outline
hand-outs
bibliography

MEDICAL INTERVIEW

I. INTRODUCTION

A. Medical interview isn't something you do to someone, like a clinical procedure (colposcopy)
B. Rather, a process you participate in; that you guide, focus, direct
C. But depends as much on pt's openness, willingness to enter into dialogue as on your skills

3 main topics - 1) Rapport 2) feelings 3) Medical Interview

II. ESTABLISHING RAPPORT

A. Why is this important?
   1. Malpractice suits - less from pts. who like their drs.
   2. Adds the pleasure to medicine
      a. Rapport helps you, as well as pt.
      b. What makes medicine worthwhile

III. RAPPORT: THE ATTITUDE

A. Bring attitude of caring and compassion, lovingkindness, to each pt. encounter
B. Remember it's always easier to be the dr. than the pt.

C. PATIENT-CENTERED APPROACH (Slide 1, Handout 1)
   1. In any medical interview, two agendas operating
      a. Physician's: history, physical exam, laboratory investigations, differential diagnosis
      b. Patient's: expectations, feelings, fears, understanding the illness experience
      c. Cues that pt's agenda has been ignored
         1. statements made out of context
         2. restatement of problem already mentioned
         3. obvious emotional arousal of pt, often at odds with objective severity of symptoms
         4. door-knob statements
   2. Pt-centered approach involves the reconciliation of the physician and patient agenda

D. INTERVIEWING VS. DIALOGUE
   1. Interviewing vs. dialoguing
      a. Mechanics of interviewing vs.
      b. Entering into relationship with the pt.
      c. Avoid reduction of clinician-patient relationship to a set of skills, competencies, objectives
      d. Interviewing, even with the appropriate skills, can become dehumanizing
      e. Assumption there is an appropriate formula for every occasion
      f. Goal is to really attend to pt., to be able to enter into their reality, help them tell their own story

2. Interviewing as narrative
   a. Help patient tell his or her own story
   b. Importance of getting beyond the official version to the alternative story
      1. not censoring or modifying
      2. not imposing own story
3. Being sincerely interested in pt., caring for the pt.
4. Medicine must be more than simply problem-solving, the application of skills

D. THERAPEUTIC CORE QUALITIES: THE ART OF INTERVIEWING (SLIDE 2)

1. RESPECT:
   a. Ability to accept pt. as unique person; nonjudgmental
   b. Being attentive, focused on pt.
   c. Introduce self; ask about pt's comfort; conduct interview at pt's level; warn when doing something unexpected or painful

2. GENUINENESS:
   a. Ability to be oneself in relation
   b. Expressing feelings within bounds of professional relationship
   c. Ability to distinguish between personal and professional selves

Diane story: pt. describing psychiatrist - oh yes, I think it's helpful except I don't think she understands me & I don't trust her - failure of rapport

3. EMPATHY:
   a. Ability to sense pt's experience and feelings accurately and communicate them back to pt.
   b. Show pt. she is understood
   c. Help pt. clarify what he is feeling

does not mean becoming friends w/ your pt.

IV. RAPPORT: THE BEHAVIOR FACILITATING BEHAVIORS WHICH EXPRESS THERAPEUTIC CORE QUALITIES (SLIDE 3)

A. NONVERBAL
   1. Eye contact, attentive posture
   2. Body language - open, withdrawn, protective, defensive
   3. Pay attention to discrepancies between verbal and nonverbal communication - your own and pts.
   4. Pointing out nonverbal behavior will often facilitate additional pt. communication

B. PARALINGUISTICS

   1. Voice quality and tone, breathy , rapid speech, nervous giggles, speed, pauses (censorship, creating an "effect," preparing to lie)
   2. Silence - good facilitative technique, especially if eye contact is maintained; responding to pt's silence with silence will usually encourage communication

C. UNDERSTANDABLE LANGUAGE
   1. Don't hide behind the role of language
   2. Language as a way of creating distance between you and your patient

D. MINIMAL ENCOURAGERS/FACILITATORS
   1. Nodding, mmhmm
   2. Repeating last word or key phrase; "What else?"

E. CLARIFICATION AND PARAPHRASING
   1. Both content and process - ask for more detail
   2. Way of showing respect and empathy
   3. Way of deepening understanding of pt.

F. CONFRONTATION
   1. Reconciliation of discrepant information, versions
   2. Goal not to prove pt. wrong, but to deepen understanding

V. HOW TO DEAL WITH PATIENT FEELINGS

scariest part of medical encounter issues of counter transference - provoke our own anxieties as physicians

A. HAPPY FEELINGS
   1. Don'ts
      a. Don't be dismissive - refocus pt. on "real" agenda
      b. Appreciation - don't minimize
   2. Do's
      a. Share in pt.'s pleasure
      b. Express your own feelings: "I'm happy for you" "It makes me feel really good to hear that"

B. SAD FEELINGS
   1. Don'ts
      a. Don't ignore, or pretent the tears aren't real
      b. Don't stifle prematurely
         1. kleenex
         2. attempt at conversation
      c. Don't change the subject (stepped on a mine)
      d. Don't reassure meaningless (it's all right)
      e. Don't project your own feelings of discomfort with tears onto the patient
   2. Do's
      a. Validate your pt's crying (It takes courage...)
      b. Reassure pt. about your response (I'm glad you're able to express your feelings in front of me)
      c. Reflect pt. feelings with words (Mrs. Sanchez, this is hard; you must be feeling very low)
      d. Encourage the pt. to cry more (Let your feelings out)
      e. Be quiet - don't say anything, but reassure nonverbally
      f. If patient is extremely distraught, calm her with a few simple questions, or instructions to verbalize her feelings
      g. Resolve your own discomfort about being in the presence of a patient's distress

C. ANGRY FEELINGS
   1. Don'ts
      a. Don't escalate
      b. Don't become defensive
      c. Don't ignore
   2. Do's
      a. Reflect the patient's feelings
      b. Clarify the patient's feelings
      c. Respect the patient's feelings
      d. Own responsibility appropriately
      e. Attempt to realign with the pt., rather than in opposition to the patient
      f. Set limits on verbally abusive or threatening behavior

VI. The MEDICAL INTERVIEW (SLIDE 4)

A. Interview Definition: "A specialized pattern of verbal interaction initiated for a specific purpose and focused on some specific content area, with consequent elimination of extraneous material" - of course, what's difficult to sort out is what is extraneous

B. Not a social conversation

VII. HISTORY-TAKING AS A CLINICAL SKILL: THE SCIENCE OF INTERVIEWING (SLIDE 5)

A. OBJECTIVITY: Unmoved mover vs. wounded healer
   1. Removing one's own beliefs, prejudices, preconceptions before making observations
   2. Avoid jumping too quickly from observation to interpretation
   3. Separate out both your own and pt's interpretations

B. PRECISION:
   1. An expression of the degree of conformity which exists between an observation and that which has been observed
   2. It is closely related to the method by which the observation was made
   3. In interviewing, basic unit of measurement is words - what is really being said
   4. Low precision, or low degree of correspondence between what the patient said or meant, and what you heard or translated into your own terms, results in a loss of information content

C. SENSITIVITY AND SPECIFICITY:
   1. Sensitivity - ability to pick up real cases of the disease in question (what is really said)
   2. Specificity - ability to rule out disease in normal people (avoid misinterpretation)

3. Well-conducted interview will yield firm data base from which to design an efficient diagnostic plan

D. REPRODUCIBILITY AND RELIABILITY
1. Likelihood that same results will be obtained if the same measuring procedures are reapplied under the same conditions
2. Tempered by fact each interviewer, each situation in time introduces new variables evolving history

VIII. STARTING THE INTERVIEW

A. The setting:
1. Establish a sense of privacy
2. Establish a sense of personal space
3. Make sure pt. is as comfortable as possible
4. Establish eye contact
5. Sit at same level, but at angle from pt.

B. How to start:
1. Introduce self - use pt's name and explain role
2. Take notes, but explain why and keep eye contact
3. Identify presenting agenda (purpose of visit)
   a. nurse/chart input
   b. How can I help you?

IX. ESTABLISHING THE CHIEF COMPLAINT (SLIDE 6)

A. The main reason pt. is seeking medical help
1. How can I help you today?
2. Tell me about your problem.
3. What symptoms made you decide to come in?
4. Can you tell me about your trouble?

B. The ostensible reason for coming in is not necessarily the same as the actual reason
1. Why now?
2. Iatrotropic stimulus: literally, what is bringing the pt toward the doctor?

X. THE PRESENT ILLNESS (SLIDE 7)

A. Use of open-ended questions good way to start
1. Move from general to specific
2. Select unbiased, nonleading questions
3. Narrow open-ended questions to target a focus: Tell me more about the pain

B. Move to closed WH questions to characterize symptoms and obtain greater specificity
   a. Where b. What (does it feel like?) c. When d. How (is it affected by time of day, by exercise, by food) e. Why (does it occur?) f. Who (consequences to

pt and other people)

C. Other types of questions
   1. laundry lists, menus
   2. Useful when pt cannot find words to express a certain characteristic

D. Importance of symptom description
   1. Find out what words mean to the patient - "not too bad" may mean pt. is barely hanging on
   2. Novice interviewer tends to establish quantitative (how many stools?) rather than qualitative (are stools soft and watery?) information

E. Agreeing on the main problem
   1. negotiate agreement between physician and pt.
   2. Explore meaning of symptoms and possible diagnosis to pt.
   3. Establish pt's view on cause and what should be done

XI. PAST MEDICAL HISTORY/ FAMILY HISTORY/ REVIEW OF SYSTEMS/ SOCIAL HISTORY

A. PMH
   1. Serious illnesses
   2. hospitalizations, surgical procedures, accidents or injuries
   3. pregnancies, deliveries, complications
   4. immunizations
   5. allergies, current medications

B. Family History
   1. systematic exploration of any illness in family that might have impact on diagnosis of present illness, or that influences pt's health or risk for future disease
   2. hereditary illnesses (sickle cell anemia)
   3. familial illness - coronary artery disease, diabetes, breast cancer; depression, schizophrenia, alcoholism

C. ROS
   1. Function is simply to uncover additional medical problems that may or may not be related to one for which pt. is seeking attention
   2. Should not be excessively time-consuming

D. Social History
   1. Learn something about pt as person
   2. Demographics, occupation (economic factors)
   3. Family, lifestyle (stress, social support)
   4. Diet, smoking, alcohol consumption, illicit drug use
   5. Implications of illness

E. In all these areas, must navigate twin dangers of getting bogged down in irrelevant details vs. missing something important

1. Be asking yourself: What is the point of this line of inquiry?
2. Am I learning information which seems useful?

XII. THE PHYSICAL EXAM

A. Research shows physical exam is stronger predictor of pt. satisfaction than the interview
B. Importance of conversation during physical exam
   1. Feedback/explanatory 3, fact-finding
   2. Reassurance
C. Touching
   1. Symbolic- laying on of hands
   2. Important even when diagnostically unnecessary

XIII. CLOSURE/SUMMARY

A. How to get out
B. Summarize by explaining findings, recommendations for management
C. Mutually negotiated problem list with priorities
D. Pt involved in plan
E. Pt opportunity for final questions, clarifications
F. Thanks and goodbye

XIV. CLINICAL JUDGMENT (SLIDE 8)

A. Diagnostic and therapeutic decisions are all experiments
   1. Formulate hypotheses, collect data
   2. Develop intervention, see what happens
   3. Modify or revise intervention based on pt feedback
B. Definition: the logical and empathic approach to decision-making in the context of uncertainty
C. Errors:
   1. Commission - do the wrong thing
   2. Omission - fail to do the right one
   3. Both may include factual mistakes, limitations of medical knowledge, breach of trust or faulty logic
   4. In current system, errors of commission (overtesting) more readily accepted than errors of omission
D. HYPOTHESIS FORMULATION
   1. Usually holding up to 5 hypotheses at one time, all of which influence interviewing process
   2. Don't gather huge mass of data, then hope to see how it fits together later
   3. PROBABILITY TESTING major feature of clinical judgment
      a. Ask questions most likely to clarify problem
      b. Consider most common diagnoses first
   4. BRANCH AND SCREEN
      a. Move logically and systematically through a decision-making tree

b. Be familiar with screening processes to avoid dead-end lines of inquiry

5. PLAN - be able to formulate a plan for testing competing hypotheses
6. DISCONFIRMATORY EVIDENCE - avoid falling so much in love with leading hypothesis that you avoid signs of disconfirmation
7. REVISION - continually revise hypotheses based on accumulation of additional data

XV. CONDUCTING THE DIFFICULT INTERVIEW (SLIDE 9)

A. TECHNICAL OR PROCESS PROBLEMS

1. Technical impairments: organic (delirium, dementia), language barrier
2. Style impairments: reticent, rambling, vague
   a. Reticent: trick is to guide pt. without asking leading questions; try different types of open-ended questions
   b. Rambling: trick is to direct pt back to task at hand without appearing rude or disinterested; acknowledge own feelings of confusion, limited time; be empathic
   c. Vagueness: give pt choice of words that mean something to you

B. TOPICAL PROBLEMS

1. Topics that are difficult to talk about: drugs, alcohol, sex, money, family violence, abortion, noncompliance
2. Topics that are idiosyncratically difficult

C. PERSONALITY STYLES

1. Dependent, demanding pt: goal is limit-setting; avoid messiah complex
2. Orderly, controlled pt: sickness threatens pt with loss of control; be orderly, systematic, provide information; help pt with feelings
3. Dramatizing, manipulative pt: retain own boundaries; use frequent summaries to regain or retain control; focus on pt. behavior, remain descriptive, not evaluative
4. Long-suffering, masochistic pt: help-rejectors; avoid minimizing pt symptoms, or being overly optimistic
5. Guarded, paranoid pt: be clear, courteous, don't try to change pt beliefs; support pt feelings
6. Superior pt: entitled demanders;

D. Difficult feelings and defenses

1. for both pt and physician
2. Anxiety, anger, depression, denial
3. Inability to cure

XVI. INSTRUCTING THE PATIENT/ NEGOTIATING WITH THE PATIENT (SLIDE 10)

A. PATIENT EDUCATION
   1. Use plain English, avoid medical jargon
   2. Be conrete and specific in language
   3. State important message first, then repeat
   4. Ask pt to paraphrase, then give corrective feedback

B. PRINCIPLES OF NEGOTIATION not sign of inexperienced physician
   1. Eliciting and respecting pt concerns, preferences, disagreements
   2. Learning about pt-specific health beliefs
   3. Understanding pt's perceptions of trade-offs between risks and benefits
   4. Reaching agreement on
      a. What the clinical information really is
      b. nature of the problem
      c. what can and should be done
      d. truly informed consent

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