions can be combined with other patient-centered gestures, for example, by saying, "How do you do, Mrs. Garcia? I'm Ms./Mr. Burns, the [medical student/physician/etc.] who will be part of the team looking after you." A student also can use the term 'student doctor' or 'student physician' to designate herself or himself, particularly when she or he is in a clerkship (10). Many believe that applying the label 'doctor' prior to graduation is inappropriate and, furthermore, is counter to the patient's wishes (10,11). Occasionally at the beginning, but more often after the relationship has matured, a first name relationship develops. The student or physician should carefully match identity terms and, thereby, avoid suggesting an unequal relationship. In other words, both the interviewer and patient are on a last name basis, or they are on a first-name basis (e.g., the interviewer should not say, "Hi, George. I'm Dr. Smith" or "Welcome, Mr. Brown. I'm Betty.").

Introductions can be difficult. A student often feels torn between misrepresenting herself or himself as a doctor and not wanting to appear inept by conveying a perceived lack of expertise (e.g., "I'm not a real doctor.") (10). However, if you are a student in this situation, honestly portraying your circumstances goes a long way toward developing a sense of professional identity, particularly as patients repeatedly accept your professional role (8,10,12). In addition to noting that you are a student doctor, you might say,

"I am part of the team taking care of you. I'll be getting much of the information about you and will be (one of) your major contact person(s)." Apologizing or otherwise devaluing yourself is not necessary (e.g., "I'm just a student, thanks for letting me talk to you."). Nor should the patient's acceptance of a student working with them be an item for questioning—the preceptor should have established this with the patient beforehand (10). As a student, you must understand and confidently convey that you are indeed a key part of the patient's care. The annals of medicine are replete with stories of students' contributions to care and with stories of patients deferring to students' opinions (e.g., when the resident or faculty makes a recommendation directly to the patient, the patient says, "I'll have to ask Ms. Burns [the student].").

Ensure Patient Readiness and Privacy

Initially and especially in hospital settings and with acutely ill patients, as an interviewer, you should ascertain if the time is convenient for the patient. Sometimes, postponing the interview is necessary (e.g., the patient is eating dinner; relatives are visiting; patient is vomiting from recent chemotherapy treatment). Severe pain, severe nausea, need for a medication, and a soiled bed, for example, are other physical problems that must be addressed before the patient is ready for an interview. Postponement is less of an issue with outpatients because outpatients generally are healthier and are on scheduled visits. Nevertheless, you should also monitor patients' circumstances for nonphysical, potentially interfering problems (e.g., a patient may have lost her or his car keys in the waiting room, may have just received a disturbing telephone call, or may be worried that the babysitter will have to leave before she or he can get home). With all patients, you should determine if pressing needs might require a brief delay in the interview (e.g., the need to use the bathroom or to get a drink of water). These courtesies not only help the patient directly, but they also enhance the patient's acceptance of you as a caring professional. Once the patient is ready, some obvious actions improve the patient's readiness and privacy, including shutting a door or respectfully excusing a curious laboratory technician.

Remove Barriers to Communication

You may have to turn off a noisy air conditioner or TV set or make efforts that require more insight, such as recognizing that the patient hears best out of one ear or that she or he needs to be able to see your mouth directly in order to lip read. If any question exists in your mind, you should inquire, "Can you hear me and see me ok?" Strategies for addressing specific communication problems are outlined in Chapter 6.

Ensure Comfort and Put the Patient at Ease

When interviewing, you should determine if anything at the immediate time is interfering with the patient's comfort. Questions like "Is that a comfortable chair (bed) for you?" "Is the light bothering your eyes?" or "Can I raise the head of the bed?" are essential. In turn, you must continue to monitor the patient's state as the interview proceeds. Our task as clinicians is to put the patient as much at ease as we can. Attention to these problems not only helps the patient and allows her or his subsequent full attention but also bespeaks our professionalism and concern.

When, as is normal, no such interfering problems need to be addressed, conducting a light conversation to put the patient at ease is appropriate, as the preceding discussions would have done for patients with some problems. You may be ready to start; but the patient often is not, and he or she still does not know much about the interviewer. This conversation should have a patient focus (e.g., "I hope you got your car parked ok with all the construction going on around here."). With an inpatient, you might inquire about the care or the food. Whatever is appropriate to the patient's situation can be briefly discussed. This helps the patient get used to talking and also allows her or him to learn what you are like. A caring, friendly atmosphere is established.

Obtaining the Agenda (Chief Complaint and Other Current Concerns) (Step 2)

In Step 2, the interviewer takes charge and focuses the patient on the agenda, just as he or she did in setting the stage for the interview. Although it is interviewer-originated, the action is patient-centered because it establishes a patient-centered atmosphere. Research shows that doctors often do not elicit the expectations that patients have for their visits (13,14), typically because they begin to explore a problem in detail before hearing all the patient's concerns (15). Agenda setting takes little time, improves efficiency, and yields increased data (15). However, it is not as easy as Step 1, and serious pitfalls arise if it is conducted improperly. *It usually takes no more than 1 minute, but it can take*

longer if many problems are present. The following substeps, summarized in Table 3.2, are usually performed in the order in which they are given.

TABLE 3.2. CHIEF COMPLAINT AND AGENDA SETTING (STEP 2)

1. Indicate time available.
2. Indicate own needs.
3. Obtain list of all issues patient wants to discuss (e.g., specific symptoms, requests, expectations, understanding).
4. Summarize and finalize the agenda; negotiate specifics if too many items on the agenda.

Indicate Time Available

Begin by indicating how much time is available for the interaction, although setting limits often is difficult for interviewers. Doing so lets the patient know whether she or he has 10 minutes or 60 minutes and helps her or him gauge what and how much to say (16).

Indicate Own Needs

As an interviewer, you should also indicate your own professional demands, such as whether you need to ask many questions to get a full history and to perform a physical examination with a new patient or if you need to follow up on a recent cholesterol test in a return patient.

Obtain a List of All Issues the Patient Wants to Discuss

Most importantly, you as an interviewer must obtain a list of all the issues that your patient wants to discuss (17,18). You can begin, for example, by covering the preceding two items and then can start on this one with a new clinic patient by saying, "We've got about 40 minutes today, and I need to ask a lot of questions and do an examination. But, more importantly, I'd like to know what you want to cover."

You want the patient to enumerate all his or her problems. Then they won't arise at the end when time has already run out (15,16,19). If too many issues are raised for this visit, you and the patient can prioritize which ones are most important (these are not always the first ones that are given) (20).

Enumeration should go beyond symptoms and should include the patient's requests (e.g., prescription for a sedative), expectations (e.g., get sick leave), and understanding about what the interaction is supposed to accomplish (e.g., perform a treadmill test). Asking once is not sufficient (21); rather, you should carefully probe for additional issues of concern and should try to learn what is most important to the patient and why he or she came at this particular time. You need to ask, "What else?" "Anything else?" "How did you hope I could help?" or "What would a good result from this visit today look like?" For patients to have just one issue is unusual; more likely, they will have three to five. Careful agenda setting forestalls the common patient complaint that he or she didn't get to talk about all his or her concerns, as well as the common physician complaint that the patient voiced his or her most serious concern at the end of the appointment.

Although I have discussed the content of agenda setting, we must next consider how to perform it. At this point, as an interveiwer, you want a list. Indeed, you should avoid details of any particular problem until the list is completed. This can be difficult because patients, understandably, often want to go right into details. When this happens, you must respectfully interrupt the patient and refocus on the list. Holding up your fingers prominently and counting the problems identified can help. For example, while holding up one finger to signify the first problem given, you might say, "Sorry to interrupt; we'll get back to the leg pain. First, I need to know if there is a second problem you'd like to talk about. I want to be certain we know what all your concerns are." You often have to do this several times as patients may give many problems and may want to discuss each as it arises.

You should encourage further discussion while setting the agenda only if the patient has raised highly charged emotional material (e.g., if the patient is acutely distraught about a recent death in the family or about a recent cancer diagnosis). Even in most emotionally charged situations, however, the agenda usually can be set and the emotional material can be delayed briefly.

Summarize and Finalize Agenda

Usually, covering all problems is possible; in that case, they would be simply summarized. This also is a good time to determine which complaint is most important, if you do not already know. Doing this identifies the chief complaint. When too many issues have been raised for just one visit, you and the patient negotiate and agree on what will be addressed and when you will consider the deferred issues.

We will now follow Mrs. Joanne Jones through her initial visit by providing a continuous transcript for each step. Later, as noted, some areas are shortened for space considerations.

Vignette of Mrs. Jones

Step 1

DOC: (enters examining room and shakes hands) Welcome to the clinic, Mrs. Jones. I'm Ms. White, the medical student who will be working with you along with Dr. Black. I'll be getting much of the information about you and will be in close contact with you about our findings and your subsequent care.

[The student welcomed the patient, used her name, and identified herself and her role.]

PT: Hi. This is my first time here.

DOC: If it's ok with you, I'll close this door so we can hear each other better and have some privacy.

[The student ensured readiness for the interview and established as much privacy as possible.]

PT: Sure, that's fine.

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

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

DOC: We'll give that back when we're finished today. They always keep them. Anything else?

PT: No.

DOC: You may want to sit in that chair. It's more comfortable than the examining table.

[The student has noticed no barriers to communication and now ensures comfort and puts the patient at ease.]

PT: Sure. Thanks. (She moves.)

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

PT: I guess not. My kids have been home the last 2 days. I'm ready to get them back to school! I'm getting spoiled with them both in school.

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

PT: You're telling me. I don't even ski!

[The student has set the stage, a light conversation has occurred, and the patient is joking.]

Step 2

DOC: (laughs) Well, we've got about 40 minutes today, and I know I've got a lot of questions to ask and that we need to do a physical exam. Before we get started, though, it's most important to find out what you wanted to cover today. You know, so we're sure everything gets covered.

[The student has given her agenda in one statement. Doing this, she first models the more difficult task to follow: obtaining the patient's agenda.]

PT: It's these headaches. They start behind my eye and then I get sick to my stomach so I can't even work. My boss is really getting upset with me. He thinks that I don't have anything wrong with me and says he's going to report me. Well, he's not really my boss, but rather is . . . (student interrupts)

DOC: That sounds difficult and really important. Before we get into the details, though, I'd like to find out if there are any other problems you'd like to look at today, so we can be

certain to cover everything you want. We'll get back to the headache and your boss after that. That's two things (holding up two fingers). Is there anything else?

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

DOC: (holding up three fingers now) Anything else you want to look at today?

PT: No. Well, I did want to find out if I need any medicine for my colitis. That's doing ok now but I've had real trouble in the past. My parents were very upset about that. It started bothering me way back in 1982 and I've had trouble off and on. I used to take cortisone and . . . (student interrupts)

[The student has now interrupted her twice in order to complete the list of complaints. Done respectfully, this was necessary to complete the agenda in a timely way.]

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

PT: No. The headache is the main thing.

DOC: So, we want to cover the headaches and the problem they cause at work, cough, colitis, and the medications for the colitis. Is that right?

[Here, the patient and interviewer would negotiate what to cover at this visit if the interviewer determined that the patient had raised too many issues to cover on this visit.]

PT: That's about it.

DOC: And, do I understand correctly that the headache is the worst problem?

[Mrs. Jones' headache was her most bothersome complaint, which we defined earlier as the chief complaint.]

PT: Yes.

Opening the History of the Present Illness (Step 3)

After setting the stage (Step 1) and obtaining the agenda (Step 2), we, as interviewers, now become truly patient-centered and incorporate the facilitating skills learned in the last chapter to begin the History of the Present Illness (HPI). As was reviewed in Chapter 1, the HPI is the most important component of the interview because it reflects the patient's current problem in its personal and medical totality. The HPI begins during the patient-centered process and continues as the first part of the doctor-centered process, as relevant details are clarified.

Step 3, summarized in Table 3.3, is quite brief; it establishes an easy flow of talk from the patient, conveys that the doctor will listen, and gives a feel for "what the patient is like." Ordinarily, *this step lasts no more that 15 to 30 seconds, during which the interviewer listens attentively,* using the following substeps.

TABLE 3.3. OPENING THE HISTORY OF PRESENT ILLNESS (STEP 3)

1. Ask an open-ended beginning question.
2. Use "nonfocusing" open-ended skills (attentive listening): silence, neutral utterances, nonverbal encouragement.
3. Obtain additional data from nonverbal sources: nonverbal cues, physical characteristics, autonomic changes, accouterments, and environment.

Open-Ended Beginning Question

Immediately after summarizing the agenda, you, as an interviewer, should use an open-ended beginning question, such as "Given what you've told me, how are you doing?" "How are things going?" or "Now, tell me some more." You should link the question to the agenda to start developing the patient's story. When she or he has raised strong but deferred emotional material during the agenda-setting, you should specifically direct the patient back to it (e.g., "Now, you mentioned that you're upset about your daughter moving."). A good beginning question, as is befitting to its nonfocusing intent, allows the patient to go anywhere, from past to present to future, and can concern anybody or anything.

You should initially avoid framing the question in a way that specifies the patient's problem (e.g., "Now, what about the chest pain?" or "What about the trouble with your wife?"). Only if the patient continues to ask (e.g., to clarify the question), should you provide such instruction. For example, in response to the query, "What do you mean?" or "You mean about my chest pain?", the interviewer can initially reply "Whatever you like" or "Whatever is most important to you." The intent of the patient-centered interview is to allow free discussion, but, at the same time, you do not want to puzzle the patient or to make her or him uncomfortable.

This open-ended beginning question is not always necessary. Once the agenda has been completed, especially if only one or a few related items need to be covered, many patients continue spontaneously.

"Nonfocusing" Open-Ended Skills (Attentive Listening)

As an interviewer, you encourage a continued free flow of information after asking the open-ended beginning question by using the nonfocusing open-ended skills described in Chapter 2. Silence, nonverbal gestures (eye contact, attentive behavior, hand gestures), and neutral utterances ("Uh-huh", "Mmm") encourage the patient. If the patient does not talk freely, you can use the focusing open-ended skills (echoing, request, summary) to promote a free flow of information (i.e., you should not continue just to sit in silence and to appear attentive with a patient who is not talking). If focusing open-ended skills are not effective, closed-ended questions about the patient's problem can be used to get a dialog going; this is rare.

Obtain Additional Data From Nonverbal Sources

Although you are passive verbally during the brief Step 3, you should be very active mentally; you should be thinking about what the information means. You also observe the patient for nonverbal cues, reviewed further in Chapter 7 (e.g, depressed facies, arms folded across chest, tapping toes nervously). You will note clues in the following areas that will give additional information about the patient (22,23): (a) *physical characteristics:* general health, skin and hair color and odor, deformities, and habitus (e.g., emaciated and disheveled, "uremic" breath, jaundice, amputated leg, kyphoscoliosis); (b) *autonomic changes:* heart rate, skin color, pupil size, skin moisture, and skin temperature (e.g., rapid pulsation of the carotid artery observed in the neck, handshake reveals cold and moist palms, pupils constricted but then dilate when relaxed, sweating at outset of interview); (c) *accouterments:* clothing, jewelry, eyeglasses, and make-up (e.g., expensive suit and jewelry, thick eyeglasses, no make-up); (d) *environment:* decorations, greeting cards, flowers, and photographs (e.g., in a hospital setting—several paintings by a grandchild, photograph of spouse, no greeting cards or flowers).

Patients seldom show emotion in this early period, but, if it is strongly expressed, you address it as explained later. Otherwise, you simply observe where the patient is going and how the emotion fits with the rest of the evolving material. The type of data that is produced makes no difference. As long as a good flow of information occurs, either symptoms (of possible disease) or personal data are acceptable.

Continuation of Vignette of Mrs. Jones

(immediately continuous with the previous vignette)

PT: Yes.

DOC: So, that's a lot going on. How are you doing with it?

[A good open-ended beginning that is linked to the agenda allows the patient to go anywhere she wants.]

PT: Oh, ok I guess.

DOC: (silence)

PT: At least now.

DOC: (sits forward slightly) Uh huh.

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

DOC: Mmmm.

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

DOC: I see.
PT: These headaches are right here (points at right temple) and just throb and throb. And I get sick to my stomach and just don't feel good. All I want to do is go home and go to bed.
[A good open-ended beginning, briefly followed by several "nonfocusing" open-ended skills, resulted in a good flow of symptoms and personal data without any focusing activity by the student.]

Continuing the Patient-Centered History of Present Illness (Step 4)

The much longer Step 4—*it usually takes between 5 and 10 minutes*—is summarized in Table 3.4 and follows immediately after Step 3. The intent changes from simply establishing a flow of information to focusing very actively on the most important story theme(s). In general, clinicians and students usually obtain first a description of the *physical* symptoms; second, the patient's *personal* but nonemotional reactions attending the physical symptoms; and, third, the patient's *emotional* reactions to both.

TABLE 3.4. CONTINUING THE PATIENT-CENTERED HISTORY OF PRESENT ILLNESS (STEP 4)

A. Physical Symptom Story
1. Obtain description of the physical symptoms (focusing open-ended skills).

B. Personal Story
2. Develop the more general personal/psychosocial context of the physical symptoms (focusing open-ended skills).

C. Emotional Story
3. Develop an emotional focus (emotion-seeking skills).
4. Address the emotion(s) (emotion-handling skills).

D. Expand Story
5. Expand the story to new chapters (focused open-ended skills, emotion-seeking skills, emotion-handling skills).

As clinicians and students, we use the focusing open-ended skills, emotion-seeking skills, and emotion-handling skills outlined in the last chapter to

identify the story theme(s) and, occasionally, the closed-ended skills for clarification. We are much more active and participatory in our verbal interaction and are often figuratively on the edge of our seat during the give-and-take interaction between ourselves and the patient. The new learner may find that this step is the most difficult of the entire interview. To help in her or his understanding, I have broken Step 4 into five substeps, which will now be considered in their usual sequence. These substeps produce the overarching story themes, which are physical, personal, and emotional.

Physical Symptom Story

Obtain a Description of the Physical Symptoms

In a medical setting, patients typically present their physical symptoms mixed with their personal context. Because most patients expect the following, I recommend an initial focus on physical symptoms while you are learning these skills; later, you can experiment with a different order. You should concentrate on the symptoms, using the focusing open-ended skills (echoing, open-ended requests, summarizing). This produces a description in the patient's own words of the immediate context in which the physical symptoms occurred. As an example, we pick up Mrs. Jones' interview again.

Continuation of Vignette of Mrs. Jones

PT: ... All I want to do is go home and go to bed.
DOC: Say more about the headaches.
[An open-ended request, one of the focusing open-ended skills, to learn more about the headaches]
PT: Well, I never had any trouble until I got here.
[Comment about the present context of her symptom and how long it has been present]
DOC: How long has that been?
[Appropriate closed-ended question for clarification]
PT: Only 4 months. The headaches started about 3 months ago.

DOC: Tell me more.

[Keeps the focus on the headaches]

PT: Well, they just throb and throb and it seems like every time I see my boss, I get one of these headaches. I sometimes just get a little nauseated and can't concentrate because of the pain.

[The student learns much more of the description of the symptom and, also, that her boss seems to precipitate the symptom.]

DOC: Your boss.

[Echoing puts the focus on how her boss relates to the headache.]

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

[The relationship between Mrs. Jones' headaches and her boss is becoming clearer.]

DOC: Not around him?

[Echoing, a focusing open-ended skill, maintains the focus.]

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

[The student has a good description of the physical symptom, knows when it began, has heard some associated symptoms, and knows that it occurs in the setting of her boss. In less than a minute, she has learned how the personal and physical interact by facilitating (encouraging) the patient's spontaneous narration. The description of the pain in this vignette has considerable diagnostic value (for migraine headaches) and also raises some considerations for treatment (e.g., avoiding her boss). Such unique data often do not arise during isolated doctor-centered interviewing. Although the reference to her boss is psychosocial material, which I focus on more in the next substep, it also is directly related to the symptom and provides its immediate context. The next substep shows that the psychosocial data no longer directly relate to the physical symptoms.]

This detailed, personal description of symptoms and their immediate context is what you, as the interviewer, want at the outset of Step 4, and it seldom takes more than a minute. In the example, the student now understands, in the patient's own words, much of the chronology of symptoms and their descriptive terms (throbbing headache and nausea) that she will expand later in the doctor-centered process, in addition to the unique personal context in which the symptoms occur. She knows that she needs more diagnostic data about a possible underlying disease (e.g., any head injury, fever, or prior investigation?), but that would insert new information, and besides, she will do just that in 5 to 10 minutes when she switches to the doctor-centered process. By avoiding a focus on the symptoms that inserts information that was not introduced by the patient or on other diagnostic data via the use of closed-ended questions (e.g., "Did you ever have a head injury?" or "How does the headache affect your vision?"), the student has learned who else is involved, what the patient thinks, and generally what is going on in the patient's life. She already has an explanation for her headaches and knows what is most bothersome to Mrs. Jones.

Although the beginning student may not be aware of this, others will realize that the physical symptom data given by Mrs. Jones are quite suggestive of migraine headaches (i.e., they are throbbing, periodic, and associated with nausea). **Highly diagnostic data for the patient's underlying disease almost always arise during the detailed description of symptoms (24).** Indeed, the great diagnostic yield here was what reportedly led Sir William Osler to say, "Listen to the patient, he is telling you the diagnosis" (25). **Research has also shown that, occasionally, data diagnostic of a disease arise here that do *not* arise in later doctor-centered interviewing (24).** On the other hand, even when symptom data are not diagnostic, the interviewer obtains in this step a good overview of the problem, one that does not need to be repeated when he or she switches to the doctor-centered process.

The symptoms are treated in the same way if only psychological complaints are seen (i.e., no physical symptoms are presented). In the above case, the interviewer should determine the personal description and immediate context of these symptoms with open-ended queries if Mrs. Jones complains of anxiety or feeling blue instead of the headaches.

In this step, the interviewer thus hears the patient's own description of the symptom data. Here the initial integration of symptoms and personal factors occurs; this represents the first view of the patient's mind–body connection. This integration is the core of the interview and of the patient-centered process. Most subsequent information in the HPI links to this core.

Personal Story

Develop the More General Personal and Psychosocial Context of the Physical Symptoms

As an interviewer, you should next learn about the patient and her or his illness in its broader personal and psychosocial context. This material relates less to the symptoms and may be of less diagnostic value for disease but is nevertheless important for an understanding of the illness. In general, the longer the interview is, the less the personal data relate to symptoms and the more they reflect the patient's general life situation. Nonetheless, important diagnostic data about actual diseases can still arise (e.g., clues to occupational or to drug or alcohol problems). These data directly influence treatment and prevention programs. You should continue to rely on focusing open-ended skills, directing them to the patient's personal statements that seem most important to understanding the personal story; in our example, Mrs. Jones' stressful job situation would be considered worthy of this exploration.

Direct Continuation of Vignette of Mrs. Jones

PT: I'm on the road a lot. No trouble then either, except one time when he called me.

DOC: Tell me more about your boss.

[The interviewer is encouraging discussion of an important personal issue rather than just keeping the focus on physical symptoms such as headache or nausea; she also could have focused on the job itself and accomplished the same goal of obtaining more personal data. Rather than making an open-ended request, she alternatively could have focused the patient by echoing ('he called you') or summarizing the personal aspects—any of the focusing open-ended skills could be used as they all lead to the same theme.]

PT: Well, he's been there a long time and I've replaced him in every way there is, except he is still in charge, at least in his title. He yells at everybody. Nobody likes him and he doesn't

do much. That's why they got me in there, the Board, so something would get done. These headaches have all come since I got this job—right here. They throb behind my eye and . . .

[Note the corroboration of earlier data: the job is linked to the headaches, but Mrs. Jones is now giving additional personal information about her situation that helps the interviewer better understand this connection.]

DOC: Wait a second, I'm not following you. You say he's in charge, but you are the lead attorney?

[The student interrupted respectfully and then summarized personal issues to refocus on the job because the patient was getting away from personal data and was going back to physical symptoms that have already been discussed; also, she plans to address symptom details about 5 to 10 minutes from this point during the doctor-centered process.]

PT: Yeah, they are phasing him out but he's still there in the meantime. Who knows how long it'll take? I hope I last.

[She is further expanding the story to personal issues that are less directly related to symptoms, allowing the student to begin to appreciate the nuances and depth of how her job and headaches interact.]

DOC: Hope you last?

[Echoing maintains the focus in this personal and psychosocial area. Note how focusing open-ended skills are used repeatedly to focus the patient and that they can be applied to the patient's immediately preceding utterances. The interviewer can also interrupt the patient to focus on others that were previously mentioned, but she or he should never introduce new data to the conversation.]

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

DOC: They said? Who are they?

[The student interrupted to focus on a bit of information mentioned just before and to redirect her to that with echoing; if she had wanted her to simply proceed, an open-ended request, such as 'Go on,' would have sufficed.]

PT: The Board, they run the company. It's not real big, but it's a good chance for someone young like me to get experience in corporate stuff.

[This adds a new layer of data that is not directly related to her headache but that provides a deeper understanding of the context.]

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

[The student summarizes what is becoming a free flow of personal data. This was abbreviated for space reasons, but she ordinarily would further develop this with more focusing open-ended inquiry.]

Patients do not always refer to stressful events in their lives, as Mrs. Jones did in this example; but they often have personal concerns about the symptom itself. Although no disease explanation is found for 20% to 75% of physical symptoms (26,27), patients exhibit several personal concerns around their physical symptoms with high rates of frequency: 67% worry about serious illness, 72% expect medications, 67% want testing, 53% expect referral, and 62% indicate interference with routine activities. Although 47%, like Mrs. Jones, describe stress and about 20% recognize depression and anxiety, only 1% consider the problem psychiatric (28). Usually, doctors view symptoms as far less serious than the patients themselves do; therefore, not surprisingly, residual unaddressed concerns account for most patient dissatisfaction (28). Other concerns include disbelief or distrust of the medical system, grief and other losses, becoming independent (young people) or dependent (older or seriously ill people), retirement, family or job problems, and administrative issues (e.g., insurance forms). **As clinicians, we want to understand these personal concerns, which are the context of our patients' physical symptoms.** In general, whether stress or disease worries, a personal focus is easily

established as we move into the broader personal context of the patient's illness. A sense of the patient's personal situation has begun to develop.

To maintain the personal focus, as the interviewer, you should avoid focusing back on previously discussed physical symptoms. You will focus on physical symptoms when moving to the doctor-centered interview in the next 5 to 10 minutes. First, however, you want to expand your understanding of the patient as a person.

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

Early on, you should focus on and facilitate whatever bits of personal data appear to be of most interest to both the patient and you. Once you have identified the narrative thread of the patient's story and its apparent meaning and significance, you should stay with this line. If the patient gets away from this theme, you should interrupt with focusing open-ended skills and should refocus on the main story thread. Such refocusing often helps because patients wander back to previously discussed physical symptoms (or other diagnostic or therapeutic data).

After no more than a few minutes, you usually have a good sense of the broader personal story—and you have further enhanced the doctor–patient relationship by addressing features of central importance to the patient's life. If emotions become evident during these early stages, you often should address them.

Emotional Story

Develop an Emotional Focus

Just as you seek to understand the personal context of the symptoms, you should now explore the emotional context of the personal and physical symptom information. This further deepens the story and makes apparent a three-way interaction among the symptom, personal, and emotional dimensions. **The mind–body link and biopsychosocial description come into full focus when we as clinicians include the emotions, an event thereby of scientific as well as humanistic significance.**

In developing an emotional focus, you should always monitor the patient's readiness to engage in this sometimes more stressful discussion by ob-

serving how well he or she has responded to the process so far and for any untoward responses to inquiries about emotion (e.g., changing the subject after the interviewer asks about them).

As an interviewer, you must first change the style of inquiry to establish an emotional focus (29). Emotion-seeking skills, both direct and indirect, temporarily supplement the focusing open-ended skills. By starting with direct inquiry about how a patient feels concerning the personal situation that she or he has so far described (e.g., "How'd that make you feel?"), you can fully and actively explore the emotional domain. Sometimes, you must make several efforts before emotion can be expressed. As I have noted, you should avoid making the patient uncomfortable. Indirect questioning using self-disclosure and inquiry methods about the patient's beliefs and their impact also may be necessary; this is used when direct inquiry does not reveal emotional content.

In addition, you should continue to expand your understanding of the emotions, once they have been identified, by using focusing open-ended skills. You do this until you feel that you have a reasonable understanding of the emotion and what produced it.

You do not need to use emotion-seeking skills when the patient is already showing or expressing emotions, as some do spontaneously following open-ended inquiry alone.

Continuation of Vignette of Mrs. Jones

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

PT: Yeah, sounds kind of bad, huh?

DOC: How do you feel about that?

[Direct emotion-seeking]

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

DOC: But how do you feel, you know personally, your emotions?

[The patient did not give any emotion the first time, and so the interviewer uses direct emotion-seeking inquiry again. To "push" like this can be appropriate as long as you are always monitoring the patient's response and readiness to engage at an emotional level.]

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

DOC: You know, an old boss of mine once put me in a bind like this. It took me quite awhile but I finally realized I was very upset.

[The interviewer changes her strategy and pushes further using self-disclosure, which, of course, must be accurate and genuine.]

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

DOC: What is the feeling?

[The patient has acknowledged her emotion, but the interviewer, pushing further to get the full picture, returns to a direct emotion-seeking question about feeling.]

PT: Well, I just want to throw something at him. He makes me so mad. I didn't do anything against him. I work really hard there, and things are going much better since I've been there. It's when I get mad that the headaches come. The nausea is even worse, and then sometimes I get these spots in my eyes and . . .

[A more precise direct link to headaches, now not just to her job situation but more specifically to being angry. Note the value of pushing for emotion: the patient is now expressing it.]

DOC: So you get mad when he gets on you?

[The student is interspersing open-ended skills, which is appropriate, as she summarizes to continue on this focus.]

Address the Emotion

When emotions have been expressed, either spontaneously during open-ended inquiry or via the interviewer's use of emotion-seeking skills, and the interviewer understands them, yet another set of skills becomes more impor-

tant temporarily. As was discussed in Chapter 2, the emotion-handling skills consist of Naming, Understanding, Respecting, and Supporting and are recalled by the mnemonic NURS.

To address an emotion, as an interviewer, you should convey that you have recognized it by naming it, that you understand it, that you respect the patient's plight (or joy), and that you are available to help in any way possible. These skills often are needed several times during the course of an interview as people may take considerable time to work through strong emotional reactions. Using these skills once is seldom enough.

Occasionally, you will use all four emotion-handling skills together in the order given. Usually, however, you will use only one or two skills at one time. You should use them selectively and should fit them smoothly and unobtrusively into the conversation because excessive use will stand out and will strike the patient as peculiar or manipulative.

Emotion-handling skills are used only after you have heard enough to understand the emotion adequately. For example, when someone expresses sadness over loss of a spouse, you cannot immediately say that you understand and appreciate how difficult the situation is. You must first listen to enough of the story open-endedly to be able to make these emotion-handling statements legitimately. On the other hand, with reticent patients, you may have to use emotion-handling skills with much less emotional information than you would normally consider desirable. For instance, you would still use the NURS quartet actively with a very reticent patient who has lost her or his job and who only acknowledges being "slightly upset."

Some interviewers resist the use of emotion-seeking and emotion-handling skills, usually because of unfamiliarity. They remark that **these skills seem forced and false** at first. For those who respond this way, I **recommend only that they try** and that they **review the compelling scientific rationale for using them** that was presented in Chapter 2 (see "Relationship-Building Skills"). Their use will indeed feel awkward and phony at first for some; however, as interviewers overcome their self-consciousness, gain confidence, and observe the benefit to their patients, they often become rapid converts. They also recognize that they themselves feel progressively more comfortable with the process, and that their responses begin to feel quite genuine. Many experienced clinicians have had to overcome these same reservations. Because emotions are a basic means of human expression (see Chapter 2), effective relationships with patients are more likely when emotion-seeking and emotion-handling skills are used, as my work and that of others has shown (1,4,29–31).

Continuation of Vignette of Mrs. Jones

DOC: So you get mad when he gets on you?

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

DOC: It sure makes sense. It seems like you've done so much there to help, and all you get is grief from him. I appreciate the way you're able to talk about it. He sure gets you mad.

[The student briefly expressed her understanding and spent more time expressing respect for her by acknowledging that she had been through a lot and that she was successful at work and in praising her for talking about her emotions. Finally, the student again names the emotion; she continues to use Mrs. Jones' term—'mad'—rather than 'anger' or another more loaded term.]

PT: He sure does. Just talking about it gets me upset and gives me a headache, right now.

[This further demonstrates the association between the headaches and emotional upset; it is now occurring as a result of anger-laden material in the interview.]

DOC: I can imagine. You've put up with a lot.

[Naming 'mad' again is unnecessary because the emotion is obvious, but the interviewer again indicated understanding and made a respecting statement.]

PT: You know, I think I'm even madder at that damn Board. They didn't tell me any of this and said everything would be ok. Who needs all this?

[As a result of addressing her emotions, the patient is now presenting new personal data and its associated emotional material; that is, the story is deepening.]

DOC: That's a tough situation.

[Interviewer again demonstrated respect.]

The first part of Figure 3.1 summarizes the critical dimensions of the first chapter of the patient's story we have just reviewed in Step 4: we begin with a physical symptom focus and then proceed to a personal, nonemotional focus and, finally, we elicit and address the patient's emotion. As you will learn next, subsequent chapters of the patient's story, also shown in Figure 3.1, usually do not include a somatic focus and, rather, concern just the personal and emotional aspects of the story.

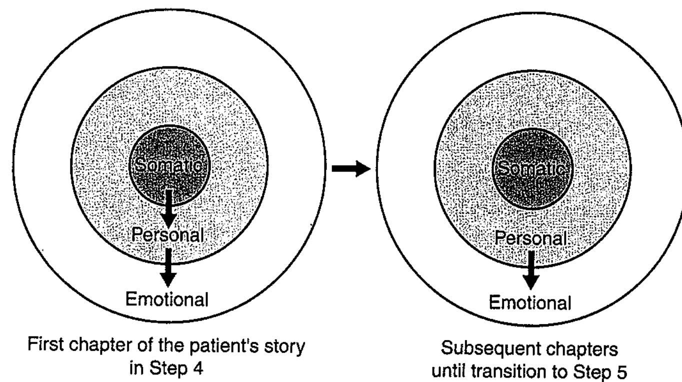

FIGURE 3.1. Somatic, personal, and emotional relationships of chapters of the patient's story in Step 4.

Expand the Story

Expand the Story to New Chapters

We now review the sequence of skills that have been outlined so far in Step 4: focusing open-ended skills, followed by emotion-seeking skills, followed by emotion-handling skills. This typically produces the beginning of the story, but it is still incomplete. To develop the story further requires the

repetitive, cyclic use of this sequence of facilitating skills. Each cycle produces a deeper level of the story (i.e., another chapter). Personal data and their associated emotions evolve in parallel, and neither is more important than the other. **This deepening of the narrative thread occurs because emotion-handling skills have a powerful facilitative effect on the patient's subsequent expression of new nonemotional, personal information.** The interviewer can then return to open-ended inquiry to develop the newly evolving, deeper thread of the story for a while; later, he or she returns to emotion-seeking and emotion-handling skills to develop the emotional dimension of the new data. This continues until she or he is satisfied with the depth of the story. This self-reinforcing effect of patients' psychological statements and emotions is key for obtaining the full psychological and emotional story. The interviewer cannot focus on just the psychological or just the emotional aspect. One supplies the context for the other, and both are developed nearly simultaneously in a progressive unfolding of the narrative theme. However, **the interviewer does not usually return to a physical focus;** rather, he or she prefers to remain in the personal, emotional realm to develop these areas better.

The story develops spontaneously as the interviewer repeatedly cycles among focusing open-ended, emotion-seeking, and emotion-handling skills. As the patient becomes comfortable in expressing emotion, fewer of the emotion-seeking skills are needed; at this stage, emotion-handling and focusing open-ended skills are alternately used, taking the patient quickly to progressively deeper levels of her or his story (see Figure 3-1).

In developing the story, you as the interviewer always will have ideas (hypotheses) about what it implies. However, paradoxically and distinct from the doctor-centered process, you do not ask directly about a hypothesis until it has first been mentioned by the patient. For example, if you think a patient's story about disliking a woman who "looks like my wife" means that the patient dislikes his wife, you cannot ask directly, "Do you not like your wife?" because that question inserts new data (dislike of wife) into the conversation. Rather, you must get the patient to raise this issue himself (e.g., by saying, "Tell me more about your wife."). The hypothesis-testing process is analogous to dancing. Although the patient leads the dance, once the patient has led the conversation to a specific place, you can maintain a focus on that spot. This is how we as interviewers test specific hypotheses: we focus, first open-endedly and then emotionally, on the area where the answer to the hypothesis lies.

Continuation of Vignette of Mrs. Jones

DOC: . . . That's a tough situation.

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

DOC: The head of the Board?

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

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

DOC: Sounds like you didn't get a full picture of this place?

[The student uses focusing open-ended summary and is still trying to learn more new information.]

PT: Yeah, it's not really fair.

DOC: How's that make you feel?

[Now she is back to emotion with a direct emotion-seeking inquiry.]

PT: Well, I must sound kind of stupid, and I feel kind of sheepish. But mostly I'm just mad.

DOC: It makes sense to me, but I don't understand why you feel sheepish. You did everything that you could.

[She moves back to emotion-handling skills with an understanding statement and a respect statement. Notice how open-ended and relationship-building skills are interwoven to generate both nonemotional data and emotions. Notice also that the interviewer can indicate lack of understanding and can ask for clarification.]

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

DOC: Dumb?

[She uses echoing. An obvious story is already present, but she is exploring further by again moving away from emotion.]

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

DOC: Smart with books but not so much with people?

[She uses a combination of a summary and an educated guess.]

PT: Yeah, maybe she's right.

DOC: How'd that feel, when she'd say that?

[She moves back to emotion with direct emotion-seeking.]

PT: Mad! Seems like a pattern, huh? And I used to get headaches as a kid too when she'd get on me. I'd forgotten that.

[This is additional supportive data about the association of headaches and anger.]

DOC: So that made you mad too. I'm impressed at how you're able to talk about it and put this together.

[The student uses a naming and a respecting statement. Depending on the length of time available, she could further address another obvious clue, the patient's mother, perhaps with an open-ended request, such as, "Tell me more about your mother." Note in this vignette that another cycle of focusing open-ended, emotion-seeking, and emotion-handling skills has been used to continue development of the story.]

PT: Well, I appreciate your saying that. Actually, it feels kind of good talking.

[A positive response to this interaction]

DOC: Say more about that.

[An open-ended request]

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

DOC: He doesn't want to talk?

[Echoing]

> **PT:** No. I think he feels bad because he thought this was the best place for me to come.
>
> **DOC:** I'm glad it's been helpful here. You've really been open. [A support statement that is followed by a respect statement. An obvious new area for further discussion, the patient's husband, has been introduced, and this could be pursued further if time allows. The patient also has referred positively to their present interaction; this often would be addressed further. Simply acknowledging it, as the student did in this case, is also appropriate. The patient's comment confirms their good relationship.]
>
> **PT:** Thanks. My headache's better now. It does help.

Because of the importance of the provider–patient relationship, the interviewer should often check with the patient to see how he or she feels the interaction is going. As an interviewer, you may inquire directly by saying something like, "So, how are we doing so far?" If you have been patient-centered, the response will usually be positive; you can simply acknowledge this (e.g., "Good. It seemed like things were going ok to me, but I wanted to check."). When the patient introduces the topic, as Mrs. Jones did in this example, this provides the answer about the relationship; a simple acknowledgment is adequate. Of course, if the patient raises problems with the interaction, you should address these (e.g., the patient indicates that he or she is becoming tired).

If an urgent personal problem exists, which can be easily determined in 5 to 10 minutes, the patient may require additional time or even immediate action. **In the absence of an urgent problem, as is the usual situation, the interviewer should begin to conclude this portion of the interview when she or he has an understanding—not of the entire story, but of the most salient, immediate aspects of the patient's story (i.e., the first few chapters).** Certainly, Mrs. Jones' story has more to it, but, given time constraints and lack of urgency, these areas can be explored another time, if they need to be at all. The student has a good understanding, and, more importantly, the patient feels understood, which is the essence of a good relationship (30).

The student still has not explored Mrs. Jones' colitis and recent cough. Usually, this is done later in the past medical history (PMH) unless the problem is urgent or is related to the chief complaint. During this portion of the interview, the student will obtain a personal description of these complaints and will address their broader personal context, just as she did with the headaches. Usually, however, no more than a few minutes are needed because these are less pressing and troubling.

Transition to the Doctor-Centered Process (Step 5)

At this point, the interviewer, realizing that she or he will soon enter a more doctor-controlled process, anticipates ending this section on a positive, supportive note. As an interviewer, you can weave the emotion-handling skills into the summary (substep 1) and can check the accuracy of the story (substep 2). Even in the most desperate situations, you can usually find something positive and supportive about the patient's situation and can provide some hope, even if it is only your personal support and availability.

TABLE 3.5. TRANSITION TO THE DOCTOR-CENTERED PROCESS (STEP 5)

1. Summarize briefly.
2. Check accuracy.
3. Indicate that both content and style of inquiry will change if the patient is ready.

Step 5 is summarized in Table 3.5; it *usually takes no more than 30 seconds*. In this step, the clinician warns the patient that the content and, more importantly, the patient-centered style of the interview are about to change (substep 3). Otherwise, the patient might be confused or taken aback by the doctor taking control in the doctor-centered style that follows.

Continuation of Vignette with Mrs. Jones

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

DOC: So, you're in a new job that hasn't worked out quite like you were led to believe and that has caused you to be somewhat upset with at least a couple people and to have quite bad headaches. Do you want to add anything?

[The interviewer summarizes nicely. A positive tone to the interaction already exists and nothing further is needed; if the patient were distraught or upset, she could highlight her and others' support.]

PT: No. I think you've pretty much got it.

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

[She is checking to make sure that it is satisfactory to change the subject; she is indicating what is going to occur.]

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

(Mrs. Jones' story continues in Chapter 5.)

Beyond Basic Interviewing

Using the techniques presented in this chapter, we as interviewers have already begun to develop a clear understanding of the patient as a complex, unique person. Focusing open-ended skills, emotion-seeking skills, and emotion-handling skills are essential vehicles for eliciting the required data, but they are just a few of the many tools in the experienced interviewer's armamentarium. Prejudices, time pressures, and preoccupation with other issues, for example, can interfere with hearing the patient's story. We, however, can offset these influences: we prepare for the interview by clearing ourselves, much as an athlete or musician might prepare for a performance (32). The student who is just learning should take care of pressing personal or professional issues beforehand, should relax and clear other issues from her or his

mind, and should focus on the patient. This is especially important if he or she wants to listen at multiple levels (32,33), a skill that can be acquired over time as the basics described in this text become reflexive. Attention to multiple levels means that she or he goes beyond the obvious content and emotion presented by the patient to consider how the patient says something, what is left unsaid, and what is implied. To be able to do so requires attention to the subtleties of grammar, syntax, verb tense, changes of subject, nonverbal cues, incongruity in verbal and emotional content, and understanding of metaphors (32,34). Changes in these areas can then be addressed using the same basic skills (e.g., "What do you mean when you keep saying 'my daughter's father?'" or "I've noticed you often say, 'You can't win for losing.'") .

SUMMARY

The five steps and 21 substeps of the patient-centered process of integrated interviewing have been presented. Two preparatory steps, setting the stage (Step 1) and identifying the chief complaint and agenda (Step 2), exist. The truly patient-centered parts of the interview are opening the HPI (Step 3) and continuing the patient-centered HPI (Step 4), where almost all interaction occurs in the latter. The transition (Step 5) prepares the patient for the doctor-centered interview to follow. In conducting the more difficult Steps 3 and 4, the interviewer orchestrates (32) the patient's personal story using the following tools: nonfocusing and focusing open-ended inquiry, occasional closed-ended questions, emotion-seeking and emotion-handling skills, and hypothesis testing. The cyclic, integrated use of these facilitating skills produces successful patient-centered interviewing and constitutes all of the longest and most important step, Step 4. These are the tools that allow the interviewer to begin to understand the depths of the human condition.

Figure 3.2 summarizes the major events in the patient-centered interview. Usually, preparing the patient takes 1 to 2 minutes, eliciting the story (physical symptoms, personal data, and emotional data) takes 5 to 10 minutes, and making the transition takes 1 minute. The 5 to 10 minutes spent in the patient-centered process just described are easily learned and lead to the remarkable advantages described in Chapter 1 (see the "Rationale"), including improved patient satisfaction, decreased lawsuits, and improved health outcomes with problems such as diabetes and hypertension.

The student or clinician has conducted the most difficult part of the interview. The data generated are easily understood, and they usually describe the primary symptoms and their personal context. The mind–body connection is established, data that will lead to an integrated biopsychosocial story have begun to emerge, and, most importantly, the patient feels understood.

Overarching View of the Patient-Centered Interview

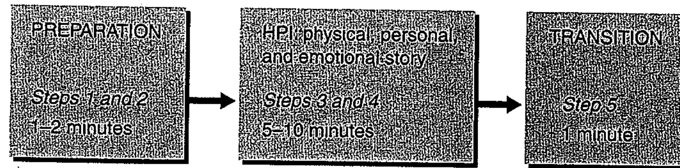

FIGURE 3.2. Overarching view of the patient-centered interview.

LEARNING EXERCISES

1. What is the truly patient-centered part of the 5-step method? What function do Steps 1 and 2 serve?
2. When is interrupting the patient appropriate?*
3. What types of concerns do patients with physical complaints have?
4. What skills are used almost entirely in the very brief Step 3?
5. Under what circumstances would you be likely not to address physical symptoms as the first order of business in Step 4?
6. What is the patient's personal and emotional response when a good relationship occurs?*

*Good test questions.

PRACTICE EXERCISES (LIKELY SPREAD OVER SEVERAL SESSIONS)

1. Practice Steps 1 and 2 together in role-play until you can do them and their six and four substeps, respectively, without looking at the book for recall. Work on simple opening statements for each step, including ways to incorporate several substeps in one sentence or so. See the vignette of Ms. Jones and the demonstration videotape (6).
2. When question #1 is mastered, practice Steps 1 to 5, covering all 21 substeps, together in role-play. Conduct the entire patient-centered interview in 15 minutes, spending about 1 minute each in Steps 1 to 3 and 5 and from 10 to 12 minutes in Step 4.
3. After you can complete all steps and substeps in role-play, conduct the same exercise with a real or simulated patient.
4. Watch for the following problems:
   a. Hurrying into the interview rather than engaging in some small talk to let the patient become accustomed to the setting.
   b. Allowing inefficient agenda-setting and omitting repeated 'what else' statements until you know all items the patient wants to discuss.
   c. Spending excessive time in Step 3, a 30- to 60-second step where you should simply listen attentively after an initial open-ended question.
   d. Not touching the key bases in Step 4: physical symptoms, personal concerns, and emotions.
   e. Not engaging in enough emotion-seeking.
   f. Not displaying enough NURS.
   g. Not signaling the transition adequately.
5. With time and practice, you will notice the following markers of success:
   a. Smooth, seamless flow of data.
   b. Understanding of mind–body links.
   c. An ability to focus wherever you wish.
   d. The ability to interrupt effectively and respectfully.
   e. Control of the interview.
   f. Skill in critiquing your own and others' interviews.
   g. Efficiency in the interview. Once facile with the five steps and 21 substeps, you will be able to conduct the patient-centered process in 5 to 10 minutes. With further mastery, you will be able to be equally effective in 3 to 5 minutes.