The health history is a conversation with a purpose. As a clinician you will draw on many of the interpersonal skills that you use every day. But talk with patients has unique and important differences. Unlike other conversations in which you have responsibility largely for yourself, the interview has as its primary goal to improve the well-being of the patient. In the most basic sense, the purpose of the interview is to gather information from the patient, to establish a trusting and supportive relationship with the patient, and to offer information and counselling. Your relationship with the patient is a primary tool in your care of the patient’s health. As a beginning clinician your energies will be focused on gathering information. Using the skills that support the relationship, you will allow the patient’s story to unfold in its most full and detailed form. Providing emotional support not only enhances the gathering of information but in itself is part of the therapeutic process of patient care.

While listening to the patient’s story, the clinician generates a series of hypotheses about the nature of the patient’s concerns. The clinician tests these various hypotheses by asking for more detailed information. Eventually, as you gain more health information, you will offer this to the patient in language that the patient can understand. Even if you discover that little can be done for the patient’s disease, your discussion with the person about the experience of being ill can be therapeutic. In the example that follows, a research protocol made the patient ineligible for treatment of her long-standing and severe arthritis.

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

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

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

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

Interviewing patients is much more than gathering pieces of information. Good interviewing requires both the knowledge of what information you need to obtain from the patient and skill in eliciting and responding to the patient’s story. This chapter outlines the structure and purposes of the health history and describes a basic approach to interviewing. It explains useful interviewing techniques, suggests ways to address difficult issues, and explores how to talk with patients of different ages and needs. At the end of the chapter, a standard format for recording a comprehensive history for adults and for children covers the range of content you might include.

The Structure and Purposes of the Health History

The scope and focus of the health history vary according to the patient’s agenda and problem, the clinician’s goals for the visit, and the clinical setting (inpatient or outpatient, amount of time available, specialty or primary care). Often the clinician targets a specific complaint, such as a cough or painful urination; a limited approach tailored to that specific problem may then be indicated. In a primary care setting, the clinician is likely to address specific preventive or health maintenance issues such as smoking or high-risk sexual behaviors. A subspecialist may do an in-depth history to evaluate a specific problem that incorporates several areas of inquiry. In other settings, you will do a comprehensive health history. Knowing the content and relevance of all the components of a comprehensive health history enables you to pick the elements that will help most in evaluating the patient’s concern in a context.

The Comprehensive Health History. The comprehensive health history has several parts, each with a specific purpose. Together they give structure to your data collection and to your final record, but their order shown here should not dictate the sequence of the interview.

Selected introductory information in the health history typically precedes the account of the patient’s story. Identifying data, such as age, birthplace, family members, and occupation, serve not only to establish who the patient is but also to give you basic information about the person you are talking to and what the likely problems might be. When patients do not initiate their own visits, the source of referral becomes important. It indicates that a written report may be necessary, and it helps you to understand the patient’s possible motivations. Persons seen at the request of school authorities or an insurance company may have different goals than those who come on their own initiative. Under some circumstances, you may also wish to comment on the probable reliability of the source of your data. Reliability varies with knowledge, memory, trust, and motivation, among other factors, and is a judgment made at the end of the interaction, not at the beginning. (Note that in the written record, p. 35, introductory information also includes the date and, in rapidly changing circumstances, the time. The source of the history, whether it be the patient, family, friends, a letter of referral, or the past
The main part of the history starts with the patient's chief complaints. These are the one or more symptoms or other concerns for which the patient is seeking care or advice. The present illness section is the clinician's statement about the scope of the patient's presenting concerns. It amplifies the chief complaints and, in its written form, gives a full, clear, chronological account of how each of the symptoms developed, their attributes, and their context. The present illness section pulls in relevant aspects of the patient's perspectives and pertinent parts of the review of systems (see below). The present illness section also includes how the patient thinks and feels about the illness, what concerns have led to seeking attention, and how the illness has affected the patient's daily life and functions. The past history explores childhood illnesses and any history of adult medical illnesses, surgery, obstetric or gynecologic events, and psychiatric conditions. Accidents and injuries, as well as transfusions, may also be included. It is wise to include issues relevant to health maintenance, including immunizations and screening examinations, lifestyle issues, and safety practices.

The family history helps you to assess the patient's risks of developing certain diseases and may also suggest family experiences relevant to the patient's concerns. The personal and social history includes information about the patient's education, family of origin, current household, and personal interests. It helps you in getting to know your patient as a person. It often suggests contributory factors in the patient's illness and helps you to evaluate the patient's sources of support, likely reactions to illness, coping mechanisms, strengths, and fears. Questions relating to the personal and social history should be woven throughout the interview.

In the review of systems you ask about common symptoms in each major body system, and thus try to identify problems that the patient has not mentioned. The main purpose of the review of systems is to make sure that you have not missed any important symptoms, particularly in areas that you have not already thoroughly explored while discussing the present illness. A fairly general question that introduces each system, or subset of a system, is helpful. It focuses the patient's attention, allows you to move from the general to the more specific in each system, and on occasion may be all you need to ask. For example:

How are your ears and hearing?
How about your lungs and breathing?
Any trouble with your heart?
How is your digestion? How about your bowels?

As you ask additional questions, the detail needed within each area depends on the patient's age, complaints, general state of health, and the purpose of the visit, among other variables. An older patient, who is at greater risk of heart disease, cancer, and hearing loss, for example, needs
more detailed questioning in certain areas than does an apparently healthy 20-year-old.

Some clinicians like to combine the review of systems with the physical examination, asking about the ears, for example, while looking at them. When a patient has few symptoms, this combination can be efficient. When a patient has multiple symptoms, however, the flow of both the history and the examination is disrupted and necessary note taking becomes awkward. If you want to try the combination, it is probably wise to wait until you master the flow of the examination.

While the present illness is usually the single most important part of a history, important data are also discovered in subsequent parts of the interview. The review of systems may uncover material that requires as full an exploration as the present illness. You may learn of a parent's death or a prior illness. Here is a good opportunity to find out what it meant to the patient. "How was it for you then?" or "What were your feelings at the time?" Keep your technique flexible. Remember that interviewing the patient is a loosely structured process that you will organize into a written format only after the interview and examination are completed.

Setting the Stage for the Interview

Obtaining a health history requires planning. You are undoubtedly eager to establish contact with the patient, but there are several things to be considered before beginning the interview that are crucial to success.

Reviewing the Chart. Before seeing the patient, review the chart. The medical chart may give you valuable information about past diagnoses and treatments, but it should not prevent you from developing new approaches or ideas. The purpose of reviewing the chart is partly to gather information and partly to develop ideas about what might be explored with the patient. You should look at the identifying data (age, gender, address, health insurance), the problem list, the medication list, and other specific details, such as the documentation of allergies. Remember that the information contained in the chart is shaped by individual observers or by the institution that created the chart formal and forms. What you learn from the chart may be incomplete or inconsistent with what you learn from the patient. The chart may not capture the essence of the person whom you are going to meet. If information from the patient and the chart differ, exploring such differences may give you new insights.

Clinician's Tasks. Before seeing a patient the clinician must clarify the goals for the interview. As a student, your goal may be to obtain a complete health history so that you can submit a write-up to your teacher. As a clinician, your goals for the interview may include completing forms needed for the hospital or testing hypotheses you have about the problem based on your review of the chart. A clinician must balance these clinician-centered goals with the goals of the patient. There can be a tension between the needs of the clinician, the needs of the institution, and the needs of the patient and their family. Part of the clinician's task is to keep these multiple agendas in mind. If you think through your
goals prior to the interview, it will be easier during the interview to establish a healthy balance between your needs and the patient’s.

**Clinician’s Mindset.** As clinicians, we encounter a wide variety of people, each one unique. Establishing relationships with individuals representing a broad spectrum of age, social class, ethnicity, and health to illness is an uncommon opportunity. Being consistently open and respectful of human differences is one of the clinician’s challenges. Because we bring our own values and assumptions to every encounter, we must work to clarify for ourselves how our expectations and reactions may affect what we hear and how we behave. *Self-reflection is a continual part of professional development in clinical practice.* The deepening personal awareness that emerges from our work with patients is one of the most rewarding aspects of patient care.

**Clinician’s Behaviors.** Just as you observe the patient throughout the interview, the patient will be watching you. Consciously or not, you send messages through both your words and your behavior. You should be sensitive to those messages and manage them as well as you can. Posture, gestures, eye contact, and words can all express interest, attention, acceptance, and understanding. The skilled interviewer seems calm and unhurried, even when time is limited. Reactions that betray disapproval, embarrassment, impatience, or boredom block communication, as do behaviors that condense, stereotype, or make fun of the patient. Although negative reactions such as these are normal and understandable, they should not be expressed. Guard against them, not only when talking with patients but also when discussing the patient with your colleagues in the hall or other public places.

**Clinician’s Appearance.** Your personal appearance may also affect the ease with which you establish a relationship. Cleanliness, neatness, conservative dress, and a name tag are reassuring to the patient. Keep the patient’s perspective about your appearance in mind. Remember that you want the patient to trust you.

**Note Taking.** As a novice, you will need to write down much of what you learn in a health history. While an experienced clinician can conduct an interview focused on a few problems without needing to take notes, no one can remember all the details of a comprehensive history. However, note taking should not divert your attention from the patient, nor should a written form prevent you from following your patient’s lead. When the patient is talking about sensitive or disturbing material, put your pen down and be especially aware of maintaining eye contact. While eliciting a comprehensive health history, jot down short phrases, specific dates, or words rather than trying to put it into a final format. Most patients are accustomed to note taking, but some may seem uncomfortable with it. If so, explore their concerns and explain your desire to make an accurate record.

**The Environment.** Make the setting as private and comfortable as possible. Although you may have to talk with the patient under difficult circumstances, such as in a four-bed room or the corridor of a busy emer-
Learning About the Patient’s Illness

Because you have invested time and energy into planning your approach to the patient, you are now fully ready to learn about the present illness and the patient’s concerns. In general, an interview moves through stages. Throughout this sequence, the clinician, must be attuned to the patient’s feelings, support their expression, respond to their content, and validate their significance. The following stages are typical:

<table>
<thead>
<tr>
<th>The Stages of the Interview</th>
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<tbody>
<tr>
<td>1. Greeting the patient and establishing rapport</td>
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<tr>
<td>2. Inviting the patient’s story</td>
</tr>
<tr>
<td>3. Establishing the agenda for the interview</td>
</tr>
<tr>
<td>4. Generating and testing hypotheses about the nature of the problem(s) by expanding and clarifying the patient’s story</td>
</tr>
<tr>
<td>5. Creating a shared understanding of the problem(s)</td>
</tr>
<tr>
<td>6. Negotiating a plan (includes further diagnostic evaluation, treatment, and patient education)</td>
</tr>
<tr>
<td>7. Planning for follow-up and closing the interview</td>
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As a student clinician, you will focus your interview on obtaining the patient’s story and creating a shared understanding of the problem. As you become more experienced, the components of negotiating a plan will become more important. Even in a comprehensive health history, the interview should include the elements listed above.

Greeting the Patient and Establishing Rapport. Greet the patient by name and introduce yourself by name. Shake hands with the patient if you feel comfortable doing so. If this is the first contact, clarify your role, such as stating your status as a student and explaining your relation to the patient’s care. It is always most appropriate to address the patient with a title, for example, Mr. O’Neil or Ms. Washington. Use of first names should be limited to conversation with a child or adolescent unless you know the patient well or the patient has specifically given you permission. Addressing unfamiliar adults as “granny” or “dear” tends to depersonalize and demeasure. Often other individuals are present in the room when you are going to conduct an interview. You need to find out the identity and the relationship to the patient of each of these individuals. Be sure to acknowledge and greet each person in turn. When other individuals are present, ask the permission of the patient to con-
duct the interview in front of them. State that you welcome the other individuals, but allow the patient to decide. For example, “I am comfortable with having your sister, Mrs. Jones, stay for the interview, but I want to make sure that this is also what you want,” or “Would you prefer that I spoke to you alone or with your sister present?”

Arranging the Room. Position yourself at a distance from the patient that enhances comfortable conversation and good eye contact. You should be within several feet, close enough to be intimate but not awkward. Pull up a chair, if possible, and sit so that you are at eye level with the patient. Remember that interpersonal distance varies by culture and personal style. In an outpatient setting, sitting on a rolling stool can help you respond to patient cues. Avoid having physical barriers (e.g., desks, bedside tables) between you and the patient. Arrangements that indicate inequality of power or even disrespect, such as interviewing a woman while she is lying supine, positioned for a pelvic examination, are unacceptable. Lighting also makes a difference. Avoid sitting between a patient and a bright light or window. Although your view may be fine, the patient must squint uncomfortably toward your silhouette. You unwittingly conduct an interrogation, not a helping interview.

The Patient’s Comfort. Be alert to the patient’s comfort. In the office or clinic, there should be a suitable place for coats and belongings other than the patient’s own lap. In the hospital, inquire how the patient is feeling and whether your visit now is convenient. Watch for indications of discomfort such as poor positioning or evidence of pain or anxiety. An improved position in bed or a brief delay so that the patient can say goodbye to visitors or finish using the bedpan may be the shortest route to a good history.

Establishing Rapport. The initial contact with the patient sets the foundation for the relationship. Be prepared to give your undivided attention. Spend enough time and energy on your greeting and the patient’s response to achieve a level of comfort on the part of the patient. Use eye contact and attend to the relative physical position of you, the patient, and any other individuals in the room. As you begin the interview, do not read the chart or take notes.

Inviting the Patient’s Story. Once rapport has been established, you need to determine the patient’s reason for seeking health care, or the chief complaint. Begin your interview with a question that allows full freedom of response, often called an open-ended question. “What concerns bring you here today?” or “How can I help you?” After the patient answers, inquire again or even several times, “Anything else?” Note that these questions do not express your point of view or require a simple yes or no answer. When the patient has finished listing all his or her concerns, the next step is to encourage further description of each concern by saying, for example, “Tell me about your headaches.”

Patients can seek health care for a routine visit for follow-up for hypertension, a complete physical examination, or a desire to discuss a health-related matter without actually having a specific complaint or problem.
At other times, patients may request a routine examination yet still have specific concerns that they are uncomfortable bringing to the forefront. In all these situations, it is still important to start with the patient's story. Additional examples of open-ended questions are, "Are there specific concerns that prompted you to schedule this appointment?" "What made you decide to come for health care now?"

**Following the Patient's Leads.** Good interviewing technique allows patients to recount their own stories spontaneously. If you intervene too early by asking specific questions prematurely, you risk trampling on the very information you are seeking. Your role, however, is not passive. You should listen actively and watch for clues to important symptoms, emotions, events, and relationships. At the initial part of the interview, using responses called continuers works best. They include nonverbal cues such as head nodding and verbal phrases such as "go on" or "I see." Continuing with open-ended questions and facilitative techniques (see p. 12), you will usually be able to obtain a general idea of the patient's principal problems and most of the necessary specifics.

You can then guide the patient into telling you more about the areas that seem most significant. This is done by using direct questioning. The process of direct questioning follows several guiding principles. Questions should proceed from the general to the specific. A possible sequence, for example, might be, "What was your chest pain like? Tell me more. Where did you feel it? Show me. Anywhere else? Did it travel anywhere? . . . to which fingers?"

*Direct questions should not be leading questions.* If a patient says yes to "Did your stools look like tar?" you must wonder if the description is the patient's or yours. A better wording is, "What color were your stools?" When possible, *ask questions that require a graded response* rather than a yes or no answer. "How many steps can you climb before getting short of breath?" is better than "Do you get short of breath climbing stairs?"

Sometimes patients seem quite unable to describe their symptoms without help. To minimize bias here, *offer multiple-choice answers.* "Is your pain aching, sharp, pressing, burning, shooting, or what?" Almost any direct question can allow at least two possible answers. "Do you bring up any phlegm with your cough, or is it dry?" *Ask one question at a time.* "Any tuberculosis, pleurisy, asthma, bronchitis, pneumonia?" may lead to a negative answer out of sheer confusion. Try, "Do you have any of the following problems?" and be sure to pause and establish eye contact with each problem listed.

Finally, use language that is understandable and appropriate to the patient. Although you might ask a trained health professional about dyspnea, the customary term is shortness of breath. As you learn and increasingly use medical language, it is easy to slip into using it with patients. This blocks communication. Appropriate words for symptoms are suggested in Chapter 2. Whenever possible, however, use the patient's words, making sure you clarify their meaning.

Establishing a nonjudgmental, nonintrusive, open-ended, and nonleading question, as in "What specifically concerns you most?" will have an initial impact and help clarify what the patient is almost always trying to say, rather than waiting for the patient to ask to talk about symptoms. An example is, "What problem is between you and living your life?" or "What is the greatest problem you face and why?" or "What symptoms concern you the most?" or "What are your expectations of medical care?"

**Generating the patient's story** about what is going on is critical. You test the patient's understanding, for example, by asking, "What is the real problem, mental, or not? Do you have any specific problems in your joints, aside from your knee injury?"

If the patient does not understand the question, rephrase it to clarify the focus of the question.
Establishing the sequence and time course of the patient's symptoms is important. You can encourage a chronologic account by such questions as "What then?" or "What happened next?" However, you will usually need further specific information to help you in testing the different hypotheses you have about the problem. Fill in the details with more direct questions that ask for specific information not already offered by the patient. In general, an interview moves back and forth from open-ended questions to directed questions and then on to another open-ended question.

Establishing an Agenda for the Interview. The clinician often approaches the interview with specific questions in mind. The patient will also have questions and concerns. It is important to identify all of the patient's concerns at the beginning of the encounter. This will help to ensure that everything is addressed, then or in the future. As a student, you may have enough time available to cover the breadth of both your concerns and the patient's concerns in one visit. However, for a clinician, time is almost always an issue. It may be necessary to focus the encounter by asking the patient to identify the one problem that is of most concern. An example of this might be, "You have told me about several different problems that are important for us to discuss. We need to decide which one or two problems to address today. Can you tell me which one is of greatest concern to you?" Stating that the other problems are also important and should be addressed in a future visit helps to establish the expectation of an ongoing collaboration. Then you can proceed with questions such as, "Tell me about that problem."

Generating and Testing Diagnostic Hypotheses. As you learn about the patient's story and the symptoms, you should be generating hypotheses about what body systems might be involved by a pathologic process. You test these theories by asking for specific information. Leg pain, for example, suggests a problem in the peripheral vascular, musculoskeletal, or nervous system. An associated swollen ankle may favor a vascular problem or a musculoskeletal problem when associated with aching joints. A severe pain that shoots down the back of one leg to below the knee indicates pressure on a nerve root.

If the present illness involves pain, for example, it is important to clarify the following elements:

<table>
<thead>
<tr>
<th>The Seven Attributes of a Symptom</th>
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<tbody>
<tr>
<td>1. Its location. Where is it? Does it radiate?</td>
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<tr>
<td>2. Its quality. What is it like?</td>
</tr>
<tr>
<td>3. Its quantity or severity. How bad is it?</td>
</tr>
<tr>
<td>4. Its timing. When did (does) it start? How long does it last? How often does it come?</td>
</tr>
<tr>
<td>5. The setting in which it occurs, including environmental factors, personal activities, emotional reactions, or other circumstances that may have contributed to the illness</td>
</tr>
<tr>
<td>6. Factors that make it better or worse</td>
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<tr>
<td>7. Associated manifestations</td>
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</tbody>
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Other symptoms should be described in similar terms. These attributes are fundamental in recognizing patterns of disease and differentiating one disease from another. As you learn more about diagnostic patterns, listening for and asking about these attributes will become more automatic. For additional data that will contribute to your analysis, use items from relevant sections of the review of systems. You can thus develop arguments for and against the various diagnostic possibilities. This kind of clinical thinking is illustrated by the tables in Chapter 2 and discussed further in Chapter 20.

Creating a Shared Understanding of the Problem. While the focus of this chapter is on the practical how-to’s of patient interviewing, it is useful to have a working understanding of the difference between illness and disease. This distinction highlights the two different perspectives that should be examined in every good interview, and the need for the patient and the clinician to find common ground. Illness can be defined as the patient’s experience of symptoms. The patient’s perspective may be shaped by many factors, including prior personal or family health experiences, how the symptoms are affecting daily life, concerns about the severity of symptoms, and expectations about medical care. Disease is the explanation that the clinician brings to the symptoms. It is the way the clinician organizes what is learned from the patient into a coherent picture that leads to a medical diagnosis. The health interview needs to take into account both of these views of reality.

Even a chief complaint as straightforward as a sore throat can illustrate these divergent views. The patient may be most concerned about pain and difficulty in swallowing, a cousin who once was hospitalized with epiglottitis, or missing time from work. The clinician, however, may focus on specific points that differentiate strep pharyngitis from other etiologies and the most cost-effective treatment for a patient with a history of allergy to penicillin.

To satisfy both the patient’s expectations and the clinician’s agenda, and to provide good health care, the clinician continues beyond the attributes of the symptoms. To learn about the patient’s illness, you ask patient-centered questions in the six domains listed below.

<table>
<thead>
<tr>
<th>Eliciting the Patient’s Perspective</th>
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<tbody>
<tr>
<td>1. The patient’s thoughts about the nature and the cause of the problem</td>
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<tr>
<td>2. The patient’s feelings about the problem, especially fears</td>
</tr>
<tr>
<td>3. The patient’s expectations of the clinician and health care</td>
</tr>
<tr>
<td>4. The effect of the problem on the patient’s life</td>
</tr>
<tr>
<td>5. Similar experiences in the patient’s personal or family history</td>
</tr>
<tr>
<td>6. Any steps that the patient has taken to address the problem</td>
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</tbody>
</table>

Ask for the patient’s ideas about the cause of the problem (“Why do you think you have this stomach ache?”) and for the patient’s feelings about the problem (“What worries you most about the pain?”). It may be helpful to ask the patient about prior experiences—“Has anything
like this happened to you or your family before?” (“I think I might have an appendicitis. My uncle Charlie died of a ruptured appendix.”). Ask what the patient has done so far to take care of the problem (most patients will have tried either over-the-counter medications or traditional remedies or sought advice of others). Inquire as to how the illness has affected the patient’s lifestyle and functioning. This question is especially pertinent for a patient with chronic illness. “What can’t you do now that you could do before? How has the backache, (shortness of breath, etc.), affected your ability to work? ... your life at home? ... your social activities? ... your role as a parent? ... your role as a husband or wife? ... the way you feel about yourself as a person?”

Negotiating a Plan. Learning about the disease and conceptualizing the illness provide the opportunity for you and the patient to create a complete picture of the problem. This multifaceted picture then forms the basis for planning further evaluation (e.g., physical examination, laboratory tests, consultations) and negotiating a treatment plan.

Planning for Follow-up and Closing the Interview. You may find that ending the interview is difficult. Patients often have many questions and, if you have done your job well, they are enjoying talking with you. Giving a few minutes’ notice before you are out of time can be helpful. Before gathering your papers or standing to leave the room, warn the patient, “We need to stop now. Do you have any questions about what we’ve covered?” Make sure the patient understands the shared treatment plan you have developed. Reviewing plans for evaluation and follow-up are helpful. “So, you will take the medicine as we discussed, get the blood test before you leave today, and make a follow-up appointment for 4 weeks.” Address any fears or concerns that the patient expresses.

Allowing the patient to ask final clarifying questions is important. It is not, however, a time to bring up new topics. If that happens (and the problem is not life threatening), simple reassurance about your interest and plans for a future time to address the problem are appropriate. “That headache sounds concerning. Why don’t you make an appointment for next week so we can discuss it.” Reaffirming that you will continue to work with the patient to improve his or her health is always important.

The Skills of Good Interviewing

Skillful interviewing relies on the use of learnable techniques. You need to practice these techniques and find ways to be observed or recorded so that you can receive feedback on your progress. The following list describes some of the fundamental skills for enriching the interview as you follow the patient’s leads.

Nonverbal Communication. Each of us sends and receives messages all the time that do not involve the use of speech. Becoming more aware of nonverbal communication allows you to use those cues effectively, both to “read” the patient and to send your own messages. Be alert to such
attributes as eye contact, body posture, head position and movement (e.g., shaking or nodding), distance from the patient, and placement of arms or legs, such as crossed, neutral, or open. Matching body positions between you and the patient is a sign of increasing rapport. Moving closer to the patient or physical contact can be used to enhance communication of empathy or to help a patient gain control. Bringing nonverbal communication to the conscious level is the first step toward using this crucial form of communication.

Closely related to nonverbal communication is paralanguage, the qualities of speech. The pacing, tone, and volume of the patient’s speech are all useful to observe, and can be mirrored to increase connection. Paralanguage and the patient’s nonverbal communication also provide information about the patient’s emotional state.

Facilitation. You use facilitation when by posture, actions, or words you encourage the patient to say more but do not specify the topic. Remaining silent yet attentive and relaxed is a cue for the patient to continue. Leaning forward, making eye contact, saying “Mm-hmm” or “Go on” or “I’m listening” all help the patient to continue.

Reflection. A simple repetition of the patient’s words encourages the patient to give you more details. This is useful in eliciting both facts and feelings, as in the following example:

Patient: The pain got worse and began to spread. (Pause)
Response: Spread?
Patient: Yes, it went to my shoulder and down my left arm to the fingers. It was so bad that I thought I was going to die. (Pause)
Response: Going to die?
Patient: Yes, It was just like the pain my father had when he had his heart attack, and I was afraid the same thing was happening to me.

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

Clarification. Sometimes the patient’s words are ambiguous or the associations are unclear. If you are to understand their meaning you must request clarification, as in “Tell me exactly what you meant by ‘a cold’” or “You said you were behaving just like your mother. What did you mean?”

Summarization. Giving a capsule summary of the patient’s story at some point in the interview is a very useful technique. It both indicates to the patient that you have been listening carefully and clarifies what you know and what you don’t know. “Now, you said you’ve been coughing for 3 days, that it’s especially bad at night, you are also now bringing up yellow phlegm. You have not had a fever or felt short of breath.

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breath, but feel congested, with difficulty breathing through your nose. Anything else?” This also allows you, the clinician, to organize your thoughts in the process of diagnostic reasoning.

**Validation.** Another important way to make a patient feel safe is to legitimize or validate the patient’s experience. If a patient who has been in a car accident has no significant physical injury but still is experiencing distress, you may reassure the patient that the experience is normal by stating something like “I can understand that the accident must have been very scary for you, and that may be why you continue to feel unsettled.”

**Empathic Responses.** Expressing empathy is part of establishing a relationship with a patient and is also therapeutic. As patients talk with you they may express—with or without words—feelings they have not consciously acknowledged. These feelings are crucial to understanding their illness and to establishing a trusting relationship. To empathize with your patient you must first identify the patient’s feelings. When you sense important but unexpressed feelings from the patient’s face, voice, words, or behavior, inquire about them rather than assuming how the patient feels. You may simply ask, “How did you feel about that?”

When feelings are expressed, respond with understanding and acceptance. Responses may be as simple as “I understand,” “That sounds upsetting,” or “You seem sad.” Empathy may also be nonverbal—for example, offering a tissue to a crying patient or gently placing your hand on an arm to convey understanding. In using an empathic response, be sure that you are responding correctly to what the patient has expressed. If you have acknowledged how upset a patient must have been at the death of a parent, when in fact the death relieved the patient from a long-standing financial and emotional burden, you have misunderstood the situation.

**Reassurance.** When you are talking with anxious patients, it is normal to want to reassure them. “Don’t worry. Everything is going to be all right.” While this may be appropriate in non-professional relationships, in your role as a clinician this approach is usually counterproductive. Unless you and the patient have had a chance to explore the nature of the anxiety, you may well be giving reassurance about the wrong thing. Moreover, premature reassurance blocks further communication. The first step to effective reassurance involves identifying and accepting the patient’s feelings. This promotes a feeling of security. The final steps come much later in the health-care encounter, after you have completed the interview, the physical examination, and perhaps some laboratory studies. At that point you can interpret for the patient what is happening and deal openly with the real concerns.

**Transitions.** Patients often feel anxious and vulnerable. One way to make them more at ease is to keep them aware of how you are organizing the flow of the interview, examination, and closing discussion. Sharing this information gives the patient a greater sense of control. As you
move from one part of the history to another and through the physical exam, you may orient the patient with brief transitional phrases. “Now I’d like to ask some questions about your past health.” Be clear about what the patient should do or expect next. “Now I would like to examine you. I will step out for a few minutes. Please get completely undressed and put on this gown.” By specifying whether the gown should open in the front or the back, you may earn the patient’s gratitude and save yourself time.

Challenges to the Clinician

Taking a History on Sensitive Topics

Clinicians must ask patients about a variety of subjects that are emotionally laden or culturally sensitive. Initially, these discussions will be particularly difficult, but even experienced clinicians have some discomfort with specific topics. The list of these topics may include use or abuse of alcohol and drugs, sexual orientation or activities, death and dying, financial concerns, racial and ethnic experiences, family interactions, domestic violence, psychiatric illnesses, physical deformities, functioning of the urinary tract and bowel, and others. These areas are difficult to explore, partially because of societal taboos. We all know, for example, that talking about bowel function is not “polite table talk.” In addition, there are strongly held cultural, societal, and personal beliefs about many of these topics. Bias about race, drug use, and homosexual practices are three obvious examples of areas that can prompt strong reactions and pose barriers during the interview. The following sections explore these and other important and sometimes sensitive areas, such as domestic violence, the dying patient, and mental illness.

Several basic principles can guide you in approaching any sensitive subject. The single most important rule is to maintain a nonjudgmental approach. The clinician’s role is to learn about the patient and help the patient achieve better health. Disapproval of behaviors or elements in the health history will only interfere with this goal. Explaining to a patient why you need to know the information and putting it into context helps to orient the patient and allows you to collect your thoughts. For example, explain that “Because sexual practices put people at risk for certain diseases, I ask all of my patients the following questions.” You should use specific language. Refer to genitalia with explicit words such as penis or vagina and avoid talking about “private parts.” Make sure that the patient understands the words you may use. “By intercourse, I mean when a man inserts his penis into a woman’s vagina.” Familiarize yourself with some opening questions on sensitive topics and learn the additional kinds of data you need to make the desired assessments.

Other ways to become more comfortable with sensitive areas include: general reading about these topics in the medical and lay literature; talking to selected colleagues and teachers openly about your concerns; special courses that assist you in exploring your own feelings and reactions.
to these sensitive topics; and ultimately, your own life experience. Take advantage of all of these resources. Whenever possible, listen to experi-
enced clinicians as they discuss such subjects with patients, and then try exploring some of these areas yourself. It is particularly important for 
you to actually practice talking about sensitive areas with patients. The 
range of topics that you can explore with comfort will widen progres-
sively.

**Bias and Cultural Differences.** Developing the ability to interact with 
patients of many backgrounds is a lifelong professional goal. Review the 
examples below, which illustrate how unconscious bias and cultural dif-
f erences can influence patient care.

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

This example of how different expectations based on different countries 
of origin can lead to ineffective health care is a readily understandable 
and nonthreatening illustration of cross-cultural miscommunication. 
However, cross-cultural communication occurs in many clinical interac-
tions and is usually more subtle.

A 16-year-old African American high school student from a lower socio-
economic urban community came to the local teen health center because of 
painful menstrual cramps that were interfering with school. The clinician, a 
30-year-old European American from a middle-class suburb, asked many 
questions that reflected incorrect assumptions. "So are you planning to finish 
high school? ... What kind of job do you want then? ... What kind of birth 
control do you want?" The teenager felt pressured to accept birth control de-
spite stating clearly that she had not had intercourse, and didn't plan to until 
she was older, and married. She was an honor student and athlete planning 
to go to college and graduate school, but these goals were not uncovered. The 
issue of cramps was given little attention by the clinician— "Oh, you can just 
take some ibuprofen. They usually get better as you get older." The patient 
will not take the birth control pills that were prescribed nor will she seek 
health care soon again. She has experienced ineffective health care due to 
cross-cultural misunderstanding and clinician bias.

The failure in both of the cases above is due to the clinician's assump-
tions or biases. In the first case, the clinician did not take into account 
the many variables that can shape a patient's beliefs about health and at-
titudes toward medical care. In the second case, the clinician allowed 
stereotypes to dictate the agenda instead of listening to and respecting 
The patient as an individual. As individuals we each have our own cul-
tural background and biases. These do not simply slip away as we become clinicians. As you encounter an expanding array of patient concerns, behaviors, and backgrounds, it is important to understand how culture shapes not just the patient's beliefs and behaviors but our own.

*Culture* is a system of shared ideas, rules, and meanings which individuals inherit or acquire that tell them how to view the world, how to experience it emotionally, and how to behave in relation to other people and to the environment. It can be understood as the "lens" through which individuals perceive and make sense out of the world they inhabit. While learning about specific cultural groups is important, without a framework it may lead to developing a series of stereotypes. Work on an appropriate and informed clinical approach to all patients by becoming aware of your own biases and values, developing communication skills that transcend cultural differences, and building therapeutic partnerships based on respect for the patient's life experiences. This framework will allow you to approach each patient as unique and distinct.

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

Another, more challenging, part of learning about yourself is the task of bringing your own values and biases to a conscious level. **Values** are the standards we use to measure beliefs and behaviors, which may appear to be absolutes. **Biases** are the attitudes or feelings that we attach to the awareness of difference. Being attuned to difference is a normal, and in the distant past, life-preserving ability. Intuitively knowing members of one's own tribe is a survival skill that societally we have outgrown but is still actively at work. We often feel so guilty about our biases that it is hard to recognize and acknowledge them. Start with less threatening constructs, like the way an individual relates to time. This can be a culturally determined phenomenon. Are you always on time?—a positive value in the dominant Western culture. Or do you tend to run a little late? How do you feel about people who have the opposite habit from you? Next time you attend a meeting or class, notice who is early, on time, or late. Is it predictable? Think about the role of physical appearance. Do you consider yourself thin, medium, or heavy? How do you feel about your weight? What does prevailing U.S. culture teach us to value in body habitus? How do you feel about people who have different weights?

**Learning About Others.** Given the complexity of culture, no one can possibly know the health beliefs and practices of every culture and subculture. Therefore, remember that the patients you are working with are

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1 This approach reflects the conceptual framework of the Cross-Cultural Education Committee at the University of Rochester School of Medicine and Dentistry.

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experts on their own unique cultural perspectives. Patients may not be able to identify or define their values or beliefs in the abstract, but should be able to respond to specific questions. Find out about the patient's cultural background. Use some of the same questions discussed in "eliciting the patient's perspective" (see p. 10). Maintain an open, respectful, and inquiring stance. "What did you hope to get from this visit?" If you have established rapport and trust, patients will be willing to teach you. Be ready to acknowledge your ignorance or bias. "I know very little about Ghana. What would have happened at a clinic there if you had these concerns?" Or, with the second patient and with much more difficulty, "I mistakenly made assumptions about you that are not right. I apologize. I must have some biases about teenage girls of color that I need to work on. Would you be willing to tell me more about yourself and your future goals?"

Learning about specific cultures is still valuable because it helps to expand what you, as a clinician, identify as areas you need to explore. Do some reading about the life experiences of ethnic or racial groups that live in your region. Go to movies that are made in different countries or explicitly present the perspective of different groups. Learn about the perspectives and concerns of different consumer groups with visible health agendas. Seek out healers of different disciplines and establish collegial relationships with them. Most importantly, be open to learning from your patients.

Building a Partnership. Through continual work on self-awareness and an active attempt to learn about the "lens" of others, the clinician lays the foundation for the collaborative relationship that will best support the health of the patient. Creating communication that is based on trust, respect, and a willingness to reexamine assumptions will allow patients to express aspects of their concerns that may run counter to the dominant culture. These concerns may be associated with strong feelings such as anger or shame. You, the clinician, must be willing to listen to and validate these feelings, and not let your own feelings prevent you from exploring painful areas. You must also be willing to reexamine your beliefs about what is the right approach to clinical care in a given situation. A willingness to be flexible and creative in your plans, a respect for patients' knowledge about their own best interests, and a conscious effort to clarify the truly acute or life-threatening risks to the patient's health are helpful approaches. Remember that if the patient stops listening, doesn't follow your advice, or doesn't return, your partnership has not been successful.

Alcohol and Drugs. One difficult area for many clinicians is asking patients about their use of alcohol and drugs, illegal or prescription. Yet alcohol and drugs are often directly related to a patient's symptoms, and the use of or dependence on a substance may affect future care. Remember that it is not your role to disapprove of the use of substances. It is your job to gather data, assess the impact on the patient's health, and plan a response.