The doctor may also learn more about the illness from the way the patient tells the story than from the story itself. (1861–1954)

James B. Herrick, MD

This chapter describes a user-friendly step-by-step method for the beginning of the medical interview that has been effective in many hands for more than 25 years.1–9 Your first task is to master the 5 steps and 21 substeps shown in Table 3-1. We urge you to learn these thoroughly, to the point that they become reflexive—this is easily accomplished by studying and then practicing them. Even though this may seem like a lot to learn, just as you learn the intricacies of cardiac physiology, this is your major task in mastering the medical interview. Using these steps and substeps will make you a more scientific and more humanistic physician—and your patients will benefit (see Appendix B for a detailed humanistic and scientific rationale for being patient-centered). To assist you, we also have developed a video that demonstrates the same skills described here: www.accessmedicine.com/SmithsPCI (see Preface). (See AccessMedicine video titled “How to Interrupt”: www.accessmedicine.com/SmithsPCI.)

When first learning these steps, use them in the order presented, primarily as a learning tool. As you become more skilled, you can vary the steps and substeps to experiment as well as to adapt to specific occasions and needs. You may find that some substeps can be omitted and, in other instances, you may want to change the ordering as you follow the patient’s lead.10 The steps and substeps are simply a pathway to lead you through the interview; use them flexibly to individualize and enhance your own style and the patient’s individuality.
### TABLE 3-1. 5-Step Beginning of the Interview

<table>
<thead>
<tr>
<th>Step</th>
<th>5-Step Patient-Centered Interviewing</th>
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| Step 1: Set the stage for the interview (30–60 s) | 1. Welcome/greet the patient  
2. Use the patient's name  
3. Introduce yourself and identify specific role  
4. Ensure patient readiness and privacy  
5. Address barriers to communication (sit down)  
6. Ensure comfort and put the patient at ease |
| Step 2: Elicit chief concern and set agenda (1–2 min) | 7. Indicate time available (e.g., “We’ve got about 20 minutes together today …”)  
8. Forecast what you would like to have happen during the interview (e.g., “… and I see that we need to review the blood tests you had done yesterday, …”)  
9. Obtain a list of all issues patient wants to discuss; specific symptoms, requests, expectations, understanding (e.g., “… but before we do that, let’s make a list of the things you wanted to discuss today.” “Is there something else?” “What else?”)  
10. Summarize and finalize the agenda; negotiate specifics if too many agenda items (e.g., “You mentioned 8 things you were hoping to cover. In the time we have together today, I don’t think we can address them all. Can you tell me which one or two are most troublesome for you; we’ll do a good job with those and I’ll see you back soon to work on some of the others.”) |
| Step 3: Begin the interview with nonfocusing skills that help the patient to express her/himself (30–60 s) | 11. Start with open-ended question/statement (Tell me all about your headache.)  
12. Use nonfocusing open-ended skills (attentive listening): silence, continuers, nonverbal encouragement  
13. Obtain additional data from nonverbal sources: nonverbal cues, physical characteristics, autonomic changes, accoutrements, environment, and self |
| Step 4: Use focusing skills to learn 3 things: symptom story, personal context, and emotional context (3–10 min) | 14. Obtain a further description of the symptom  
- Description of symptoms, using focusing open-ended skills such as:  
  - Echoes (repeat the patient’s words, e.g., “excruciating pain?”)  
  - Requests (“That sounds important; can you say more about it?”)  
  - Summaries (“First you had a fever, then 2 days later your knee began to hurt, and yesterday you began to limp.”)  
15. Elicit/develop personal context  
- Broader personal/psychosocial context of symptoms, patient beliefs/attribution, again using focusing open-ended skills.  
16. Elicit/develop emotional context  
- Use emotion-seeking skills.  
  - Direct: “How are you doing with this?” “How does this make you feel?” “How has this affected you, emotionally?”  
  - Indirect: Impact (e.g., “How has this affected your day-to-day life?” “What has your knee pain been like for your family?”); Beliefs about the problem (e.g., “What do you think might be causing your knee pain?”); Intuit how the patient might be feeling (e.g., “I think I might be frustrated if that happened to me;” “I can imagine that this might be worrying for you.”); Triggers (e.g., “What made you decide to come in now for your …?” “What else is going on in your life?”)  
17. Respond to feelings and emotions with empathy skills  
- Respond with words that empathically address the emotion (NURS):  
  - Name: “You say being disabled by this knee pain makes you angry.”  
  - Understand: “I can see how you could feel this way.”  
  - Respect: “This has been a difficult time for you.” “You show a lot of courage.”  
  - Support: “I want to help you get to the bottom of this and see what we can do.”  
18. Expand the story to new chapters  
- Continue eliciting further personal and emotional context, address feelings/emotion with NURS. |
20. Check accuracy.  
21. Indicate that both content and style of inquiry will change if the patient is ready (“I’d like to switch gears now and ask you some questions to better understand what might be going on.”). Continue with middle of interview. |
The five steps in the beginning of the interview establish the clinician–patient relationship and encourage the patient to express what is most important to him/her. Throughout this book, an ongoing interview with “Ms. Joanne Jones” illustrates each step; this and other examples are derived from real patients and situations; we changed all names and identifying information to protect the confidentiality of our patients.

Let’s first talk about the preparatory skills of setting the stage (Step 1) and determining the agenda (including the chief concern) for the interview (Step 2). These steps prepare both you and the patient for the patient-centered interviewing skills you will use in Steps 3 and 4, where the data-gathering and relationship-building skills you learned in Chapter 2 are incorporated.

■ STEP 1: SETTING THE STAGE FOR THE INTERVIEW

Setting the stage for the interview begins before entering the patient’s room. It is helpful to prepare for the interview, much as an athlete or musician might prepare for a performance. Begin by reviewing the patient’s record, getting a sense of the patient’s problem list, medications, allergies, and reading notes from recent visits/hospitalizations. However, do not allow this information to bias you before you meet the patient—every clinician-patient encounter is unique and medical records may contain inaccuracies.

Determine your agenda for the encounter; for example, you may want to update the patient’s immunizations or follow-up on chronic conditions. As you will learn, the patient will also have an agenda that may differ from yours.

We recommend taking a “mindful moment” before entering the patient’s room to mentally prepare yourself to be fully present to whomever is behind the door. Some clinicians take a breath in and “breathe out” the last patient, making the intention to be open to the next patient. Others use hand sanitizer or soap and water as an ablution to “wash away” the last encounter and ready themselves for next. Mindful practice has been demonstrated to reduce clinician burnout and improve empathy. (See DocCom Module 2.)

The skills in Step 1 are simple, but often overlooked courtesies that ensure a patient-centered atmosphere. Table 3-2 lists these substeps in their usual order of use at the first meeting with a patient; appropriate adjustments are made when the patient is already known to the clinician. These skills establish or reaffirm participants’ identities, put both the clinician and the patient at ease, and ensure that the setting is appropriate for the interview. These preparatory steps should take no more than 30 to 60 seconds.
Welcome/Greet the Patient

As noted above, maintain patient safety and hygiene by washing your hands before entering the patient’s room.

When people become patients and enter our healthcare system, they experience many “micro-aggressions”—such as being partially clothed or being barged in on while using the commode—that can negatively affect their experience of care. Knocking and then waiting for permission to enter is a “micro-courtesy” that can help to re-empower the patient and restore dignity.

Greetings set the stage for relationships and their absence can make the relationship difficult to salvage. The clinician who enters the patient’s room and says, “So what seems to be the problem here?” is missing an opportunity to use the relationship as therapy.

In day-to-day life, we often greet others by saying, “How are you?” or “How are you doing?” We suggest not using these words in healthcare settings. Why? When a clinician, simply trying to greet a patient, asks, “How are you?”, many patients begin to talk about their ailment. Others will say (or think), “If I was well I sure wouldn’t be here!”. We recommend using different greetings with patients, such as, “It’s nice to meet you” or “Nice to see you again!” This keeps the interview from jumping ahead to Step 2 before you are ready.

A handshake is an important part of greetings in many cultures. Because of cultural taboos about touch, a male clinician should generally wait for a female patient to begin to extend her hand first, before reaching out to shake it. Women clinicians should also be sensitive to nonverbal cues and cultural norms that indicate that the patient may not be open to a handshake. For example, among some Muslims and orthodox Jews shaking hands in a cross-gender situation is viewed as culturally inappropriate. When it is not possible to shake hands, for example with very ill patients, a friendly pat on the hand or arm is equally beneficial to the relationship. You can develop some important initial nonverbal impressions about the patient from the handshake; for example, a hearty handshake suggesting a confident person,

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<tr>
<th>TABLE 3-2. Step 1: Setting the Stage (30–60 s)</th>
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<tr>
<td>1. Welcome/greet the patient</td>
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<td>2. Use the patient’s name</td>
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<tr>
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<tr>
<td>6. Ensure comfort and put the patient at ease</td>
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a cold sweaty palm suggesting anxiety, and the feeble handshake of someone very ill. Healthcare professionals have mixed feelings whether to ban, change, or allow handshaking due to hygiene risk. We suggest you make your own informed decision on handshaking as a greeting. Remember that the patient is also reading your nonverbal cues, so personal awareness is crucial. Smiling; having a friendly, personable, polite, and respectful demeanor; being attentive and calm; making eye contact; and making the patient feel like a priority will enhance the relationship with the patient. Alternatively, fidgeting, frequently glancing at your watch or mobile device, avoiding eye contact, or looking distracted may be interpreted negatively by the patient.

**Use the Patient’s Name**

Patients are divided on how they want to be addressed. Some patients want their first name to be used when they are greeted; but others prefer either their last name or both their first and last names. We recommend that you use formal terms of address, Mr., Miss., Mrs., or Ms., and the patient’s first and last name in your initial greeting. It is easier to go from more formal to less formal terms of address than the reverse. If the patient has an unusual name, you may need to ask how to pronounce it. It is sometimes useful as a way of creating a welcoming atmosphere to ask if a non-English name, for example, Rakesh, Ming, Ganady, Kwesi, has a translation into English and what it means.

Some patients reject or do not conform to the male–female gender binary. To avoid misperceiving the gender identity or expression of gender nonconforming patients, you can ask, “Out of respect for my patients’ right to self-identify, I ask all patients what gender pronoun they’d prefer I use for them. What pronoun would you like me to use for you?”

**Introduce Yourself and Identify Your Specific Role**

When introducing yourself, be sure to match identity terms to avoid suggesting an unequal relationship. As with patients, initially use your full name—“Hi Mr. James Brown, I’m Dr. Jane Smith.” You should not say, for example, “Hi George, I’m Dr. Smith” or “Welcome Mr. Brown, I’m Betty.” Occasionally at the beginning but more often after some time, a relationship on first-name basis may develop. After you introduce yourself, mention your official role, for example, “resident physician,” “medical student,” “PA student,” or “nursing student.” Medical students can use the term “student doctor” or “student physician” after they pass USMLE Step 1. However, it is not appropriate to
use a professional label like “doctor,” “nurse,” “nurse practitioner,” or “physician assistant” until you have been certified to do so.

It is common for new learners, particularly preclinical students, to feel uncomfortable in their first patient interviews. You may feel like an imposter, that you are intruding or being voyeuristic, or that you are not playing a meaningful role in the patient's care. Remember that every clinician learned to interview through the generosity of patients. Patients often are quite happy to help a young clinician learn if you politely ask, express thanks, and understand why some patients may feel too ill to participate in this way. As a clinical trainee however, you are an important and legitimate member of the medical team, so you should not apologize or otherwise devalue yourself (“I’m just a student, thanks for letting me talk to you.”). The annals of medicine are replete with stories of new learners’ contributions to care, as they are with stories of patients deferring to trainees’ opinions; for example, when the resident or attending physician makes a recommendation directly to the patient, the patient may say, “I’ll have to ask Ms. Burns [the trainee] first.” To respect patient autonomy, your supervisor/attending physician should ensure that the patient has no reservations about being interviewed or cared for by a trainee.

When visitors are in the room, ask the patient to introduce them and their relationship to the patient; this allows the patient to control the flow of information. Greet each person by name as above. Ask the patient if visitors or family members should remain in the room during the interview. You might ask, “I’m going to be asking you a lot of questions; some of them are very personal. Should we ask your brother to wait in the family room while we talk or would prefer that he stay?” If the patient elects to have the visitor(s) stay, you may need to ask sensitive questions at another time when you can be alone with the patient. This is particularly important if intimate partner violence is suspected (see Chapter 5).

Substeps 1, 2, and 3 of Step 1 can be combined in a single statement like “Mr. George Brown? Hello, I’m Larry Burns. I’m the medical (or nurse practitioner, PA) student on the team that will be looking after you.”

**Ensure Patient Readiness and Privacy**

Clinicians often assume that patients are always ready to speak with them but, especially in hospital settings and with very ill patients, it is important to determine if the patient is ready for the interview. Sometimes it is necessary to postpone the interview; for example, until after the patient has eaten dinner or relatives have departed; or until the vomiting from recent chemotherapy has abated. Severe pain, severe nausea, need for a medication, and a soiled bed,
for example, are physical problems that must be addressed before an interview is appropriate. It is also important to monitor the patient’s circumstances for nonphysical, potentially interfering problems; for example, a patient may have lost his car keys in the waiting room, just received a disturbing telephone call, or be worried that the baby sitter will have to leave before she gets home. With all patients, it is important to determine if there are pressing needs that might require a brief delay in the interview; for example, to use the bathroom, get a drink of water. These courtesies not only help the patient directly but enhance patients’ acceptance of you as a caring professional. Once ready, some actions that will improve the patient’s readiness and privacy are shutting the door, pulling a curtain around the hospital bed, or respectfully excusing extra visitors from the room.

**Address Barriers to Communication**

You may have to ask permission to turn off a noisy air conditioner or TV set, or make efforts requiring more insight such as recognizing that the patient hears best out of one ear or needs to be able to directly see the clinician’s mouth in order to speech-read. If there is any question, ask the patient whether s/he can hear you well. Strategies for addressing specific communication problems are outlined in Chapter 7.

Patients experience that you have spent more time with them if you sit, so do so whenever possible, asking permission to do so in the hospital setting. Communication is optimal if you and the patient are at the same eye level. If you are both sitting, orienting the chairs at approximately a 90-degree angle is optimal for communication (see DocCom Module 14). Attention to the nonverbal aspects of communication is important and is covered in more detail in Chapter 8, section “Nonverbal Dimensions of the Relationship.” And remember, at the end of the encounter, it is just as important to turn the TV you asked permission to turn off, back on!

Exam-room computing may be one of the biggest barriers to the clinician–patient relationship. If you plan to use a computer during the interview, be sure that it is placed so that you both can see the screen. Explain to the patient that you will be taking some notes or entering information into the computer and ask whether this is okay. Write or enter information in the medical chart or computer only intermittently, and not until the patient has finished speaking. When writing or entering information, pause frequently and make eye contact with the patient. We suggest that you focus on the patient and not the computer during the beginning, patient-centered part of the interview and use the computer as a communication tool. See Chapter 10 for more details.
Ensure Comfort and Put the Patient at Ease

Determine if anything at the immediate time is interfering with the patient’s comfort. Ask, “Is that a comfortable chair for you?”, “Is the light bothering your eyes?”, “Are you comfortable there?”, or “Can I raise the head of the bed for you?” Continue to monitor the patient’s comfort as the interview proceeds. Your task is to put the patient at ease, as much as you can. Attention to these potential barriers fosters the patient’s subsequent full attention and also shows your caring and concern.

When clinically appropriate, a little social conversation—“small talk before big talk”—can help put the patient at ease before discussing intimate issues related to bodily or psychological concerns.37 This brief social conversation should have a patient focus such as, “I hope you got your car parked OK with all the construction going on around here.” With an inpatient, you can ask about get well cards or flowers in the room, or the food; whatever is appropriate to the patient’s situation can be briefly discussed. This allows the patient to get more comfortable with you and shows your humanity.

STEP 2: OBTAINING THE AGENDA (CHIEF CONCERN AND OTHER ACTIVE PROBLEMS)

In Step 2, you will focus on the patient and setting the agenda for the interview. This fosters the patient-centered interaction to follow (Steps 3 and 4) because it orients and empowers the patient and ensures that concerns are properly prioritized and addressed. Some clinicians unwittingly preclude agenda setting by saying “What brings you in today?” Patients often interpret this as an invitation to tell the story of the first concern on their list, rather than generating a list of concerns. This often leads clinicians to miss important information and fail to meet patients’ expectations.38–42 Setting an agenda usually takes little time, improves efficiency, empowers patients,43 and yields more information. However, it is not necessarily easy and serious pitfalls can arise if it is conducted improperly.14,15,44,45 The following four substeps, summarized in Table 3-3, usually are performed in the order given. It generally takes no more than 1 to 2 minutes.

Indicate Time Available

Setting limits is difficult for many clinicians, so do not be surprised if this substep feels uncomfortable at first. Begin by indicating how much time is available for the interaction. This orients patients by letting them know the visit length and helps patients gauge what and how much to say.46 One common pitfall is to use the word “only,” as in, “We only have 20 minutes today,” which has a negative
connotation. Rather say, “Good, we’ve got about 20 minutes together today.” In the inpatient setting, where visits are not usually on a schedule, it may be easier to use phrases such as “few,” “short,” “medium,” or “long,” for example, “I’d like to take a few minutes of your time to...” Of course, in any setting there will be occasional times when you must extend the visit beyond what was scheduled or you had planned, for example, if a patient has gotten bad news or where you may be concerned about a patient’s physical or emotional safety.

**Forecast What You Would Like to Have Happen During the Interview**

Tell the patient what you need to do during the interview to make sure the patient is properly cared for. For example, with a new patient, you may need to ask many routine questions or perform a physical examination; with a returning patient, you may need to discuss the results of a recent diagnostic test.

**Obtain a List of All Issues the Patient Wants to Discuss**

Most importantly, you must obtain a list of all issues your patient wants to discuss to ensure that the most important concerns are addressed during the encounter and to minimize the chance of an important concern being raised at the end of the conversation when time has run out. This substep is usually combined with the first two substeps in one sentence, for example, “Good, we’ve got about 40 minutes together today; I need to ask you a lot of questions and do an examination but let’s start by making a list of all the things you want to discuss.” Notice the use of the words “we” and “together” that help to establish a partnership with the patient.

You may need to help the patient enumerate all problems. Possible patient agenda items include, but are not limited to symptoms, requests (prescription for a sleeping pill), expectations (get a note for work), and understanding about the purpose of the interaction (perform an exercise stress test).
Obtaining a complete list may require some persistence. Often, the patient will try to give details of the first problem. When that happens, you must respectfully interrupt and refocus the patient on setting the agenda. The art of interrupting can be learned as any other communication skill. (See AccessMedicine video titled “How to Interrupt.”) Holding up fingers prominently as you count concerns helps to communicate that a list is being sought, not details of each symptom or concern. For example, while holding up one finger to signify the first problem given, you might say “Sorry to interrupt, that’s important and we’ll get back to the leg pain in a moment, but first I need to know if there are additional problems you’d like to talk about. I want to be certain we get a list of all your concerns.” You may have to do this several times, asking questions like, “Is there something else?”, “What else?”, “How did you hope I could help?”, “What would a good result from this visit today look like?”, or “Was there something else you were worried about?” In the outpatient setting it is unusual for patients to have just one concern; one study found that diabetic patients had on average three concerns they wanted to share with their clinician, the third one mentioned being the most important from their perspective. Importantly, 70% of these patients never got to share their most important concern.

Only if the patient raises a highly charged emotional issue while setting the agenda should you postpone agenda-setting and encourage further discussion at that point (e.g., if the patient is acutely distraught about a recent death in the family or a recent diagnosis of cancer in himself). In most situations, however, you can set the agenda and briefly delay addressing the emotional issue. Careful agenda-setting prevents patients’ common complaint that they did not get to talk about all their concerns, as well as the common clinician complaint that the patient voiced his/her most serious concern at the end of the appointment.

**Summarize and Finalize the Agenda**

This substep allows you to prioritize the list and, if it is too long for the time available, to empower the patient to decide what will be addressed and what will be deferred to the next visit: “You mentioned eight concerns you wanted to cover. I don’t think we’ll have time to address them all in the time we have together today. Can you tell me which one or two are most troublesome to you today? We’ll focus on those together and I’ll see you back soon to work on the others.” Of course, if one of the items is medically concerning (e.g., blood in the stool, substernal chest pain suggesting heart disease), you need to address it even if not chosen by the patient.
Note how mentioning the time available at the beginning of Step 2 allows you to refer to it without it being off-putting to the patient. You and the patient are aligned against the allotted time, instead of you and the time being aligned against the patient.

Usually, however, because different symptoms may be related to a common cause it is possible to cover all the patient’s concerns, in which case these are simply summarized. This also is a good point to determine, if not already known, which concern is most important to the patient, for example, “Which one would you like to start with?” This identifies the chief concern (“chief concern” is preferred over “chief complaint” because “complaint” has a pejorative connotation. In response to hearing the word “complaint,” patients have said, “I’m not complaining, it hurts!”).

We now begin to follow Ms. Joanne Jones through her initial visit by providing a continuous transcript for each step; some areas are shortened as noted for space considerations.

**Vignette of Ms. Joanne Jones**

**Step 1**

**Clinician:** (Knocks)

**Patient:** Come in.

**Clinician:** (Enters examining room). Ms. Joanne Jones? Welcome to the clinic. I’m Michael White, the medical student who will be working with you along with Dr. Black. (Patient extends her hand and clinician shakes it.) [Clinician uses his and her full names, welcomes the patient, and identifies his role in her care.]

**Clinician:** 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.

**Patient:** I wasn’t sure who I was going to see. This is my first time here.

**Clinician:** If it’s OK with you, I’ll close this door so we can hear each other better and have some privacy. [The clinician now ensures readiness for the interview and establishes as much privacy as possible.]

**Patient:** Sure, that’s fine.

**Clinician:** Anything I can help with before we get started?

**Patient:** Well, they didn’t give my registration card back to me. I don’t want to lose it.

**Clinician:** We’ll give that back when we’re finished today. They always keep them. Is there something else?

**Patient:** No.
Clinician: (Sits down) Would you like to sit in that chair? It's more comfortable than the examining table. [The clinician addressed this barrier to communication, established equal eye level, ensured comfort, and put the patient at ease.]

Patient: Sure. Thanks. (She moves.)

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

Patient: 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. [Patient places the topic “kids” and her feelings about the kids being home “on the table” for discussion.]

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

Patient: You're telling me. I don't even ski! [The stage is set, a light conversation ensued, and the patient is joking.]

Step 2

Clinician: (laughs) Well, we've got about 40 minutes together today and I know I've got a lot of questions to ask you and that we need to do a physical exam. Before we get started, though, I'd like to get a list of the things you wanted to address today. You know, so we're sure everything gets covered. [Clinician gives his agenda in one statement. Doing this first models the more difficult task to follow: obtaining the patient's agenda.]

Patient: 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 … [Clinician artfully and respectfully interrupts. She places “boss” on the table for discussion.]

Clinician: That sounds difficult and important. Before we get into the details, though, I'd like to find out if there are some other problems you'd like to look at today, so we can be certain to cover everything you want to. We'll get back to the headache and your boss after that. Your headache and your boss—that's two things (holding up two fingers). Is there something else you wanted to address today?

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

Clinician: (Holding up three fingers now): OK, cough; what other concerns do you have?
Patient: 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. It started bothering me back in 2010 and I’ve had trouble off and on. I used to take cortisone and … (clinician interrupts); [Notice that the clinician has now interrupted the patient twice in order to complete the list of concerns. This is necessary, done respectfully, to complete the agenda in a timely way.]

Clinician: (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 something else?

Patient: No. The headache is the main thing.

Clinician: 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? [It is here that the patient and clinician would negotiate what to cover at this visit if the clinician determined that the patient had raised too many issues to cover on this day.]

Patient: That’s about it.

Clinician: And do I understand correctly that the headache is the worst problem? [Ms. Jones’ headache is her most bothersome concern, what we earlier defined as the chief concern.]

Patient: Yes.

OPENING THE HISTORY OF PRESENT ILLNESS (STEP 3)

Having set the stage (Step 1) and obtained the agenda (Step 2), we now use the patient-centered skills learned in Chapter 2 to begin to elicit the history of the present illness (HPI). As reviewed in Chapter 1, the HPI is the most important component of the interview because it reflects the patient’s current problem in its psychosocial and biomedical totality. The HPI begins at the beginning of the interview (patient-centered part) and continues into the middle of the interview (clinician-centered part), where relevant details are clarified using clinician-centered interviewing skills.

Step 3, summarized in Table 3-4, consists of asking one open-ended question (or making one open-ended request) and then allowing the patient to talk. It establishes an easy flow of talk from the patient, conveys that the clinician is attentively listening, and gives a feel for “what the patient is like.” Ordinarily, Step 3 lasts no more than 30 to 60 seconds as the clinician listens attentively, using the following substeps.
Start with Open-Ended Beginning Question/Statement

When first learning the medical interview, some new learners are so worried about what they should say next that they don’t hear what the patient is saying! Step 3 gives you the opportunity to take a deep breath, relax, and listen to the patient. It starts with an open-ended beginning question or statement, for example, “So headaches are the big problem, tell me more.” Avoid saying, “Tell me a little bit about the headache,” because you do not want to hear a little bit about the symptom, you want to encourage a detailed, chronological narrative. Sometimes, especially with reticent or disorganized patients, it is helpful to be clear about your desire: “Tell me all about the headache, starting at the beginning and bringing me up to now.” Sometimes an open-ended beginning question is not necessary; having completed the agenda, especially if there are only one or a few related items, many patients continue spontaneously.

Use “Nonfocusing” Open-Ended Skills (Attentive Listening)

Following the open-ended beginning question, allow the patient to talk freely for 30 to 60 seconds or so to get the gist of his/her primary concern. Encourage a continued free flow of information using the nonfocusing open-ended skills described in Chapter 2. Silence, nonverbal gestures (eye contact, leaning forward, hand gestures), and continuers (e.g., uh-huh, mmm, go on) encourage the patient to continue speaking. Listen carefully to the patient’s opening statement for clues to the patient’s story. Using these nonfocusing open-ended skills encourages the patient to put information “on the table,” typically details about the patient’s symptom story and its personal and emotional context.

Some clinicians are reluctant to use nonfocusing skills in the beginning of the interview because of fears that patients will talk incessantly, and that nothing will get accomplished. Research shows that when patients are given all the time they need to complete their initial statement, in nearly 80% of the cases it lasts 2 minutes or less; in the few instances where it went longer, physicians agreed that the patients were giving important information.56

Although uncommon, patients sometimes do not talk freely. If this occurs, and 4 seconds or so of silence does not lead the patient to resume talking, you

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<th>TABLE 3-4. Step 3: Opening the HPI (30–60 s)</th>
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<td>1. Open-ended beginning question/statement</td>
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…
can use focusing open-ended skills (echoing, request, summary) to promote a free flow of information. If focusing open-ended skills are not effective, you can also ask closed-ended questions about the patient’s problem to get a dialogue going. This may be necessary in very shy patients, especially adolescents.

**Obtain Additional Data from Nonverbal Sources**

Although you are verbally quiet during the brief Step 3, you should be very mentally active, noticing the information the patient is putting “on the table” and thinking about what it means. Observe the patient for nonverbal cues (reviewed in Chapter 7), for example, depressed facial expression, arms folded across the chest, toes tapping nervously that may indicate psychological conditions or a style of relating to the clinician. Observe also for clues in the following areas that will give additional physical information about the patient\(^{57,58}\): (1) physical characteristics: general health, skin and hair color, odor, deformities, habitus (e.g., emaciated and disheveled, “uremic” breath, jaundice, amputated leg, kyphoscoliosis); (2) autonomic changes: heart rate, skin color, pupil size, skin moisture, 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); (3) accoutrements or accessories: clothing, jewelry, eyeglasses, makeup (e.g., expensive suit and jewelry, thick eyeglasses, tattoos and body piercings, no makeup or poorly applied makeup); (4) environment: in the hospital setting, items such as greeting cards, flowers, photographs (e.g., several paintings by a grandchild, photograph of spouse, or their absence); (5) self: becoming aware of your own emotions and reactions to patients in real time is an important clinical skill.\(^{4,21,59}\) We cover this important topic in detail in Chapter 9 (also see DocCom Module 2).

**Continuation of Ms. Jones Visit**

**Patient:** Yes.

**Clinician:** So, tell me all about the headache. [An open-ended beginning statement that is linked to the chief concern.]

**Patient:** It’s not bad at the moment, I guess.

**Clinician:** (sits forward slightly) Uh Huh.

**Patient:** Things weren’t so good last week, though, when I made the appointment.

**Clinician:** Mmmm.

**Patient:** 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.
Clinician: I see.

Patient: They’re 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 followed, briefly, by several “nonfocusing” open-ended skills have resulted in a good flow of symptom and personal data without any focusing activity by the clinician.]

CONTINUING THE PATIENT-CENTERED HPI (STEP 4)

Learners often wonder how long to let Step 3 go on for, that is, how long to use the nonfocusing open-ended skills of attentive silence, continuers, and nonverbal encouragement. As noted above, most patients will spontaneously stop talking in about 90 seconds; if 3 or 4 seconds of respectful silence does not encourage the patient to continue, additional skills will be needed. As a general rule, as long as you are hearing the information you need in order to be of service to the patient, you can continue to use the Step 3 skills. Other clues that indicate it’s time to move on to Step 4 are if the patient begins to repeat already stated information or if the patient goes off on a tangent and does not rather quickly return to telling the symptom story, its personal context, or its emotional context. (Some patients exhibit circumstantial speech, taking “the long way around” to get to the point. Patients with tangential speech get lost and never return to the point. You will learn during clinical rotations in psychiatry that tangential speech can be an indicator of schizophrenia, bipolar disorder, or some organic brain disorders.)

In any case, the transition to Step 4 is marked by the next time you speak (other than using continuers). Summarized in Table 3-5, Step 4, usually lasts

**TABLE 3-5. Step 4: Continuing the Patient-Centered HPI (3–10 min)**

1. Use focusing open-ended skills to obtain further description of physical or other symptom (symptom)
2. Use focusing open-ended skills to elicit/develop personal context of symptom (personal context)
3. Use emotion-seeking skills to elicit/develop emotional context of symptom and/or its personal context (emotional context)
4. Use empathy skills to address the emotion(s) expressed by naming, understanding, respecting, and supporting (NURS)
5. Use sequences of focusing open-ended skills → emotion-seeking skills → empathy skills to expand the story to new chapters (expand story)
from 3 to 10 minutes, depending on the clinical setting and the information the patient presents.

In addition to attentive listening, use focusing open-ended skills to help the patient continue his/her unique story of the present illness. In this step, you are picking things up “from the table” in order to learn more about them. First, direct the patient to talk more about the symptom (usually physical, but can also be cognitive, emotional, or other); second, the personal context of the symptom; and, third, the emotional context, that is, the patient’s emotional reactions to the symptom and/or the personal context. This flow mirrors the way that patients often describe their concern to their clinician.

Use the focusing open-ended skills, emotion-seeking skills, and empathy skills outlined in Chapter 2 to identify the story theme(s); rarely, use closed-ended skills for clarification. You will usually be much more active and verbally participatory in Step 4, compared with Step 3; often figuratively on the edge of your seat during the give-and-take interaction between you and the patient as you help the patient build the history. You may initially find this step to be the most difficult of the entire interview. To help in understanding it, we have broken Step 4 down into five substeps, now considered in their usual sequence. These substeps produce the overarching story themes: symptom, personal, and emotional.

**Obtain a Further Description of the Symptom**

In a medical setting, patients typically present with symptoms mixed with their personal and emotional context. Because most patients expect it in a medical setting, we recommend an initial focus on physical symptoms while learning these skills; later, you can experiment with a different ordering. Use focusing open-ended skills (echoing, open-ended requests, summarizing) to help the patient to further describe the symptom(s) in his or her own words. This usually helps uncover the personal context in which the symptom(s) occurred. Let’s pick up Ms. Jones’ interview again.

**Continuation of Ms. Jones Visit**

**Patient:** All I want to do is go home and go to bed. [Four seconds of silence]

**Clinician:** Say more about the headaches. [Since silence—a nonfocusing skill—was ineffective, the learner tries an open-ended request, one of the focusing open-ended skills, to learn more about the headaches.]

**Patient:** Well, I never had any trouble until I got here. [Comment about personal context of her symptom and how long it has been present.]
Clinician: How long's that been? [Appropriate closed-ended question for clarification]

Patient: Only 4 months. The headache started about 3 months ago.

Clinician: Tell me more. [Keeps the focus on the headache]

Patient: Well, they just throb and throb and it seems like every time I see my boss any more I get one of these headaches. I sometimes just get a little nauseated and can't concentrate because of the pain. [We learn much more of the description of the symptom and, also, that her boss seems to precipitate the symptom.]

Clinician: Nauseated? [echoes a word he wants to learn more about]

Patient: Yeah, queasy like I might throw up, but I never have.

Clinician: What more can you tell me about the headaches or nausea? [Continuing to use open-ended questions to elicit more details of her symptom(s)]

Patient: That's all I can think of. [The patient's response suggests that open-ended skills are unlikely to result in a further description of the symptom. Some patients will begin to repeat themselves in describing their symptom(s). Either of these behaviors indicates that it is time to develop the personal context. We have a good description of the symptom, know when it began, have heard some associated symptoms, and know (from Step 3) that it occurs in the setting of her boss. In less than a minute, the clinician has learned how the personal context and symptom interact by facilitating (encouraging) the patient's spontaneous narration.]

Notice that at the outset of Step 4 the clinician used focusing open-ended skills to learn the patient's description and chronology of symptoms and learned some of the classic descriptive terms (throbbing headache and nausea but no vomiting), continuing in this way until the patient demonstrated she had no more details to offer. The clinician needs more diagnostic data about possible underlying disease (e.g., any head injury, fever, vision changes, prior investigation), but these details are not “on the table” and asking those specific questions here would run the risk of not exploring the patient's personal and emotion context, which are so important for diagnosis and patient satisfaction. The clinician should resist the urge to use clinician-centered skills at this point (“Did you ever have a head injury?” or “How does the headache affect your vision?” or pursuing other diagnostic data with closed-ended questions), and instead explore the personal and emotional context of the patient's story—those topics that the patient has placed on the table. The clinician will be asking closed-ended questions soon in the middle of the interview to answer these appropriate but premature questions.
While the new learner may not be aware of this, the symptom data given by Ms. Jones are quite suggestive of migraine headaches; that is, they are throbbing, unilateral, periodic, and associated with nausea. When given the chance, patients almost always provide information about their symptom that is highly diagnostic. Indeed, it is the great diagnostic yield of the beginning of the interview that led Sir William Osler to say, “Listen to the patient, he (sic) is telling you the diagnosis.” We also know that, occasionally, information diagnostic of a disease arises here that does not arise in later clinician-centered interviewing. On the other hand, even when symptom data are not diagnostic, you will obtain a good overview of the problem, one that does not need repeating after your transition to the middle of the interview.

If there are only psychological concerns (no physical symptoms presented), the psychological symptoms are treated in the same way as for physical symptoms; for example, if Ms. Jones was complaining of anxiety or feeling blue and down instead of having headaches, the clinician would elicit the description of these psychological symptoms, using open-ended skills. (See AccessMedicine video for an example of a mental health interview, titled "Patient with a Mental Health Disorder": www.accessmedicine.com/SmithsPCI.)

Develop the Psychological and Social Context of the Symptom (Personal Context)

Your next task is to learn about the patient and his/her illness in its broader psychosocial/personal context. This information relates less to symptoms and may be of less value for diagnosing disease, but is important for understanding the patient’s illness. In general, the longer the interview, 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, for example, stress-related disorders, occupational, or drug/alcohol problems. This information will directly influence treatment and prevention recommendations. Continue to rely upon focusing open-ended skills, redirecting the patient to personal statements “on the table” that seem most important to understanding his/her personal context—in this instance, Ms. Jones’ stressful job situation.

Continuation of Ms. Jones Visit

Clinician: You mentioned your boss. [Invites patient to talk about how her boss relates to the headache]

Patient: 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
of Ms. Jones’ headaches and her boss are becoming clear and we hear some considerations for treatment; perhaps avoiding her boss. Such information often does not arise during isolated clinician-centered interviewing.]

**Clinician:** Not around him? [Echoing, a focusing open-ended skill, maintains the focus on the relationship of boss to symptoms.]

**Patient:** I’m on the road a lot. No trouble then either, I guess … except once when he called me.

**Clinician:** Tell me more about him. [Encourages discussion of an important personal issue rather than keeping the focus on symptoms such as headache or nausea, because of the patient’s prior indication that further description of the symptom would be unlikely without the use of clinician-centered interviewing skills; the clinician also could have focused on the job itself and accomplished the same goal of obtaining more personal data. Rather than an open-ended request, the clinician also could have focused the patient by echoing (“he called you”) or summarizing the personal aspects; that is, any of the focusing open-ended skills could be used. They all lead to the same theme.]

**Patient:** 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 … [Note the corroboration of earlier data: the job is linked to the headaches but Ms. Jones is now giving additional personal information about her situation that helps the clinician better understand this connection. Note too that she is repeating herself in describing her symptom, again indicating that patient-centered inquiry about the symptom is unlikely to be of high yield.]

**Clinician:** Wait a second, I’m not following you. You say he’s in charge but you are the lead attorney? [Clinician interrupts respectfully, and then summarizes personal issues to refocus on the job because the patient is getting away from personal data and going back to symptoms already discussed; also, the clinician knows he will address symptom details just a few minutes from this point, during the middle of the interview.]

**Patient:** 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 less directly related
to symptoms, allowing the clinician to begin to appreciate the nuances and depth of how her job and headaches interact.

**Clinician:** Hope you last? [Echoing will maintain the focus in this personal/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, or they can interrupt them to focus on utterances previously mentioned—but they never introduce new data to the conversation. The clinician develops a free flow of information from the patient, focusing the patient where intuition suggests the most key information resides, typically emotional information.]

**Patient:** 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 …

**Clinician:** They said? Who are they? [Clinician interrupts to focus on a bit of information mentioned just before and redirects her to that with echoing; if the clinician wanted her to simply proceed, using nonfocusing skills or an open-ended request would have sufficed, such as “Go on.”]

**Patient:** The Board, they run the company. It’s not real big, but it’s a good chance for someone like me to get experience in the corporate world. [A new layer of data that is not directly related to her headache but provides a deeper understanding of its context]

**Clinician:** 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? [Clinician summarizes what is becoming a free flow of personal data. This is abbreviated for space reasons, but the clinician ordinarily would further develop this with more focusing open-ended inquiry.]

Although no disease explanation is found for 20% to 75% of physical symptoms, patients often have several personal concerns around their symptoms. In one study, 67% of patients worried about serious illness, 72% expected medications, 67% wanted testing, 53% expected referral, and 62% indicated interference with routine activities. While 47% of patients who, like Ms. Jones, described stress and about 20% recognized depression and anxiety, only 1% considered their problem to be psychiatric in nature. In that study clinicians viewed the symptoms as being far less serious than patients did; and, not surprisingly, unaddressed concerns accounted for most of the patient dissatisfaction. Other patients may have disbelief/distrust of the medical system, grief and other losses, concerns about becoming independent (young people) or
dependent (older or seriously ill people), issues concerning retirement, family or job problems, and administrative issues (needing an insurance form filled out). It is these personal concerns, the personal context of your patient’s symptoms, that you want to understand. In general, whether the symptom is physical or psychological, you can easily establish a personal focus as you inquire into the broader personal context of the patient’s illness.

To maintain the personal focus, avoid directing the patient back to previously discussed symptoms. You will focus on them when moving to the clinician-centered interview in a few minutes. At this point in the interview, you want to expand your understanding of the patient as a person.

Patients will occasionally share their stories 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 a deeply personal story. Because of this step-by-step unfolding of the account, you must use focusing open-ended skills repeatedly to draw out the underlying narrative thread.

Early on, direct the patient to whatever bits of personal data appear to be of most interest to the patient and you. Once you identify the narrative thread of the patient’s story and its apparent meaning, stay with it. If the patient gets away from this theme, respectfully interrupt with focusing open-ended skills and refocus the patient on the main story thread. Such refocusing is often needed because patients wander back to previously discussed symptoms (or other diagnostic or therapeutic data).

After no more than a few minutes, you will get a good sense of the broader personal context—and have further enhanced the clinician–patient relationship by addressing features of central importance to the patient’s life. If emotions are “placed on the table” during these early stages, address them as discussed later.

It is here that the initial integration of symptoms and personal factors occurs, the first view of the patient’s mind–body connection, with further integration to occur when you address feelings and emotions.

Uncommonly, patients may volunteer only physical symptom details in response to your patient-centered inquiry. In this case, we recommend that you “prime the pump” for personal data by using the indirect emotion-seeking skills described in Chapter 2 (impact, belief, intuiting how the patient might be feeling, and triggers). For example, if a patient offers no personal context of the physical symptom, you might ask, “How’s that affecting your day-to-day life?”, “How’s that affecting your spouse?”, “What do you think is causing the problem?”, “Many patients with these sorts of symptoms are worried,” or “What made you decide to come in now for your (symptom)?” See also Chapter 7, section entitled “The Stoic/Unemotional Patient.”
Develop an Emotional Focus (Emotional Context)

Just as you sought to understand the personal context of the symptoms, you now seek to understand the emotion associated with the personal and symptom information. This further deepens the story and makes apparent the three-way interaction among symptom, personal, and emotional dimensions. The full mind–body link and the biopsychosocial description become clear as you include the patient’s emotional response to the illness. In developing an emotional focus, always monitor the patient’s readiness to engage by observing how he or she is responding to the process so far and for any untoward responses to inquiry about emotion; for example, changing the subject after the clinician inquires about emotion. As you develop experience with the interview, you will notice that many patients will offer the personal and emotional contexts of their story as a natural progression of describing the symptom. This will help you recall that it is often not just the symptom that motivates a person to seek healthcare and become a patient, but also how the symptom interacts with the personal and emotional contexts of the person’s life. Patients often seek healthcare because they are concerned. If the patient does not spontaneously put the emotional context “on the table,” you will need to develop an emotional focus.

To establish an emotional focus, you will need to change the style of inquiry. Emotion-seeking skills, both direct and indirect, temporarily supplant focusing open-ended skills. Start to explore the emotional domain with direct inquiry about how the patient feels about the personal situation so far described (“How is this for you?”,”How does that make you feel, emotionally?”). If the patient is uncomfortable or simply reticent, you may need to make several efforts before emotion can be expressed. Indirect inquiry about impact, beliefs and triggers, and intuition how the patient might be feeling also may be necessary and are used when direct inquiry does not reveal emotional content (see Chapter 2).

Once you identify an emotion, ask for clarification using open-ended skills to get a good understanding of the emotion and what produced it so that you can then respond empathically.

As noted earlier, emotion-seeking skills are not needed if the patient is already showing or expressing emotions, as many will do spontaneously following open-ended inquiry alone.

Continuation of Ms. Jones Visit

Clinician: 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?

Patient: Yeah, sounds kind of bad, huh?
Clinician: How do you feel about that? [Direct emotion-seeking]
Patient: Oh, I don’t know. The headache is what bothers me.
Clinician: But how do you feel, you know, emotionally? [She did not give any emotion the first time and clinician uses direct emotion-seeking inquiry again. It is okay to encourage emotional expression, as long as the patient does not protest or try to change the subject.]
Patient: Oh, nothing really bothers me that much. We were taught to turn the other cheek.
Clinician: You know, I think I would be upset if I were put in a bind like this. [Changes strategy and tries intuiting how the patient might be feeling.]
Patient: Well, yeah, I guess I am too, now that you mention it.
Clinician: What is the feeling? [She has acknowledged emotion (upset) but the clinician wants to get an accurate description, returning to a direct emotion-seeking question about feeling.]
Patient: 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 encouraging emotion: she is now expressing it.]
Clinician: So you get mad when he gets on you? [Interspersing open-ended skills is appropriate as the clinician summarizes to continue this focus.]

Address Feelings and Emotions with Empathy Skills

When the patient names a feeling or expresses emotion, either spontaneously during open-ended inquiry or after you use emotion-seeking skills, and once you have clarified with open-ended skills why this patient has this feeling or emotion, use the empathy skills outlined in Chapter 2: Naming, Understanding, Respecting, and Supporting, recalled by the mnemonic NURS.

To address an emotion or feeling, convey to the patient that you have recognized it by naming it, that you understand it, that you respect the patient’s situation, and that you are available to help in any way possible. These skills typically are used multiple times during the course of an interview. It may take you considerable time to work through strong emotional reactions. Using these skills once is seldom enough.
You can use all four empathy skills together as a set, in the order given; we recommend this when first learning them. Once they are learned, however, in addition to using all four at once, you can use one or two skills at a time to avoid their repeated use as a quartet from striking the patient as peculiar or scripted.

Empathy skills are used only after you have heard enough to adequately understand the patient's feelings and emotions. For example, when a patient expresses sadness over loss of a spouse, it is not appropriate to immediately say you understand the patient's sadness. You must first listen to enough of the story in an open-ended manner to be able to legitimately make these empathic statements. Stating that you “understand” before the patient describes the feeling conveys an attempt to blindly follow communication scripts rather than real understanding. Patients may then respond, “How can you understand what I’m going through!” Allow and encourage the patient to describe the feeling in some depth; then your statement of “understanding” the feeling will be authentic. Words such as “see,” “appreciate,” and “imagine” can also be used to express understanding, for example, “I can see why you’d be sad,” “Given what you’ve told me, I can appreciate why you are sad,” “I can only imagine how sad this makes you.”

On the other hand, with reticent patients you may have to use empathy skills with much less emotional information than is desirable. For instance, in a very reticent patient who has lost a job and will only acknowledge being “slightly upset,” you can still use the NURS skills effectively.

Some new learners resist emotion-seeking and empathy skills, usually because of unfamiliarity. They worry that these skills will seem forced and false. It may be helpful to recall the compelling scientific rationale for using them (see Appendix B). It may indeed feel awkward and contrived at first for some but, as self-consciousness is overcome, confidence is gained, and benefit to the patient is observed, most clinicians become converts, recognizing that they feel progressively more comfortable themselves, that their responses become quite genuine, and that patients respond favorably to this emotional connection, sometimes even saying, “You know, I’m feeling better already.”

**Continuation of Ms. Jones Visit**

**Clinician:** So, you get mad when he gets on you?

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

**Clinician:** You get furious. 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. Maybe you and I can
talk more later about how you might handle that. [The clinician names the feeling using her exact word—furious, expresses understanding briefly, and spends more time expressing respect for her: acknowledging she had been through a lot, that she was successful at work, and praising her for talking about her emotions. Finally, the clinician supports the patient by offering to work with her on managing her anger.]

**Patient:** That would probably help. Just talking about it gets me upset and gives me a headache, right now. [This further demonstrates the association between headaches and emotional upset, now occurring as a result of anger-laden material during the interview.]

**Clinician:** I can imagine. You’ve put up with a lot. [Naming “mad” or “furious” again is unnecessary because it’s obvious, but the clinician again indicates understanding and makes a respecting statement.]

**Patient:** 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 deepens as the narrative thread further unfolds.]

**Clinician:** That’s a tough situation. [Clinician again respects, using just one of the NURS quartet.]

The rich description of symptom(s), personal context, and emotional context obtained in the first four substeps of Step 4 provides the first chapter of the patient’s story. Subsequent chapters are developed by expanding the story as shown in Fig. 3-1 and described in substep 5 below. As you will learn next, subsequent chapters of the patient’s story do not usually return to symptoms, but concern just the evolving personal and emotional aspects of the story—the narrative thread.

**Expand the Story to New Chapters**

Let us review the sequence of skills outlined so far in Step 4: focusing open-ended skills followed by emotion-seeking skills and then empathy skills. This typically produces a beginning, but still incomplete, story. To develop the story further requires the repetitive, cyclic use of this sequence of patient-centered interviewing skills. Each cycle produces a deeper level of the story, another chapter. Personal information and its associated emotion(s) evolve in parallel—neither is more important than the other. This deepening of
the narrative thread occurs because empathy skills stimulate the patient to place new personal information “on the table,” offering you an opening to inquire about them and develop the story further. Then, you can return to emotion-seeking and empathy skills to develop the emotional dimension of the new data. Do this until you are satisfied with the depth of the story. The self-reinforcing effect of patients’ psychological statements and emotions is key to obtaining the full personal and emotional story. This does not mean that you should focus on just the personal or just the emotional aspect. Both are developed nearly simultaneously in a progressive unfolding of the narrative theme. Returning to a symptom focus is generally not recommended, rather, remaining in the personal, emotion realm will help you better develop the narrative thread.

The story will develop spontaneously as you repeatedly cycle through focusing open-ended, emotion-seeking, and empathy skills. As the patient becomes comfortable in expressing emotion, fewer of the emotion-seeking skills are needed and empathy and focusing open-ended skills alternate, taking the patient quickly to progressively deeper levels of his/her story.

You will find that in developing the story, you will have ideas (hypotheses) about what it implies. Paradoxically and distinct from the middle of the interview (clinician-centered part), you should not directly ask about your hypotheses until they have first been mentioned by the patient—only what is placed “on the table” for discussion by the patient can be commented on during this portion of the interview. This is a principle drawn from nondirective psychotherapy in which the meaning of an event or experience for the patient becomes apparent over time and without interpretations from the clinician. For example, if you thought a patient’s story about disliking a woman who
“looks like my wife” meant that the patient disliked his wife, you should not ask directly (“Don’t you like your wife?”) because it would insert new data (dislike of wife) into the conversation. Rather, get the patient to continue talking about what he put on the table by saying, for example, “Tell me more about your wife.” The hypothesis-testing process is analogous to dancing or playing jazz. While the patient leads the dance or musical performance, once the patient has led to a specific place, the clinician can maintain a focus on that spot.

**Continuation of Ms. Jones Visit**

Clinician: That’s a tough situation.
Patient: 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!

Clinician: The head of the Board? [The clinician shifts away from empathy 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 empathy skills.]
Patient: 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.

Clinician: Sounds like you didn’t get a full picture of this place. [Focusing open-ended summary, still trying to learn more new information]
Patient: Yeah, it’s not really fair.
Patient: How’s that for you? [Now back to emotion with a direct emotion-seeking inquiry]
Patient: Well I must sound kind of stupid, and I feel kind of sheepish; but mostly just mad.

Clinician: It makes sense to me, but I don’t understand why you feel sheepish. You did everything that you could. [Back to empathy skills with understand and respect statements. Notice how open-ended and relationship-building skills are interwoven to generate both emotional and nonemotional data. Notice also that one can indicate lack of understanding and ask for clarification.]
Patient: Yeah, I guess, but I still feel kind of dumb.

Clinician: Dumb? [Echoing; an obvious story is already present but the clinician is exploring further by again moving away from emotion.]
Patient: That’s what my mother used to say, that I was smart but dumb. You know what I mean?
Clinician: Smart with books but not so much with people? [A combination of a summary and an educated guess]

Patient: Yeah, maybe she’s right.

Clinician: How’d that feel, when she’d say that? [Back to emotion with direct emotion-seeking]

Patient: I felt 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. [Additional supportive data about the association of headaches and anger]

Clinician: So that made you mad, too. I’m impressed at how you’re able to talk about it and put this together. [Clinician uses a name and a respect statement. Depending on the time available, the clinician could have further addressed 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 empathy skills has been used to further develop the story.]

Patient: Well, I appreciate your saying that. Actually, it feels kind of good talking. [A positive response to this interaction and an indication of a good clinician–patient relationship.]

Clinician: Say more about that. [An open-ended request]

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

Clinician: He doesn’t want to talk about it? [Echoing]

Patient: No. I think he feels bad because he thought this was the best place for me to come.

Clinician: Well, I’m glad it’s been helpful here. You’ve really been open. [A support statement followed by a respect statement. An obvious new area for further discussion has been introduced, the patient’s husband, and this could be pursued further if time allowed. The patient also has referred positively to their present interaction. Simply acknowledging it, as the clinician did is appropriate.]

Patient: Thanks. My headache’s better now. It does help.

The first three chapters of Ms. Jones’ story are illustrated in Fig. 3-2.

Given the importance of the clinician–patient relationship, it is important to check how the interaction is going if the patient does not raise it. You can inquire directly, such as “So how are we doing here so far?” If you have been patient-centered, the response usually will be positive and you simply
acknowledge this; for example, “Good, it seemed like things were going OK to me, but I wanted to check.” When the patient mentions the clinician–patient relationship, as Ms. Jones did, this provides the answer about the relationship and you can simply acknowledge it. Of course, if the patient raises problems with the interaction, for example, getting tired, address these.

If an urgent personal problem exists, easily determined in 5 to 15 minutes, the patient may require additional time, even immediate action. For example, if you discover a patient is a victim of intimate partner violence, you may have to take additional time to ensure his/her immediate safety. In the absence of an urgent problem, the usual situation, prepare to transition into the middle portion of the interview when you have an understanding—not of the entire story, but of the most salient, immediate aspects of the patient’s story; that is, the first few chapters. Certainly, there is more to Ms. Jones’ story but, given time constraints and lack of urgency, these areas can be explored another
time, if at all. You will now have a good understanding and, most important, the patient feels understood, the essence of a good relationship.68

Ms. Jones’ colitis and recent cough have not yet been explored. This is usually done in the middle of interview, in other active problems (OAP) or past medical history (PMH), unless they already have arisen while talking about the chief concern. Most often, only the chief concern, negotiated by you and the patient, is explored in Step 4.

**TRANSITION TO THE MIDDLE OF THE INTERVIEW (STEP 5)**

Realizing that you will soon begin a more clinician-controlled interview process, you should anticipate ending on a positive, supportive note. You can weave the empathy skills into the summary (substep 1 in Table 3-6) and check the accuracy of the story (substep 2). Even in the most desperate situations, you usually can find something positive and supportive about the patient’s situation and provide some hope, even if only your personal support and availability.69

Step 5 is summarized in Table 3-6 and should take no more than 30 to 60 seconds. Notify the patient that the content of the interview and, more importantly, the patient-centered style are about to change (substep 3). Otherwise, the patient might be confused or taken aback because the clinician-centered style to follow places the clinician in much more control of the interaction.

**Continuation Ms. Jones Visit**

**Patient:** Thanks. My headache’s better now. It does help.

**Clinician:** So, you’re in a new job that hasn’t worked out quite like you were led to believe and that has caused you some upset with at least a couple of people and quite bad headaches. Did I miss anything you mentioned? [A nice summary. A positive tone to the interaction already exists and nothing further is needed; if the patient were distraught or upset, the clinician would highlight his and others’ support.]

**Patient:** No. I think you’ve pretty much got it.

**TABLE 3-6. Step 5: Transition to the Middle of the Interview (30–60 s)**

1. Brief summary
2. Check accuracy
3. Indicate that both content and style of inquiry will change if the patient is ready. Continue with middle of interview.
Clinician: If it’s OK then, I’d like to shift gears and ask you some specific questions about your headaches and colitis, as well as a lot of questions to get to know you better as a person. [The clinician is checking if it is satisfactory to change the subject and indicating what is going to occur.]

Patient: Sure, that’s what I came in for.

(Ms. Jones’ visit continues in Chapter 5)

BEYOND BASIC INTERVIEWING

We have already begun to develop a clear understanding of the patient’s story and the psychological, social, and emotional meaning it has for him/her. It is at this point that you can clarify your understanding of the story and begin developing preliminary hypotheses about what might be causing the problem(s) and what opportunities there might be to remedy them. Focusing open-ended skills, emotion-seeking skills, and empathy skills are essential for eliciting the required data, but there are many more skills in the experienced clinician’s toolbox. Prejudices, time pressures, and preoccupation with other issues, for example, can interfere with hearing the patient’s story. Take care of pressing personal or professional issues beforehand, relax, clear other issues from your mind, and focus on the patient. As noted above, it is often useful to breathe deeply or simply close your eyes and become aware of your state of mind and what you would most like to accomplish with this patient for a few seconds before entering the clinic or hospital room. This will help you listen at multiple levels,11,70,71 a skill that will improve over time as the basics described in this text become reflexive.

Attention to multiple levels means going 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. This requires attention to subtleties of grammar, syntax, verb tense, changes of subject, tone of voice, nonverbal cues, incongruity in verbal and emotional content, and understanding metaphors.72,73 These areas are addressed using the same basic skills; for example, “What do you mean when you say, ‘my daughter’s father’?”; “I’ve noticed you often say, ‘You can’t win for losing.’”

SUMMARY

The beginning of the medical interview consists of two preparatory steps during which we set the stage (Step 1) and the agenda (Step 2); followed by an open-ended beginning of the HPI (step 3), continuation of the HPI (Step 4),
and transition to the middle of the interview (Step 5). The transition (Step 5) prepares the patient for the more direct clinician-centered style of the middle of the interview. In Steps 3 and 4, you use the following patient-centered skills to “build the patient’s history”\(^60\): nonfocusing and focusing open-ended inquiry, rare closed-ended questions, emotion-seeking and empathy skills. The cyclic, integrated use of these patient-centered skills occurs in Step 4. These tools allow you to begin to understand the richness and complexity of the human condition.

Figure 3-3 summarizes the major events in the beginning of the medical interview. Usually, preparing the patient takes 1 to 3 minutes, eliciting the beginning of HPI (symptoms with personal and emotional contexts) takes 4 to 12 minutes, and making the transition takes 30 seconds. Using patient-centered interviewing skills primarily and delaying clinician-centered skills for 6 to 15 minutes will lead to the remarkable benefits described in Appendix B, for example, improved patient satisfaction, decreased risk of malpractice law suits, and improved health outcomes. After this investment, you will find the rest of the interview to be fairly easy and routine. The data you generate will be easily understood and usually describe the primary symptoms and their personal context. The mind–body connection will be established; data that will lead to a biopsychosocial story will begin to emerge; and, most important, the patient will feel listened to, understood, and cared for.
KNOWLEDGE EXERCISES

1. What is the truly patient-centered part of the 5-step method? What is the function of Steps 1 and 2?
2. When is interrupting the patient appropriate? How does one interrupt?
3. What kinds of concerns do patients present with?
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 experience when a good relationship occurs?

SKILLS EXERCISES

(Likely spread over several sessions)

1. Practice Steps 1 and 2 together in role play until you can do them without looking at the book to recall all the substeps. Work on simple opening statements for each step, including several substeps in one sentence or so. See the vignette of Ms. Jones and the demonstration video.
2. When question #1 is mastered, practice Steps 1 to 5 together in role play, covering all 21 substeps. Conduct the entire patient-centered interview in 10 to 15 minutes, spending about 1 minute each in Steps 1 to 3 and 5—with 5 to 10 minutes in Step 4.
3. After you can complete all steps and substeps in role play, conduct the same exercise with a real or a simulated patient.
   A. Problems to watch out for:
      a. Hurrying into the interview rather than engaging in some small talk to let the patient get comfortable with you.
      b. Inefficient agenda-setting, omitting repeated “what else” statements until you know all items the patient wants to discuss.
      c. Excessive time spent in Step 3 which is just a 30 to 60 second step where you simply listen attentively—after an initial open-ended question—the next comment you make that isn’t a continuer starts Step 4.
      d. Not touching the key bases in Step 4: symptoms, personal concerns, emotions
      e. Too little emotion-seeking
      f. Not enough NURS
      g. Not adequately signaling the transition
   B. With time and practice, you will notice the following markers of success:
      a. Smooth, seamless flow of data
      b. Understand mind–body links
      c. Ability to focus wherever you wish
      d. Ability to effectively and respectfully interrupt
      e. Control of the interview
      f. Skilled critiquing ability of your own and others’ interviews
      g. Efficient interview. Once facile with the 5 steps and 21 substeps, you will be able to conduct the patient-centered process in 6 to 15 minutes. With further mastery, you will be able to be equally effective in 3 to 6 minutes.
REFERENCES


30. Frankel RM, Morse D, Suchman AL, Beckman HB. Can I really improve my listening skills with only 15 minutes to see my patients? *HMO Pract.* 1991;5:114–120.


