

Interviewing a Patient

- The art of History-taking

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In the current medical scene, where a new test, thanks to a new machine appearing every hour, clinicians are prone to pay short shift to a patient's own version of the problem, and go for a battery of investigations loftily (or lab-oratorily) called Profile-this and Profile-that. Symptoms are fuzzy and cannot be measured, Signs and tests are demonstrable in terms of mm, ml, mg., giving you a measure of this and that, to create for the unwitting but willing patient, a thick file of objective tests that allow the clinician to say *Mea*-sure or I am sure. The patient develops a file-area of the yet undiagnosed illness. No wonder, iatrogenic illness and deaths, in all "advanced" nations including India, compete with cancer and car accidents. Physicians, (please) humble thyself!

Before expanding on the import of a good history, it pays to discover the BBB of modern medicine. BBB stands for Basic Binary Blindness. The animal or the plant body is made up of an assembly of Binary units 0 and 1, as in computer, the 0 representing the typical cell and 1 denoting the collagenous fibre to house the cell. Modern cytology and fibrology has, through intensive, extensive and expensive research arrived at the knowledge that, when it comes to the cell and fibre, modern medicine essentially knows next to nothing. The Blindness is Basic, and Binary. So humility is the basic virtue that no medical specialist can afford to do without.

Physicianly humility brings her/him to the importance of history, a tale told by the patient, listened to unhurriedly by the doctor, and helping the latter heuristically to even clinch the diagnosis *sans* any tests, or poking the patient in this orifice or that. Lexicon defines heuristic as that which helps/assists a discovery. Could we acronymically read

history as Heuristically Important Story Telling Of Recounter's Yatna (= dis-ease, pain, illness, problem).

We all rush through life so that we often hear but do not listen, and look but do not see. History-taking demands *off* the physician an unhurried, uninterrupted attention to what the patient recounts or relates. A leading question, never intimidating, is welcome to spur the patient on. The expression on the doctor's face is one of a student or a learner, ready to pick up from the Guru-patient the smallest clue, the gentlest hint. In epistemological parlance, the patient's own experience of the problem outweighs all the knowledge that the doctor's degrees could boast about. An ounce of experience outweighs a ton of knowledge. History-taking is a dialogue between the doctor-disciple and the patient-performer. A dialogue reported in the *New England Journal of Medicine* (USA) tells of a negro-lady-patient hesitating to confide into the solicitous doctor, with the argument that "Doctor I am afraid of you, for you are too well-dressed for me." The doctor is not to be overbearing, supercilious, accusing, or smacking of levity. A good history tells you the diagnosis, *albeit* in parenthesis. At the Melbourne General Hospital, they studied as to how many diagnoses could be precisely arrived at by history alone. The figure they got was a whopping 76%. Another 20% could be clinched by methodical, deliberate, bedside examination. Another 3% could be arrived at by routine tests on urine, stool or blood. Only 1 out of a 100 needed an X-ray *et seq.* It pays you to be patient with the patient's patient narration. Never forget the fact that a test or an investigation is like a leader. If the leader can lead, the leader can as well – and so often – mislead. Also, go to the etymology of the

word *investigation* to realize that it is rooted, basically in *vestige* = trace, or a footprint. Modern iatrogeny is the brainchild of modern test-mindedness, not only of the doctors but of the patients, their kith and kin, lawyers and judges as well. Paul Dudley White, famed US cardiologist and personal physician to US presidents has quoted an anonymous wit: "A doctor who cannot take a good history and a patient who cannot give one are in the danger of giving and receiving bad treatment."

One of the things the average doctor does not have time to do is to catch up with the things he didn't learn in school, and one of the things he didn't learn in school is the nature of human society, its purpose, its history and its needs... If medicine is necessarily a mystery to the average man, nearly everything else is necessarily a mystery to the average doctor.

-Milton Mayer

A medico can't afford to be bookish to the point of being a bore. She/he ought to be versed as much with Vinoba, Vivekanand, Voltaire and Volleyball as with Recent Advances, Modern Trends, Medline and Medlar. A verse-a-tile doctor adds spice to the patient's narration by comments that applaud the patient and expand the narration. This would mean that the doctor will see not an illness in a patient, but see the person who incidentally is carrying some illness. The story that would tell how cultured, informed or stoic the patient is, and that will allow tests and treatments to be suitably titrated. Just as the best war is one that was never fought, likewise the best test or treatment is one that, in the very first place never had had to be done. Many a good history resolves the fears, phobias and misgivings of the patient, who having come with a heavy face, leaves the

doctor's room charged with confidence and a smile on the face.

DOCTOR (one) implies Destruction Of Confidence Through Ostensible Ritual. DOCTOR (two) renders Development Of Confidence Through Organized Reassurance. DOCTOR- two does not sell a sop to the patient, but arrives at a scientifically based reassurance, that disburdens the harried patient.

Interviewing a patient in the ultimate analysis is to establish an intellectual and emotional rapport with the patient, who thereby is encouraged to share the doctor's knowledge as also her/his ignorance. If to a patient, with manifest cancer or cardiac problem, you honestly declare that the patient is fit enough to attend the healthy looking doctor's funeral, you are indulging not in dramatics, but merely uttering an age-old truth.

Think continually how many physicians are dead after often contracting their eyebrows over the sick; and how many astrologers after predicting with great pretensions the deaths of others; and how many philosophers after endless discourses on death or immortality.

-Marcus Aurelius
(121 AD - 180 AD)

It pays to tell your patient, and repeatedly to your own honored self, that the diseased do not always die, nor do the healthy always survive. With each breath, you and your patient, first INSPIRES and, then EXPIRES. So, if the next breath arrives, both live to talk. If it does not, the patient may face mortification of the doctor's demise. One Dr Banerjee, years ago stood on the stage to advise on how to prevent heart attack only to collapse from the same in the midst of his learned oration! Physician, humble and heal thyself, by paying heed to the person across the table.



Amazing.... Scrabble (sent by Ann Tacey)

PRINCESS DIANA When you rearrange the letters:

END IS A CAR SPIN

MONICA LEWINSKY When you rearrange the letters:

NICE SILKY WOMAN

Introduction: From Hahnemann to Today

ABSTRACT: I want to introduce this subject of Interview techniques from Hahnemann's eyes. Ie what the Master has said about it in the Organon.

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In the Organon of Medicine, Dr Hahnemann discusses history taking techniques, (without using the word interview) through Aphorism 83 to Aphorism 103, right from the method of collecting information to forming the totality of symptoms. It is different for acute and chronic cases, in hypochondriac patients, in the indolent and in epidemic and in sporadic cases. This too is individualization – the basic premise of the homoeopathic prescription.

So let us briefly run through History Taking

Dr Hahnemann says that the physician must know

- 1) How to ascertain what is to be known about the patient in order to cure the disease?
- 2) To gain knowledge about the instruments adapted for the cure ie the pathogenetic power of the medicines.
- 3) Know the most suitable method of employing medicines, ie artificial disease for the cure of natural diseases.

For the purpose of this issue, we will limit ourselves to the first, ie How to ascertain what is to be known from the patient in order to cure the disease?

However this can be and are only general directions, the physician has to bear in mind to use only what is applicable to use each individual case.

First and foremost the physician shall:

Be unprejudiced and of sound senses, be attentive in observing and fidelity in tracing picture and evolution of the disease.

He shall not be disturbed emotionally and shall not have fixed ideas beforehand which may make him prejudiced.

The patient details the history of his suffering while those in attendance would describe his complains and his behaviour and unusual changes they have noticed in him.

Tell the patient to speak slowly. Physician must keep silent while patient is narrating the symptoms; and not interrupt him unless he wanders to an irrelevant topic. If the patient is interrupted his chain of thoughts may break and he may not remember the same thing when asked again. Physician writes it down in the patient's expression, each symptom in a separate line one below the other. He can thus add when patient is subsequently asked details like what time it occurred, what kind of pain, what was the precise location? Describe in plain words.

However there shall be no leading questions which suggest the answer or whose answers are in yes or no.

If the details are not available by voluntary description, then physician has liberty to ask more precise and special questions. Eg What is the character of the stool, What kind of food he relishes, etc.

When the physician has finished writing down these particulars, he then makes a note of what he himself has observed.

Whether the disease has come on in a short time? Whether the chronic condition had an obvious cause, this the pt or his relatives would mention if they are privately and carefully interrogated. The questions should be framed wisely in certain cases of attempted suicide, excesses in alcohol, infection of venereal disease, unfortunate love, jealousy, worry, grief, family misfortune etc.

In chronic diseases, ask about the mode of living, diet and domestic situation to ascertain any maintaining cause. In females ask in detail about the menstrual history and obstetric history.

Each case must be considered as if it were something new and unknown and investigate thoroughly for itself, never substituting conjecture for actual observation, never taking for granted that he knows the case beforehand.

This type of interview would help the physician

to obtain an original unmodified picture of the disease or a portrait of the disease. Once the totality of the case is formed from this history the most difficult part of the task is accomplished.

Today the most important use of an interview is to use it as a diagnostic and curative solution. This will be demonstrated by some cases. Can we save this marriage? and by Dr Tiwari's article on Interview Techniques.

Therapeutic Interviewing Skills- an overview

ABSTRACT: *In this issue you will find various interesting articles, assembled together, truly masterpieces, penned down by the rich experience of our teachers. Not only experiences but difficulties faced while interviewing and how to overcome it. Same applies to this article where I took on the onus to write on the therapeutic part of the interviewing skills to break the monotony of how and what of -Interviewing techniques.*

This issue will help you to tackle all the difficult cases with ease such that in the end you will be left with an interviewing transaction which would leave you enough data to ponder upon and sketch a further course of action.

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Interview is primarily directional: From the interviewee → to interviewer.

Directional, yes, since when the patient comes to you he is full of events in his life. The responsibility is on the physician to direct the interview in such a way that it leads you in a direction so as to obtain information through which one can outline the exact portrait not to forget the key word directional, to interrupt when the data is going haywire.

A good interviewing is definitely a skill whether it is inbred or you have learned it.

It is not only artistic but also scientific.

One should not forget that interview is more than a simple communication.

That interviewing is one of many techniques

through which one person exerts influence over another, true both ways the doctor to the patient and the patient to the doctor. Interview is indeed a special instance of interpersonal relations.

The interview skills are important and in order to achieve it listening and understanding aspects of communication should be valued.

While we are at the novice stage, the training emphasizes a lot on teaching interviewing skills. Unfortunately there is essentially no single "correct" way to interview, nor can interviewing easily be taught. Good interviewing requires much practice, careful scrutiny of one's work and most important, an appreciation of fact that the interview is a human relationship. Thus it should take care of the confidentiality of the patients, his right to re-

veal what and when the patient wants to reveal the real life data.

THREE VARIABLES THAT AFFECT THE INTERVIEWER-INTERVIEWEE INTERACTION

1. Content

The content of the life events, whether it is interesting enough for the doctor to carry on the interview. There would be data which in the patient's view point would be not important because as a layman he does not realize the importance of it at the medical point of view.

2. Style of communication

Style of communication, the language of communication should be feasible so as to bring out the innermost feelings of the patient outright.

3. Quality of the interaction

Should put the patient at ease to reveal everything without any hesitation.

CHARACTERISTICS OF A THERAPEUTIC INTERVIEW

Here patient speaks openly, revealing themselves, and where the Counselor has to keep a tight rein on interfering, just offering openings to so that the interview continue in a manner where one gets a flow of events.

WHO CAN ELICIT A SUCCESSFUL INTERVIEW OR THERAPY SESSION?

- 1) An interview or therapist who is
 - a. Intelligent: He should be gifted, sharp, quick and alert to all the stimuli to pick up any data which is not harmonious.
 - b. Caring: Helpful, considerate, thoughtful, kind, gentle. Concerned for the well being of the patient.
 - c. Perceptive: Sensitive, observant, insightful for the troubles a person must be facing.
- 2) Real interviewing: This terminology tackles the Commitment from both the sides and the thinking process involves the best interest of the patient's problems and set a course of actions for the further interview.

Therefore a therapeutic interviewing is more dicey than an academic interview and consequently more effective.

PRELIMINARY CONSIDERATION

Purpose Of The Interview

The purpose of the interview is primarily information gathering and understanding. Although it is true that there is much similarity between a good interview and a good therapeutic session the purpose may derive cathartic or insightful benefit from the relatively concise investigation of the areas touched on in the interview.

Skilful interviewing allows patients and clients to reveal themselves in the context of a dyadic relationship.

Keeping in mind that understanding is often guided towards a specific end depending on circumstances and in order to foster the patients self-revelation the interviewer should refrain from following a structural format.

SPECIFIC INTERVIEW PURPOSES

a. DIAGNOSIS

Requirements for diagnostic classification should be fulfilled by Hospitals, Mental health Clinics, Social Agencies and Veteran Hospitals.

A Conceptual Diagnosis

- Is often useful.
- Which reflects the psychological processes underlying the patients problems
- Which incorporates both aetiology and prognosis

CONCERN OF A DIAGNOSIS

Whether or not the patient has psychiatric problems

b. PATIENT MANAGEMENT

Initial interviews must help the interviewer to decide on diagnosis and thus plan an appropriate treatment strategy.

If therapy is selected the interviewer must decide on:

- Individual therapy
- Group or family therapy
- Or a combination therapy
- Frequency of the sessions

An Interview Includes

- An understanding
- An explanation of the patients presenting com-

- complaint
- Conceptualization of the psychotherapy
- Diagnosis
- Treatment
- Recommendations
- And prognosis

The interview must be sufficient to provide the above information.

c. DECIDING A TEST BATTERY

DETAILED INFORMATION: Psychologist will need enough and detailed information to enable selection of an appropriate test battery.

d. DISPOSITION

Particularly in an inpatient setting an interview is often conducted with patients prior to discharge in order to assess their current functioning and assist them in making plans for readjusting, to living outside the hospitals and for follow-up outpatients visits.

e. TEST FEEDBACK

When conducting an interview for the purpose of giving test feedback to a patient or client the psychologist is normally doing most of the talking, which makes the situations different in this respect from the other interview situations.

f. history taking

The interview designed to elicit historical information alone is a specialized technique. These interviews should involve more structural format than the diagnostic interviews. A thorough history should include the following categories:

- Preliminary History
- Patients Narrative
- Personal History
- Medical History
- Occupational Data
- Sexual History
- Menstrual History
- Marital History
- Family history
- Addictions
- Family Mental History

The interviewer should make a special effort to note the patients own words as this method often

reveals salient information about the patients thought, attitudes and emotion.

g. THE SETTING

It is the clinician's responsibility to provide the patient with a comfortable, pleasant atmosphere in which he can talk about his problems, concerns and aspirations.

PHASES OF INTERVIEW

THE BEGINNING

A good interviewer understands that the interview begins at the time appointment is made. Discussion with the referring person prior to interviewing patient is not only good etiquette but also offer's the interviewer an opportunity to learn something of the background of the patient.

- **INITIAL OBSERVATION:** Observation begins as soon as the interviewer lays his/her eyes on the patient. On how the patients sits and respond to your initial greetings.
- **IN THE INTERVIEWING ROOM:** Interpretations of the patients behavior in these situations must be carefully made.

THE MIDDLE

- The presenting complaint
- Develop rapport
- Questioning
- Look for change
- Elicit effect
- Delusions and hallucinations
- Silence
- Verbal and non-verbal behavior

THE END

Terminating the interview is problematic for many interviewers usually because they are unsure what to tell the client or how to answer best the client's question. The interview session should leave the doctor with a considerable amount of portrayal of the patients problem and the patient should be left with a satisfaction that his problems have been discussed well and has been put across and should leave the interview session with an optimism that there is a solution.